Behavioral Health Integration and Collaborative Care Registry Strategies in Medical Settings

The workflow to support integrated behavioral health care models such as collaborative care is a data-driven process, requiring the care team to actively use a caseload management tool. It is important that these tools are used in conjunction with the practice's electronic health record (EHR) if they are not already built into it. Patient tracking systems that support measurement-based care vary widely in their sophistication, functionality, cost, and scalability.

Options include:

1. **A spreadsheet used alongside the EHR,**
2. **A caseload management application used alongside the EHR, or**
3. **A customized registry build in an EHR**
4. **The AIMS Caseload Tracker**

Whichever option is selected, the registry needs to incorporate 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 progress.

2. **Track patient engagement across a caseload**
   The behavioral health provider is responsible for ensuring patients stay engaged in treatment. Reminders or alerts can help the provider 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 score. Measurement of outcomes over time makes trends visible and aids the team in evaluating treatment response. Recent values and dates of measurement should be available in real-time.

4. **Facilitate efficient, systematic psychiatric caseload review**
   Behavioral health providers 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 allows the behavioral health team to sort or filter patients by specific screening results and is critical for efficient caseload review. Tracking previous case review dates is also important for prioritizing patients for discussion. The ability for providers to manually flag patients for psychiatric consultation and review can also be helpful.

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

Functional Requirements for Tracking Measurement-Based Treatment to Target

Registry Inclusion Rules

Inclusion rules should include specific, measurable outcomes that identify patients and track individual response to treatment. Examples of inclusion rules include:

- **Diagnosis(es)**
- **Psychotropic medication prescription**
- **PHQ-9 score > 9 (or other cut-off score determined by the organization)**
- **Level of suicide risk**
- **Referral to substance use treatment or other specialty services**

Population of Focus

Patient populations of focus can be defined by diagnosis, by payer status, and/or by eligibility for a clinical service. For example, an organization might establish its initial population of focus to be all patients with diabetes and/or heart disease with a recent PHQ-9 score greater than 9. Depression care and outcomes for the patients who meet these criteria would be included in the registry.

Treatment Status

There are generally four treatment status categories in collaborative care programs:

1. **Enrolled in program but no contacts with provider to date**
2. **Active treatment phase** - in regular contact with provider
3. **Relapse prevention plan** - patient has completed the active treatment phase and is likely to graduate or be discharged soon
4. **Discharged or graduated** from the program

Episodes of Care

An episode of care is defined as 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 target goal. For example, an episode of depression care would start when a patient is enrolled into a collaborative care program with a baseline PHQ-9 score of 18.

The impact of treatment is monitored from this baseline score until the patient's PHQ-9 scores are reduced to, for example, a score of 9 (a 50% reduction from the baseline). Other programs may elect to treat and monitor patients until they reach a target score of 5 (remission). Once target scores and other patient goals are achieved, patients are discharged and the episode of care ends.

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 PHQ-9 score.

If an episode of care extends beyond six months and goals are not achieved, the AIMS Center recommends that the practice consider if more intensive or specialized treatment strategies might benefit the patient.

Patient-Level Reports

Patient-level reports display more detail about each individual patient's treatment history and generally include the following:

1. **List of contacts and contact attempts with provider name, medications at that visit, dosage, PHQ-9 and GAD-7 scores**
2. **Graphs of outcome measurement scores over time**
3. **Other risk factors** (e.g., socioeconomic status or other selected factors)
4. **Care plan goals and interventions**
5. **Care management and care coordination activities** (e.g., patient outreach/engagement and referral tracking)
6. **Caseload review support** (e.g., tracking that the behavioral health provider's notes and recommendations have been forwarded to the primary care provider)

Reminders

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

Reminders should include:

1. **Appointment reminders**
   Behavioral health providers should receive appointment reminders when a patient is referred to the behavioral health program, but an initial behavioral health provider appointment has not yet occurred. These reminders should also occur every 2 weeks for patients with a PHQ-9 score of 10 or above and every 4 weeks for patients in relapse prevention status.
2. **Referral reminders**
   Four weeks after referring a patient to external services, a referral reminder should prompt the behavioral health provider to follow up with the patient to ensure they followed through on their referral(s).

Caseload-Level Tracking on Patient Progress

Caseload-level tracking supports efficient psychiatric case review in collaborative care. Caseload-level reports display a list of all patients in a behavioral health provider'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:

1. **Patient identifiers** (e.g., name, MRN)
2. **Treatment status**
3. **Flag for safety risk or discussion at next psychiatric case review**
4. **Whether psychotropic medications are prescribed**
5. **Key service dates**
   These dates can include a patient's first and most recent visit with a behavioral health provider, their most recent psychiatric case review, number of weeks spent in treatment, and their next appointment date and time.
6. **Clinical outcome measures**
   These measures typically include but are not limited to patients' baseline and most recent PHQ-9 and GAD-7 scores and dates of measure administration. Each measure should include a visual

indicator for whether the patient has achieved remission, is not in remission but is showing improvement, or is not improving.

Caseload Summary Reports

Population-level reports address ongoing monitoring requirements, including supervision, quality monitoring, and reporting requirements. These reports display data for patients who are currently in active treatment, aggregated by payer, provider, clinic, or organization. Population report columns might include:

1. **Caseload size**
2. **Patient engagement**
   This could include the number and percent of patients who have had at least one contact with their behavioral health provider and who have had a baseline PHQ-9 score captured. It could also include patients' average baseline measurement scores.
3. **Follow-up contacts**
   This could include the number and percent of patients who have had a follow-up contact with their behavioral health provider and have had at least one follow-up measurement score captured. It could also include patients' average number of in-clinic visits and phone contacts.
4. **Clinical outcomes**
   This could include an average of patients' most recent score on the PHQ-9, the number and percent of patients whose PHQ-9 score < 5 after 4-8 months in treatment, and the number and percent of patients whose PHQ-9 score was 50% improved after 4-8 months in treatment. It could also include the number and percent of patients who are not improving (i.e., do not meet the previous criteria) and whose cases have not been reviewed with the psychiatric consultant within the past 8 weeks.
5. **Relapse prevention plan**
   This could include the number and percent of patients with a relapse prevention plan.
6. **Psychiatric case review**
   This could include the number and percent of patients who are flagged for discussion at the next case review. It could also include the number and percent of patients whose cases have been reviewed by the psychiatric consultant.

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