James L. Holly, M.D.

SETMA's approach to fulfilling the HCAHPS: Steps of action and SETMA's Video of our Care Transitions Process

Yesterday, July 15, 2013, Drs. C. Deiparine, Qureshi, Anwar, Leifeste, Holly and Brandon Sheehan met with the Baptist administrative healthcare team in a monthly review of SETMA's performance on inpatient care. The major discussion was around the HCAHPS patient satisfaction survey done by a contractor for Baptist. There was on the part of providers a sense of futility as the standard required is extraordinarily high and the judgment of whether or not a provider meets that standard is totally subjective on the part of the patient and/or patient's family. Because we deal with an extremely vulnerable population, including a large population of those who have not been part of the healthcare system previously, we find these standards difficult.

SETMA's goal is to solve this problem in a systemic and sustainable fashion rather than simply try to use gimmicks which are a hit and miss effort. And, it is our goal to solve this problem in a manner which will contribute to the quality of care all of our patients receive. SETMA requested a copy of the content of the standard and that has been given to us. (see the attached) We will review that this morning in our monthly provider meeting. A copy of the attached will be given to each of SETMA's providers and I will hold a meeting with our hospital care team and review it with them. SETMA's ***Seven Step Plan to meet HCAHPS Standard***::

1. **Hospital Admission Plan of Care** - For almost a year now, SETMA has been producing a document upon the patient's admission to the hospital which includes: diagnoses, reconciled medication list, procedures, tests, consultations planned for the hospitalization, potential for readmissions and detailed contact information. We are going to make one change. Rather than the hospital staff giving this to the patient, it will be placed at the front of the chart and the attending physician will give this to the patient and explained it to them. For those unfamiliar with this document a de-identified copy of a recent admission is attached above.

   The Hospital Care Team will review this document to see how we can strengthen it. We will ask the attending physician to note on the Daily Progress Note after admission that this document has been given to the patient and explained to the patient and/or family.

2. **Notification to the patient of the attending** - Our Hospital Care team will be given a script for how to address the identity of the patient's attending physician. It will say

something like, "I am a member of SETMA's hospital care team and I work closely with Dr. _____, who will be your attending physician for this admission. We know that Dr. _____ is your personal physician but he has asked Dr. _____ to see you during this hospitalization. All of your information will be communicated to Dr. _____ and I and your attending physician has access to all of your medical history and past medical treatment. Don't hesitate to ask us about your care. We will be happy to explain anything that is not clear. We want your hospital care experience to be a good one."

3. **For Those Who Round Early -** There is a tremendous advantage to the patient for early rounding, but on occasion (over 80% of the patients are awake and eager to talk to the doctor no matter how early he/she makes rounds. There is more frustration for the patient and family when the provider rounds very later in the day - after 3 PM - than when a provider rounds early), the patient is not alert. As a consequence, we will ask all provider who round before 6 AM to make the following statement to the patient AND to document this on the patient's chart.

   "SETMA has a healthcare team who works in the hospital all day to make sure that you get the care you need. That team communicates throughout the day with me (the attending), but because I round early, I know sometime all of your questions do not get answered. Therefore, the Hospital Plan of Care which I have given you has my office and cell phone number on it. If you have a question, call me. If your family or medical power of attorney would like to meet with me, call my office and they will schedule a conference at the office in the afternoon. It is important to me that you and I work together to provide you the best possible care. We start early because we do not want to waste your time and we want all of your care to begin as soon as possible."

4. **Further Step for Those Who Round Early** - When a patient's care is complex and when the patient is unable to comprehend their care and when others are not present, the attending will ask a member of the Hospital Care Team to return during the daylight hours to explain the plan of care to the patient's family and to arrange for a conference with the attending if it is desired.

5. **Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan** -- Upon discharge, the patient is presented with a copy of their Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan and their personalized Hospital Follow-up instructions. (A copy of that document is attached for the same patient whose Hospital Admission Plan of Care is presented above. In the past 4.3 years SETMA has discharged more than 21,000 patients from the hospital. 98.7% of the time, the Hospital Care Summary and the Follow-up instructions have been given to the patient at the time of discharge.

   SETMA's providers and hospital care team will review this document to make sure that it is complete and a renewed effort will be made to make sure the patient and/or family receives the Follow-up Plan with the following statement, "Dr. _____ has asked me to

make sure that you receive this document so that you know exactly what your care is to be. Is there anything you don't understand and are you able to care out these plans? Dr._____has asked me to arrange for you to receive a follow-up telephone fall tomorrow to make sure that you have your medications and understand you care."

6. **Care Coordination Follow-up Call** - Every patient discharged from the hospital receives a 12-30 minute telephone call from SETMA's Care Coordination Department the day after discharge. They will be instructed to say, "Your attending physician, Dr. _____, has asked me to call you to see if you have any questions about your hospitalization, your medications or your follow-up care." The Coordination Department will repeat the medication reconciliation and will review all follow-up plans.

7. **Follow-up with Primary Care Provider** - If a patient is high risk for readmission, he/she will be seen by SETMA within two days of discharge and if they are not they will be seen by their primary care provider within five days of discharge.

This process is sound; we will attempt to make it more personalized. The following is a video tape of SETMA's Care Transitions program. It is 120 seconds long and was requested by the Robert Wood Johnson Foundation:

James (Larry) Holly, M.D.
C.E.O. SETMA
www.jameslhollymd.com

Adjunct Professor
Family & Community Medicine
University of Texas Health Science Center
San Antonio School of Medicine

Clinical Associate Professor
Department of Internal Medicine
School of Medicine
Texas A&M Health Science Center