Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

Date

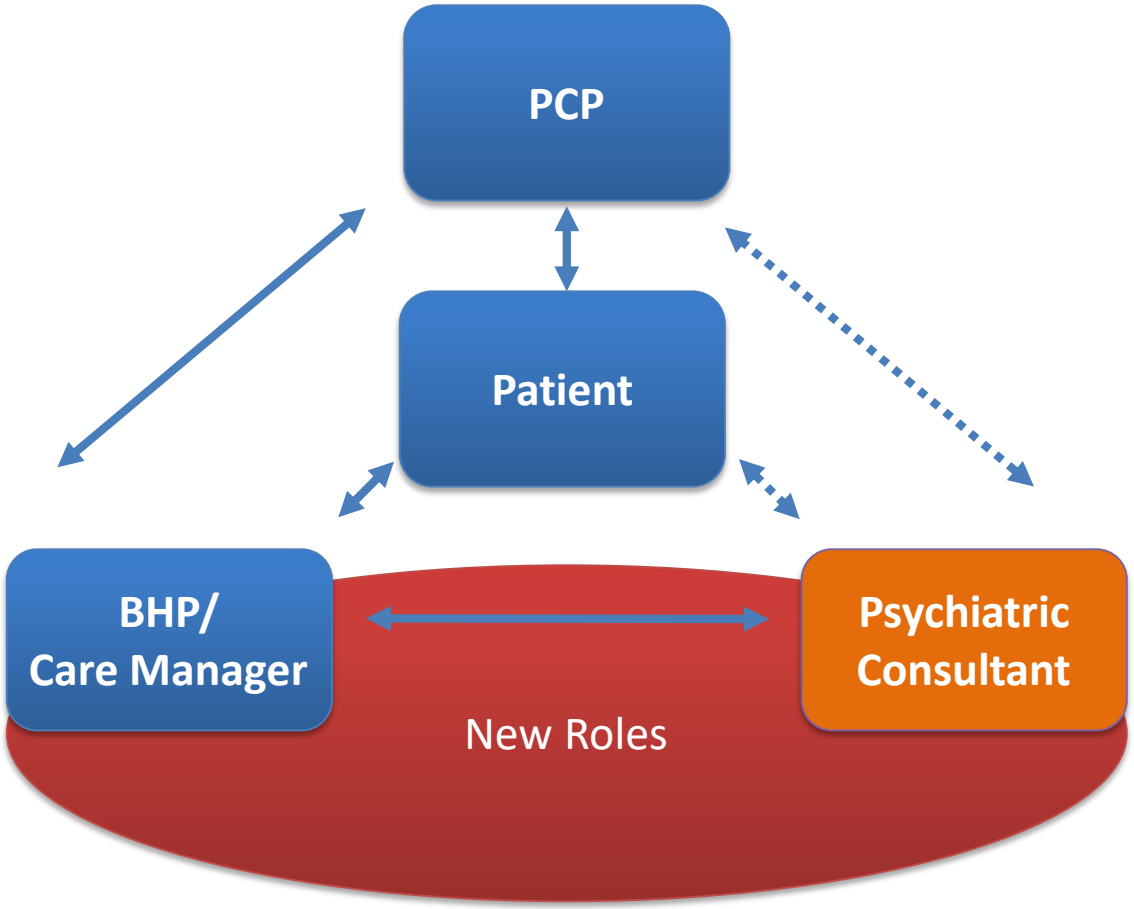
Best Caseload Review Practices

Jessie Whitfield
University of Washington Medical Center
AIMS Center

Learning Objectives

- Identify roles and responsibilities of psychiatric consultant within CoCM
- List best practices and strategies for systematic caseload reviews
- Explain how applying these strategies helps achieve aim of population-based care

Psychiatric Consultant Role



1. Clinical Consultations: Direct, Indirect and curbside consultations
2. Educator
3. Leadership

Roles of Psychiatric Consultant

Clinical Consultation	Liaison

• Evidence –base
  - Core principles
• Assessment
  - Screening and identification
  - Registry
• Treatment
  - Measurement-based treatment to target
  - Indirect case review
  - Relapse prevention
	• Liaison
	  - Assessment of the situation
	  - Support for the team
	• Learning
	  - Integrating education into clinical care
	  - Direct teaching
	• Leadership
	  - Implementation
	  - Continuous quality improvement

How is this role different from traditional psychiatry?

- Indirect patient management
- Consulting remotely
- Making a treatment plan in a short amount of time and with limited information
- Thinking about the treatment needs of a population of patients

Caseload Reviews

- Regular meetings between psychiatric consultant and care manager to review patients in systematic way
- Utilizes registry
- Indirect psychiatric care is key component of achieving CoCM core principles

Common questions about caseload reviews

- What happens in a caseload review?
- How much time should we spend talking about each patient?
- What should we be reviewing for each patient?
- How should we be selecting patients to discuss?
- How can we use our time efficiently?
- How often should we meet?
- How do we use the registry in caseload review?

Function of Caseload Reviews

Goal

- Leverage psychiatric expertise to serve larger population more efficiently
- Support delivery of evidence-based tx
- Anchor and nurture teamwork around patient
- Track engagement and progress to target

CoCM Core Principle

- **Population-based care**
- **Evidence-based care**
- **Patient-centered collaboration**
- **Measurement-based care**

Best practices

- Regular meeting times
- Using time efficiently
  - Preparing beforehand
  - Agenda setting
  - Targeting 4-6 patients per hour
- Being strategic about patient choice
  - Utilizing registry to assist pt selection
- Supporting care manager

PC responsibilities in caseload review

- Review available data in EHR
- Complete and communicate recommendations to PCP and care manager
- Clinically supervise care manager
- Support care manager
- *Ownership of caseload panel*
  - *Health outcomes*
  - *Systematic approach*

Sample agenda

Prior to meeting: Prepare in advance by systematically reviewing patients on the registry to identify priority patients

1. Brief administrative and workflow check-in (2-3 minutes)
    - Changes in the clinic
    - Systems and resource questions
2. Set agenda (2-3 minutes)
    - Identify patients for discussion using criteria in Table above
3. Conduct case reviews (40-45 minutes)
    - Goal: generate recommendations to change treatment or change strategy to overcome barriers to care and implement a prior recommendation
    - CoCM principles: measurement-based care, evidence-based care, patient-centered care
    - Refer to template for case presentation
4. Brief updates (5-10 minutes)
    - Goal: introduce accountability and encourage appropriate outreach and tracking
    - CoCM principles: population-based care, accountable care
    - Follow through to ensure that recommendations are implemented
5. Wrap-up (5 minutes)
    - Celebrate successes!
    - Set clear action plans and assign ownership for tasks
    - Confirm next SCR session date/time

After meeting: Document recommendations, communicate recommendations to primary care provider and patient, send educational resources discussed

Guidelines for meeting frequency

Caseload size	SCR Time Allocation*
0-15 patients	½ hour every other week
15-30 patients	½ hour weekly or 1 hour every other week
30-50 patients	1 hour weekly
50-75 patients	1 ½ hours weekly
75-100 patients	2 hours weekly

Patient selection

Criteria to prioritize patients for review

- Newly enrolled patients who have not been reviewed and have a diagnostic or treatment question
- Patients with current concerns necessitating review (e.g., side effects, not tolerating treatment, recent emergency room visits or hospitalizations)
- Patients who may benefit from direct psychiatric evaluation
- Patients with elevated symptom scores (e.g., PHQ-9, etc.) who have not been reviewed in the last 4 weeks
- Patients who are not adequately engaged in care (e.g., no follow-up with care manager for 4 weeks or more)
- Patients who have achieved treatment target and may be appropriate for relapse prevention planning and program graduation

Patient selection using registry

Report run on 7/29/20

Flags	Patient ID	PHQ-9		GAD-7		Contacts					
		First Score	Last Score	First Score	Last Score	Date of Initial Visit	Date of Last Follow-up	Psychiatric Case Review	Relapse Prevention Plan	# Sessions	# Weeks in Treatment
	1	23	10*	7	7*	2/21/2020	6/2/2020	6/10/2020		14	25
	2	17	4	4	4*	9/5/2019	7/21/2020	1/29/2020		18	46
	3	16	7	6	6*	3/4/2020	7/28/2020	7/21/2020	7/28/2020	14	24
	4	25	25	2	2*	6/18/2020	7/29/2020	6/24/2020		4	5
	5	8	7	19	17	9/3/2019	7/19/2020	4/1/2020	6/18/2020	16	46
	6	19	9	19	6	3/18/2020	6/30/2020	4/15/2020		7	18
	7	9	8	18	20	6/9/2020	7/28/2020	6/10/2020		3	6
	8	21	5	13	5	5/28/2020	7/4/2020	7/1/2020		8	10
	9	9	8*	13	6*	6/6/2020	7/18/2020	7/18/2020		2	7
	10	17	13	3	3*	1/1/2020	7/4/2020	6/10/2020		15	36
	11	10	10	19	18*	5/29/2020	7/24/2020	7/19/2020		3	8
	12	18	6	0	0*	3/21/2020	7/2/2020	7/3/2020		14	20
	13	11	0	18	2	1/30/2020	7/21/2020	6/10/2020	4/17/2020	8	25
	14	17	9	6	6*	9/19/2019	7/9/2020	1/9/2020		13	45
	15	13	20	11	11	5/21/2020	7/20/2020	7/2/2020		7	10

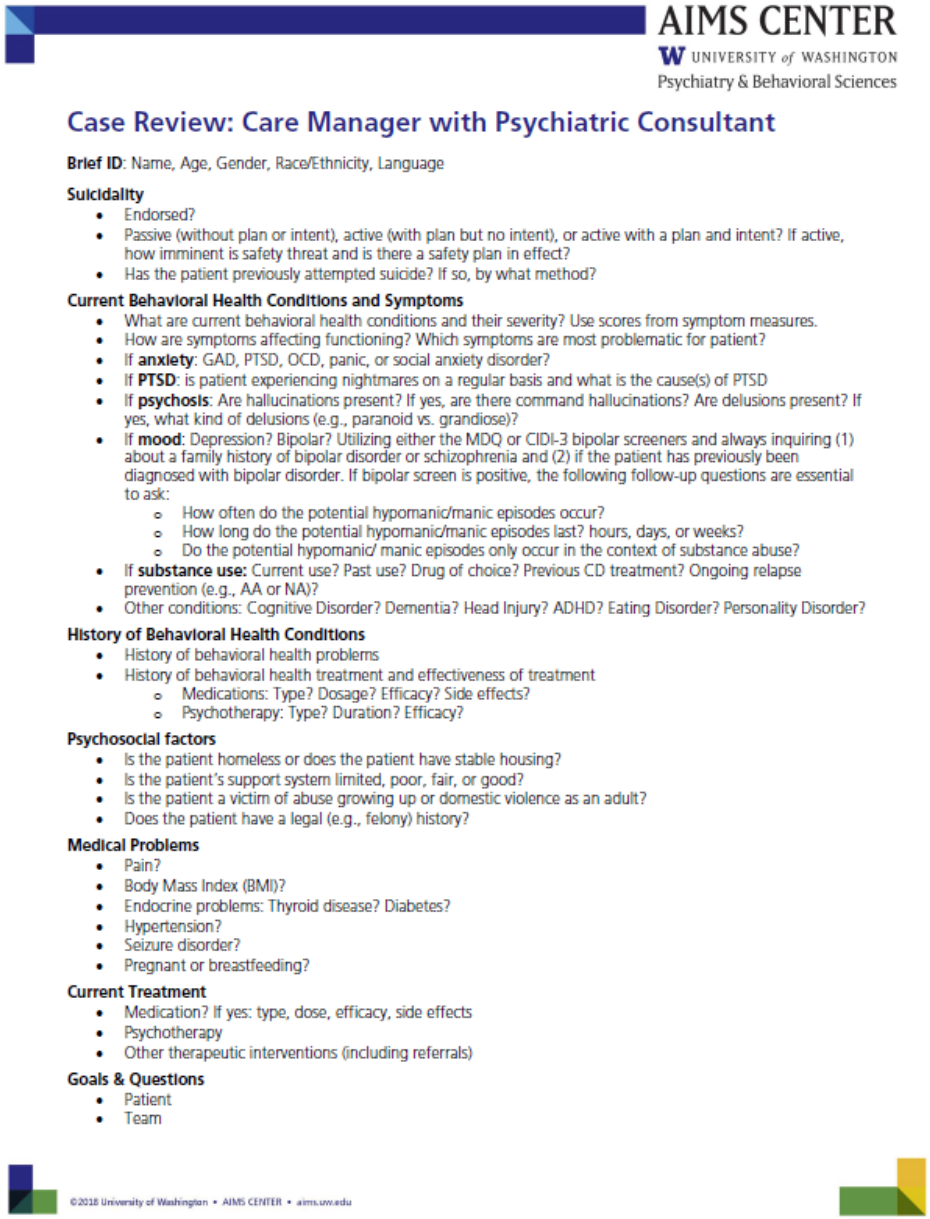
- 1) Urgent or safety concerns or acute significant worsening (usually flagged): 1, 15
- 2) Pts not improving or high scores without note over 4 weeks: 4, 5, 7, 11
- 3) Poor engagement: 6, 1
- 4) Not reviewed in 3 months: 2, 14
- 5) New: none
- 6) Program graduation/RPP: 13, 8

Evidence-based strategies

- Psychiatric review for patients not improving within 8 weeks after initiating treatment:
  - doubled rate of new antidepressant prescriptions
  - higher likelihood of improvement at 24 weeks
- 2 care manager contacts in first month

Case presentation

- Explicit presentation guidance can be helpful
- Balance between efficiency and sufficiency



AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Case Review: Care Manager with Psychiatric Consultant

Brief ID: Name, Age, Gender, Race/Ethnicity, Language

Suicidality
- Endorsed?
- Passive (without plan or intent), active (with plan but no intent), or active with a plan and intent? If active, how imminent is safety threat and is there a safety plan in effect?
- Has the patient previously attempted suicide? If so, by what method?

Current Behavioral Health Conditions and Symptoms
- What are current behavioral health conditions and their severity? Use scores from symptom measures.
- How are symptoms affecting functioning? Which symptoms are most problematic for patient?
- If **anxiety**: GAD, PTSD, OCD, panic, or social anxiety disorder?
- If **PTSD**: is patient experiencing nightmares on a regular basis and what is the cause(s) of PTSD
- If **psychosis**: Are hallucinations present? If yes, are there command hallucinations? Are delusions present? If yes, what kind of delusions (e.g., paranoid vs. grandiose)?
- If **mood**: Depression? Bipolar? Utilizing either the MDQ or CIDI-3 bipolar screeners and always inquiring (1) about a family history of bipolar disorder or schizophrenia and (2) if the patient has previously been diagnosed with bipolar disorder. If bipolar screen is positive, the following follow-up questions are essential to ask:
  - How often do the potential hypomanic/manic episodes occur?
  - How long do the potential hypomanic/manic episodes last? hours, days, or weeks?
  - Do the potential hypomanic/ manic episodes only occur in the context of substance abuse?
- If **substance use:** Current use? Past use? Drug of choice? Previous CD treatment? Ongoing relapse prevention (e.g., AA or NA)?
- Other conditions: Cognitive Disorder? Dementia? Head Injury? ADHD? Eating Disorder? Personality Disorder?

History of Behavioral Health Conditions
- History of behavioral health problems
- History of behavioral health treatment and effectiveness of treatment
  - Medications: Type? Dosage? Efficacy? Side effects?
  - Psychotherapy: Type? Duration? Efficacy?

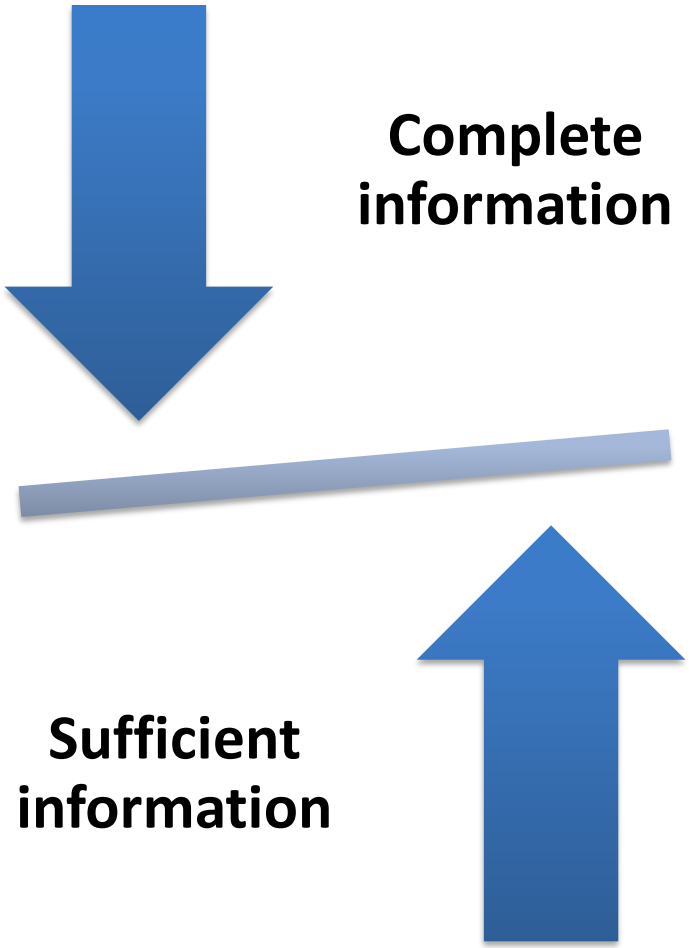
Psychosocial factors
- Is the patient homeless or does the patient have stable housing?
- Is the patient's support system limited, poor, fair, or good?
- Is the patient a victim of abuse growing up or domestic violence as an adult?
- Does the patient have a legal (e.g., felony) history?

Medical Problems
- Pain?
- Body Mass Index (BMI)?
- Endocrine problems: Thyroid disease? Diabetes?
- Hypertension?
- Seizure disorder?
- Pregnant or breastfeeding?

Current Treatment
- Medication? If yes: type, dose, efficacy, side effects
- Psychotherapy
- Other therapeutic interventions (including referrals)

Goals & Questions
- Patient
- Team

Tolerating Uncertainty



- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing

Troubleshooting

Challenges	Solutions
• Drift to ad-hoc review meetings	• Find time that can be protected in advance
• Drift to pt selection without clear strategy	• Set clear agenda for pt selection at beginning
• Not being efficient in reviewing patients	• Review cases ahead of meeting, or use presentation template
• Measurement tools used irregularly	• Set time to probe issue and trial solution (ex: involve IT to help with electronic tools)

Takeaways

- Regular, protected times for caseload review with an agreed-upon structure can help prevent scheduling drift
- Having a strategy for selecting patients (especially those not improving) can help achieve population health aims
- Registry use is a critical part of caseload review, treatment to target and patient tracking

Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself

Registration

- If you have not yet registered, please email uwictp@uw.edu and we will send you a link