Kalispell Regional Health Complex Management Program

Identify high-risk patient

- Daily high utilizer report
- Admission risk assessment
- CM/SW discretion
- Outpatient risk assessment (OBS, same day surgery, emergency department "at risk")

Referral to Complex Care Team

Hospital interview (if possible) vs. home visit within 48 hours

Assign team and team lead (communicate back to Complex Care Team and PCP)

- −RN
- −ASSIST
- −Mental health specialist
- −Payer case manager
- −PCP case manager
- −CHWs/Volunteers
- −Disease-specific case manager
  - •CHF
  - •Diabetes

	Hospice/LTC	Distance Discharge	Local Home Discharge	Short-Term Local Facility Discharge
Follow-up		Phone call day after Discharge ↓ Weekly calls until 30 days ↓ Tablet technology	Home visit day after Discharge ↓ Accompany to first post-discharge visits (PCP, specialist) ↓ Weekly visits until 30 days ↙ Monthly visits ↘ Continue weekly visits	Weekly visits until discharge ↓ Accompany to first post-discharge visits (PCP, specialist) ↓ Weekly visits until 30 days

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