

Bartlett Regional Hospital

Board Quality Committee

November 13, 2019

4:00 p.m.

Agenda

Mission Statement

Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

Call to order

Approval of the minutes – [September 8, 2019](#)

Standing Agenda Items:

- [2019 BOD Quality Dashboard](#)

S. Hargrave

Old Business:

- [Focus and Execute Summary Report](#)

Quality Dept.

New Business:

- 2020 Priorities
- [Person and Family Engagement Handout](#)

Discussion

Next Scheduled Meeting: January 8, 2020 4:15 p.m.

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Board Quality Committee September 18, 2019 Minutes

Attendance: Rosemary Hagevig (BOD), Brenda Knapp (BOD), Kenny Solomon-Gross (BOD), Sarah Hargrave (Quality Director), Rose Lawhorne (CNO), Deborah Koelsch (Clinical Quality Coordinator), Carmi Clark (Quality Data Analyst), Gail Moorehead (Education Director), Mark Johnson (BOD), Kevin Benson (CFO), Billy Gardner (COO), Bradley Grigg (CBHO), Marshal Kendziorek (BOD), Dr. Lindy Jones (BOD)

Approval of the minutes – July 10, 2019 – minutes approved as written.

Standing Agenda Items:

Quality Dashboard (reported quarterly) – Ms. Hargrave reviewed the Board Quality Dashboard. All scores look good. The HCAHPS Quarter 3 results were great. Currently, new initiatives were implemented to strengthen the relationship between patients and caregivers. Ms. Hargrave thinks this will help us increase our HCAHPS score next quarter. Severe Sepsis/ Septic Shock Measure is at 54%. There was a spike in Readmission rates for Quarter 2 but we continue to monitor. Heart Failure Readmission rates are 0. The Screening for Metabolic Disorders measure continues to be a strong performer.

Discussion was held on the impact to patient satisfaction of redundant questions from hospital staff as patients move through the hospital system.

Mr. Garner mentioned the ongoing construction at RRC and asked if it is affecting our HCAHPS scores. Ms. Hargrave will monitor the Cleanliness and Quietness results next quarter.

New Business:

Value Based Purchasing Summary Report

Ms. Hargrave presented the Hospital Value Based Percentage Payment Summary Report for Performance Period 1/1/2018-12/31/2018. The Hospital Value Based Purchasing (VBP) Program is a Centers for Medicare and Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for quality care provided to Medicare beneficiaries. VBP is also required by Congress. This ties hospital reimbursement to the quality of care, not just the quantity of inpatient acute care services provided. As a result of our high quality care on the safety measures, HCAHPS measures, and clinical outcomes metrics, Bartlett will see a net increase of 1.43% on our DRG payments beginning in October of this year. In addition, our Medicare Spending per Beneficiary is below the national median.

Patient Family Engagement

Ms. Moorehead presented the CMS Person and Family Engagement strategy. It is about proactive communication and partnered decision-making between healthcare providers and patients, families and caregivers.

The current projects in progress are Bedside shift reporting, Pre admission Checklist, Patient Portal Collaboration and Website Improvements.

There are several future projects coming up including Admission Paperwork and Process, Rounds with Families and Community and Hospital Information Sessions. The new Patient Family Engagement Coordinator is Autumn Muse, BSN, RN.

There was a discussion about the handoff process between ER Physicians and Admitting Physicians. Ms. Hargrave will check with Dr. Benjamin and Dr. Jones about exploring this addition to the physician hand-off project.

Mr. Benson shared about an Admission App that allows patients to fill out their registration when they arrive in to the hospital on an IPAD. Ms. Hagevig pointed out that not all patients are familiar or comfortable with new technology.

Old Business:

OPPE

Ongoing Professional Practice Evaluation (OPPE) is a requirement by CMS and The Joint Commission (TJC). It is a routine monitoring and evaluation of current competency and professional behavior. Provider scorecards are provided to Credentials committee to be considered during reappointment. The goal is to allow the organization to identify professional practice trends that impact on quality of care and patient safety. The challenge in this process is finding metrics that are meaningful to rate. Ms. Hargrave presented the sample Ongoing Professional Practice Evaluation Scorecard.

RCA2

Ms. Hargrave presented the update of the RCA2. The Goal is to identify system vulnerabilities so they can be eliminated and mitigated. The outcomes on this process are Physician and Nurses engagement, Structures and Solution Focused. Ms. Hargrave reports the Year to Date results from this project. There were 9 RCA2 completed and 6/9 had intermediate or strong action plan elements.

SEPSIS

September is Sepsis Awareness Month, the Sepsis Process Improvement (PI) team has organized activities to spread awareness to staff and the community. There are newly designed badge buddies for clinical staff, Pink cake and lemonade was distributed in the hospital cafeteria on World Sepsis day (Sept 13), bulletins boards in the hospital are updated with Sepsis Awareness information. Next week, the Sepsis PI team will visit the units and ask Sepsis Trivia questions and give away some prizes.

There is a new Sepsis Care Pathway starting September 30th at Bartlett Regional Hospital. This includes Code Sepsis and the Code Sepsis paper tool.

Ms. Koelsch added that there were approximately 25-30 Sepsis cases each Quarter here at Bartlett. The Sepsis Early Management Bundle Compliance has increased compared with last year. A higher score is better. Bartlett Regional Hospital's goal for the measure is 55%. June, July, and August (to-date) data exceeded this goal.

Dr. Lindy Jones added with the i-STAT starting last August we might see improvements in the Sepsis measure rate. The i-STAT machine delivers faster results at bedside for certain lab draws.

Next Quality Board meeting: November 13, 2019 4:15PM

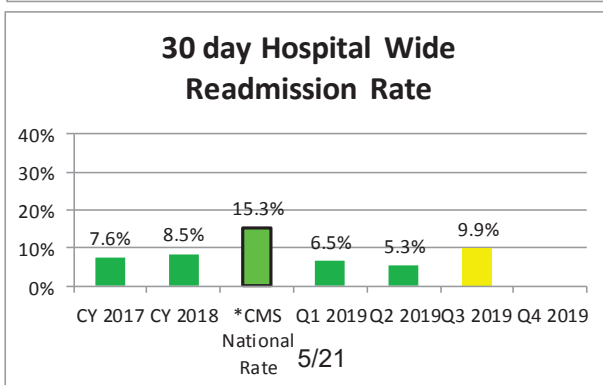
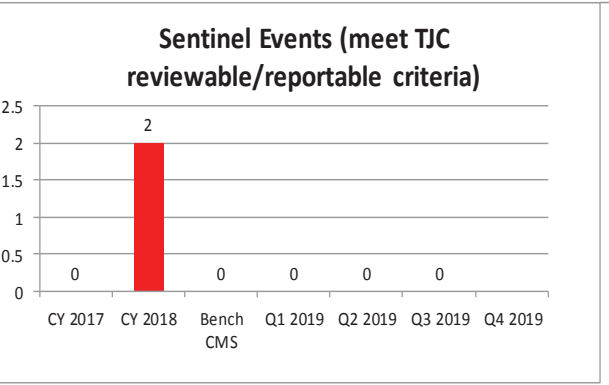
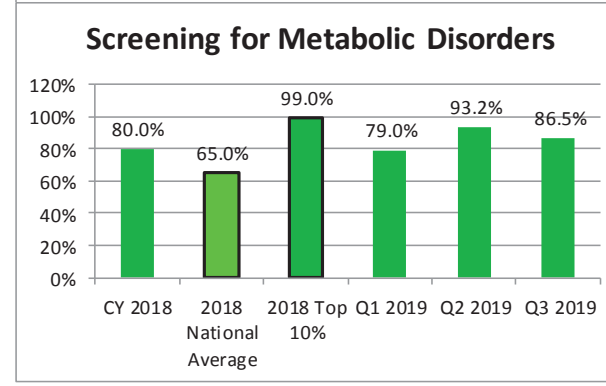
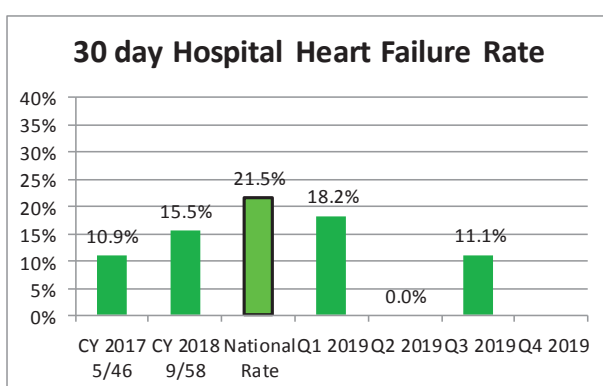
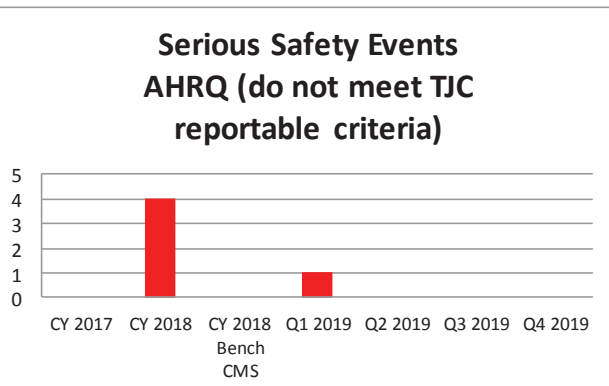
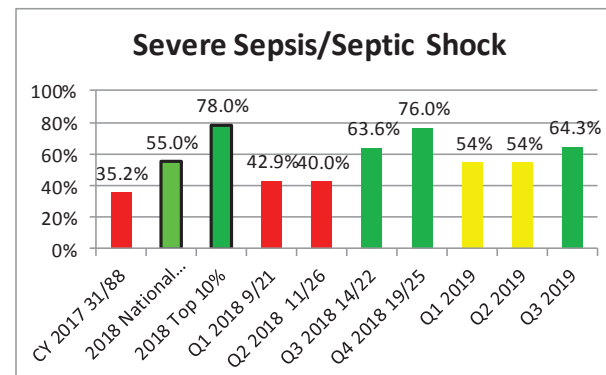
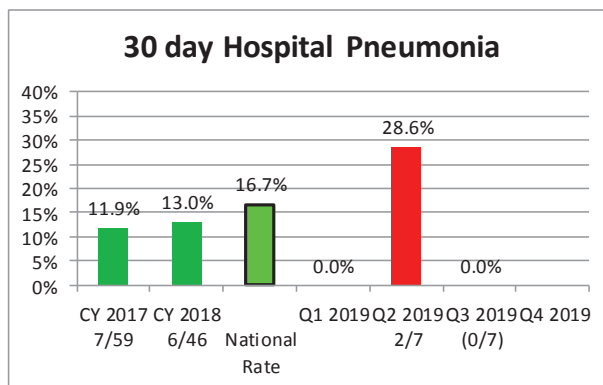
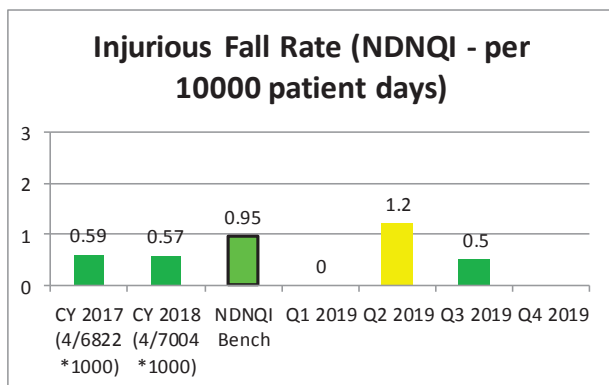
Adjourned at 5:00 pm

DRAFT

RISK MANAGEMENT—lower is better

READMISSION RATES— lower is better

CORE MEASURES—higher is better



Notes:

Risk Management: Adverse Medication Event Rate: defined as rate of reported events of harm (potential or real) experienced by a patient as a result of exposure to a medication. **Fall rates** are per the NDNQI definition: Med/Surg and CCU only with injury/minor or greater). **SSEs:** An event that is a deviation from generally accepted practice or process that reaches the pt and cause severe harm or death.

Readmission Rates: **Pneumonia and Heart Failure:** patient is readmitted back to the hospital within 30 days of discharge for the same diagnosis. **30 day:** patient is readmitted back to the hospital with 30 days of discharge for any diagnosis.

Core Measures: **Sepsis:** measure that demonstrates use of evidenced based protocols to diagnose and treat Sepsis.

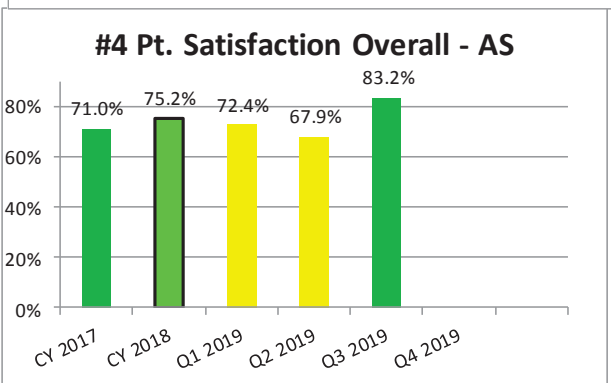
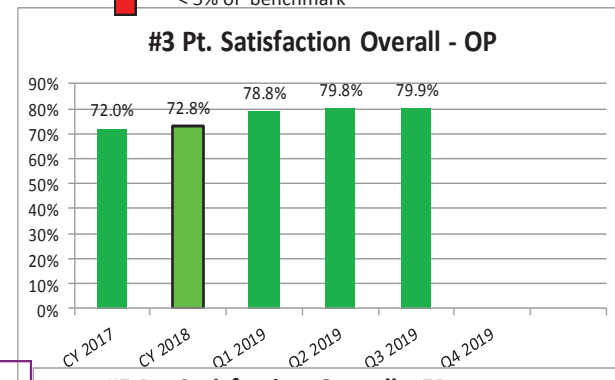
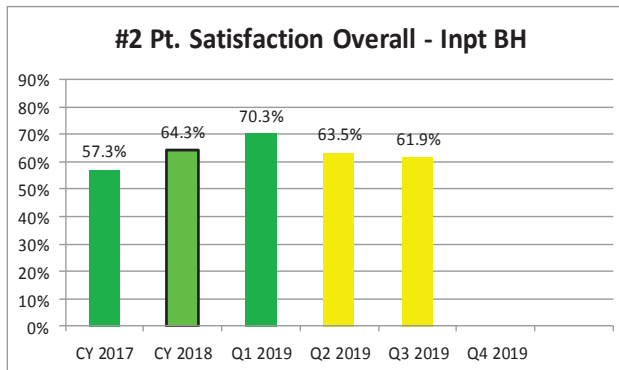
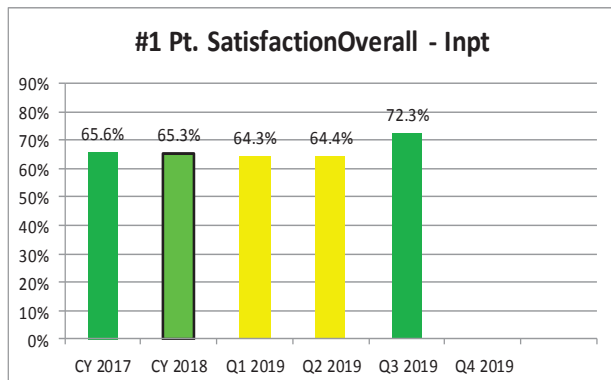
Screening for Metabolic Disorders: % of psychiatric patients with antipsychotics for which a metabolic screening was completed in 12 months prior to discharge

Indicates Benchmark ■

<https://www.medicare.gov/hospitalcompare/search.html?>

BOARD OF DIRECTORS QUALITY SCORECARD—

■ At or above benchmark
■ Within 5 % of benchmark
■ < 5% of benchmark



Notes on Patient Experience:

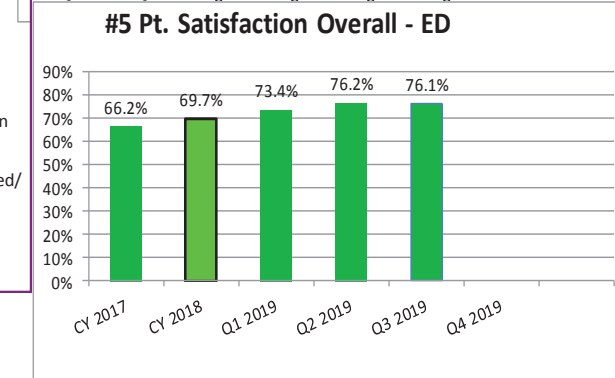
Press Ganey is the vendor for CMS Patient Experience and HCAHPS Scores.

** publically reported

#1 , # 3, #4 and #5 benchmark is 2016. Benchmark for #2, not a full year r/t new domain added in 2016

HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems: includes only Med/ Surg, ICU and OB

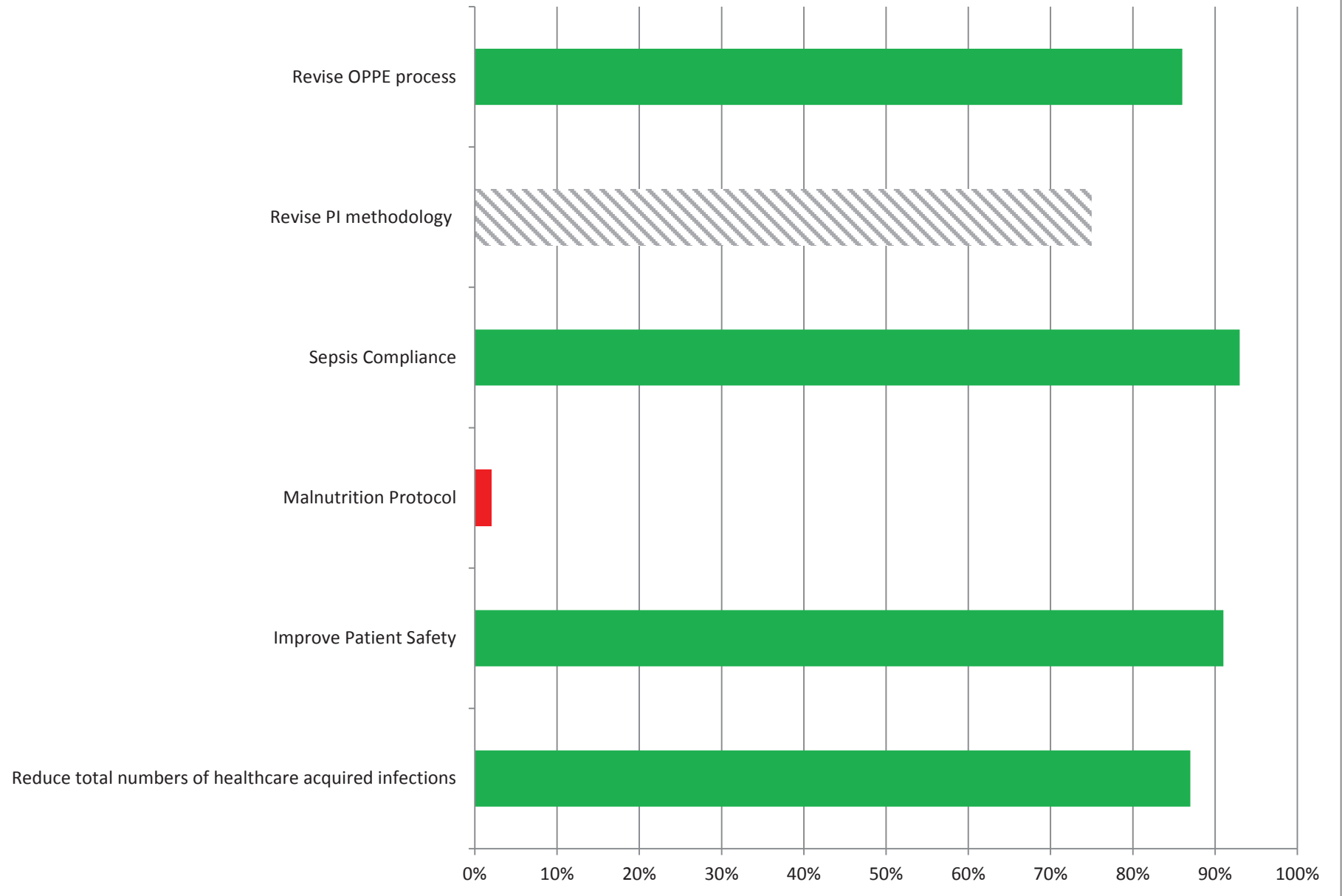
Top Box: HCAHPS results are publicly reported on Hospital Compare as “top-box,” “bottom-box” and “middle-box” scores. The “top-box” is the most positive response to HCAHPS Survey items.



HCAHPS Results 2017-2019 current

CAHPS	2017	2018	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	CMS Achievement Threshold	CMS Benchmark (top perf.)
	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	01/2017-12/2017	01/2017-12/2017
Overall Rating	74.5 ▲	74.1 ▼	72.3 ▼	70.6 ▼	79.1 ▲	75.0 ▼	69.4 ▼	71.6 ▲	80.8 ▲	70.85%	84.83%
Comm w/Nurses	82.5 ▲	81.4 ▼	82.8 ▲	77.3 ▼	85.6 ▲	80.6 ▼	85.3 ▲	84.2 ▼	85.2 ▲	78.69%	86.97%
Comm w/ Doctors	86.2 ▲	84.5 ▼	86.5 ▲	81.0 ▼	85.0 ▲	86.3 ▲	90.6 ▲	83.5 ▼	89.4 ▲	80.32%	88.62%
Response of Hosp Staff	75.7 ▼	76.3 ▲	72.6 ▼	77.8 ▲	80.3 ▲	73.9 ▼	83.8 ▲	68.6 ▼	78.4 ▲	65.16%	80.15%
Comm About Medicines	66.3 ▼	66.0 ▼	73.0 ▲	67.1 ▼	63.6 ▼	60.6 ▼	60.8 ▲	71.6 ▲	70.0 ▼	63.26%	73.53%
Cleanliness and Quietness of Hosp Environment	70.4 ▼	72.5 ▲	75.8 ▲	72.1 ▼	72.7 ▲	69.7 ▼	64.0 ▼	66.6 ▲	74.9 ▲	65.58%	79.06%
Discharge Information	89.4 ▲	86.8 ▼	85.3 ▼	87.7 ▲	87.2 ▼	86.9 ▼	88.3 ▲	88.6 ▲	89 ▲	87.05%	91.87%
Care Transitions	55.8 ▲	55.3 ▼	58.4 ▲	51.2 ▼	55.8 ▲	56.5 ▲	58.0 ▲	57.1 ▼	64.0 ▲	51.42%	62.77%

2019 Strategic Priorities: Quality and Safety



PERSON & FAMILY ENGAGEMENT STRATEGY

Sharing With Our Partners



INTRODUCTION

The purpose of this strategy is to...

- 1 Enhance person and family engagement (PFE).
- 2 Establish definitions and consistency for frequently used terms to help people engage in their healthcare.
- 3 Serve as a guide to support meaningful, intentional application of person and family engagement principles to all policies and programs addressing health, and wellbeing.
- 4 Create a foundation for expanding awareness and enhance person and family engagement.

Person and family engagement goes beyond informed consent. It is about proactive communication and partnered decision-making between healthcare providers and patients, families, and caregivers. It is about building a care relationship that is based on trust and inclusion of individual values and beliefs.

Who Is This Strategy For?

Many partners are necessary and essential to successfully engage individuals in their healthcare. CMS hopes that a wide variety of stakeholders will be able to utilize this strategy to expand and spread PFE values, goals, and culture.

Partners:

- Federal, state, territorial, tribal, and local governments
- Business
- Industry
- Private sector
- Professional philanthropic organizations
- Community and faith-based organizations
- Beneficiaries and other citizens

CMS has developed this strategy to share the Agency's person and family engagement vision and encourage the entire healthcare community to consider and take action to incorporate the principles into their work practices.

A Call To Action

This document serves as a guide for individuals and groups looking to incorporate PFE principles into clinical practice, program development, community health initiatives, and other arenas where shared decision making and appreciation of individual values are paramount. This document also provides people with tools and methods to become engaged in their care.

Some specific examples of how this document can be used to:

- Broaden and deepen awareness of PFE principles
- Advance understanding and definitions for common PFE terms
- Identify the values and foundational principles used by CMS to inform and support PFE programs and initiatives
- Understand how PFE is integrated into CMS' overarching goals, through its inclusion in the CMS Quality Strategy and other strategic agency priorities
- Obtain insight into the goals, objectives, and desired outcomes CMS is pursuing in relation to PFE
- Highlight areas where CMS is driving implementation of PFE principles
- Identify potential areas for collaboration between CMS and other stakeholders
- Identify what the next steps are in moving forward with PFE work

Definitions

CMS Definition of PFE

“Patients and families are partners in defining, designing, participating in and assessing the care practices and systems that serve them to assure they are respectful of and responsive to individual patient preferences, needs, and values. This collaborative engagement allows patient values to guide all clinical decisions and drives genuine transformation in attitudes, behavior, and practice.”



Person

The term “person” is used to reflect an individual’s identity as more than a patient, to recognize his or her participation in prevention and wellness.



Family

The term “family” is used broadly to include participants in a person’s healthcare including informal caregivers, along with the primary caregivers of persons who are person who are in need of the support of their caregivers to make informed healthcare decisions.



Provider

The term “provider” refers to any provider of care and services including both individuals and institutions.



CMS PFE Values

Person Centered – CMS puts the best interest of the public first and actively encourages persons to engage with their providers, and empowers patients and advocates to communicate their personal preferences. CMS applies PFE best practices by meaningfully including patients and advocates in their policy discussions.

Health Literacy – CMS recognizes the importance of health literacy and its role in improved health outcomes. Recognition of low health literacy is essential to ensure every person is able to understand the information presented to them, and able to make informed decisions about their care. Documented information provided to the person and/or family should include definitions of medical terms, diagrams, and pictures of functions and common language in concise single concept sentences for enhanced readability at all levels. Providers, practitioners, and community partners should tailor their guidance and support to accommodate the individual needs of those for who they are providing care and services.

Accountability – CMS has a unique and privileged role in the healthcare of our nation and earns trust by taking responsibility for the outcomes of its actions. CMS continually strives to include the patient’s voice, data and evidence in its policy decisions and seeks to make information transparent. CMS provides a structure between the providers of healthcare and the recipients of that care, which encourages persons and providers to co-create their healthcare goals.

Respect – CMS recognizes that a successful person-centered approach requires mutual respect between individuals and the providers of their care.

These PFE values will strengthen
CMS’ ability to reach the three broad aims of
the National Quality Strategy:



Affordable
Care



Healthier People
and Communities



Better
Care

CMS PFE Foundational Principles

Promote Informed Decision Making: CMS wants individuals to have meaningful tools and information for making decisions about their health and participating in bi-directional decision making with their providers. Through a secure environment that is respectful of privacy, CMS also aims to give individuals electronic access to their health information, and encourages the use of web portals to obtain reliable information about healthcare conditions and related information.

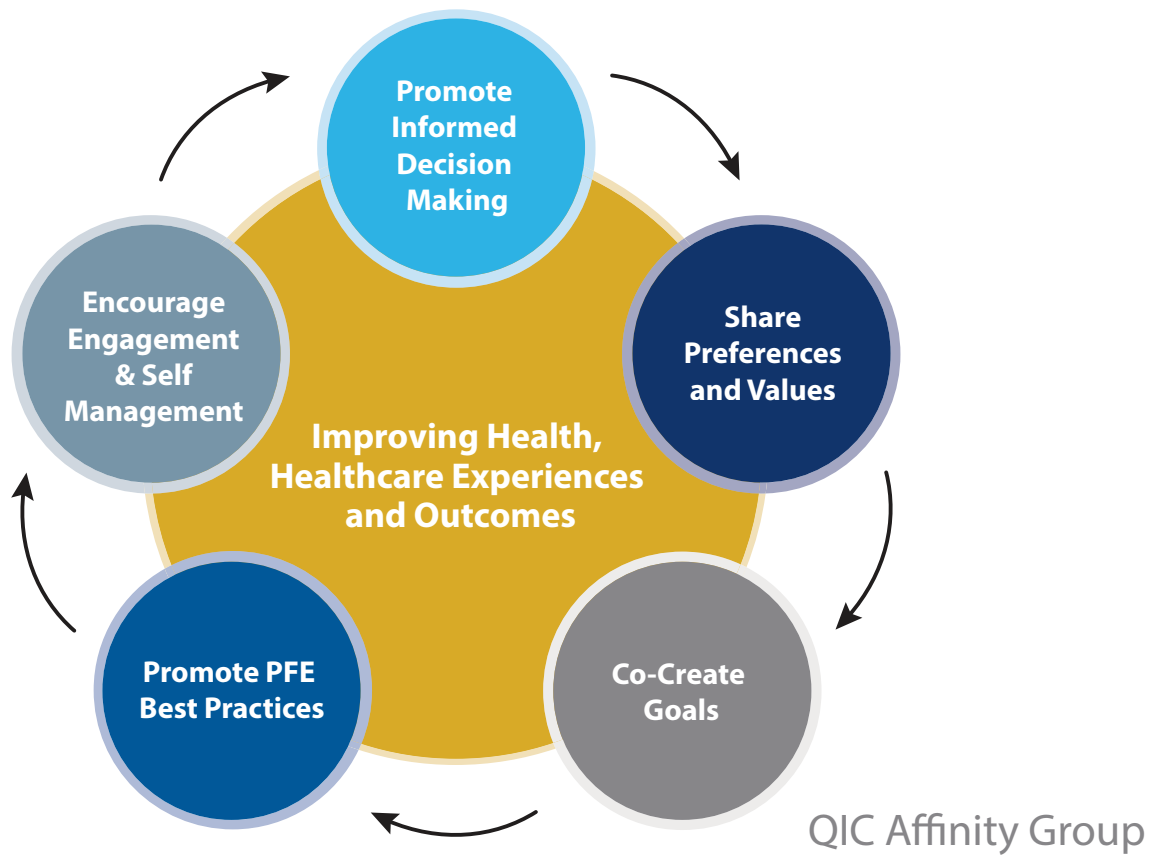
Share Preferences and Values: Persons who are engaged in their care are empowered to communicate their health-related preferences to their healthcare provider. CMS encourages persons to achieve their own optimal results, and providers should engage with persons, families, and caregivers to set realistic goals based on these preferences and values.

Co-Create Goals: CMS encourages persons having a clear understanding of their circumstances, diagnosis, prognosis, and healthcare options. Based on this, persons can work together with their healthcare providers to co-create goals to ensure that individual preferences are considered in the healthcare goal setting process.

Promote PFE Best Practices: Providers should have access to person and family engagement best practices and techniques that improve experience of care for persons and families.

Encourage Engagement and Self-Management: Individuals' accountability and responsibility for their healthcare should be increased. CMS encourages providers to actively engage persons and families in discussions about their healthcare self-management, taking both preventive measures and active steps to improve their health. It is essential to regularly ask individuals about their priorities and experiences to identify any obstacles related to self-management.

Foundational principles guide CMS' actions in achieving its goals for PFE.

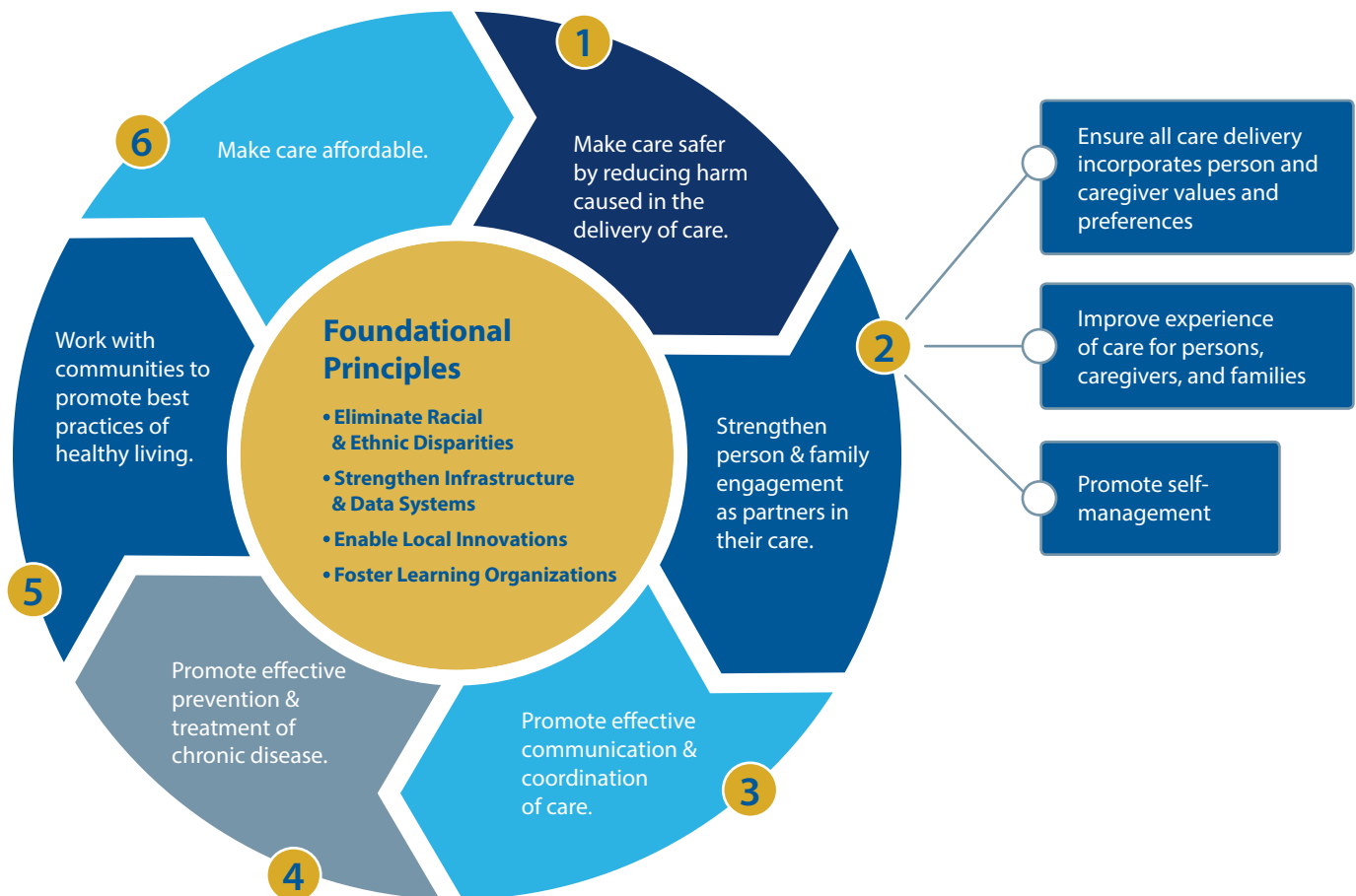


Alignment to the CMS Quality Strategy

CMS is working to build a healthcare delivery system that is better, smarter, effective, and efficient, – a system that delivers improved care, spends healthcare dollars more wisely, and one that makes our communities healthier. Built on the foundation of the CMS Strategy and the HHS National Quality Strategy, the CMS Quality Strategy identifies 6 priority areas of focus. The PFE Strategy directly aligns with one of these priority focus areas.

CMS Quality Strategy Goals

Better Care. Healthier People. Healthier Communities. Smarter Spending.



== PFE STRATEGY GOALS ==

Goal 1: Partnership with Communities

Actively encourage person and family engagement along the continuum of care within the broader context of health and well-being, and in the communities in which they live. This will exceed the traditional boundaries of setting-specific care, and will identify opportunities to bridge and forge partnerships among providers, persons, and community resources.

Goal 2: Values, Preferences & Self-Managing Care

Promote tools and strategies that reflect person and/or family values and preferences and enable them to actively engage in directing and self-managing their care.

Goal 3: Creating a Culture of Partnership

Create an environment where persons and their families work in partnership with their healthcare providers to develop their health and wellness goals informed by sound evidence and aligned with their values and preferences.

Goal 4: Experience & Best Practices

Improve experience and outcomes of care for persons, caregivers, and families by developing criteria for identifying person and family engagement best practices and techniques in the field from CMS programs, measurements, models, and initiatives, that are most ready for widespread scaling and integration across the country.

Goal 1 Partnership with Communities

Actively encourage person and family engagement along the continuum of care within the broader context of health and well-being, and in the communities in which they live. This will exceed the traditional boundaries of setting-specific care, and will identify opportunities to bridge and forge partnerships among providers, persons, and community resources.

Identify and promote community resources already in place that are culturally and linguistically appropriate.

- Duplication of effort is minimized and we build upon existing resources and best practices.
- Community partners learn from one another and encourage ongoing improvement.
- Health and well-being is promoted across all settings of care.

Enhance existing relationship between trusted community partners and patient advocates (e.g. senior centers, libraries, and faith based organizations).

- Goals/efforts identified by the community are based on needs and preferences of the citizens.
- Community partners use two-way communication with healthcare providers/systems to guide priorities within each community.
- Community partners support and form alliances with each other.
- Community partners are relied on for continuing education and efforts.



Goal 2 Values, Preferences, & Self-Managing Care

Promote tools and strategies that reflect person and/or family values and preferences and enable persons to actively engage in directing and self-managing their care.

Promote deployment of self-management and empowerment programs.

- Persons and families believe that engaging in their care and partnering with providers and organizations will help improve the quality and safety of care.
- Persons and families have awareness of and access to promising practices and tools that reflect their personal values and preferences.
- Healthcare navigators, electronic healthcare information, and translation services are used more often.
- New population based payment models include the perspective of persons and families in program design and development.
- The shared decision making process is documented (including all preferences, goals, treatment plans, treatment risks, and benefits) in the medical record or electronic health record.

Create, expand, and maintain National Person and Family Engagement (PFE) Networks, including National Patient Advisory Councils.

- Individuals have access to advocates who can assist them in navigating the healthcare system and/or aid in developing effective communication strategies for discussing health goals with their providers, practitioners, and community partners.
- Individuals feel they have access to the support they need to make the healthcare decisions that are most likely to improve their health.
- Persons and families experience better quality, improved experiences, and greater satisfaction through improved access to necessary healthcare or community resources such as transportation or language access services.

Incorporate and integrate person and family centered initiatives into CMS programs addressing healthcare quality, disparities, regulations, and Conditions of Participation.

- Persons and families are active partners in identifying, obtaining, and maintaining their health and wellness needs to enable them to achieve better health, better care, and lower costs.
- Future CMS policies, programs, quality measures, and innovations in payment models are developed with intentional alignment with the PFE strategy goals and desired outcomes.
- Persons receiving care and their advocates are included in the CMS policy and program design and decision making.
- Among persons who rely on others to manage their health, the identity of the person who helps them is documented by providers and support this relationship in the decision making process.
- CMS consistently uses a person-centered approach to policy and program design and decision making.





Goal 3 Creating a Culture of Partnership

Create an environment where persons and their families work in partnership with their healthcare providers to develop their health and wellness goals informed by sound evidence and aligned with their values and preferences.

Develop and promote the use of person and family experience surveys and quality outcome measures that evaluate the impact of best practices across the entire healthcare system, promote healthcare quality improvement and align results with CMS’ person and family directed goals.

- Experience surveys are designed in a way that makes it easy for recipients of care and their family and caregivers to express concerns and self-manage personal health and wellness goals
- Experience surveys are translated into multiple languages as appropriate, are administered via a method that improves response rates for limited English proficiency (LEP) populations and include appropriate questions about the availability of language services.
- Experience surveys are used to identify individuals with language or literacy assistance needs and survey results are utilized to improve health literacy and/or health outcomes.
- Quality measures are developed that are of value to persons, families and providers and are informative in decisions about care
- Persons, families, and providers collaborate to identify survey results and quality measures to implement the best practices for improving individuals’ expression of concerns and self-management of personal health and wellness goals.
- Experience surveys and quality measures incorporate family perspectives, concerns and objectives for persons who rely on a family member to enact their health and wellness goals.

Encourage a partnership between providers and the patient and families to co-create health and wellness goals.

- Healthcare providers across the continuum of care attend educational programs on improving person and family/caregiver experience, as well as form partnerships to develop and achieve person-directed health and wellness goals.
- Recipients of care and their family/caregivers have information, resources, and education on how to partner with providers in co-designing and managing health and wellness goals.
- Providers, persons, and families have the culturally and linguistically appropriate information and resources needed to participate in pertinent health prevention and care management initiatives such as the Million Hearts Campaign, CDC’s Prevent Diabetes STAT, Everyone with Diabetes Counts.
- Providers, persons, and families have information and education on resources to complete advance directives that align with the person’s wishes concerning end-of-life treatment and care.
- Providers receive training on how to initiate and participate in end-of-life treatment and care discussions with persons and their families/caregivers.
- Providers are strongly encouraged to designate specific time to initiate and participate in end-of-life treatment and care discussions with persons and their families/caregivers.

Goal 4 Experience & Best Practices

Improve experience and outcomes of care for persons, caregivers, and families by developing criteria for identifying person and family engagement best practices and techniques that are ready for widespread scaling and integration across the country.

Develop criteria, guidelines and/or standards for person and family engagement best practices and techniques that are aligned with CMS' PFE goals.

- PFE best practices and techniques are identified.
- The voice of the person and family is activity sought in the development of policy, programs, and innovative payment models.
- Increase access to understandable health information based on language and health literacy level.
- Measures of family engagement are identified and incorporated in the evaluation of PFE for persons who rely on a family member to enact their healthcare plan.
- Providers are trained to utilize standardized person and family engagement behaviors.

Improve PFE through widespread implementation of best practices

- PFE best practices and techniques are successfully implemented nation wide in healthcare settings and alongside community partners
- Peer-to-peer mentoring and technical assistance is provided with materials and templates that organizations and their healthcare teams can use while communicating with low English proficiency and low health literacy populations.

Implementation plan and strategies, resource allocations, and evaluation criteria are specifically re-assessed on an ongoing basis.

- PFE best practices and techniques are continuously improved and successful strategy methods for implementation are shared.



Engaging Persons and Families

CMS Recognizes that PFE is essential to the health and well-being of our communities, and is committed to supporting, implementing, and integrating PFE principles into all of our actions and programs. Examples of CMS initiatives that incorporate PFE principles include:

- CMMI: The Center for Medicare and Medicaid Innovation
- The Partnership for Patients (PFP) Person and Family Engagement Roadmap
- Coverage to Care Initiative CMMI’s Accountable Care Communities
- Medicaid Family Counseling Programs
- CMS experience of care surveys
- Quality Improvement Networks National Coordinating Center- Trends in PFE call series

CMS Integration of Person and Family Engagement

Communication	Preferences and Values	Collaboration	Engagement
Accommodate for different person/family literacy levels and disabilities (e.g. vision, dexterity issues, hearing).	Experiences from patient surveys are utilized to improve communication, engagement, and quality of care received.	Increase collaboration and sharing opportunities among coordinators, group leaders, and staff.	Creation of PFE emerging best practices inventory containing over 350 tools and resources.
From Coverage to Care: National initiative to support consumers with low health literacy and limited English proficiency.	Improve access to integrated community prevention efforts.	Provide schools, families, and communities with tools for promoting healthy living.	Identify patient centered measures.
Create and expand the development of a wide variety of resources available in multiple languages.	Treat family members with respect, provide emotional support for values and preferences.	Partner with all providers (e.g. pharmacists) to increase the understanding of medication side effects.	Encourage patient and family use of online resource center (e.g. use a mix of communication techniques, beneficiary liaisons).

== NEXT STEPS ==

CMS Next Steps

CMS is committed to furthering PFE work. Some next steps for the agency include:

Continuing to incorporate and promote PFE principles in our daily work

- Successfully achieve defined goals and objectives by including PFE principles into of all CMS' programs and policies.
- Monitor success indicators for each PFE goal and objective to assess impact and opportunities for improvement.

Partnering to create a better outcome

- Continually soliciting feedback from stakeholders to inform and enhance PFE work across the agency.
- Expand existing avenues for two-way communication existing avenues for two-way communication with beneficiaries.

Strengthen PFE principles over time

- Continuously strengthen PFE principles.

What Are Your Next Steps?

CMS challenges you to evaluate your programs and take action in incorporating PFE related concepts to improve how you interact with persons and their families, ultimately improving their experiences and outcomes.
