Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

Patient Registry Development Guide

The patient registry is an essential component of the Collaborative Care model, allowing the BHCM and psychiatric consultant to actively monitor the caseload from both the population and patient level, ensuring no patients 'fall through the cracks.'

This guide should be used alongside the **EHR Documentation Guide**[1] to ensure appropriate information can be pulled from the EHR into the patient registry and all appropriate information is documented.

Registry Columns:

This list includes items that should be included in the registry, as well as items we recommend and those that are optional and can be included as desired. Examples of a required and recommended registry are available (see **CoCM Registry Examples**[2]).

Sorting the registry allows the behavioral health care manager (BHCM) to actively monitor the caseload. The items that should have the capability to be sorted are indicated (*); however, all columns may have the capability to be sorted, if desired. The columns can be ordered based on organization and/or provider preference, and some columns (indicated below) can be optionally included. Registries may differ as organizations and clinicians work to balance optimizing convenience and quantity of information included.

Required Columns:

- Patient Name (Last *, First)
- Patient MRN/ID Number
- Date of birth
- Program enrollment date * (i.e., date patient was enrolled in CoCM program)
- Last PHQ-9 score *
- Last PHQ-9 screening date *
- Change in PHQ-9 score (i.e., difference between last and initial scores[3])
- PHQ-9, Question #9 (e.g., 0, 1, 2, or 3) *
- Last GAD-7 score *
- Last GAD-7 screening date *
- Change in GAD-7 score (i.e., difference between last and initial scores)
- Program enrollment status (e.g., pending, active, inactive) (If all enrollment statuses cannot be built, the registry should indicate which patients are "active") *
- Location (e.g., which clinic does the patient visit, if the registry is shared by several clinics) *

[1] Available via https://mccist.org/implementation/pre-implementation/ehr/
[2] Available via https://mccist.org/implementation/pre-implementation/patient-registry/
[3] Initial PHQ-9 and GAD-7 scores are the scores recorded on the date closest to the program enrollment date and may have been performed within two weeks of the enrollment date.

Recommended Columns:

- Baseline PHQ-9 score (i.e., first PHQ-9 score following enrollment into CoCM program)
- Baseline GAD-7 score (i.e., first GAD-7 score following enrollment into CoCM program)
- Last panel review date * (i.e., date the patient was discussed in panel review with the psychiatric consultant and BHCM)
- Last panel review recommendations implemented (e.g., yes, no) (i.e., the recommendation made by the psychiatric consultant was approved by the patient and primary care provider and integrated into the patient's treatment plan)
- Flag for discussion at next panel review * (i.e., to indicate the patient's case should be discussed with the psychiatric consultant during panel review)
- Next contact date (if not included in the EHR, this can be manually entered by the BHCM) *

Optional columns:

- Sex
- Contact frequency (i.e., how often the BHCM should contract the patient, each CHC may choose varied definitions for the level of care) [e.g., 1 (low-need, contact every 3 months), 2 (medium-need, contact every 1 – 3 months), 3 (high-need, contact monthly or more frequently)]
- Next PCP appointment
- PCP name

*These items should be sortable

Reminders:

Consider embedding these reminders in the EHR/registry. In addition to the next contact date, these reminders will help the BHCM proactively follow up with patients.

Consider the following reminders:

- Initial contact reminder 7 days after patient referred to program
- Contact reminder for patients 28 days after completing a PHQ-9 and/or GAD-7