

Most Important Things to Know About the Patient Tracking Spreadsheet

1. The PRIMARY purpose of the registry is to help you support the clinical work of the team.

The Patient Tracking Spreadsheet is designed to serve YOU. If you feel like you're serving the registry, something is wrong and we can help. Let us know! We can show you how to use the registry so that it serves you and helps you with your job.

2. The registry works best when you use it every day throughout the day.

The registry can help you quickly and easily see who is getting better (time for a relapse prevention plan), who is not (time for a chat with the psychiatric consultant), and who needs contact. The registry can only help with these tasks if you use it every day alongside your electronic health record.

3. The registry helps guide patient contacts.

The registry facilitates patient contacts (phone or in person) with a patient by reminding you when a follow-up contact is due.



Getting Started

The following scenario is designed to help you learn how to use the Patient Tracking Spreadsheet to facilitate delivery of high-quality evidence-based mental health care.

✓ **Checklists at the end of each section indicate Patient Tracking Spreadsheet skills learned.**

To get started, please open the [Patient Tracking Spreadsheet with Example Data](#), and make sure you click “Enable Editing” and “Enable Content” in the yellow bar at the top of the page.

This scenario is meant to be used in conjunction with the [Patient Tracking Spreadsheet Template Instructions for Care Managers](#), which contains further instructions for each column on the spreadsheet. It’s strongly encouraged that you read pages 5-6 in these instructions to orient yourself to how the spreadsheet is organized.

We recommend that you read each scenario first, and then enter applicable information into the spreadsheet. After you have entered the information, use the checklists at the end of each section to ensure you have included the appropriate pieces of information. There are also “Registry Tips” in some scenarios to inform you of best practices or give suggestions on how to enter information.

Setting the Scene 12/2/2017

Dr. Anderson approaches you in the clinic about a new patient, Emily Richards, who came to the clinic reporting fatigue, abdominal pain, and headaches. She has a PHQ-9 score of 18. You step into the exam room to introduce yourself. Emily, a student at a local community college, has been having difficulties managing the stress of school and is not sure if she can go on with her degree. She is the first person in her family to go to college, and she fears being a disappointment to everyone in her family if she cannot stay in school. Emily had treatment for depression in the past at another clinic but stopped because she didn’t want her friends at school to think she was “crazy.”

Emily agrees to start depression treatment at the clinic. Dr. Anderson explained Collaborative Care to her and gave her a flyer that describes the team, including Dr. Anderson, Emily, you, and a psychiatric consultant who helps guide treatment.

You ask if she has time to stay for ~30 minutes to talk with you further. Emily says she can stay for about 15 minutes until she needs to leave to get to a class.

With only 15 minutes before Emily needs to leave the clinic, you gather the most important information you need to get started. You open your copy of the Patient Tracking Spreadsheet on the computer that is in the exam room and add Emily as a new patient (MRN 9876).

Since you have limited time, you ask Emily if she can return to complete the Initial Assessment within the week. You schedule an appointment with her for Tuesday, 12/8/2017 at 3:30 PM.



Registry Skills:

- Enroll a new patient**
- Add an Appointment: Care Manager Contact Notes (Optional; could be entered in EHR only)**

Registry Tip: The required fields for every new patient on the spreadsheet are MRN, Name, Treatment Status, Episode Number, and Actual Contact Date. To enter these items, first enter the MRN, Name, and Treatment Status (“Active”) into the white cells in the first row of the new patient record. (This is known as the Initial Assessment row, which provides you with a snapshot of where the patient started in the current episode of care.) Then, go down to the next (second) row and fill in the Episode Number (“1” if this the first time the patient has enrolled in care) and Actual Contact Date. The other white cells in this row should be filled out as well, but the aforementioned information is required for the spreadsheet to function properly. See pages 9-13 of the [Instructions](#) for further information on these columns.

Registry Tip: If you want to add appointments to the spreadsheet (in addition to the EHR), the best way to do this is to put them in the Care Manager Contact Notes column, then change the font color to something that you can use consistently to differentiate appointments from other notes. Some care managers like to use this method for appointment reminder calls or contact attempts as well. (Using “Alt+Enter” will allow you to start a new line of text within the same cell.) See page 15 of the [Instructions](#) for further information on this option. Be very careful **not** to enter upcoming appointments into the Actual Contact Date column; you should only enter a date once you have actually had contact with the patient, otherwise you will not be notified of past due appointments in the Tickler column if the scheduled appointment does not occur (e.g., missed, canceled, etc.).

Registry Tip: Whenever scores (PHQ-9 or GAD-7) are not obtained during a session, make sure there is a period in the cell rather than leaving it completely blank, since a blank will register as a score of 0. If you leave the cell blank, or leave any other cells blank that must contain a value for the spreadsheet to function properly, the cell will turn red. If you see red cells anywhere on the spreadsheet—other than the “Past Due” reminder in the Tickler column—you must enter a value so that the Caseload Overview worksheet displays correctly.



12/8/2017

Emily comes into the clinic for her Initial Assessment. She completes a PHQ-9 in the waiting room, and gives it to you as you walk to a consultation room.

When you get to the consultation room, you open the registry and tell Emily that the clinic uses a computer program that helps make sure that patients are getting the most effective treatment for depression. The registry also helps the team know when it's time to consider making a change in treatment.

You educate Emily that MOST patients need at least 1 change in the treatment plan before they get better, and that it's not uncommon to make 2 or more changes in treatment to get completely better. This doesn't mean that the treatments or the patient are bad— it's a normal part of the treatment process.

Everyone on the team —you, Dr. Anderson, the psychiatric consultant, and Emily herself— will know whether the treatment is working by tracking her symptoms with the PHQ-9. You will re-measure her symptoms most of the times you meet or talk on the phone, and this information will make sure she gets the best possible results from treatment.

You reiterate that you will keep in touch with her over the phone between in person visits to see how she's doing and to follow-up on the things that you discuss when you see each other in person. You give Emily a blank copy of the PHQ-9 to take home to use as a reference when you talk on the phone because it's easier to do the PHQ-9 over the phone if you have one to look at for reference.

Emily tells you that her greatest concern is that she may have to drop out of school if her depressive symptoms don't improve. She was briefly in treatment for depression in March 2017, and was given Celexa®. She doesn't remember the dose. She stopped taking the medication that summer because she was feeling fine. In the fall, she began experiencing depression symptoms again.

Emily is not doing well in school because it's hard for her to get motivated to do homework or go to class and she is having difficulty concentrating. She was recently let go from her job as a hostess because she kept cancelling her shifts. Emily explained: "I was too tired and didn't think it was worth it and I'm not good with people anyway".

Emily has a close group of friends at school, but she fell out of contact with them in the last few months. She usually enjoys playing piano and running, but now has little interest in these activities. Emily lives with her parents. Her mother has told Emily that she has struggled with depression off and on over the course of her adult life and is currently taking medication but Emily doesn't know which one.

You review the PHQ-9 Emily completed in the waiting room and enter her score into the registry. You tell her that her score of 15 indicates severe depressive symptoms. Emily reports she has never been



suicidal. Emily also completes the GAD-7, which is a measure of severity of anxiety symptoms. Her score on this is 12.

Now you talk with Emily about the options for treatment. You let her know that the clinic can offer medication and/or counseling. You tell her that research shows that both are equally effective— they each get about 50% of people better. There are over 20 FDA approved antidepressant medications available, and there are also several different types of counseling that are effective for depression.

You say there are several things to consider when deciding where to start with treatment, and the most important among these is what the patient prefers. You ask Emily if she has a preference for medication, counseling, or both.

Emily says that the Celexa® worked so well the last time she was depressed that she would like to try it again. She says that she's so busy with school that she is concerned that the time commitment necessary for counseling would add to her stress rather than help with it.

You tell her that you'll let Dr. Anderson know she is interested in re-starting Celexa®. You will call her on the phone to let her know if Dr. Anderson wants to see her in person again before starting the medication or whether she can pick up the medication from the clinic's pharmacy.

Next, you let Emily know that it often takes time for the medication to start working. You tell her that it's important that she start re-engaging in the kinds of activities she enjoyed before she became depressed, even if she doesn't feel like it yet. You discuss a care plan goal with her to play the piano for 10 minutes on Friday and Sunday. You briefly document this in the "Care Manager Contact Notes" section so that you can refer to it the next time you talk with Emily.

You are concerned about the severity of Emily's depression and want to see her on a weekly basis for now. Emily says that she doesn't have time to come in again next week because of her school schedule. make an appointment to talk with her by phone on Tuesday, 12/15/2017, at 4:00 PM to see how she's doing and to check in on progress toward her goals.

You flag Emily for Psychiatric Consultation so you can get information for the PCP about medication dosage and titration recommendations.

Registry Skills:

- Enter Initial Assessment Contact Date, PHQ-9 score, and GAD-7 score
- Document Care Plan Goal in Care Manager Contact Notes if desired
- Assign a Follow-up Schedule
- Flag for Psychiatric Consultation



Registry Tip: Most documentation for the Initial Assessment will go directly into your EHR. However, some components, such as the PHQ-9 score, will be entered into the registry. Generally the Care Manager Contact Notes section will only be used for critical pieces of information or notes about the patient's care plan, but it is available to use however you find most useful.

12/12/2017

To prepare for your weekly caseload consultation with Dr. Fernandez, the Psychiatric Consultant, you refresh the Caseload Overview worksheet in the Patient Tracking Spreadsheet and use the filters in the column headers to prioritize patients for case review. Since Emily is flagged for psychiatric consultation, you select her as one of your cases. After reviewing Emily's record, Dr. Fernandez recommends that Dr. Anderson prescribe 20mgs Celexa® once daily, since that medication worked for her in the past and was well-tolerated. Dr. Fernandez enters that recommendation into the EHR. You enter the date of this note into the Date of Psychiatric Case Review column on the Patient Tracking worksheet, and you remove the flag for psychiatric consultation.

Registry Skills:

- Refresh the Caseload Overview Worksheet
- Utilize Sorting/Filtering on the Caseload Overview Worksheet
- Record Date of Psychiatric Case Review
- Remove Flag for Psychiatric Consultation

Registry Tip: Both Care Manager and Psychiatric Consultant use the registry during the consultation hour. To identify/prioritize patients and conduct reviews, you can sort your caseload to identify patients by the severity of presentation, or who have had a consultation requested by a BHP/CM (flag), have not improved and do not have a psychiatric consultation note, are disengaged from care, or are ready for relapse prevention or referral.

Registry Tip: To remove a flag, simply go to the patient's record in the Patient Tracking worksheet, click on the cell with the flag that you added, then press the "Delete" key.



12/14/2017

You call Emily to let her know that Dr. Anderson wrote a prescription for Celexa® and that it is waiting for her at the pharmacy. You leave a message on her voicemail reminding her about your phone appointment tomorrow and encouraging her to call if she has any questions before then.

Registry Skill:

- Contact Attempt: Care Manager Contact Notes**

Registry Tip: The best way to enter contact attempts is to put them in the Care Manager Contact Notes column, then change the font color to something that you can use consistently to differentiate contact attempts from other notes. (Using “Alt+Enter” will allow you to start a new line of text within the same cell.) See page 15 of the [Instructions](#) for further information on this option.

12/23/2017

When you open your spreadsheet and use the Tickler column to sort for “Past Due” appointments, you notice that Emily appears on the list. She never called back. You call Emily again and this time she answers. She tells you that she picked up the prescription and started taking it but doesn’t feel much better yet. You ask to complete the PHQ-9 over the phone but she declines and she sounds quite depressed. You ask about her care plan goal to play the piano and she says that she did it once but not again. She agrees to come in on 12/30/2017 at 4:00 PM.

Registry Skills:

- Filter Tickler Column for “Past Due” Follow-up Contacts**
- Enter a Follow-up Contact**
- Add an Appointment: Care Manager Contact Notes (Optional; could be entered in EHR only)**



Registry Tip: You can remove ticklers by entering a value of any kind in the Actual Contact Date column for the specific row in which the tickler appears. If a patient does not show up for an appointment, but you are unable to make contact, you may not want to remove the tickler right away, as it will serve as a reminder that you have not yet contacted the patient. However, if you successfully contact the patient after a missed appointment, entering something like “Missed” as the contact date will remove the tickler. Alternatively, you may prefer to just enter the follow-up contact date (when you successfully contacted the patient) and make a note about the missed or canceled appointment(s). Just be careful not to remove the tickler if it has not been acted upon in order to prevent patients from falling through the cracks. See page 10 and pages 12-13 of the [Instructions](#) for further information on how ticklers and contact dates are calculated and interact.

12/30/2017

Emily completes the PHQ-9 in the waiting area before her appointment. Her score of 10 indicates moderate depressive symptoms.

Emily reports that she doesn't feel much better yet. You acknowledge that she still has moderately high symptoms, but also point out that some of her symptoms have gotten a bit better since last time. She is surprised by this and says “Maybe the medicine is starting to help. I don't know.”

You check in with Emily about her care plan goal to play the piano. She says that it was helpful for you to ask about when you spoke on the phone and she has played again a few more times but not as consistently as she would like. She still doesn't really feel like playing. You give her reinforcement for pushing herself to do something for herself even when she didn't feel like it.

You ask her to make a new care plan goal and she says that she wants to try to reach out to one of the friends. She makes a plan to send her a text message by the end of the week to suggest getting together over the weekend for coffee.

You switch Emily to a two-week follow-up schedule. Emily schedules a phone appointment in two weeks on Wednesday, 1/13/2018, at 1:00 PM.

Registry Skills:

- Enter a Follow-up Contact
- Adjust Follow-up Schedule
- Add an Appointment: Care Manager Contact Notes (Optional; could be entered in EHR only)
- Document Care Plan Goal in Care Manager Contact Notes



1/13/2018

At her phone follow-up, Emily explains she has been feeling much better and doesn't think she needs to continue treatment. She plans to continue the medication but she is really busy with school and doesn't want more things on her plate.

She completes the PHQ-9 with you over the phone; she scores 5.

Since Emily's score is under 10, you suggest that the two of you complete a Relapse Prevention Plan over the phone right now and then let her know that you'll call her once a month for the next couple of months to check in with her to see how she's feeling. If she's still doing well in a couple of months you'll remove her from your care management list. She agrees.

Emily plans to continue taking her medication. You provide some psycho-education about the importance of taking the anti-depressant medication for 6-12 months after she is feeling better to decrease the risk of relapse of depression symptoms.

Emily reports that her personal warning signs are feeling tired, eating less, and spending more time alone. To minimize her symptoms, Emily will reduce her time spent alone or online, spend more time doing physical activity and playing piano, and be sure to stay in contact with her friends.

Registry Skills:

- Enter a Follow-up Contact**
- Adjust Follow-up Schedule**
- Change Treatment Status to Relapse Prevention**

2/13/2018

You call Emily to check-in with her to see how she's doing. She doesn't answer so you leave a voicemail message and ask her to call you back.

Registry Skill:

- Contact Attempt: Care Manager Contact Notes**



3/5/2018

You call Emily to check-in with her. She doesn't answer again so you leave a voicemail message and ask her to call you back.

Registry Skill:

- Contact Attempt: Care Manager Contact Notes**

4/18/2018

You call Emily to check-in with her. She doesn't answer— again. You leave a voicemail message letting her know that you're going to take her off your care management list but that she should make sure to call the clinic if symptoms start to return. You change her status to "inactive" and use the Treatment Status column filter to hide her from your active caseload.

Registry Skills:

- Contact Attempt**
- Discharge a Patient/Change Treatment Status to Inactive**
- Filter Treatment Status Column to Remove Inactive Patients from View**

9/3/2018

Dr. Anderson pulls you aside in the clinic - Emily tore a ligament in her knee playing soccer. She stopped taking her anti-depressant medication several months before the accident, but after her knee injury, her symptoms returned with increased severity. Dr. Anderson restarted the Celexa® and wants you to reach out to Emily for care management support until she's stable again. He also wants you to suggest to Emily to add counseling to the treatment plan. You create a new Episode of Care and meet with Emily to do an Initial Assessment the same day; her PHQ-9 score is 17.

Registry Skills:

- Filter Treatment Status Column to Display Inactive Patients**
- Change Treatment Status to Active**
- Begin a New Episode of Care**
- Enter Initial Assessment Information**

