

The patient registry is a key component and invaluable tool used to implement and operate the Collaborative Care Model (CoCM). Health systems can choose their preferred patient registry platform. There are three primary categories of patient registry options: a simple spreadsheet, a standalone registry application, or a registry integrated into an electronic health record (EHR).

CoCM team members use the patient registry to record outcome measures from validated behavioral health assessments, such as the PHQ-9 and GAD-7. They then can view how each patient is progressing with their treatment over time. As a result, the CoCM team can easily recognize and prioritize patients in need of a treatment adjustment. They also can identify patients at risk of falling out of care.

CoCM Team Member Roles and Responsibilities with Patient Registry

In CoCM, the Behavioral Health Care Manager (BHCM) is the primary user of the patient registry; however, all members of the CoCM team will access and interface with the patient registry at various points in the treatment cycle.

Team Member	Roles and Responsibilities
Behavioral Health Care Manager (BHCM)	<ul style="list-style-type: none"> Primarily oversees the patient registry, inputs longitudinal behavioral health assessments and other relevant follow-up data for each enrolled patient; Tracks patient engagement, including appointments, referrals, and reminders for follow-up patient engagement; Shares data among CoCM team members; Communicates regularly with PCPs to review/discuss patient progress and get input on treatment; Coordinates referrals; and Updates EHR.
Psychiatric Consultant (PC)	<ul style="list-style-type: none"> Reviews registry data, including screening and follow-up behavioral health assessments; Monitors patient progress; and Makes initial and ongoing treatment plan recommendations to the PCP through the BHCM.
Primary Care Provider (PCP)	<ul style="list-style-type: none"> Reviews registry data; and Utilizes registry for care coordination and treatment planning.

Key Patient Registry Functions

Key features and functions of an efficient patient registry include:

- Track clinical outcomes and progress at both the individual patient level and overall caseload level for the target population;
- Facilitate measurement-based treatment to target by clearly demonstrating whether patients have reached specific symptom improvement targets in an easily understandable and actionable way; and
- Facilitate efficient psychiatric consultation and case review, allowing providers to easily prioritize patients who are new to the caseload, who are at risk of falling out of care, or who need to be evaluated for changes to a treatment plan.

Tracking clinical outcomes and progress

A patient registry should track the baseline behavioral health assessment score(s) (i.e., PHQ-9 or GAD-7), which can be obtained during the initial in-take evaluation. Patient registries also track patient assessment score(s) from each month the patient is enrolled in the CoCM program. The BHCM should compare the patient's most recent score(s) to their initial score(s), as well as their score(s) from previous months to determine progress. Furthermore, a registry can track a patient's treatment history over time, including medication management, which monitors medication dose changes based on symptom severity or adverse effects. When tracking clinical outcomes and progress for a target population, a registry can track caseload size, the frequency of patient encounters with clinicians, and clinical outcomes, such as the number or proportion of enrolled patients who have achieved the evidenced-based treatment target.

Prompting measurement-based treatment to target

Measurement-based treatment to target is one of five principles of CoCM. Each patient's treatment plan should outline individual goals and clinical outcomes that are routinely measured by evidenced-based behavioral health assessments. A patient registry supports treatment to target by documenting each patient's progress toward evidence-based clinical outcome goals. The CoCM team uses this information in decision making for treatment plans, including making treatment adjustments for patients not demonstrating improvement.

Streamlining psychiatric consultation and case review

A patient registry is used by the Psychiatric Consultant, in collaboration with the BHCM, to efficiently review the entire patient caseload, as well as focus on individual patient cases that are either new to the CoCM program, flagged for a possible treatment plan change, ready for relapse prevention planning, or appropriate for discharge. A patient registry can track information from previous case reviews and can identify patients who need more targeted mental health consultations. The registry also tracks when patients are discussed during case review sessions, which prompts the BHCM and Primary Care Provider (PCP) to review each patient at least once monthly while they are in active treatment. This, in turn, ensures case review sessions are not exclusively focused on patients with acute concerns to the detriment of patients with less urgent, but still noteworthy treatment needs.

Patient Registry Options

There are three primary categories of patient registry options:

- 1) a simple and secure spreadsheet;
- 2) a pre-made, standalone registry application; or
- 3) a customized registry built into the electronic health record (EHR).

It is important that all registries be used in conjunction with the EHR, even if they are not completely integrated. Below are considerations for the options for a patient registry.

Registry Option	Considerations
1. A simple and secure spreadsheet	<ul style="list-style-type: none"> • Low or no additional cost; • Simple to use, customize, and update; • Requires some double documentation when not integrated into the EHR: clinical activities documented and tracked within independent system must be updated and uploaded into EHR for effective care collaboration across multidisciplinary care teams; and • Must ensure safeguards and HIPAA protections are in place for protected health information (PHI).
2. Pre-made, standalone registry application	<ul style="list-style-type: none"> • Typically has moderate additional cost; • May be interoperable with the EHR using an Application Programming Interface (API); and • Requires some double documentation when incompatible with the EHR: clinical activities documented and tracked within independent system must be uploaded/input into EHR for effective care collaboration across multidisciplinary care teams.
3. Customized registry built into a health systems' electronic health record (EHR)	<ul style="list-style-type: none"> • Typically has significant additional cost, time, and personnel requirements during the building and implementation phases; • Allows all CoCM information technology resources to be in the same technological environment; • Can be customized to eliminate double documentation; and • Can help optimize and streamline billing directly from the patient registry.

Decision Matrix for Health Systems Key Registry Options

Below is a decision matrix to help health systems and clinical teams decide which primary category of patient registry options.

