Care/Case Management Model Cover Sheet

Program Name: ReSource Teams/Complex Care Management

Population Focus:

High cost, High needs patients. 2 or more hospital admission and/or multiple ED visits in a six month period. Not end of life. Ambulatory sensitive conditions with social determinants of health impacted life circumstances.Patients benefit from better coordination of primary care

Program Objectives:

1. Reduce IP readmissions and inappropriate ED utilization
2. Reduce overall cost of care pre/post intervention
3. Improve patient satisfaction
4. Improve provider satisfaction and efficiencies
5. Address community gaps in care

Program Description:

Mountain-Pacific Quality Health undertook the CMS funded Rural Frontier Super-utilizer Special Innovation Project (SIP) to bring community outreach teams, or ReSource Teams, to rural Montana. Multiple community resources in the Billings, Helena and Kalispell areas were brought together for the first time to improve the coordination of care for over a 150 “super-utilizer” patients. These are patients with multiple medical conditions and social/behavioral problems, a high frequency of hospital readmissions and emergency department visits and often have fragmented care. These problems are compounded by rural/frontier settings with poor coordination of services. The ReSource Team consisted of a nurse and community health workers (CHWs) who coordinated with primary care physicians, pharmacists and other clinical staff. The teams identified patients who were super-utilizers and established a relationship of trust with them. The team then brought together more than a dozen health care and community resources such as hospitals, primary care physicians, behavioral health professionals, pharmacists, insurers, state and county health resources, Veterans Affairs (VA) resources and other services to coordinate these patients’ services while cultivating patient engagement and process participation. The ReSource Team worked to deliver as many services as possible to the patients in their home setting by identifying medical and social issues. Tablet technology and CHWs visiting patients in their homes were techniques used to reduce travel by other staff and to increase the patients’ access to services. The project has

demonstrated reduced mortality, reduced readmissions and reduced emergency department utilization. In one community, the project demonstrated an early ROI of 8:1 with a savings of $1.8 million from 36 patients.

Required Care/Case Management Staff:

Health System=RN + CHW+ iPad
QIN QIO= Program Staff and Community Coalitions
Adjunct: Pharmacy, Behavioral Health, nutrition

Program Demographics

Monthly member count:

More than 550 patients have been touched by programs in 3 locations

Average monthly program cost per member:

Average monthly total benefit cost per population member: ROI of 8 to 1

Monthly provider count: teams are working with multiple PCPs in each location

Average # of members per provider:

Average monthly provider program revenue:

Program Measurements

P Utilization, Ed utilization, cost of care, patient satisfaction, provider satisfaction, tracking social determinants of health, clinical conditions and patient demographics for emerging trends across more than 550 patients to date.