Patient Population Tracking FAQ

Why is tracking a population of patients important in Collaborative Care?
Effective management of chronic health conditions such as depression and diabetes requires a coordinated team and shared information. The ability of the team to track clinical outcomes for populations of patients and to support systematic changes in treatment for patients who are not improving as expected is one of the basic tenents of Collaborative Care.

Q: What supports a measurement-based, treatment-to-target approach?
A: A care management tracking system. Care management tracking systems drive care by structuring encounters with patients, identifying those who aren't improving, prompting changes in treatment, and tracking effectiveness across different providers and caseloads – all while making the work of each team member more efficient and effective. They also track whether or not clinical targets are being met.

Q: Do we have to use a web-based registry?
A: No. Paper tracking systems and Microsoft Excel®-based systems can also be used. A web-based registry is the tool we most commonly recommend because of its greater functionality.

Q: Are care management tracking systems the same as Electronic Health Records (EHRs)?
A: No. A disease management registry is **not** a paper or electronic medical record, nor is it intended to act as a replacement. Medical records are a storehouse of information about a specific patient's care that can be used for clinical and/or billing purposes. Although some electronic medical records (EMRs) can use queries or filter functions to cue clinical activities or create specified patients list, most have limited functionality in this regard and need extensive – and oftentimes costly – customization.

Q: If we provide Collaborative Care, will we continue to use our EHR?
A: Most likely. There is information EHRs provide that care management tracking systems do not. Efforts are underway to integrate the two data sets but nothing is currently available.

Q: Can we only use our EHR if we want to provide Collaborative Care?
A: No. EHRs have limited functionality.

- EHRs do not allow a care manager to quickly see all the patients they are currently treating which is needed to provide POPULATION-BASED care.
- EHRs cannot quickly summarize which patients are NOT improving which is needed for TREATMENT-TO-TARGET CARE.
- EHRs cannot generate caseload statistics about the number of patients improving and other quality measures which are required for ACCOUNTABLE CARE.

Q: Can we reconfigure our EHR to provide the information we need for Collaborative Care?
A: Maybe. EMRs can sometimes be designed to cue specific clinical activities but this is not a core feature and typically requires a significant investment in customization of both time and money.

Q: Will using a care management tracking system mean a lot more work?
A: No. Most care mangers will need to do some double documentation (usually 1-5 minutes extra per patient). However, you will be able assess and triage your entire caseload more efficiently.

Q: Is there key information that should be tracked to implement Collaborative Care?
A: Yes. At a minimum, the following processes and outcomes should be tracked at both the individual patient and treating provider levels. If possible, it is also helpful to track them at the clinic (site) and organization level.

Clinical Outcomes

1. Number (#) and proportion (%) of patients in treatment for at least 10 weeks with significant clinical improvement as measured by a validated rating scale (definition of "significant clinical improvement" varies based on the condition being measured and the measurement tool being used). Minimum goal should be 40% of patients demonstrating significant clinical improvement.
2. Proportion of patients (%) in active treatment who have a baseline measure of the clinical condition(s) being treated and the mean (average) of that score
3. Proportion of patients (%) in active treatment who have a follow-up measure of the clinical condition(s) being treated and the mean (average) of that score

Key Processes of Care

1. Total number (#) of patients discharged (no longer active)
2. Total number (#) of patients active
3. Proportion (%) of active patients receiving any kind of follow-up (in-person, group, phone) during past month
4. Mean (average) number of contacts since treatment started
5. Mean (average) length of time in treatment
6. Proportion (%) of patients in treatment who have been reviewed by a psychiatric consultant who has made recommendations to the primary care-based treating medical / behavioral health providers
7. Proportion (%) of patients in treatment for at least 10 weeks who are not improved and who have not been reviewed with the psychiatric specialist

Q: Do you have recommendations about choosing a care management tracking system?
A: Yes. Ask prospective vendors if their product can deliver the ten key metrics above