

Care Partners CMTS Required Fields

Patient Information Screen (when adding a new patient)

Required fields:

- Program Information
 - Primary care clinic name
 - Enrollment Date
 - Check box for a negative score on the Callahan Six-Item Screener (memory screener)
 - Patient ID - automatically generated by CMTS
 - Medical Record Number (MRN)
 - Check box for a negative score on the bipolar screener of your choice
 - PCC Care Manager name
 - CBO Care Manager name
- Demographic Information
 - First name of patient
 - Last name
 - Date of birth
 - Gender (can choose 'Unknown or not reported')
 - Race (can choose 'Unknown or not reported')
 - Ethnicity (can choose 'Unknown or not reported')
 - Language

The screenshot shows a web application interface for adding a new patient. The top navigation bar includes 'Patient', 'Caseload', 'Tools', and 'Logout'. A search bar is labeled 'Search Patient: Name or Patient ID'. The user is identified as 'Hello, Ashley (aheal)'. The main content area is titled 'PATIENT INFORMATION' and is divided into two sections: 'Program Information' and 'Demographic Information'. Red circles highlight the required fields in each section.

Program Information:

- Clinic : *
- Enrollment Date : *
- Negative Callahan Memory Screening :
- PCC Care Manager : *
- Primary Care Provider :
- Pharmacist :
- Patient ID : *
- MRN : *
- Negative Bipolar Screening :
- CBO Care Manager : *
- Psychiatric Consultant :

Demographic Information:

- First Name : *
- Date of Birth : *
- Race : *
- Language (Interpreter Needed) : *
- E-mail :
- Last Name : *
- Gender : *
- Ethnicity : *
- Payor Status :

Initial Assessment & Follow Up Contacts

Required fields:

- Date of contact
- Current Medications
 - Confirm with patient that current medications list is up-to-date
- Diagnosis
- Session attendees
- Session location and length of time

Patient Caseload Tools Logout Search Patient: Hello, Ashley (aheadcm)

INITIAL ASSESSMENT

Patient, Tom
Patient ID: 000010 | MRN: 121121
Age: 65 | DOB: 6/5/1950 | Male

Date of Contact: * / /

Patient Concerns history

Prior Mental Health Treatment
 Inpatient Hospitalization Outpatient Mental Health Treatment / Psychotherapy Inpatient Substance Abuse Treatment
Details:

Prior Medications

NAME	DAILY DOSE	DURATION	HOW LONG AGO	EFFICACY	SIDE EFFECTS
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Current Medications history

* Confirmed with the patient Confirmed in the patient's medical record Deferred

NAME	DOSAGE
<input type="text"/>	<input type="text"/>

Diagnoses * Pending

Depression Anxiety Alcohol/Substance Abuse Bipolar Disorder
 PTSD Psychotic Disorder Cognitive Disorder Chronic Pain
Other:

Appointments

DATE & TIME	PROVIDER	VISIT TYPE	ADD'L INFO.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Discuss with Psychiatric Consultant history

Would you like to discuss this patient with the psychiatric consultant?

Notes for Psychiatric Consultant:

Session attendees * !

Patient Primary Care Staff CBO Staff Psychiatric Consultant Family/Friend

This session was * with and took minutes

Items that are not required in order to close out a note but are necessary for this project

- PHQ-9 scores
 - PHQ-9 is used as both a screener and follow-up measure in Collaborative Care. It is administered regularly over the course of treatment and needs to be entered into CMTS
- Psychiatric Consultation notes:
 - Psychiatric consultants meet with care managers over the phone or in person on a weekly basis for usually an hour to do systematic case reviews of new patients and patients not improving as expected.
 - Recommendations stemming from this consultation are entered into the patient's CMTS record as a Psychiatric Consultation Note
- Family members / Friends of patients
 - For those sites involving friends or family in Collaborative Care, information such as name, relationship, and contact information needs to be entered into CMTS in the Patient Information page
- Care Plans
 - This will help you document the current care plan and care plan goals for the patient, as well as changes in treatment. About half of patients will need some sort of change in treatment over the course of their care and this CMTS function will help you track and manage that.