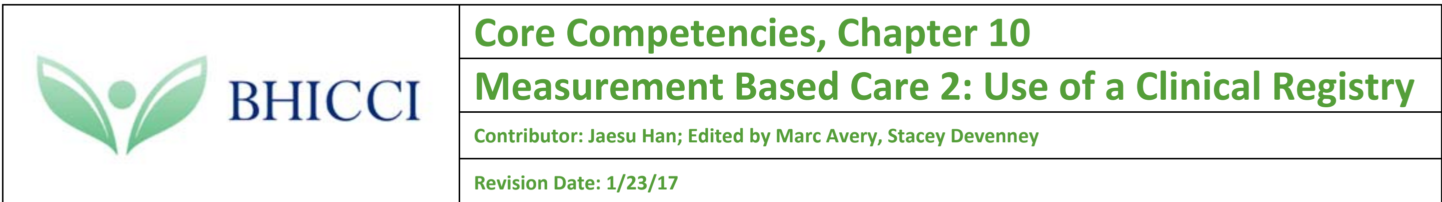

Core Competencies, Chapter 10

Measurement Based Care 2: Use of a Clinical Registry

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Definition and Why Measurement Based Care and Use of a Clinical Registry is Important to Integrated Complex Care

The caseload registry is the pivotal tool necessary for implementing population based care and optimizing measurement based care. It allows the care team to systematically track standardized measures of health, identify patients/clients not reaching goals, and target interventions for those who would benefit the most. The registry also tracks which patients/clients are not engaged in care and may benefit from more intensive services.

Example

A diabetes care manager demonstrated the use of a clinical registry when she decided to keep track of her patients' diabetes measures (HbA1c) and depression scores (Patient Health Questionnaire -9) all on one spreadsheet. After using this "clinical registry" just a short while, she noticed that her uncontrolled diabetes patients seemed to divide into two groups: those with high depression scores and those without. This helped her to quickly identify patients who might benefit from consultation with the behavioral health clinician versus those that were more in need of diabetes treatment escalation. She brought a copy of this registry data to weekly clinical team meetings to help prioritize and organize cases for review.

Narrative Description

Population based care refers to the practice of systematically assessing the health measures of a target population followed by effectively implementing an intervention to improve the health of that population. Usual care has the disadvantage of placing the entire burden of monitoring health conditions on the primary care or behavioral health provider who may not have sufficient time during a clinic appointment to adequately monitor the health conditions. The ability to systematically assess and intervene in population based care is made possible by the use of registries and ensures patients do not "fall through the cracks." Measurement based care refers to the use of specific and objective information (standardized measures) to determine if treatment or a change in treatment is indicated. Registries offer an efficient mechanism to organize and track this process.

Caseload registries in essence contain standardized measures obtained over time that correspond to the control or severity of health conditions we are interested in for individual patients/clients. What makes registries powerful is how this information can be sorted and filtered to drive care in real-time:

1. Registries Facilitate population based care: At the caseload level, the care manager can sort by individual standardized measure and see which patients are not being adequately monitored at the appropriate interval or most severely away from goal. The care manager is able to display this data in real-time during care team meetings and efficiently prioritize patients who needs special attention.
2. Registries Assist to Monitor Clinical Outcomes: the caseload view also allows monitoring of what number and percentage of patients/clients are reaching health goals for a give care manager, care team, provider and organization. Providing comparative provider data has been shown to be a powerful motivating tool for improvement for providers.
3. Registries facilitate measurement based care: At the individual patient level, standardized measures not at goal can be tracked over time and trends observed in response to evidence based treatment interventions. It is this quality that allows registries to function not only as a tool to detect patients/clients at risk for poor health outcomes, but also as a tool to ensure evidence based treatments are delivered and helping.
4. Registries Assist in Patient Engagement/Adherence: In addition to the standardized clinical measures, registries are also able to track measures that indicate engagement of the patient with the care team. These

measures include how many times and the last time patients/clients were engaged over the phone and in person.

Available Resources

1. The BHICCI Excel Registry Technical Manual
2. Videos (in development) for specific tasks within the registry.
3. Some basic background on Registries from the Advancing Integrated Medical Solutions Center: http://aims.uw.edu/sites/default/files/CollaborativeCareRegistryRequirements.pdf

BHICCI Plan for Learning/Teaching/Coaching

The BHICCI team has a phased approach for the implementation and training in the use of care registries. Training in the importance and use of registries will be specific to organizational role and clinical assignments. Since use of clinical registries is new to most, clinicians involved in Integrated Complex Care will receive individualized coaching throughout the BHICCI process. Once procedures are developed, focus will shift to maintaining and sustaining these clinical processes.

How will Competence in this area be Measured?

Following completion/verification of the above learning/teaching/coaching plan, each clinician will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician's competency in each of the following by:

1. Observation of the clinician sorting utilizing the registry, or
2. Observation of clinician presenting registry information at team meetings, or
3. Direct observation of clinician's interaction with teammates and/or patients/clients.

COMPETENCY AREA	EVIDENCED BY:	SUPERVISOR'S RATING*
Clinicians will have the ability to sort data in the caseload registry at the caseload level and individual patient level.	• Demonstrate the ability to sort patient/client data in the registry. • Demonstrate the ability to analyze data from the registry • Demonstrates evaluation of clinical outcomes and/or adjustments of care based on registry information.	1 2 3 4 5
The ability to identify which patients/clients would benefit additional attention at the weekly care team meetings.	• Effectively utilizes team meetings to present patients/clients who would benefit from staffings. • Demonstrates efficient use of data from registry use during care team meetings. • Understands and effectively utilizes ACG's.	1 2 3 4 5
The ability to effectively and efficiently present caseload registry data at weekly care team meetings.	• Communicates patient/client data and history clearly and efficiently. • Open and welcoming of feedback from team members on clients presented at team meetings. • Demonstrates clear documentation of case presentations at team meetings. • Documents follow through of patient/client staffing from team meetings.	1 2 3 4 5

*1= Excellent results with no need for prompting or support.
3 = good results and/or required some prompting or support.
5 =required much support and/or was unable to complete necessary skills.