Team Training

Training Objectives:

1. Understand the unique role of the ReSource Team in the community and working with PCP's
2. Understand transitional care management, care coordination, and community collaboration
3. Learn community resources available in your community and establish working relationships with key stakeholders
4. Orientation and application of available tools:
   a. Assessment tools
   b. Patient identification and stratification tools
   c. EHR
   d. CrossTx
   e. iPad video chats
5. Understand measurement and recording for project purposes

ReSource Teams in the Community and Working with PCPs

The community has long envisioned a means to better work with high cost high needs patients crossing multiple health systems and agency programs. Acting on this desire, several Montana communities looked towards interventions to intensively manage and coordinate care for these super-utilizer patients drawing on resources across community.

Community coalitions in conjunction with Mountain Pacific Quality Health (Mountain-Pacific) wrote for and were awarded a CMS Special Innovation Project (SIP) to work with Medicare beneficiaries and a Robert Wood Johnson Foundation grant to further the reach of ReSource Teams to patients beyond Medicare.

The SIP document is available for review.

The role of the ReSource team members in the community is really a function of community collaboration and is seen as a neutral party trying to bridge resources and wrap services around these vulnerable patients. In addition, the team members will be a resource to primary care providers (PCPs) and seek to establish PCPs when a patient does not have one and better coordinate care with existing providers. The primary role of the ReSource team is to build trust with the selected patients, improve

communication among stakeholders in the patient's life and medical care, and help the patients break down barriers to care so they can become more self sufficient in serving their own needs.

Transitional Care, Care Coordination, and Collaboration

As part of the training for these positions, you will be enrolled in the University of Pennsylvania (UPenn) School of Nursing Transitional Care Model (TCM) training. This training ~~is~~ addresses the transition of care from a hospital setting and demonstrates many of the useful tools and techniques for success. This training is a 4 module course with additional readings. ~~and~~ CME for nurses is available.

In addition, as a result of technical assistance from the Robert Wood Johnson Foundation, several resources and background readings have come available for your education. The memo below has significant information on successful programs for care coordination. The heading links will take you to resources.

MPQHF TA Memorandum 6-6-16.

Further, the monthly care transitions community collaboration meetings are a great source of information and a means for networking with other stakeholders.

Community Resource and Network Orientation

ReSource Teams are all about relationships. In great part it is about the relationship with the patients, but it is also about being able to link together community stakeholders and resources. Therefore, an important part of training will be getting into the community and making the connections that will make your patients as well as the ReSource Teams successful~~.~~.~~and your patients successful~~.

ASSIST has put together a community resource guide and this will be shared with you.

Here is a list of connections to make:

Contact Name	Role	Contact Info	Resource	
Mandi Cole	Director, Case Management	mcole@krmc.org	Case Mgmt Meetings each M,W, F	
			Shadow Case Managers in the Hospital	
Heather Mackenstadt	Quality Director, Physicians Network	hmackenstadt@krmc.org	Overview	

			TOC Monthly Meeting	
Jane Emmert	Director, Assist Flathead	250-1456 jemmert@krmc.org	Home Visits	
Laura Gambino	Clinical Supervisor, Montana Health Improvement Program	751-8254 lgambino@flathead.mt.gov	Over view	
? Laura G will have a name		751-8100	City/County Health Dept.	
Renae Solum	Care Coordinator, Rocky Mountain Heart and Lung	Rsolum@krmc.org	Overview of Program, issues, readmission rates, etc.	
? HIT/Christine	KRMC Health Information Technology Dept		Reports	
Michelle Christensen	Regional Program Officer Senior and Long Term Care Mcd	755-5420 Mchristensen@mt.gov	Overview	
John Freemole	Supervisor, Physically Disabled and Elderly as well as the Serious Disabling Mentally Ill Medicaid Waiver Programs	752-0580 Johnfreemole@benefis.org	Overview of the two Medicaid Waivers, and the role of these Case Managers.	
Cathy Liskowski	Clinical Supervisor	751-4100 clisowski@krmc.org	Journey To Wellness Wellness Coaching	
Diane Conte	Director, Western Montana Mental Health	257-1336 Dconti@wmmhc.org	PACT Team	
Jim Kelly	Adult Protective Services	751-5968 Jamkelly@mt.gov	Overview of their program, guardianship issues, competency, etc.	

Chris Krager	Samaritan House	257-5801	Services, homelessness in the area, medical issues for this population	
Sherry Stevens	United Way	752-7266 caring@northwestmontanaunitedway.org	Area and Statewide Resources Community Needs Assessment	
	Veterans Health Clinic	758-2700		
Danelle Whitten	Community Action Partnership of NW Montana	752-6565	Housing LIEAP	
Kris Carlson	A Plus Health Care	752-3697 extension 2000 Kcarlson@aplushc.com	Home Care Services Private Duty Nursing Waiver Other Programs	
Inga Lake	Agape Home Care	755-4633 inga.lake@agapehomecareinc.com	Home Care Services	
Tammy Harmon	Office of Public Assistance	751-5920 Tharmon@mt.gov (best way to reach)	Field Supervisor Willing to consult with problematic cases	
Lisa Sheppard	Agency on Aging Director	752-2481 Lsheppard@flathead.mt.gov	Meals on Wheels Senior Services Medication Reminders and other services	
Lennie Eaton	Love, Inc. of North Flathead	892-3544 LennieEaton@loveincnf.org	Volunteer agency that coordinates social services amongst churches, non profits, etc.	
?	Flathead Food Bank	752-3663		
Lynae West	Summit Independent Living	257-0048	Assistance with Medicare Enrollment, Disability Rights	
Jennifer Crowley	Eagleview West	Jennifer@eagleviewest.com		
Courtney Rudabach	Pathways	756-3950 crudbach@krmc.org		
Dave Grady	Big Sky IV	davegrady@bigskyivcare.com		

Jim Brew	North Valley Hospital DC Planner	Jbrew@nvhosp.org		
Barbara Hinkley	Home Options	751-4200 bhinkley@krmc.org	Home Health and Hospice	

1. Mon., Wed., and Friday case management meetings
2. TOC meeting – Heather Mackenstadt runs this meeting monthly
3. Mandi Cole and Shadow case managers in the hospital.
4. Meet with Heather Mackenstadt, Quality Director, Physicians Network
5. Jane Emmert, Director of ASSIST Flathead, and her team from Assist and to go on home visits
6. Laura Gambino, Clinical Supervisor, Montana Health Improvement Program (MHIP)\
7. City/County Health Department
8. Renae Solum, Care Coordinator-Rocky Mountain Heart & Lung
9. HIT person to run reports or Quality or Christine in HIM
10. Michelle Christensen, Program Officer, Senior and Long Term Care, Medicaid
11. Medicaid Waiver Team
12. Cathy Liskowski, Wellness Coaching, Journey to Wellness @ the Summit
13. Attend Northwest Montana Care Transitions Coalition
14. Diane Conti, Western Montana Mental Health PACT Team
15. Special Improvement Project Work Group Northwest Montana Care Transitions Coalition
16. VA Clinic
17. Adult Protective Services
18. Samaritan House
19. United Way
20. CAP Community Action Partnership (electric service payment assistance, utility service payment assistance, subsidized housing, rental assistance, weatherization, etc.)
21. Personal Care Agency
22. Agency on Aging
23. Love, Inc.
24. Shepards Hand (Free Medical Clinic?)
25. Meals on Wheels
26. Transportation
27. Prescription options
28. Faith based services
29. KRMC Foundation
30. Introduction to Primary Care teams

Tools

Here are some useful tools to consider when starting with a patient.

Assessments

For the patient

Health Literacy, "How confident are you about filling out medical forms by yourself?"

For care givers

Advanced Directives Resources and POLST

Five Wishes https://agingwithdignity.org/shop/product-details/five-wishes-online

The Conversation Project website: www.TheConversationProject.org

http://www.polst.org/

Visit the National Guidelines Clearinghouse (www.guideline.gov/)

Measurements

Patient Demographic information including distance to care (zip code)

IP admissions

- Number
- Reason for readmission
- Planned admission
- Unplanned admission
- Origin of readmission (where did they come from)

ED admissions

- Number
- Reason for readmission

Total cost of care

IP Costs

OP Costs

# of patient contacts

- Phone
- Home visits
  - Within 24-48 hour of hospital d/c
  - Med reconciliation
  - general

- Video chats

Type of contact

- Patient education
- Medication change
- Assessment
- Patient engagement, goal setting, revisiting goals

Time that can be billed using CPT codes for transitional care and care coordination

Patient Satisfaction

Collect Patient Stories

- Good outcomes
- Poor outcomes