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The utility of a caseload registry: perceptions of behavioral health clinicians working in an integrated primary care and mental health program

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ABSTRACT

Objectives: This study evaluated the perceived benefits and limitations of a Web-based clinical support tool for behavioral health clinicians serving patients in an integrated primary care and mental health program in Washington State community health centers.
Methods: We surveyed 71 clinicians who utilize a Web-based clinical support tool ("the caseload registry") in treating patients. Follow-up interviews were scheduled with a subset ($n=32$) of respondents. Comments made during these interviews were analyzed using qualitative methods.
Results: Survey responses were favorable on 4 of 7 questions regarding specific benefits of the caseload registry. Notably, clinicians agreed that the caseload registry helps track patients and their clinical progress. Clinicians also agreed that the caseload registry adds an additional documentation burden to their work duties.
The most common positive themes identified during follow-up interviews were that the registry is useful and improves care. The most common critical themes identified were that the tool is burdensome and sometimes does not encompass important elements of care.
Conclusions: Behavioral health clinicians working in an integrated primary care and mental health program report that use of a caseload registry adds value and improves care. They express that it helps provide more comprehensive care and tracks patient progress.

1. Introduction

More people in America receive mental health care from their primary care provider than from a mental health specialist [1]. However, few receive adequate mental health care [2,3]. Confounding the problem, two thirds of primary care providers report difficulty accessing appropriate mental health services for their patients [4]. To address this need, integrated models of care, such as the IMPACT program, have been implemented in primary care settings nationwide and there is now considerable evidence showing these models to be significantly more effective in improving mental health outcomes than the traditional model [5–10].

The IMPACT study, a pivotal study in demonstrating the effectiveness of integrated care, evaluated the treatment of depression using an integrated care model across 18 clinics in 5 states. The program was found to more than double the effectiveness of depression treatment [5,11]. Integrated care models, also known as collaborative care, are patient centered and structured around the addition of a behavioral health clinician, often a social worker or licensed mental health counselor, to augment primary care. In this model, appropriate patients are identified by the primary care provider or via structured depression and anxiety screening tools [such as the Patient Health Questionnaire 9 (PHQ-9)]. The behavioral health clinician then contacts the patient and offers mental health counseling, care coordination and other services as clinically indicated. The care and clinical outcomes are tracked using an electronic caseload registry [11]. The behavioral health clinician also consults regularly with a psychiatrist who provides caseload consultation and medication reviews as needed. The addition of the behavioral health clinician and consulting psychiatrist to the care team provides much needed support to primary care physicians who may otherwise not have the time [12] or resources to provide proper mental health care [4].

The Mental Health Integration Program (MHIP) is based on the IMPACT model of care and was first piloted in 2008 in Washington State. The program began in two counties (29 clinics) and expanded 2

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years later to 150 clinics located across the state. To date, MHIP has provided patient-centered mental health care via the integrated care model to over 35,000 publicly funded patients.

Many integrated care programs utilize an electronic caseload registry that is used by the behavioral health clinician to facilitate service delivery. The core functionality of these registries include the ability to maintain accurate lists of caseloads, track targeted clinical outcomes and alert the clinician when patients are due for follow-up or not meeting treatment goals. This study reviews a specific caseload registry: the Mental Health Integrated Tracking System, used by behavioral health clinicians within the MHIP across Washington State. This caseload registry was developed using the registry created as part of the IMPACT Project as a prototype and has been in continuous development since. With this caseload registry, outcomes are measured using standardized measurement tools, such as PHQ-9 to evaluate patient progress. The registry also features built-in clinical templates and user feedback to help structure clinical workflow and guide interventions.

With the growth and success of integrated care models, the use of caseload registries has also expanded; however, there has been little written to describe the success when clinicians utilize these registries [13] and how effective they are in supporting care services. MHIP provides an opportunity to evaluate clinicians' perceptions of the utility of caseload registries within an established evidenced-based integrated care program. This study evaluated the opinions and perspectives of behavioral health clinicians with regard to working with the caseload registry.

2. Methods

2.1. Setting

This study was conducted in two phases: an online anonymous survey of behavioral health clinicians working in 150 health centers across Washington State, followed by an optional semistructured telephone interview for participants that agreed to be contacted. The health centers consisted of federally qualified community health clinics and community mental health clinics located in both rural and urban settings. All clinics have at least one behavioral health clinician working on site. This study was conducted in collaboration with the AIMS Center in the Department of Psychiatry and Behavioral Sciences at the University of Washington and the Community Health Plan of Washington (CHPW). CHPW is a nonprofit organization responsible for implementing and managing the program as well as providing training and resources to the behavioral health clinicians. Study protocols were approved by the institutional review board of the University of Washington.

2.2. Procedure

The survey was programmed, administered and managed using an online survey program through the University of Washington. All responses in the survey were anonymous, though upon completion of the survey, respondents had the option of being contacted for a follow-up interview. Identifying information was only collected for those who opted to be contacted for a follow-up interview. The survey was divided into 3 sections: Advantages and Disadvantages of MHIP, Rural Adaptations and Benefits and Disadvantages of the caseload registry. Survey questions included both structured queries using a Likert scale as well as the ability to provide detailed free-text explanations or clarifications of their responses.

Respondents who agreed to a follow-up interview were contacted by email. Two researchers on the research team conducted all interviews over 15 days. Interviews were conducted following an interview guide where participants were asked a standardized series of open-ended questions based on a priori themes identified from survey responses. Questions were related to their perceptions of the program, their opinions related to the behavioral health clinician role, whether they perceived any issues in working with primary care providers and clarification regarding specific answers given on the survey. All interviews were recorded, partially transcribed and later reviewed with potential themes extracted as described below.

2.3. Target sample

We aimed to survey all behavioral health clinicians ($n=125$) across Washington State. The behavioral health clinicians are trained professionals certified or licensed in the state of Washington to provide behavioral health services. Most possess master's degrees or higher and have backgrounds in nursing, psychology, social work or counseling, and all receive additional training from the CHPW. Training consists of Web-based and in-person training sessions on mental illnesses, various therapeutic intervention skills, medications and collaborative care. Typical services and interventions provided by behavioral health clinicians include medication education, teaching coping skills, CBT, assistance in accessing social services and appointment reminders and follow-up. Behavioral health clinicians were recruited via email to participate in the survey. Participants were excluded from analysis if they did not work directly with at least one primary care clinic or if they did not have regular clinical contact with patients enrolled in the program at the time of the study. We received 71 completed surveys, 61% ($n=43$) agreed to be contacted for a follow-up interview (all agreed to have the interview recorded). We contacted all 43 respondents who agreed to follow-up interviews and completed 32 interviews. Seven behavioral health clinicians were excluded from our analysis based on exclusion criteria outlined above.

Information about eligible behavioral health clinicians who completed the follow-up interview was collected (Table 1). About half of behavioral health clinicians interviewed (48%) had been working in MHIP for at least 3 years. Seventy-four percent currently work in an urban setting. Most behavioral health clinicians interviewed (59%) had a caseload of more than 30 at the close of the study (July 2013). We were unable to collect information about all behavioral health clinicians who participated in the survey because survey responses were anonymous.

2.4. Data analysis

Survey data was pooled and responses were given number codes in order from 1 to 5 for "Strongly Disagree" to "Strongly Agree." Results were then analyzed using standard statistical methods to find mean, median, mode and standard deviation of responses to each question. Comments from the online survey were analyzed for themes and compared to themes from the follow-up interviews.

Table 1
Characteristics of behavioral health clinicians who completed follow-up interviews ($n=27$).

	% of clinicians (n)
Duration worked as behavioral health clinician	
≤12 months	14% (4)
13–24 months	19% (5)
25–36 months	19% (5)
>36 months	48% (13)
Current clinic location	
Urban	74% (20)
Rural/frontier	26% (7)
Caseload	
<30	41% (11)
30–56	29% (8)
57–84	26% (7)
>85	4% (1)

Characteristics of behavioral health clinicians are listed for the 27 eligible follow-up interviews. Duration worked and caseload was gathered from the caseload registry as of the close of the study (7/2013). Caseload is based on CHPW's minimum caseload standard of 56. Current clinic location was reported from clinician responses on the survey.