Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

Caseload Review Meeting Guide

Goal

Caseload review meetings allow the behavioral health care manager (BHCM) and clinical supervisor(s) to complete a high-level review of the caseload. The goal is to keep the caseload "fluid," allowing the BHCM to continue accepting new patients. During these meetings, the team will discuss which patients are ready to complete a relapse prevention plan, would benefit from a different level of care, should be contacted at a different frequency, or could be discharged from the program.

Frequency

Caseload review meetings should begin 2-3 months after the launch of the Collaborative Care program.

Program Status	Characteristics	Approximate Timeline	Frequency
Developing programs	Continuing to revise the clinical workflow; undergoing programmatic changes	First 3-6 months after launch	Monthly
Mature programs	Demonstrating strong fidelity, successful patient outcomes, and have not undergone recent programmatic change	After 6 months of enrollment or once the program has stabilized	Quarterly
Programs undergoing change	May include staffing, leadership, or workflow changes	--	Monthly

Participants

- Behavioral Health Care Manager
- Clinical Supervisor
- Psychiatric Consultant (Optional)

See next page for instructions on how to conduct a caseload review meeting.

How to Conduct a Caseload Review Meeting

Preparing for the Meeting

The BHCM should complete the following tasks:

- Update the **patient registry**, including all patient outcomes and documentation
- Ensure the clinical supervisor is able to access the registry during the caseload review meeting, either via the BHCM's screen or via their own computer

During the Meeting

The clinical supervisor and BHCM will use the **patient registry** to facilitate discussion. Sort the registry by:

Enrollment date in Collaborative Care (*old to new*)

- Criteria: Patients who have been enrolled for 6+ months
    - **Is the patient improving?**
        - If not, is the treatment plan being actively adjusted? If the patient is consistently not improving despite multiple psychiatric recommendations and treatment changes, is it necessary to refer the patient to a different level of care?
        - If so, is the patient ready for a relapse prevention plan and to move toward discharge?
    - **Is the patient engaging with the program?** If a patient is difficult to reach, it may be time to send a letter and discharge the patient from Collaborative Care.
        - Your clinic will ultimately determine the timeline for when it is time to discharge a non-engaging patient. Suggested discharge criteria:
            - Patient has not completed outcome measures for 3+ months
            - Patient has not returned 3+ phone contacts
            - Patient has not been present in clinic for 3+ months and has no upcoming appointments

PHQ-9 and GAD-7 scores (*low to high*)

- Criteria: Patients with PHQ-9 and GAD-7 scores that are *both* under 10
    - **Has the patient consistently had low scores for 2+ months?**
        - If so, are they ready for decreased contact frequency or a relapse prevention plan with a goal to move toward discharge?
        - If no, consider whether treatment changes or a referral may be needed

After the Meeting

The BHCM should complete all tasks that were identified during the meeting, including:

- Contact patients to administer outcome measures
- Complete **relapse prevention plans** or revisit self-management plans
- Make a note to discuss this patient in panel review
- Follow up with a PCP
- Send **patient letters**
- Refer patients to a different level of care
- Discharge a patient