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SETMA's Care Coordination Department's Functions
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Formed as an integral part of SETMA's Patient-Centered Medical Home, the Care Coordination Department currently consists of four full-time staff members including the Director, a Care Coordination Technician, Registered Nurse and Licensed Vocation Nurse.

The Department began its work in August, 2010. At that time, there were two nurses that made calls to patients that were discharged from the hospital. Simultaneously with the creation of the Department, and after attending a Care Transitions Workshop at the National Quality Forum, the traditional **Hospital Discharge Summary** was renamed to **Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan**. This longer but more functional name became the hub of SETMA's Care Transition and established a seamless continuity of care between the inpatient and ambulatory care settings. It also became the laboratory in which other tools were developed in order to make sure that better care (a process) resulted in better health (an outcome). One of those tools is that now upon admission to the hospital, each patient receives a "Hospital Plan of Care," which tells them why they are being admitted, how long they should expect to stay, their risk of readmissions after being discharged, a reconciled medication list, planned procedures and tests, consultations, etc.

Pursuing the goals of the Institute for Healthcare Improvement's (IHI) Triple Aim, NCQA PC- MH, AAAHC Medical Home, and SETMA's goal of decreasing avoidable readmissions, a new function was added to the "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan" which is: the "Hospital Follow-up Telephone Call" and the "Clinic Follow-up Telephone Call." All patients discharged from the hospital receive a telephone call which lasts from twelve to thirty minutes. (With the frail elderly, the telephone call can last for two hours.) Following a clinic visit, when a patient's care is complex and adherence is critical, a function was established to enable a note to be sent from the healthcare provider in the clinic to the Care Coordination Department. This allows for a follow-up call to be placed to the patient; at the provider's discretion, that call can be scheduled for two days, three days, or for any interval chosen by the provider. SETMA's tutorial for the use of these follow-up-telephone functions can be reviewed at http://www.jameslhollymd.com/epm-tools/Tutorial-Hospital-Follow-up-Call.

Care Coordination Department Role

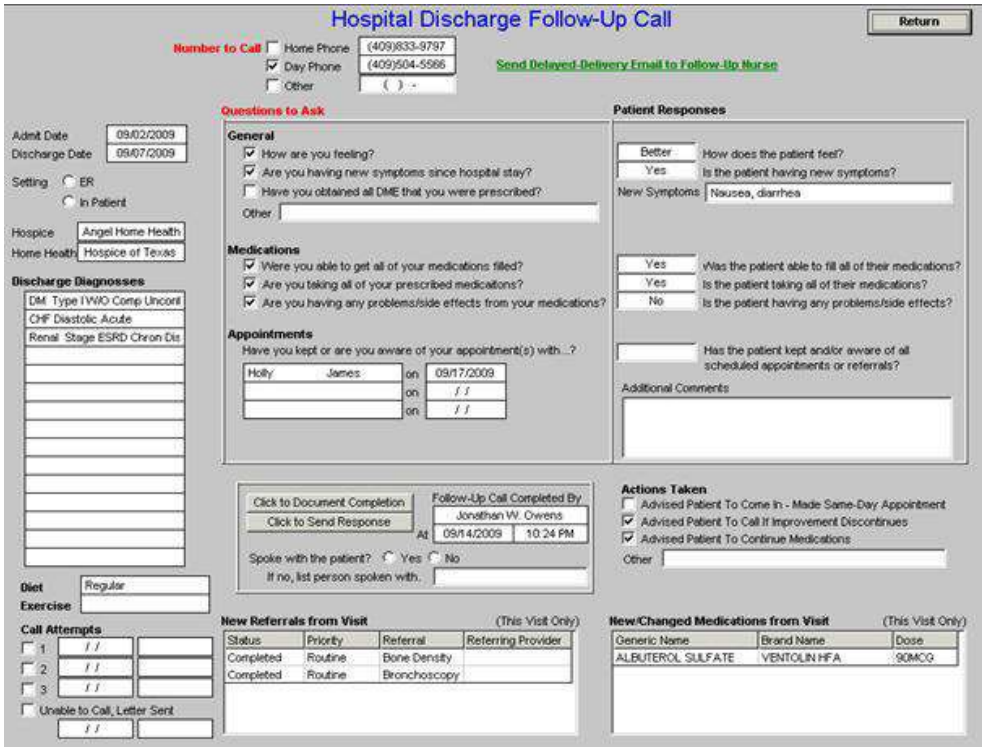
At this review (01.08.13), the department completes on average 2500 outgoing calls per month (30,000 per year). This number does not include incoming calls for patient complaints, requests for assistance from the SETMA Foundation, or calls from patients that use the department for "information".

The Care Coordination Department exists to enhance patient safety and convenience. The Department does this by forming a connection between the plan created by the provider and patient at their office visit, or at their discharge from the hospital. This connection assists patients in accessing the care which has been prescribed by SETMA providers, to assist patients with their recovery from a hospital stay, and to help insure that all their medical needs are being met to the best of SETMA's ability. The Care Coordination Department also expedites care when a referral would create a delay which would decrease the quality of the patient's care. This is particularly the case when the patient states they cannot keep their appointment for lack of transportation. Care Coordination can almost always get transportation arranged quickly. In addition, a portion of each call to patients is utilized in patient education regarding medications, symptoms they may be experiencing and/or the disease processes with which they are dealing.

Passing the Baton

The Department's involvement with patient education during the hospital and clinic follow-up calls, enable SETMA to "pass the baton" to the patient so that the patient can be involved in their own care with the caveat that we are always available by phone or secure web portal, if assistance is needed. Our goals are to make certain that patients are accessing the care agreed to with their provider and to enable them to benefit from that care.

The following is the template for the creation of the Hospital Discharge Follow-up Call. This is how the Hospital Care Team sends the order to the Care Coordination Department.


Hospital Discharge Follow-Up Call
Return
Number to Call
Home Phone (409)833-9797
Day Phone (409)504-5586
Other ( ) -
Send Delayed-Delivery Email to Follow-Up Nurse
Admit Date 09/02/2009
Discharge Date 09/07/2009
Setting ER
In Patient
Hospice Angel Home Health
Home Health Hospice of Texas
Discharge Diagnosses
DM Type I W/O Comp Uncont
CHF Diastolic Acute
Renal Stage ESRD Chron Dis
Diet Regular
Exercise
Call Attempts
1 / /
2 / /
3 / /
Unable to Call, Letter Sent / /
Questions to Ask
General
How are you feeling?
Are you having new symptoms since hospital stay?
Have you obtained all DME that you were prescribed?
Other
Medications
Were you able to get all of your medications filled?
Are you taking all of your prescribed medications?
Are you having any problems/side effects from your medications?
Appointments
Have you kept or are you aware of your appointment(s) with...?
Holly James on 09/17/2009
on / /
on / /
Patient Responses
Better How does the patient feel?
Yes Is the patient having new symptoms?
New Symptoms Nausea, diarrhea
Yes Was the patient able to fill all of their medications?
Yes Is the patient taking all of their medications?
No Is the patient having any problems/side effects?
Has the patient kept and/or aware of all scheduled appointments or referrals?
Additional Comments
Click to Document Completion
Click to Send Response
Follow-Up Call Completed By
Jonathan W. Owens
At 09/14/2009 10:24 PM
Spoke with the patient? Yes No
If no, list person spoken with.
Actions Taken
Advised Patient To Come In - Made Same-Day Appointment
Advised Patient To Call If Improvement Discontinues
Advised Patient To Continue Medications
Other
New Referrals from Visit (This Visit Only)
Status Priority Referral Referring Provider
Completed Routine Bone Density
Completed Routine Bronchoscopy
New/Changed Medications from Visit (This Visit Only)
Generic Name Brand Name Dose
ALBUTEROL SULFATE VENTOLIN HFA 90MCG

Care Coordination stems from SETMA's commitment to making certain that patients have access to the care prescribed and that they can also afford that care. To this end, SETMA's partners formed The SETMA Foundation through which care can be obtained for patients which are uninsured, or who cannot afford co-pays, medications, etc. From 2009-20012, the partners of SETMA have contributed $2,000,000 to the Foundation.

The Baton

"The Baton" is a pictorial representation of the patient's "plan of care and treatment plan," which is the instrument through which responsibility for a patient's health care is transferred to the patient's responsibility. SETMA believes that 8,760 is the most important number in healthcare today. It is the number of hours in a year. If a patient receives a great deal of care, he or she will be in a healthcare provider's presence for twenty hours a year, which means that for 8,740 hours a year, the patient is responsible for his or her own care. If the patient does not know how to care for his self or herself, or if the patient is not able to perform the care needed, the entire healthcare team will fail.

Framed copies of "The Baton" hang in all public areas in SETMA's five clinics and a poster of "The Baton" hangs in over 130 examination rooms. Often, it is forgotten that the member of the healthcare delivery team who carries the „baton" for the majority of the time is the patient and/or the family member who is the principal caregiver. If the „baton" is not effectively transferred to the patient or caregiver, the patient's care will suffer.

The poster declares:
Firmly in the providers hand
--The baton – the care and treatment plan
Must be confidently and securely grasped by the patient, If change is to make a difference
8,760 hours a year.

"Grasped" is the precise word for the baton because it has a physical connotation as in grasping the plan in the hand, and it also has a mental component, as in "understanding the care plan." The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan – the "baton" – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

The Department of Care Coordination was created by SETMA as part of the development of our Medical Home. Actually, the genius and promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display will continually remind the provider and will inform the patient, that to be successful, the patient's care must be coordinated (a process), which must result in coordinated care (an outcome). SETMA's coordination of care begins at the points of "transitions of care" from one venue to another, i.e., from the inpatient care setting to the ambulatory care setting. The work of the healthcare team – patient and provider – is that together they evaluate, define and execute that care.

The Care Coordination Department also attempts to find resources in the community to assist patients with their healthcare needs. This often results in the Department assisting patients in accessing government programs. In addition, when no other resource is available, with resources from the SETMA Foundation, SETMA providers are able to assist patients with

financial needs presented by their medical problems (i.e., co-pays for medications and procedures needed, dental services, transportation costs.).

The Universal Joint

If the "Baton" is the tool of care transitions – uniting and sustaining care from one venue to another -- the Care Coordination Department is like a "universal joint" – transferring the power of the healthcare engine to the patient – making it possible to access and apply the care which is prescribed. In the automobile, the power created by the internal combustion engine is transferred to the axles and subsequently to the wheels by the "universal joint." Without the joint, the powerful engine can run and the high quality wheels and tires can support the vehicle, but the car will not move.

The same is true of the high powered, evidenced-based medicine which is prescribed by excellent providers. No matter how outstanding the provider is; no matter how accurate the diagnosis is or how correct the treatment is, without the transferring of the knowledge and skills to the patient, nothing will happen. Care Coordination, whether in education, explanation, scheduling, organizing, communicating, makes it possible for patients to access the care they need.

SETMA's Care Coordination Department

At its founding in 2010, the Department had five functions. The following are a list of "duties" performed by the Care Coordination Department at the beginning of 2013. Keep in mind that the Department's staff encounters many patient needs which are dealt with as they arise. These needs do not always fall into one of the following categories. :

1. Hospital follow-up calls the day after hospital discharge for every patient. At the time of the call, the staff also does an assessment for any barriers the patient may have to their medical care. A third medication reconciliation is done at that time, also. The first was on admission, the second was at discharge and the fourth will be at the follow-up clinic visit.
2. Clinic follow-up calls at a time designated by the provider when the call is ordered. Every patient who is seen in the clinic does not need a follow-up call, but many benefits from a call. Often, after leaving the hospital and after receiving the Hospital Follow-up Call and after the patient is seen in the clinic follow-up visit, another follow-up call, now considered a Clinic Follow-up call will be scheduled by the provider.
3. On Fridays, patients that are in the Care Coordination Department's workflow before 11:30am, showing that they are being discharged that day, are contacted by phone and information is given to them on how to contact the SETMA provider on call for afterhours and through the weekend. These patients are also encouraged to contact the

provider before simply returning to the emergency department, although they are assured that if they think their personal safety warrants it, they can return to the emergency department.

4. Clinic follow-up calls for patients that are at high-risk for readmission to the hospital or who have complex treatment needs are scheduled by this department after the initial follow-up call. These calls are made to the at-risk patient three days after the initial call, or in the case of a patient that sees the provider on the third day after discharge, the patient is contacted the fourth day.
5. Follow-up calls to patients that miss a hospital follow-up appointment. A report of patients who missed hospital-discharge follow-up visit to the clinic is generated and sent to the Care Coordination Department at 8:30 AM daily. A call to follow-up these patients is given a high priority. If the Department is to contact the patient, an attempt is made to reschedule a same-day appointment. Also, at this time, the staff does an assessment for any barriers the patient may have to accessing the medical care they need.
6. Follow-up calls to patients with hypertension or diabetes and who miss a scheduled appointment are made each day. The Department also assesses any barriers the patient may have to receiving the needed care.
7. The Care Coordination Department also sends upcoming visit reminders, pre-visit information and information after a visit to patients who have accounts with SETMA's secure web portal. Information about medications, laboratory tests, referrals and other care needs are communicated to patients by messages through the portal and by patient access to secure information on their portal accounts.
8. The Department initiates calls to all patients that have three or more referrals at one time. Attempts are made to make increase patient convenience and adherence to recommended care. Barriers to completion of referrals are discussed and attempts to schedule all referrals on the same day are made. The patient is asked if they are in agreement with the treatment plan. If there are transportation issues, co-pay issues or scheduling issues, the department works to resolve those.
9. The Department also completes all Infectious disease reporting. Patient demographics and documentation regarding the disease (chart notes, lab work) are faxed to the Beaumont Health Department's epidemiology nurse. SETMA's EMR has an electronic tool built which identifies all 87 reportable conditions in Texas. When the provider documents one of those diagnoses, an e-mail is automatically sent to Care Coordination which then reports the condition to the State Department of Health.
10. The Department receives and processes all patient complaint calls. The Department researches the facts about complaints, communicates that to the provider and a response is generated. Every effort is made to resolve the issues. Complaints are documented and sent to the Director of Operations and the supervisor of the area where the complaint originated.

11. The Department receives and processes all request to the SETMA Foundation for assistance. Patients in need are contacted and information is sent to the SETMA Foundation for approval.
12. The Department arranges assistance through community programs as needed (Meals on Wheels, Transportation for Seniors, Adult and Child Protective Services, when appropriate, etc).