Community Care Transition Team of Billings

WHAT WORKS IN MONTANA PROJECT 22

GOALS AND ACTIVITIES

This project aims to decrease utilization of emergency and hospital services in Yellowstone County by providing wraparound services for residents who are "super-utilizers" of emergency room and hospital services.

The Care Transition Team receives client referrals from Billings Clinic, St. Vincent Healthcare, and RiverStone Health. They conduct home visits and develop individualized care plans that aim to decrease stressors brought on by frequent illness, gain access to resources in the community, communicate with their healthcare team, and create the ability to better tolerate life circumstances.

Team members begin by managing their clients' individual care needs and work towards graduation with the client managing their own daily needs. Services provided by team members may range from education on health and safety to assistance with finding new housing.

POPULATIONS SERVED

Individuals living in Yellowstone County with five or more Emergency Department admissions and two or more hospital admissions in a rolling six month period.

MAJOR PARTNERS AND FUNDERS

Adult Resource Alliance, Billings Clinic, St. Vincent Healthcare, Healthy by Design, RiverStone Health, Montana Department of Health and Human Services, Montana Healthcare Foundation, Mountain-Pacific Quality Health Foundation, Robert Wood Johnson Foundation, and The Centers for Medicare & Medicaid Services.

The planning team for this project was convened by Healthy By Design and funded by the Montana Healthcare Foundation and Mountain Pacific Quality Health

MAJOR OUTCOMES

Several clients have shown a decrease in or cessation of emergency room and hospital visits. Clients are now contacting their primary care physician office prior to going to the emergency department for non-emergencies. Communication across organizations and offices has improved. Many clients have powerful individual stories of how the team helped them find stability.

INGREDIENTS FOR SUCCESS

The unity and shared vision by all three major healthcare organizations in the community was a key factor.

The planning committee consistently had vice-president-level representation at the table when the pilot was being designed, which allowed for real-time collaborative decision-making.

A variety of data measures are being used to demonstrate impact and evaluate needs and gaps: admissions, admission avoidance, chronic conditions, Z-code data, intervention type, and time spent with clients.

ADVICE FOR OTHERS

"Be creative. No two individuals or circumstances are alike once they are outside of the hospital walls. Take the time to really listen to the person and their thoughts about the reason for their current state – all too often, they just want to be heard."

— Jennifer Hough RN, MSN, CCRN, Adult Resource Alliance

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