DELTA CARE

CHANGING LIVES

A CARE TRANSITION PROGRAM of

EPHRAIM MCDOWELL HEALTH

DR. JOAN HALTOM, PHARM.D, FKSHP

GAIL SHEARER, BSN, MBA,CCM

DELTA CARE

Delta Care is an Innovative approach to transitioning our patients home and coaching patients through the first 30 days after their hospital discharge.

- It starts with changing some INPATIENT care components

- After discharge the patient receives weekly calls from multidisciplinary Delta Care team coaches

- We monitor for signs of problems and help navigate the patient to Delta coach, PCP, or ED *INSTEAD* of readmitting to hospital

DELTA CARE

- **HOW WILL A CARE TRANSITION PROGRAM HELP?**

  Delta Care has been designed to address the biggest pitfalls that keep patients from following their prescribed discharge plan.

  - Provide disease education
  - Teach and reinforce patient self monitoring and management of disease state symptoms
  - Dispenses critical rescue meds home w/patient
  - Navigates follow up visits with Primary care provider (PCP)
  - Provides for patient to be seen in clinic if PCP cant give them a timely appointment and symptoms worsening
  - Provides them with resources when questions arise

ADMISSION INPATIENT PROCESS

Intervention	Responsible
▲ Assessment for DELTA program	Case manager
▲ Consent to participate ▲ Provide Delta Support Kit	Case manager
▲ HF education book	Nursing
▲ Focus education with teach back on medications	Nursing
Care Plan	Nursing
▲ Get Protocol Order from doctor & update anticipated date of DC	Case manager

ADMISSION INPATIENT PROCESS (cont)

Intervention	Responsible
DC Medication reconciliation- let PHA know patient dcd	Pharmacy
Follow-up appointments 3-5 days post-DC	Nursing
DC with 30 day supply Diuretic for HF Patient teaching by Pharmacist/ Pharm student	Pharmacy
Delivery of HF Medications to patient room	Pharmacy
Send DC Summary to PCP	Team leader

DELTA CARE

After discharge, Delta patients will be asked to :

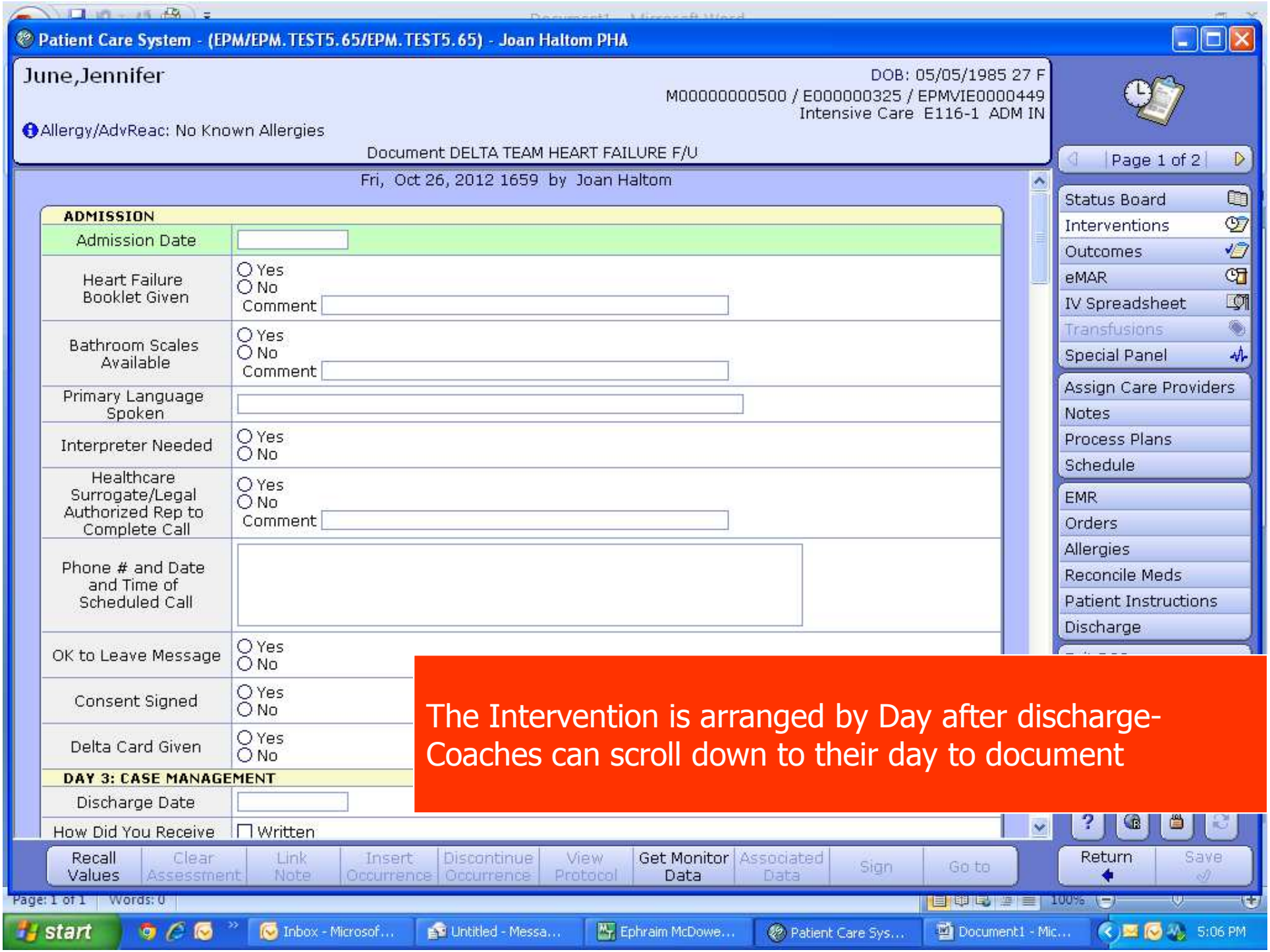
1. Self monitor daily (weigh or peak flow)
2. Accept phone calls from Coaches (day 3, 7, 14,21,28)
3. Incorporate 1 dietary change
4. Set ambulation/exercise goal
5. Know and understand medications
6. Start rescue meds if symptoms worsen/call Coach if meds started
7. Make f/u appointments

HF POST DISCHARGE PROCESS

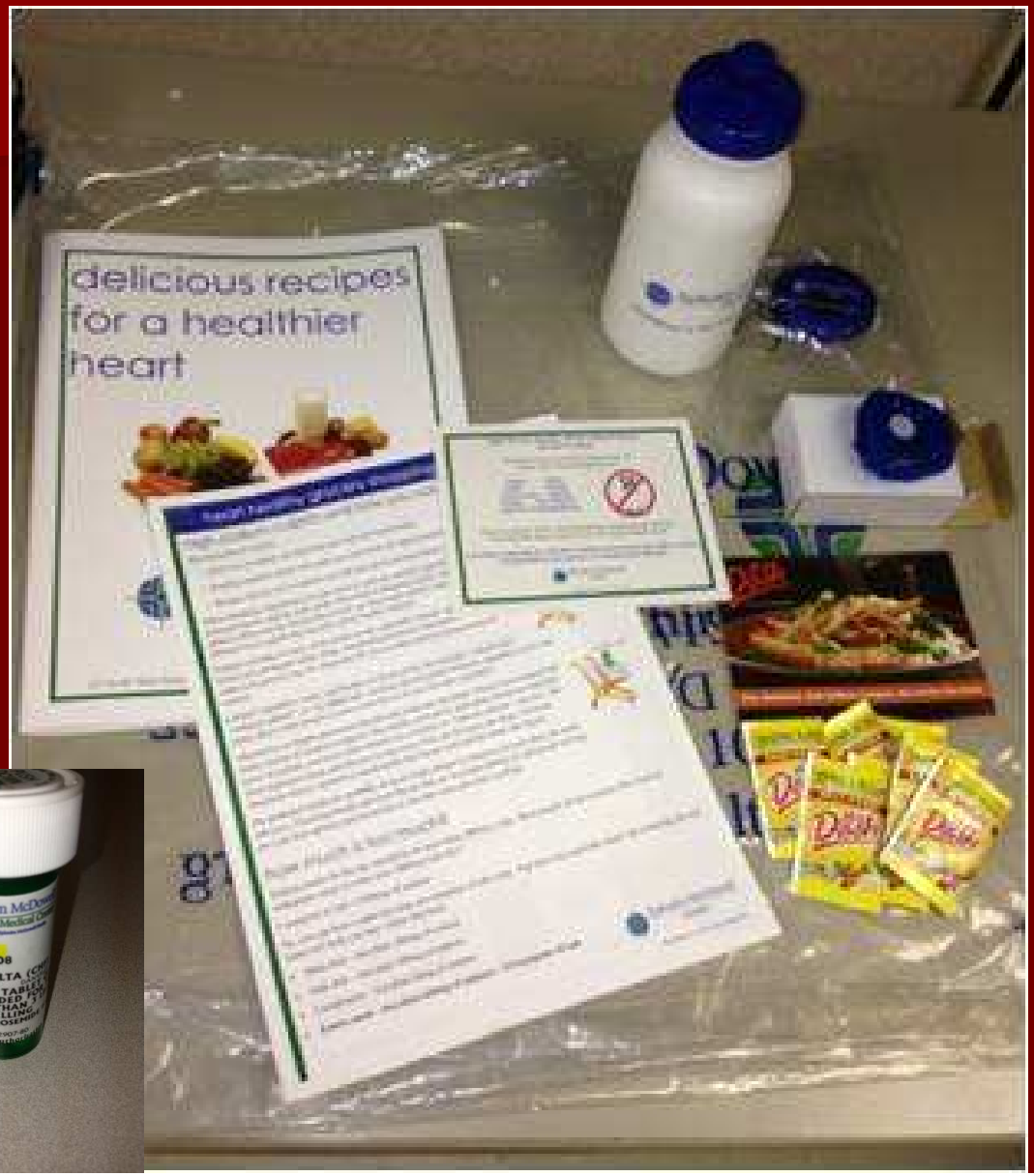
Post Discharge Day	Heart Failure Intervention	Responsible	Care Packages
3 ▲ ▲	Phone interview to review follow-up appointments, weight, salt intake, and fluid intake. HF phone survey questionnaire	Case manager ▲	Medication packet, support items (water btl, pedometer, recipes, Mrs Dash, tape measurer , scale) if needed given on day of discharge
7* ▲	Phone call to review follow-up appointments, change of medications, weight, use of PRN medications, and other educational areas identified	Pharmacy **Trigger a Delta Coach call or home visit if not on track with discharge plan or experiencing setback**	
8-10	If triggered- Home visit or Primary care provider	Case manager/or Pharmacist Scheduled by /Pharmacist	

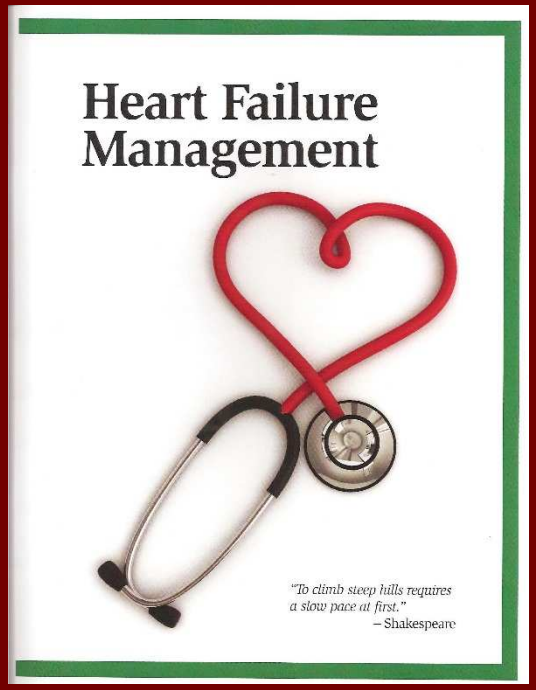
HF POST DISCHARGE PROCESS

Post DC Day	Heart Failure Intervention	Responsible	Care Packages
14 ▲	Phone interview to discuss ambulation and activity goal	Case manager	Dietary newsletter
21 ▲	Phone interview to discuss medications, refills, ask about Wellness pass/ambulation	Pharmacy	
28 ▲	Phone interview to discuss dietary issues /'Grocery Challenge' Patient Satisfaction Survey	Dietitian	
31 ▲	Send 'Thank You' note for participating & Discharge patient from Delta Care	Team leader	


Patient Care System - (EPM/EPM.TEST5.65/EPM.TEST5.65) - Joan Haltom PHA
June,Jennifer
DOB: 05/05/1985 27 F
M00000000500 / E000000325 / EPMVIE0000449
Intensive Care E116-1 ADM IN
Allergy/AdvReac: No Known Allergies
Document DELTA TEAM HEART FAILURE F/U
Page 1 of 2
Fri, Oct 26, 2012 1659 by Joan Haltom
ADMISSION
Admission Date
Heart Failure Booklet Given
Yes
No
Comment
Bathroom Scales Available
Yes
No
Comment
Primary Language Spoken
Interpreter Needed
Yes
No
Healthcare Surrogate/Legal Authorized Rep to Complete Call
Yes
No
Comment
Phone # and Date and Time of Scheduled Call
OK to Leave Message
Yes
No
Consent Signed
Yes
No
Delta Card Given
Yes
No
DAY 3: CASE MANAGEMENT
Discharge Date
How Did You Receive
Written
Status Board
Interventions
Outcomes
eMAR
IV Spreadsheet
Transfusions
Special Panel
Assign Care Providers
Notes
Process Plans
Schedule
EMR
Orders
Allergies
Reconcile Meds
Patient Instructions
Discharge
Recall Values
Clear Assessment
Link Note
Insert Occurrence
Discontinue Occurrence
View Protocol
Get Monitor Data
Associated Data
Sign
Go to
Return
Save
The Intervention is arranged by Day after discharge- Coaches can scroll down to their day to document
Page: 1 of 1
Words: 0
100%
start
Inbox - Microsof...
Untitled - Messa...
Ephraim McDowe...
Patient Care Sys...
Document1 - Mic...
5:06 PM

Delta Heart Failure Kits





Ephraim McDowell Health

DELTA CARE COPD

- Delta Care Coach will call you on days 3, 7, 14, 21 and 28 after discharge.
- Make and keep appointments with primary care provider and any specialists.
- Check your Peak Flow daily.
- Take medications as directed.
- Increase fluids you drink.
- Set activity/exercise goals – keep moving!
- If ordered, use oxygen therapy.
- Stop smoking/reduce exposure to smoke.

If you have questions call Delta case manager at (859)239-5055.
If your symptoms worsen please call your primary care provider.
Please present this card at Registration/Emergency Room.

Place Patient Label Here

DELTA CARE REWARDS

Ephraim McDowell Pharmacy
❑ Nicotine patches $10 off/box ($25 per 14-count box); limit six boxes

McDowell Wellness Center
❑ FREE two-week pass to gym/pool (must use within 30 days of discharge)

Ephraim McDowell Medication Therapy Management
❑ FREE visit; call (859)239-1711 for two-month follow-up appointment

Ephraim McDowell MedSource
❑ 10% off any blood pressure monitor

DELTA CARE

- DELTA Team:
- Coaches making calls will attempt each call on 3 consecutive days (denote attempts in Meditech)
- Navigate patient post discharge based on patient self monitoring and symptoms
- Will meet bi-monthly during launch period to evaluate program and discuss any needed modifications
- Will compile time spent calls & intervention time from documentation in Excel worksheet
- Will evaluate outcome metrics
- Prepare "Delta"kits with support items & booklets

DELTA CARE RESULTS Comparison of readmission rates 2012 v 2013

DRG	2012% readmission	2013% readmission	2012 O/E	2013 O/E	Change %
COPD 190	33	24.18	1.73	1.4	-19%
COPD 191	25	24.18	1.56	1.4	-10%
COPD 192	0	0.6	0.0	0.6	Increase
HF 291	50	23.23	2.44	1.08	-56%
HF 292	25	19.32	1.19	0.98	-18%
HF 293	50	17.28	2.73	1.05	-62%

DELTA CARE Results

Data	HF patients	COPD patients	Combined
Enrolled in Delta	42	44	86
Complete 2 or more calls with coach	18	24	40
Avg # calls completed	3.5	3.1	3.3
PCP visit w/in 7 days	83% (15/18)	41% (9/22)	60% (24/40)
Adhere to meds 6-7 days /week	78% (14/18)	88% (21/24)	83%
Daily self monitoring	Weights 53% (208/396)	Peak flow 41% (55/133)	50% (263/529)

DELTA CARE Results

Data	HF patients	COPD patients	Combined
Wellness pass used (Exercise)	36%	0%	
Adopted at least 1 dietary change	83% (15/18)	69% (11/16)	77% (26/34)
Adopted multiple dietary changes	78% (14/18)	19% (3/16)	50% (17/34)
Avg Engagement Score	35 (possible 82)	38 (possible 62)	
Avg Coaching time (minutes)	47.8	44.8	
Avg Total time= intervention + call time (minutes)	104.7	74.1	

DELTA CARE Results

Data	HF patients	COPD patients	Combined
Avg labor cost per Delta patient/month	$93.31	$60.39	$76.85
Cost of Delta discharge protocol meds/support kit	$10.75	$43.54	
Avg Total expense per Delta patient per month	$104.06	$103.93	$104.00
# patients readmitted w/in 30 days	11% (2/18)	17% (4/24)	14%
# readmissions within 12 months	32% (9/28)	63% (15/24)	

DELTA CARE Results

Objective	Results %
Patients are seen by primary care provider within 5-7 days of hospital discharge.	60%
Patients are able to obtain and comply with prescribed medications post discharge	83%
Patients are able to meet clinical goal for self monitoring their disease states (daily weights for HF, peak flow for COPD)	50%
Patients are able to identify and implement at least one recommended dietary change goal	77%
Patients are able to recognize and seek appropriate level of care when their condition worsens to avoid hospital re-admission within 30 days of discharge	85%

DELTA CARE
Patient Survey Results

38% rate or return
Scale of 1-5 with 1 being least helpful and 5 being most helpful

Data	Survey response
Do you think Delta program helped you understand your disease?	4.6 Avg
Do you think Delta program helped you understand your medications?	4.8 Avg
Do you think Delta program helped you recognize symptoms of your condition?	4.8 Avg
Do you think Delta program helped you understand your diet and exercise?	4.5 Avg

Time Line for Delta HF Implementation at Ephraim McDowell Fort Logan

(critical access hospital)

- July- Designate team members and leader
- Aug 19- Attend HF Collaborative and participate in monthly collaborative calls
- Aug 30- FL Delta Team to assure tools and process operational and feasible
- Sep- Get Delta HF protocol approved Med Staff
- Sep- Complete 1:1 training with EMRMC Delta counterpart for FL Delta coaches
- Oct 1- Initiate FL Delta service

Replicating the Delta Model

- Get C-Suite support for transition of care services
- Evaluate your highest at risk populations for readmissions (Case Management)
- Evaluate your institutions potential financial penalty (Finance/Case Mgmt)
- Identify key stakeholders from other disciplines who have an existing expertise in patient coaching/education for those disease states
- Evaluate what patient education products you already have available. Modify /edit to include post discharge goals and self monitoring.

Replicating the Delta Model

- Look for duplicate services across disciplines or cost centers and evaluate how to streamline your efforts
- Create medical staff approved protocols
- Build documentation templates for coaching
- Consider clinic based transition of care services
- Solicit physician support (primary care and specialists)
- Create effective patient worklist process to coordinate coaching calls
- Evaluate cost per patient
- Delegation of tasks to technicians to free up licensed staff time

QUESTIONS ?

DELTA TEAM MEMBERS Back row (L-R) Gail Shearer, Case Mgmt Director, Joan Haltom, Director of Pharmacy and Respiratory, Sarah Vickey, Outpatient Pharmacy & MTM manager Front row (L-r) Jennie Devine, Case Manager, Bridget Hagan, Dietitian, Gina Vaught, Respiratory Manager

Delta Team Contacts

- Gail Shearer, Director Case Management 859.239.3419 gshearer@emrmc.org
- Joan Haltom, Director of Pharmacy & Respiratory Therapy 859.239.1721 jhaltom@emrmc.org
- Jennie Devine, Case Manager 859.239.5055 jdevine@emrmc.org
- Sarah Vickey, Outpatient PharmacyManager 859.239.1711 svickey@emrmc.org
- Gina Vaught, Respiratory Therapy Manager 859.239.1411 gmorgan@emrmc.org
- Bridgett Hagan, Clinical Dietitian 859.239.1821 bhagan@emrmc.org