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Improving HCAHPS Scores for SETMA – A Disgusting Event and SETMA's Plan

It was really disgusting. I really wanted the HCAHPS experiment to fail. Why, because if it succeeds, it means I have to change how I have done inpatient care for 40 years of practicing medicine. Can an old dog really learn new tricks?! Two days ago, SETMA started trying a different approach to our inpatient care. I would still argue that the approach does not change the **science** of our healthcare, but it certainly will change its **sensitivity**. When I was explaining the program to my wife, she said, "Well, that's going to make you better doctors!" That's when the fight broke out! "We have always been good doctors!" I exclaimed.

But overnight and this morning, it began to dawn on me that my resistance to valuating an improvement in our **Hospital Consumer Assessment of Healthcare Providers and Systems** (**HCAHPS**) scores was really an indictment of my pretense of SETMA being a Patient-Centered Medical Home (PC-MH). We have been recognized and accredited as a PC-MH by two of the four agencies which evaluate practices for Medical Home functions. And, we are presently preparing to apply this year to a third for Medical Home accreditation and in 2014, we expect to apply to the fourth. This will make SETMA the first practice in America simultaneously to have approval by all four agencies (NCQA, AAAHC, URAC, Joint Commission). Yet, with all of that work, it only occurred to me today that HCAHPS is really a measure of the effectiveness of our patient-centered care. This experiencing is helping me understand more clearly why the Triple Aim phrasing has changed from "improving care" to "improving the patient's experience of care."

What was disgusting?

It is awkward for me to sit down in a patient's room. (Remember, a provider should never sit on the patient's bed, ever. Even if it means standing, don't sit on the bed.) I have always focused on making sure that

- all laboratory values, tests, procedures, consultants notes are reviewed;
- all procedures are addressed;
- all medications are correct,
- all diagnoses are correct and being addressed.
- all documents and orders have been signed

- all immunizations are up to date
- all discharge planning is done
- all care is done in a timely and efficient manner
- all discharge orders are given before noon
- all transitions of care needs are met and communicated to the patient

I did this like a machine and I did this well. But the one thing I often neglected was "how does the patient feel or think about all of this?" Then, there is the practicality of sitting down to talk to the patient. Sometimes, there is no chair to sit in. Sometimes a family member is occupying the only chair. Other times the patient's bed is higher than the available chair. Other times the only chair available is a lounge chair which is heavy and cumbersome to move into the view of the patient. But all of that seemed to dwindle in significance this morning.

I had seen three patients this morning, sitting with each, doing a proper history and physical, and then asking the patient if he/she understands the plan of care, giving the patient SETMA's printed Hospital Plan of Care and Treatment Plan, and then making sure the patient had no unanswered questions or unaddressed issues. I made sure that I listened as long as the patient wanted to talk without interruption.

Because I am generally the only physician on the ward when I round, I always have nurses with me. The nurses always have the current vital signs including bowel history, diet, appetite, etc. ready for me. Two of them commented how natural it appeared for me to sit and talk to the patient. They were encouraging about the new approach to "patient-centeredness" and then it happened.

Then the "disguising thing happened." As I had moved to the next patient's room, one of the nurses rounding with me walked up and said, "Mr._____, said, 'Dr. Holly has NEVER sat down and talked to me when I was in the hospital.'" The nurse said that she asked the patient, "How did you like it?" And she gave the patient's answer, "It was very nice!" Doomed!! If that doesn't take the cake I am stuck. **That which I would have argued creates inefficiency and is irrelevant to quality care is greatly valued by the patient!!**

The Program - In step with:

- SETMA's effort to respond to the patient-centered standards of HCAHPS and as
- SETMA has already prepared to contract with a vendor to achieve the **NCQA Distinction in Patient Experience Reporting***(see below for more information about this program) to help practices capture patient and family feedback through the newly developed **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home (PCMH) Survey**. Because consumer experience is a critical component of quality of care, giving more prominence to patient engagement is a crucial change to the PCMH program

SETMA's Plan of action is:

- Continue to expand our understanding of HCAHPS and of HCAHPS-PCMH
- Incorporate the following into our hospital care of patients:
- Knock on the door before entering in order to respect patient privacy
- Sit at eye level with the patient when addressing their care. Each provider will develop their own "style" some will examine the patient before sitting. Others will sit and talk and then examine the patient but all will talk to the patient rather than talk down at them. There will be exceptions such as in ICU because it is not always possible to sit and talk to the patient but is possible to sit when talking to the family.
- Offer the patient and/or family the opportunity to ask questions or to voice concerns without being interrupted.
- Beginning with the first visit determine if there are special care needs which must be met before the patient can be safely discharged home. This will include but not be limited to determining if the patient lives alone and if they do to have that documented in the patient's medical record. (Remember, that ICD-9 and ICD-10's code has a description of "Lives Alone," but that SNOMED, which all providers must use by 2015 describes this code as "Lives Along - No Help Available." This is the critical issue.)
- Also, at the first visit the attending physician will give the Hospital Plan of Care to the patient. This morning the nurse on T3 had placed those on the chart for two new admissions, because she heard me say yesterday that this will be the new SETMA plan. (The nurses especially like our new approach to rounding).
- Before terminating the visit every provider will ask, "Do you have any other questions or concerns?" "Do you have anything else on your mind that you would like to address?"
- Here is my contact information; don't hesitate to call me if you have a question or concern.
- I know that Dr._____is your personal physician. I will make sure that he/she knows that you are here and that he/she knows what is going on with your treatment.
- Have our Care Coordination include HCAHPS questions in their follow-up telephone calls. This will give us "real time" responses from all of our patients (not just a sampling) which will allow us to measure our own performance quickly) and it will let our patients know we value the quality of their experience.

New Information about HCAHPS

Who is included in and who is excluded from HCAHPS

(Hospital Consumer Assessment of Healthcare Providers and System)

Who is included in HCAHPS samples?

- Patients 18 years or older at time of admission
- Include patients of all payer types (not just Medicaid)
- Admission includes at least one overnight stay in the hospital
- Non-psychiatric patients (defined by MSDRG) as principle diagnosis at discharge

- Alive at time of discharge

Who is excluded from HCAHPS samples?

- "No-Publicity" patients
- Court/Law enforcement patients (i.e., prisoners)
- Patients with a foreign home address
- Patients discharged to hospice care
- Patients who are excluded due to state regulations

Baptist Leadership Group

http://www.healthstream.com/Libraries/whitePapers/HCAHPS_Imperative.sflb.ashx

This is the link to

The HCAHPS Imperative for Creating a Patient-Centered Experience
by Katie Owens Baptist Leadership Group 2011

Baptist Leadership Group is a consulting practice owned by **Baptist Health Care**, the nationally known pioneer of performance excellence in healthcare. We provide Patient Centered Excellence Consulting - the patient is at the center of everything we do. Our tools, tactics and best practices are evidence-based, outcomes driven, and tested and proven at our living laboratory at Baptist Health Care. We provide custom, individualized coaching that produces measurable, sustainable increases in patient satisfaction, employee engagement, quality outcomes, and profitability.

I am eager to see what the future holds, but there is no doubt that in a practical and real way, with this effort, SETMA has move a step closer to being a "real" Patient-Centered Medical Home.

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***NCQA's New Distinction in Patient Experience Reporting**

NCQA developed the optional Distinction in Patient Experience Reporting to help practices capture patient and family feedback through the newly developed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home (PCMH) Survey. Because consumer experience is a critical component of quality of care, giving more prominence to patient engagement is a crucial change to the PCMH program. The CAHPS PCMH Survey assesses several domains of care:

- Access
- Information
- Communication
- Coordination of care
- Comprehensiveness
- Self-management support and shared decision making.

NCQA PCMH-Recognized practices may use the CAHPS PCMH survey to obtain the distinction. Practices without recognition may still submit and CAHPS PCMH results, but may earn distinction only after achieving NCQA PCMH Recognition.

Submitted data will be used to develop a benchmarking database that will allow comparison across practices. In addition to earning distinction and being listed in directories as having distinction, practices will receive credit in PCMH 2011.
The program details include:

- Practices must use an NCQA certified vendor to ensure a standardized method of data collection and reporting. Click here for a list of trained and certified 2013 CAHPS PCMH survey vendors.
- NCQA-Recognized practices, or practices applying for recognition, are eligible for the distinction. All practices may submit data, but may not be eligible for the distinction. CAHPS PCMH Distinction Frequently Asked Questions for practices document is NOW available. Click here to access the FAQs.
- There are two data submission periods per year: the first is in April; the second in September.

The distinction is effective for one year after NCQA receives the practice's data. Practices must submit data annually (through the vendor) to maintain distinction. Practices have the option of submitting data during both data submission periods, but it is not required.