Core Competency, Chapter 12

Population-Based Caseload Consultation

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Definition and Why Population Based Caseload Consultation is Important to Integrated Complex Care

An overwhelming percentage of healthcare dollars are spent on a small minority of individuals. More specifically, about 25% of these expenses are incurred by 1% of the population. The vast majority of this high utilizing population has multiple chronic medical and behavioral health conditions. Their needs are multi-faceted and require a complex and wide range of resources. An increasing number of studies have been published, demonstrating the effectiveness of team-based care on improving the outcomes of these complex populations. One of the central elements of successful team based care, is the implementation of measurement-based practice and the utilization of systematic processes that include the provision of caseload consultation by both medical and psychiatric providers. The presence of caseload consultants on the team results in routine review and monitoring of individuals who are not improving, and highly efficient and rapid adjustments in treatment. The consultation and resulting recommendations result in the advancement of care in a much timelier manner than might occur in more traditional approaches.

Example

An integrated care team consisting of a primary care provider, care manager, the mental health provider, the diabetes nurse, and a care coordinator meet to review a caseload of patients. The doctor asks to sort the patients today according to their most recent HgA1c level. Six patients jump to the top of the list – with Mr. JD at the top!

The care manager presents Mr. JD, who is a 60-year-old veteran with hypertension, diabetes mellitus, depression and post-traumatic stress disorder, who has had increasing HgA1c over the past 18 months, along with unstable housing and poor social support. Lately, he has no-showed to a couple of his appointments.

The primary care provider is puzzled – “why is the patient non-compliant with his medications lately?” The care manager volunteers that the reason is not “medical” – but rather the patient is living in the woods and his meds are often lost or stolen. Since days are spent trying to obtain the most basic needs: food and shelter – and medications often just get forgotten.

“Ah” said the primary care provider. Given that, let’s stop all but the essential medications for now, and let’s make all of them into once a day dosing.” And, the Care Manager volunteered that the church feeding center, where he eats lunch every day, allows patients to securely lock up their own medications for safekeeping. All agreed that this would be a good next plan for this client.

This total discussion took less than 7 minutes. They moved on to talk about 6 other patients during the one hour meeting and came up with similar strategies for each to try.

At the end of the meeting – everyone on the team felt like they each had learned one new thing about chronic care. They also enjoyed the sense of teamwork and the feeling that everyone was bringing their own personal set of skills to the table for the benefit of their patients.

Narrative Description

One of the central elements of the BHICCI, is the implementation of measurement-based practice. Individual team members will be accountable for collecting specific measurements at certain defined intervals (i.e., patient health questionnaire-9 monthly, or blood pressure at each visit). These values will populate the registry and will then

accessible to view from a population level to determine the overall health of the target population, as well as from the individual view, to see data on an individual patient/client. The registry can then be brought to a Systematic Case Review meeting, where the team meets to discuss their caseloads. Priority can be placed on discussing those individuals who are the furthest from their goals and this can be determined by a fairly quick view of the registry, which can be sorted based on outcomes measurements.

The team members who have the caseloads and have collected the data come from a variety of backgrounds, including nursing, behavioral health, social work, peer support. They bring a tremendous wealth of knowledge about the patients/clients in terms of their strengths, challenges and histories. The combination of the measurements collected and the wealth of information that the team members have provide a primary care consultant (who may or may not have ever met the patient), sufficient data to make a well-informed assessment. From this assessment, the caseload consultant is also then able to make recommendations for treatment, which can be shared with the primary care provider caring for that individual.

It is easier for the consultant to "paint a clinical picture" in his/her mind, if specific data elements are presented in a systematic fashion. In order to expedite this process, it is helpful for the consultant to meet with the team members who will be presenting the information prior to getting started, to ensure that all of the data is collected that would be required for the consultant to make an informed assessment (examples of templates can be found below). This process can be challenging initially, as it may represent new ways of thinking and talking for the various team members. However, by maintaining a mutual respect, a desire to improve team effectiveness, and a little humor, the process quickly becomes smooth.

The goal of systematic caseload reviews is to prioritize focus especially on those that are not achieving expected outcomes and/or those patients who appear to be "falling off the radar screen." Note the systematic caseload reviews are NOT the same as a more detailed "multidisciplinary case conference." The latter conferences tend to be detailed, length discussions, often with few conclusions to offer at the end.

Caseload reviews are typically much shorter, and structured around outcomes measurements. They are also iterative - cases are often discussed briefly several times during a treatment episode. The effectiveness of caseload consultation can be improved by considering each member present as a valuable contributor. Each person should strive to participate at the top of their "scope", allowing others to contribute as well.

Available Resources

1. For examples of templates used by both the consultant and the team members when before and after discussing individuals on their caseloads: (see appendix A-33-A-40) https://www.icsi.org/_asset/8gvdyx/CHPWCOMPASStoolkit.pdf

BHICCI Plan for Learning / Teaching / Coaching

- Agency clinicians READ the materials presented in Core Competency 11 - Population Based Caseload Consultation, and discuss with the practice coach.
- ATTEND OR VIEW Web-training or In-Person Presentation: Review of basics of Population Based Caseload Consultation.
    - Develop a Plan by Jen Clancy Consulting team/Agency for next steps of implementation at end of Web-training or training to implement integrated complex care using the plan-do-study-act.
    - Following training plan includes encouragement for the team to carve out time to evaluate and refine their process via the plan-do-study-act
    - Utilize video demonstrating population based caseload consultation.
        - Audience: primary care providers, care managers and clinic staff

How will Competence in this area be Measured?

This competency is likely one that will continue to improve the longer it is practiced. The goal will be to create a team environment whereby the functioning of the team (including the consultant) is continually evaluated during a carved out, routine time where-in all elements of the team are assessed and evaluated for areas of potential improvement, and PDSAs are developed to test those ideas.

Following completion/verification of the above learning/teaching/coaching plan, each clinician will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician's competency in each of the following by:

1. Case discussion of 3 or more complex care patients, or
2. Chart review of 5 or more patients, or
3. Direct observation of clinician interaction and conversation with patients/clients and/or teammates

COMPETENCY AREA	EVIDENCED BY:	SUPERVISOR'S RATING*
Convenes and Conducts Consultation Meeting	• Draws meeting to order in a timely fashion. • Communicates clearly with team members during case consultation. • Prioritizes patients for discussion using data or standardized measures. • Builds strong working relationships with other internal departments	1 2 3 4 5
Conducts caseload consultation on individual patients.	• Succinctly summarizes case touching on pertinent findings and facts. • Seeks input from other team members. • Summarizes recommendations for each patient. • (If serving as meeting scribe) – documents clinical discussion in medical file for sharing with care providers.	1 2 3 4 5

*1= Excellent results with no need for prompting or support.
3 = good results and/or required some prompting or support.
5 = required much support and/or was unable to complete necessary skills.