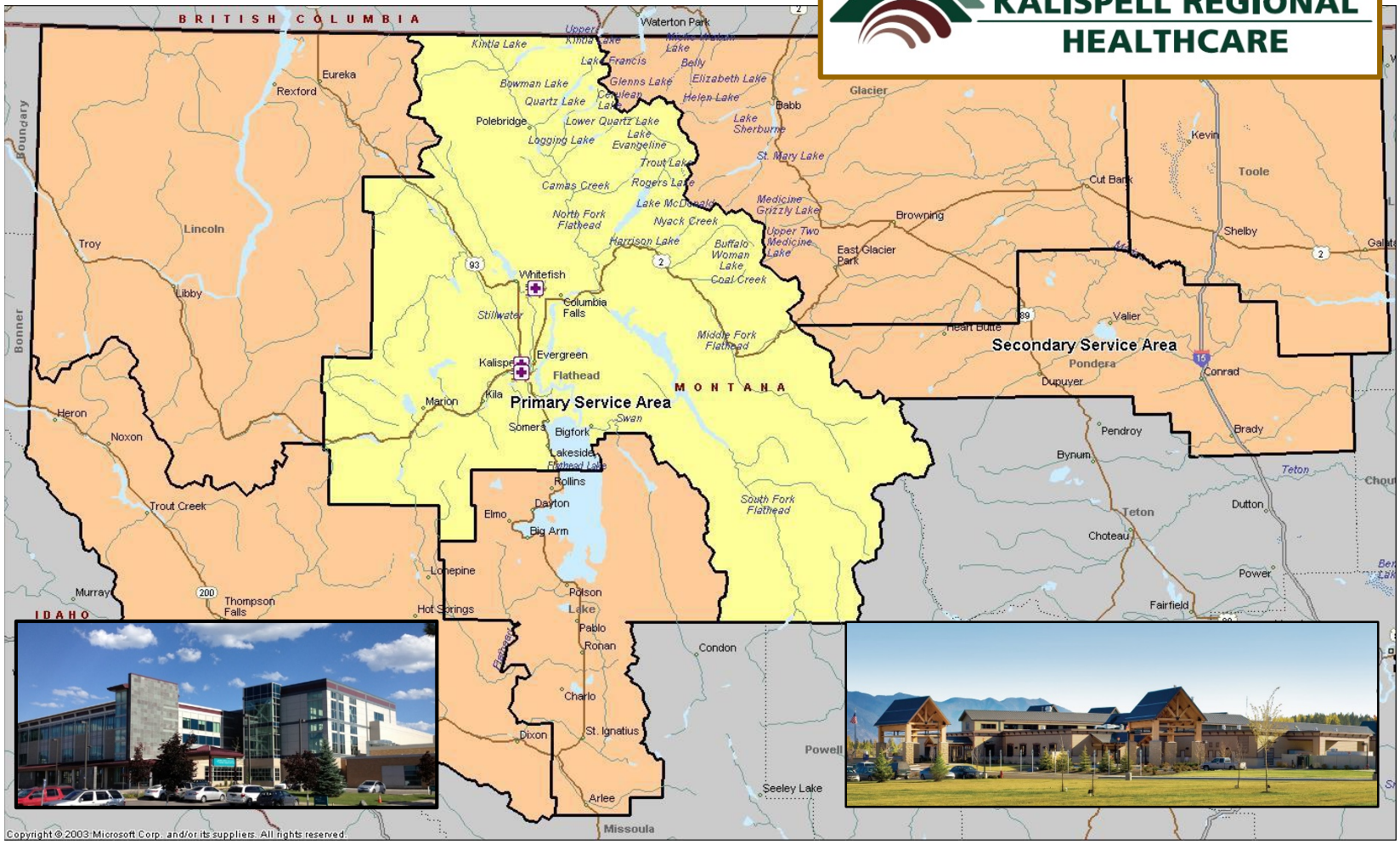
Why coordinate care?

Managing the Needs of Medically and Socially Complex Patients

KALISPELL REGIONAL HEALTHCARE



What is Transitional Care?

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.**

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How do we coordinate care?

- Primary care physician
- Pharmacist
- ReSource nurse
- Behavioral health professional
- Community health worker and
- Variety of community resources

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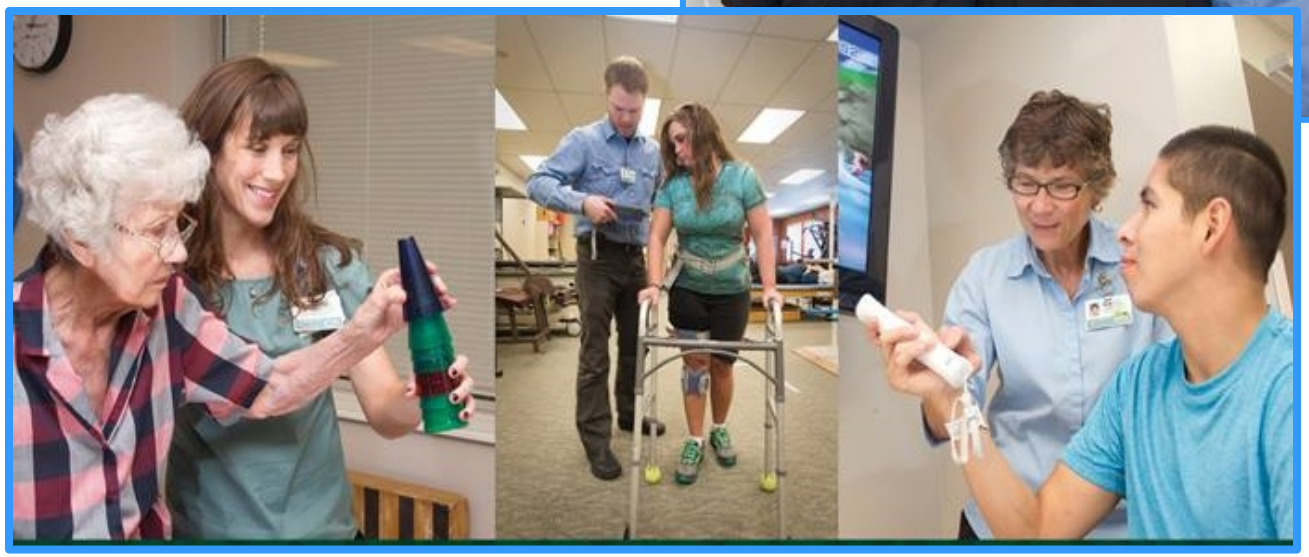

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Who is served?

This approach focuses on patients who are completing a hospital stay, or who have had repeated utilization:

- **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**
- **are not end-of-life**
- **do not have conditions that will continually get worse**
- **have documented or undocumented mental health issues correlating to superutilization**

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Who are our partners?

Flathead Community Health Center

Family Medicine Residency of Western Montana

ASSIST
NEIGHBORS HELPING NEIGHBORS
Affiliated with Kalispell Regional Healthcare

WMMHC
Western Montana Mental Health Center

Northwest Montana Care Transitions Coalition

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What are the 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.

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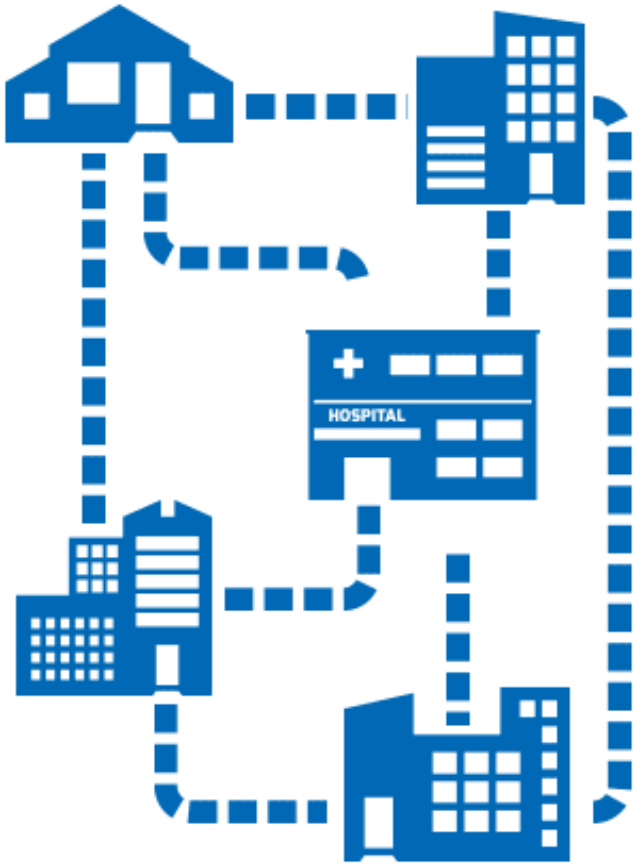
Summary

- Engaging patients to commit to and participate actively in their health care.
- Motivational interviewing, trauma-informed care and substance use awareness.
- ReSource team that can function across multiple levels of care and social determinants.



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