

Best Practices for Systematic Case Review in Collaborative Care

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Conducting systematic case reviews (SCRs) is a critical skill for psychiatrists leveraging their expertise to provide collaborative care in a primary care setting; however, there is little literature to guide best practices for executing an SCR. This column offers guidance to psychiatrists on best practices for conducting SCRs by drawing on experience from psychiatrists who teach collaborative care and who directly

observe SCRs in established programs. Furthermore, it describes several common threats to successful SCR and presents potential solutions to assist programs in implementing indirect psychiatric care, an essential component of collaborative care.

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The collaborative care model (CoCM) for treating common mental disorders in primary care settings is an evidence-based strategy recognized as a best practice for improving patient outcomes. CoCM services are reimbursable by Medicare, some Medicaid programs (e.g., Maryland, New York, North Carolina, and Washington), and some private insurers. CoCM billing codes require initial and ongoing review by a psychiatric consultant (psychiatrist or psychiatric nurse practitioner) and treatment adjustments based on consultant recommendations. CoCM review represents a new role for psychiatrists, and 3,500 psychiatrists recently completed CoCM training from the American Psychiatric Association. Such indirect psychiatric care is regarded as an essential “active ingredient” contributing to improved outcomes of CoCM while leveraging a psychiatrist to serve a larger population than could be served with direct visits alone (1). With few exceptions (1, 2), there is little literature to guide psychiatrists adopting this new role. The literature reveals that CoCM that includes indirect psychiatric care is associated with better patient outcomes (3, 4), potentially because of greater treatment adjustment (5). Among patients whose depression persisted 8 weeks after initiating treatment, systematic case review (SCR) by a psychiatrist was associated with a doubling in the rate of new antidepressant prescriptions (5) and a higher likelihood of improvement at 24 weeks (3). Thus, increasing indirect care may further enhance outcomes within CoCM, although workforce development is required (6). In one of the few residency programs offering a CoCM rotation, indirect care was the only area in which most trainees (70%) lacked confidence (7). Two reports briefly summarize indirect care

(1, 2), yet psychiatric educators have dubbed such care “difficult to describe” (8). This column outlines best practices—based on experience performing case reviews, training psychiatric consultants, and directly observing psychiatrists during SCR sessions—for SCR used in CoCM.

Definitions, Principles, and Logistics of SCR

Of the many terms to describe indirect care in CoCM, we prefer “systematic case review,” which emphasizes both detailed attention to each patient and the management of a defined population of patients. Hereafter, “psychiatrist” refers to all psychiatric prescribers serving as CoCM psychiatric consultants.

A psychiatrist and care manager are required for SCR. Psychiatric specialists—rather than general medical providers or clinical pharmacists—are needed for their expertise with diagnosis and psychosocial interventions. Training

HIGHLIGHTS

- Indirect psychiatric care is a key component of effective collaborative care.
- Best practices for conducting systematic case reviews reinforce principles of effective collaborative care, such as population-based and measurement-based care.
- Common threats that may undermine the effectiveness of systematic case reviews can be managed with straightforward solutions.

in psychopharmacology and evidence-based psychotherapies allows psychiatrists to support delivery of the full range of evidence-based treatments. Psychiatrists have special experience managing boundaries and therapeutic relationships with patients with challenging histories. Providing support during and outside SCR to new care managers learning to manage a complicated caseload helps to develop high-functioning teams and to prevent burnout. Some teams may include ancillary members (e.g., health navigator, addictions counselor, pharmacist) (1). Efficiency in CoCM depends in part on the support that care managers receive for tasks such as scheduling, obtaining nine-item Patient Health Questionnaire scores, documentation, and requesting records (9). Well-supported care managers can serve larger caseloads and focus on clinical duties.

SCR meetings should be routinely held and occur regardless of caseload size in order to avoid poor outcomes when SCR occurs ad hoc (4, 9). Weekly SCR is recommended in order to tailor treatment (e.g., to patient preferences or side effects of medications) and avoid delays in implementing treatment recommendations. The appropriate amount of time in SCR depends on the complexity of the patient population, the rate of caseload turnover (review of new patients takes longer than rereview of ongoing patients), the efficiency and experience of the team, and program metrics (e.g., desired interval for reviewing patients who are not improving). We recommend reviewing every 4 weeks patients who are not improving in order to ensure timely treatment adjustments. (Guidelines for SCR time allocation for a straightforward caseload are available as an online supplement to this column.) Administrators should be reminded that CoCM provides psychiatric input for significantly more patients per hour compared with direct patient care. For populations with higher complexity (e.g., medical, psychosocial, substance use), SCR time should be extended and may need to be doubled. For new programs, consider allotting more SCR time for learning and growth, then addressing efficiency by using quality-improvement methods as the program matures (9).

SCR may occur in person or remotely by HIPAA-compliant interactive video (e.g., Zoom, BlueJeans, etc.) or telephone. For newly formed CoCM teams (e.g., new program or team member turnover), consider meeting in person for several sessions to identify team members' strengths and develop communication styles. All SCR participants should have access to the patient registry and medical records (e.g., electronic health record) and should reserve time before and after sessions for preparation, documentation, and follow-up.

Best Practices for SCR Preparation, Conduct, and Follow-Up

Using the registry to quickly sort the caseload, each participant should prepare for SCR by prioritizing patients (i.e., patients who may benefit from treatment adjustment; are not following up; are new to care, especially those with

diagnostic dilemmas; or need treatment recommendations) (see online supplement). Relapse prevention or program graduation for improved patients should be discussed briefly. Where available, direct psychiatric evaluation should be discussed—prior to scheduling to best leverage this scarce resource—for the subgroup of patients who may benefit. Frequently, initial steps toward recovery can be instituted while patients await direct evaluation.

Clinical information of patients identified for review should be previewed. For follow-ups, this information includes prior treatment recommendations and updates in their implementation. This material can be built into a note template assembled by the care manager before the SCR session. Prioritizing patients in advance and using the first few minutes of SCR to generate consensus on the patients for review ensures that SCR is systematic and allows for succinct and organized data-driven case discussions. These processes optimize use of SCR time, thereby reinforcing the CoCM principles that care is population based and measurement based (6).

SCR sessions begin with agenda setting, then individual patients are discussed in order of priority by using a standardized format for case presentation and documentation (see online supplement). In our direct observation of 16 SCR sessions in several CoCM programs ranging in maturity, the time to review an individual patient varied widely (range <1 minute to 30 minutes; median=3 minutes). For a clinician to make treatment recommendations, in-depth clinical review typically requires 4–8 minutes but may take up to 20 minutes for new patients or patients with complex or extensive histories. When a skilled care manager has already assembled data on a new patient, efficiency improves. Treatment recommendations should encompass the full spectrum of biopsychosocial interventions and not be restricted to psychotropic medication review.

Toward the end of the SCR meeting, psychiatrists can refer to the registry to ensure that patients are not forgotten and to reinforce the principle of accountable care (6) through brief patient updates (<2 minutes). Success as a CoCM consultant requires skills in systems-based practice to overcome barriers to implementing treatment recommendations. For example, psychiatrists may recommend strategies to reengage patients with whom there is limited contact. The psychiatrist can also advise a care manager to ask about common barriers, to use motivational interviewing skills, and to identify reasons a patient or primary care provider might not follow recommendations.

Before adjourning, the team should establish consensus on ownership of each action item. Ensuring effective implementation of a care plan is a critical function of SCR and should be a top priority for psychiatrists. By demonstrating interest in implementing recommendations and by identifying workflow barriers to care, the psychiatrist models accountability and provides leadership in developing clear structures—which can be important for driving improved patient outcomes—that address system barriers.

Psychiatrists should communicate treatment recommendations to the medical provider and document them in the patient's medical record, using templates (see online supplement) to do so quickly. This practice reinforces accountability (by requiring the psychiatrist to step actively into patient care), improves the visibility of recommendations among team members, and facilitates access to prior recommendations. Psychiatrists will be more successful by suggesting changes to the primary care team rather than by telling them what to do.

Variation in how teams organize and conduct SCR may help teams adapt to local circumstances, such as whether the psychiatrist is located on site, whether direct psychiatric consultation is offered, medical providers' comfort providing treatment, and whether SCR is being conducted in a training environment (9) (see online supplement). The relative time allotted to various tasks or their order may need adjustment to fit with the setting. Time allocation may change from week to week provided the essential tasks are accomplished regularly. When introducing variation, monitoring program-level outcomes is imperative to ensure continued quality.

On training sites, rotating primary care residents may be unfamiliar with CoCM, and their patients may lack continuity of care. Inviting medical residents to join SCR can orient them to CoCM more rapidly; however, effective team-based care requires clear delineation of cross-coverage responsibilities, crisp communication, and strong attending provider engagement. Psychiatry trainees should observe the attending psychiatrist conducting SCR for several sessions before coleading alongside the attending psychiatrist (8). Because of the nuanced requirements of the role, residents should not conduct SCR without the attending psychiatrist present. Psychiatry trainees can support CoCM while consolidating core psychiatric knowledge by providing targeted education to medical providers and trainees (9).

SCR best practices require only minor modifications for CoCM contexts involving co-occurring disorders. The CoCM team should have members with expertise in the target co-occurring substance use or medical condition (e.g., generalist or specialist such as diabetologist, obstetrician), the registry should include measures for target conditions, and care managers should have relevant training (2). To account for more complex decision making, SCR time should be extended and may need to be doubled for a comparable caseload. Finally, teams should consider how to prioritize treatment for the co-occurring disorders. For example, if severe depression interferes with a patient's self-management of diabetes, it would be logical to address depression before engaging the patient in more aggressive diabetes management.

Threats and Solutions

Effective CoCM requires a proactive approach that can be threatened by immediate clinical demands. Five common threats and potential solutions are outlined below.

Threat 1: drift to ad hoc review. When caseloads are small or patients have had limited follow-up from a care manager, teams may be inclined to cancel SCR meetings or schedule them "as needed."

Commit to a subsequent meeting time at the end of each SCR meeting and do not cancel. Decrease meeting length, meet every other week, or both. This solution is less time intensive (although reduced frequency may affect CoCM billing) yet maintains program momentum. Develop a plan for care manager or psychiatrist absences with cross-coverage to keep on track. If time remains once all patients have been discussed, promote CoCM sustainment by troubleshooting how to grow the caseload and by engaging primary care providers in order to determine whether and how the program is meeting their needs (9). Psychiatrists can also offer targeted education to the care manager in a specific clinical area (9).

Threat 2: neglect of population management. Clinical management of challenging patients can be time consuming and must be balanced with the need to oversee the care of an entire population.

Consider caseload size and allow adequate time for regularly scheduled SCR. Use a timer during SCR meetings. Use the registry to assess whether all eligible patients have been approached for the program, received follow-up, and been reviewed. Develop program-level quality metrics that track process and fidelity to the CoCM model and review them periodically (e.g., monthly) with clinic administrators (9).

Threat 3: avoidance of patients who are not improving. Discussing patients who are making progress is rewarding, but care management is particularly powerful for patients not recovering as expected.

Support team morale by celebrating successes without diverting excessive time to patients who have met their goals. Psychiatrists should encourage outreach and problem-solving to tougher cases while supporting discharge of patients not ready to make changes.

Threat 4: diversion of SCR time to other behavioral health matters. If SCR time is not protected, it may become derailed by nonurgent administrative or clinical issues requiring attention from CoCM team members.

Maintain clear purpose by anchoring SCR to the principles of effective CoCM (6). Use an agenda and manage time effectively during SCR. Arrange separate meetings for other issues needing attention.

Threat 5: boundaries with patients. Newer care managers may become overwhelmed by the complex needs of some patients and try to solve all life problems, risking burnout for themselves and dependency by patients.

Psychiatrists can monitor this issue and help care managers learn when to "lean in" to help depressed and low-energy patients and when to "lean back" to allow patients to solve some of their own issues.

Conclusions

Indirect clinical care and effective SCR are key elements of effective CoCM and represent a new role for psychiatrists. The best practices outlined herein serve as a guide for psychiatrists to leverage their expertise and serve a vital role in improving mental health on a population level. When done correctly, SCR can be a wonderful team experience and support effective mental health care for patients with complex needs who otherwise might lack access. It can also provide timely and effective case-based learning to care managers and (in the form of recommendations) to primary care team members. To advance research on SCR, future studies could examine what recommendations are most helpful and lead to treatment changes, incorporate predictive modeling to identify those needing more input, and examine the optimal timing and frequency (i.e., “dose”) of rereview and whether or when to include direct psychiatric evaluation. Such knowledge about allocation of scarce psychiatric resources could further inform program design and improve program efficiency and reach. SCR offers access to psychiatric expertise much more quickly than face-to-face visits, helps to triage those who may need higher-level services into the few slots available, and speeds recovery for patients whose lives are impaired by mental illness.

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