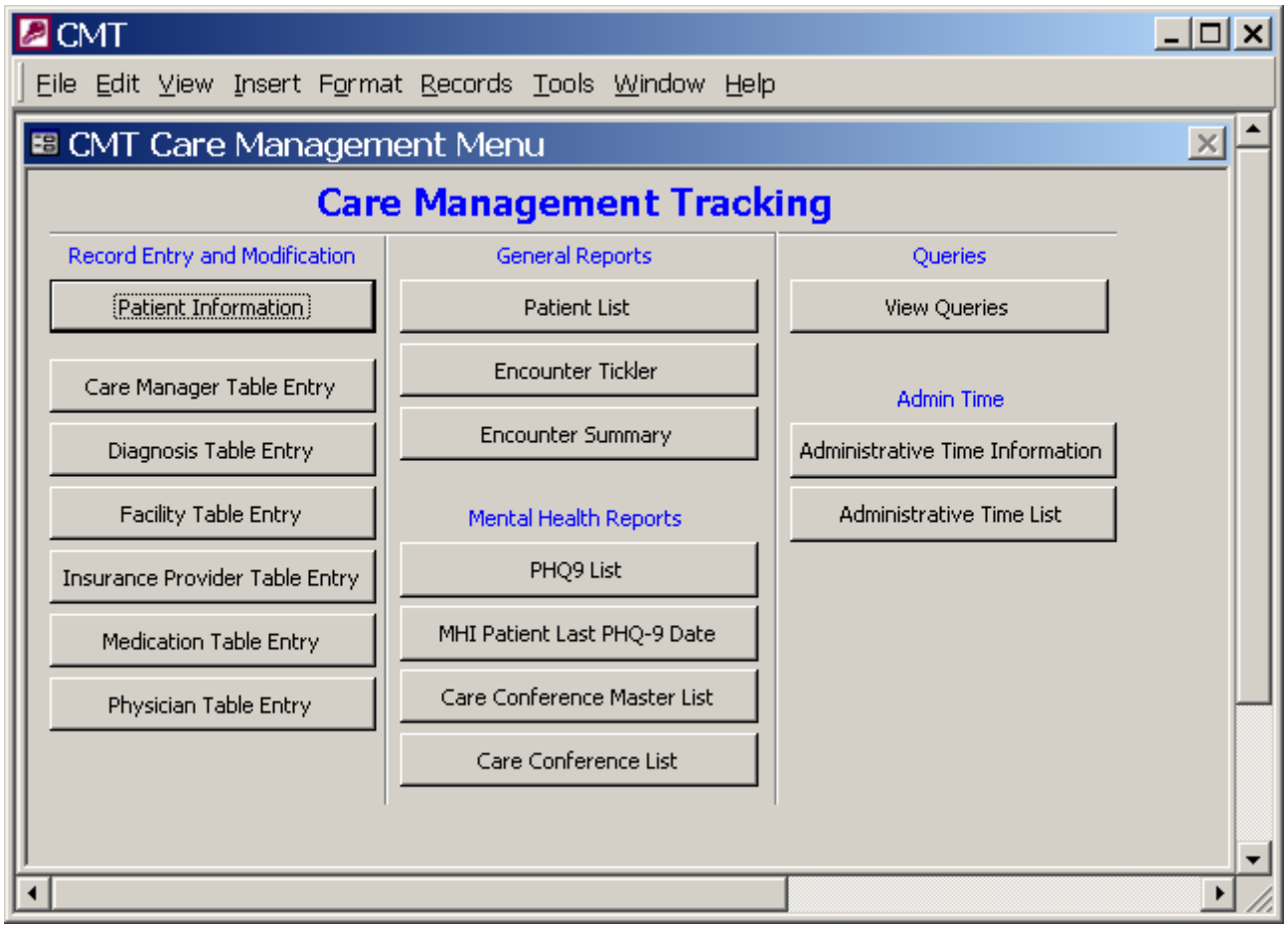
Care Management Tracking (CMT) Software User Manual (Mental Health)



Care Manager Tracking (CMT) Software

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Installing the Database

To install the database for a single user, download and save the CMT.mdb file to the desired folder on a local drive/computer. For multiple users, install the database on a network drive. Users can be given access rights/permissions to that drive, map the drive to their computer, and create a shortcut on their desktop to access the live database.

Opening the Database

To open the database, double click the "Shortcut to CMT.mdb" icon on your desktop. The CMT Care Management Menu will appear (Fig. 1)

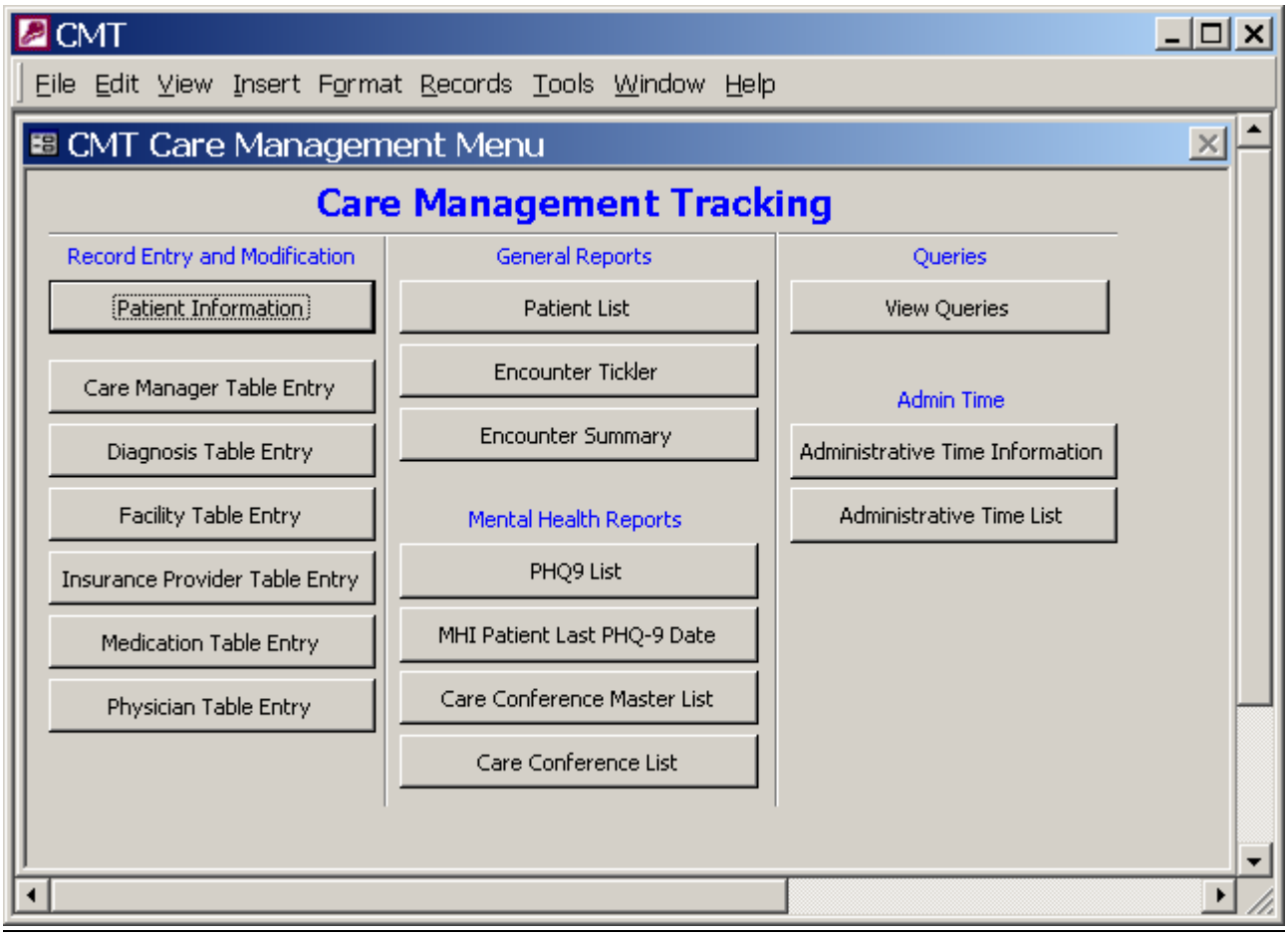


Figure 1

The CMT Care Management Menu

The Care Management Tracking Database Main Menu is composed of 6 sections: Record Entry and Modification, General Reports, Mental Health Reports, Diabetes Reports, Queries, and Admin Time.

Record Entry and Modification Section

This section includes buttons to access the main Patient Information screen, as well as table information for Care Managers, Physicians, Diagnoses, etc., which appear as selections in the drop-down fields throughout the database.

Entering Values on Main Menu for Care Managers, Diagnoses, Facilities, Insurance Providers, Medications, and Physicians

- Click on the "Diagnosis Table Entry" button or other "Table Entry" button from the main menu. A pop-up window (Fig. 2) will appear with all of the values for that category currently in the database table/available in the drop-down menus. To add a new one, scroll down the window to the blank line. Type in the new value and close the window. It will now automatically save to that table and appear as an alphabetized choice in the drop-downs within the database.

  Please note: If you are looking to add an entry for another category other than those listed on the Main Menu, please contact your database administrator/programmer. These will need to be entered "behind the scenes".

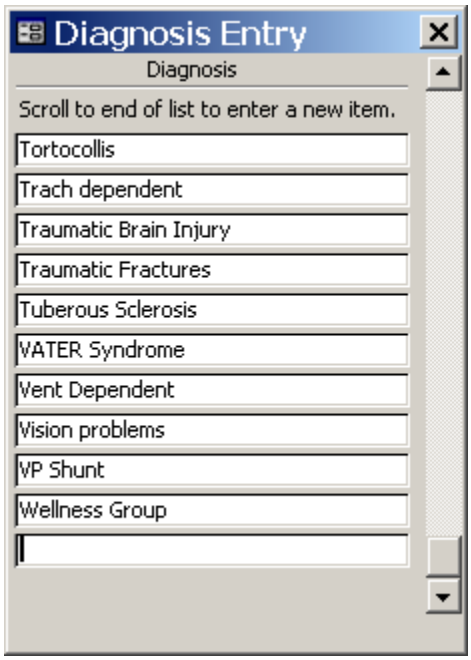


Figure 2

Patient Information

The Patient Information button brings you to the main data entry screen (Fig. 3). Here you will locate/enter new Patients, record new encounters, assessments, and diagnoses. The top portion of the screen displays Patient demographics as well as information regarding the Patient's status with the Care Manager. The middle section of the screen consists of several "windowpanes" which summarize and provide at-a-glance data entered via the navigation buttons on the bottom left of the screen. Also indicated within a thick black box on the right side of the screen is the Patient Search section. The bottom of the screen houses the navigation buttons for entering data for the selected patient, creating new patients, saving and deleting patients, and generating clinical note summaries.

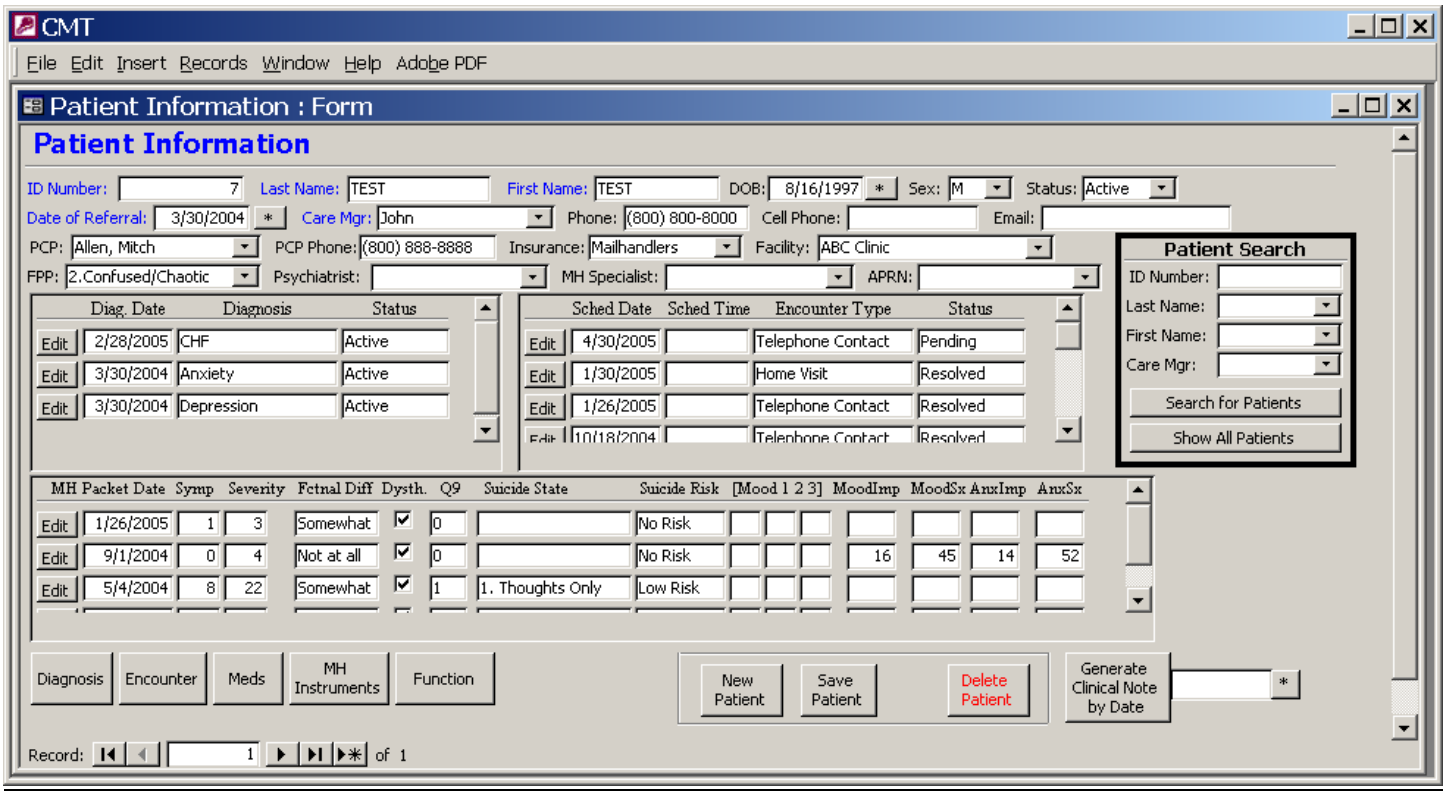


Figure 3

- ADDING A NEW PATIENT

Search for the Patient to see if he/she exists in the database:
Go to the Patient Search section on the right side of the Patient Information screen. Enter in an ID Number, Last Name, First Name, or Care Manager/Diabetes Educator from the drop-down lists to search (Typing the first letter of a name will bring you to the right place in the list quickly). Click the "Search for Patients" button. You may search using a combination of fields, such as a first and last name, to further narrow the search. Please note that once you have searched, you will be seeing a subset of the records in the database. For example, you may search on "Brown" as a last name. There may be several Browns in the database. Check the record indicator number at the bottom left of the main Patient Information form to see which record you are on and how many records you are viewing. You may see "Record 1 of 4" if 4 Browns have been found. If the current record displayed isn't the record you are looking for, you can use the "VCR-like"  back and  forward buttons to move to the previous and next records, respectively, until you find the record you are looking for.

Please note: To get back to viewing ALL Patients, click on the "Show All Patients" button in the Patient Search area. You are now viewing ALL records in the database instead of just the subset of Browns.

If nothing comes up, the Patient has not yet been entered into the database, so click the **"New Patient"** button on the bottom of the screen to clear the screen fields and enter the Patient information.

Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):

- Full Name (Last and First Names)
- ID Number – Number unique to a Patient in your organization
- Care Manager/Diabetes Educator
- Date of Referral

Click the **"Save Patient"** button on the bottom of the screen. You must save the record before any other data can be entered on pop-up screens.

- ADDING DIAGNOSES, ENCOUNTERS, MH INSTRUMENTS, ASSESSMENTS, ETC:

Click the "Diagnosis", "Encounter", or "MH Instruments", etc. button at the bottom left of the screen. This will pop up an entry screen. All records entered of that type for the Patient you are currently viewing will be retrieved. Once this screen appears, you will see the latest (most recent date) entry record of that type for the current patient. **Be sure to click the "New" button to clear the screen**, or you will overwrite an existing record! If you wish to, you can navigate through these records using the navigation arrows next to the Record number on the bottom of the pop-up screen if necessary.

Click the “Save” button and close the window to return to the main Patient Information screen. You will notice that the record you just entered will now automatically appear in the corresponding “windowpane” on the main Patient Information screen for that Patient (if your database has that specific windowpane).

- **Diagnosis**: Clicking this button will bring up the following Patient Diagnosis screen (Fig. 4). Enter the Diagnosis information. Status has a default value of “Active”.

  To enter multiple Diagnoses, enter them separately (even though they may have the same date) instead of combining using the Notes field. That way if one Diagnosis has a Status of “Resolved” and another “Active”, they can be tracked separately.

  Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):
  - Diagnosis Date
  - Diagnosis

  Click the “Save Diag.” Button to save the record and close the window to return to the main Patient Information screen.

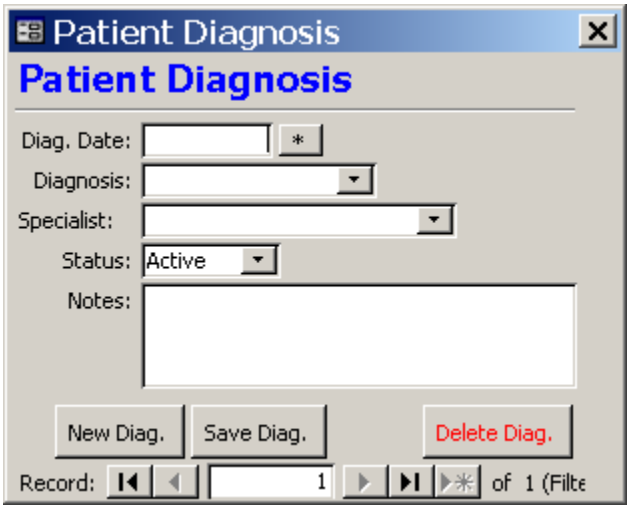


Figure 4

- **Encounter:**

  Clicking this button will bring up the following Patient Encounter screen (Fig. 5). Enter the Encounter information. Please note that Scheduled Time must be entered in the format "HH:MM AM" or "HH:MM PM".

  For a future Encounter to appear on the Encounter Tickler Report accessed from the database Main Menu, you MUST enter the top half (above the line) of the Encounter pop-up entry screen. This portion drives the report.

  Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):
  - Scheduled Date

  Click the "Save Encounter" Button to save the record and close the window to return to the main Patient Information screen. You will notice that the windowpane for Encounters on the Patient Information screen will display that Encounter as "Pending".

  Once the Encounter has been completed, go back to the Encounter screen for the Patient to fill in the bottom portion (below the line) of the Encounter record. Filling in an Actual Date will cause the windowpane on the Patient Information screen to display "Completed" and the Encounter to drop off the Encounter Tickler "to-do" List.

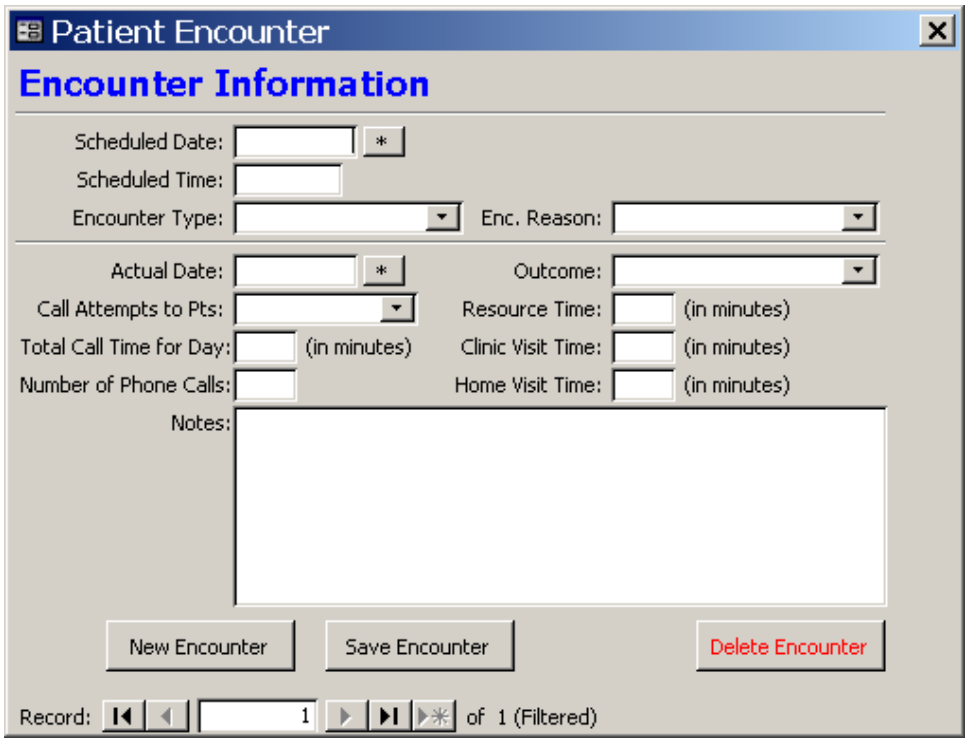


Figure 5

- **Meds:**

  Clicking this button will bring up the following Patient Medication screen (Fig. 6). Enter the Medication information.

  Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):
  - Medication

  Click the "Save Med" Button to save the record and close the window to return to the main Patient Information screen.

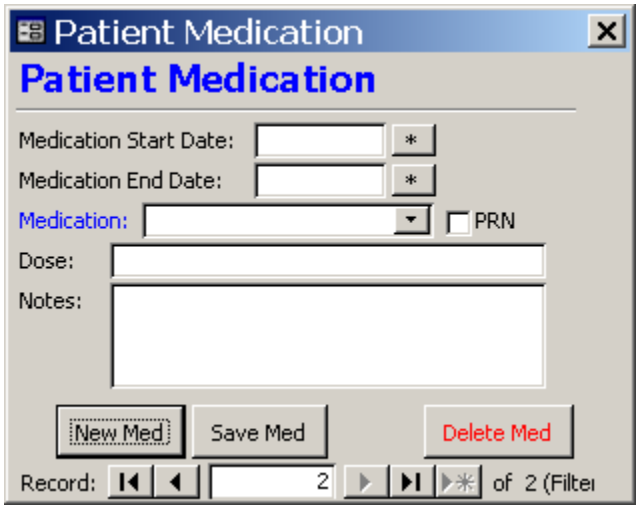


Figure 6

- **MH Instruments:**

  Clicking this button will bring up the following Mental Health Instruments screen (Fig. 7). Enter the Mental Health Instruments information. Scores entered on this screen originate from corresponding instruments such as the PHQ-9 (Patient Health Questionnaire), which are available for download with the CMT database.

  Data entered on this screen will display on the Care Conference List Report from the Main Menu (Mental Health version of the CMT database only).

  Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):
  - Date

  Click the "Save Instrument Data" Button to save the record and close the window to return to the main Patient Information screen.

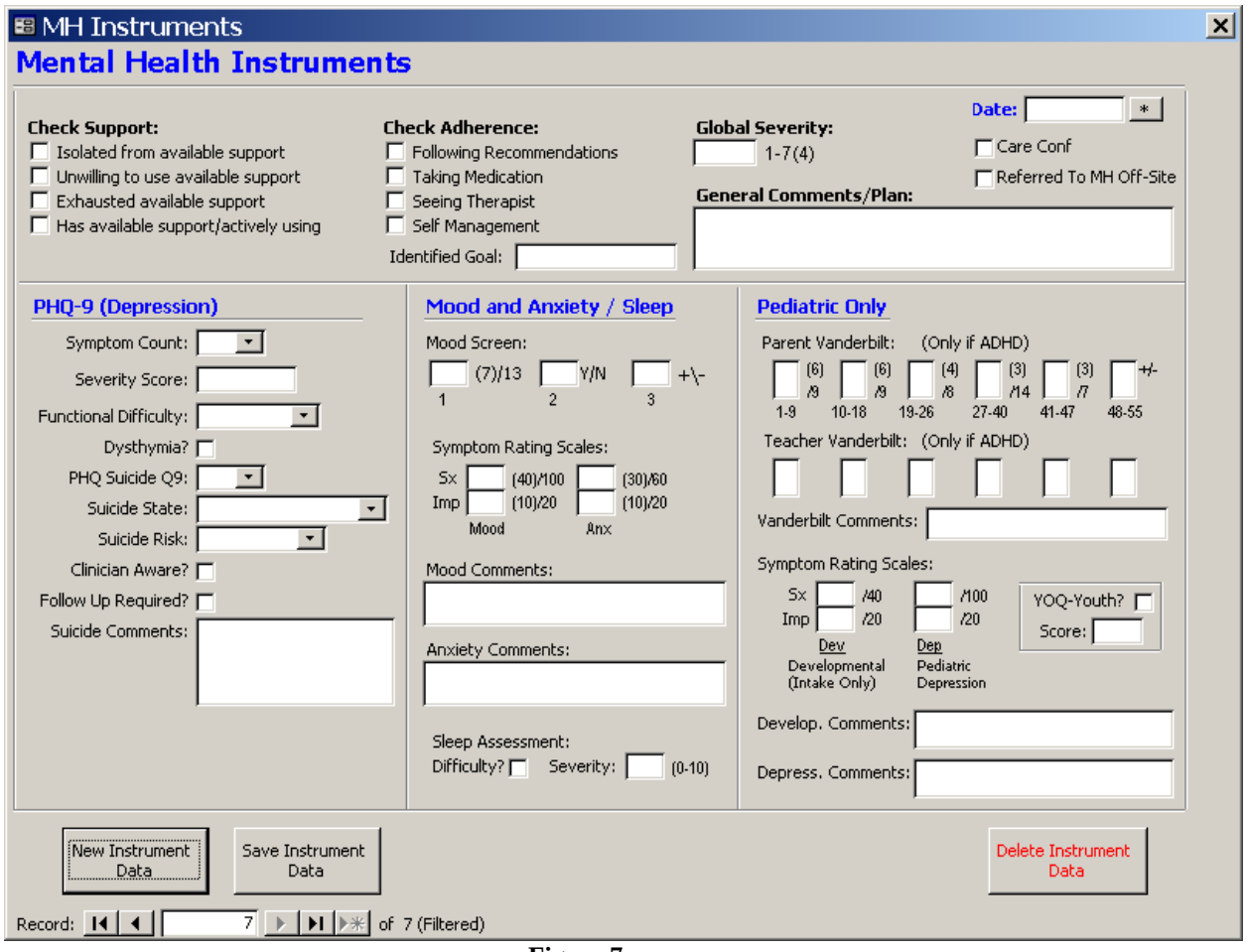


Figure 7

- **Function:**

  Clicking this button will bring up the following Function screen (Fig. 8). Enter the Function information.

  Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):
  - Assessment Date

  Click the "Save Function Assess" Button to save the record and close the window to return to the main Patient Information screen.

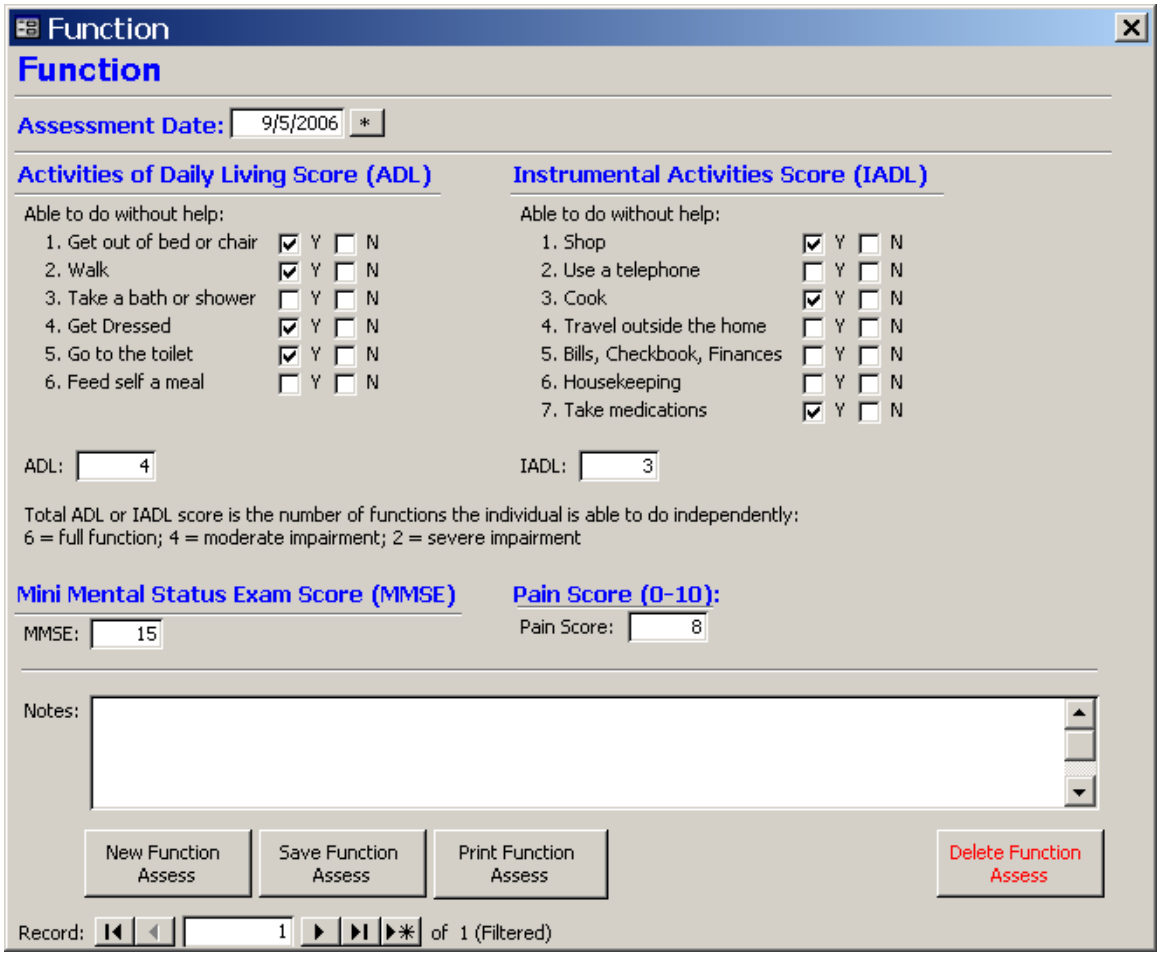


Figure 8

- MODIFYING PATIENT INFO:

  Search for the Patient first to see if he/she exists in the database. (See above instructions):

  - To change demographic and status information on the main Patient Information form, modify fields and click the “Save Patient” button.
  - On Diagnoses, Encounters, Mental Health Instruments, etc., click the ‘Edit’ button on the corresponding “windowpane” to get a pop-up directly to that specific record, and click the “Save” button before closing the pop-up window.

- GENERATE CLINICAL NOTE BUTTON:

  This tool will save you from copying and pasting back and forth between windows when you need to go to another electronic charting method to enter a Note with results from Encounters, Mental Health Instruments, Diagnoses, etc. just entered into the CMT database.

  1. Choose a date: Enter a date in the white text box to the right of the button **OR** click the asterisk button to the right of the date field to pop up a calendar for reference (In case you are looking for "Last Friday", for example, and don't know the date off the top of your head).

  2. Click the "Generate Clinical Note by Date" button and a Clinical Note Summary Screen window (Fig. 9) will pop up which will summarize all events for **the day you selected** for **that patient** (the record you are currently viewing).

     Any Encounters matching that date, **Any MH Instruments recorded** matching that date, and **ALL Diagnoses for that Patient (regardless of date)** will appear. We included all Diagnoses for an at-a-glance reference--you may not wish to copy and paste an earlier Diagnosis that doesn't relate to the date with which you are concerned.

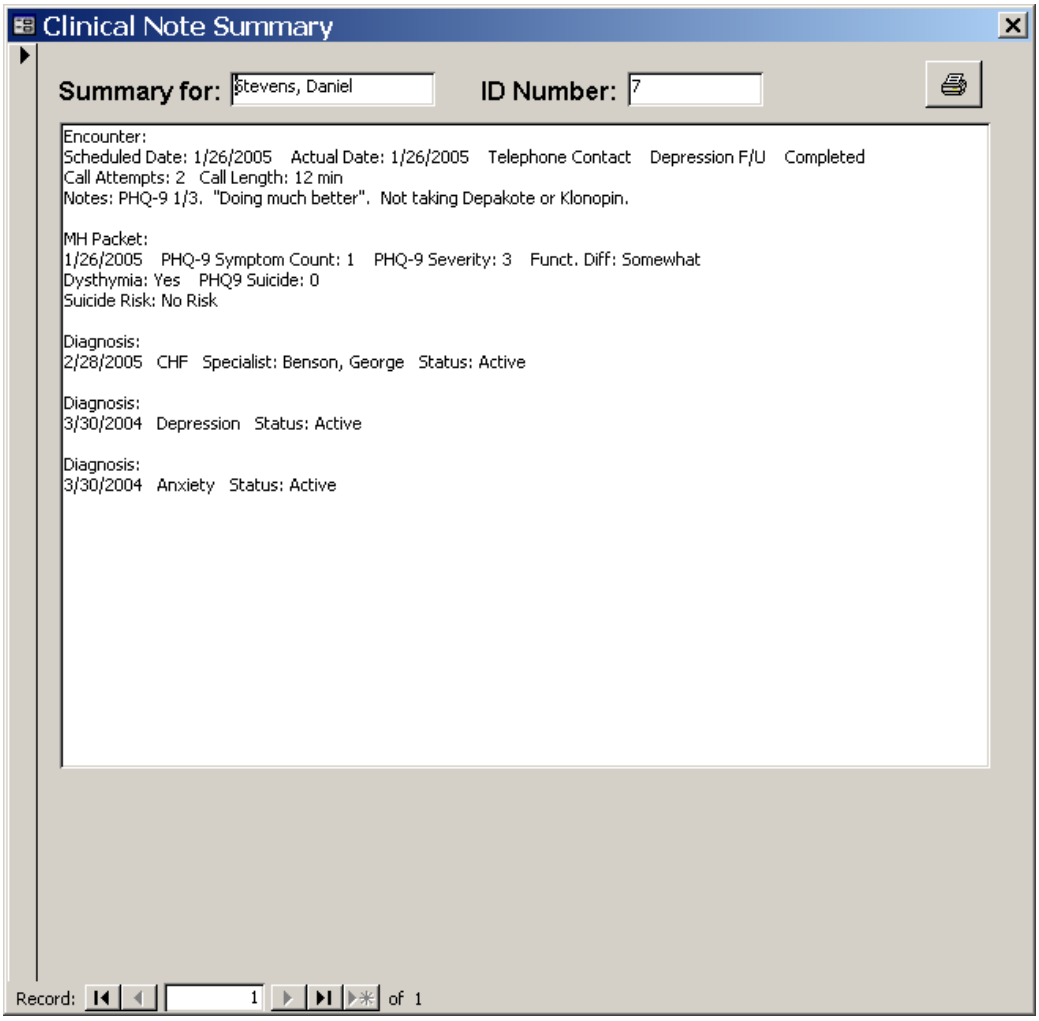


Figure 9

3. To copy the text (as much as you need to transfer to another program):
   Click inside the box where the summary appears. Highlight the text you want to copy. Right-click and choose "Copy" from the menu. (Not highlighting first and just right-clicking will highlight everything and save time if that's what you want to do.)

4. Paste the text into the other electronic charting location:
   Open the program into which you wish to paste your Note. Once you choose your Patient in that system, go to where you normally enter a Note to type in or copy in information and do a Control-V sequence. (Hold down the "Cntrl" key in the bottom left of the keyboard and then press the "V" letter key on the keyboard). This is a shortcut to the Paste command. Your electronic charting system may not let you Right-click and choose "Paste" as we did with "Copy".

Please Note: You may also print from this screen by clicking the printer icon on the top right of the screen.

General Reports

Patient List

Clicking on the “Patient List” button will bring up the following Patient List Parameters screen (Fig. 10). The Patient List report generated is a list of Patients assigned to the selected Care Manager/Diabetes Educator. This report can be sorted by first name, last name, diagnosis, insurance, PCP (Primary Care Physician), or status.

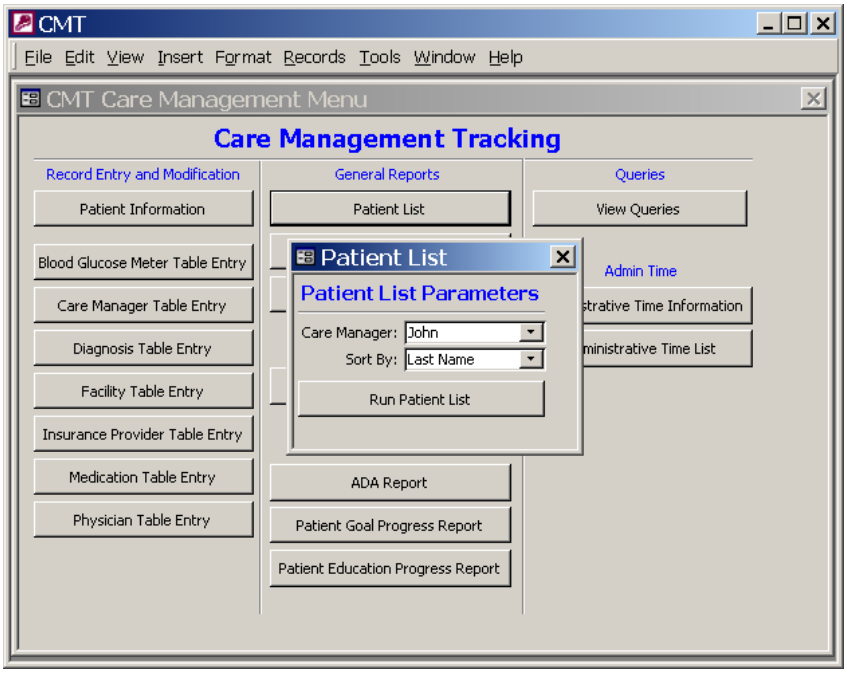


Figure 10

Click “Run Patient List” to run the report (Fig. 11).

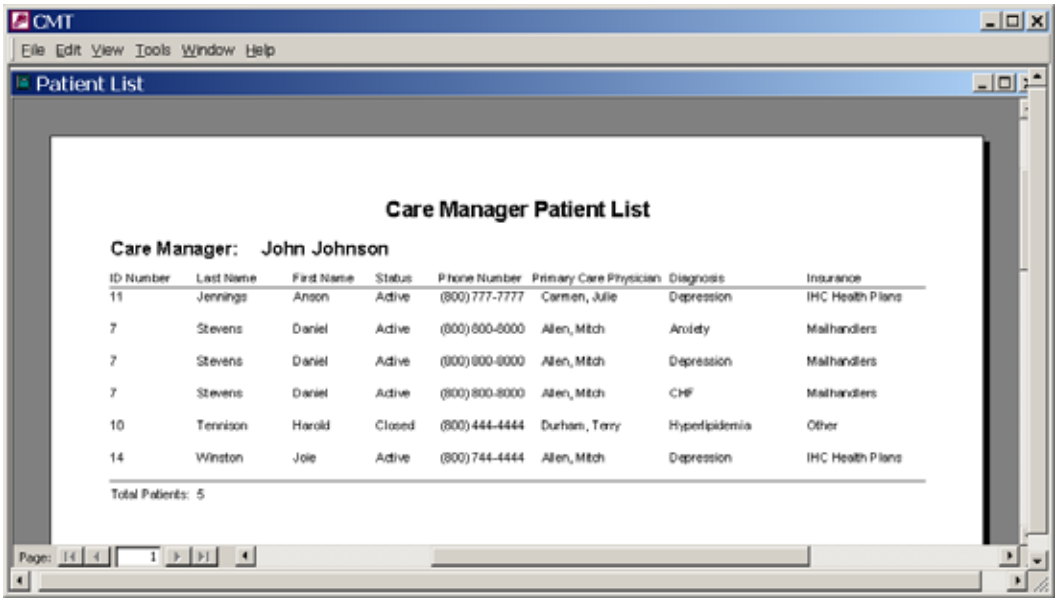


Figure 11

Encounter Tickler

- Clicking on the "Encounter Tickler" button will bring up the following Tickler List Parameters screen (Fig. 12). The Encounter Tickler report generated is a Tickler/To-do list for contact by date range for Patients assigned to the selected Care Manager/Diabetes Educator.

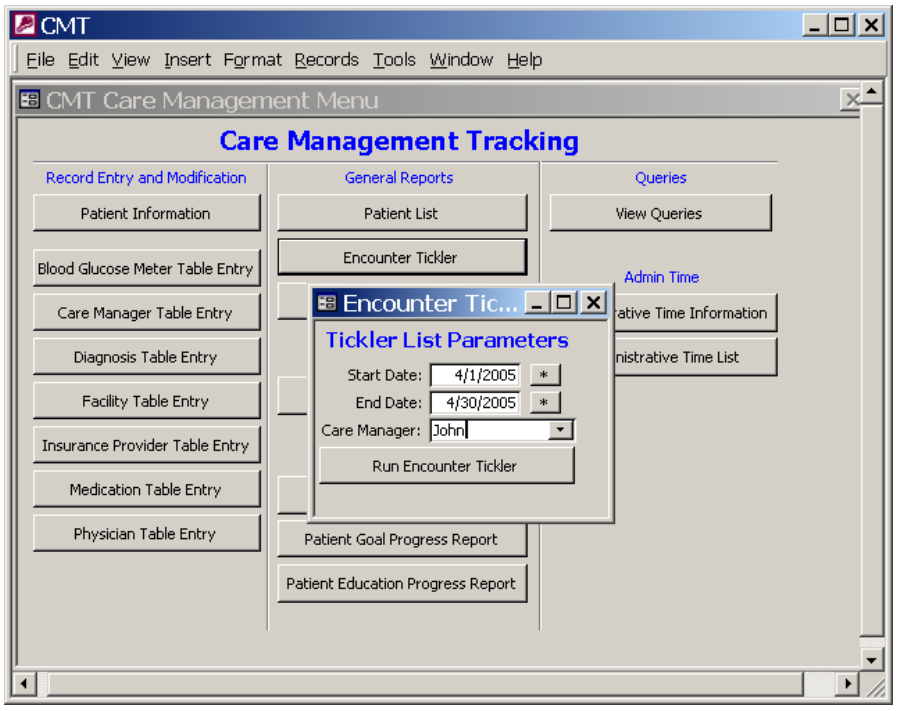


Figure 12

Click "Run Encounter Tickler" to run the report (Fig. 13).

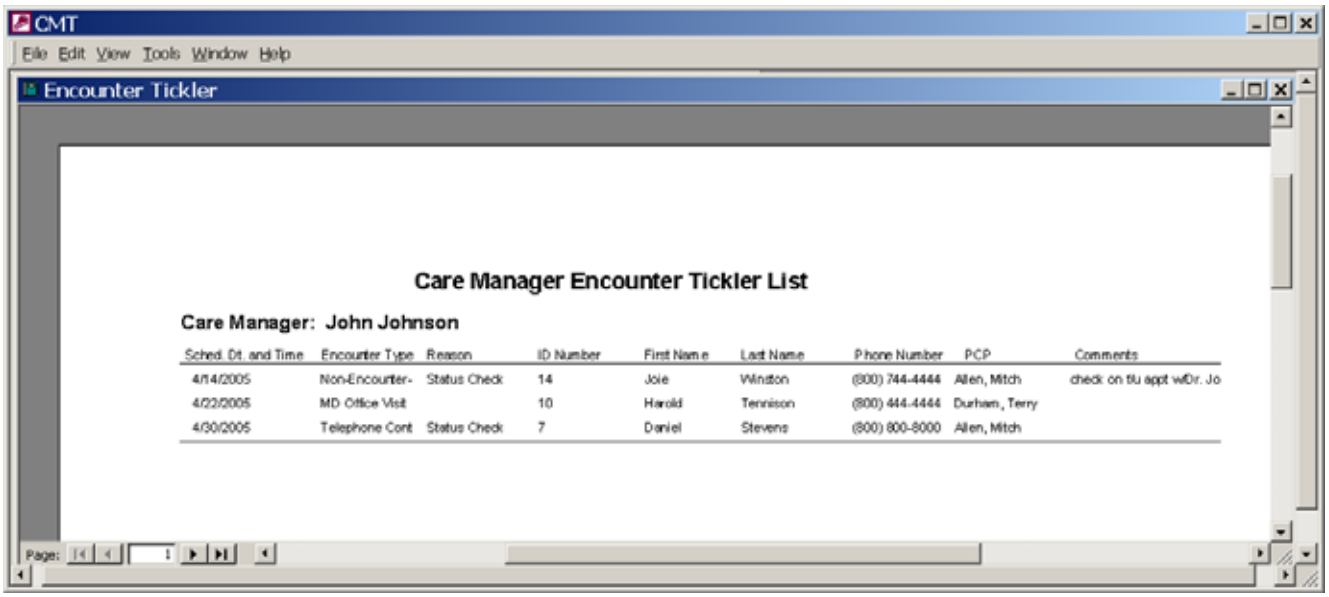


Figure 13

Encounter Summary

- Clicking on the "Encounter Summary" button will bring up the following Encounter Summary List Parameters screen (Fig. 14). The Encounter Summary report generated is a summary of Encounters by date range for Patients assigned to the selected Care Manager/Diabetes Educator. This report can be sorted by first name, last name, encounter date, encounter type, or encounter outcome.

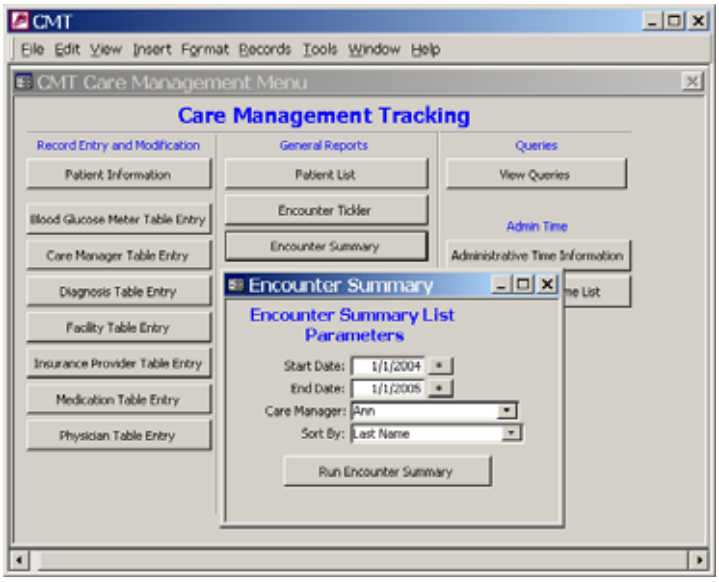


Figure 14

Click "Run Encounter Summary" to run the report (Fig. 15).

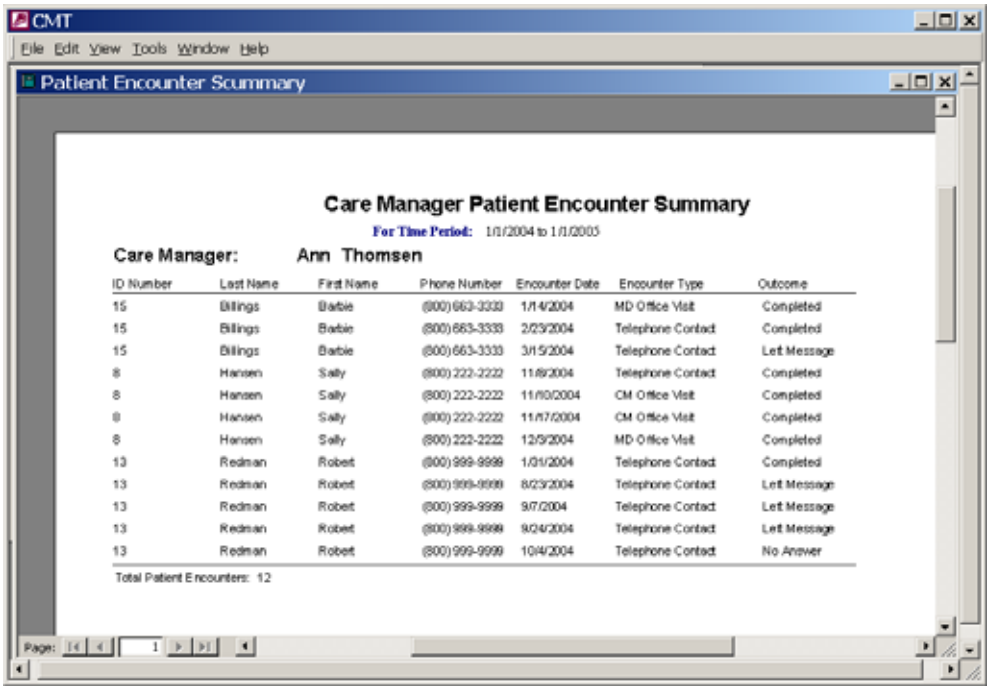


Figure 15

Mental Health Reports

PHQ9 List

- Clicking on the "PHQ9 List" button will bring up the following PHQ9 List Parameters screen (Fig. 16). The PHQ9 List report generated is a list of PHQ9 scores for Patients assigned to the selected Care Manager/Diabetes Educator. This report can be sorted by date, first name, last name, or suicide risk. The report is especially helpful for viewing progress over time.

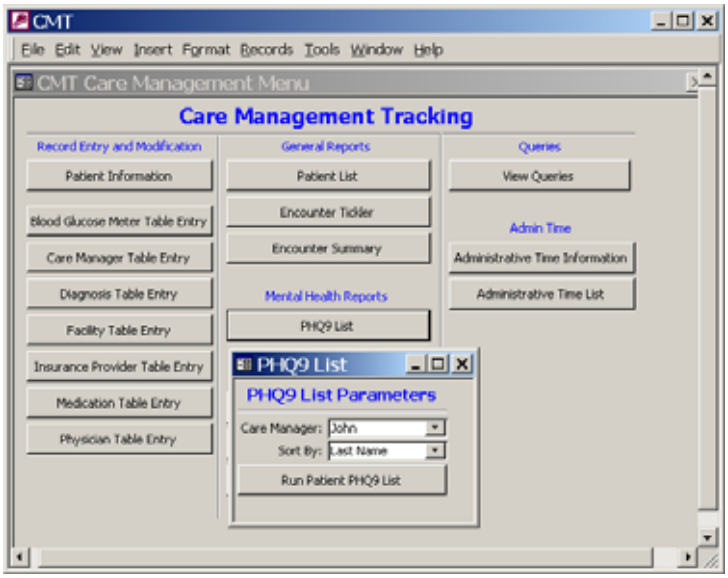


Figure 16

Click "Run Patient PHQ9 List" to run the report (Fig. 17).

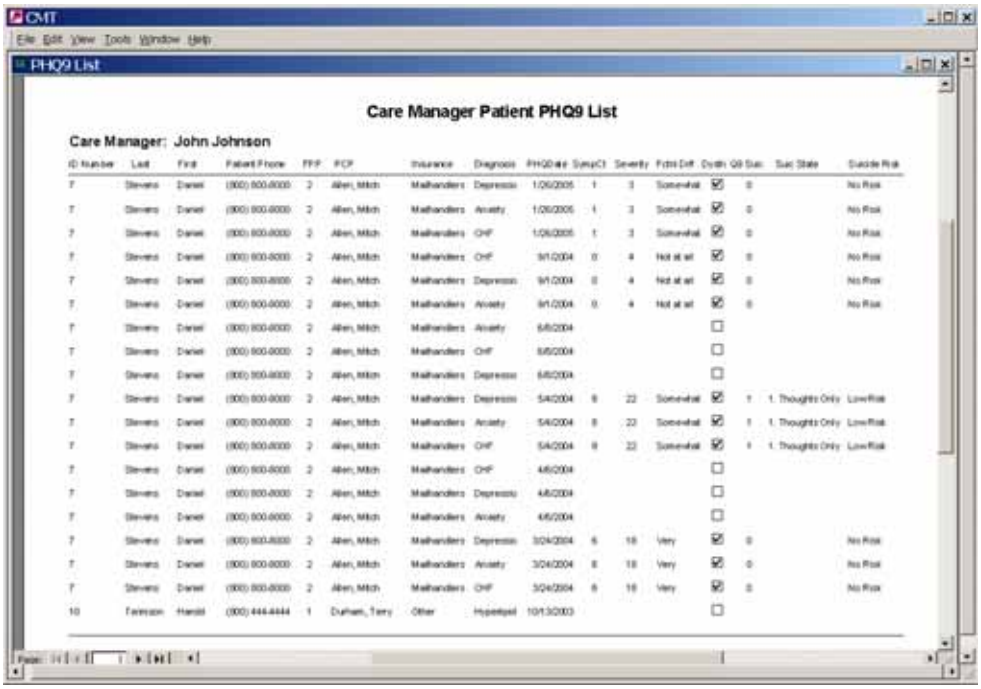


Figure 17

MHI Patient Last PHQ-9 Date

- Clicking on the "MHI Patient Last PHQ-9 Date" button will bring up the following MH PHQ9 Latest Date List Parameters screen (Fig. 18). The MHI Patient Last PHQ-9 Date report generated is a list of the latest/most recent PHQ-9 date and score for Patients assigned to the selected Care Manager.

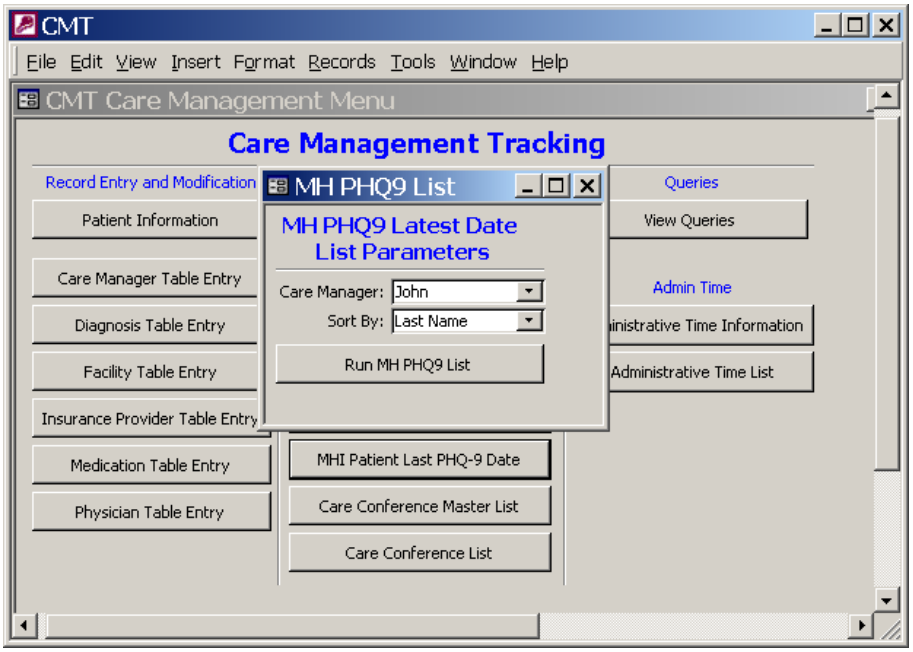


Figure 18

Click "Run MH PHQ9 List" to run the report (Fig. 19).

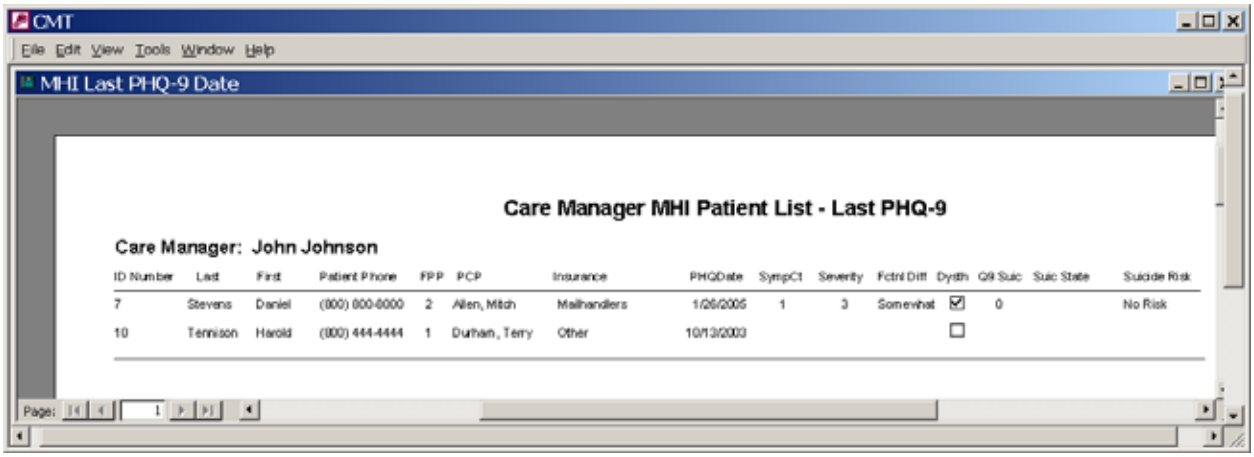


Figure 19

Care Conference Master List

- Clicking on the "Care Conference Master List" button will bring up the following Care Conf Master List Parameters screen (Fig. 20). The Care Conference Master List report generated is a Master List of all those Patients assigned to selected Care Manager for whom a Care Conference Report will be generated, sorted by Facility.

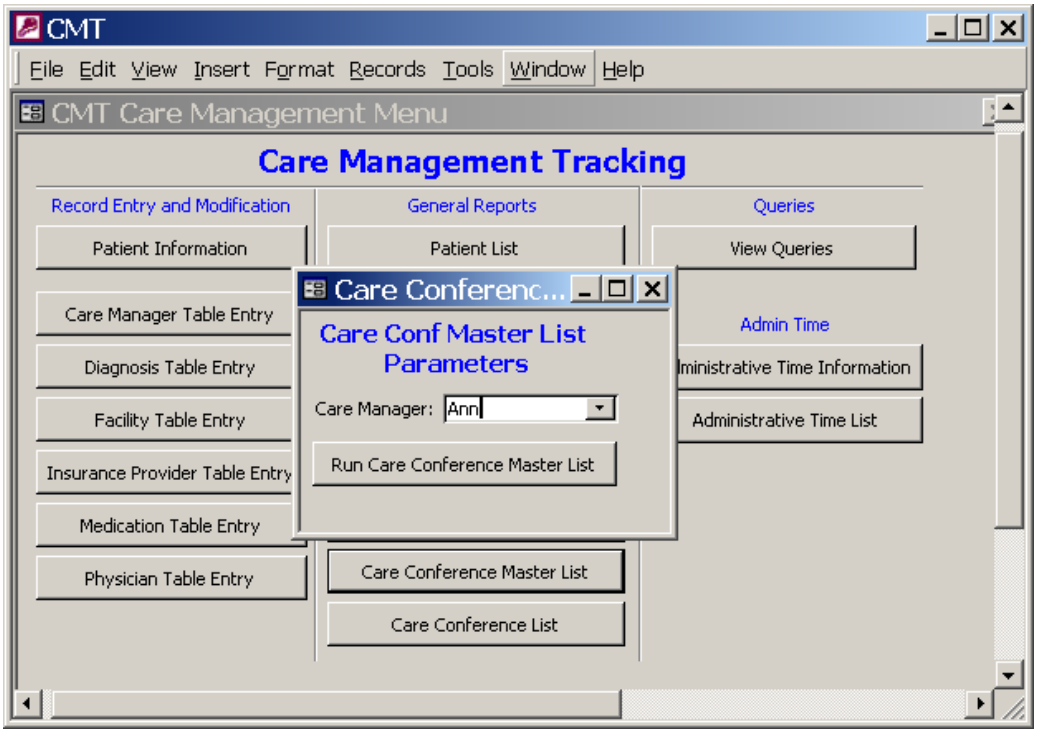


Figure 20

Click "Run Care Conference Master List" to run the report (Fig. 21).

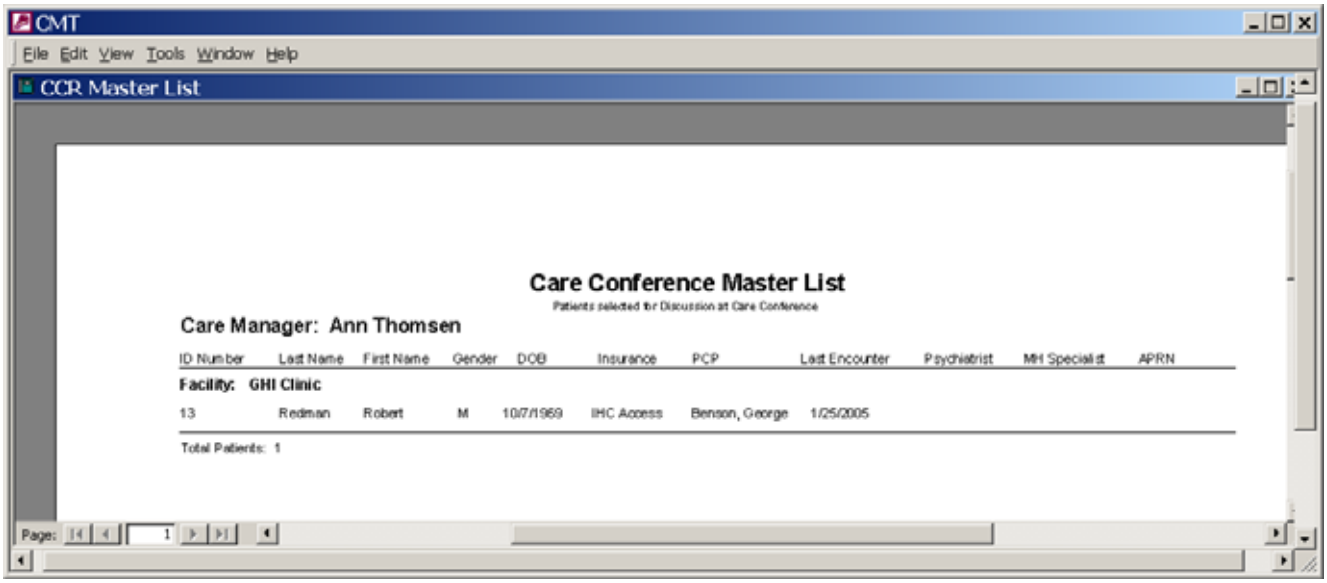


Figure 21

Care Conference List

- Clicking on the "Care Conference List" button will bring up the following Care Conference List Parameters screen (Fig. 22). The Care Conference List report generated is a batched report of MHI Patients assigned to the selected Care Manager and targeted for discussion at a Care Conference (as evidenced by checked "Care Conference" checkbox on the MH Instruments screen).

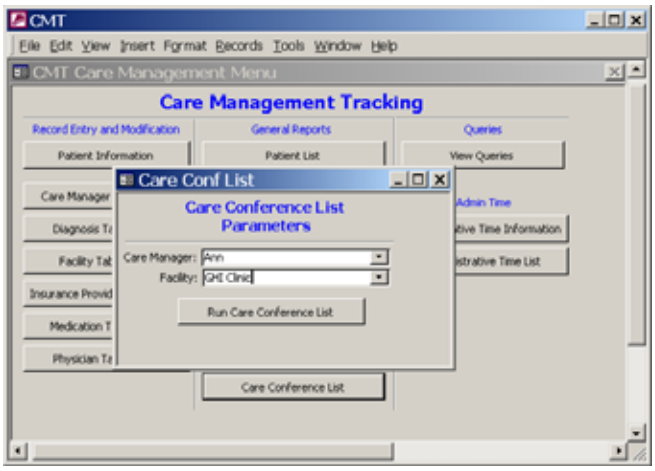


Figure 22

Click "Run Care Conference List" to run the report (Fig. 23).

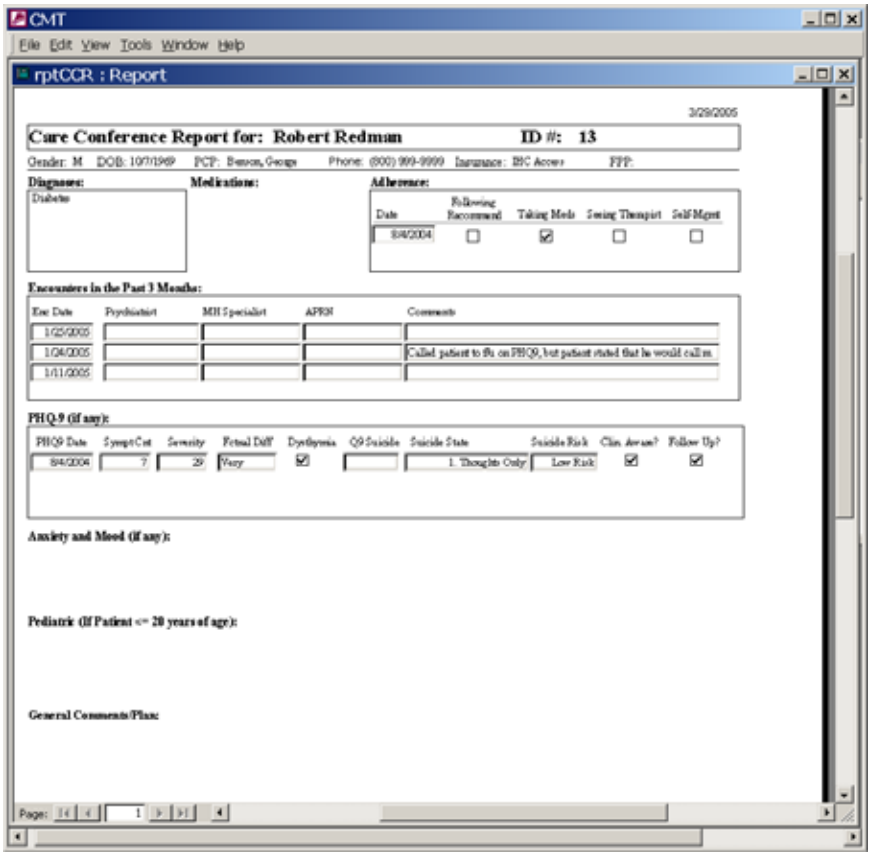


Figure 23

Queries

View Queries

Clicking on the “View Queries” button will bring up the following Queries screen (Fig. 24).

- Generate queries by entering a date range (Start and End Date) and choosing the button corresponding to the query you wish to run.
- These listed Queries are “canned” queries. Any queries not listed here are not available to the users unless this screen is customized by a programmer.

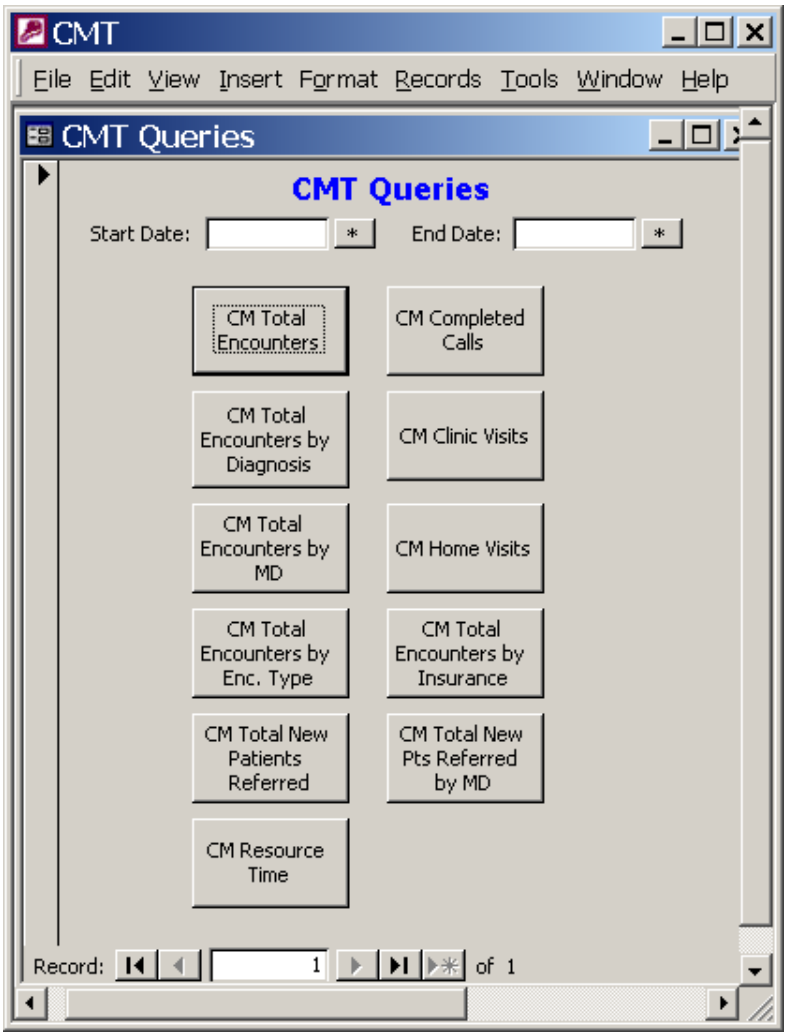


Figure 24

CM Total Encounters:
Clicking on the "CMT Total Encounters" button will bring up the following query screen (Fig. 25). This query displays the number of Care Manager-Patient Encounters falling within the entered date range.

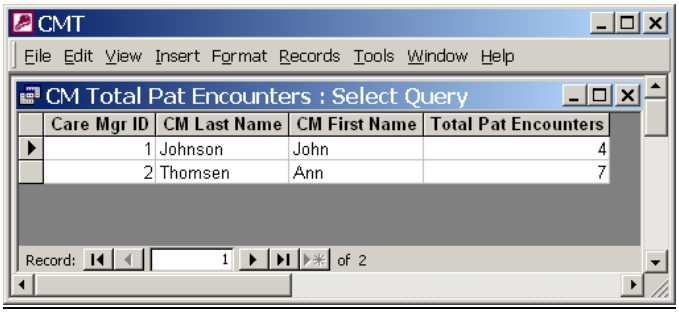


Figure 25

CM Completed Calls:
Clicking on the "CM Completed Calls" button will bring up the following query screen (Fig. 26). This query displays the number of Care Manager Telephone Calls and Average Call Length for Care Manager-Patient Encounters falling within the entered date range.

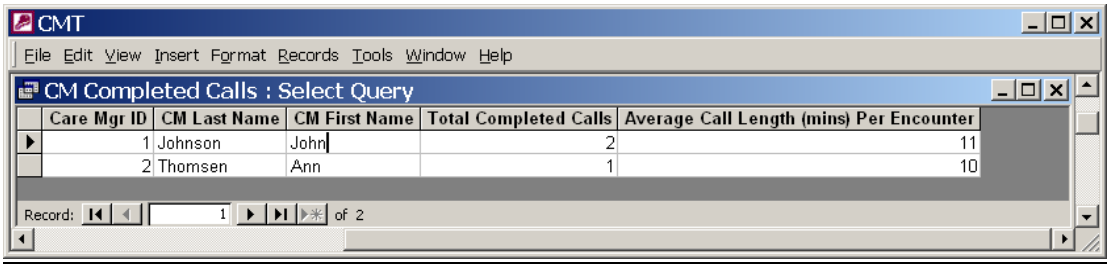


Figure 26

CM Total Encounters by Diagnosis:
Clicking on the "CM Total Encounters by Diagnosis" button will bring up the following query screen (Fig. 27). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Diagnosis. **Please note**: In the CMT database, encounters are not linked with specific diagnoses. Therefore, it cannot be deduced that there were 6 encounters geared specifically for Diabetes management in this time period (see Fig. 27). Rather it suggests that there were 6 encounters within this time period with Patients who have Diabetes in the Problem List.

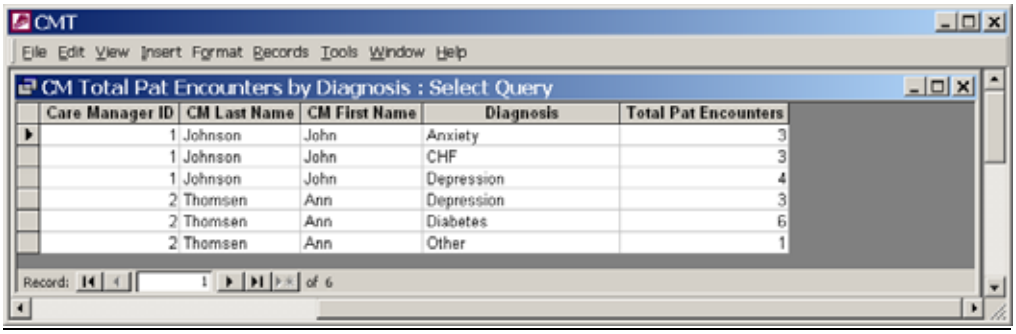


Figure 27

CM Clinic Visits:
Clicking on the "CM Clinic Visits" button will bring up the following query screen (Fig. 28). This query displays the number of Care Manager-Patient Encounters of type Clinic Visit falling within the entered date range, and the Average Clinic Visit Time with those Patients.

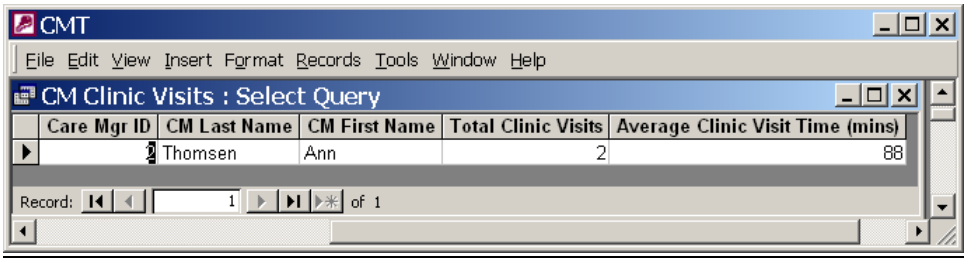


Figure 28

CM Total Encounters by MD:
Clicking on the "CM Total Encounters by MD" button will bring up the following query screen (Fig. 29). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Primary Care Physician.

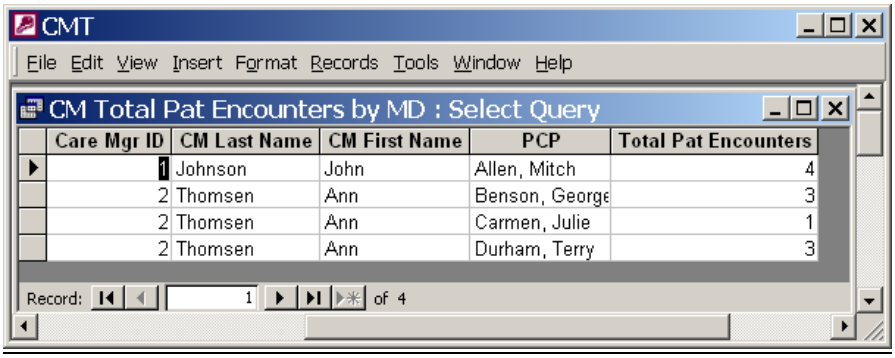


Figure 29

CM Home Visits:
Clicking on the "CM Home Visits" button will bring up the following query screen (Fig. 30). This query displays the number of Care Manager-Patient Encounters of type Home Visit falling within the entered date range, and the Average Clinic Visit Time with those Patients.

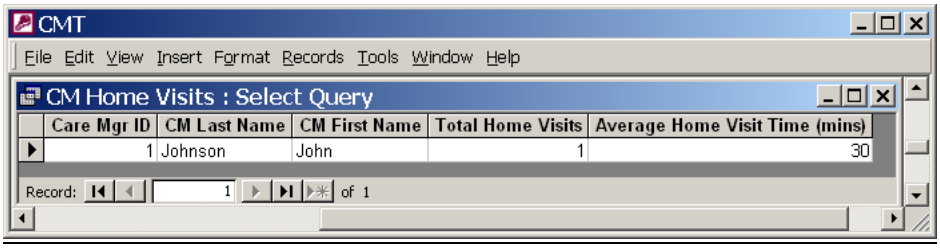
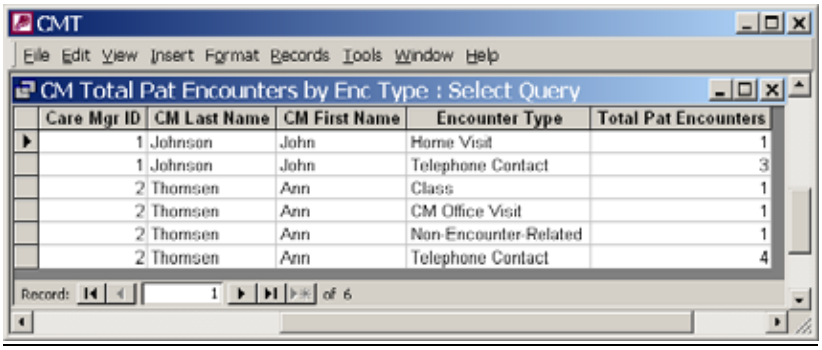


Figure 30

CM Total Encounters by Enc. Type:
Clicking on the "CM Total Encounters by Enc. Type" button will bring up the following query screen (Fig. 31). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Type of Encounter.

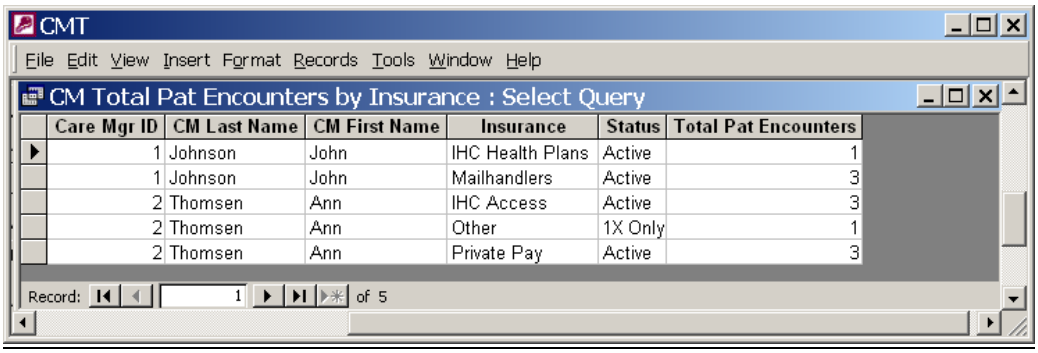


Care Mgr ID	CM Last Name	CM First Name	Encounter Type	Total Pat Encounters
1	Johnson	John	Home Visit	1
1	Johnson	John	Telephone Contact	3
2	Thomsen	Ann	Class	1
2	Thomsen	Ann	CM Office Visit	1
2	Thomsen	Ann	Non-Encounter-Related	1
2	Thomsen	Ann	Telephone Contact	4

Record: 1 of 6

Figure 31

CM Total Encounters by Insurance:
Clicking on the "CM Total Encounters by Insurance" button will bring up the following query screen (Fig. 32). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Insurance Provider and Patient Status.

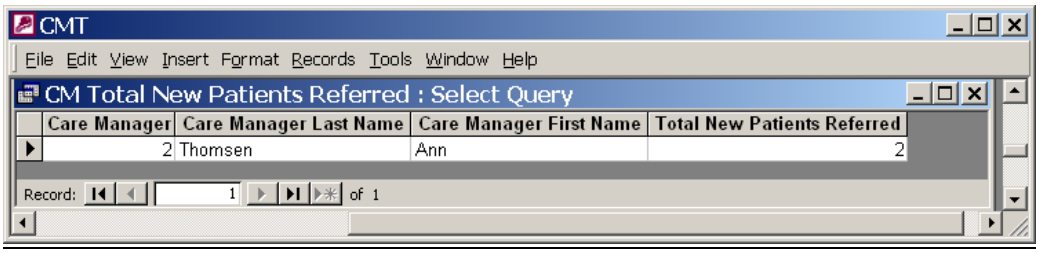


Care Mgr ID	CM Last Name	CM First Name	Insurance	Status	Total Pat Encounters
1	Johnson	John	IHC Health Plans	Active	1
1	Johnson	John	Mailhandlers	Active	3
2	Thomsen	Ann	IHC Access	Active	3
2	Thomsen	Ann	Other	1X Only	1
2	Thomsen	Ann	Private Pay	Active	3

Record: 1 of 5

Figure 32

CM Total New Patients Referred:
Clicking on the "CM Total New Patients Referred" button will bring up the following query screen (Fig. 33). This query displays the number of New Patients referred to the Care Manager with a Date of Referral within the entered date range.



Care Manager	Care Manager Last Name	Care Manager First Name	Total New Patients Referred
2	Thomsen	Ann	2

Record: 1 of 1

Figure 33

CM Total New Patients Referred by MD:
Clicking on the "CM Total New Patients Referred by MD" button will bring up the following query screen (Fig. 34). This query displays the number of New Patients referred to the Care Manager with a Date of Referral within the entered date range, sorted by Patient's Primary Care Physician.

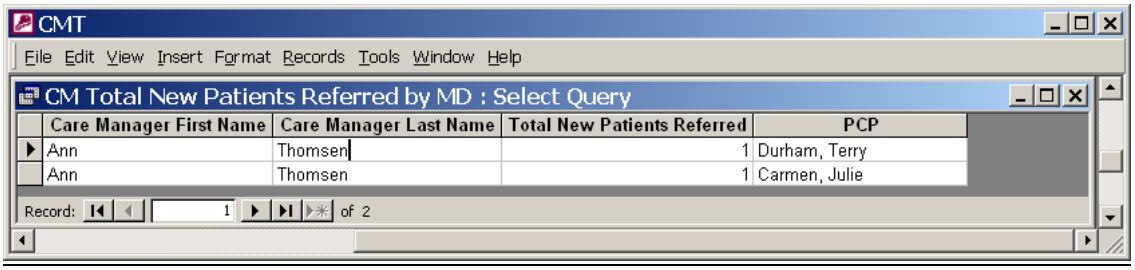


Figure 34

CM Resource Time:
Clicking on the "CM Resource Time" button will bring up the following query screen (Fig. 35). This query displays the Total Care Manager-Patient Encounter Resource Time within the entered date range, and the Average Resource Time for those Encounters.

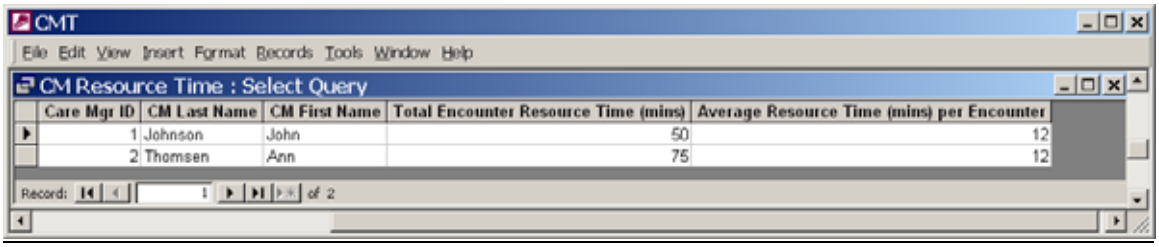


Figure 35

Admin Time

Administrative Time Information

Module to enter Care Manager time not spent on Patient Encounters such as meeting times, education, and vacation. (Fig. 36). Enter the Administrative Time Information. The total time for the day will be automatically calculated. Each day should be entered separately.

Click the "Save Day's Time" Button to save the record and close the window to return to the CMT Care Management Menu (Main Menu).

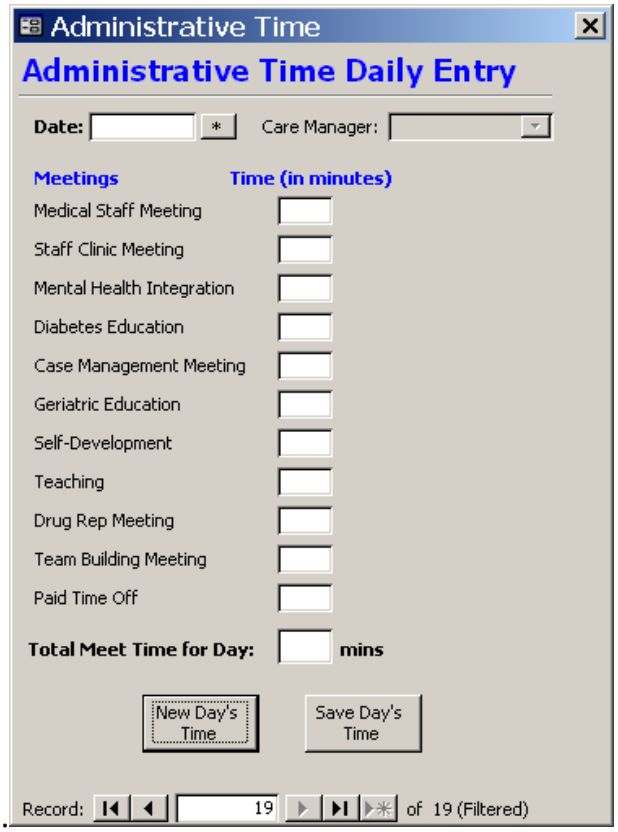


Figure 36

Administrative Time List

- Clicking on the "Administrative Time List" button will bring up the following Admin Time List Parameters screen (Fig. 37). The Administrative Time List generated is a summary report for all Care Manager database users generated from the Administrative Time Information module.

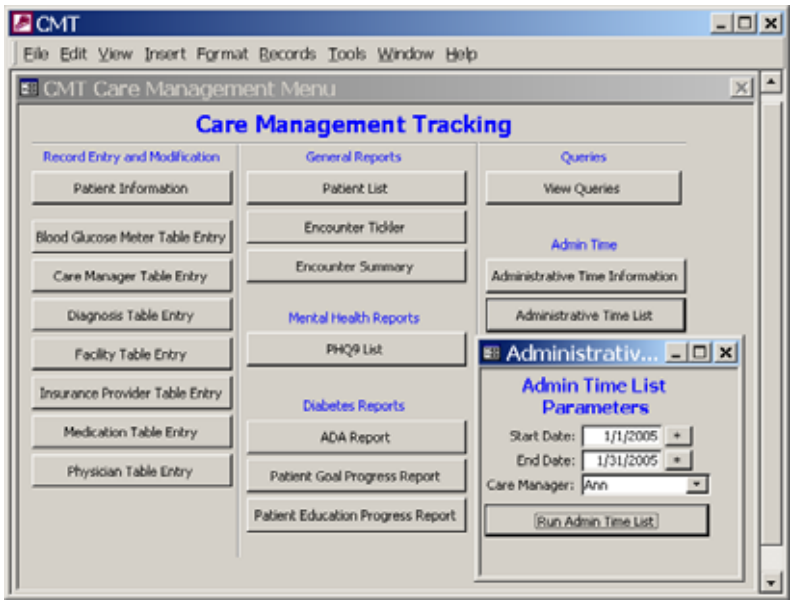


Figure 37

Click "Run Admin Time List" to run the report (Fig 38).

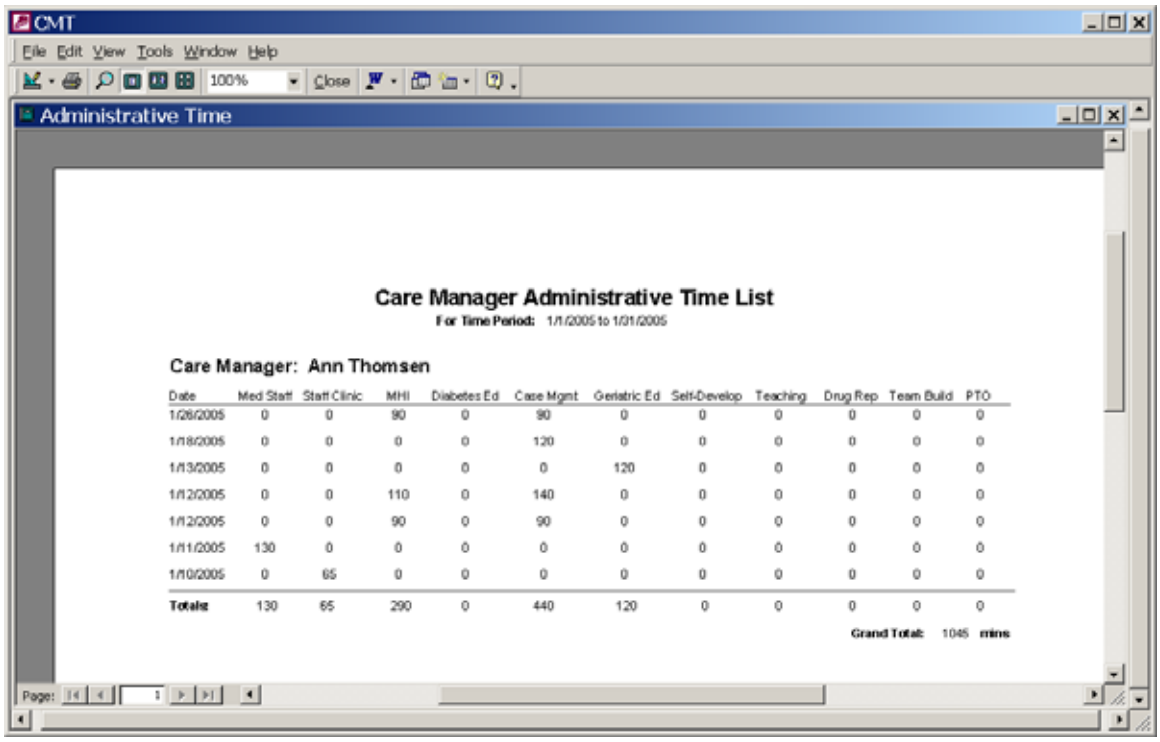


Figure 38

Tips for Entry / Data Integrity

- Using drop-downs—Always drop-down to select—NEVER type in an entry. If it needs to be added, do so in Value List from the Main Menu or request a change from your database administrator/programmer.

- Dates: If typing in a date, you must use the MM-DD-YYYY format (‘03’ instead of ‘2003’ will generate an error), or click on the “*” button for a pop-up calendar.

- Consult the Data Dictionary and/or Data Manager for your program when in doubt as to what to enter into a field.

Technical/Programmer Use Only

Following are instructions for revealing and hiding the tables of the CMT software so that programmers may customize it.

1) Right-click on the title bar of the CMT Care Management Menu.
2) Choose Form Design.
3) Right-click again on the title bar of the CMT Care Management Menu.
4) Choose Properties.
5) Scroll down to the Form's "On Load" property and click on the words "Event Procedure". Click the button with the 3 dots.
6) Change all the "False" booleans to "True".
7) Close out of the database (all the way).
8) Open it again 2 more times. The 3rd time you should see the database window.

After you make your changes,

Please go to "Tools" on the main Access toolbar. Choose Database Utilities and "Compact and Repair Database". It may take a few moments, but then your windows will pop back up.

Repeat the earlier steps to get to the code window or in Design view of the Main Menu choose View and "Code" from the main Access toolbar. In the SetStartUp Properties, change all of the "True"s back to “False”. Close out of the database and go back in 2 more times (3rd time's a charm!) to make sure the database window is no longer visible.

Data Element	Type/Control	Values	Required	Definition
PATIENT INFORMATION				
ID Number	Textbox	Numeric	Yes	Unique Number specific to a Patient in your organization
Last Name	Textbox	Free Text	Yes	Patient's Last Name
First Name	Textbox	Free Text	Yes	Patient's First Name (& Middle Initial, if desired)
DOB	Date field	Date MM/DD/YYYY	No	Patient's Date of Birth
Sex	Drop-down	M (Male); F (Female)	No	Patient's Gender
Status	Drop-down	Active; Closed; 1X Only	No	Patient's status with Care Manager
		Closed		*Deceased, Moved, etc.*
Date of Referral	Date field	Date MM/DD/YYYY	Yes	Date Patient was Referred/Assigned to Care Manager/Diabetes Educator
Care Mgr	Drop-down	From Care Manager Table/Values	Yes	Care Manager assigned to Patient
Phone	Textbox	Numeric (000) 000-0000	No	Patient's Contact Phone Number
Cell Phone	Textbox	Numeric (000) 000-0000	No	Patient's Cell Phone Number
Email	Textbox	Free Text	No	Patient's Email Address
PCP	Textbox	From Physician Table/Values	No	Patient's Primary Care Physician
PCP Phone	Textbox	Numeric (000) 000-0000	No	Patient's Primary Care Physician Phone Number
Insurance	Drop-down	From Insurance Table/Values	No	Patient's Primary Insurance carrier. Defaults to "Unknown" if not entered
Facility	Drop-down	From Facility Table/Values	No	Care Manager's Facility
FPP	Drop-down	1.Disconnected/Avoidance; 2.Confused/Chaotic; 3.Secured/Balanced	No	Patient's Family Pattern Profile: "An assessment of the relationship pattern/style that is most like the family of the patient."
Psychiatrist	Drop-down	From Physician Table/Values	No	Patient's Psychiatrist, if any
MH Specialist	Drop-down	From Physician Table/Values	No	Patient's MH Specialist, if any
APRN	Drop-down	From Physician Table/Values	No	Patient's APRN, if any

Data Element	Type/Control	Values	Required	Definition
PATIENT DIAGNOSIS				
Diag. Date	Date field	Date MM/DD/YYYY	Yes	Date Diagnosis Management began
Diagnosis	Drop-down	From Diagnosis Table/Values	Yes	Patient's Active Problem from Problem List
Specialist	Drop-down	From Physician Table/Values	No	Physician managing the Diagnosis
Status	Drop-down	Active; Resolved	No	Status of the Diagnosis
Notes	Textbox	Free Text	No	Notes relating to the Diagnosis
PATIENT ENCOUNTER				
Scheduled Date	Date field	Date MM/DD/YYYY	Yes	Date for Patient's scheduled phone call/visit
Scheduled Time	Time field	Time HH:MM AM/PM	No	Time for Patient's scheduled phone call/visit
Encounter Type	Drop-down	CM Office Visit; Class; MD Office Visit; Home Visit; Telephone Contact; Group Visit; MHI Conference; Email; Non-Encounter-Related; Diab Initial; Diab Followup; Diab Class 1; Diab Class 2; Diab Class 3; Diab Class 4; Diab Class 5; Diab Class 6; Diab Additional Class; Diab Inpatient; Diab Insulin Start	Yes	Type of Care Manager-Patient Encounter
		Class		*Patient Education*
		Non-Encounter-Related		*Filling out forms, admin, other charting, etc.*
Enc. Reason	Drop-down	DEA Screen; PHQ-9 F/U; MHI F/U; DM F/U; Depression F/U; DM/Depression F/U; Med. Assist.; Medication Mgmt Agreement; Status Check; Resource Management; New Patient	No	Reason for the Care Manager-Patient Encounter

Data Element	Type/Control	Values	Required	Definition
		Med. Assist. = Medication Assistance		Assisting Patients in obtaining Medications (Financial Assistance)
		Medication Mgmt Agreement		Agreement between Physician and Patient re: Narcotic use
		Resource Management		Assisting Patient with Referrals, Procurement, Research, etc. (ex: finding MDs or Nursing Home, obtaining equipment)
Actual Date	Date field	Date MM/DD/YYYY	No	Date Patient Encounter Actually took place
Outcome	Drop-down	Completed; No Show; Cancelled; Reschedule; Wrong Number; No Answer; Left Message; Letter Sent; Disconnected; Deceased	No	Outcome of Care Manager-Patient phone call/visit
		No Answer		*Includes Busy Signal*
Call Attempts to Pts	Drop-down	1;2;3;4;5+	No	Number of tries to reach Patient by Phone
Total Call Time for Day	Textbox	Numeric	No	Total Length of time on phone (in minutes) for the day for the Encounter
Number of Phone Calls	Textbox	Numeric	No	Total Number of phone calls for the Encounter
Resource Time	Textbox	Numeric	No	Total Time spent on any preparatory work, charting, travel, research, admin, etc. (in minutes) for the Encounter
Clinic Visit Time	Textbox	Numeric	No	Time spent on Patient Visit in Clinic (in minutes) - Face-to-face
Home Visit Time	Textbox	Numeric	No	Time spent on Patient Visit in Home (in minutes) - Face-to-face
Notes	Textbox	Free Text	No	Notes relating to the Care Manager-Patient Encounter
PATIENT MEDICATION				
Medication Start Date	Date Field	Date MM/DD/YYYY	No	Date Medication Started
Medication End Date	Date Field	Date MM/DD/YYYY	No	Date Medication Ended
Medication	Drop-down	Medications from Table/Values	Yes	Medication Name
PRN	Checkbox	Yes/No	No	Medication PRN?
Dose	Textbox	Free Text	No	Medication Dose

Data Element	Type/Control	Values	Required	Definition
Notes	Textbox	Free Text	No	Notes relating to the Patient Medication
MH (MENTAL HEALTH) INSTRUMENTS				
Date	Date field	Date MM/DD/YYYY	Yes	Date MH Instruments administered/recorded
Check Support				**CM Relational Isolation Assess**
Isolated from available support	Checkbox	Yes/No	No	Patient isolated from available support?
Unwilling to use available support	Checkbox	Yes/No	No	Patient unwilling to use available support?
Exhausted available support	Checkbox	Yes/No	No	Patient exhausted available support?
Has available support/actively using	Checkbox	Yes/No	No	Patient has available support/actively using?
Check Adherence				
Following recommendations	Checkbox	Yes/No	No	Patient following recommendations?
Taking medication	Checkbox	Yes/No	No	Patient taking medications?
Seeing therapist	Checkbox	Yes/No	No	Patient seeing therapist?
Self-Management	Checkbox	Yes/No	No	Patient practicing self management?
Identified Goal	Textbox	Free Text	No	Patient Identified Goal
Global Severity 1-7 (4)	Textbox	Numeric	No	Severity of Patient validated, standard measure of impairment over time
Care Conf	Checkbox	Yes/No	No	Include Patient at next MH Care Conference?
Referred to MH Off-site	Checkbox	Yes/No	No	Was Patient referred to MH off-site?
General Comments/Plan	Textbox	Free Text	No	General MH Comments for Patient
PHQ-9 (Depression)				
Symptom Count	Drop-down	0;1;2;3;4;5;6;7;8;9	No	Depression Symptoms Score based on the personal health questionnaire nine symptom checklist (PHQ-9) calculated by totaling the values for each depression symptom question.
Severity Score	Textbox	Numeric	No	Severity Score based on the personal health questionnaire nine symptom checklist (PHQ-9) calculated by totaling the values for each severity question
Functional Difficulty	Drop-down	Not at all; Somewhat; Very; Extreme	No	Level of difficulty or degree to which depression impacts daily activities (ex: doing work, taking care of things at home, or getting along with other people)

Data Element	Type/Control	Values	Required	Definition
Dysthymia?	Checkbox	Yes/No	No	Does Patient have Dysthymia? Steadman's defn: "A chronic mood disorder manifested as depression for most of the day, more days than not, accompanied by some of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness."
PHQ Suicide Q9	Drop-down	0;1;2;3	No	Suicide Score based on the personal health questionnaire nine symptom checklist (PHQ-9) calculated by totaling the values for each suicide question.
Suicide State	Drop-down	1. Thoughts Only; 2. Thoughts and Plans; 3. Thoughts/Plans/Actions	No	The state of risk for Suicide for the Patient
Suicide Risk	Drop-down	No Risk; Low Risk; Medium Risk; High Risk	No	Potential Patient has in taking his/her own life
Clinician Aware?	Checkbox	Yes/No	No	Is Clinician aware of Suicide risk?
Follow Up Required?	Checkbox	Yes/No	No	Follow-up needed for Suicide risk?
Suicide Comments	Textbox	Free Text	No	Comments relating to suicide
Mood and Anxiety / Sleep				
Mood Screen 1	Textbox	Numeric	No	Score (7)/13
Mood Screen 2	Textbox	Free Text	No	Y/N
Mood Screen 3	Textbox	Free Text	No	+\-
Symptom Rating Scales Sx-Mood	Textbox	Numeric	No	Score (40)/100
Symptom Rating Scales Sx-Anx	Textbox	Numeric	No	Score (30)/60
Symptom Rating Scales Imp-Mood	Textbox	Numeric	No	Score (10)/20
Symptom Rating Scales Imp-Anx	Textbox	Numeric	No	Score (10)/20
Mood Comments	Textbox	Free Text	No	Comments relating to Patient mood
Anxiety Comments	Textbox	Free Text	No	Comments relating to Patient anxiety
Sleep Assessment				
(Sleep) Difficulty?	Checkbox	Yes/No	No	Patient having difficulty sleeping?
(Sleep) Severity	Textbox	Numeric	No	Severity of Sleep Difficulty (Scale of 0-10)
Pediatric Only				

Data Element	Type/Control	Values	Required	Definition
Parent Vanderbilt (Only if ADHD)				
Parent Vanderbilt 1-9	Textbox	Numeric	No	Parent reported Vanderbilt Questions 1-9
Parent Vanderbilt 10-18	Textbox	Numeric	No	Parent reported Vanderbilt Questions 10-18
Parent Vanderbilt 19-26	Textbox	Numeric	No	Parent reported Vanderbilt Questions 19-26
Parent Vanderbilt 27-40	Textbox	Numeric	No	Parent reported Vanderbilt Questions 27-40
Parent Vanderbilt 41-47	Textbox	Numeric	No	Parent reported Vanderbilt Questions 41-47
Parent Vanderbilt 48-55	Textbox	Numeric	No	Parent reported Vanderbilt Questions 48-55
Teacher Vanderbilt (Only if ADHD)				
Teacher Vanderbilt 1-9	Textbox	Numeric	No	Teacher reported Vanderbilt Questions 1-9
Teacher Vanderbilt 10-18	Textbox	Numeric	No	Teacher reported Vanderbilt Questions 10-18
Teacher Vanderbilt 19-26	Textbox	Numeric	No	Teacher reported Vanderbilt Questions 19-26
Teacher Vanderbilt 27-40	Textbox	Numeric	No	Teacher reported Vanderbilt Questions 27-40
Teacher Vanderbilt 41-47	Textbox	Numeric	No	Teacher reported Vanderbilt Questions 41-47
Teacher Vanderbilt 48-55	Textbox	Numeric	No	Teacher reported Vanderbilt Questions 48-55
Vanderbilt Comments	Textbox	Free Text	No	Comments relating to Patient Vanderbilt Scores
Symptom Rating Scales Sx-Dev	Textbox	Numeric	No	Score /40 - Developmental (Intake Only)
Symptom Rating Scales Sx-Dep	Textbox	Numeric	No	Score /100 - Pediatric Depression
Symptom Rating Scales Imp-Dev	Textbox	Numeric	No	Score /20 - Developmental (Intake Only)
Symptom Rating Scales Imp-Dep	Textbox	Numeric	No	Score /20 - Pediatric Depression
YOQ-Youth?	Checkbox	Yes/No	No	YOQ-Youth administered?
YOQ-Youth Score	Textbox	Free Text	No	YOQ-Youth Score
Develop. Comments	Textbox	Free Text	No	Comments relating to Development
Depress. Comments	Textbox	Free Text	No	Comments relating to Depression
FUNCTION				
Assessment Date	Date Field	Date MM/DD/YYYY	Yes	Date of Function Assessment
Activities of Daily Living Question 1	Checkbox	Yes/No	No	ADL Question: Is Patient able to "Get out of bed or chair" without help?
Activities of Daily Living Question 2	Checkbox	Yes/No	No	ADL Question: Is Patient able to "Walk" without help?
Activities of Daily Living Question 3	Checkbox	Yes/No	No	ADL Question: Is Patient able to "Take a Bath or Shower" without help?
Activities of Daily Living Question 4	Checkbox	Yes/No	No	ADL Question: Is Patient able to "Get dressed" without help?

Data Element	Type/Control	Values	Required	Definition
Activities of Daily Living Question 5	Checkbox	Yes/No	No	ADL Question: Is Patient able to "Go to the toilet" without help?
Activities of Daily Living Question 6	Checkbox	Yes/No	No	ADL Question: Is Patient able to "Feed self a meal" without help?
ADL	Textbox	Numeric	No	Activities of Daily Living Score (Values 1 to 6)
Instrumental Activities of Daily Living Question 1	Checkbox	Yes/No	No	IADL Question: Is Patient able to "Shop" without help?
Instrumental Activities of Daily Living Question 2	Checkbox	Yes/No	No	IADL Question: Is Patient able to "Use a telephone" without help?
Instrumental Activities of Daily Living Question 3	Checkbox	Yes/No	No	IADL Question: Is Patient able to "Cook" without help?
Instrumental Activities of Daily Living Question 4	Checkbox	Yes/No	No	IADL Question: Is Patient able to "Travel outside the home" without help?
Instrumental Activities of Daily Living Question 5	Checkbox	Yes/No	No	IADL Question: Is Patient able to do "Bills, Checkbooks, Finances" without help?
Instrumental Activities of Daily Living Question 6	Checkbox	Yes/No	No	IADL Question: Is Patient able to do "Housekeeping" without help?
Instrumental Activities of Daily Living Question 7	Checkbox	Yes/No	No	IADL Question: Is Patient able to "Take Medications" without help?
IADL	Textbox	Numeric	No	Instrumental Activities of Daily Living Score (Values 1 to 7)
MMSE	Textbox	Numeric	No	Mini Mental Status Examination Score
Pain Score	Textbox	Numeric	No	Pain Score (Scale 0-10)
Notes	Textbox	Free Text	No	Comments relating to Function