

# Registry Essentials for BH Care Managers



# This Presentation

- **Describes what a registry is**
- **Shows how the registry is used in each phase of Integrated Behavioral Health care**
- **Shows which team members use the registry for which functions**



# Registry

- **Terminology**
  - “Registry” is a generic term that describes any tool that practices use to keep track of a defined population of patients.
- **Purpose**
  - Active tracking of individual patient progress  
AND tracking population progress



# Registry

- **Who uses it?**
  - **Care Managers (CM)**
    - Each CM has their own Registry
  - **Psychiatric Consultants (PC)**
    - Looks at CM Registry during Case Consultation
  - **Clinical Supervisors/Practice Leadership**
    - Aggregate data from multiple Care Managers to assess effectiveness of care



# The Registry is critical to support Collaborative Care

- **Tracks clinical targets**
- **Identifies patients who aren't improving**
- **Prompts changes in treatment**
- **Facilitates psychiatric consultations**
- **Shows aggregate population improvement data**



# Delivering Care as a Team



**Identify &  
Engage**

**Establish a  
Diagnosis**

**Initiate  
Treatment**

**Follow-up  
Care & Treat  
to Target**

**Complete  
Treatment &  
Relapse  
Prevention**



# Identify & Engage



## Team Activities at this Phase:

**Patient:** completes screening and PCP assessment

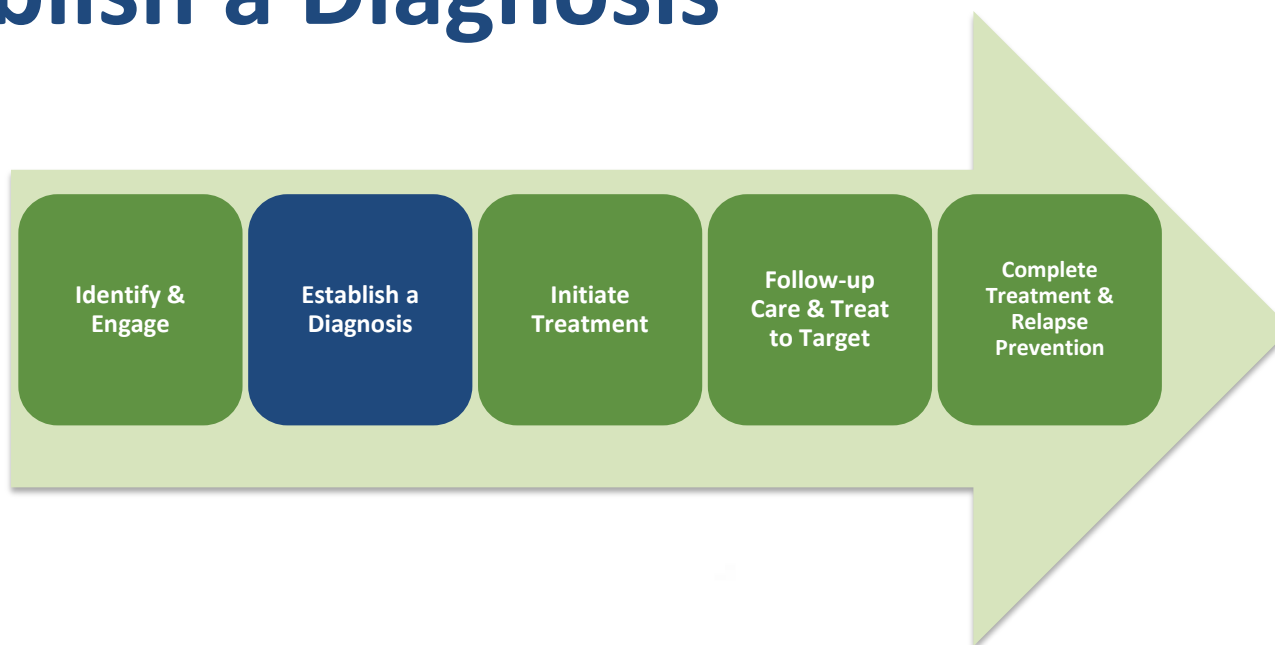
**PCP:** Introduces concept of CC and also CM if possible

**Care Manager:** is available for warm hand-off, outreach, or appt with patient, *enters patient info into Registry*

**Psychiatric Consultant:** no task yet



# Establish a Diagnosis



## Team Activities at this Phase:

**Patient:** provides accurate and honest information to PCP and CM

**PCP:** reviews/rules out physical causes of MH distress

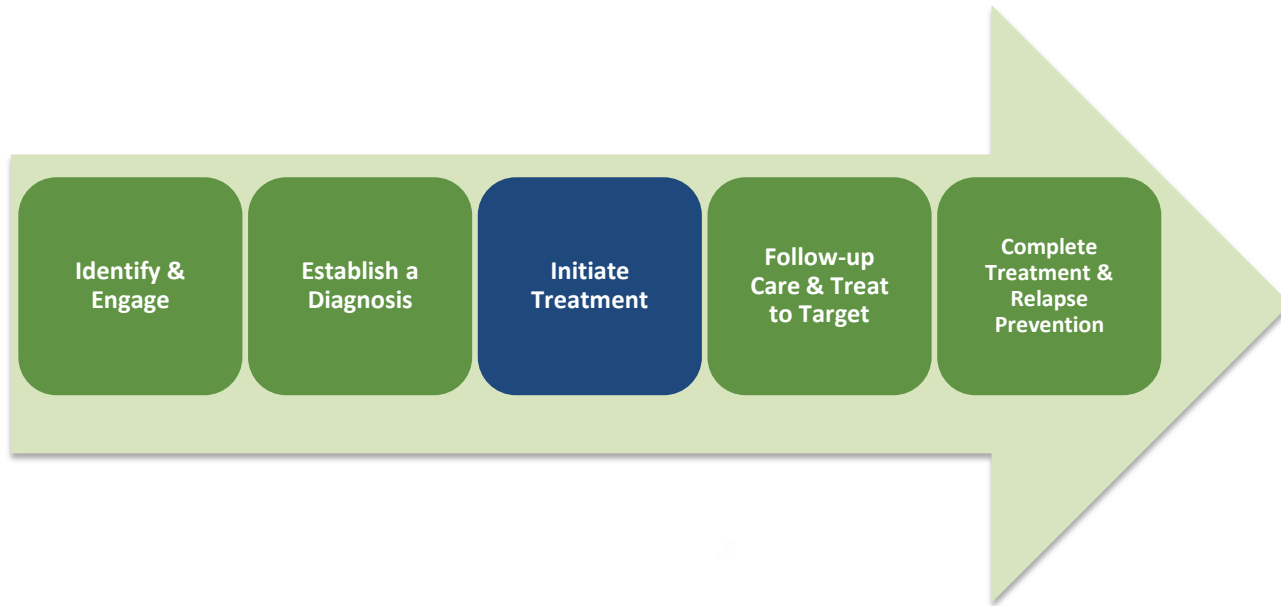
**Care Manager:** completes assessment and additional screening, *records any additional screening results in the Registry*

**Psychiatric Consultant:** *reviews the screening information in the Registry*, hears the CM's observations during case review, determines diagnosis





# Initiate Treatment



## Team Activities at this Phase

**Patient:** Engages with PCP and CM, asks questions, communicates concerns

**PCP:** Writes RX, monitors labs, addresses side effects

**Care Manager:** educates patient, monitors response, initiates psychosocial interventions, records clinical notes in the EHR and *creates an encounter entry in the Registry at each visit*

**Psychiatric Consultant:** *monitors response by viewing the measurement scores in the Registry*, guides CM and patient education

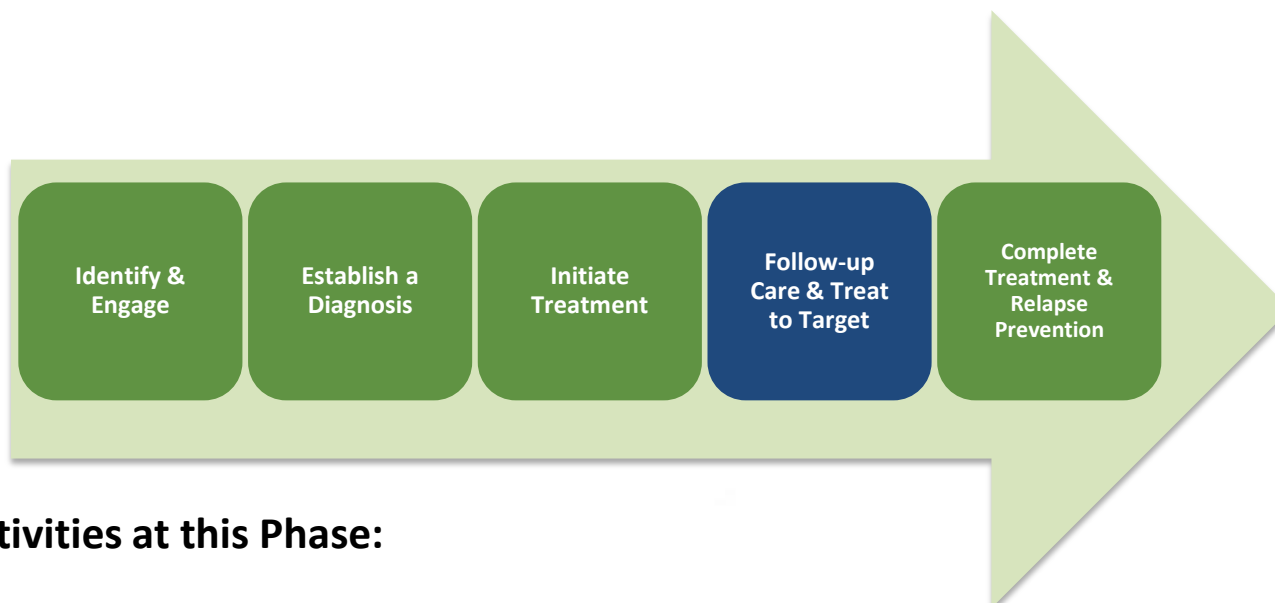


# Encounter Entries

- Document Measurement Tool scores
- Allows Care Manager to compare data from previous contacts.
- Can flag patients for safety risk and/or lack of improvement and discussion at next Psychiatric Consultation.



# Follow-up & Treat to Target



## Team Activities at this Phase:

**Patient:** works on adherence to meds and Behavioral Interventions, reports progress or challenges to CM and PCP

**PCP:** makes adjustments according to PC recommendations

**Care Manager:** monitors response to the initiation of treatment, reviews progress with Psychiatric Consultant, adjusts BH Interventions, *records outcome measures at every visit in the Registry*

**Psychiatric Consultant:** assesses response by *reviewing outcome measures in the Registry*, recommends changes if needed



# Caseload Overview

- Must be able to sort by symptom severity, score values and score improvement trends, due to be seen, time in treatment, last psych consult, etc.
- Shows patients flagged for discussion at next Psychiatric Consultation.

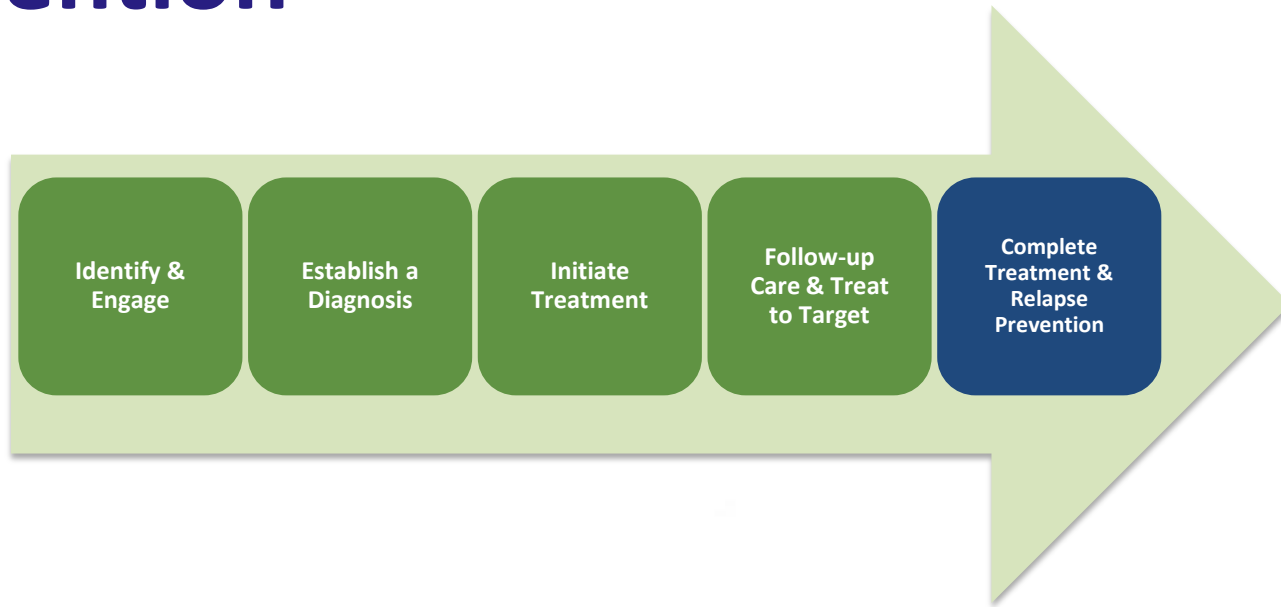


# Reminders/Alerts Functions

- Brings to Care Manager attention patients that are due for an appointment based on treatment frequency.
- Brings to Care Manager attention patients to review with Psychiatric Consultant
- Brings to Care Manager attention any patient safety concerns



# Complete Treatment & Relapse Prevention



## Team Activities at this Phase:

**Patient:** Develops a Relapse Prevention Plan with PCP and CM

**PCP:** Continues monitoring medication response and implements long term medication plan

**Care Manager:** *Continues to record contacts in Registry*, helps pt develop RPP and recognize warning signs, educates pt about maintaining healthy living *and closes episode when goals are met*

**Psychiatric Consultant:** Helps PCP develop long term medication plan



# Thank you!

**For more information about registries and their function in measurement-based, treatment-to-target care visit the UW AIMS website.**

**<https://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/identify-population-based>**