January 2015 – The COMPASS Consortium

Annotatation 4:
Systematic Case Review

Systematic Case Review (SCR) is the weekly evaluation of all new patients and patients who have not reached their goals. The SCR team is made up of a consulting medical physician, consulting psychiatrist, care manager and other ancillary medical staff as appropriate. The weekly SCR team meetings are organized around these core functions:

1) Ensuring individual patient treatment intensification takes place until goals for targeted conditions are met and sustained
2) Reviewing the caseload to ensure all patient are engaged in COMPASS care and prioritized for interventions
3) Improving team functioning around the care of the patient, including the patient, SCR team members, and the patient's regular physician/primary care team.

The meetings offer a time to review aspects of behavioral intervention, management of depression, diabetes or coronary heart disease, relationship strategies and avoidance of hospital and ED use. The SCR team works collaboratively with the primary care team to determine, monitor and manage individualized patient treatment goals.

Do not underestimate the challenge of "role and cultural changes" facing each member of the team. For example, primary care physicians may not be used to receiving recommendations from a colleague regarding medical management of one of their patients, when delivered by a care manager. Allowing each care manager the opportunity to "role play" this scenario and receive coaching feedback regarding how to effectively partner with a busy clinician may be beneficial. Partnering effectively includes identifying the PCP's preference for the most effective and efficient way to communicate with him/her regarding the patient (e.g., voicemail, email, EMR notes, in person).

Tracking of Patient Outcomes

The following patient outcomes should be actively tracked as a standard part of systematic case reviews:

- PHQ-9 score
- Hospitalizations/ED encounters
- Clinic-derived blood pressure, and home blood pressure
- HgbA1c and date when last test was done
- Statin adherence monitoring
- Patient's stated goals and level of activation
- Patient's adherence with prescribed medications, diet, exercise and self-monitoring regimens

Lipid management guidelines significantly changed during the implementation of the COMPASS model. The field is in transition on the effective use of statins. LDL is an eligibility criteria; however, monitoring of laboratory values is no longer relevant. The focus is now on medication adherence.

SCR Team Functions: Care Manager and Physician Consultants

The weekly SCR team meetings with the consulting psychiatric and medical physicians are a substantial change from usual practices. It is expected that the care manager and the physician consultants have open discussions about the process of the SCR sessions, particularly to agree about expectations about all party's roles during the sessions.

Care Manager Preparation for SCR Team Meetings

The care manager is responsible for prioritizing which patients are discussed at in the SCR and presenting the pertinent information to the SCR team. Many teams are using Situation Background Assessment Recommendations (SBAR) as a format for this.

Prior to the weekly SCR team meeting, it is essential that care managers review the previous SCR recommendations in order to assess implementation of the recommendations, including patient progress. The care manager should also update the registry and/or EHR for key disease control measures, medication doses (optional), and hospitalization and/or ED use in order to make these sessions as productive as possible. The care manager needs to be able to articulate patient progress or lack thereof in each of the diabetes, depression, and CVD outcomes.

Consulting Physician Responsibilities for SCR Team Meetings

The consulting physicians are responsible for attending weekly SCR team meetings. They focus their treatment intensification recommendations based on their specialized body of knowledge (i.e., medical or psychiatric).

The care managers present patient cases to the consultants at the SCR team meeting. The consultants then probe to learn what the individual patient's situation is prior to making customized recommendations based on evidence-based guidelines as agreed upon by the practice and/or organization.

Consulting physicians make recommendations to the PCP team to reach treatment targets via the care manager, and may communicate directly with other physicians as needed. The PCPs do all the actual prescribing.

SCR Team Meeting Priorities

The priorities for SCR team meetings should be on:

1. Newly enrolled patients.
2. Patients who are not reaching goal and may require intensification or change of treatment
3. Patients with recent hospitalization/ED visit
4. Patients who have not or are not engaged in their care
5. Patients whose primary care teams are not responding to the SCR team's recommendations (this may require physician-to-physician communication to resolve)
6. Reviewing the full patient panel, as well as quality improvement reports and create action plan to address

Best practices of the SCR team meeting could include:

- Initially meeting face-to-face so the teams can establish relationships and roles that build trust and communication channels. Subsequently, this can be done by telephone or via the web, however, there continue to be many advantages to meeting in-person.
- The care manager should have access by phone, e-mail or face-to-face with consultants and the primary care team.

- Access to other members of the behavioral health team, such as psychologists, social workers, depression care coordinators, etc. who may be able to provide suggestions on helping patients with non-adherence or other behavioral issues.
- Access to ancillary members of the medical team such as diabetes educators, nutritionists, pharmacists and others who may provide guidance for patients' medical care.
- A communication style that facilitates effective and efficient reviews that produce important and valued recommendations for the primary care team.
- If there are numerous SCR teams throughout the health system, care managers may benefit from hearing about each other's cases.
- Documentation of the recommended treatment/medication changes should be made in the registry during or after the SCR by the care manager.

Systematic Case Review Outline

Each SCR team will determine a structured outline for each patient discussed during the systematic case reviews that meets their preferences and local needs. The following questions are recommended:

- What are the current outcomes versus targets in the treatment plan?
  - PHQ-9
  - HgbA1c
  - SBP
  - LDL
  - Self-care
- Has the patient recently been hospitalized or visited the ED?
- Is the patient active in self-care?
  - Taking medicines (name, dose, frequency)
  - Medication adherence evaluation
  - ASA use (if not contraindicated)
  - Weight monitoring (heart failure)
  - Blood pressure monitoring
  - Glucose monitoring
  - Physical activity
  - Nutrition
  - Social and environmental factors
  - Pleasant activities, especially for depressed patients

- Have treat-to-target goals been reached?
  - If no, adjust or intensify treatment, referral to complement collaborative care management, medication changes, etc. See also SCR Overview.
  - If yes, treat-to-target goals have been reached and no adjustment is planned, document.

Treatment Plan, Next Steps

During weekly systematic case reviews, the physician consultants recommend initial choices or changes in medications and treatments tailored to patient history and clinical response. Following the meeting, these steps take place:

1. The care manager (or consulting physician) brings the SCR team's recommendations to the primary care team by whichever mechanism is identified within the system.
2. The primary care team acknowledges and accepts the recommendations, or provides rationale for refusal.
3. Appropriate follow-up appointments, which could include labs, eye exams, nutrition consults, etc., are scheduled.
4. Medication and treatment changes are documented in the registry.
5. The care manager contacts the patient with the treatment plan to help implement it.

In addition to the data tracking tools, a Systematic Review Action List can be used to ensure that all patients receive interventions discussed by the team and that plans discussed are easier for the care manager to remember.

The primary care team and the SCR team collaborate in caring for the patient. To support the patient's successful self-management, partnership amongst the health care teams is a necessity.

Supporting Documents

- *Care Manager Role Description*
- *Consulting Psychiatrist Role Description*
- *Consulting Medical Physician Role Description*
- *TEAMcare Clinical Checklist*
- *TEAMcare Action List*
- *Systematic Case Review Effectiveness Checklist*
- *Systematic Case Review Workflow Example*
- *Systematic Case Review Overview*
- *SBAR Examples*
- *Healthy Days Measure*
- *TEAMcare Treat-to-Target Guide*
- *Systematic Case Review Guide Example*