Active Caseload Review & Case Presentation Skills

Please send your "Name, Role, Site" in the chat box.
This is required for attendance.

Copyright ©2021 University of Washington

1

Learning Objectives

By the end of this session, participants should be able to:

- Understand how to use the registry to identify patients who need additional support
- Recall how to provide a brief and concise presentation to the psychiatric consultant
- Describe how to facilitate communication for patient treatment recommendations

2

Copyright ©2021 University of Washington

2

PREPARING FOR THE CASELOAD REVIEW SESSION

3

3

Measurement-Based Treatment to Target

- Proactive treatment adjustment
  - Avoid patients staying on ineffective treatments for too long
  - Treatment plan "shelf life" = 10-12 weeks max.
  - Full, partial, no response
- Know when to refer for consultation/get help
  - Bridging care and referrals to specialty care are appropriate for some patients

4

Copyright ©2021 University of Washington

4

Each Appointment is a Decision Point

- Three-step process:
  1. Use a BH measure each time to provide data
     - E.g. PHQ-9
  2. Track and consider what is happening
  3. Answer this question: Do I need to consult and/or change what I am doing?

5

Copyright ©2021 University of Washington

5

How Does a Registry Help?

- Keep track so no one "falls through the cracks"
  - Ensures all patients are treated
  - Keeps the BHCM aware of what's happening for each patient
- Shows who needs additional attention
  - Not in contact
  - Not improving
  - Outcome of referrals
- Facilitates communication with PCP and psychiatric consultant

6

Copyright ©2021 University of Washington

6

Preparation for Caseload Review: Prioritizing Patients with the Weekly Task List

Weekly Task List

1. Identify patients with acute safety risks
2. Identify patients who have been in treatment for 10 weeks or more without significant improvement (defined as a score of 10 or under or at least a 50% reduction in PHQ-9 score)
3. Identify patients with no psychiatric consultation note (or whose most recent note is more than 10 weeks old) and have scores on the PHQ-9 that are over 10
4. Identify patients with no contact in the past two weeks
5. Identify patients with a score of 10 or below or whose PHQ-9 score has reduced by at least 50%, that are ready for recovery support

7

Copyright ©2021 University of Washington

7

Practical Tips for Caseload Review Sessions

1. Set the Agenda
2. PC and BHCM should discuss case presentation expectations and agree on prioritized list of patients for case review
3. Use this time as an opportunity to learn together about diagnosis, medications, therapies, etc.!

8

Copyright ©2021 University of Washington

8

Activity: Practice Caseload

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
Flagged	1	23	10*	7	7*	7/16/2020	10/26/2020	11/3/2020		14	25
	2	17	4	4	4*	1/29/2020	12/14/2020	6/23/2020		18	46
	3	16	7	6	6*	7/28/2020	12/21/2020	12/14/2020	12/21/2020	14	24
	4	25	25	2	2*	11/11/2020	12/22/2020	11/17/2020		4	5
	5	8	7	19	17	1/27/2020	12/12/2020	8/25/2020	11/11/2020	16	46
	6	19	9	19	6	8/11/2020	11/23/2020	9/8/2020		7	18
	7	9	8	18	20	11/2/2020	12/21/2020	11/3/2020		3	6
	8	21	5	13	5	10/21/2020	11/27/2020	11/24/2020		8	10
	9	9	8*	13	6*	10/30/2020	12/11/2020	12/11/2020		2	7
	10	17	13	3	3*	5/26/2020	11/27/2020	11/3/2020		15	36

Key

(flag) Indicates patient has been flagged for discussion during next psychiatric consultation

* Score in the Last column will have an asterisk (*) if it is older than the specifications for that clinical measure; 30 days for both the PHQ-9 & GAD-7.

Last PHQ-9 score:
Red: 10 or above *and* has not improved 50% from baseline
Yellow: 5-9 *or* has improved 50+% from baseline
Green: 4 or below

Last GAD-7:
Red: 10 or above *and* has not improved 5 points from baseline
Yellow: 5-9 *or* has improved 5+ points from baseline
Green: 4 or below

9

Copyright ©2021 University of Washington

9

CASE PRESENTATION SKILLS

10

10

Case Presentation Involves Translating Between Professions

- The in-depth relationship the behavioral health care manager builds with the patient is critical
- All the information you gather is important
  - Not all of this needs to be shared for case presentation/decision-making purposes

11

Copyright ©2021 University of Washington

11

What Information Does the Psychiatric Consultant REALLY, REALLY Need?

- Symptoms and history supporting diagnosis
  - Including those suggesting more serious conditions
- Medical history
- Psychiatric treatment history
- Medication List
- Risk assessment

12

Copyright ©2021 University of Washington

12

Case Review Format

Summary (gender, age, means of support, living situation, relevant cultural information, insurance coverage, children/pregnancy):

Presenting Symptoms: Depression, anxiety, psychosis, mood instability, medical complaints…

Screeners: PHq-9, GAD-7, bipolar screen if appropriate, AUDIT-C, DAST, BAM, others

Psychiatric History: Hospitalization, therapy, other.

Substance use (alcohol, drugs, tobacco, caffeine, DUI): Current: Past: Past treatment:

Psychotropic Medication History: Medication names and dosages, when taken, for how long, whether effective, any side effects, why discontinued?

Medications presently taking: [as complete as possible]

Medical History: Pain, hypertension, diabetes, thyroid, seizure disorder, traumatic brain injury, others…

Pregnancy or breastfeeding status, or means of contraception.

Psychosocial history: Legal issues Housing status: Support system. Status of relationship with partner: Employment status.

Trauma history: Victim: Witness:

Behavioral Observations: In your own words, how does patient look and behave?

Safety Concerns:

- Current suicidal ideation [assess passive / active, plan, intent, access to lethal means], prior attempts, lethality.
- Homicidal ideation [specific individual, access to means, level of intent]
- Ability to care for self in community.

Patient's goals:

Working Diagnosis:

Provisional Treatment Plan: Therapy, Medication, Referral, Other?

13

Copyright ©2021 University of Washington

13

Model Consultation Hour

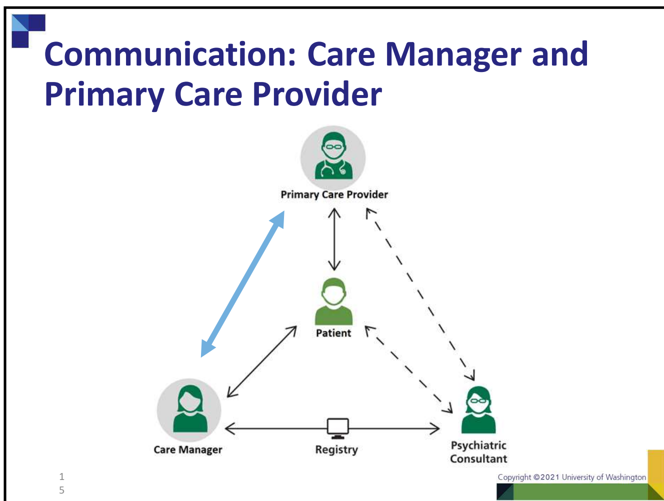
- Set an agenda
- Brief check-in
  - — Changes in the clinic
  - — Systems questions
- Identify patients and conduct reviews
  - — Follow-up on prior week's recommendations
  - — Presentation to consultant of cases for review
  - — Diagnostic and treatment decision making
  - — Action planning, next steps on who will do what follow up steps
- Wrap up
  - — Celebrate successes!
  - — Confirm next consultation hour and how to be in touch between consultations if needed
  - — Send any educational resources discussed

14

Copyright ©2021 University of Washington

14

Communication: Care Manager and Primary Care Provider



15

Copyright ©2021 University of Washington

15

Case Narrative #1: Billy

Maximizing the Psychiatric Case Review

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Case Narrative: Billy

Billy is a 24-year-old gay male and recent college graduate who works as a baggage handler at the airport. He has medical insurance through work and lives in an apartment with roommates. He is referred by his PCP, based on his report of feeling tired all the time for several months. He has trouble falling asleep, but he can get up with his alarm. He reports some trouble focusing at work. His performance reviews are only ok, though he doesn't think the job is hard and he rarely misses work. He admits to some low mood and feeling like life is just not that great over the last 4-5 months. He notes these feelings get worse during the dark winter months.

Billy was treated briefly once in the past for "nerves," he thinks with an antidepressant. He took the medication for 2-3 weeks, and then stopped because he felt better and thought the medication was making him gain weight. He's unsure about taking medications again, but he is willing to talk about it and learn more. Today, his PHQ-9 score is 14, and his GAD score is 10.

He does not endorse symptoms consistent with mania, and he denies ever having heard voices, or had paranoid thinking. He has occasional fleeting thoughts of wishing to be dead when he is unhappy with his life but does not have any active suicidal plan or intent, and no history of suicidal behavior.

He reports that his mother has been in treatment for depression with medication, and that his father and brother have a history of alcoholism. In college, Billy would sometimes drink to intoxication and use recreational drugs, but he no longer uses alcohol or drugs as he worries he is "susceptible to addiction." He has some close friends, but has not been in a romantic relationship yet, and he is concerned he'll always be alone, since he is "24 already, and not really even dating." He reports his family's southern Baptist affiliation makes it hard for him to talk to them about his sexual orientation.

He is generally in good health, though somewhat overweight and his BMI is 31. He thinks that he should exercise regularly but doesn't find this enjoyable. He reports infrequent sexual encounters and practices safe sex; however, he still worries about STDS and gets tested regularly. His results have been negative. He does not have a significant history of traumatic experiences and gets along fairly well with his family. He would like to not be so tired all the time, and to "be making more progress" in his life.

Now review a sample case presentation for Billy:

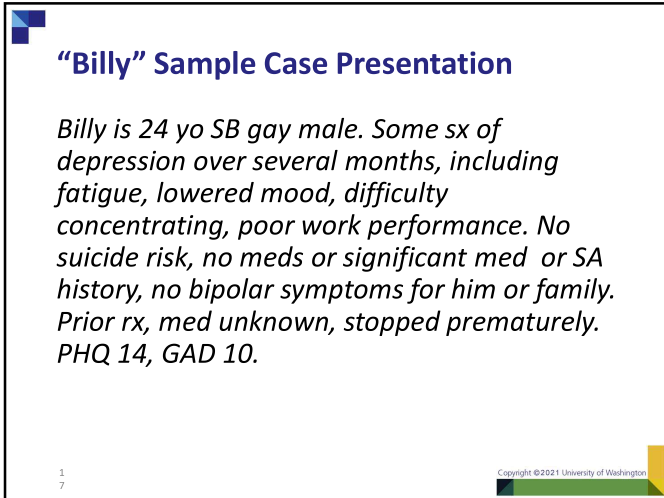
Billy is 24 yo SB gay male. Some sx of depression over several months, including fatigue, lowered mood, difficulty concentrating, poor work performance. No suicide risk, no meds or significant med or SA history, no bipolar symptoms for him or family. Prior rx, med unknown, stopped prematurely. PHQ 14, GAD 10.

©2020 University of Washington • AIMS CENTER • aims.uw.edu

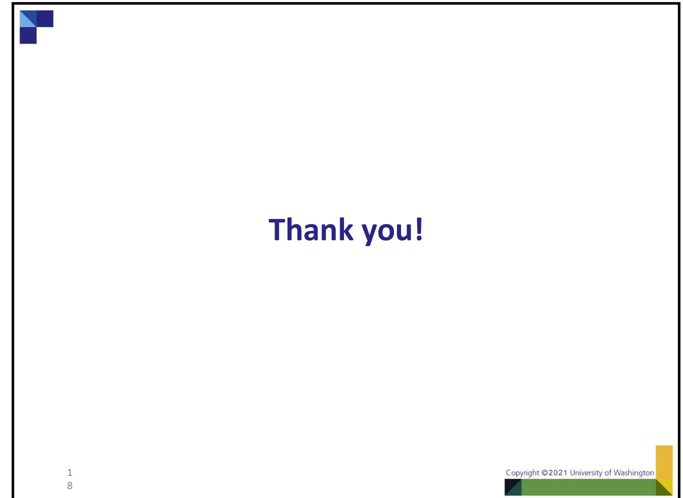
16

Copyright ©2021 University of Washington

16



17



18