

12-11-2018

# High Risk, High Reward: How Team-Based Care Helps the Most Complex Patients

Deborah Satterfield

*Providence Medical Group*, [deborah.satterfield@providence.org](mailto:deborah.satterfield@providence.org)

Kathleen Fraser

Mary McLaughlin-Davis

Vanessa Casillas

*Providence Medical Group*, [vanessa.casillas@providence.org](mailto:vanessa.casillas@providence.org)

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## Recommended Citation

Satterfield, Deborah; Fraser, Kathleen; McLaughlin-Davis, Mary; and Casillas, Vanessa, "High Risk, High Reward: How Team-Based Care Helps the Most Complex Patients" (2018). *Presentations, Posters, Etc.*. 22.

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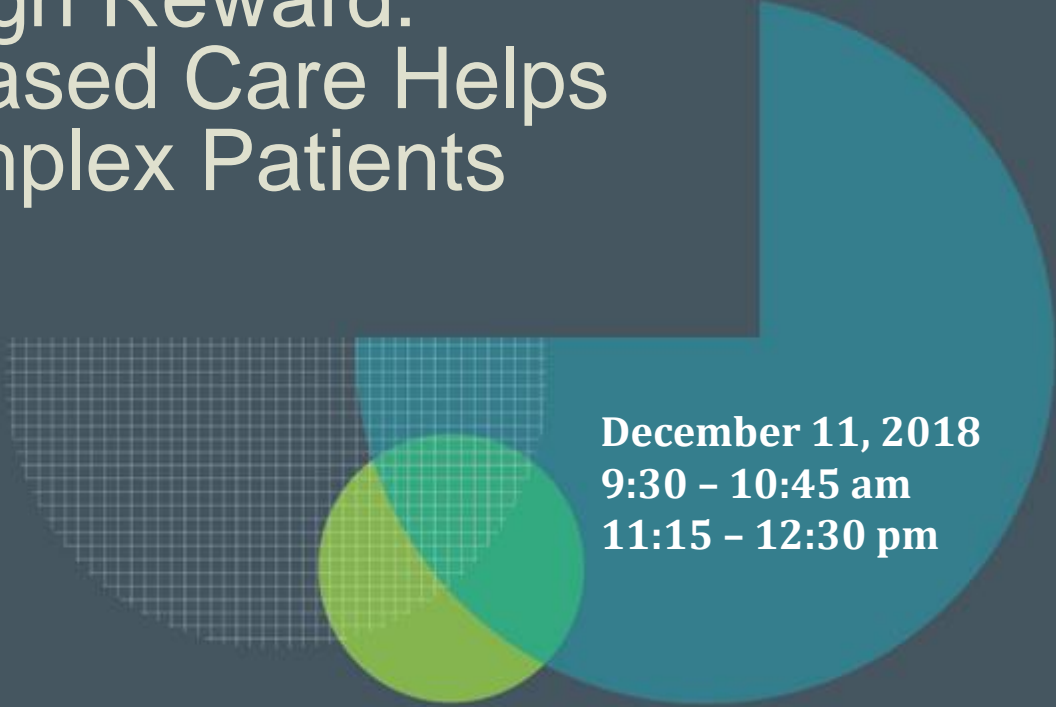


Institute *for*  
Healthcare  
Improvement

Session Code

This presenter has  
nothing to disclose

# High Risk, High Reward: How Team-Based Care Helps the Most Complex Patients



December 11, 2018  
9:30 – 10:45 am  
11:15 – 12:30 pm

#IHIFORUM

# Speakers

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- Deborah Satterfield, MD
  - Area Medical Director at Providence Medical Group
- Vanessa Casillas, PsyD
  - Director of Psychology at Providence Medical Group
- Mary McLaughlin Davis, DNP, ACNS-BC, NEA-BC, CCM
  - Senior Director of Care Management at Cleveland Clinic
- Kathleen Fraser
  - Executive Director of The Case Management Society of America



# Session Objectives

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- Apply effective techniques for leading a team-based approach to deliver high-value care to targeted populations
- Describe and take next steps to integrate complex case conferences into primary care
- Describe process for Case Management Integration and Care Transitions across the continuum of care

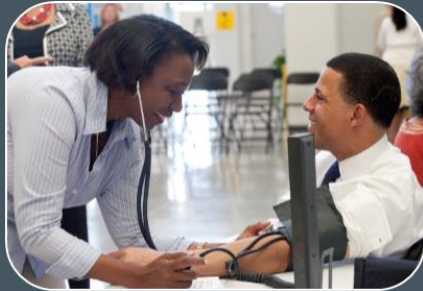
# Understanding Health Complexity

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- Presence of both medical and behavioral conditions
- Multiple chronic conditions
- Severe and persistent mental illness
- Social barriers
- Health system barriers



# Triage for Complexity



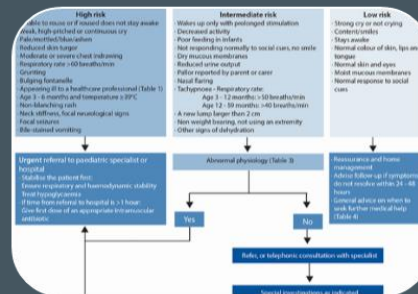
Health Risk Assessments and Screenings



Claims History



Pharmacy History



Risk Algorithms: Predictive Modeling



# Complexity = Risk

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- Multifaceted Challenges
  - Medical conditions
  - Behavioral/mental conditions
  - Social concerns
  - Poor access to care and services
  - Impairments or disabilities
  - Financial concerns



# Patient Concerns

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- Individuality
- Preferences
- Respect
- Relief from suffering
- Illness understanding
- Uncertain future





# Integrated Case Manager

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- **Understands**

- Core signs and symptoms of the diagnosed condition(s).
- The types of therapies that may be prescribed.
- Common classes of medications used to treat a condition.
- When should improvement be expected once treatment has been initiated.
- How to document progress or lack of progress.

- **Knows**

- Resources needed to gain additional medication information.
- How a patient should be monitored for their condition.
- What constitutes a good response to treatment or how to look for non-responses.
- When and what to report if a patient is not making progress.



# An Integrated Case Management Approach Supports Population Health Improvement

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Establishes trusted patient-case manager relationships

Is an holistic approach

Prioritizes risk for targeted intervention to reduce use of resources

Requires case managers to be life-long learners

Supports a case manager functioning at the top of their license

Demonstrates patient-centered care

Supports demonstration of positive health outcomes, improved quality of life and quality measures



# PMG Risk Stratification

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- Risk stratification algorithm that assesses for:
  - Emergency department visits
  - Hospital admission
  - High-risk medications or polypharmacy
  - Weighted co-morbidity
- Stratifies our entire patient population monthly into 4 risk tiers:
  - Very Intense
  - Intense
  - Moderate
  - Low



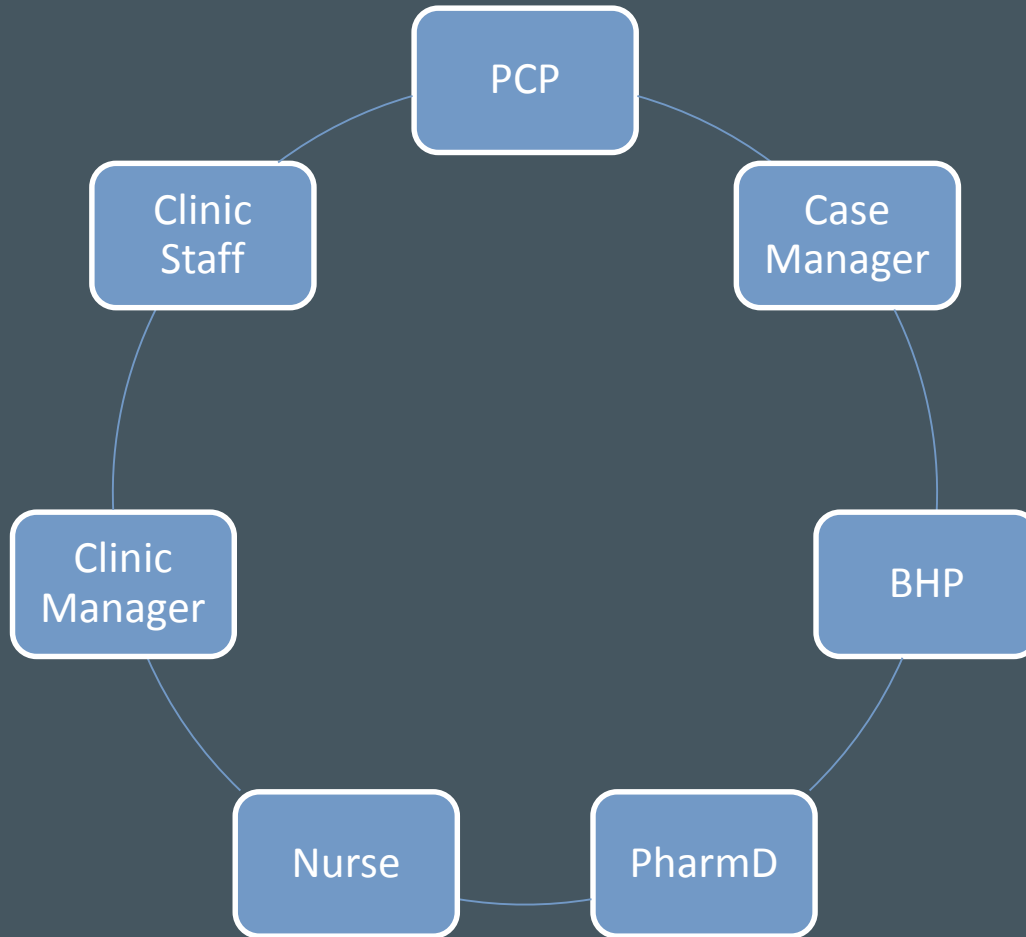
# Validation Process

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- PCP/Care Team reviews risk level assigned by methodology
- Adjust patient's risk level as needed based on clinical judgment and patient knowledge
- The risk level can be changed by utilizing the Health Maintenance Module in Healthy Planet
- The risk level designated by the PCP/Care Team will override the risk level assigned by the methodology



# Care Conferences



# Pre-Care Conference Work

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- Identify reason for referral to care conference
- Consider the following and be prepared to discuss:
  - Patient's current status
  - Patient goals and preferences of care (not disease specific)
  - Barriers to care including SDOH and physical barriers
  - Patient's support system
  - End of life goals of care
  - Mobility and fall risk if applicable
  - Score of most recent SLUMS or MoCA if applicable
  - Date of most recent medication review by PharmD if applicable



# Care Conference Tips

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- Identify a facilitator for the meeting
- Take notes!
- Document who is in attendance
- Have EHR available to review if needed
- Allow for discussion with each person
- Identify action items and responsible team member
- Ensure everyone agrees on the plan



# Post-Care Conference Work

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- Document the plan in the patient's chart!
- CC the plan to all care team members
- Let other service areas know about the plan if needed
- Schedule time to review plan with the patient
- Develop a contingency plan for goals
- Schedule follow-up care conferences as needed





# Best Practices

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- Anyone on the care team can request a care conference
- Set aside dedicated time for conference
- Create a process to complete the pre-work!
- Create a process to document the care plan!
- Consider co-visits with the patient and care team



# Audience Cases and Questions

