

Behavioral Health Integrated (BHI) Patient Tracking Registry

INSTRUCTIONS MANUAL FOR VERSION 8.7

Table of Contents

Information Regarding HIPAA Compliance	4
Spreadsheet Manager(s).....	4
Section I – Using the Spreadsheet	5
Getting started in Excel®	5
Spreadsheet Orientation and Data Entry.....	5
Fixed top rows.....	6
Saving the document and using auto-backup –.....	6
Transferring a patient to another care manager’s spreadsheet –.....	6
Section II – Face Sheet: Overview of Functionality.....	8
Basic Info.....	8
Monthly Data	8
Section III – Calculations: Overview of Functionality.....	9
Row 2: Measurement Year	10
Column B: Care Type.....	10
Column C: Measure Type.....	10
Column D: Measure	10
Column E: Numerator	10
Column F: Denominator.....	10
Section IV – Specialist Notes: Overview of Functionality	11
Column B: MRN.....	11
Column C: Patient	11
Column D: Consultation Date	11
Column E: Consultation Note.....	11
Column F: Consultation Reviewed/Resolved.....	11
Column G: Date of Resolution	11
Section V – Integrated Patient Tracking Worksheet: Overview of Functionality	12
Column B: MRN.....	12
Column C: Name	12
Column D: Treatment Status	12
Column E: Tickler	12
Column F: Episode Number	12
Column G: Date Follow-up Due	13

Column H: Actual Contact Dates.....	13
Column I: Type of Contact.....	13
Column K: PHQ-9 Score.....	13
Column L: Percent Change in PHQ-9 Score.....	14
Column M: GAD-7 Score	14
Column N: Percent Change in GAD-7 Score.....	14
Column P, R, T, W: Date.....	14
Important note on Biometric Measures:.....	14
Column Q: BMI/Weight.....	15
Column S: SBP	15
Column T: DBP	15
Column V: HbA1C.....	15
Column X: LDL	15
Column Z-AB: Care Manager Contact Notes and Flag for Psychiatric Case Review	15
Column AC: Date of Psychiatric Case Review	15
Section VI – Integrated Caseload Overview: Overview of Functionality	16
Column B: MRN.....	16
Column D: Treatment Status	16
Column E: Name	16
Column G: Date of Initial Assessment.....	16
Column H: Date of Most Recent Contact.....	16
Column I: Number of Follow-up Contacts	16
Column J: Weeks in Treatment	16
Column K: Average Contacts per Month	16
Column L: Initial PHQ-9 Score	16
Column M: Last Available PHQ-9 Score	17
Column N: Percent Change in PHQ-9 Score.....	17
Column O: Date of Last PHQ-9 Score	17
Column P: Initial GAD-7 Score.....	17
Column Q: Last Available GAD-7 Score	17
Column R: Percent Change in GAD-7 Score	17
Column S: Date of Last GAD-7 Score.....	17
Column T, V, X, AA: Date.....	17

Column U: BMI/Weight..... 17

Column W: SBP 17

Column X: DBP 17

Column Z: HbA1C 17

Column AB: LDL..... 17

Column AC: Flag Date..... 18

Column AD: Flag..... 18

Column AD: Date of Most Recent Case Review 18

Information Regarding HIPAA Compliance

It is the responsibility of the organization to establish a system for storing and sharing information contained in the Behavioral Health Integration Patient Registry in a way that complies with HIPAA regulations. It is strongly encouraged that the organization consult with whomever manages HIPAA compliance at the organization to ensure a secure plan is put into place.

In many cases, it is acceptable to store the spreadsheet on a network drive—never a local hard drive—with password protection. The password protection feature can be accessed by selecting File > Save As > Tools > General Options. The password can then be shared between the care manager, psychiatric consultant, and other personnel directly involved in care, if applicable.

Spreadsheet Manager(s)

Due to the complex nature of the formulas and coding in the Behavioral Health Integration Patient Registry, each organization will need to utilize their specific Health Management Associates practice coach to get in touch with the registry developers to make any changes to the structure of the spreadsheet. The registry tracking tool can currently accommodate up to 200 patients and has room for 500 specialist comments; in the event that you need a larger spreadsheet for more patients or want to have fewer columns (so you are tracking fewer measures), your HMA coach can provide assistance.

Section I – Using the Spreadsheet

Getting started in Excel®

Below are some basics for getting around in Excel®:

Excel® has columns (vertical, designated by letters), rows (horizontal, designated by numbers) and cells (individual boxes at the intersection of a column and row).

To move from one cell to another, you can always use the mouse to click on different cells. In addition to the mouse, there are many different keyboard shortcuts. Below are some common keyboard shortcuts to move from one cell to another:

Action	Keyboard Shortcut
Move to the cell below	Press the “Enter” key
Move up, down, right, or left	Use the arrow keys
Move right	Press the “Tab” key
Move several rows up or down	Press the “Page Up” or “Page Down” key
Automatically move to the far left (Column A)	Press the “Home” key
Search the document to find a specific word/phrase (e.g., MRN)	Press “Ctrl+F” and type the word or phrase you would like to find, in the pop-up box

You can also undo or redo an action. If you want to undo something, click the curved ("backward") arrow in the top-left corner of the screen, or press “Ctrl+Z”; each time you click it, it will undo the previous step. It will go all the way back to when you last saved the document. You can also reverse this "undo" command by clicking the other ("forward") arrow, or press “Ctrl+Y.” This redo command can also be used to repeat the last action you performed.

If you need to create a new line of text within the same cell (e.g., if you want two different lines of text in the Care Manager Contact Notes), press “Alt+Enter” when you want to jump to the next line.

Spreadsheet Orientation and Data Entry

Each care manager will use an individual copy of the spreadsheet. If patients need to be transferred from one care manager’s spreadsheet to another, the information can be copied and pasted to the necessary spreadsheet.

The spreadsheet contains five (5) separate worksheets called Face Sheet, Calculations, Specialist Note, Integrated Patient Tracking, and Integrated Caseload Overview. You can switch between the worksheets using the tabs in the bottom-left corner.

- The Face Sheet houses basic demographic information of the site and individual inputting information into the registry. It also has a monthly tracker of some basic data points to ensure the site and individual has access to broader information.
- The Integrated Patient Tracking worksheet is where you will enter data related to patient contacts.
- The Integrated Caseload Overview worksheet provides a summary view of that data which can be used to identify and sort patients for necessary case review, typically by a specialist (like a psychiatric provider).

- The Specialist Note worksheet is where a specialist (eg. a psychiatric provider) might put notes about a particular patient for the primary care giver to review (PCP for example).
- The Calculations worksheet automatically calculates pre-determined measures to track progress.

On the Integrated Patient Tracking worksheet, some cells are shaded, and some are white. **Enter information only into cells that are white.** All other cells on the worksheet are locked because they either contain formulas critical to the spreadsheet working or are not intended to contain information. For this reason, you will need to contact your practice coach with Health Management Associates to make any significant changes to the spreadsheet, like adding rows or deleting columns.

The first two rows (headers) give information about what is contained in the cells below for each patient. For example, all information regarding PHQ-9 and GAD-7 scores is under the Row 1 heading “Measurements,” and all contact dates are under the Row 1 heading “Contacts.”

The required fields for every new patient on the spreadsheet are MRN, Name, Treatment Status, Episode Number, and Actual Contact Date. To enter these items, first enter the MRN, Name, and Treatment Status into the white cells in the first row of the new patient record. Then, go down to the next (second) row and fill in the Episode Number¹ (“1” if this the first time the patient has enrolled in care and they can be reactivated without the need for entering old data if they have a return of symptoms requiring follow-up) and Actual Contact Date. The other white cells in this row should be filled out as well, but the aforementioned information is required for the spreadsheet to function properly.

Fixed top rows – Both worksheets are formatted so that the top rows with the descriptors are always visible, so as you move down to the lower rows, the headings will stay put. Additionally, the “MRN” and “Name” columns are fixed so that you can always see them if you need to scroll laterally.

Saving the document and using auto-backup – You should make a habit of saving backups of your spreadsheet. Ideally, you will change the name by adding the current date rather than continuously saving it as the same document. This way, if something odd happens in your working version, you will be able to revert to a backup. However, this can be cumbersome, so you should determine the best practice for your workflow.

Transferring a patient to another care manager’s spreadsheet – When a patient’s care is transitioned to another care manager, the information will need to be transferred to the care manager’s individual copy of the spreadsheet. Keep in mind that locked cells cannot be copied and pasted. One systematic way to transfer information is as follows:

1. If you have two computer monitors, pull up an instance of Excel in each one so that you can view the spreadsheets side-by-side.
2. Copy (“Ctrl + C”) white cells for MRN, Name, and Treatment Status (Columns B, C, and D) and paste (“Ctrl + V”) into the new spreadsheet
3. Copy white cells with an Episode Number (Column F) and paste into the new spreadsheet

¹ See Column F: Episode Number on page 12 for a more complete description of Episode Number.

4. Choose the appropriate follow-up schedule in the first cell of Column H of the new spreadsheet
5. Continue copying the white cells as you go across, keeping in mind you cannot copy or paste into locked cells.

Section II – Face Sheet: Overview of Functionality

Included below is a description of the function of each of the columns and rows in the Face Sheet worksheet (the first sheet in the BHI Patient Tracking Spreadsheet).

Basic Info

The table labeled “Basic Info” allows the team member utilizing the registry to input basic demographic information, including:

- Calendar Year
- Practice Name
- Practice Type
- Clinic/Site Name
- Care Manager Name
- Target Population

Some of the fields are optional and can be altered. To adjust the input categories, please contact your practice coach within Health Management Associates to revise these for you.

Monthly Data

The table following the “Basic Info” allows the team member utilizing the registry to input data (i.e., monthly totals) from your EHR on a monthly basis. The number you put in should, ideally, reflect the total number of individuals within the current measurement year. In other words, in January, you will only use numbers from January; in February, you will use numbers from *both* January and February; in March, numbers from January *through* March. This will give you a “running total” of the unique number of individuals over the course of the year. Many EHRs have reporting functions that allow you to easily prepare these counts. These measures are critical to the measurement calculations taking place on the following sheet, Calculations (See Section III – Calculations: Overview of Functionality).

The monthly data that is input into the data table is:

- Total Encounters
- Unique Patients Seen
- Adults (≥ 18)
- Adolescents (≥ 12 to <18)
- Adults with an PHQ screen
- Adolescents (12-17) with any PHQ screen
- Adults with any GAD screen

Some of the fields can be altered to the overall goals of your practice/site, while others are required for the measurement calculations. To adjust the input categories, please contact your practice coach within Health Management Associates to revise these for you.

Section III – Calculations: Overview of Functionality

Included below is a description of the function of each of the columns and rows in the Calculations worksheet (the second sheet in the BHI Patient Tracking Spreadsheet).

The measures that are calculated in the table allow progress for specific identified measures over the duration of the specified measurement year. The numerator and denominator are automatically calculated within the worksheet, pulling data from several different sources.

Although these measures are *based* on HEDIS measures, there are some significant differences in how they are calculated and should not be confused with measures that adhere to the strict HEDIS definition. Rather, they should be used to give you a general measure of how you are doing. As you enter into Value Based Contracts or are at risk for performance on quality measures, these results will not tie exactly to how you are measured on these contracts but can be used to inform your performance directionally.

The three process measures—Adult Depression Screening, Adolescent Depression screening, and Audit C screening—are derived from the “Face Sheet” and, ultimately, your EHR. The four outcomes measures are calculated based on information contained in the spreadsheet, which is why accurate recording and use of the registry is so important. Below, we described how each measure is calculated.

- Percent in active treatment with evidence of depression who had 50% reduction or more in PHQ9 score at <6 months
 - Denominator
 - “Active treatment” status (Integrated Caseload Overview, Column D)
 - Initial PHQ-9 of 10 or higher (Eg. ‘evidence’ of depression) (Integrated Caseload Overview, Column L)
 - Fewer than 26.1 weeks between the initial PHQ-9 (Integrated Caseload Overview, Column G) and the most current PHQ-9 score (Integrated Caseload Overview, Column O)
 - Numerator:
 - Overall change in PHQ-9 score of -50% (Integrated Caseload Overview, Column N)
- Percent in active treatment with evidence of depression who had 50% reduction or more in PHQ9 score at <12 months
 - Denominator
 - “Active treatment” status (Integrated Caseload Overview, Column D)
 - Initial PHQ-9 of 10 or higher (Eg. ‘evidence’ of depression) (Integrated Caseload Overview, Column L)
 - Fewer than 52.1 weeks between the initial PHQ-9 (Integrated Caseload Overview, Column G) and the most current PHQ-9 score (Integrated Caseload Overview, Column O)
 - Numerator:
 - Overall change in PHQ-9 score of -50% (Integrated Caseload Overview, Column N)
- Percent in active treatment with evidence of depression who had remission (PHQ9<5) at <6 months

- Denominator
 - “Active treatment” status (Integrated Caseload Overview, Column D)
 - Initial PHQ-9 of 10 or higher (Eg. ‘evidence’ of depression) (Integrated Caseload Overview, Column L)
 - Fewer than 26.1 weeks between the initial PHQ-9 (Integrated Caseload Overview, Column G) and the most current PHQ-9 score (Integrated Caseload Overview, Column O)
- Numerator:
 - Most Recent PHQ-9 score of <5 (Integrated Caseload Overview, Column M)
- Percent in active treatment with evidence of depression who had remission (PHQ9<5) at <12 months
 - Denominator
 - “Active treatment” status (Integrated Caseload Overview, Column D)
 - Initial PHQ-9 of 10 or higher (Eg. ‘evidence’ of depression) (Integrated Caseload Overview, Column L)
 - Fewer than 52.1 weeks between the initial PHQ-9 (Integrated Caseload Overview, Column G) and the most current PHQ-9 score (Integrated Caseload Overview, Column O)
 - Numerator:
 - Most Recent PHQ-9 score of <5 (Integrated Caseload Overview, Column M)

Row 2: Measurement Year

The row houses the calendar year in which the BHI Patient Tracking Spreadsheet is being utilized. Additionally, it should automatically reflect the year selected on the Face Sheet.

Column B: Care Type

This column houses the type of care that relates the specific measure (Column D).

Column C: Measure Type

This column showcases the category of the calculated measure, whether it is a process or outcome measure.

Column D: Measure

This column is a description of the measure being calculated through the numerator and denominator.

Column E: Numerator

The column showcases the number of cases tabulated for the numerator of the specific measure in that particular row.

Column F: Denominator

The column showcases the number of cases tabulated for the denominator of the specific measure in that particular row.

Section IV – Specialist Notes: Overview of Functionality

Included below is a description of the function of each of the columns and rows in the Specialist Notes worksheet (the third sheet in the BHI Patient Tracking Spreadsheet). This section may be used for specialist notes (such as a reviewing psychiatric provider) or in some cases to track external referrals to specialists. In this instance once the referral is completed the note can be resolved.

You will notice on this page that there are drop down boxes available in the header row. As you fill out this sheet—for example in the “Patient” column—you can select a specific patient and review all the comments regarding him/her. Be sure to remember to go back to that drop-down menu, however, and check the “select all” box to go back to the standard view of all comments for all patients. Because of limits in excel, you cannot sort this list alphabetically.

Column B: MRN

This column will automatically display the medical record number once a Patient is selected.

Column C: Patient

This column is a dropdown menu of all currently entered Patient Names. When you first use the sheet, the drop-down menu will be blank, but it will fill up over time. Names will be displayed in alphabetical order (starting with whichever name (first/last) you chose to use). When you only have a few names, you may need to scroll down in the drop-down menu to find the names. Once you select a Patient, that patient’s MRN will automatically display in Column B.

Column D: Consultation Date

This column shows the date in which the team member entered the subsequent comment (Column E). This field is automatically completed when the comment is entered. This also feeds the column AB in the Integrated Patient Tracking Tab, for Date of Last Psychiatric Review

Column E: Consultation Note

This column houses the specific comment made by the specialist reviewer (i.e. a psychiatric provider) or another team member made related to the patient identified in Columns B and C. Entering a comment automatically enters the current date in Column D, and changes Column F to the default value of “No”.

Column F: Consultation Reviewed/Resolved

When a comment in column E is entered, this default value in this column becomes “No”. When the main care provider reviews the comment, this value should be changed to “Yes” in the dropdown menu. This ‘greys out’ the comment, to indicate that the comment is complete. This can be used for each comment, even if, over time, there are multiple comments for the same patient.

Column G: Date of Resolution

This column is automatically populated with the current date when Column F (Comment Reviewed/Resolved) is changed to “Yes”.

Section V – Integrated Patient Tracking Worksheet: Overview of Functionality

Included below is a description of the function of each of the columns and rows in the Patient Tracking worksheet.

Column B: MRN

When you type the patient’s MRN into the first row it will automatically populate to the rows underneath. Enter the MRN only in the top row of each patient section. See Spreadsheet Orientation for information about how patient sections are organized.

MRN is required to properly display information on the Caseload Overview worksheet (see Section VI – Integrated Caseload Overview: Overview of Functionality) and the Specialist Notes worksheet (see Section IV – Specialist Notes: Overview of Functionality).

Column C: Name

When you type the patient’s name into the first row it will automatically populate to the rows underneath. Enter the patient name only in the top row of each patient section. You may choose whichever name format you would like for this column (e.g., First Last or Last, First).

Column D: Treatment Status

In the first (Initial Assessment) row for each patient, there is a white cell in Column D. If you select this cell, you will see a drop-down menu arrow appear that allows you to select “Active,” “Relapse Prevention,” or “Inactive.”

Column E: Tickler

This is a formula-driven column. It will notify you if a contact is past due for a patient or if there is a contact due tomorrow. The notice for “Due tomorrow” or “Due Today” will appear prior to the date that the next follow-up is due (Column G), and it will count down until the day the contact is due. If the follow-up due date has passed AND there is no actual contact date recorded (Column H), then Column E will display the message “Past Due” in red.

Column F: Episode Number

A treatment episode or episode of care is defined as the time period between when a patient is identified as having symptoms of a mental illness (i.e. a PHQ-9 score over 10), and when they have achieved remission, a reduction in symptoms (measured by a 50% drop in PHQ-9 score), or stop receiving care (eg. Because they no longer come in for visits). This column is used to track a patient’s active episode of care while retaining information from their previous episode(s). The number in the first row (maize box) for a given patient reflects their current episode of care, and it will automatically populate with the most current episode based on the values entered in the rest of the column.

The number in this column is not the same as the follow-up contact number. Typically, the number in this column will always be “1” unless the patient has been discharged and re-entered care. Going down the column, the episode number will correspond to the respective follow-up contact.

Example: If follow-up contact number 4 took place during the patient’s first episode of care, and contact number 5 took place during the patient’s second episode, then the number in Column F for contacts 1-4

should be 1, and the number for contact 5 and beyond should be 2. The number in the first row (purple box) automatically populates with the most recent episode number, so it will display 2 in this case.

Column G: Date Follow-up Due

This column is formula-driven. The dates that appear in this column also drive the messages that appear in Column E (Tickler). In order for follow-up due dates to appear, an assessment date must be entered in Column H.

The only cell you can edit in this column is the white cell in the first row for each patient. If you select this cell, a drop-down menu arrow appears that allows you to select “1-week follow-up schedule,” “2-week follow-up schedule,” or “1-month follow-up schedule.” These selections determine the dates that populate the remainder of the column. If you do not select anything, an error message will appear in subsequent cells.

The follow-up due dates are calculated according to the schedule that you choose in the first row; however, they will re-calculate according to the actual contact dates you enter in the next column (Column H). For example, if you choose a 2-week follow-up schedule, the dates in Column G calculate in 2-week increments from the last actual contact date in Column H.

If, in the middle of a patient’s treatment episode, you want to change the frequency of follow-up contacts (e.g., from a 2-week follow-up schedule to a 1-month follow-up schedule), you can do so by changing your selection in the first row of Column G. Because the follow-up due dates are calculated from the last actual contact date, the next follow-up date will automatically adjust according to your new schedule.

Column H: Actual Contact Dates

This column is used to enter the date that you had contact with the patient. This includes the date of the initial assessment, which would be the date of your first contact with the patient or the date when you first begin using the Patient Tracking Spreadsheet Template with them. Enter the date in the first white cell of Column G. Dates in this column also affect the follow-up due dates that appear in Column G. See Column G: Date Follow-up Due for more information on how dates are calculated.

Column I: Type of Contact

Enter the type of contact for each follow-up contact here. A drop-down menu is supplied to quickly choose “In Person,” “Phone,” “Group,” “Home,” or “Other.” Any comments about the specific type of contact can be made in Column P: Care Manager Contact Notes.

Column K: PHQ-9 Score

The PHQ-9 score for a given contact is entered in Column K of the corresponding row for that contact. The Initial Assessment score will automatically populate in the first (gray) cell of the column, giving you a quick visual for the patient’s initial score for the current episode of care.

At least one PHQ-9 score must be entered for a given patient in order for any other scores to display properly on the Caseload Overview worksheet.

When a patient has reported a PHQ-9 score of <5, the cell with that score will turn green when entered. This indicates that the score is at target and can aid in identifying patients ready for relapse prevention planning.

Disclaimer regarding target scores: This spreadsheet reflects PHQ-9 improvement scoring that is consistent with HEDIS depression metrics. NCQA has not established a metric for anxiety symptoms utilizing the GAD-7. GAD-7 scoring of less than 10 is considered mild anxiety.

Column L: Percent Change in PHQ-9 Score

This column has a formula that shows the change in the PHQ-9 score from the Initial Assessment. A value with a negative sign (e.g., -47%) means that the PHQ-9 score has decreased by 47%. A positive value means that the PHQ-9 score has increased by the amount shown.

Disclaimer regarding target scores: This spreadsheet reflects PHQ-9 improvement scoring that is consistent with HEDIS depression metrics. NCQA has not established a metric for anxiety symptoms utilizing the GAD-7. GAD-7 scoring of less than 10 is considered mild anxiety.

If your organization uses different targets for PHQ-9 or GAD-7 scores, please contact your practice coach within Health Management Associates to revise these for you.

Column M: GAD-7 Score

The GAD-7 score for a given contact is entered in Column M of the corresponding row for that contact. The Initial Assessment score will automatically populate in the first (gray) cell of the column, giving you a quick visual for the patient's initial score for the current episode of care.

When a patient has reported a GAD-7 score of <5, the cell with the score will turn green when entered. This indicates that the score is at target and can aid in identifying patients ready for relapse prevention planning.

Disclaimer regarding target scores: NCQA has not established a metric for anxiety symptoms utilizing the GAD-7. However GAD-7 scoring of less than 10 is considered a clinically significant response and <5 is considered remission

Column N: Percent Change in GAD-7 Score

This column has a formula that shows the change in the GAD-7 score from the Initial Assessment. A value with a negative sign (e.g. -47%) means that the GAD-7 score has decreased by 47%. A positive value means that the GAD-7 score has increased by the amount shown.

Disclaimer regarding target scores: NCQA has not established a metric for anxiety symptoms utilizing the GAD-7. However GAD-7 scoring of 50% reduction is considered clinically significant and <5 is remission.

Column P, R, T, W: Date

Columns P, R, T, and W, are to represent the date the subsequent measures were taken related to BMI/Weight, HbA1C, systolic and diastolic blood pressure, and LDL, respectively.

Important note on Biometric Measures:

There are separate dates for these measures since it is not expected that these will be obtained on the same interval. Weight/BMI and BP are expected to be taken every time a patient comes in for a visit; but lab-related value (HbA1C and lipid values) will occur less frequently and needn't be completed every time or with the same dates as other measures.

Column Q: BMI/Weight

This column houses the most recent BMI or weight reading to one decimal point.

Column S: SBP

This column houses the most recent systolic blood pressure (SBP) reading.

Column T: DBP

This column houses the most recent diastolic blood pressure (DBP) reading.

Column V: HbA1C

This column houses the most recent hemoglobin A1C (HbA1C) reading. This should be a percent.

Column X: LDL

This column houses the most recent low-density lipoprotein (LDL) reading.

Column Z-AB: Care Manager Contact Notes and Flag for Psychiatric Case Review

Column Z is automatically populated when the user puts information into Column AA. Column AA is an all-inclusive notes section. The primary function should be to document information that the user wants to highlight for a specialists to review. This could include changes in symptoms, experience of medication side effects, or other information that might inform how care should be changed. This field can also be used to record other information about patient care including explanations of symptoms (including suicidality or other safety risk), side effects, personal stressors, referral to specialty services, appointment reminder calls, and anything else from a contact that was not covered in the other columns. If necessary, use “Alt+Enter” to separate lines of text if there are other notes entered in the same cell (see Getting started in Excel®).

Column AB for each patient can be used to flag a patient for discussion with the psychiatric consultant, flag a patient as a safety risk, or flag both for discussion and as a safety risk. These flags provide a visual indicator for priority patients in the Caseload Overview worksheet. Flags that have not been reviewed by a Specialist will be displayed on the Integrated Caseload Overview tab.

Column AC: Date of Psychiatric Case Review

This field is automatically populated based on information that is placed into the Specialist Note tab when a specialist adds a note. The yellow box in this column will always display the most recent that a specialist has reviewed and provided notes on this patient’s case.

Section VI – Integrated Caseload Overview: Overview of Functionality

Included below is a description of the function of each of the columns and rows in the Integrated Caseload Overview worksheet. The Caseload Overview worksheet is entirely locked down and only summarizes and displays information from the Integrated Patient Tracking Worksheet. You do not need to input any information directly into the Caseload Overview worksheet. If there are any errors, please check the content of the Patient Tracking worksheet or contact your HMA Coach.

Column B: MRN

This column provides a reference to each patient’s specific record (MRN) on the Patient Tracking worksheet. Clicking on the hyperlink will take you to the full record for that patient under the Integrated Patient Tracking tab.

Column D: Treatment Status

This column displays the current treatment status of the patient with the corresponding MRN. If you would like to ‘hide’ patients who are inactive (they are already greyed out), you can select the drop-down menu from the header row and de-select “inactive”. If you did this previously, you will need to do it again if there are newly inactive patients.

Column E: Name

This column displays the patient’s name.

Column G: Date of Initial Assessment

This column displays the Initial Assessment date.

Column H: Date of Most Recent Contact

This column displays the last Actual Contact Date (in Column H of the Patient Tracking worksheet) entered for the patient’s current episode. It excludes contacts for which anything except a date is entered (e.g., “Canceled” or “Missed”).

Column I: Number of Follow-up Contacts

This column counts the number of Actual Contact Dates that have a date entered (regular text is not counted) in Column H of the Patient Tracking worksheet. It is

Column J: Weeks in Treatment

This column counts the number of weeks that have passed since the Initial Assessment date.

Column K: Average Contacts per Month

This column displays the average number of contacts per month (a month defined as 4 weeks or 28 days) that have been made with that particular patient since their Initial Assessment. “N/A” will be displayed if the patient is enrolled for fewer than 4 weeks

Column L: Initial PHQ-9 Score

This column displays the patient’s PHQ-9 score from the Initial Assessment. If no score is available, this cell will remain blank. At least one PHQ-9 score must be entered for a given patient in order for any other scores to display properly on the Caseload Overview worksheet.

Column M: Last Available PHQ-9 Score

This column displays the most currently available PHQ-9 score for the patient's current episode. If no score is available, this cell will remain blank.

Column N: Percent Change in PHQ-9 Score

This column calculates the percent change in the PHQ-9 score from the Initial Assessment. A value with a negative sign (e.g., -47%) means that the PHQ-9 score has decreased by 47%. A positive value means that the PHQ-9 score has increased by the amount shown.

Column O: Date of Last PHQ-9 Score

This column displays the date on which the last available PHQ-9 score was obtained.

Column P: Initial GAD-7 Score

This column displays the patient's GAD-7 score from the Initial Assessment of the current episode. If no score is available, this cell will remain blank. At least one GAD-7 score must be entered for a given patient in order for the GAD-7 score to display properly on the Caseload Overview worksheet.

Column Q: Last Available GAD-7 Score

This column displays the last available GAD-7 score for the patient's current episode. If no score is available, this cell will remain blank.

Column R: Percent Change in GAD-7 Score

This column calculates the percent change in the GAD-7 score from the Initial Assessment. A value with a negative sign (e.g., -47%) means that the GAD-7 score has decreased by 47%. A positive value means that the GAD-7 score has increased by the amount shown.

Column S: Date of Last GAD-7 Score

This column displays the date on which the last available GAD-7 score was obtained.

Column T, V, X, AA: Date

Columns T, V, X and AA, are to represent the date the subsequent measures were taken related to BMI/Weight, HgA1C, systolic and diastolic blood pressure, and LDL, respectively.

Column U: BMI/Weight

This column houses the most recent BMI or weight reading.

Column W: SBP

This column houses the most recent systolic blood pressure (SBP) reading.

Column X: DBP

This column houses the most recent diastolic blood pressure (DBP) reading.

Column Z: HbA1C

This column houses the most recent hemoglobin A1C (HbA1C) reading.

Column AB: LDL

This column houses the most recent low-density lipoprotein (LDL) reading.

Column AC: Flag Date

This column displays the date the most recent flag was applied. It is the most current date from Column Z on the Integrated Patient Tracking tab of the worksheet.

Column AD: Flag

This column displays the most recent flag that was raised by the care manager or psychiatric consultant on the Integrated Patient Tracking worksheet. This information is derived from Column AB on the Integrated Patient Tracking tab of the worksheet. This field will be empty if a specialist has provided a on the Specialist Note tab with a recorded date *after* the date recorded under Flag Date (column AC).

Column AD: Date of Most Recent Case Review

This column displays the most recent consultant or case review note as displayed in on the Patient Tracking worksheet. If no note has been entered (or if the most recent note was from a past episode of care) the cell will be blank. This is derived from Column D (Comment Date) on the Specialist Note tab.