Best Practices for Systematic Case Review in Collaborative Care
Online Supplement

Guidelines for SCR meeting times in established, high functioning teams

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

*This is SCR meeting time only and does not include the time required for care managers and psychiatrists to prepare, document and follow-up on recommendations.

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

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Sample structure for weekly SCR meeting

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

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Sample templates for case presentation and documentation

Initial Psychiatric Case Review

The below treatment considerations and suggestions are based on consultation with the patient's care manager and a review of information available in the (*registry +/- electronic health record*). 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.

SUMMARY:

Depressive symptoms: PHQ-9:
Suicidality: (C-SSRS):
Bipolar symptoms: (CIDI or MDQ):
Anxiety symptoms: GAD-7:
PTSD symptoms: PCL-5:
Psychotic symptoms
Past Treatment:
Substance use: AUDIT:
Psychosocial factors:
Medical Problems:
Current medications:
Goals:

ASSESSMENT:

RECOMMENDATIONS:
Generally worded as suggestions rather than orders. These should be brief, practical and can include a teaching point for the primary care provider (e.g. how to cross taper or drug interactions).

Name, Psychiatric Consultant.
Telephone: XXX-XXX-XXXX.
Pager:
E-mail:

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Follow-Up Psychiatric Case Review

The below treatment considerations and suggestions are based on consultation with the patient's care manager and a review of information available in the (*registry +/- electronic health record*). 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.

SUMMARY / INTERVAL HISTORY:

Depressive symptoms: PHQ-9: (initial and most recent)
Bipolar symptoms:
Suicidality:
Anxiety symptoms: GAD-7:
PTSD symptoms: PCL-5:
ASSESSMENT:

RECOMMENDATIONS:
Name, Psychiatric Consultant.
Telephone: XXX-XXX-XXXX.
Pager:
E-mail:

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Examples of Variability in Systematic Case Review

The relative time allotted to various tasks or their order may need adjustment to optimize the program's fit with the setting. Time allocation need not be constant from week to week as long as the essential tasks are accomplished regularly. When introducing any variation, it is imperative to monitor program-level outcomes to ensure that program quality is not compromised.

Example: Adjusting the amount of time for SCR. A clinic has an on-site psychiatrist who has capacity to see patients directly one day per week in addition to serving as psychiatric consultant to an embedded CoCM program with one full-time care manager. On the psychiatrist's clinic day, she receives informal updates on some patients directly from primary care providers and from staff when the patient is in clinic for medical appointments, labs, or other purposes. In addition, for every patient the care manager sees in clinic that day, she discusses the patient directly with the psychiatrist prior to concluding the care management visit. As a result, the psychiatrist has more up-to-date and in-depth knowledge about patients than in CoCM programs with an off-site psychiatric consultant who does not see patients directly. Therefore, this team is able to allocate less time for their SCR meetings because the case presentations tend to take less time and some patients have already been discussed outside SCR time during the clinic day. They reduce SCR time from 1 hour per week to 30 minutes per week and monitor program outcomes to ensure that patients are continuing to improve.

Example: Adjusting the order of activities during SCR. A CoCM team has been reviewing 3 or 4 patients in-depth each week, but as the program expands, they have struggled to find time to follow up on whether recommendations were implemented for patients they already reviewed. They are concerned that patients are starting to "fall through the cracks". The following week, the team decides to begin SCR with updates on cases recently reviewed. They quickly check in on the timely implementation of recommendations for the patients reviewed in the last several weeks, after which they proceed to more detailed discussion of patients with diagnostic questions or needing treatment adjustments. After several weeks, they have caught up on their discussions of patients. They spend slightly less time per patient on the challenging ones, but find that it is still sufficient to drive treatment adjustments and now they are also able to follow up on implementation of recommendations routinely.

Example: Allocating SCR differently from week-to-week. A CoCM team has a psychiatrist who comes to the clinic once a month and can see up to 4 patients directly. In the first week of the month, the team discusses every patient on the caseload briefly to identify which patients to schedule for direct psychiatric evaluation, triage patients who need outreach by the care manager, determine whether recommendations have been implemented, and identify patients who need to be scheduled with the primary care provider for follow-up. In the subsequent weeks, the SCR meetings are streamlined and the team can focus on those patients requiring changes to their treatment. Their recommendations are timely because they can prioritize based on who has been in for a visit and do not lose sight of those patients who are not showing up.

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Example: Providing on-demand case review. A CoCM team has a psychiatrist with a flexible schedule who could provide on-demand access to staff cases rather than waiting for the weekly SCR meeting time. The team is considering replacing the scheduled weekly SCR meeting with real-time case review and believes it will expedite patient care. They agree to test out a new workflow so the care manager pages the psychiatrist to discuss each patient when the patient is in clinic that week. They determine that the workflow is operating smoothly, but the team is concerned that switching to real-time case review will miss patients who are not coming in for follow-up visits. Instead of replacing the scheduled weekly SCR meeting time, the team maintains the regularly scheduled SCR meeting. Because many patients have already been reviewed through the on-demand process, they shorten the duration of the scheduled weekly SCR meeting to 30 minutes. They refer to the registry to identify when a patient has fallen out of contact or needs more attention and prioritize these patients for review during the scheduled SCR time. By supplementing real-time case review with a regularly scheduled time to follow up on recommendations and identify patients on the caseload who are not attending visits or are at risk of falling through the cracks, they are able to ensure effective population management.

Example: Unacceptable variability. A CoCM team has a 0.10 FTE psychiatrist who serves as the psychiatric consultant to a CoCM program with 40 active patients. The psychiatrist has told the clinic that most of his work will be indirect psychiatric consultation during SCR, however he is available to see select patients for direct psychiatric evaluation. His clinic template has one slot per week for this purpose. The providers in the clinic do not appreciate how limited his availability is and tell their patients that they can be seen directly by the psychiatrist. Within a few weeks, the psychiatrist's appointment slots have been booked out for 4 months. He is struggling with indirect management for several complex patients with diagnostic dilemmas that he wants to see directly. Because he cannot schedule them in a timely manner, he and the care manager decide to reduce the SCR frequency to every other week so he can see the patients directly instead and make additional recommendations for their care. Because he has not dedicated enough time to SCR, his struggles with indirect management continue, most of the patients on the caseload have not been reviewed recently, and the depression improvement rate in the program is eroding. The care manager notices that the no-show rate for the appointments scheduled for the psychiatrist by the front desk is much higher than for the patients identified during SCR that she schedules directly. The psychiatrist realizes that most of the patients scheduled by the front desk are lower complexity and that he could have provided recommendations indirectly much sooner if he had had time to discuss them in SCR. The psychiatrist, care manager, medical director and clinic manager meet and agree that he needs to re-establish adequate time for SCR and will continue to see some patients directly, but these must be approved by the SCR team prior to scheduling them. The psychiatrist sets up a time with the primary care staff to explain the plan that he will now see patients only if they are approved for direct consultation during the SCR team meeting and that for patients needing ongoing direct psychiatric care, they will be referred to psychiatric providers in the community.