

A Novel Approach...

ReSource Teams: Community
Collaboration and Caring for High-risk
Patients in their Home Settings

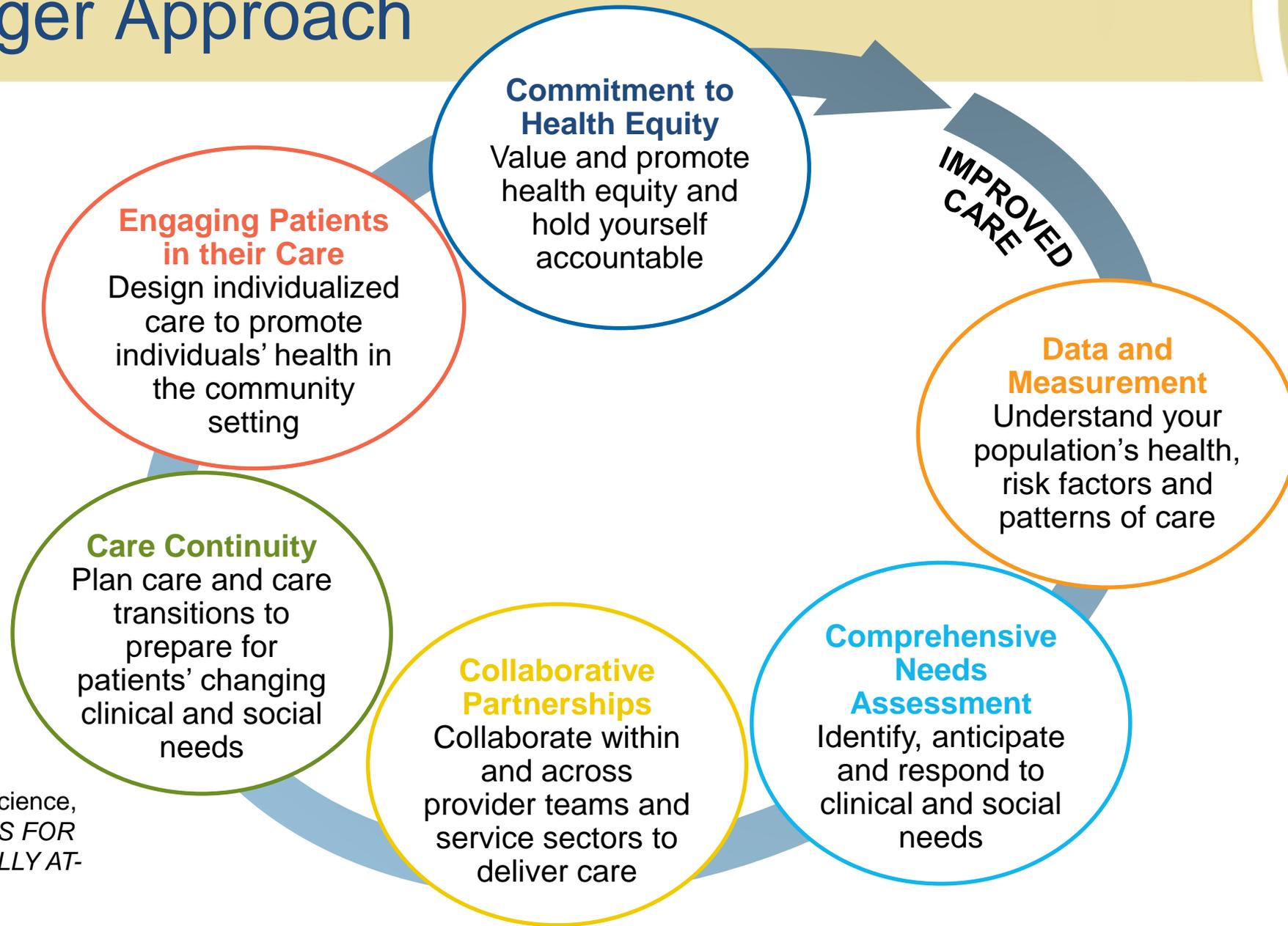
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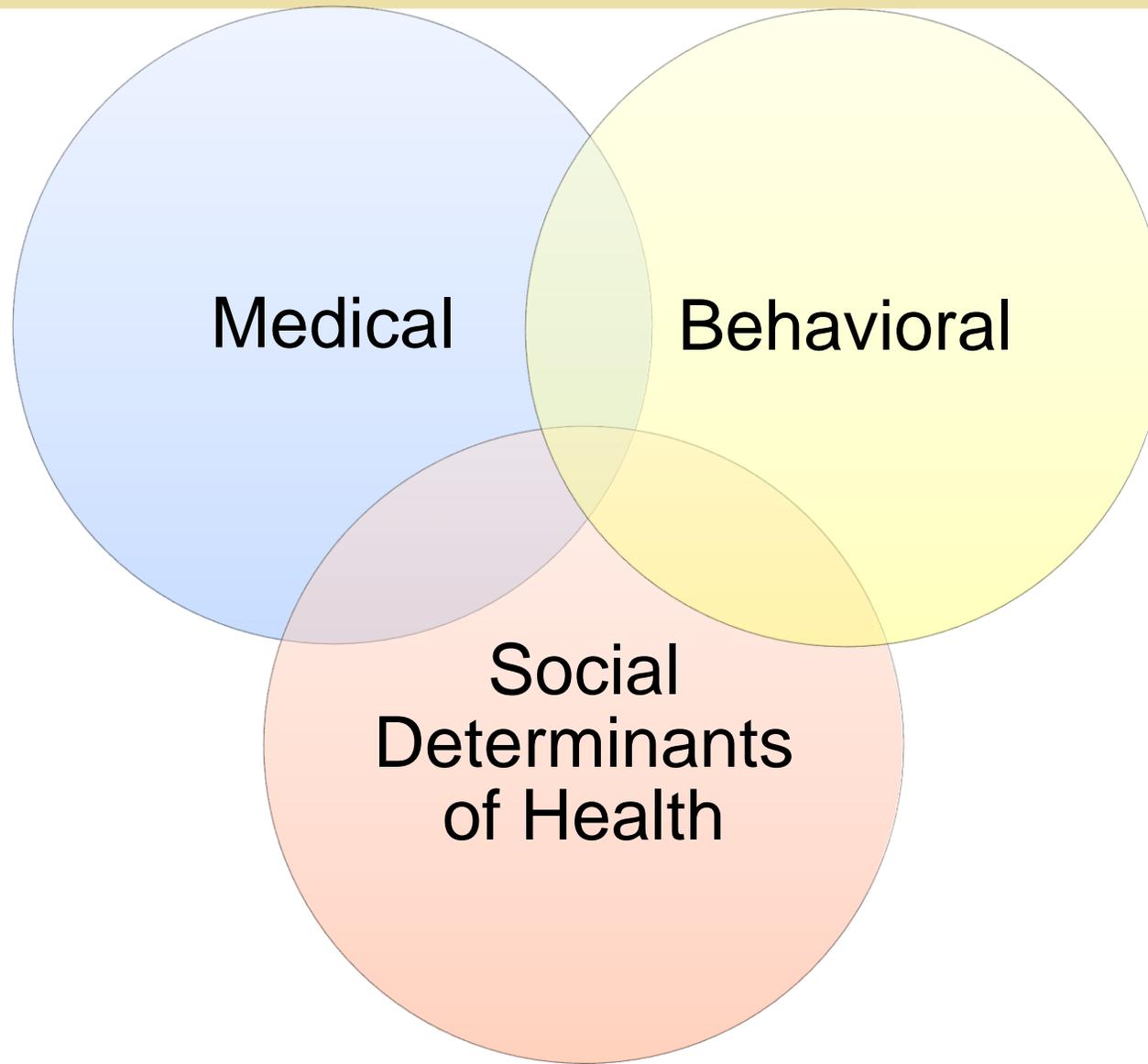
Where Is CMS Going...?

A Larger Approach



Source:
National Academy of Science,
*SYSTEMS PRACTICES FOR
THE CARE OF SOCIALLY AT-
RISK POPULATIONS*

Balancing the Whole Patient



Elements of the Program



Community Readiness: Aligning Key Stakeholders

- QIO-led community coalition
- Local case conferences – Who’s problem is it?
- Defining elements of “super-utilizer” and creating a shared vision



Intervention ReSource Teams

- Clinical and nonclinical services wrapped around the patient for 90-day intervention



Education and Continuous Improvement

- QIO-led statewide steering committee, including payers, foundations and universities
- Statewide case conferences

The Project: ReSource Teams

- RN + CHW + tablets
- Patients with two or more inpatient admissions and/or emergency department visits in six months
- Patient is not end-of-life
- Social determinants of health
- In-home visits and intensive case management
- Rural location



Community Organizing



Coalition Resources

- Health system/hospital/OP clinics
- FQHC
- Community behavioral health/Sunburst
- LTC
- Transportation
- Housing
- Medicaid



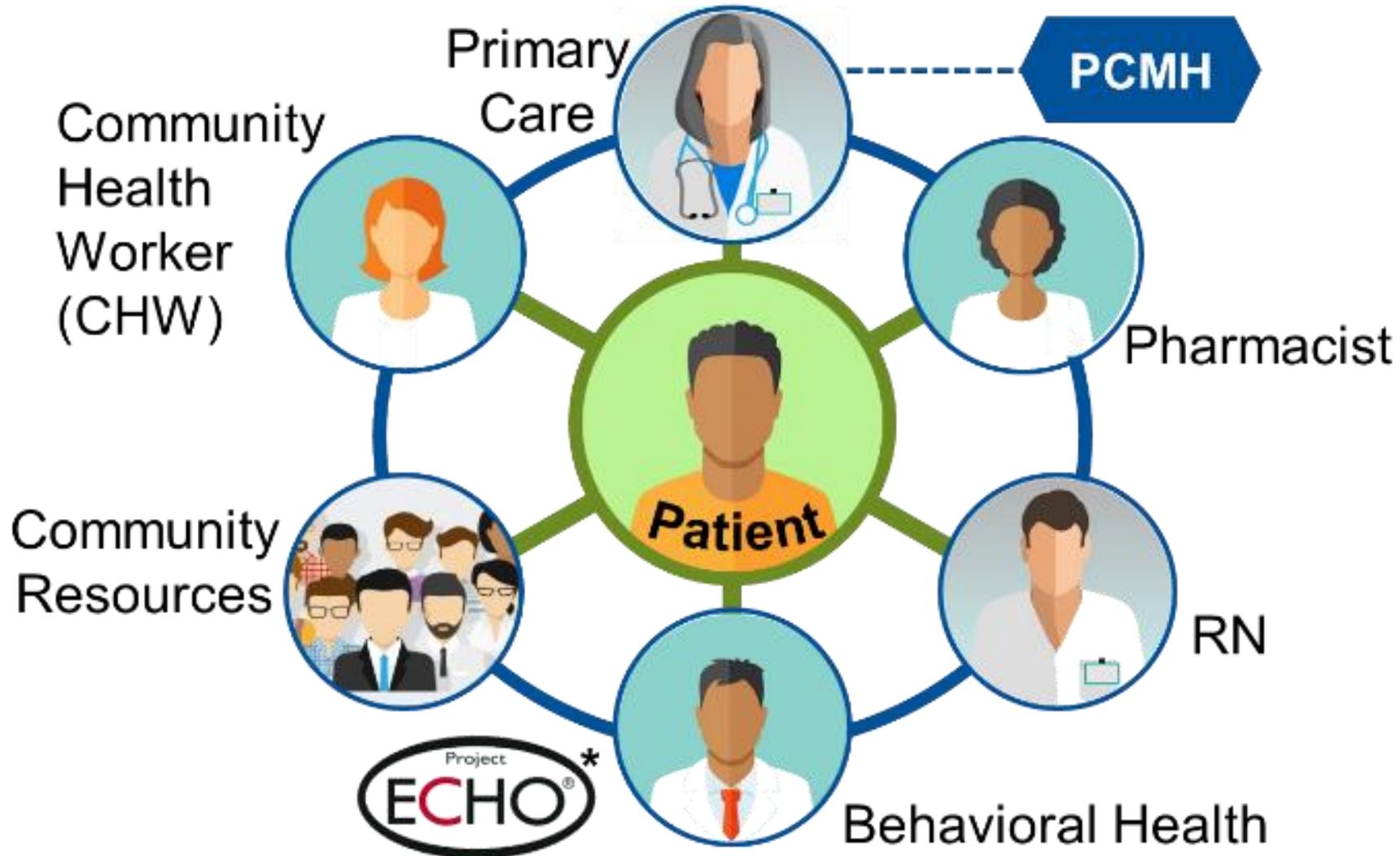
ReSource Teams



Patient

- State DoH
- Gaps in care
- Challenges

Larger Collaborative Model



Super-Utilizer SIP Success

(data thru April 2018)

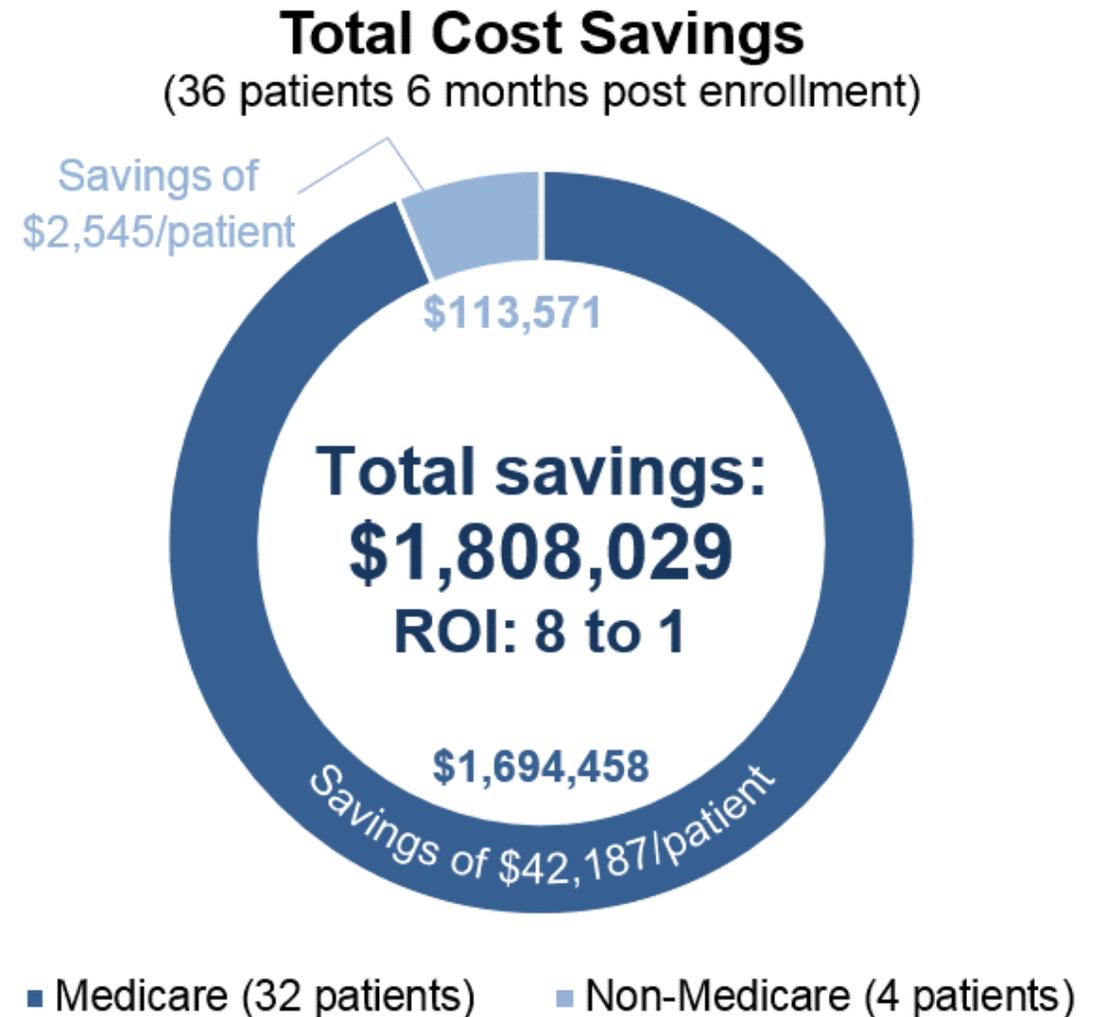
		Billings	Helena	Kalispell	Total
Target # of Patients		50	55	65	170
YTD # of Patients	Medicare	9	172*	22	203
	Medicare/ Medicaid	12	74*	22	108
	Medicare Advantage	3	39*	11	53
	Other	14	51*	10	75
Current	Total # of Past/Present Patients in Program	31	471*	65	567
	# of Handoffs	20	15**	49	84

*Patients received phone intervention only

**Helena requires few handoffs due to the care team being clinic case managers

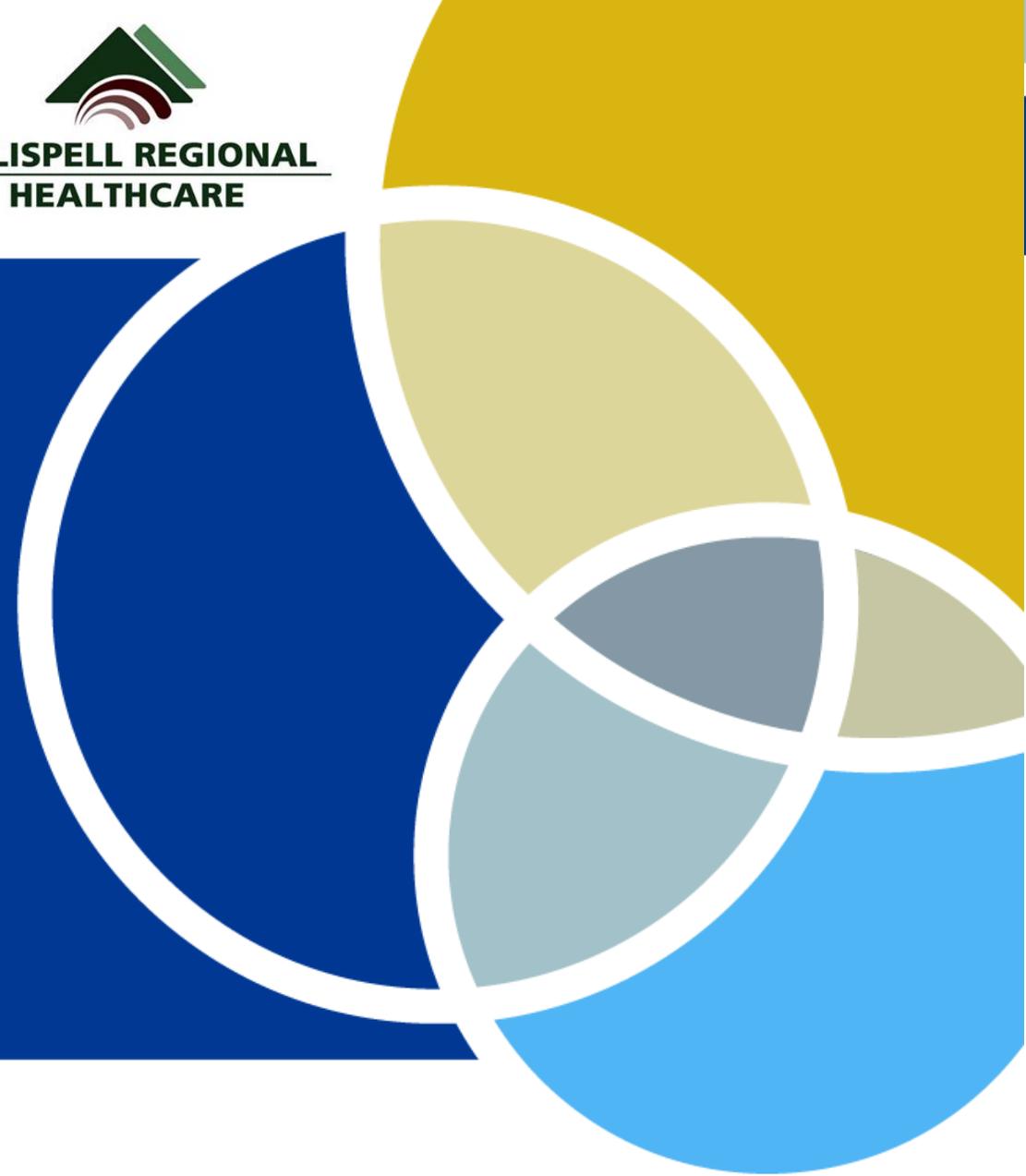
Making the Business Case

- Cost efficiencies through RNs work at the top of their licensure
- CHWs build capacity in workforce
- Movement towards population health and alignment with Advanced Payment Models (APMs)
- Better patient satisfaction
- PCP clinic efficiencies and information
- Decreased utilization of ED and IP readmissions



Team Interventions on the Ground:

Working with Patients



Simple Demographics

Kalispell (n = 65)

Average Age	Males	Females	Don't Own Their Home	Owned a Car	Active Drivers
					
61	30	35	38 (58%)	50 (77%)	38 (58%)

Complex Care Team



+



Simple Demographics

Kalispell (n = 65)

CHF Dx		Diabetes Dx	COPD Dx		CKD Dx	ESRD Dx	Cancer Hx	Chronic Pain Dx
28		25	25		21	6	13	30
43.1%		38.5%	38.5%		32.3%	9.2%	20.0%	46.2%
Insomnia Dx		Sleep Apnea	Depression Dx	Anxiety Dx		Other MH Dx	Brain Injury Dx	CVA Hx
17		22	30	22		15	8	8
26.2%		33.8%	46.2%	33.8%		23.1%	12.3%	12.3%
IP MH 12 mos	Antidepressant Rx	Benzo Rx	Opioid Rx	Narcotic Dependency		Methodone Clinic	Marijuana	Caregiver
5	32	17	34	12		3	12	10
7.7%	49.2%	26.2%	52.3%	18.5%		4.6%	18.5%	15.4%

Social Determinants of Health (SDoH)

Kalispell ReSource Team Patients ICD-10 Codes to Identify SDoH [n=65]	# of Patients with SDoH	% of Patients with SDoH
Problems related to education and literacy, unspecified	51	78.5%
Problems related to housing and economic circumstances	40	61.5%
Lack of adequate food and safe drinking water	21	32.3%
Insufficient social insurance and welfare support	7	10.8%
Problem related to housing and economic circumstances, unspecified	23	35.4%
Problems related to social environment	39	60.0%
Problems of adjustment to life-cycle transitions	24	36.9%
Problems related to living alone	17	26.2%
Other problems related to primary support group, including family circumstances	37	56.9%
Other stressful life events affecting family and household	23	35.4%
Problem related to primary support group, unspecified	27	41.5%
Problem related to unspecified psychosocial circumstances	51	78.5%

Complex Care Team-to-Patient Ratio



1 RN
1 CHW
iPads

1 RN
2 CHWs
iPads

2 RNs
2 CHWs
iPads

25

50

100

Complex Care Patients

Pharmacy and Tele-visits

Pharmacy and behavioral health important partners



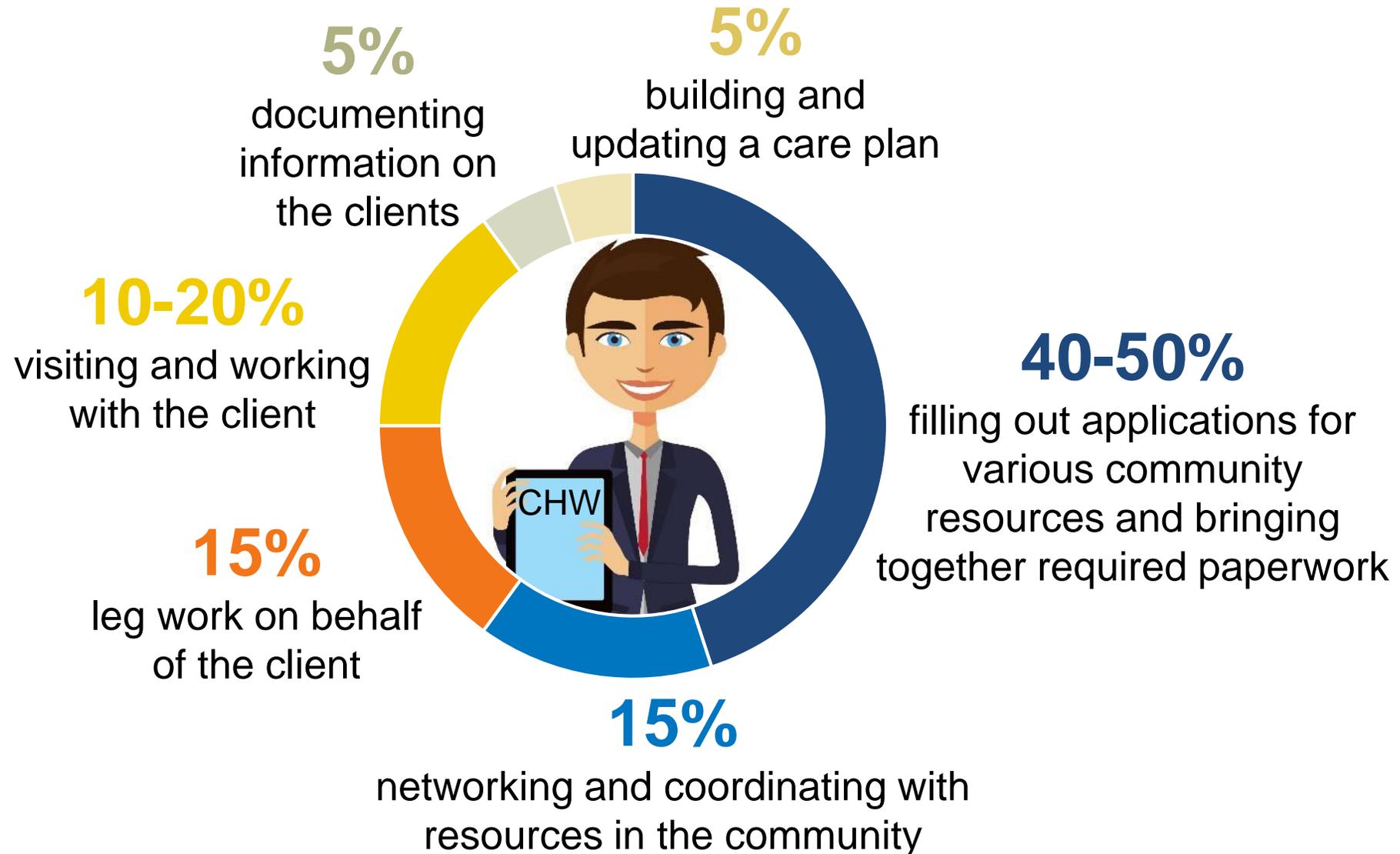
Pharmacy intervention needed for:

- Medication reconciliation
- Medication education
- Finding alternative low cost meds
- Answering patient questions

Help with narcotic intervention and pain

	Billings n=31	Kalispell n=65
Opioids	18	34
Benzodiazepines	6	17
Narcotic dependency ICD-10 F11.02	16	12
	51.6%	18.5%

CHWs Duties



Patient Goals: Individual Driven not Agenda Driven

goals

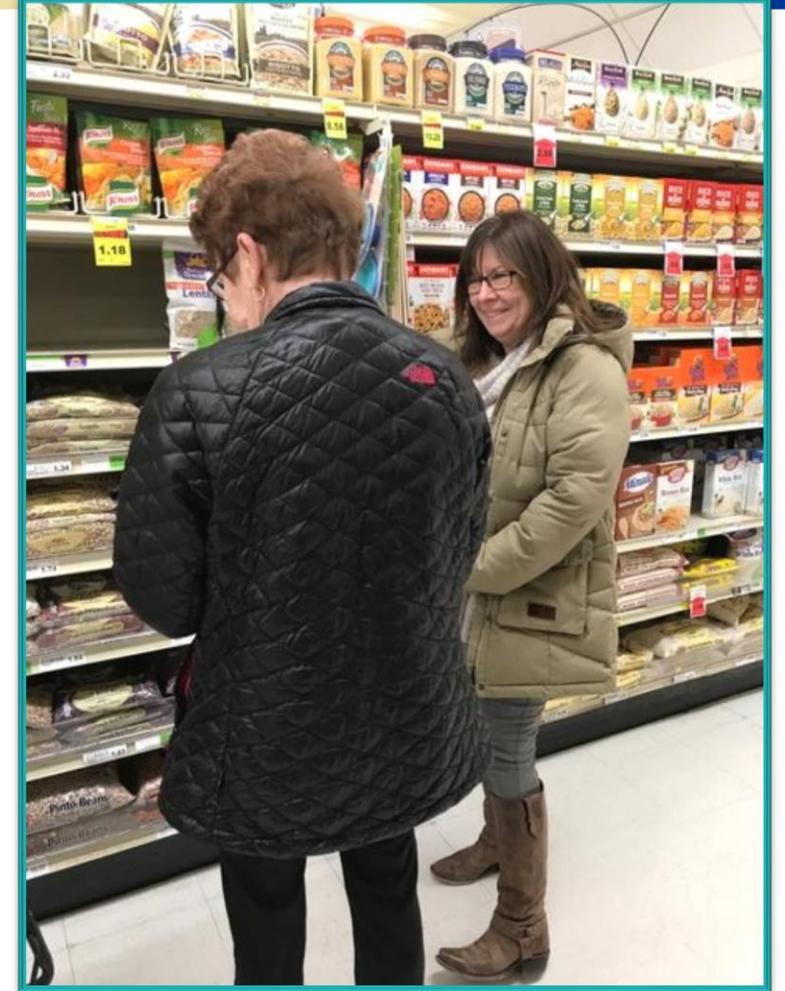
- ① walk more
- ② visit family, grandkids
- ③ Go fishing 😊

- Have a Life "go on a date"
- Find a Hobby
- Travel & Camp

Goals

- Increase SS by a \$1,000 a Month Wound Care?
- ① Visiting family in Iowa & California
 - ② Wound Care? Walking Boot?
 - ③ fix up pickup, Feel better so I can do more & be Active

Patient-Centered



In Summary

- Earliest innovators and model builders in Montana (since 12/2014)
 - Data on more than 550 patients
 - Translates across communities (Kalispell, Billings, Helena)
 - Speaking nationally on the model
- Community organizing and feedback loops
 - Community coalitions
 - Case conferences
- Patient-led goals/motivation
- Telehealth – Bringing in additional disciplines:
 - Pharmacy – Medication consults
 - Primary care and specialty navigation
 - Behavioral health integration
 - Nutrition
- Medical/social model – Deals with medically complex AND behavioral health/SUD
- Reach across the silos

Questions or Comments:

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