Care Management Tracking (CMT) Software
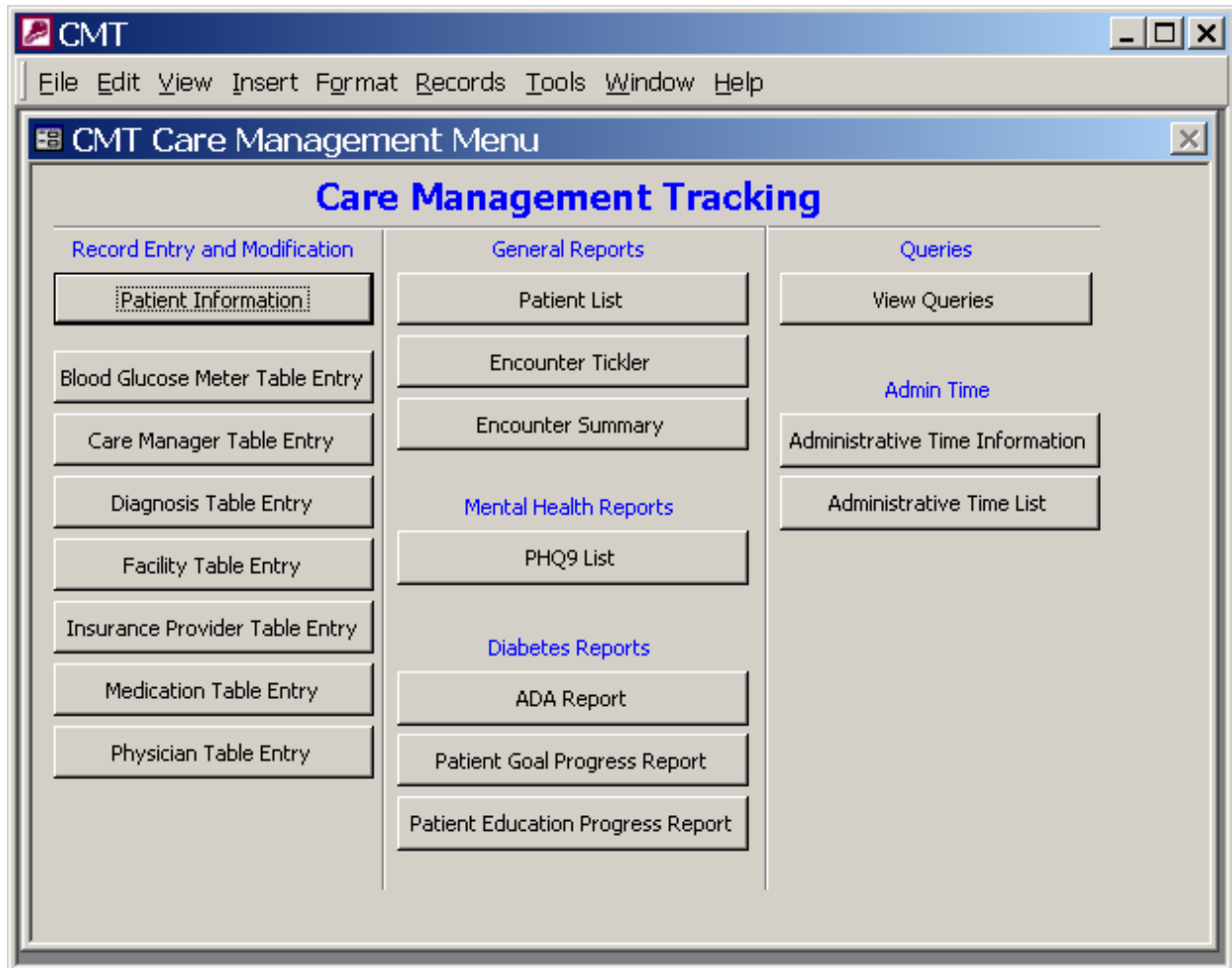# User Manual (General Use)

Care Manager Tracking (CMT) Software

Table of Contents

Care Manager Tracking (CMT) Software

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)
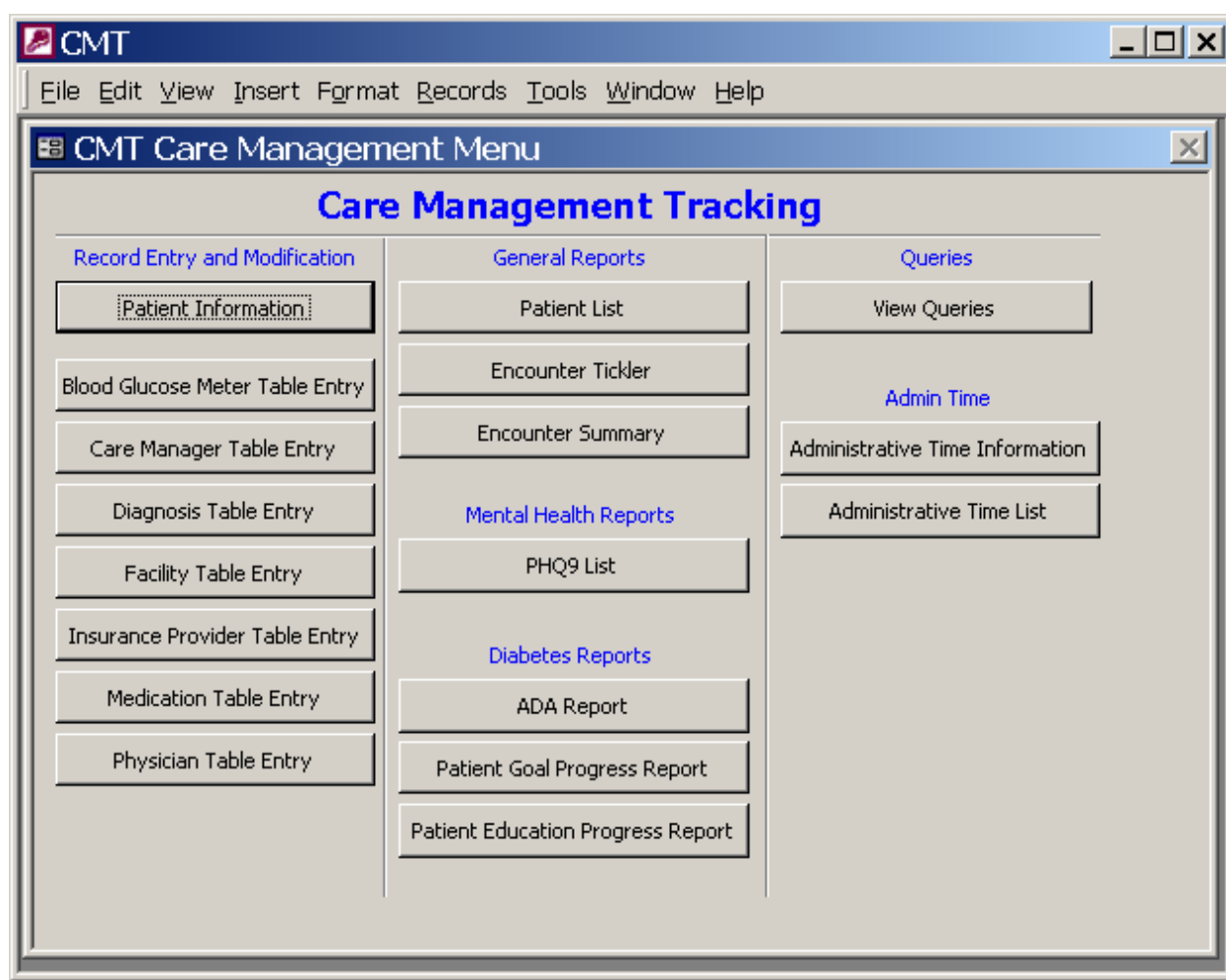

Figure 1

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 Blood Glucose Meters, 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".
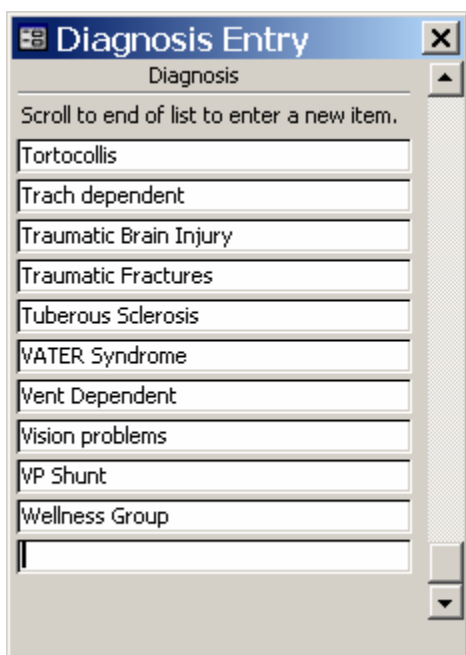

Figure 2

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.
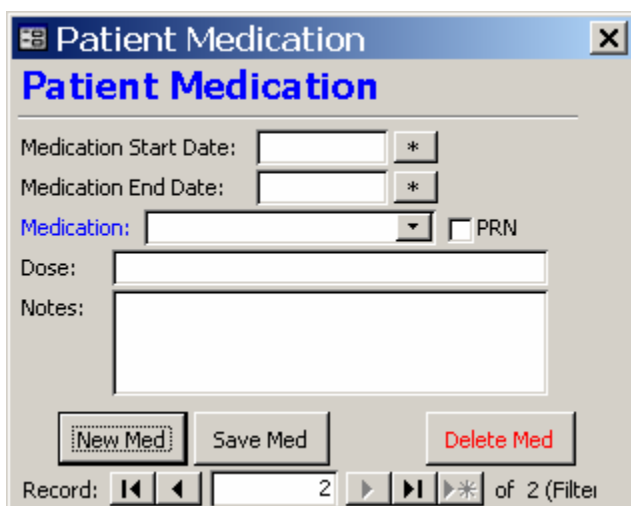

Figure 5

- **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

- **Pediatric Assess:**

  Clicking this button will bring up the following Individual Health Plan (Pediatric Assessment) screen (Fig. 8). Enter the Pediatric Assessment information. Please note that you may also print a copy of this screen/form by clicking the "Print Ped Assessment" button on the bottom left of the screen.

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

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

Figure 8

- **Diabetes History:**

  Clicking this button will bring up the following Diabetes Assessment screen (Fig. 9). Enter the Diabetes Assessment information. Default values for checkboxes are "No", and defaults for drop-downs are "Never", "None" or "Not At All", as indicated in Figure 9. Please note that you may also print a copy of this screen/form by clicking the "Print Assessment" button on the bottom left of the screen.

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

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

Figure 9

- **Pre/Post Knowledge Assess:**

  Clicking this button will bring up the following Diabetes Education Assessment screen (Fig. 10). Enter the Diabetes Education Assessment information. **Please note**: The Patient Name field at the top of the screen will be automatically populated from the Patient record you are currently viewing. Also, you may print a copy of this screen/form by clicking the "Print Assessment" button on the bottom left of the screen.

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

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

Figure 10

- **Patient Goals:**

  Clicking this button will bring up the following Patient Goals screen (Fig. 11). Enter the Patient Goals information. Default values for scores are zero. **Please note**: The Patient ID field at the top right of the screen will be automatically populated from the Patient record you are currently viewing. Also, you may print a copy of this screen/form by clicking the "Print Goals" button on the bottom left of the screen.

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

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

Figure 11

- **HF Follow-Up:**

  Clicking this button will bring up the following Heart Failure Follow-Up screen (Fig. 12). Enter the Follow-Up information. Please note that you may also print a copy of this screen/form by clicking the "Print Follow-Up" button on the bottom left of the screen.

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

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

Figure 12

- **Function:**

  Clicking this button will bring up the following Function screen (Fig. 13). Enter the Function information.

  Required fields are in blue (Omitting these fields will generate a pop-up error message when you save the form):
  - o 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 13

- 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. 14) 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 14

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. 15). 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.
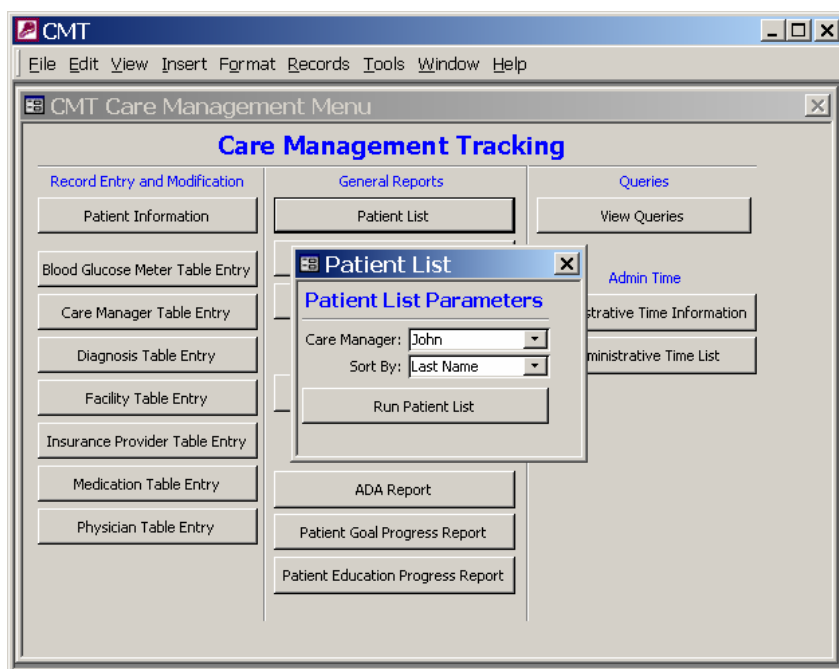
Figure 15

Click "Run Patient List" to run the report (Fig. 16).
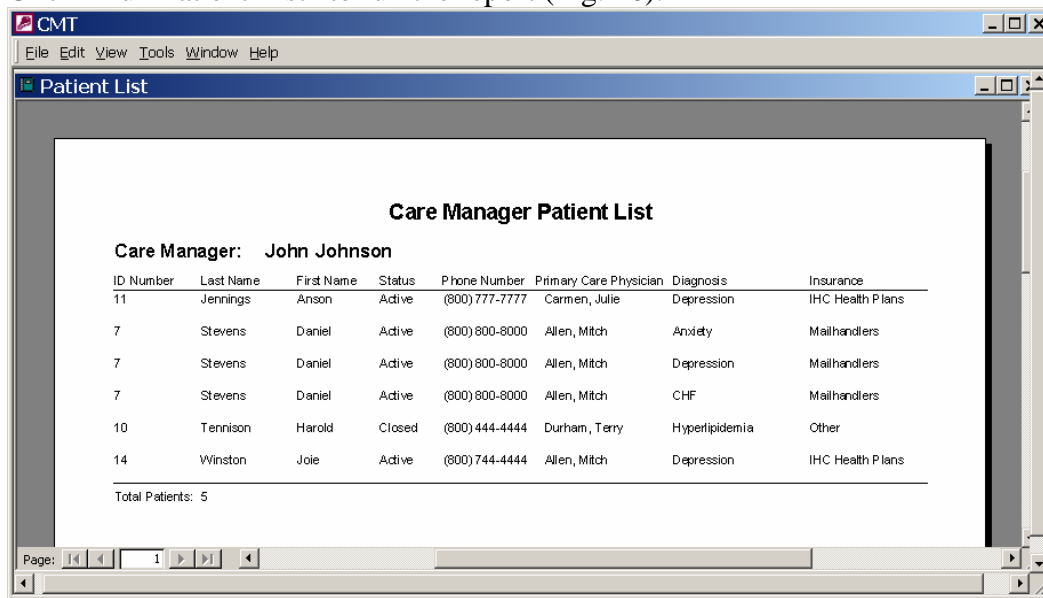
Figure 16

Encounter Tickler

- Clicking on the "Encounter Tickler" button will bring up the following Tickler List Parameters screen (Fig. 17). 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.
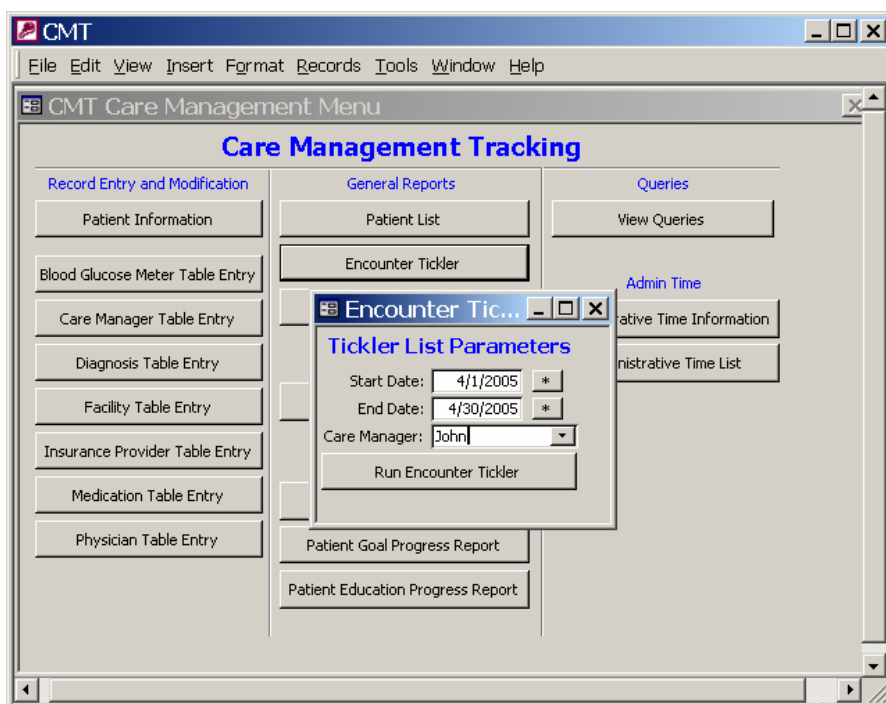
Figure 17

Click "Run Encounter Tickler" to run the report (Fig. 18).
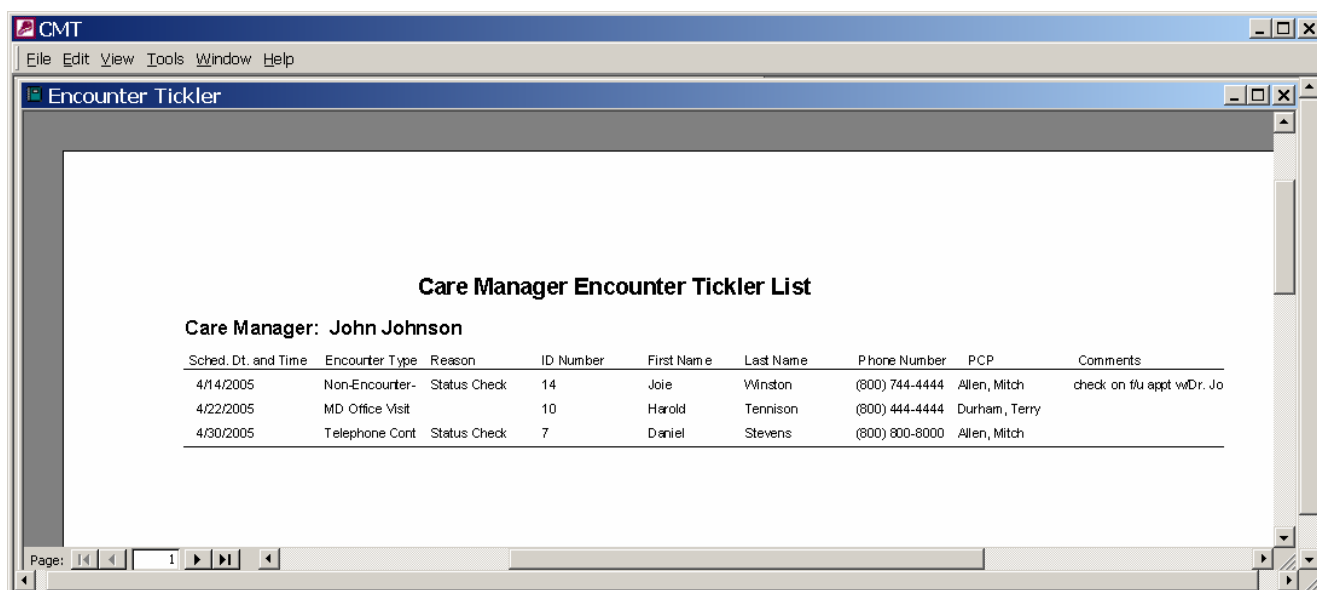
Figure 18

Encounter Summary

- Clicking on the "Encounter Summary" button will bring up the following Encounter Summary List Parameters screen (Fig. 19). 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.
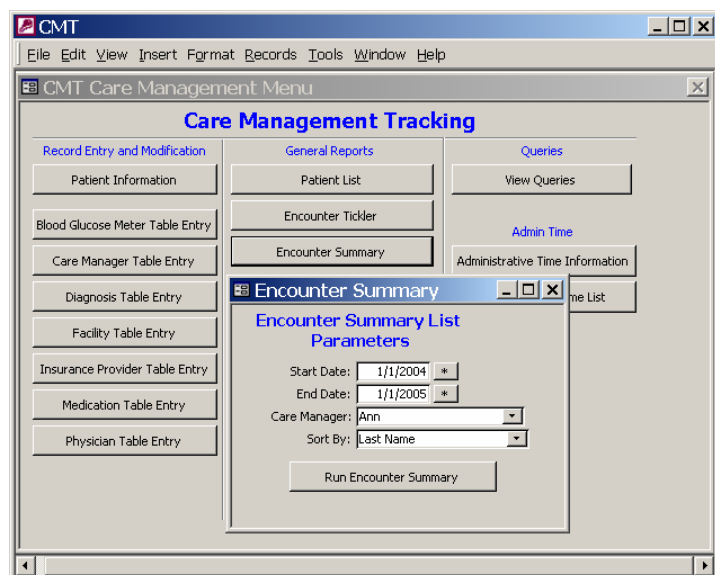
Figure 19

Click "Run Encounter Summary" to run the report (Fig. 20).

Figure 20

Mental Health Reports

PHQ9 List

- Clicking on the "PHQ9 List" button will bring up the following PHQ9 List Parameters screen (Fig. 21). 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.
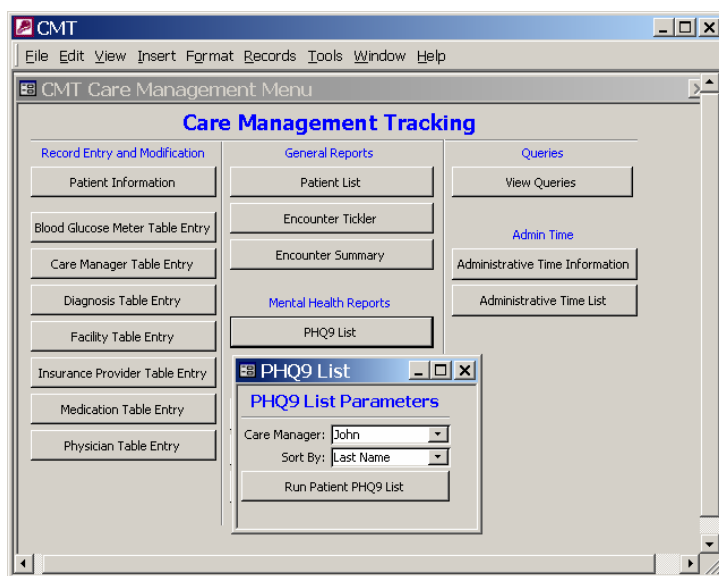
Figure 21

Click "Run Patient PHQ9 List" to run the report (Fig. 22).

Figure 22

Diabetes Reports

ADA Report

- Clicking on the "ADA Report" button will bring up the following ADA Report Parameters screen (Fig. 23). The ADA Report generated is a summary report by date range for submission to the American Diabetes Association.

Figure 23

Click "Run ADA Report" to run the report (Fig. 24).

Figure 24

Patient Goal Progress Report

- Clicking on the "Patient Goal Progress Report" button will bring up the following Patient Goal Progress Parameters screen (Fig. 25). The Patient Goal Progress Report generated is a summary report generated from the Patient Goal screen sorted by Care Manager/Diabetes Educator.
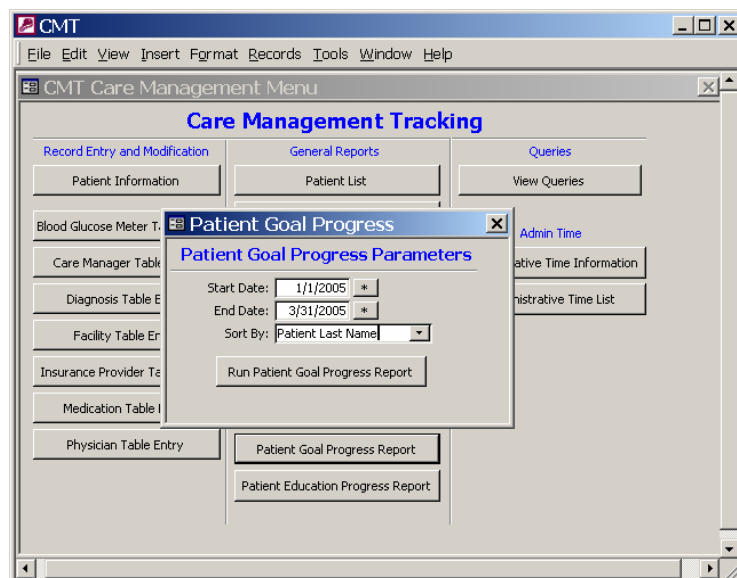
Figure 25

Click "Run Patient Goal Progress Report" to run the report (Fig. 26).

Figure 26

Patient Education Progress Report

- Clicking on the "Patient Education Progress Report" button will bring up the following Patient Education Progress Report Parameters screen (Fig. 27). The Patient Education Progress Report generated is a summary report generated from the Patient Diabetes Education Assessment screen for the selected Care Manager/Diabetes Educator.
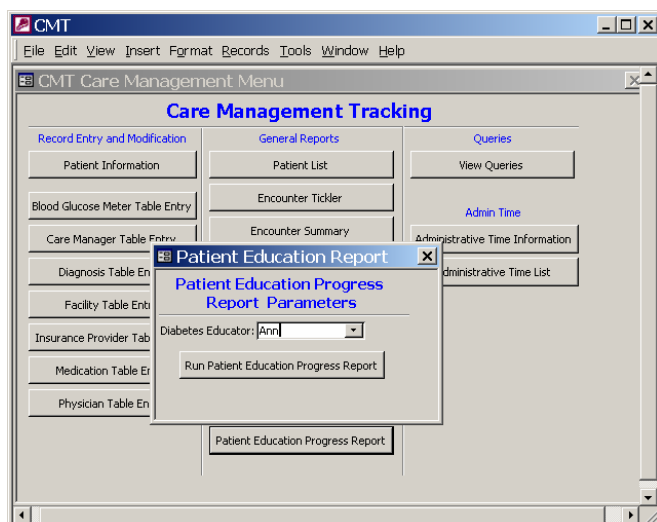
Figure 27

Click "Run Patient Education Progress Report" to run the report (Fig. 28).
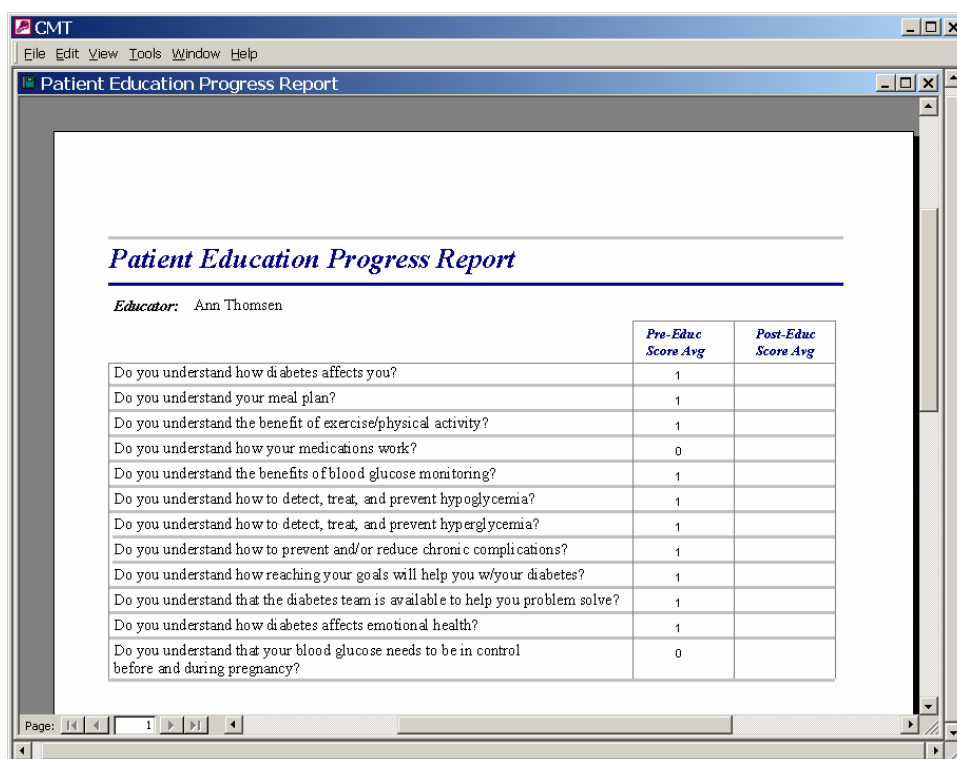
Figure 28

Queries

View Queries

Clicking on the "View Queries" button will bring up the following Queries screen (Fig. 29).

- Generate queries by entering a date range (Start and End Date) and choosing the button corresponding to the query you wish to run. If a button has red text, no date entry is required to run the query.
- 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.
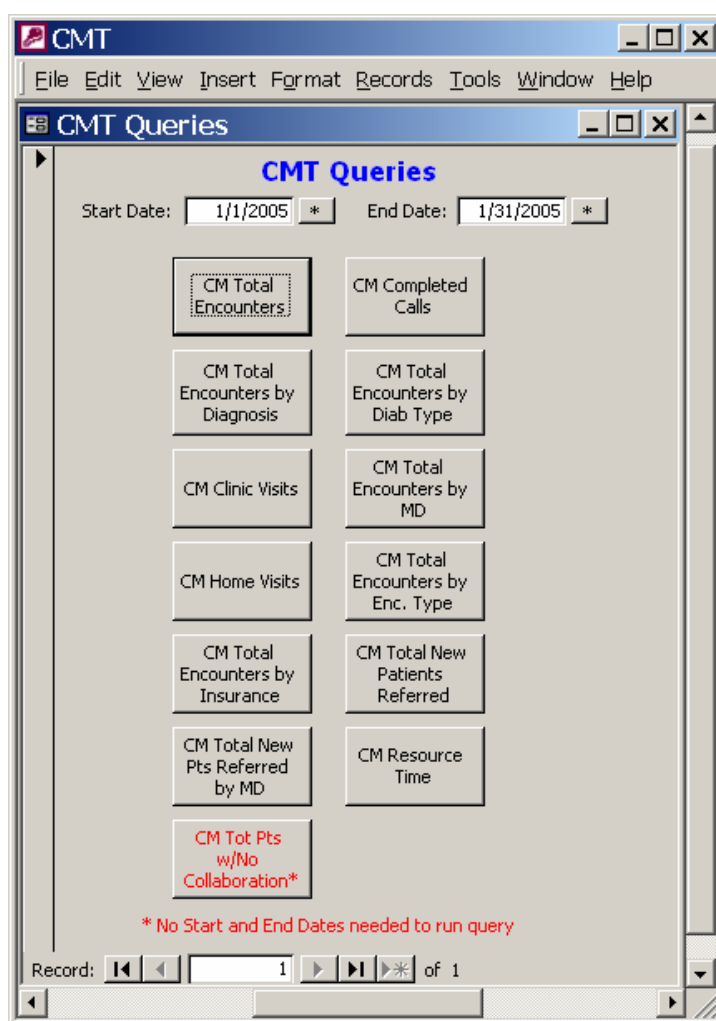
Figure 29

CM Total Encounters:
Clicking on the "CMT Total Encounters" button will bring up the following query screen (Fig. 30). This query displays the number of Care Manager-Patient Encounters falling within the entered date range.

Figure 30

CM Completed Calls:
Clicking on the "CM Completed Calls" button will bring up the following query screen (Fig. 31). 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 31

CM Total Encounters by Diagnosis:
Clicking on the "CM Total Encounters by Diagnosis" 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 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. 32). Rather it suggests that there were 6 encounters within this time period with Patients who have Diabetes in the Problem List.

Figure 32

CM Total Encounters by Diab Type:
Clicking on the "CM Total Encounters by Diab Type" button will bring up the following query screen (Fig. 33). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Diabetes Type. The Type of Diabetes with which a Patient has been diagnosed is recorded on the Diabetes History/Assessment screen.

Figure 33

CM Clinic Visits:
Clicking on the "CM Clinic Visits" button will bring up the following query screen (Fig. 34). 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 34

CM Total Encounters by MD:
Clicking on the "CM Total Encounters by MD" button will bring up the following query screen (Fig. 35). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Primary Care Physician.

Figure 35

CM Home Visits:
Clicking on the "CM Home Visits" button will bring up the following query screen (Fig. 36). 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 36

CM Total Encounters by Enc. Type:
Clicking on the "CM Total Encounters by Enc. Type" button will bring up the following query screen (Fig. 37). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Type of Encounter.

Figure 37

CM Total Encounters by Insurance:
Clicking on the "CM Total Encounters by Insurance" button will bring up the following query screen (Fig. 38). This query displays the number of Care Manager-Patient Encounters falling within the entered date range, sorted by Insurance Provider and Patient Status.

Figure 38

CM Total New Patients Referred:
Clicking on the "CM Total New Patients Referred" button will bring up the following query screen (Fig. 39). This query displays the number of New Patients referred to the Care Manager with a Date of Referral within the entered date range.

Figure 39

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. 40). 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 40

CM Resource Time:
Clicking on the "CM Resource Time" button will bring up the following query screen (Fig. 41). 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 41

CM Tot Pts w/No Collaboration:
Clicking on the "CM Total Pts w/No Collaboration" button will bring up the following query screen (Fig. 42). This query displays the Number of Patients for which there has been no collaboration for Diabetes recorded (as evidenced by an unchecked "Diab Collaboration" checkbox on the main Patient Information form). This query is mainly used as a "check" to identify those Patients who need collaboration, which will also be displayed on the ADA Report accessible from the Main Menu.
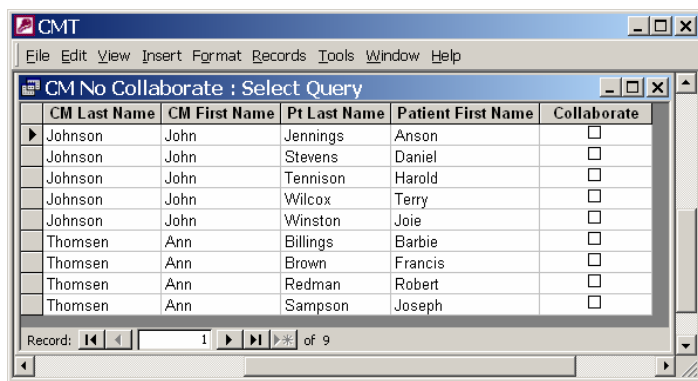
Figure 42

Admin Time:

Administrative Time Information

Module to enter Care Manager time not spent on Patient Encounters such as meeting times, education, and vacation (Fig. 43). 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 43

Administrative Time List

- Clicking on the "Administrative Time List" button will bring up the following Admin Time List Parameters screen (Fig. 44). The Administrative Time List generated is a summary report for all Care Manager database users generated from the Administrative Time Information module.
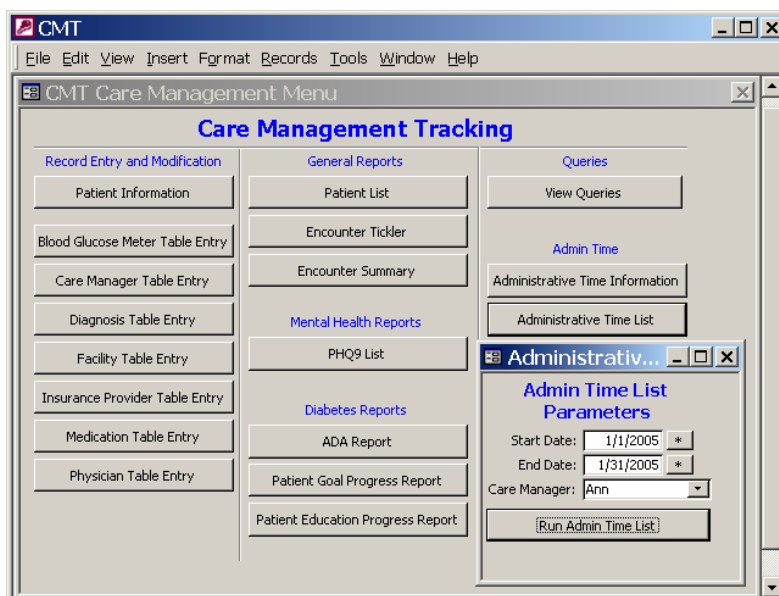
Figure 44

Click "Run Admin Time List" to run the report (Fig. 45).

Figure 45

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
Age	Drop-down	<19; 19-44; 45-64; >= 65	No	Automatically calculated from Patient's DOB
Race	Drop-down	White/Caucasian; Am Indian/Alaskan Native; Black/African Am; Asian/Chinese/Japanese/Korean/Pacific Islander; Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino	No	Patient's Race Classification
Sex	Drop-down	M (Male); F (Female)	No	Patient's Gender
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
Diab Collaboration	Checkbox	Yes/No	No	Has at least 1 RN and 1 RD, as Diabetes Education Instructors, collaborated on Patient?
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."
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

Data Element	Type/Control	Values	Required	Definition
Status	Drop-down	Active; Closed; 1X Only	No	Patient's status with Care Manager
		Closed		*Deceased, Moved, etc.*
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. Defaults to "Active".
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.*

Data Element	Type/Control	Values	Required	Definition
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
		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

Data Element	Type/Control	Values	Required	Definition
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
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.

Data Element	Type/Control	Values	Required	Definition
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)
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

Data Element	Type/Control	Values	Required	Definition
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				
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
PEDIATRIC ASSESSMENT (Individual Health Plan)				
Ped Assess Date	Date field	Date MM/DD/YYYY	Yes	Date of Patient's Pediatric Assessment

Data Element	Type/Control	Values	Required	Definition
Consultants/Specialty/Phone # (6 fields)	Textbox	Free Text	No	Consultants working with the Patient (includes Consultant specialty and phone)
Home Care Nursing				
Agency Name	Textbox	Free Text	No	Home Care Nursing Agency Name
(Agency) Contact	Textbox	Free Text	No	Home Care Nursing Agency Contact Person
(Agency) Phone	Textbox	Numeric (000) 000-0000	No	Home Care Nursing Agency Phone
Services Ordered	Textbox	Free Text	No	Services ordered from Home Care Nursing Agency
Home Care Equipment				
Home Care Equipment Company Name	Textbox	Free Text	No	Home Care Equipment Company Name
(Company) Phone	Textbox	Numeric (000) 000-0000	No	Home Care Equipment Company Phone
O2 Stationary/Portable	Checkbox	Yes/No	No	Is Patient using stationary/portable O2?
Apnea Monitor	Checkbox	Yes/No	No	Is Patient using an apnea monitor?
Trach Tube	Checkbox	Yes/No	No	Does Patient have a trach tube?
Trach Tube type/size	Textbox	Free Text	No	If Patient has trach tube, what is the type and/or size of the tube?
Cuff Yes	Checkbox	Yes/No	No	Is Patient using a cuff?
Cuff No	Checkbox	Yes/No	No	Is Patient NOT using a cuff?
Formula	Checkbox	Yes/No	No	Is Patient on formula?
Formula (text)	Textbox	Free Text	No	If Patient is on formula, formula name and/or notes
N/G Tube	Checkbox	Yes/No	No	Is Patient using an N/G tube?
Carseat	Checkbox	Yes/No	No	Is Patient using a Carseat?
BP Monitor	Checkbox	Yes/No	No	Is Patient using a BP Monitor?
O2 oximeter (SAT)	Checkbox	Yes/No	No	Is Patient using an O2 oximeter?
Suction Machine/supplies	Checkbox	Yes/No	No	Is Patient using Suction Machine/supplies?
Vent	Checkbox	Yes/No	No	Is Patient using a Vent?
Vent Type	Textbox	Free Text	No	If Patient using Vent, what type?
Feeding Pump/supplies	Checkbox	Yes/No	No	Is Patient using Feeding Pump/supplies?
GT/GJ	Checkbox	Yes/No	No	Is Patient using GT/GJ?
GT/GJ Type	Textbox	Free Text	No	If Patient using GT/GJ, what is the type?
GT/GJ Size	Textbox	Free Text	No	If Patient using GT/GJ, what is the size?
Wheelchair	Checkbox	Yes/No	No	Is Patient using a Wheelchair?
Other	Checkbox	Yes/No	No	Is Patient using other Home Care Equipment?

Data Element	Type/Control	Values	Required	Definition
Other (text)	Textbox	Free Text	No	Other Home Care Equipment items/notes
Home Care Comments	Textbox	Free Text	No	Comments relating to Home Care
Developmental/Rehab				
Company Name	Textbox	Free Text	No	Developmental/Rehab Company Name
(Company) Phone	Textbox	Numeric (000) 000-0000	No	Developmental/Rehab Company Phone
PT	Checkbox	Yes/No	No	Patient in Physical Therapy?
PT (text)	Textbox	Free Text	No	Comments relating to Physical Therapy
Speech	Checkbox	Yes/No	No	Patient in Speech Therapy?
Speech (text)	Textbox	Free Text	No	Comments relating to Speech Therapy
OT	Checkbox	Yes/No	No	Patient in Occupational Therapy?
OT (text)	Textbox	Free Text	No	Comments relating to Occupational Therapy
Vision	Checkbox	Yes/No	No	Patient in Vision Therapy?
Vision (text)	Textbox	Free Text	No	Comments relating to Vision Therapy
Developmental/Rehab Comments	Textbox	Free Text	No	Comments relating to Developmental/Rehab
School				
School	Textbox	Free Text	No	Patient's School
(School) Phone	Textbox	Numeric (000) 000-0000	No	Patient's School Phone
Community Resources				
DSPD Case Worker	Textbox	Free Text	No	Patient's DSPD Case Worker
(DSPD Case Worker) Phone	Textbox	Numeric (000) 000-0000	No	Patient's DSPD Case Worker Phone
DSPD Applied	Checkbox	Yes/No	No	Has Patient/Family Applied for DSPD?
DSPD Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for DSPD?
DSPD Denied	Checkbox	Yes/No	No	Has Patient/Family been denied DSPD?
SSI Applied	Checkbox	Yes/No	No	Has Patient/Family Applied for SSI?
SSI Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for SSI?
SSI Denied	Checkbox	Yes/No	No	Has Patient/Family been denied SSI?
Waiver Program Technology Dependent Children	Checkbox	Yes/No	No	Waiver Program Technology Dependent Children?
Waiver Program TBI	Checkbox	Yes/No	No	Waiver Program TBI?
Waiver Program DDMR	Checkbox	Yes/No	No	Waiver Program DDMR?
Waiver Program Applied	Checkbox	Yes/No	No	Has Patient/Family applied for Waiver Program?
Waiver Program Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for Waiver Program?
Waiver Program Denied	Checkbox	Yes/No	No	Has Patient/Family been denied Waiver Program?

Data Element	Type/Control	Values	Required	Definition
Workforce Service Food Stamps	Checkbox	Yes/No	No	Workforce Service Food Stamps?
Workforce Service Child Care	Checkbox	Yes/No	No	Workforce Service Child Care?
Workforce Service Applied	Checkbox	Yes/No	No	Has Patient/Family applied for Workforce Service?
Workforce Service Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for Workforce Service?
Workforce Service Denied	Checkbox	Yes/No	No	Has Patient/Family been denied Workforce Service?
WIC Applied	Checkbox	Yes/No	No	Has Patient/Family applied for WIC?
WIC Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for WIC?
WIC Denied	Checkbox	Yes/No	No	Has Patient/Family been denied WIC?
Housing Assistance Applied	Checkbox	Yes/No	No	Has Patient/Family applied for Housing Assistance?
Housing Assistance Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for Housing Assistance?
Housing Assistance Denied	Checkbox	Yes/No	No	Has Patient/Family been denied Housing Assistance?
Medicaid Caseworker	Textbox	Free Text	No	Medicaid Caseworker assigned to Patient
(Medicaid Caseworker) Phone	Textbox	Numeric (000) 000-0000	No	Patient's Medicaid Caseworker Phone
Medicaid Applied	Checkbox	Yes/No	No	Has Patient/Family applied for Medicaid?
Medicaid Accepted	Checkbox	Yes/No	No	Has Patient/Family been accepted for Medicaid?
Medicaid Denied	Checkbox	Yes/No	No	Has Patient/Family been denied Medicaid?
Community Resources Comments	Textbox	Free Text	No	Comments relating to Community Resources
Mental Health				
Mental Health	Textbox	Free Text	No	Comments relating to Mental Health
Phone	Textbox	Numeric (000) 000-0000	No	Mental Health Professional Phone
Other				
Other (text)	Textbox	Free Text	No	Other Comments
Last Revision Date	Textbox	Date MM/DD/YYYY	No	Date Pediatric Assessment last revised
DIABETES HX/ASSESSMENT				
Assess Date	Date field	Date MM/DD/YYYY	Yes	Date of the Diabetes Assessment
Diabetes Type	Drop-down	Type 1; Type 2 Diet; Type 2 Oral; Type 2 Oral/Insulin; Type 2 Insulin; GDM; Pre-Diabetes/IGT	No	Patient's Diabetes Type

Data Element	Type/Control	Values	Required	Definition
Special Needs	Drop-down	Visual Impairment; Hearing Impairment; Low Literacy; Eng 2nd Language	No	Patient Special Needs
Smoker?	Checkbox	Yes and No Fields	No	Does Patient smoke?
Drinker?	Checkbox	Yes and No Fields	No	Does Patient drink alcohol?
History				
Hypertension	Checkbox	Yes and No Fields	No	Does Patient have a history of Hypertension?
Heart Attack/Heart Disease	Checkbox	Yes and No Fields	No	Does Patient have a history of Heart Attack/Heart Disease?
High Cholesterol	Checkbox	Yes and No Fields	No	Does Patient have a history of High Cholesterol?
Family Hx Diabetes	Checkbox	Yes and No Fields	No	Does Patient have a family history of Diabetes?
How long have you had Diabetes?	Textbox	Free Text	No	How long has Patient had Diabetes?
Hospitalized for Diabetes in last year?	Checkbox	Yes and No Fields	No	Has Patient been hospitalized for the Problem of Diabetes in the last year?
If Yes (Hospitalized), Explain	Textbox	Free Text	No	If Patient has been hospitalized for Diabetes in the last year, details
Height/Weight				
Height (ft)	Textbox	Free Text	No	Patient Height (in feet)
Height (in)	Textbox	Free Text	No	Patient Height (in inches)
Weight (lbs)	Textbox	Free Text	No	Patient Weight (in lbs)
Weight Change in last 6 months?	Checkbox	Yes and No Fields	No	Any Patient Weight change in the last 6 months?
Do you want to lose weight?	Checkbox	Yes and No Fields	No	Does Patient want to lose weight?
At what weight have you felt healthy?	Textbox	Free Text	No	Weight (in lbs) at which Patient felt most healthy
Are you experiencing any of the following now?				
Blurred vision	Checkbox	Yes and No Fields	No	Patient now experiencing blurred vision?
Fatigue	Checkbox	Yes and No Fields	No	Patient now experiencing fatigue?
Frequent Infections	Checkbox	Yes and No Fields	No	Patient now experiencing frequent infections?
Increased Thirst	Checkbox	Yes and No Fields	No	Patient now experiencing increased thirst?
Increased Urination	Checkbox	Yes and No Fields	No	Patient now experiencing increased urination?
Numbness, tingling, pain in hands and feet	Checkbox	Yes and No Fields	No	Patient now experiencing numbness, tingling, or pain in hands/feet?

Data Element	Type/Control	Values	Required	Definition
Sores that won't heal	Checkbox	Yes and No Fields	No	Patient now experiencing sores that won't heal?
Pain/Tightness in Chest	Checkbox	Yes and No Fields	No	Patient now experiencing pain/tightness in chest?
Stress	Checkbox	Yes and No Fields	No	Patient now experiencing Stress?
Sexual Difficulty	Checkbox	Yes and No Fields	No	Patient now experiencing Sexual Difficulty?
Other Medical Conditions	Textbox	Free Text	No	Patient's Other Medical Conditions not listed above
Financial Concerns?	Checkbox	Yes and No Fields	No	Does Patient have financial concerns?
Monitoring				
Last Diabetes Foot Exam	Drop-down	Never; Within the last year; Within the last 2 years, > 2 years ago	No	Time frame for Patient's last Diabetes Foot Exam
Last Dilated Eye Exam	Drop-down	Never; Within the last year; Within the last 2 years, > 2 years ago	No	Time frame for Patient's last Dilated Eye Exam
Last Dental Exam	Drop-down	Never; Within the last 6 months; Within the last year; Within the last 2 years, > 2 years ago	No	Time frame for Patient's last Dental Exam
Do you have a Blood Glucose Meter?	Checkbox	Yes and No Fields	No	Does Patient have a blood glucose meter?
(If Meter), Type	Drop-down	None; Bayer Ascensia; Bayer Dex; Bayer Glucometer Elite; Chronimed; Lifescan SureStep; Lifescan Ultra; Lifescan Ultra Smart; One Touch Basic; Other; Precision Extra; Precision QID; Precision SofTac; Prestige; Profile; Roche AccuCheck Active; Roche AccuCheckAdvantage; Roche AccuCheck Compact; Therasense Flash; Therasense Freestyle	No	Type/Brand of Patient's blood glucose meter

Data Element	Type/Control	Values	Required	Definition
(If Meter), Approx. how old is it?	Drop-down	< 1 year old; 2 years old; 3 years old; 4 years old; 5 years old; > 5 years old	No	Approximate Age of Patient's blood glucose meter
(If Meter), How often do you test?	Drop-down	Not at all; 2 or 3 times weekly; 1-2 times daily; 3-4 times daily; 5-8 times daily; > 8 times daily	No	Patient Testing Frequency with blood glucose meter
Date of Last HgbA1C	Drop-down	Never; Unknown; Within the last 3 mos.; Within the last 6 mos.; Within the last year; > 1 year ago	No	Date of Patient's last HgbA1C test
Result HgbA1C	Textbox	Free Text	No	Result of Patient's last HgbA1C test
What type of Activity do you do?	Drop-down	Walking; Running; Biking; Swimming; Weight Lifting ; Other	No	Patient Exercise/Activity
(Activity Text)	Textbox	Free Text	No	Notes relating to Exercise/Activity
Physical Limitations that impact activity	Textbox	Free Text	No	Patient's Physical Limitations that may prevent them from exercising
Meal Plan	Textbox	Free Text	No	Meal Plan Patient follows, if any
Do you skip meals?	Checkbox	Yes and No Fields	No	Does Patient skip meals?
What's your insulin to carbohydrate ratio?	Textbox	Free Text	No	Patient's insulin-to-carb ratio
Last Diabetes Education	Drop-down	None; Within the last year; 1-5 years ago; > 5 years ago	No	When did the Patient last participate in Diabetes Education?
Have you seen a Dietitian?	Checkbox	Yes and No Fields	No	Has Patient seen a Dietitian?
How often do you eat out?	Drop-down	< 1 time a week; 1-2 times a week; 3 or more times a week	No	How often does Patient eat outside the home?
Food Allergies?	Checkbox	Yes and No Fields	No	Does Patient have any food allergies?
If Yes (Food Allergies), What?	Textbox	Free Text	No	If Patient Allergies, list them
What is the most difficult part of living with Diabetes?	Textbox	Free Text	No	What is the most difficult thing for the Patient in living with Diabetes?
Sad/Blue?	Checkbox	Yes and No Fields	No	Is Patient sad/blue? (Depression Screening)

Data Element	Type/Control	Values	Required	Definition
Lost Interest?	Checkbox	Yes and No Fields	No	Has Patient lost interest? (Depression Screening)
Someone to talk to?	Checkbox	Yes and No Fields	No	Does Patient have someone to talk to? (Depression Screening/FPP)
PRE/POST KNOWLEDGE ASSESSMENT (Diabetes Education Assessment)				
Patient Name	Textbox	From Patient Table/Values	No	Patient Name automatically populated from Patient record currently selected
Person(s) Instructed	Textbox	Free Text	No	Name of Person(s) given Diabetes Education (Patient, family members, etc.)
Assessment Date	Date field	Date MM/DD/YYYY	Yes	Date of Diabetes Education Assessment
Before Education				**Score BEFORE diabetes education**
Do you understand how diabetes affects you?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how diabetes affects him/her?
Do you understand your meal plan?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand his/her meal plan?
Do you understand the benefit of exercise/physical activity?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand the benefit of exercise/physical activity?
Do you understand how your medications work?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how his/her medications work?
Do you understand the benefits of blood glucose monitoring?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand the benefit of blood glucose monitoring?
Do you understand how to detect, treat, and prevent hypoglycemia?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how to detect, treat, and prevent hypoglycemia?
Do you understand how to detect, treat, and prevent hyperglycemia?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how to detect, treat, and prevent hyperglycemia?
Do you understand how to prevent and/or reduce chronic complications?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how to prevent and/or reduce chronic complications?
Do you understand how reaching your goals will help you with your diabetes?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how reaching his/her goals will help with diabetes?
Do you understand that the diabetes team is available to help you problem solve?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand that the diabetes team is available to help him/her problem solve?
Do you understand how diabetes affects emotional health?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand how diabetes affects emotional health?

Data Element	Type/Control	Values	Required	Definition
Do you understand that your blood glucose needs to be in control before and during pregnancy?	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	Score: Does Patient understand that his/her blood glucose needs to be in control before and during pregnancy?
After Education	Drop-down	1. (Poor); 2. (Fair); 3. (Good); 0. (N/A)	No	**Score AFTER diabetes education for each question above**
Instruct Date / Instructor	Textbox	Free Text	No	**Instruction Date and Instructor For Each question above**
Follow-up Plan	Textbox	Free Text	No	**Follow-up Plan For Each question above**
Instructors (1)	Textbox	Free Text	No	For 1st Diab Educ Instructor "signature"
Instructors (2)	Textbox	Free Text	No	For 2nd Diab Educ Instructor "signature"
Instructors (3)	Textbox	Free Text	No	For 3rd Diab Educ Instructor "signature"
Instructors (4)	Textbox	Free Text	No	For 4th Diab Educ Instructor "signature"
Collaborate Date	Date field	Date MM/DD/YYYY	No	Date of Collaboration on Patient if not as part of class/education above (Ex. Meeting re: Patients)
PATIENT GOALS				
Goals Assess Date	Date Field	Date MM/DD/YYYY	Yes	Date of Patient Goals Assessment
Patient ID	Textbox	Free Text	No	Patient ID Number automatically populated from Patient record currently selected
Goals:				
Nutrition Management	Checkbox	Yes/No	No	Does Patient have Goal of Nutrition Management?
Nutrition Management (text)	Textbox	Free Text	No	Details for Nutrition Management Goal
Physical Activity	Checkbox	Yes/No	No	Does Patient have Goal of Physical Activity?
Physical Activity (text)	Textbox	Free Text	No	Details for Physical Activity Goal
Meds	Checkbox	Yes/No	No	Does Patient have Goal of Meds?
Meds (text)	Textbox	Free Text	No	Details for Meds Goal
Monitoring	Checkbox	Yes/No	No	Does Patient have Goal of Monitoring?
Monitoring (text)	Textbox	Free Text	No	Details for Monitoring Goal
Preventing Acute Complications	Checkbox	Yes/No	No	Does Patient have Goal of Preventing Acute Complications?
Preventing Acute Complications (text)	Textbox	Free Text	No	Details for Preventing Acute Complications Goal
Risk Reduction	Checkbox	Yes/No	No	Does Patient have Goal of Risk Reduction?
Risk Reduction (text)	Textbox	Free Text	No	Details for Risk Reduction Goal

Data Element	Type/Control	Values	Required	Definition
Psychosocial Adj.	Checkbox	Yes/No	No	Does Patient have Goal of Psychosocial Adj.?
Psychosocial Adj. (text)	Textbox	Free Text	No	Details for Psychosocial Adj. Goal
Other (Goal)	Checkbox	Yes/No	No	Does Patient have Other Goal not listed?
Other (text)	Textbox	Free Text	No	Details for Other Goal
Follow-up Dates:				
Nutrition Management	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Nutrition Management
Physical Activity	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Physical Activity
Meds	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Meds
Monitoring	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Monitoring
Preventing Acute Complications	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Preventing Acute Complications
Risk Reduction	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Risk Reduction
Psychosocial Adj.	Date field	Date MM/DD/YYYY	No	Follow-up Date for Goal of Psychosocial Adj.
Other (Goal)	Date field	Date MM/DD/YYYY	No	Follow-up Date for Other Goal not listed
Scores:				
Nutrition Management	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Nutrition Management
Physical Activity	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Physical Activity
Meds	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Meds
Monitoring	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Monitoring
Preventing Acute Complications	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Preventing Acute Complications
Risk Reduction	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Risk Reduction
Psychosocial Adj.	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Goal of Psychosocial Adj.
Other (Goal)	Drop-down	1; 2; 3; 4; 5; 6; 7; 8; 9; 10	No	Score for Other Goal not listed
Notes	Textbox	Free Text	No	Notes relating to Patient Goals
HF FOLLOW-UP (HEART FAILURE)				
Call Date	Date Field	Date MM/DD/YYYY	Yes	Date of Discharge Follow-up Call
Discharge Date	Date Field	Date MM/DD/YYYY	Yes	Hospital Discharge Date this Call followed from
To	Drop-down	Home; Assisted Living; Deceased; ECF/SNF/LTCF	No	Place Patient is at time of Call
Hospital	Drop-down	From Location Table/Values	Yes	Hospital Discharged From
Talked To	Drop-down	Patient; Spouse; Significant Other; Health Care Provider; Other	No	Person Actually spoke with on Call

Data Element	Type/Control	Values	Required	Definition
Medication Review				
Are you following your discharge medications?	Drop-down	Yes; No; Unknown	No	Is Patient following discharge medications?
If not, which ones are you not following?	Textbox	Free Text	No	If Patient not following discharge medications, which ones is the Patient not following?
Why are you not following your discharge meds?	Textbox	Free Text	No	If Patient not following discharge medications, why is Patient not following discharge medications?
Reviewed the importance of compliance, not running out / refilling meds?	Drop-down	Yes; No; Unknown	No	Did Care Manager review with the Patient the importance of compliance, not running out/refilling meds?
Reminded patient to take all medications to follow-up appointment?	Drop-down	Yes; No; Unknown	No	Did Care Manager remind the Patient to take all medications to the Patient's follow-up appointment?
Activity				
Are you trying to stay active daily?	Drop-down	Yes; No; Unknown	No	Is Patient trying to stay active daily?
How are you tolerating activity since discharge?	Drop-down	Stable; Better; Worse; Unknown	No	How is the Patient tolerating activity since discharge?
Weights				
Is there any change in weight?	Drop-down	Unchanged (Stable); Moderate Gain (Up to 2 lbs in one day/up to 5 lbs over optimum); Significant Gain (> 5 lbs in one day); Weight Loss (Down > 5 lbs since discharge); Not Checked (Weight has not been tracked)	No	Any change in Patient weight?
Diet/Fluid Restriction				
Do you understand your low-salt diet?	Drop-down	Yes; No; Unknown	No	Does Patient understand his/her low-salt diet?
Are you following a low-salt diet?	Drop-down	Yes; No; Unknown	No	Is Patient following a low-salt diet?
Are you limiting fluids to < 2 liters/day	Drop-down	Yes; No; Unknown; N/A	No	Is Patient limiting fluids to less than 2 liters a day?
Symptoms				
How is your breathing?	Drop-down	Better; Stable; Worse; Severe; Unknown	No	How is Patient's breathing?

Data Element	Type/Control	Values	Required	Definition
Are you lightheaded?	Drop-down	Yes; No; Unknown	No	Is Patient lightheaded?
Swelling in the feet, abdomen, or ankles?	Drop-down	Better; Stable; Worse; Severe; Unknown	No	Does Patient have swelling in the feet, abdomen, or ankles?
Follow-up				
Instructed to contact provider (non-urgent)	Checkbox	Yes/No	No	Did Care Manager instruct Patient to contact his/her Provider (non-urgent) for follow-up?
Instructed to seek immediate treatment (urgent)	Checkbox	Yes/No	No	Did Care Manager instruct Patient to immediately seek treatment (urgent) for follow-up?
Teaching seminars schedule offered	Checkbox	Yes/No	No	Did Care Manager offer to Patient a schedule of teaching seminars for follow-up?
Next phone call scheduled	Checkbox	Yes/No	No	Is the next Care Manager phone call scheduled?
None	Checkbox	Yes/No	No	Is no Follow-up with Patient necessary?
Other	Textbox	Free Text	No	Other follow-up for Patient: (Specify)
Notes	Textbox	Free Text	No	Comments relating to the Discharge Follow-up
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?
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?

Data Element	Type/Control	Values	Required	Definition
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