Collaborative Care Registry Design Considerations

This guide describes the features of a registry to support Collaborative Care (CoCM) workflows. The descriptions can help you evaluate whether a registry will meet the needs of your program, or as a starting point for building your own tool.

CoCM registries vary widely in their sophistication, functionality, cost, and scalability. Options include:

- A spreadsheet used alongside the EHR
- The AIMS Caseload Tracker
- A custom registry within the EHR or care management software system

Whichever option is selected, a CoCM registry needs to include these key functions:

1. **Track clinical outcomes across a population of focus**
   The care team is accountable for clinical outcomes across the patient population of focus. Population-level reports allow providers to evaluate current values and trends in validated behavioral health measures, such as the PHQ-9. It can also be used by supervisors to monitor workloads and program effectiveness.

2. **Track patient engagement across a caseload**
   The Behavioral Health Care Manager (BHCM) is responsible for ensuring patients stay engaged in treatment. Reminders or alerts can help the BHCM easily see patients that are due for an appointment or who may require more intensive efforts to engage them in care. These functions can help focus outreach efforts to ensure patients don't fall through the cracks.

3. **Prompt measurement-based treatment to target**
   The care team must be able to adjust a patient's treatment plan based on clinical outcome measures, such as the PHQ-9. Measurement of outcomes over time makes trends visible and aids the team in evaluating treatment response. Recent scores and dates of measurement should be available in real-time.

4. **Facilitate efficient Systematic Caseload Review**
   BHCMs and Psychiatric Consultants track patient progress at the caseload-level to prioritize patients who are not improving as expected and may need a treatment adjustment. A caseload-level report that helps the team prioritize patients is critical for efficient Systematic Caseload Review. Tracking previous individual case consultation dates is also important for prioritizing patients for discussion. The ability for BHCMs to manually flag patients for individual case consultation can also be helpful.

5. **Monitor individual patient progress**
   The BHCM is responsible for monitoring the individual patients on their caseload. Patient-level reports should display a summary of treatment history over time, including baseline and most recent symptom scores, and should visually graph outcome measures such as the PHQ-9 score.

Inclusion Criteria

Determining which patients to include in the registry is an important consideration. Some registries include all patients in the population of focus of the CoCM program using factors such as screening scores, diagnosis, or program eligibility, while others only include patients that have consented and engaged in treatment.

Registries can be most effective when the care team can manually curate their own caseload list, so that patients are included after they have consented to treatment and are removed when they have completed an episode of care. Each program should develop enrollment and deactivation guidelines to ensure caseloads are managed consistently.

Episodes of Care

An episode of care is the period of time in which a patient is receiving treatment. During this time, providers monitor progress and adjust treatment as needed to reach a goal.

The first score from a validated behavioral health measure in the episode of care is considered the baseline score from which progress will be measured. For example, an episode of depression care would start when a patient is enrolled into a CoCM program with an elevated (baseline) PHQ-9 score of ten or above.

The impact of treatment is monitored until symptom scores are significantly reduced using evidence-based definitions of remission, response or significant improvement. For example, when using the PHQ-9 to monitor depression symptoms, the patient's goal could be to achieve response (defined as a 50% improvement from baseline) or remission (score under 5). Once target scores and other patient goals are achieved, the episode of care is completed.

If the patient returns to treatment after 6 months have elapsed, a new episode of care could be started. Patient progress would be measured from a new baseline score.

If an episode of care extends beyond six months and goals are not achieved after several adjustments in treatment, consider whether more intensive or specialized treatment strategies might benefit the patient.

Treatment Status

Patients will generally move through three status categories during an episode of care. It can be useful to track each patient's status for easy reference:

1. **Active treatment:** the patient is engaged in treatment and is in regular contact with the BHCM.
2. **Relapse prevention plan**: the patient has improved and is ready for less frequent contact in preparation for completing an episode of care.
3. **Deactivated:** the patient has completed an episode of care.

Patient-Level Summaries

Patient-level reports display more detail about each patient's treatment history during the latest episode of care. The following information could be included, dependent upon clinic needs and resources:

- List of contacts and contact attempts with provider name, medications at that visit, dosage, and symptom scores
- Graphs of symptom scores over time

- Other risk factors (e.g., socioeconomic status or other selected factors)
- Care management and care coordination activities (e.g., patient outreach/engagement and referral tracking)
- Psychiatric case consultation support (e.g., tracking that the Psychiatric Consultant recommendations have been forwarded to the Primary Care Provider)

Reminders

Reminders should appear on a prominent screen that the BHCM reviews daily. Ideally, these reminders should be visible to all providers on a patient's care team. Reminders should include:

- **Appointment reminders**: BHCMs should receive appointment reminders when a patient is initially referred to CoCM and the initial appointment is needed. Appointment reminders should also occur every 2 weeks for patients with a PHQ-9 score of 10 or above, or every 4 weeks for patients in relapse prevention plan status.
- **Referral reminders**: Four weeks after referring a patient to external services, a referral reminder should prompt the BHCM to follow up with the patient to ensure they followed through on the referral.

Caseload-Level Report

Caseload-level reports display a list of all patients in a BHCM's active caseload. All columns should be sortable, allowing providers to quickly rank patients by symptom scores or by the date of last contact.

Caseload reports filtered by payer, clinic, or other organizational level can address specific reporting needs. Caseload report columns might include:

- **Patient identifiers** (e.g., name, MRN)
- **Treatment status** (e.g. active treatment, RPP, deactivated)
- **Flag for safety risk**
- **Flag for discussion at next Systematic Caseload Review**
- **Whether psychotropic medications are prescribed**
- **Key service dates:** These dates can include a patient's first and most recent visit with a BHCM, their most recent individual case consultation, length in treatment, and upcoming scheduled appointments.
- **Symptom scores**: Symptoms scores relevant to the population of focus should be included to display each patient's current symptom severity and an indication of how much improvement has been achieved from the baseline score (defined as the first score in the current episode of care). For example, display the baseline and most recent PHQ-9 scores and dates. Each measure should include a visual indicator for whether the patient has achieved remission, response, or significant improvement following published cut-off scores.

Caseload Summary Reports

Population-level reports address ongoing supervision, quality monitoring, and reporting requirements. These reports display data for patients who are currently in active treatment and could be aggregated by provider, clinic, or payer. Reports could include the following types of information:

Caseload Size

- number of patients currently in active treatment

Engagement and Contacts

- average number of BHCM contacts per patient
- average duration of contacts (in minutes)
- proportion of contacts that had completed scale score recorded
- average length of treatment episode
- number of patients with a relapse prevention plan in place

Systematic Caseload Review

- number of patients who are flagged for discussion at the next Systematic Caseload Review
- number of patients whose cases have been reviewed by the Psychiatric Consultant
- number of patients who are not improving and whose cases have not been reviewed with the Psychiatric Consultant within the past two months

Outcomes

- average baseline and most recent symptom scores
- number of patients who have met remission, response, or significant improvement criteria

Program Performance Metrics

Program-level metrics are less useful for showing immediately actionable information to drive clinical care, but can show performance trends in your CoCM program, in terms of both process effectiveness and patient outcomes. These metrics can be useful for gauging whether your program is on track, and for driving continuous quality improvement efforts. Metrics can be shown for past time periods, such as performance each month for the past 12 months.

- **Caseload Reach:** Proportion of patients that were newly enrolled during the performance period.
- **Engagement:** Patients with at least one BHCM contact during the performance period.
- **Measures Completion**: Proportion of BHCM contacts that had a completed scale during the performance period.
- **Depression Response**: Proportion of patients that achieved 50% improvement on PHQ-9 score during the performance period as compared with the episode baseline score.
- **Anxiety Improvement**: Proportion of patients that achieved 5-point improvement on GAD-7 score during the performance period as compared with the episode baseline score.
- **Psychiatric Case Consultation**: Proportion of patients that have not improved during the performance period that had an individual case consultation within the previous two months.

Additional Resources

- AIMS Center coaching for individualized implementation support:
  https://aims.uw.edu/implementation-support/
- AIMS Center Office Hours:
  https://aims.uw.edu/office-hours/
- AIMS Caseload Tracker registry:
  https://aims.uw.edu/aims-caseload-tracker/