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.
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