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

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Presentation to Montana DPHHS Nov 7, 2018
Community-Informed and Patient-Centered Care

Involve patients and their families in decision-making and tailor care to reflect their goals, values, capacities and community social context.

Where Is CMS Going…? A Larger Approach

- **Engaging Patients in their Care**: Design individualized care to promote individuals' health in the community setting.
- **Care Continuity**: Plan care and care transitions to prepare for patients’ changing clinical and social needs.
- **Collaborative Partnerships**: Collaborate within and across provider teams and service sectors to deliver care.
- **Comprehensive Needs Assessment**: Identify, anticipate and respond to clinical and social needs.
- **Commitment to Health Equity**: Value and promote health equity and hold yourself accountable.
- **Data and Measurement**: Understand your population's health, risk factors and patterns of care.

Source: National Academy of Science, SYSTEMS PRACTICES FOR THE CARE OF SOCIALLY AT-RISK POPULATIONS
Balancing the Whole Patient

Medical

Behavioral

Social Determinants of Health
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

QIO = Quality Improvement Organization
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
# Super-Utilizer SIP Success
(data thru April 2018)

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

*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

Total Cost Savings
(36 patients 6 months post enrollment)

- Total savings: $1,808,029
- ROI: 8 to 1

Savings of $2,545/patient

Savings of $42,187/patient

- Medicare (32 patients)
- Non-Medicare (4 patients)
Team Interventions on the Ground:

Working with Patients
## Simple Demographics
### Kalispell (n = 65)

<table>
<thead>
<tr>
<th>Average Age</th>
<th>Males</th>
<th>Females</th>
<th>Don’t Own Their Home</th>
<th>Owned a Car</th>
<th>Active Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>30</td>
<td>35</td>
<td>38 (58%)</td>
<td>50 (77%)</td>
<td>38 (58%)</td>
</tr>
</tbody>
</table>
Complex Care Team
## Simple Demographics
### Kalispell (n = 65)

<table>
<thead>
<tr>
<th>CHF Dx</th>
<th>Diabetes Dx</th>
<th>COPD Dx</th>
<th>CKD Dx</th>
<th>ESRD Dx</th>
<th>Cancer Hx</th>
<th>Chronic Pain Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>25</td>
<td>25</td>
<td>21</td>
<td>6</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>43.1%</td>
<td>38.5%</td>
<td>38.5%</td>
<td>32.3%</td>
<td>9.2%</td>
<td>20.0%</td>
<td>46.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insomnia Dx</th>
<th>Sleep Apnea</th>
<th>Depression Dx</th>
<th>Anxiety Dx</th>
<th>Other MH Dx</th>
<th>Brain Injury Dx</th>
<th>CVA Hx</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>22</td>
<td>30</td>
<td>22</td>
<td>15</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>26.2%</td>
<td>33.8%</td>
<td>46.2%</td>
<td>33.8%</td>
<td>23.1%</td>
<td>12.3%</td>
<td>12.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IP MH 12 mos</th>
<th>Antidepressant Rx</th>
<th>Benzo Rx</th>
<th>Opioid Rx</th>
<th>Narcotic Dependency</th>
<th>Methodone Clinic</th>
<th>Marijuana</th>
<th>Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>32</td>
<td>17</td>
<td>34</td>
<td>12</td>
<td>3</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>7.7%</td>
<td>49.2%</td>
<td>26.2%</td>
<td>52.3%</td>
<td>18.5%</td>
<td>4.6%</td>
<td>18.5%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>
### Social Determinants of Health (SDoH)

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

- 1 RN, 1 CHW, iPads: 25 Complex Care Patients
- 1 RN, 2 CHWs, iPads: 50 Complex Care Patients
- 2 RNs, 2 CHWs, iPads: 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

<table>
<thead>
<tr>
<th></th>
<th>Billings n=31</th>
<th>Kalispell n=65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>18</td>
<td>34</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Narcotic dependency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F11.02</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>51.6%</td>
<td>18.5%</td>
</tr>
</tbody>
</table>
CHWs Duties

- **5%** documenting information on the clients
- **5%** building and updating a care plan
- **10-20%** visiting and working with the client
- **15%** leg work on behalf of the client
- **15%** networking and coordinating with resources in the community
- **40-50%** filling out applications for various community resources and bringing together required paperwork
Patient Goals:
Individual Driven not Agenda Driven

1. Walk more
2. Visit family, grandkids
3. Go fishing

- Have a life "go on a date"
- Find a hobby
- Travel & Camp

- Increase $5 by $1,000 a month
- Wound Care?
- Visiting family in Iowa & California
- Wound Care? Walking Boot?
- Fix up pickup, feel better so I can do more & be active
Patient-Centered
Medical and Community Collaboration

- Inpatient Medical Collaboration
- Outpatient Medical Collaboration
- Housing
- Transportation
- Food Scarcity
- Social Isolation and Family Estrangement
- Community Resources
- Social Services

Patient

Complex Care RN

CHW

C就戦

Veteran's Pantry

Ray of Hope

National Pawn Shop

Fairgrounds Manager

C Falls Sober House

Samaritan's House

406 Property Mgt

2nd Helping Thrift Store

East Haven Baptist Church

Dial a Ride

SB Village

DMV

Glacier Taxi

Eagle Transit
Presenting Nationally…

Care coordination at its best – Kalispell Regional Health Care shares an example of the impact of its complex care navigator program — helping a single patient make 75 unique connections for medical and community support.

Monster Shout-Out to Lara Shadwick from Mountain Pacific Quality Health and Lesly Starling of Kalispell Regional Healthcare for their elegant and ingenious solution driving coordination of care deep into the heart of a community. Their presentation at the recent Vizient Connections Summit demonstrated a resourceful partnering of Health Professional with community-based assets to reduce hospital readmissions and avoidable ED utilizations.
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