The SETMA Seven Stations of Success for Treating Diabetes

DR. JAMES L. HOLLY, CEO
SOUTHEAST TEXAS MEDICAL ASSOCIATES, LLP

PATIENT-CENTERED PRIMARY CARE COLLABORATIVE
SHAREHOLDERS WORKSHOP MEETING

WASHINGTON, DC

MARCH 30, 2011

The Dr. and Mrs. James L. Holly Distinguished Professorship

- University of Texas Health Science Center at San Antonio Announces Endowment of a Distinguished Professorship

- A Permanent Endowment…the Distinguished Professorship will promote a model of patient-centered primary care and education.

Distinguished Professorship

"The Distinguished Professorship also will promote interdepartmental and interdisciplinary education, collaboration and practice-model development between Internal Medicine, Family Medicine, Pediatrics and the School of Nursing's advance practice program."

Distinguished Professorship

"This endowment illustrates the commitment of Dr. James L. Holly, Class of 1973, and the Southeast Texas Medical Associates ("SETMA") partners to provide the highest level of patient care and to improve the quality of care for all patients....The endowment will allow the UTHSCSA leadership to acknowledge and reward the same patient-centered aspects Dr. Holly and the SETMA partners have imbued in their own nationally-recognized clinical practice."

Distinguished Professorship

Letter of commitment

"What began as a commitment to establish an award for clinical excellence, has grown into a distinguished professorship to promote patient-centered medical homes, the future of healthcare and the vision we share for the care of which your School of Medicine will be known....your vision...will create the first-in-the-country academic endowment focused on the patient-centered medical home model, a notable milestone in the history of the Health Science Centered."

William L. Henrich, MD, M.A.C.P,
President, University of Texas Health Science Center, San Antonio

SETMA Achievements

- July 2010 - NCQA PC-MH Tier Three
- July 2010 – Joslin Diabetes Center Affiliate
- August 2010 - NCQA Diabetes Recognition Program
- August 2010 - AAAHC Medical Home
- August 2010 - AAAHC Ambulatory Care
- April 2010 - ONC of HIT Initiation to Speak to Staff

Diabetes Care Improvements

From 2000 to 2011

- HgbA1C standard deviation improvement from
  1.98 to 1.33
- HgbA1C mean (average) improvement from
  7.48% to 6.65%
- Elimination of Ethnic Disparities of Care in Diabetes

Diabetes Care Initiatives and Results

- 2000 - Design and Deployment of EHR-based Diabetes Disease Management Tool
  - **HgbA1C improvement 0.3%**
- 2004 - Design and Deployment of American Diabetes Association certified Diabetes Self Management Education (DSME) Program
  - **HgbA1C improvement 0.3%**
- 2006 - Recruitment of Endocrinologist
  - **HgbA1C improvement 0.25%**

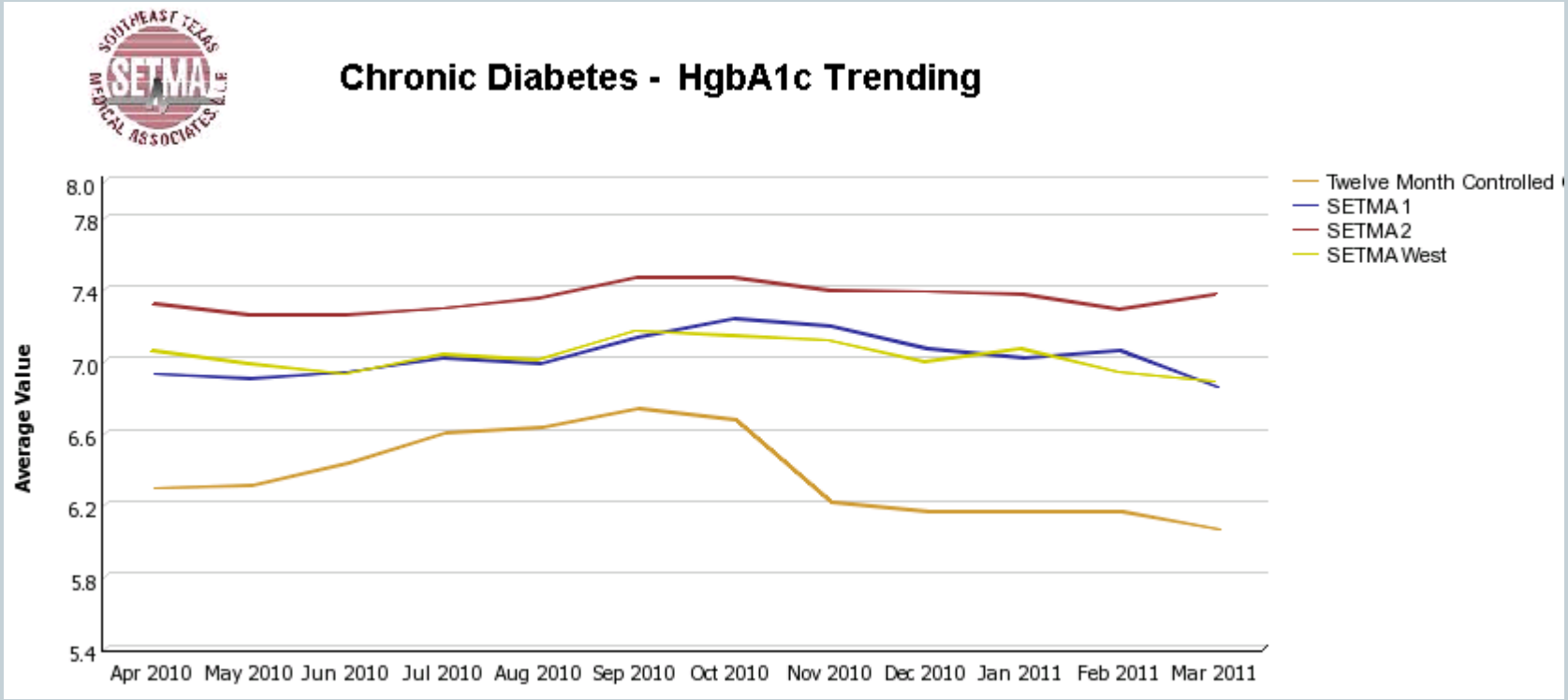
SETMA's 2010 NCQA Diabetes Metrics

NCQA Diabetes Measures

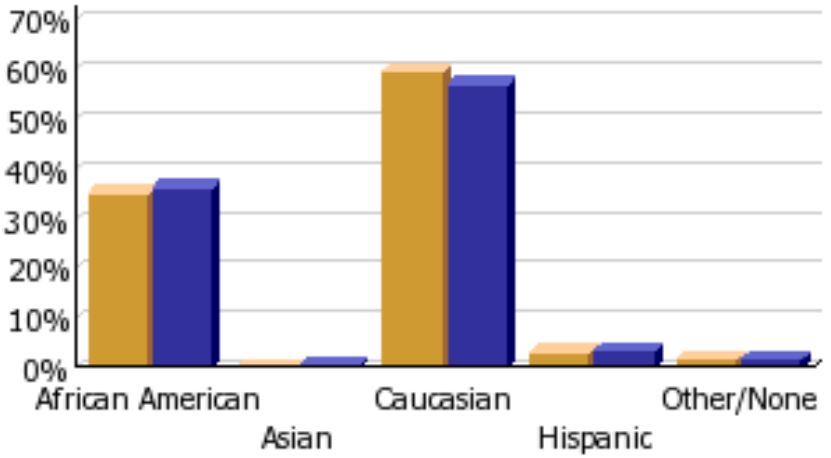
Encounter Date(s): January 1, 2010 to December 31, 2010

Location	Provider	Encounters	A1c >9.0 <= 15%	A1c < 8.0 >= 60%	A1c < 7.0 >= 40%	BP > 140/90 <= 35%	BP < 130/80 >= 25%	Eye Exam >= 60%	Smoking Cessation >= 80%	LDL >= 130 <= 37 %	LDL < 100 >= 36%	Nephropathy >= 80%	Foot Exam >= 80%	Total Points
SETMA 1	Aziz	953	12.2%	81.0%	61.5%	30.2%	43.5%	53.0%	71.1%	11.9%	67.5%	69.0%	63.3%	70
	Duncan	669	8.8%	81.3%	63.1%	11.5%	72.0%	58.7%	78.8%	14.5%	67.9%	60.4%	81.5%	75
	Henderson	747	11.2%	78.2%	58.9%	9.6%	68.1%	60.4%	86.8%	17.1%	65.3%	72.0%	92.8%	95
	Murphy	1,408	7.2%	83.2%	63.6%	20.2%	55.8%	42.3%	55.7%	10.2%	71.8%	75.3%	85.4%	75
	Sims	421	11.6%	79.1%	59.1%	22.8%	51.3%	47.0%	82.2%	17.8%	60.6%	62.5%	72.9%	80
	Thomas	697	11.8%	70.6%	49.6%	14.8%	59.1%	66.6%	73.2%	14.3%	57.7%	62.6%	75.8%	80
SETMA 2	Ahmed	3,452	18.8%	63.1%	38.1%	9.1%	62.5%	66.7%	51.2%	10.9%	67.5%	46.3%	98.7%	68
	Anthony	995	12.1%	78.1%	59.9%	13.6%	70.3%	62.9%	68.8%	14.0%	64.9%	89.1%	97.0%	90
	Anwar	1,488	7.1%	81.5%	57.7%	5.9%	77.8%	71.8%	70.5%	12.2%	63.7%	85.8%	88.1%	90
	Cricchio	838	10.5%	79.2%	62.8%	8.5%	72.4%	66.0%	60.3%	14.7%	63.8%	85.3%	81.4%	90
	Holly	459	10.5%	80.0%	63.2%	6.3%	74.3%	78.0%	61.3%	10.0%	65.1%	92.8%	86.7%	90
	Leifeste	960	8.7%	79.0%	63.5%	13.4%	63.6%	72.4%	58.9%	9.7%	66.0%	86.0%	81.7%	90
	Wheeler	623	9.0%	81.9%	59.2%	17.5%	56.0%	56.5%	77.2%	16.4%	59.6%	79.1%	86.8%	75
SETMA West	Curry	477	11.7%	70.9%	50.5%	15.1%	61.2%	61.2%	57.7%	10.5%	64.2%	72.1%	89.9%	85
	Deiparine	687	8.2%	64.3%	47.7%	18.2%	57.9%	58.7%	87.3%	9.3%	52.4%	57.4%	91.1%	85
	Halbert	1,218	10.3%	75.9%	58.0%	26.8%	48.9%	47.5%	53.1%	14.5%	58.6%	40.2%	68.8%	70
	Horn	857	6.7%	79.0%	61.3%	4.2%	71.9%	47.7%	75.9%	12.7%	56.5%	70.9%	96.1%	75
	Satterwhite	426	11.3%	70.0%	50.0%	28.9%	47.2%	66.4%	82.7%	15.3%	51.6%	80.8%	76.1%	95

COGNOS Diabetes Audit - Trending



COGNOS Diabetes Audit – Ethnicity

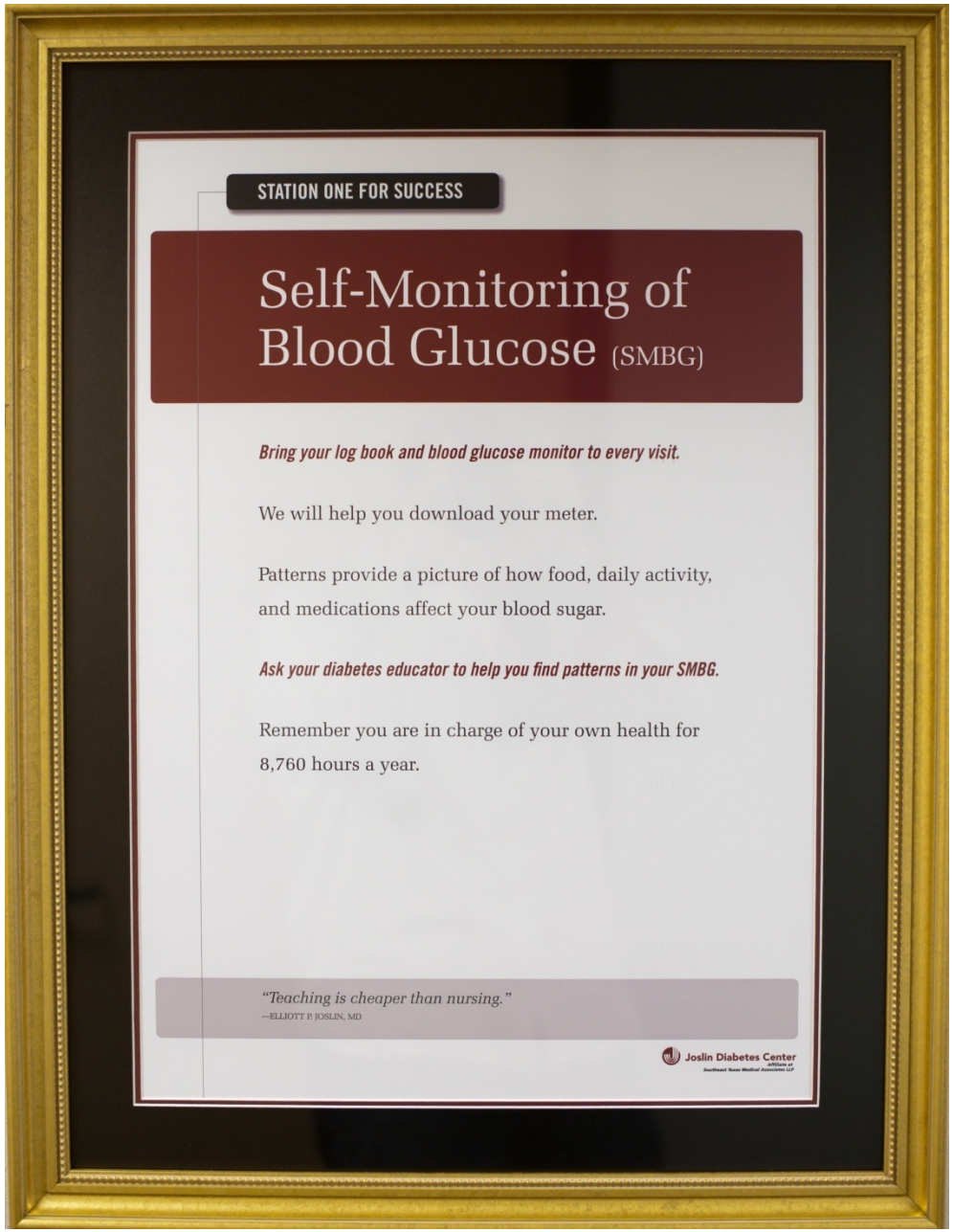


	African American	Ethnicity Asian	Caucasian	Hispanic	Other/None
Controlled	35.3%	0.3%	59.6%	3.2%	1.6%
Selected	36.4%	0.9%	57.2%	3.6%	2.0%

The Seven Stations of Success

SETMA Designed the Seven Stations of Success as visual reminders of the leverage points for improving the care of patients with diabetes by providers and by the patients themselves.

1. A set of the stations are displayed in the hallway leading to the Joslin Affiliate Clinic.
2. A framed copy of each station is displayed at the point of care for each activity within the clinic.
3. Station Seven entitled “SETMA is Your Health Home” is displayed on the door through which the patient exits the Joslin Clinic.


STATION ONE FOR SUCCESS
Self-Monitoring of Blood Glucose (SMBG)
Bring your log book and blood glucose monitor to every visit.
We will help you download your meter.
Patterns provide a picture of how food, daily activity, and medications affect your blood sugar.
Ask your diabetes educator to help you find patterns in your SMBG.
Remember you are in charge of your own health for 8,760 hours a year.
"Teaching is cheaper than nursing."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 1
Self-Monitoring of Blood Glucose

- Bring your log book and blood glucose monitor to every visit.
- We will help you download your meter.
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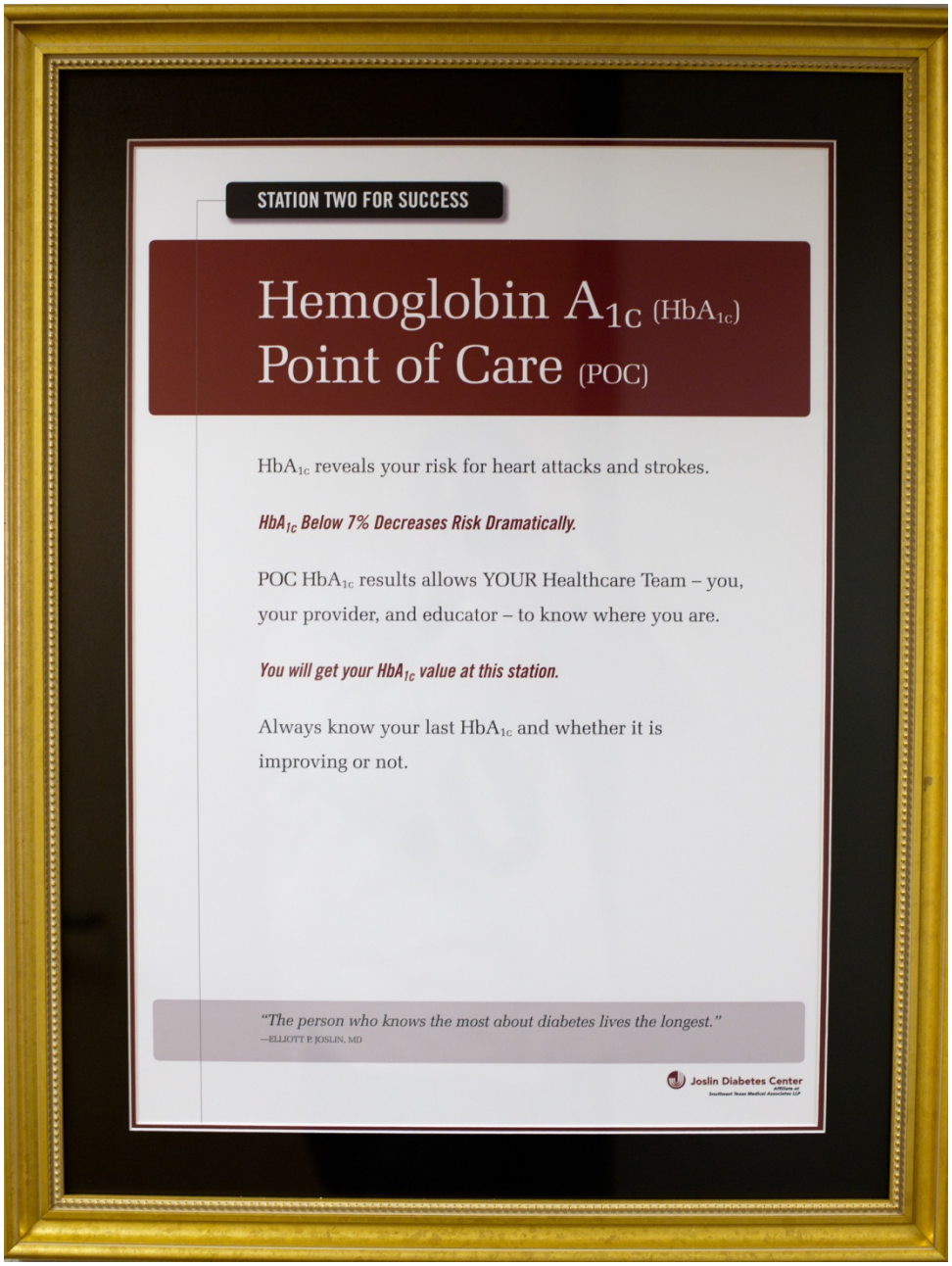
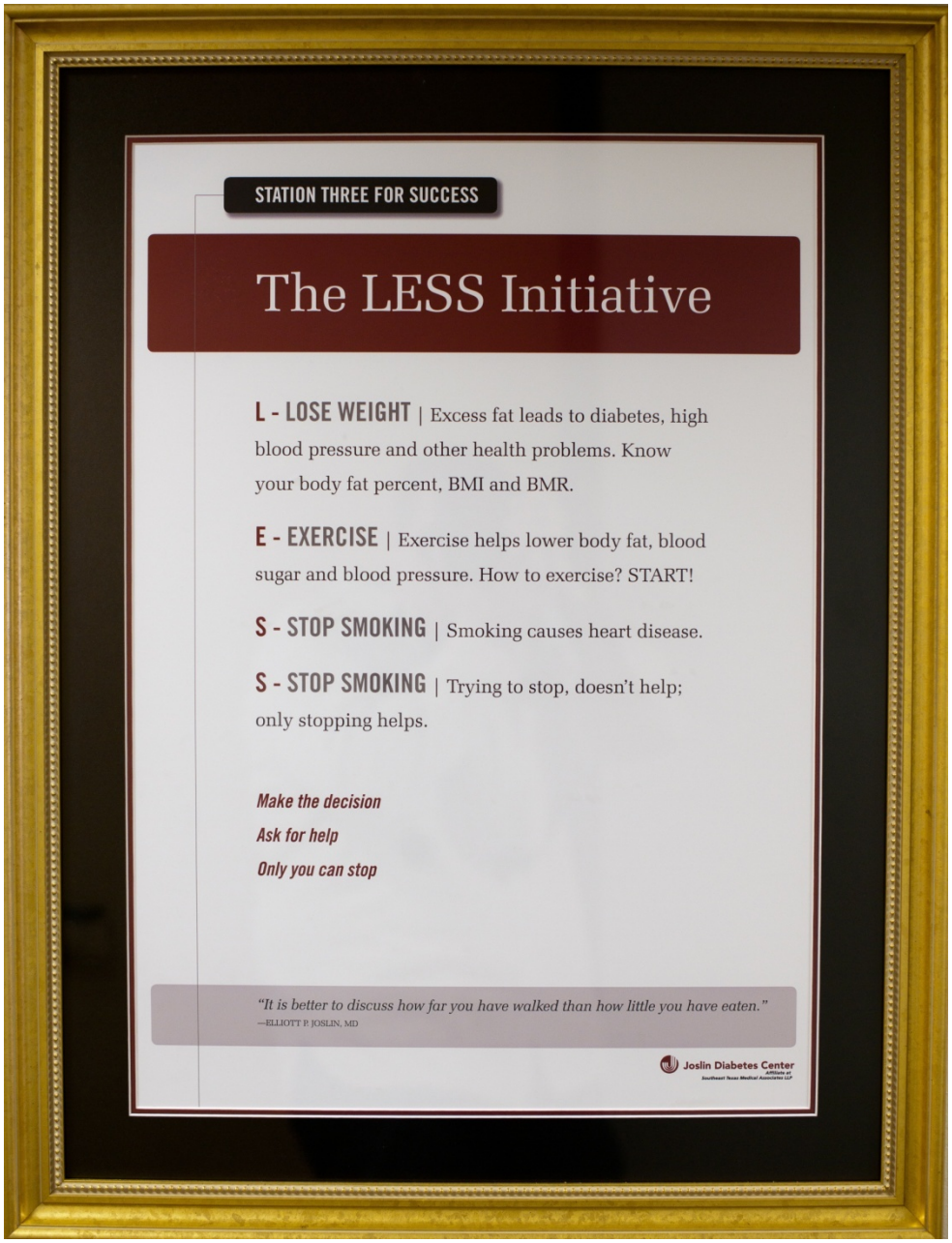

STATION TWO FOR SUCCESS
Hemoglobin A1C (HbA1c)
Point of Care (POC)
HbA1c reveals your risk for heart attacks and strokes.
HbA1c Below 7% Decreases Risk Dramatically.
POC HbA1c results allows YOUR Healthcare Team – you, your provider, and educator – to know where you are.
You will get your HbA1c value at this station.
Always know your last HbA1c and whether it is improving or not.
"The person who knows the most about diabetes lives the longest."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 2
HgbA1c Point of Care

- HgbA1c reveals your risk for heart attacks and stroke.
- HgbA1c below 7% decreases risk dramatically.
- POC HgbA1c results allows your healthcare team – you, your provider and educator – to know where you are.
- You will get your HgbA1c value at this station.
- Always know your last HgbA1c and whether it is improving or not.

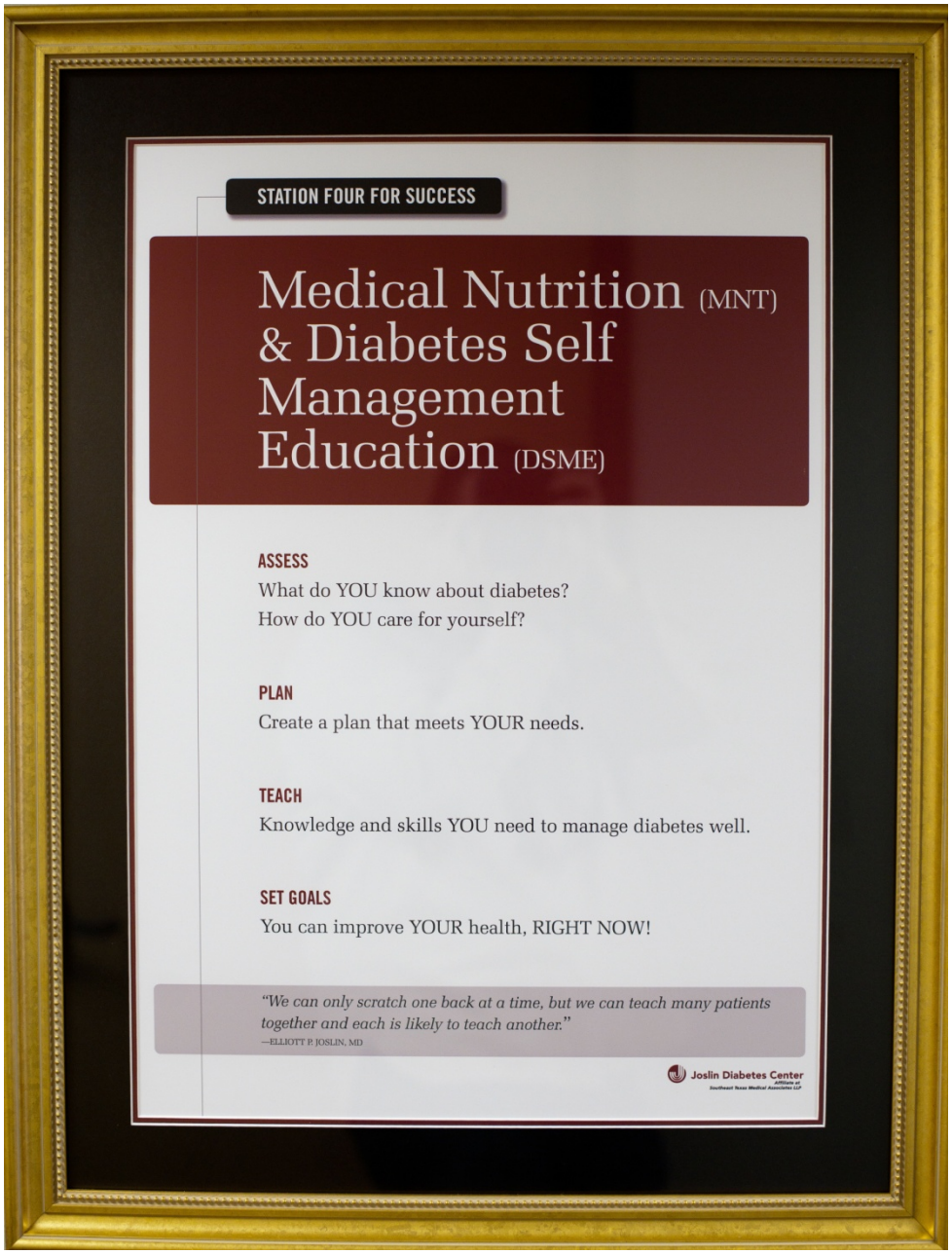
"The person who knows the most about diabetes lives


STATION THREE FOR SUCCESS
The LESS Initiative
L - LOSE WEIGHT | Excess fat leads to diabetes, high blood pressure and other health problems. Know your body fat percent, BMI and BMR.
E - EXERCISE | Exercise helps lower body fat, blood sugar and blood pressure. How to exercise? START!
S - STOP SMOKING | Smoking causes heart disease.
S - STOP SMOKING | Trying to stop, doesn't help; only stopping helps.
Make the decision
Ask for help
Only you can stop
"It is better to discuss how far you have walked than how little you have eaten."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 3
The LESS Initiative

- **L – Lose Weight – Excess fat leads to diabetes, high blood pressure and other health problems. Know your body fat, BMI and BMR.**
- **E – Exercise – Exercise helps lower body fat, blood sugar and blood pressure. How to exercise? START!**
- **S – Stop Smoking – Smoking causes heart disease.**
- **S – Stop Smoking – Trying to stop doesn't help; only stopping helps.**

"It is better to discuss how far you have walked than how little you have eaten."


STATION FOUR FOR SUCCESS
Medical Nutrition (MNT) & Diabetes Self Management Education (DSME)
ASSESS
What do YOU know about diabetes?
How do YOU care for yourself?
PLAN
Create a plan that meets YOUR needs.
TEACH
Knowledge and skills YOU need to manage diabetes well.
SET GOALS
You can improve YOUR health, RIGHT NOW!
"We can only scratch one back at a time, but we can teach many patients together and each is likely to teach another."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 4
Medical Nutrition & Diabetes Self Management Education

- **Assess – What do YOU know about diabetes? How do YOU care for yourself?**
- **Plan – Create a plan that meets YOUR needs.**
- **Teach – Knowledge and skills YOU need to manage diabetes well.**
- **Set Goals – You can improve YOUR health, RIGHT NOW!**

"We can only scratch one back at a time, but we can teach many patients together and each is likely to teach another."

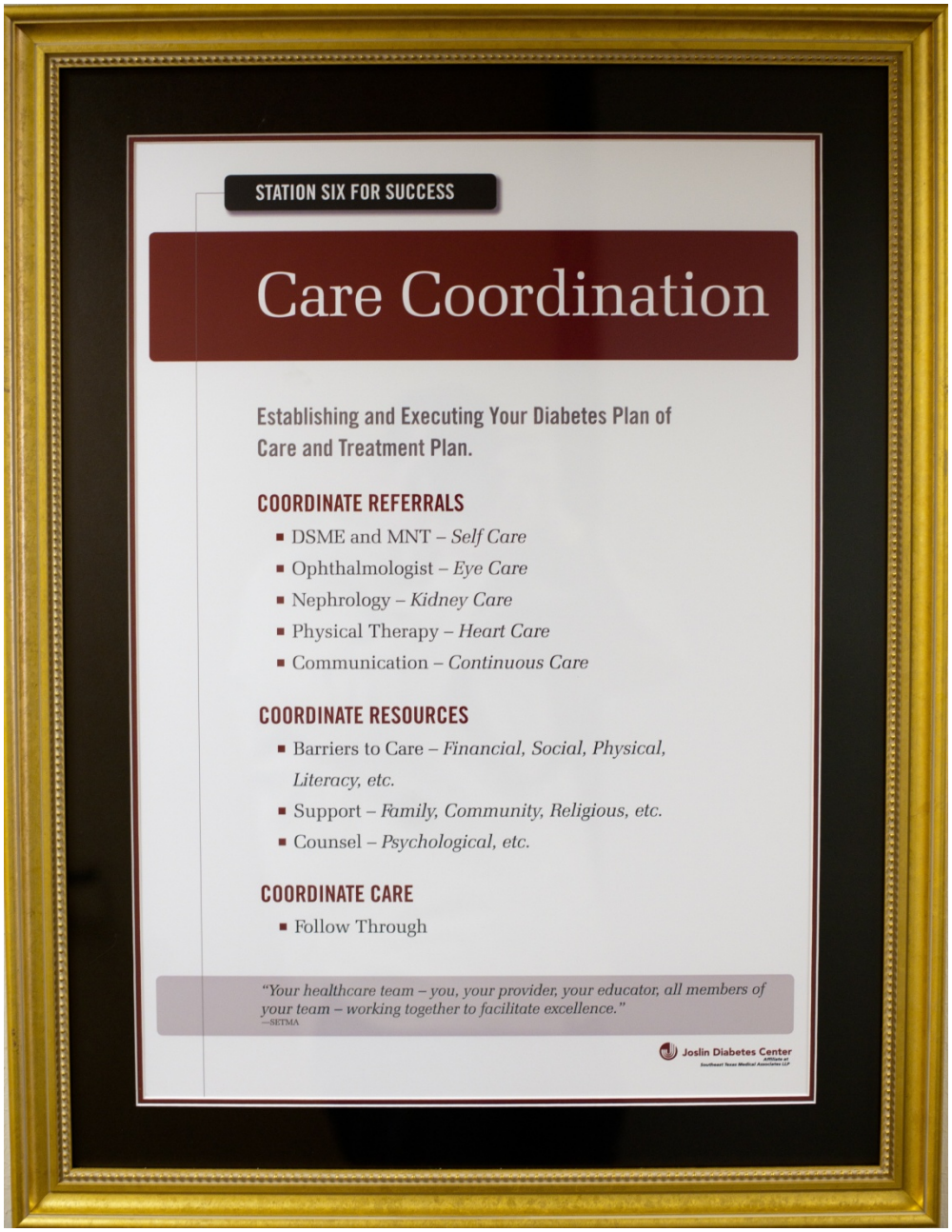

STATION FIVE FOR SUCCESS
Physician Partnership With YOU
TOGETHER, set goals of blood glucose, blood pressure and cholesterol.
TOGETHER, determine your risk of complications.
TOGETHER, plan for preventing complications.
TOGETHER, review and agree on treatment plan.
"You and your healthcare provider are 'in this together.' Be an active part of YOUR team."
—SETMA
Joslin Diabetes Center

Station 5
Physician Partnership with YOU

- **TOGETHER, set goals of blood glucose, blood pressure and cholesterol.**
- **TOGETHER, determine your risk of complications.**
- **TOGETHER, plan for preventing complications.**
- **TOGETHER, review and agree on treatment plan.**

"You and your healthcare provider are 'in this together.' Be an active part of YOUR team."

-SETMA


STATION SIX FOR SUCCESS
Care Coordination
Establishing and Executing Your Diabetes Plan of Care and Treatment Plan.
COORDINATE REFERRALS
DSME and MNT – Self Care
Ophthalmologist – Eye Care
Nephrology – Kidney Care
Physical Therapy – Heart Care
Communication – Continuous Care
COORDINATE RESOURCES
Barriers to Care – Financial, Social, Physical, Literacy, etc.
Support – Family, Community, Religious, etc.
Counsel – Psychological, etc.
COORDINATE CARE
Follow Through
"Your healthcare team – you, your provider, your educator, all members of your team – working together to facilitate excellence."
—SETMA
Joslin Diabetes Center

Station 6
Care Coordination

Establishing and Executing Your Diabetes Plan of Care and Treatment Plan

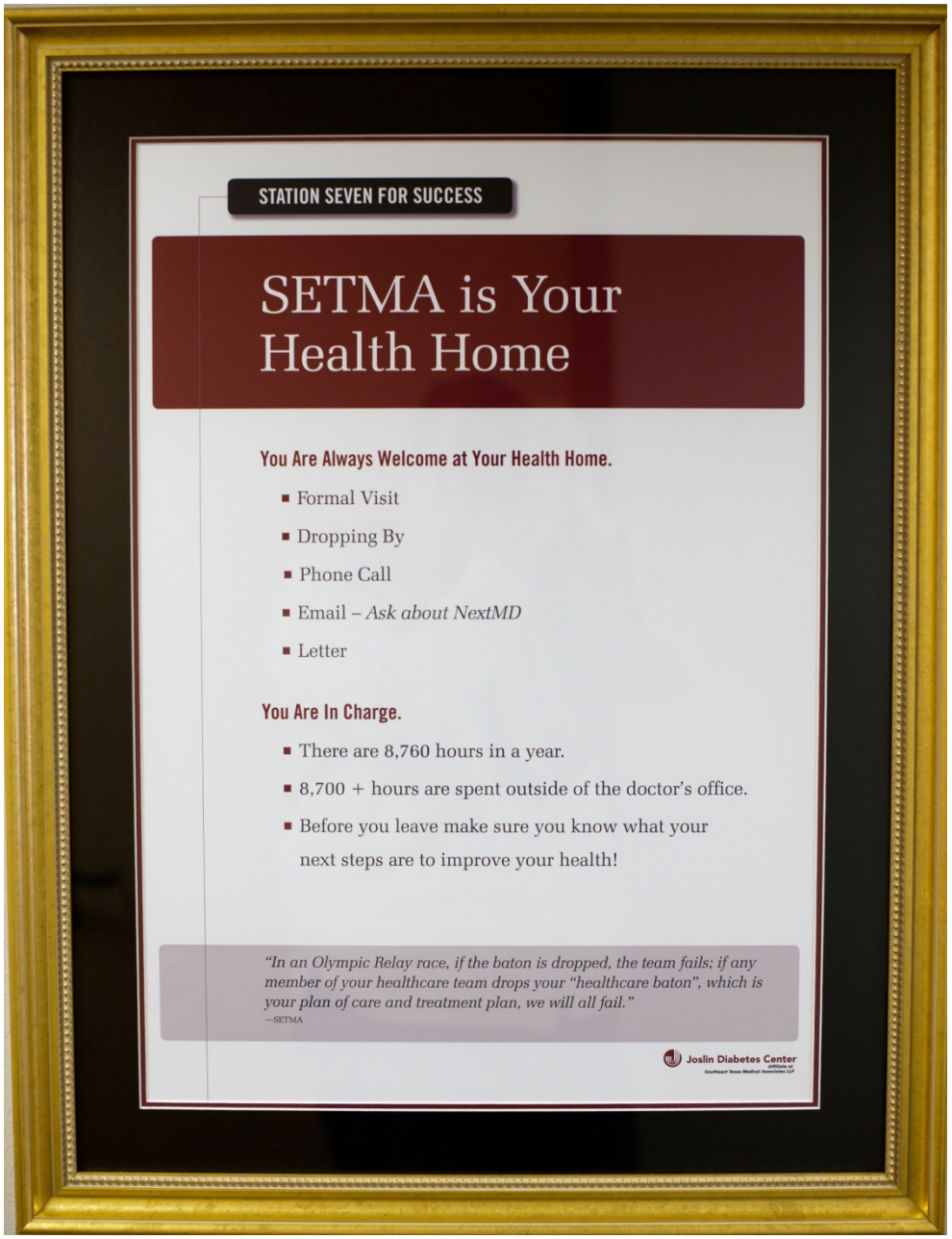
- **Coordinate Referrals**
  - **DSME and MNT – Self Care**
  - **Ophthalmology – Eye Care**
  - **Nephrology – Kidney Care**
  - **Physical Therapy – Heart Care**
  - **Communication – Continuous Care**

Station 6
Care Coordination

- **Coordinate Resources**
  - **Barriers to Care – Financial, Social, Physical, Literacy, etc.**
  - **Support – Family, Community, Religious, etc.**
  - **Counsel – Psychological, etc.**
- **Coordinate Care**
  - **Follow Through**

"Your healthcare team – you, your provider, your educator, all members of your team – working together to facilitate excellence."

-SETMA


STATION SEVEN FOR SUCCESS
SETMA is Your Health Home
You Are Always Welcome at Your Health Home.
Formal Visit
Dropping By
Phone Call
Email – Ask about NextMD
Letter
You Are In Charge.
There are 8,760 hours in a year.
8,700 + hours are spent outside of the doctor's office.
Before you leave make sure you know what your next steps are to improve your health!
"In an Olympic Relay race, if the baton is dropped, the team fails; if any member of your healthcare team drops your "healthcare baton", which is your plan of care and treatment plan, we will all fail."
—SETMA
Joslin Diabetes Center

Station 7
SETMA is Your Health Home

- **You Are Always Welcome at Your Health Home**
  - **Formal Visit**
  - **Dropping By**
  - **Phone Call**
  - **Email – *Ask about NextMD***
  - **Letter**

Station 7
SETMA is Your Health Home

- **You Are Always Welcome at Your Health Home**
  - **There are 8,760 hours in a year.**
  - **8,700 + hours are spent outside of the doctor's office.**
  - **Before you leave make sure you know what your next steps are to improve your health.**

"In an Olympic relay race, if the baton is dropped, the team fails; if any member of your healthcare team drops your 'healthcare baton,' which is your plan of care and treatment plan, we will all fail."

-SETMA

Firmly in the provider's 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.

The Baton

Firmly in the provider's 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.

The Baton – What Does it Mean?

In all public areas and in every examination room, SETMA's "Baton" poster is displayed. It illustrates:

- That the healthcare-team relationship, which exists between patient and healthcare provider, is key to the success of the outcome of quality healthcare.
- 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.

The Baton – What Does it Mean?

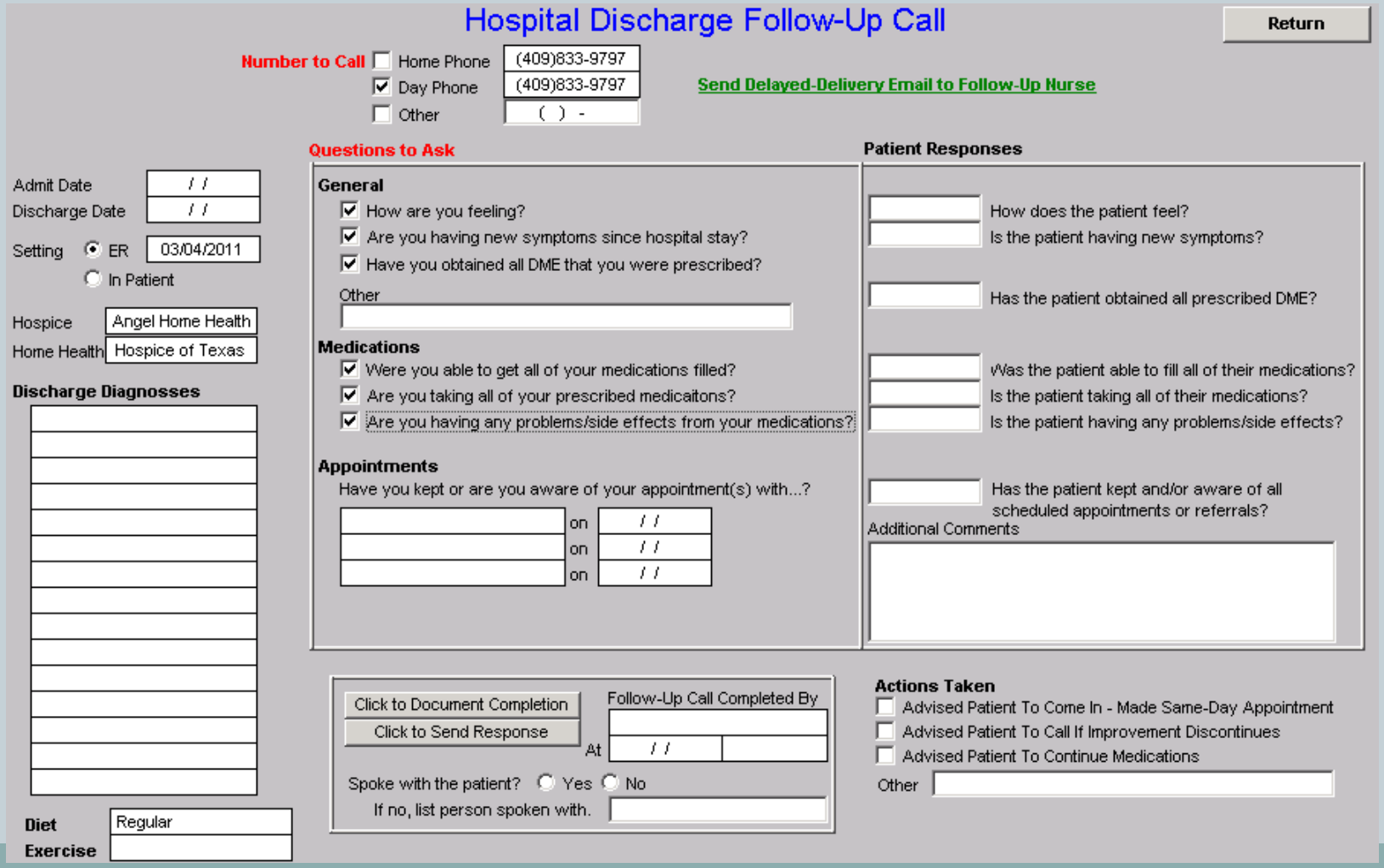
- That the means of transfer of the “baton”, which has been developed by the healthcare team .is a coordinated effort between the provider and the patient.
- That typically the healthcare provider knows and understands the patient’s healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider’s knowledge is useless to the patient.
- 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.

The Baton – What Does it Mean?

- 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.

- 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.

Transition of Care Measurement



Hospital Discharge Follow-Up Call

Return

Number to Call
- ☐ Home Phone (409)833-9797
- ☑ Day Phone (409)833-9797
- ☐ Other ( ) -

Send Delayed-Delivery Email to Follow-Up Nurse

Admit Date / /
Discharge Date / /

Setting ◉ ER 03/04/2011
○ In Patient

Hospice Angel Home Health
Home Health Hospice of Texas

Discharge Diagnosses

Diet Regular
Exercise

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 medicaitons?
- ☑ Are you having any problems/side effects from your medications?

Appointments

Have you kept or are you aware of your appointment(s) with...?

on / /
on / /
on / /

Patient Responses

How does the patient feel?
Is the patient having new symptoms?
Has the patient obtained all prescribed DME?
Was the patient able to fill all of their medications?
Is the patient taking all of their medications?
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

At / /

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

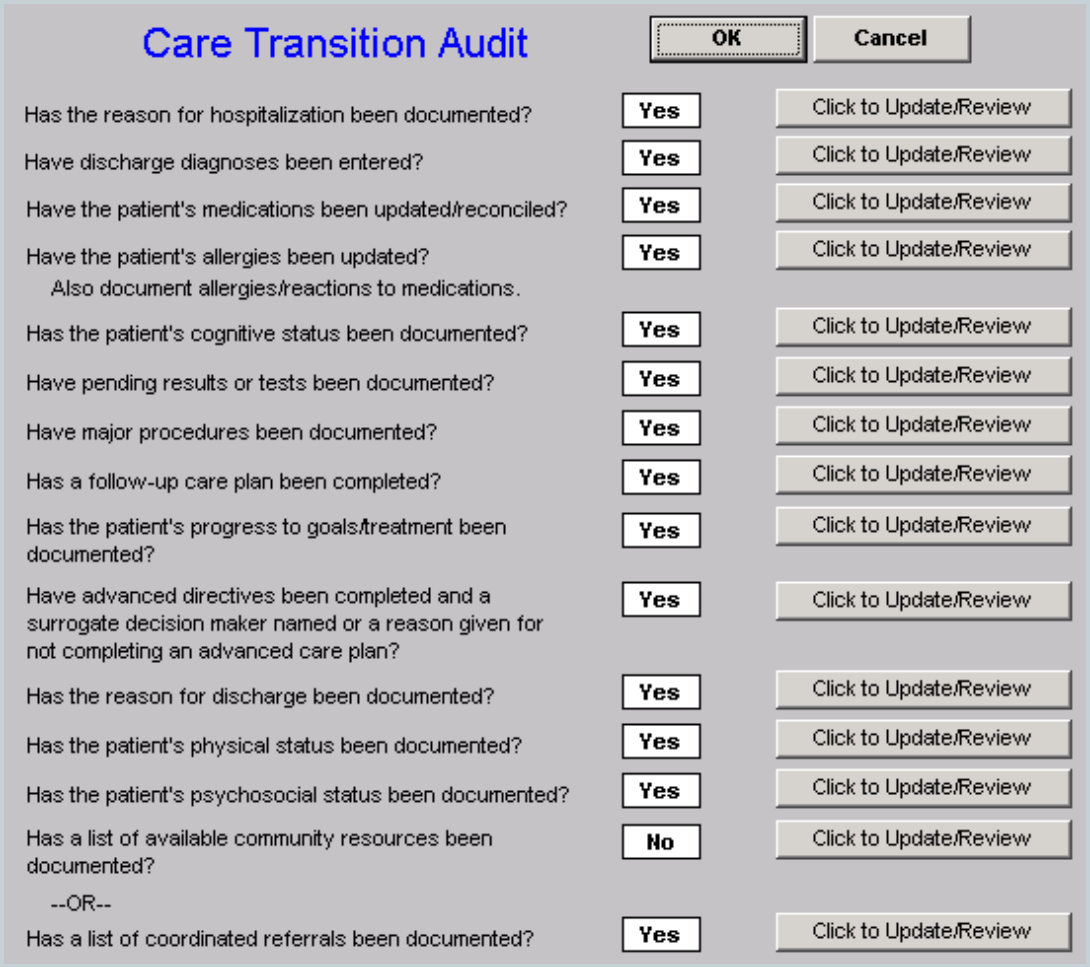
Other

The Baton – What Does it Mean?

- There are numerous points of “care transition” in the patient's care. In the transition of care from the hospital, there are potential eight different types of care transition.

- PCPI has published a “Transition of Care Measurement Set,” which is illustrated here.

Transition of Care Measurement



Transition of Care Measurement

Has the current/reconciled medication list been discussed with the patient/family/caregiver?	(•) Yes	( ) No	Benn Sanford	03/07/2011 2:42 PM
Have the discharge orders been discussed with the patient/family/caregiver?	(•) Yes	( ) No	Benn Sanford	03/07/2011 2:42 PM
Have the follow-up instructions been discussed with the patient/family/caregiver?	(•) Yes	( ) No	Benn Sanford	03/07/2011 2:42 PM
Have the discharge materials been printed and given to the patient/family/caregiver?	(•) Yes	( ) No	Benn Sanford	03/07/2011 2:42 PM

Transition of Care Measurement

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	95.0%	100.0%	82.4%	88.9%	93.5%	92.9%	90.7%	93.7%	95.0%
Aziz	98.4%	100.0%	95.2%	94.7%	96.7%	98.2%	95.6%	97.2%	95.6%
Colbert	100.0%	100.0%	50.0%	50.0%	83.3%	100.0%	66.7%	100.0%	100.0%
Cricchio	91.7%	94.4%	94.4%	91.7%	94.4%	91.7%	88.9%	88.9%	91.7%
Curry	99.1%	100.0%	97.2%	95.3%	96.2%	100.0%	95.3%	98.1%	98.1%
Deiparine	97.7%	100.0%	90.0%	95.8%	97.2%	96.3%	95.6%	96.3%	97.4%
Groff	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.2%	99.5%	94.1%	95.0%	95.9%	98.2%	94.1%	95.4%	96.3%
Henderson	84.0%	100.0%	64.0%	96.0%	96.0%	96.0%	88.0%	92.0%	92.0%
Holly	94.2%	99.7%	87.3%	94.0%	96.8%	91.8%	91.2%	91.3%	93.9%
Leifeste	97.6%	100.0%	88.0%	95.3%	98.6%	95.5%	95.9%	96.6%	96.4%
Murphy	98.7%	99.6%	95.7%	94.5%	95.3%	98.7%	95.3%	97.9%	94.5%
Qureshi	90.4%	100.0%	84.6%	96.2%	98.1%	90.4%	92.3%	94.2%	88.5%
Satterwhite	98.3%	100.0%	90.4%	90.4%	94.8%	99.1%	93.9%	93.0%	98.3%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.3%	99.7%	87.2%	93.9%	96.5%	95.5%	97.1%	95.2%	97.1%
Vardiman	96.9%	100.0%	88.8%	91.8%	96.9%	98.0%	93.9%	98.0%	95.9%
Young	86.8%	100.0%	73.6%	88.7%	86.8%	86.8%	86.8%	83.0%	86.8%
SETMA Totals :	96.4%	99.8%	89.1%	93.8%	96.4%	95.1%	93.7%	94.6%	95.4%

Transition of Care Measurement

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

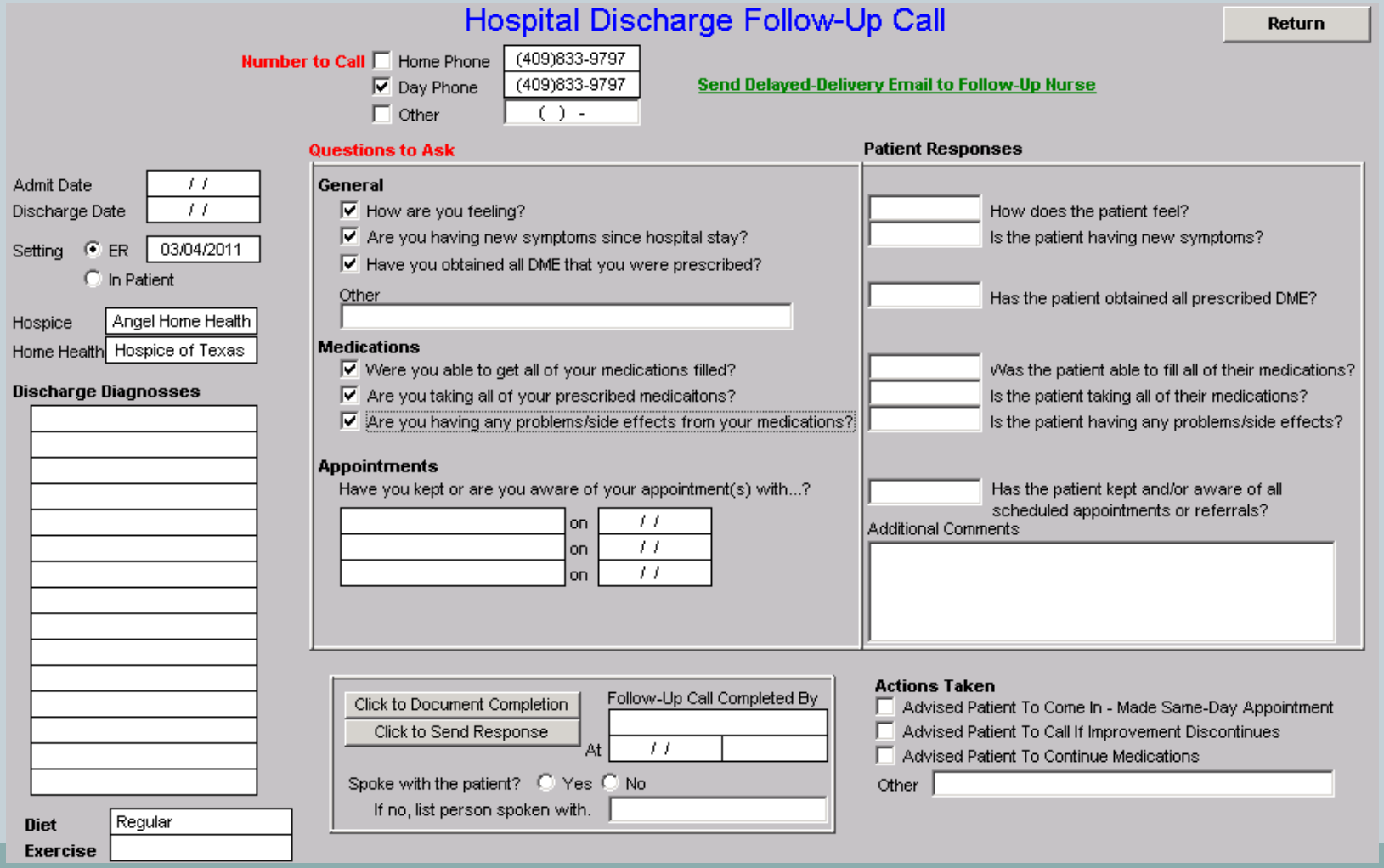
Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

Transition of Care Measurement

- The second, third and fourth of the transition s of care involve “follow-up call” scheduling:

- The day following discharge from the hospital – this goes to follow-up call nursing staff in our Care Coordination Department. These calls differ from the “administrative calls’ initiated by the hospital which may last for 30 seconds are less. These calls last from 12-30 minutes and involved detailed discussions of patient’s needs and conditions.

Transition of Care Measurement



Hospital Discharge Follow-Up Call

Return

Number to Call
- ☐ Home Phone (409)833-9797
- ☑ Day Phone (409)833-9797
- ☐ Other ( ) -

Send Delayed-Delivery Email to Follow-Up Nurse

Admit Date / /
Discharge Date / /

Setting ◉ ER 03/04/2011
○ In Patient

Hospice Angel Home Health
Home Health Hospice of Texas

Discharge Diagnosses

Diet Regular
Exercise

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 medicaitons?
- ☑ Are you having any problems/side effects from your medications?

Appointments

Have you kept or are you aware of your appointment(s) with...?

on / /
on / /
on / /

Patient Responses

How does the patient feel?
Is the patient having new symptoms?
Has the patient obtained all prescribed DME?
Was the patient able to fill all of their medications?
Is the patient taking all of their medications?
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

At / /

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