Cross-Sector & Multidisciplinary Teams

Collaboration through Team Conferences

The Total Care Collaborative (TCC):

- Accountable Communities for Health, State Innovation Model grant recipient
- Partners: Vail Place, North Memorial Health Care, Broadway Family Medicine Clinic and Portico HealthNet
- Target population: adults with serious mental illnesses and co-occurring medical diagnoses

TCC Interventions:

Enhanced Coordination for MH

- Referral to Rapid Access to Case Management
- Referrals to Care Navigation for patients

Proactive Team Communication

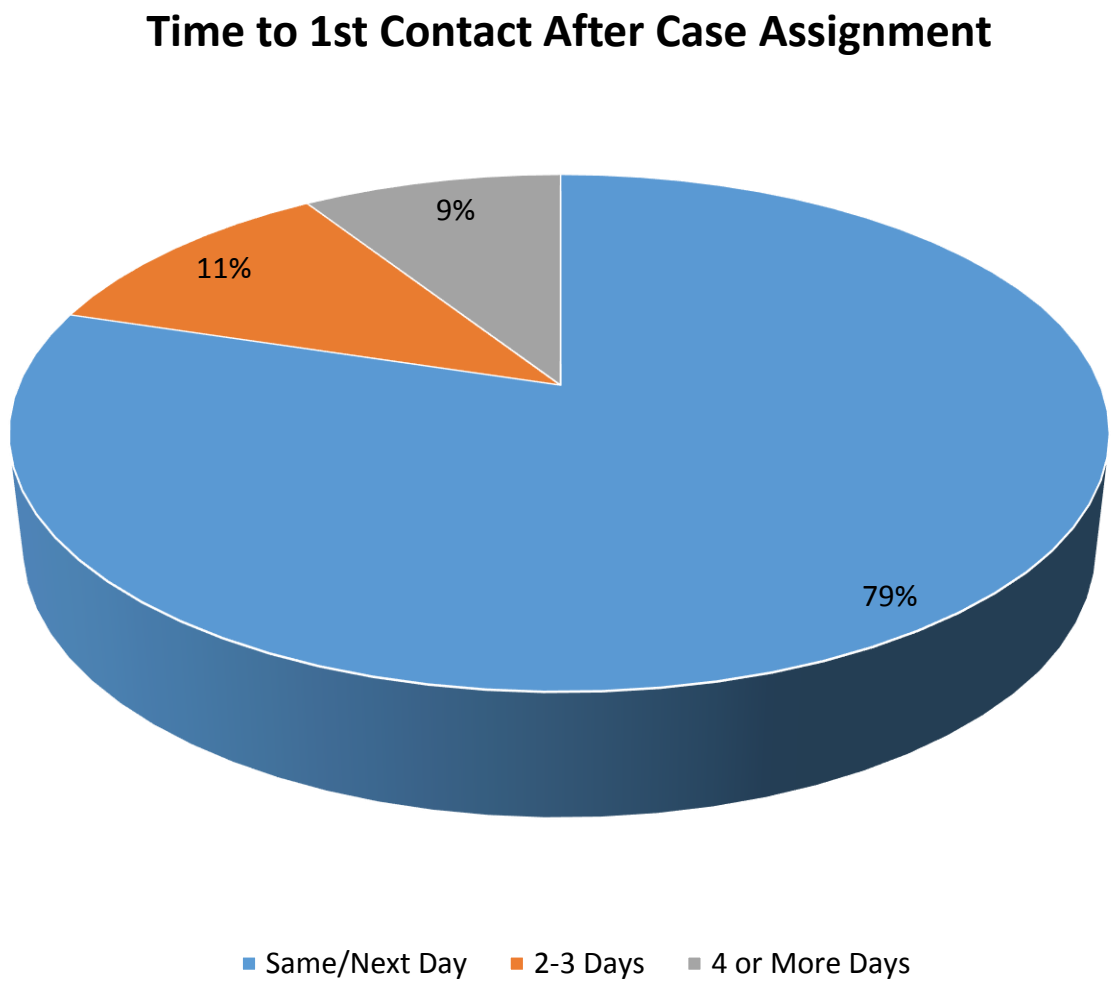
- Rising Risk Team Conference
- ED High Utilizers Care Conference
- Primary Care Clinic Care Conferences

Improved Referrals and Communication

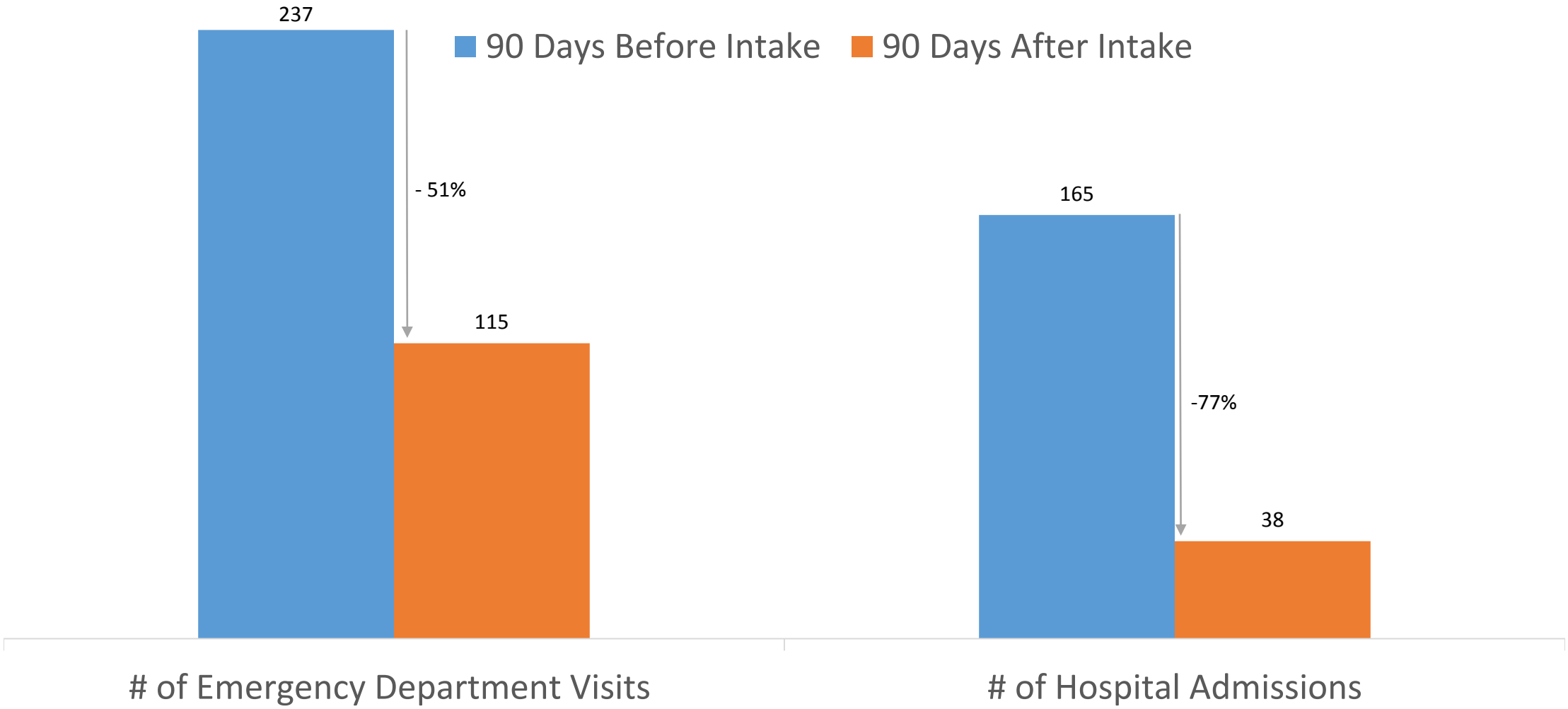
- Health system referrals to Community-Based Services via Epic
- Ongoing follow-up and communication across sectors
- Health education support at community settings through CP connection

Example: Rapid Access to Case Management

- Adults with Serious and Persistent Mental Illnesses
- Collaborative discharge planning
- Improved transitions of care
- Same day/next day goal of first contact



Impact: Rapid Access to CM



TCC Sustainability

- Behavioral Health Home certification
- Continued focus on ACO populations (Integrated Health Partnerships)
- Direct engagement in Mental Health and Addiction Clinic
- Exploring funding for Rapid Access and Care Navigation models

Team Conferences – Planning

**Borrowing from what works:*

- Vail Place Case Management Team Meetings
- NMHC Clinic ED High-Utilizer Conferences
- NMHC Community Paramedic and Care Coordination Huddle Case Review
- BFMC Clinic Team Conferences

Team Conferences – Planning cont.

1. Define overarching goal of team conference
2. Determine focus population
3. Outline participants and other stakeholders
4. Define length, frequency, and other logistics
5. Outline workflow (including initial vetting, prep, conference agenda, documentation, intervention assignment and follow-up)
6. Measure results and continue to adapt (PDSA)

Rising Risk Team Conference

Overarching goals:

1) Test cross-sector and multidisciplinary team,

2) Reduce total cost of care for IHP Population

Target Population:

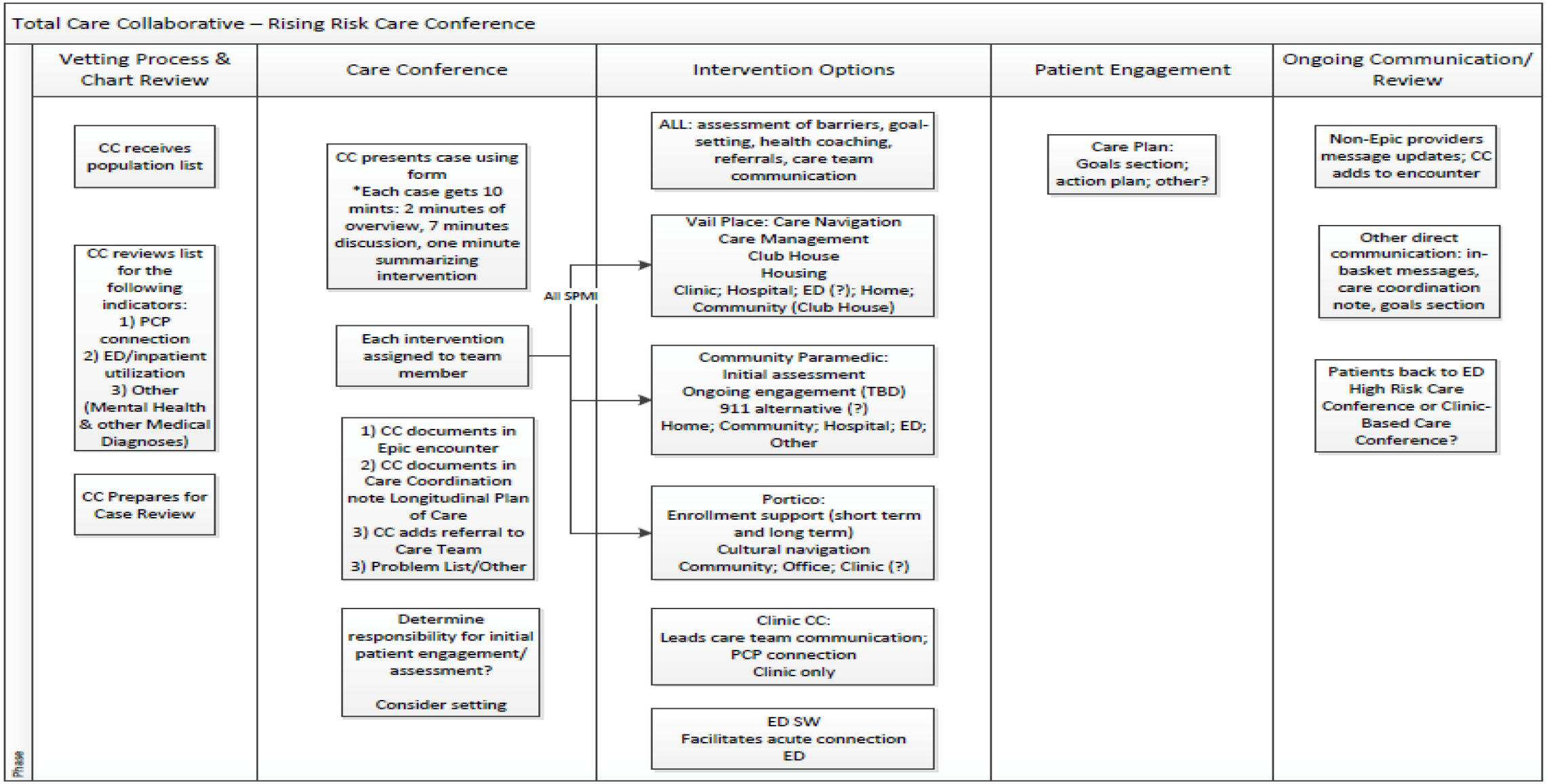
- Individuals engaged with North Memorial's Integrated Health Program (IHP) – Medicaid population
- Serious Mental Illness and Complex Care Needs
- Engagement with engaged clinics – Brooklyn Center, Brooklyn Park and BFMC
- 5 + ED visits in last year

Rising Risk Team Participants & Meeting Logistics

Clinic Care Coordinators / Administration	**Vail Place Care Navigator**	**Rapid Access Case Management**
ED Doctor / Community Paramedic Medical Director	**Community Paramedic**	**Emergency Department Social Worker for High Utilizers**

- Meet twice monthly for 60 minutes for case review
- Assigning roles (including time keeper) is important

Rising Risk Team Conference Workflow



Rising Risk Review:

- Patient situation
- Patient diagnoses and chronic disease outcomes
  - Mental health and medical
- Number of hospitalizations / ED visits
- Housing
- Social Supports
- Medications
- Interventions
- Follow up

Rising Risk Interventions:

- Referrals to:
  - Care Navigation
  - Clubhouse Program
  - Community Paramedic Services
  - Community Support Services
  - Support Groups
  - Benefits/insurance assistance
  - Chronic pain alternative therapy
  - Transportation
  - In-home services (PT, OT, Adult Mental Health Rehabilitation Services)
- Coordination/communication with providers

Key Considerations & Lessons Learned

- Defining Population
- Documentation
- Follow Up

Multidisciplinary Team Conference Demo