Systematic Case Review Guidelines

This document is intended to guide systematic case review training, including maximizing the efficiency of each systematic case review session.

Logistics

FREQUENCY
For a 0.5 FTE behavioral health care manager (BHCM), systematic case review will typically be held 1 hour per week with the psychiatric consultant (PC). Additional time should be made available for curbside consults (by phone, page, email, etc.).

FORMAT
Systematic case review can be held in person or via HIPAA-compliant videoconference.

EHR/REGISTRY
The BHCM and PC should have all applicable EHRs and registries open during systematic case review. Documentation protocol will vary based on EHR and registry format and access.

DYAD COLLABORATION
While this document provides guidelines for conducting systematic case review, each PC and BHCM dyad will personalize and optimize their own format over time. Additionally, the PC and BHCM should approach the dyad relationship as a learning, mentoring, and coaching relationship.

Maximizing Efficiency

SYSTEMATIC CASE REVIEW PREPARATION
The BHCM should spend time preparing for systematic case review. For newer BHCMs and dyads, this may be up to an hour of preparation time. The BHCM should plan for case presentations (e.g., new patients) and ensure patient information is gathered and organized. Information might include pertinent labs, medications, outcome measure scores, substance use history, and treatment history (see case presentation template for further details). New BHCMs may benefit from physically documenting this information on the case presentation template. As the BHCM and PC learn one another's presentation and review styles, preparation time may decrease.

SYSTEMATIC CASE REVIEW STRUCTURE
The goal is to review 6-8 patients per 1-hour session. This requires that case presentations are succinct, yet include enough information that the PC can make recommendations. The complexity of the patient will affect the review time.

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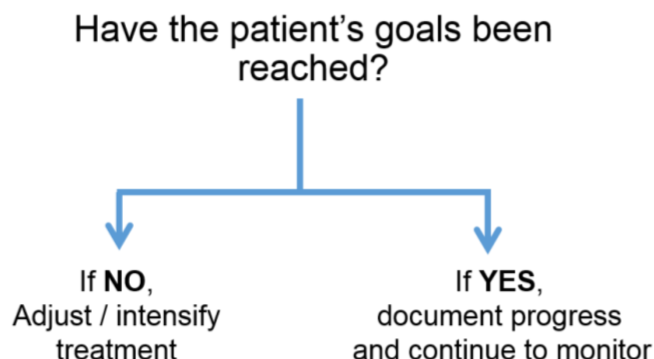
Systematic case reviews are typically conducted according to the following format:

1. Brief check-in
    a. Discuss pertinent information regarding the clinic as well as system-level questions.
2. Urgent patients
    a. Generally, urgent or emergent questions should be handled through paging/curbside consultation. However, if for some reason this is not possible or does not occur, these issues should be addressed at the beginning of the systematic case review.
3. Specific case questions from treating provider, patient, or BHCM
    a. Address and document. Send note to treating provider and/or BHCM as appropriate, and BHCM should plan necessary follow-up.
4. New patients
    a. Each new patient should be reviewed within 1-2 weeks of enrollment. Typically, new patients should not be reviewed until assessment is complete and baseline measures are obtained. Systematic case review prior to a complete intake assessment may be warranted if a patient has urgent clinical issues.
5. Systematic Case Review – Complete systematic case review through various registry sorting methods
    a. Patients who are worsening or not improving
        i. Sort by PHQ-9 and GAD-7 recent scores (high) or score changes to identify
    b. Patients with PHQ-9 or GAD-7 scores in the severe range
        ii. PHQ-9 ≥ 20; GAD-7 ≥ 15
    c. Patients not recently discussed with PC
        iii. Sort by date of last systematic case review to identify
    d. Patients who are not engaging in care
        iv. BHCM may identify specific patients or sort by date of last PHQ-9 or GAD-7 score to identify patients who have not completed outcomes as scheduled
    e. Patients who are in remission and may be ready for relapse prevention planning
        v. Sort by PHQ-9 and GAD-7 scores (low) to identify
6. Wrap up
    a. Confirm next systematic case review time
    b. Confirm plans for treating provider follow-ups for BHCM and/or PC

COLLABORATIVE CARE TREATMENT GUIDELINES

CoCM is a tailored, treatment-to target model. Generally, if a patient is not improving, the PC is very proactive in recommending a treatment change.



BHCM CASE PRESENTATION FORMAT

The following actions are suggested for each individual case presentation:

1. BHCM presents case uninterrupted.
    a. This will take around 3-5 minutes per case. In a new dyad relationship, it may be most efficient for the BHCM to present by reading directly from a prepared template. Over time, the BHCM will become more comfortable with the presentation format, and the PC will learn to hold questions until the end.
2. PC asks clarifying questions.
    a. PC will include questions/discussion about brief interventions planned or conducted.
    b. BHCM answers these if able. If not, BHCM makes a note to further assess patient in next contact.
3. PC discusses treatment recommendations, explaining rationale to BHCM. PC explains BHCM's role in the implementation (e.g., monitoring frequency, providing resources, modifying self-management plans).
4. BHCM asks clarifying questions.
5. PC documents treatment recommendations in the EHR, CC'ing the BHCM and treating provider if possible.

SYSTEMATIC CASE REVIEW FOLLOW-UP

BHCM reviews PC's documentation and follows up with treating provider and patient, as appropriate. Treating provider remains the team lead and can then decide whether to implement the treatment recommendations. BHCM continues as a liaison between treating provider and PC, and can facilitate contact between these team members, if needed.

Case Presentation Template

MRN

BRIEF ID *(name, age, sex/gender)*

REFERRED BY

CHIEF COMPLAINT *(reason for referral, patient's main concern)*

SYMPTOMS OF CONCERN *(diagnostic criteria – mood, affect, sleep, energy, memory, etc.)*

OUTCOME MEASURE SCORES *(do individual items match up with symptoms of concern?)*

SI/HI *(positive Q9? elaborate on nature of SI, along with safety planning and history)*

BEHAVIORAL HEALTH HISTORY AND TREATMENT *(previous episodes, therapy, hospitalizations, effectiveness)*

CURRENT PSYCHOTROPIC MEDICATIONS *(length, dose, efficacy, side effects, compliance)*

PREVIOUS PSYCHOTROPIC MEDICATIONS *(length, dose, efficacy, side effects, compliance)*

SUBSTANCE USE *(current, past)*

MEDICAL CONDITIONS

ALLERGIES

PSYCHOSOCIAL CONCERNS

INITIAL TREATMENT PLAN *(next planned contact, psychoeducation provided, brief interventions, self-management plan, etc.)*

OTHER IMPORTANT DETAILS

Documentation Example: Psychiatric Consultant to Treating Provider

Hello [TREATING PROVIDER NAME],

I had the opportunity to discuss your patient, [NAME], with the clinic's behavioral health care manager, [NAME], in our weekly clinical meeting. Please see below for my recommendations. Please feel free to contact me with any further questions.

Brief Summary
24-year-old woman with a history of anxiety, depression, and a history of physical abuse. Patient continues to have sleep problems, worry, and panic symptoms.

Recommendations

1. After about 4-6 weeks of Zoloft 50mg PO Qday, may further increase dose to 100mg PO Qday. Can further titrate dose by 50mg every 4-6 weeks if mood and anxiety symptoms persist. Max dose is typically 200mg PO Qday.
2. May increase melatonin to 6mg-9mg PO QHS first to target sleep difficulties. Of note, there is little data about melatonin in general. However, the max dose typically is about 9mg. If melatonin is not helpful, may consider trazodone 50-100mg PO QHS to target sleep difficulties.

Behavioral health care manager [NAME] will continue to follow patient for symptom monitoring and support.

Possible Side Effects
GI side effects (including nausea, vomiting, diarrhea), initial increase in anxiety (especially in individuals with an anxiety disorder), sexual dysfunction, headaches, or insomnia. Inform patient to notify clinician immediately if any unusual changes in mood or behavior.

Scores
PHQ-9: 22
GAD-7: 19

Background and Decision-Making
See above. Further titration of SSRI may be beneficial as described above.

Safety Concerns
Passive SI. No prior attempts. No acute safety concerns.

Substance Use Concerns
None

Previous Medication Trials
Fluoxetine up to 20mg PO Qday – caused "numbness" and memory concerns.

The above treatment considerations and suggestions are based on consultation with the care manager and a review of information available in the chart. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.

[PSYCHIATRIC CONSULTANT NAME]
Pager: 55555

Communication Example: BHCM to Treating Provider

Hello [TREATING PROVIDER NAME],

I'm writing to follow up on the psychiatric consultation note that was entered by [PC NAME] on [DATE] for [PATIENT NAME]. I'm wondering if you've had a chance to review this recommendation. If you agree with the recommendation to [insert recommendation- e.g., increase Sertraline to 100mg] and are willing to send this in to the pharmacy, I would be happy to call the patient to let them know. I'll be sure to provide the necessary education around this medication regarding side effects, etc.

[If applicable]: I will also plan to follow up with the patient within 1-2 weeks for medication monitoring.

Please let me know if you have any questions or concerns.

Thank you!
[BHCM SIGNATURE]