

**Kalispell Regional Healthcare**  
Kalispell, Montana  
**Managing the Needs of Medically and  
Socially Complex Patients or  
Superutilizers**



A small number of individuals drive much of the cost in the American health care system, a system that is designed to work for the average patient. Like many large systems, it struggles to help patients with multiple comorbidities, or outliers, i.e., the small number of patients with complex, hard-to-manage needs and chronic conditions. These outliers are known as superutilizers, i.e., patients who have frequent contact with the medical system without measurable improvements in their health. Over time, their chronic conditions worsen, leading to ever more expensive, invasive and risky treatment.

## **TRANSITIONAL CARE MODEL**

Kalispell Regional Healthcare has teamed with Mountain-Pacific Quality Health Improvement Organization to introduce a modified transitional care model, which is intended to provide comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The goals are to (1) improve the health and well-being of patients frequenting the health care system by identifying high-cost, high utilizers and, (2) reduce unnecessary use of health care resources by improving care coordination and communication across community assets including health care, housing, transportation, meals and safety-net resources. In addition the model will test tablet technology as a health care extender to rural patients living in frontier regions.

## **BACKGROUND**



Under the direction of the Centers for Medicare & Medicaid Services (CMS), Mountain-Pacific Quality Health

is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Hawaii, Alaska, the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands. They partner with health care providers, practitioners, stakeholders, patients and their families in these states and territories.

Kalispell Regional Healthcare (KRH) is 343-bed health care system located in Kalispell, Montana. KRH serves more than 190,000 people within a geographical region of 20,000 square miles and employs more than 4,000 team members. Comprising the health care system are two acute-care hospitals – Kalispell Regional Medical Center (KRMC) and

North Valley Hospital (NVH) – and a mental health and substance abuse facility. Core services include cancer care, cardiovascular care, neuroscience and spine care, trauma level III emergency services, neonatal intensive care and orthopedics. In addition, the system includes six primary care clinics certified by the National Committee for Quality Assurance for their Patient-Centered Medical Home programs.

KRMC is a regional referral center, offering a full spectrum of health care services provided by a medical staff of more than 400 physicians, physician assistants and nurse practitioners, and 3,400 employees throughout 100 departments. . Nearly 70 physician specialists see patients at outreach clinics



NVH is a 25-bed Critical Access Hospital based in Whitefish, Montana, and is a public benefit non-profit corporation. Core services include 24/7 emergency, Birth Center, orthopedics and minimally invasive surgery. NVH operates primary and specialty care clinics in Whitefish, Columbia Falls, Kalispell and Eureka, Montana, in addition to a structured outpatient mental health service in Whitefish.

In 2014, Mountain-Pacific Quality Health applied for and received nearly two million dollars in funding for a Special Innovations Project (SIP) from the Centers for Medicare & Medicaid Services (CMS) to apply Transitional Care Model philosophies in Montana, bringing together new and existing resources and technologies to develop intervention teams – called ReSource Teams – and support superutilizer patients. The award was combined with a \$250,000 grant from the Robert Wood Johnson Foundation, and the SIP is being demonstrated across Montana.

## RESOURCE TEAMS



ReSource teams are multidisciplinary groups of trained professionals that include a primary care physician, pharmacist, ReSource nurse (RSN), behavioral health professional and community health worker (CHW) linked to a variety of community resources. ReSource teams are adapted to each community. Unlike a traditional Transitional Care Model, which adds resources to a dense geographic area, ReSourcing would bring together new and existing community resources and technologies to develop an intervention team covering a broader range of geography. In this instance, the team is linked to [Project ECHO®](#) (Extension of Community Healthcare Outcomes), a model aimed at increasing access to specialty expertise, knowledge and support in underserved areas.

In this community-based approach, the RSN acts as a care coordinator for the patient and does medical assessments, caregiver burden assessment, patient safety

assessment, patient and caregiver education and medication reconciliation. The RSN also coordinates with the physician and helps to establish the patient's medical home. Community Health Workers augment the non-medical care and break down barriers to care, including many social determinants of health such as lack of transportation, secure housing and food. In addition, a behavioral health consultant helps the team, not the patient, develop strategies to work with patients having coinciding mental health needs. The motto is, "I do, we do," that is, teams teach patients self-reliance and move them toward primary care management.

## HOW IT WORKS

This approach focuses on patients who are completing a hospital stay, or who have had repeated utilization within six months, such as:

- two or more inpatient admissions
- two or more observation stays
- three or more emergency department visits

ReSource teams help patients who:

- can benefit from more coordinated primary care
- have medical problems that can be prevented, such as diabetes
- are not end-of-life
- do not have conditions that will continually get worse
- have documented or undocumented mental health issues correlating to superutilization

A nurse will visit the patient prior to discharge from the hospital to determine the need and appropriateness for participation in the program. If enrolled, within the first week of discharge to home, the RSN will visit and gather clinical information, which can then be shared with the CHW, who can then focus on the social determinants of health. Tablet computers are used to facilitate communication between patients at home and members of the ReSource team in the hospital, which is necessary for implementing or modifying a plan of care for socially and medically complex patients living in frontier Montana.

The CHW and RSN will make additional visits and, upon the end of 30 days, assess symptoms, review care plan compliance and assess progress on socialization to be shared with the ReSource team. The patient may then graduate, extend enrollment or be referred to their medical home. If the enrollment is extended, the CHW and RSN will continue visiting up to 90 days, at which time the team will review the patient's chronic disease self-management skills, health care navigation skill and compliance with the plan of care. The RSN and CHW summarize the information for the patient's primary care physician in a coordinated plan of care.

The program also offers care coordination software that allows entities to share patient information. With the software, the patient's primary care physician can see that they're enrolled in various community resources such as shuttles or "Meals on Wheels" to

prevent duplicating efforts. The software also allows the team to track whether the patient avoids medical crises after progressing from the outpatient care program.

Essential to the success of the effort is the ability of the RSN to serve not only as a medical mediator, but to coordinate activities across the breadth of community resources. This suggests recognizing that the challenge is more than just filling medical gaps; rather, it is observing the whole picture of a person's life and identifying unmet basic needs. By building trusting relationships with patients, the ReSource team is better able to achieve improved compliance and more favorable outcomes.

Rural teams often work in isolation. Monthly case conferences with experts and peers addressing de-identified complex cases are essential for learning and knowledge transfer and imperative to achieving the desired outcomes.



To achieve this goal of clearly seeing and effectively responding to the whole picture, a diverse range of community organizations – including [Western Montana Mental Health](#), Pathways Treatment Center, Summit

Medical Fitness Center, [ASSIST](#), [Flathead Community Health Center](#), Brendan House skilled nursing facility

and others – convened in 2012 and formed the Northwest Montana Care Transitions Coalition. It has become an integral part of the SIP and provides partners with a way to collect data that documents whether or not the effort is working. It also allows the coalition to extend its reach.



## OUTCOMES

KRH will track admissions/readmissions, emergency department visits, in-person and video chat visits and patient satisfaction. By the conclusion of its second year, this special innovation project is projected to reach 65 patients and reduce inappropriate visits to the emergency department by 1 per patient for savings of approximately \$83,400. This would translate to almost \$1 million in savings to Medicare, Medicaid and the Indian Health Service through reduced readmissions.

## CONCLUSION

Every patient is different as is their motivation for utilizing health care. Every provider is different, and it is imperative that they communicate with one another to meet the needs of their patients and reduce unnecessary use of health care resources. Population health will improve by enhancing care coordination and communication across community organizations, including health care, housing, transportation, meals and safety-net resources.

Engaging patients to commit to and participate actively in their health care is critical to success and requires a supportive environment led by an empathetic leader. The need for motivational interviewing, trauma-informed care and substance use awareness are important characteristics for the ReSource nurse. A ReSource team that can function across multiple levels of care and social determinants will be in the best position to achieve the program goals.

ReSource teams offer an approach to improving the health and well-being of patients who frequent the health care system, conserving scarce resources by identifying high-cost high utilizers and coordinating their care. Ultimately, this approach will improve the experience of care for both caregivers and recipients as outcomes improve and efficiency is achieved.