Care Manager Guide
CHAMP CMTS

Care Management Tracking System

Last updated 7/1/2022

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TOP 10 TIPS & TRICKS

1. You don't need to answer every question. Only those marked with an asterisk (*) are required.

2. Choose which page appears first each time you log in. Navigate to *Tools > Preferences*, and set your "First Page after Login."

3. Enter your notes while the patient is in the room with you. Concurrent documentation makes the process easier and more efficient!

4. While you are with your patients, remember to flag individuals who need discussion with your Psychiatric Consultant by clicking the "Discuss" checkbox in your contact note.

5. On the Caseload List page, click the column headings to sort your caseload. You can easily see who has been in treatment longest, who is not improving, who hasn't been seen for a while, etc.

6. Any blue bold text is a clickable link and will take you to more information about that topic.

7. To transfer information between your EHR and CMTS, open both windows at the same time.

    - Use the "export to text" button to strip page formatting
    - Select the text and right-click, choose copy
    - Paste into your EHR.
    - It should take less than 15 minutes PER DAY to port notes from CMTS to your EHR.

8. Use the "Add Icon" ⊕ to open new contact notes directly from your Caseload List page.

INTRODUCTION

The Care Management Tracking System (CMTS) is a population-based care management registry designed to facilitate Collaborative Care by tracking treatment outcomes and prompting action founded on evidence-based clinical algorithms. Collaborative Care requires the coordination of a primary care provider, care manager, and psychiatric consultant, and is by definition patient-centered and accountable. In contrast to electronic health records that simply collect and store information, CMTS helps facilitate clinical decision making and program management. Your version of CMTS has been customized to support the Collaborating to Heal Addiction and Mental health in Primary Care (CHAMP) study.

CMTS helps clinicians structure their encounters with patients, identify those who are not improving as expected, prompt changes in treatment as needed, and monitor a large caseload. Because it is web-based, the program has the ability to facilitate consultation from a mental health specialist even if the specialist is not on-site, a useful feature in rural or other resource-poor areas.

CMTS enables coordination of care across health care providers and organization and helps program managers track the effectiveness of treatments across different providers and caseloads.

CARE MANAGER ACCOUNT ROLE

The care manager account is given privileges to view and enter protected health information. Although CMTS patient data is not considered the legal medical record, this information should be treated with the same policies that apply to any other protected health information. Care manager accounts should be issued only to those who require this level of access to complete their duties.

> TIP: You should *never* share your username and password with another care manager. CMTS accounts should be unique to each person.

On the login page, you will be prompted for your username and password. Your username and password will be issued to you by your Account Administrator. Account Administrators are responsible for setting and maintaining appropriate permissions for each account, including your care manager account.

If you are unable to log in to CMTS, but you have the correct login information, it is possible that your account has been disabled. User accounts can be disabled manually by Account Administrators, or they can be automatically disabled after 5 incorrect login attempts or after 90 days of non-use.

ACCESSING CMTS

Because CMTS is a web-based software application, it requires an internet connection (broadband is recommended), and the latest version of one of the following internet browsers:

- Microsoft Edge

- Mozilla Firefox

- Google Chrome

- Apple Safari

It is not recommended that two or more of these browsers be used at the same time.

In the event that CMTS becomes unavailable, the clinician will continue to see patients as usual. The screening tools and outcome measurement tools will be recorded on paper copies or in the electronic medical record system. Data will be entered into CMTS when availability is reestablished. The PHQ-9 and GAD-7 screening tools are available at http://www.phqscreeners.com/ in a variety of languages.

SITE NAVIGATION OVERVIEW

The navigation toolbar is located in the black bar at the top of the screen. The toolbar is context-dependent, so the options that are available in the menu will depend on which patient is currently selected (if any).
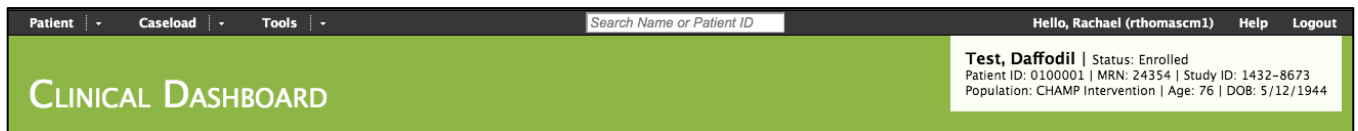
Basic patient information appears in a white box in the top-right corner of the page when a patient is selected. The following options appear in the navigation toolbar:

Patient Menu

These options are available only when a patient is selected:

- New Contact
- Contact Attempt
- No Show
- Patient Enrollment

- Encounter List
- Treatment History
- Clinical Dashboard
- Provider & Clinic List

- Appointment List
- Referral List

These options are always available:

- New Patient
- Search Patient

Caseload Menu

- Caseload List
- Caseload Statistics
- Monthly Time Tracker
- Quality Aims

Tools Menu

- Reminders
- Appointment Calendar
- Message Board
- Print
- Preferences
- Password
- Providers

Logout

Sign out of your account when leaving your workstation to keep patient information secure.

Search Patient

This box is always visible in the navigation toolbar as a quick way to find patients using Patient ID or name. All matching patient records will be returned for patients assigned to your organization(s).

SITE-WIDE FEATURES

These features apply to all pages throughout CMTS.

Sortable Lists: You can sort reports by clicking on the column header. Clicking once will sort from least recent to most recent, or in alphabetical order, and clicking again will sort in the opposite order.

Tooltips: Hovering the cursor over the tooltip icons ⓘ will display additional information about items and features throughout CMTS.

Links to Patient Information: Clicking on a Patient ID Number will display the Patient Enrollment page and Patient Name will display the Clinical Dashboard page for that patient. These preferences can be changed by navigating to *Tools > Preferences*.

Required Fields: Indicated on questions with an asterisk (*). These questions must be answered before a form can be submitted.

"Add" icons: Green plus icons can be clicked to add a new note or a new item.

"Delete" or "Remove icons: Clicking these icons (or) will permanently delete the associated data or item.

Information that was carried forward from one note to the next without changing is marked with a dagger symbol (†).

REMINDERS PAGE

The Reminders page is the first page that appears each time you log in, and can also be accessed at any time by navigating to *Tools > Reminders*. There are two sections on this page: Autosaved Notes and Reminders.

Autosaved Notes

When entering information into encounter note templates, CMTS will automatically save a draft of the note every three minutes. If note entry is interrupted for any reason, the autosaved draft of the note can be retrieved by navigating to *Tools > Reminders*.

If you attempt to submit a note without completing all required fields, an alert message will appear with a prompt to complete the minimum information. This also triggers a draft of your note to be autosaved.

Autosave – Uncommitted Changes					
Date & Time Auto Saved	**Patient ID**	**Name**	**Page**	**Action**	**Expires**
8/25/2020 13:38:02	0100008	Name, Fake	Care Manager Encounter	Add	9/24/2020

The Autosave section only appears if you have an autosaved note. Autosaved notes will be automatically deleted after 30 days of inactivity. The section includes this information:

- Date and time the note was saved
- The ID number and name for the patient
- The type of contact note
- The "Action" column shows whether the note was an update to an existing note, or the addition of a new note

- The "Expires" column shows the date (MM/DD/YYYY) that the note will be deleted. Text will turn red 3 days before the expiration date.

> TIP: Autosaved notes are not yet part of your patient's treatment record and cannot be seen by other people using CMTS. Pending autosaved notes can also prevent other people from entering a new note for that patient, so be sure to clear your autosaved notes frequently by deleting or finalizing each note.

Click on the date and time of the auto-saved note to resume editing. Once the note is submitted, it will disappear from your Autosaved Notes section, and will become part of the patient's treatment record.

To permanently discard your autosaved note, click the "Delete" icon 🔲 next to the date and time information.

Reminders

The main Reminders section appears just below the Autosaved Notes section. These reminders provide alerts about important due dates for Care Manager Encounters and Referrals. CHAMP study patients will also be listed if they have a missing study ID. Hover your mouse over the blue tooltip icons in the column header to see complete descriptions of how each reminder is triggered.

> TIP: Patients who have no reminders will not be listed on the Reminders Page.

PATIENT ID ⬆	MRN	NAME	POP. ⓘ	CARE MANAGER ENCOUNTER ⓘ	REFERRAL ⓘ	MISSING STUDY ID ⓘ	NEXT APPT ⓘ
0200003	283747	Buff, Buffy	C	33 days overdue ⊕	🔲	Missing 🔲	9/15/20 12:00 PM 🔲
0200012	0990009	Name, Fake	C	Due today ⊕	🔲		🔲

1 – 2 of 2   Per page: 30 ⌄

1. **Care Manager Encounter:** A Care Manager Encounter is due immediately upon enrollment and every 7 days for patients in active treatment. This decreases to every 14 days after the first 30 days of enrollment, and to 30 days for patients in Recovery Support Plan status. If a Care Manager Encounter is not entered on the patient's enrollment date, a reminder will appear. If it is 7 or more days overdue, the reminder text will turn from black to **red**.

2. **Referral:** Referrals for a patient should be closed within 28 days of being opened. The Referral reminder will turn **red** after 14 days of being overdue. For information about how to close a referral, see the Referral List section.

3. **Missing Study ID (CHAMP study patients only):** Disappears when Study ID is entered on Patient Enrollment page.

4. **Next Appointment:** Displays the date of the next appointment scheduled for each patient. The date will turn red if the appointment date has passed and there has not been a note entered on or after the next appointment date.

CASELOAD LIST PAGES

The Caseload List pages display an overview of all patients on your caseload, allowing you to manage populations and prevent patients from 'falling through the cracks.'

With these reports, care managers can

- sort their caseload by score severity
- identify which patients are not improving as expected
- identify patients who may need discussion with a consultant
- find patients who are due for an appointment with a care manager

> TIP: You can view the caseload for any provider at your organization by selecting a name from the drop-down list located in the upper right-hand corner.

To view the Caseload List pages, navigate to *Caseload > Caseload Lists* and choose one of the following categories:

1. **New Patients:** Displays all patients for the selected provider that have not yet had a Care Manager Encounter entered.

2. **Active Patients:** Displays all patients for the selected provider that are currently enrolled, including patients on a Recovery Support Plan.

3. **Inactive Patients:** Displays all patients for the selected provider that are currently discharged.

4. **Custom Search:** Includes Quick Search bar and Advanced Search option for filtering patients based on Patient ID, MRN, Study ID, First Name, Last Name, Enrollment Date, Discharge Date, BH Care Manager, Psychiatric Consultant, Primary Care Provider, Site, Clinic, Flag, or Population.

							BH CARE MANAGEMENT						PHQ-9		GAD-7	
FLAGS	PATIENT ID	MRN	NAME	POP. ⓘ	STATUS ⓘ	WKS IN TX ⬆ ⓘ	LAST CM ENCOUNTER ⓘ	# CM ENCOUNTERS ⓘ	LAST P/N ⓘ	NEXT APPT ⓘ	BA CONTACTS ⓘ	CM No SHOW RATE ⓘ	FIRST ⓘ	LAST ⓘ	FIRST ⓘ	LAST ⓘ

Each of the Caseload List pages shows a summary of information listed in columns, detailed below. Hover your mouse over the ⓘ tooltip for more information about the column's data.

1. **Flags:** Can be toggled on and off from the Caseload List page by clicking the flag icon. Flags can also be turned on/off from within contact notes, or from the Clinical Dashboard page.

    -   Yellow Flag 🚩: Indicates that you wish to discuss this patient with a Psychiatrist Consultant. When a new Psychiatrist Consultation Note is entered for the patient, this flag is automatically unchecked.

2. **Patient ID:** Click to view the Patient Enrollment page. You can customize this by navigating to *Tools > Preferences*.

3. **MRN:** Medical Record Number.

4. **Patient Name:** Click to view the Clinical Dashboard page.

5. **Population:** Indicates if patient is participating in CHAMP Control (C) or is Non-Study (N).

6. **Status:**

    -   Newly Enrolled (E)
    -   Active Treatment (T)
    -   Recovery Support Plan (RSP)
    -   Discharged (D)

7. **Weeks in Treatment:** Weeks since first Care Manager Encounter.

8. **BH Care Management:**

    -   Tracks CM encounters, Psychiatric Consultant notes, and next appointment date
        -   Next Appt. date will turn **red** if the appointment date has passed and there has not been a note entered by the provider who originally made the appointment
    -   Shows % of contacts with at least one Behavioral Activation activity recorded and % of CM appointments missed in last 90 days
    -   Records the first and last PHQ-9 and GAD-7 score entered for a patient in the current episode of care
        -   Score in the **First** column will appear gray if it is the only score entered for that patient
        -   Score in the **Last** column will have an asterisk (*) if it is older than the specifications for that clinical measure (ex: if the PHQ-9 is older than 30 days)
    -   Improvement indicator colors appear for patients that have been in treatment for a minimum period. The tooltip ⓘ in each column describes how the indicator colors are determined

CASELOAD STATISTICS PAGE

To view the Caseload Statistics page, navigate to *Caseload > Caseload Statistics*. This report displays data summarized by Provider, Clinic, or Organization rather than by individual patient.

With this information you can view the average status of patients at baseline and at their most recent visits, make comparisons between clinic vs. phone/video encounters, identify which patients are not improving AND have not yet had a Psychiatric Consultation note entered, and track CM no show rates.

BH CARE MANAGER	CURRENT CASELOAD	CARE MANAGER CONTACTS					PSYCHIATRIC CONSULTATION NOTE			AVERAGE PHQ		AVERAGE GAD		PHQ		GAD	
		AVG # CM ENC	CONTACTS W/ SCALE	AVG # BY PHONE/VIDEO	CM NO SHOW RATE	# IN RSP	# FLAGGED	# W/ P/N	NOT IMPRV W/O P/N	FIRST	LAST	FIRST	LAST	NO RESPONSE	NO REMISSION	NOT IMPROVED	SCORE OF 10+

> TIPS: Clicking any numbers that are blue links will allow you to drill-down and see the list of patients included in that particular calculation.
>
> Use the drop-down menu in the top-right corner to aggregate the report by provider, clinic, or organization.

The sum of all the rows in the "# Pts" columns may be more than the "All" total in the bottom row. This is because a patient may be assigned to multiple clinics or providers, but will not be counted more than once in the "All" total in the bottom row.

ENROLLING NEW PATIENTS

To enroll a new patient, navigate to *Patient > New Patient*.

Patient Populations

Populations can be used to separate patients into different categories for reporting purposes.

Your Care Manager account will allow you to view records for any patient at your organization, regardless of the patient's population.

To update a patient's population after they have been enrolled:

- Select the correct patient and navigate to *Patient > Patient Enrollment.*
- Click the "update" button located in the green area at the top of the screen.
- Make any updates to the population checkboxes.
- Click "Update" at the bottom of the form.

> TIP: Populations can be used to separate patients for reporting purposes. The checkboxes at the bottom of the Caseload report pages can be used to filter out patient populations.

MANAGING PROVIDER AND CLINIC ASSIGNMENTS

Providers are people who provide care to patients, either directly or through consultation. Providers can include BH care managers, primary care providers and psychiatric consultants.

Assigning Providers or Clinics to Patients

Providers and Clinics may be assigned to new patients at time of enrollment on the Patient Enrollment page.

For existing patients, provider and clinic assignments are managed on the Clinical Dashboard page, accessed by clicking on any patient's name. You will see a list of all providers and clinics currently assigned in the Patient Enrollment section. You can also update provider assignments from the Provider & Clinics List page, by selecting the correct patient, and navigating to *Patient > Provider and Clinic List*.

Current Providers

Type	Name	Phone	Email	Service Begin	Service End	Deactivate
BH Care Manager	Rachael Thomas	206-221-6830	rlthom@uw.edu	9/10/2020		
Primary Care Provider	Johnny Mao, PCP C	425-213-8760	jmao@uw.edu	9/10/2020		🔗
Psychiatric Consultant	Suzy Hunter, CP	206-221-6408	smhunter@uw.edu	9/10/2020		🔗

Select new provider type: [⌄]
Select new provider name: [⌄]
[Assign]

Adding a Provider Assignment
Select the appropriate type of provider (care manager, psychiatric consultant, etc.) using the "Select new provider type" menu. All providers of that type at your organization will be available for selection in the "Select new provider name" menu. Once the provider's name is selected, click "Assign".

This process can be repeated to add multiple providers to the patient's care team. Patients will appear on the Caseload List and Reminders pages for all providers assigned to them.

If a provider's name is not listed, you will need to contact your Site Manager or Account Administrator so that they can create a user or provider account for that individual.

Removing a Provider Assignment

Click the "Deactivate" icon 🔗 to remove provider assignments. A dialogue box will appear to confirm this action. After selecting "OK," the provider will be deactivated. Patients will no longer appear on the Caseload List and Reminders pages for past providers.

Past providers can be displayed by clicking the check box located in the section header, titled "Show all providers including past providers".

> TIP: Deactivated Providers will still appear on reports (such as the Caseload Statistics page) if there are any active patients still assigned to them, but will not appear if there are no active patients assigned.

Transferring a Patient to a New Provider
To transfer a patient from one provider's caseload to another, remove the assignment for the existing provider, and add an assignment for the new provider following the instructions above.

Current Clinics	☐ Show all clinics including past clinics						
SITE	**CLINIC**	**MRN**	**PRIMARY**	**SERVICE BEGIN**	**SERVICE END**	**UPDATE**	**DEACTIVATE**
Test Site	Test Clinic	92831	✔	1/30/2014		**Update**	
Select new clinic:	[▼] Assign						

Adding Clinic Assignment
Current clinic assignments are automatically displayed on the Provider & Clinic List Page. To add a new clinic to this list, select an option from the Select New Clinic drop-down menu. This menu displays all clinics within your organization. Once you select assign, the patient will appear on the list of patients for the new clinic.

Newly assigned clinics are automatically updated as the patient's primary clinic. If this is incorrect, select the blue Update text for the clinic you would like to set as the patient's primary clinic, and select the Set as Primary Box.

Removing Clinic Assignment
To remove a clinic from a patient, select the deactivate icon 🔗 next to the clinic that is no longer active. This icon will only appear if a patient is assigned to multiple clinics, to avoid removing all clinic assignments. The inactive clinic will now appear in the Past Clinics list.

To view past clinic assignments, select the *Show all clinics including past clinics* check box. Inactive assignments will appear grey.

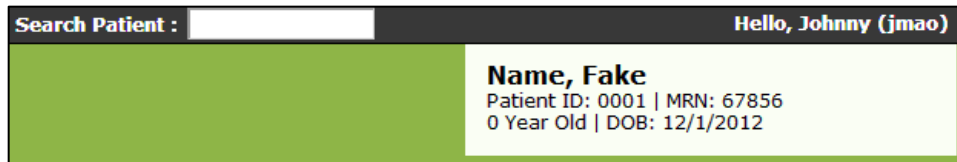| Current and Past Clinics	☑ Show all clinics including past clinics						
SITE	**CLINIC**	**MRN**	**PRIMARY**	**SERVICE BEGIN**	**SERVICE END**	**UPDATE**	**DEACTIVATE**
Test Site	Test Clinic	92831		1/30/2014	5/12/2015	**Update**	
Test Site	Downtown Test Clinic	92831	✔	5/12/2015		**Update**	
Select new clinic:	[▼] Assign						

Reactivating Clinic Assignment

To reactivate a clinic assignment, simply re-add the clinic using the **Select New Clinic** drop down menu.

CONTACT NOTES

This section will review the different types of contact notes that can be entered.

Search Patient :		Hello, Johnny (jmao)
	Name, Fake Patient ID: 0001 | MRN: 67856 0 Year Old | DOB: 12/1/2012	

Be sure the correct patient is selected by confirming their information in the white box on the upper-right corner of the screen. Navigate to *Patient > New Contact*, and select the appropriate note type. The types of notes available will depend on the patient's treatment status. For example, a Care Manager Encounter cannot be entered until a Care Manager Initial Encounter note has been entered.

> TIP: While you are in the process of entering a new contact note for a particular patient, nobody else will be able to simultaneously enter a new note for the same patient. CMTS will lock the patient's record from editing to prevent conflicts.
>
> You may open CMTS in multiple browser windows or tabs by right-clicking any link. Just be sure to edit only one note at a time to prevent overwriting your own changes.
>
> Notes must be added **sequentially**. You will receive error if you try to enter notes out of order.

Initial CoCM Screening

BH Care Managers may optionally enter a PHQ-9 and/or GAD-7 scale score that was collected up to 30 days before the patient's Enrollment Date by navigating to *Patient > New Contact >* Initial CoCM Screening. This pre-enrollment screening score will be used as the patient's baseline score throughout CMTS and must be dated before the first Care Manager Encounter.

Care Manager Encounters

The first encounter with the patient after enrollment is called the Care Manager Initial Encounter. You will see an alert on the Reminders page to complete the Care Manager Initial Encounter immediately after enrollment. Subsequent Care Manager Encounter notes are similar, with some information such as diagnoses and psychotropic medications carried forward from the last visit.

Shared Plan for Treatment Intensification

The Treatment Plan identifies potential changes a Care Manager and patient might discuss to enhance medical and/or behavioral health treatment. Treatment Plans are updated within Care Manager Encounter notes, with the most recent plans displayed on the patient's Clinical Dashboard. Select which changes to treatment you discussed with your patient during this encounter. Hover your tooltip over the ⓘ icon to see an explanation of each item.

BA Element Delivered
Several Behavioral Activation elements are presented here that a Care Manager might discuss with a patient. At least one option must be selected. If no BA elements were discussed, check the first item to indicate that "No BA material was covered". Record any notes about the session in the BA Notes text area.

Psychiatric Consultation Note

Psychiatric Consultation Notes are used to track systematic case reviews and record assessment and treatment recommendations. This can be entered by either the care manager or the psychiatric consultant. All recommendations should also be recorded in the EHR and routed for the PCP's attention. The most recent comment from the care manager (as entered on the most recent CM Encounter) is displayed here; to view all past comments, click the History icon in the right corner.

Last updated by: Rachael Thomas, 9/2/2020 history

Enter the psychiatric consultant's treatment recommendations directly into the text box. Select the session location from the drop-down list:

This session was ✓
    phone contact with CM
    in-person contact with CM
    phone contact with patient
    in-person contact with patient
    phone contact with PCP
    in-person contact with PCP
    by video with patient – patient at home
    by video with patient – patient in clinic

th Rachael Thomas ⌄ and took [＿＿＿] minutes

Recovery Support Plan

The Recovery Support Plan (RSP) should be completed when the patient's recovery seems stable and they are ready to transition out of Collaborative Care treatment, and the plan has been finalized and given to the patient. Care Manager Encounter reminders will decrease from every 2 weeks to every 4 weeks. The length of time that a patient should be in maintenance varies based on clinical factors including severity of symptoms at treatment initiation, number of prior depressive episodes, and number of treatment changes necessary to achieve significant improvement. Most patients are followed in maintenance for 3-6 months before being discharged from treatment.

> TIP: If a patient needs to come back into active treatment, you can edit the existing Recovery Support Plan note by clicking "update" and enter a Plan End Date. This will remove the patient from Recovery Support Plan status and reminders will revert to their original frequency.

Discharge

Patients should be discharged when a BH Care Manager will no longer monitor or follow their care. CHAMP study patients must be enrolled at least 6 months before discharge. For assistance with early discharge, contact your CHAMP Study Manager. After a Discharge Note is entered, the patient will be removed from your Active Caseload List. All patient information and data is archived and retained, and the patient will be visible on your Inactive Patients Caseload List. Reminders are not received for Inactive (Discharged) patients.

You must select a reason for Discharge from the drop-down list, as shown below:

Contact Attempt

Care Managers can use Contact Attempt notes to document unsuccessful outreach attempts to reach the patient, such as a voicemail message.

No Show

Track patient engagement by documenting missed appointments with the BH Care Manager here. Each patient's No Show rate will be displayed on the Caseload List and Caseload Statistics reports.

Saving and Updating Information

Once all required information is entered, click the "Add" or "Update" button at the bottom of the page to submit your note. If there is a problem with any of the information you entered, you will see an alert message. Red arrows will point to sections with missing or incorrectly formatted information.

After the note is submitted, you can make changes to the note in its entirety by clicking the green "Update" button at the top of the page.

> TIP: To make changes to a single section without leaving the page, click the "Update" button located in each section header.

For other options such as "Export as Text" and printing directly from CMTS, please refer to the Exporting and Printing Data section in this guide.

Errors and Alert Messages
Your Contact Note will not be accepted unless all required questions, indicated with an asterisk (*) have been completed. The AIMS Center has developed a minimum standard set of questions that require

responses in order to facilitate the delivery of collaborative care. For each form, a response is required for the following questions:

1. **Patient Enrollment:** Clinic, Patient ID, Population, Enrollment Date, BH Care Manager, Primary Care Provider, First Name, Last Name, Date of Birth, MRN (Medical Record Number)

2. **Care Manager Encounter:** Date of Contact, Diagnoses, Psychotropic Medications, Location of Session, Session Duration

3. **Psychiatric Consultation Note:** Date of Contact, Session Location, Session Duration

4. **Recovery Support Plan:** Date of Contact

5. **Discharge:** Date of Contact, Reason for Discharge

If a required question is missed, an alert message will appear. After closing the dialogue box you will be taken back to the form, and will see new icons or messages in red that will prompt you to add or change your answers.

Red arrow(s): by itself, the red arrow denotes a required response that is blank and must be filled in to submit the form.

"Not valid" or "Wrong format": denotes an integer response that requires a specific number of integers, where the current entry must be changed to include less or more numbers, or only numbers.

"Must be unique": occurs for unique identifiers such as ID numbers, where the current entered value is a duplicate that has already been entered for a different patient/site/user.

"An error occurred while processing": This usually denotes an error or bug which requires the attention of CMTS support staff. CMTS programmers will be notified automatically by email and will work to address the problem.

Partially completed outcome measure questionnaires: For example, "*The scale PHQ-9 was only partially completed. If you continue, the score will not be included in any reports or metrics.*" You can choose to submit the note with a partially completed measurement tool, or go back to complete the measurement tool. Total scores will not be calculated for partially completed measurement tools.

RE-ENROLL A DISCHARGED PATIENT INTO NEW EPISODE OF CARE

Care Manager Encounters and Psychiatric Consultation Notes may be entered for Discharged patients; the option remains available from the navigation toolbar under *Patient > New Contact*. Even if a new note is entered, the patient will remain on your Inactive Caseload List and you will not receive Reminders for the patient.

If a Discharged patient returns to treatment and you wish to return them to your Active Caseload, you may re-enroll the patient by navigating to *Patient > New Episode*.

By selecting this option, you are creating a second "Episode of Care" for the patient. You will be asked to update the Patient Enrollment page before entering a new note.

If a patient has multiple Episodes of Care, the Encounter List and Treatment History pages (refer to the "Patient Summary Pages" section of this guide) will include a drop-down menu at the top of the screen that will allow you to view historical information for each episode of care separately. The Caseload List page will display information only from the most recent episode of care.

PATIENT SUMMARY PAGES

Encounter List Page

To view a patient's Encounter List, confirm that the appropriate patient is selected in the white summary box on the upper-right corner of the screen, then navigate to *Patient > Encounter List*.

The Encounter List displays all contacts during the course of treatment, including Care Manager Encounter Notes, Psychiatric Consultation Notes, Recovery Support Plan Notes, Discharge Notes, Contact Attempts, and No Shows. Clicking a particular "Date of Contact" will open that note, where you can then view and/or update information.

Treatment History Page

To view a patient's Treatment History page, confirm that the appropriate patient is selected in the white summary box on the upper-right corner of the screen, then navigate to *Patient > Treatment History*.

The Treatment History page displays a summary of information including Diagnoses, Contact History, a Patient Progress graph, and Referrals.

Diagnoses							
Anxiety, Depression, Opioid Use Disorder, SUD – Benzodiazepine							

Contacts							
DATE OF CONTACT	**CONTACT TYPE**	**WEEKS IN TX**	**VISIT TYPE**	**PHQ–9**	**GAD–7**	**PCL–5**	**CURRENT MEDICATIONS**
9/10/2020	Care Manager Initial Encounter	0	Clinic	18	15		

The "Contacts" section displays one row for each note, not including Contact Attempts. Click any date to view the complete note. The "Weeks in Tx" column shows how many weeks the patient had been in treatment, i.e. the number of weeks elapsed since the Care Manager Initial Encounter note.

The "Current Medications" column shows which Psychotropic medications the patient was taking at the date of each visit. Medications that carried forward from the previous note without changing are marked with a dagger symbol (†).

Clinical Dashboard

The Clinical Dashboard page contains ALL data that has been recorded for a patient. Other than the Caseload List page, most of a Care Manager's work can be done from the Clinical Dashboard.

There are several ways to navigate to a patient's Clinical Dashboard:

- Confirm that the appropriate patient is selected in the white summary box on the upper-right corner of the screen, then navigate to *Patient > Clinical Dashboard*.
- Click on a patient's name or Patient ID number from the Caseload List page.

Navigating the Clinical Dashboard
To make this large amount of data more manageable, the page is divided into sections which can be toggled on and off using the buttons on the left-hand side of the page.

Customize Dashboard View

- **ON** Patient Enrollment
- **ON** Medications
- **ON** Clinical Measures
- **ON** Diagnosis
- **ON** Treatment Plan
- **ON** Psychiatric Consultant
- **ON** Treatment History
- **ON** Appointments
- **ON** Referrals
- **OFF** Discharge Information

> TIP: You can customize the sections that are turned on by default each time you visit the Clinical Dashboard page by setting your preferences. Navigate to *Tools > Preferences*.

Viewing Patient History in the Clinical Dashboard

As new notes are entered for a patient, historical information will remain available in the Clinical Dashboard, allowing you to track changes over time. To see the dated history log for most items, click on a 'History' button on the section heading.

Reminders in the Clinical Dashboard

Reminders and current patient status information appears in the bottom-left side of the Clinical Dashboard.

Reminders: appear if the patient is overdue to be seen. The same reminders appear on the Reminders page.

Last Contact: Information about the most recent Contact Note entered for the patient.

Next Appointment: Contains information for the next appointment date. If the next appointment for the patient has passed and there is not an accompanying note entered on or after the appointment date by the scheduled provider, the text will turn red.

Flags: Indicates if any provider has flagged this patient for discussion during the next Psychiatric Consultation. These flags also appear on the Caseload List page and on Care Manager Encounter notes.

Status: Indicates the current status of the patient as:

- **Enrolled:** If the patient has not yet had a Care Manager Initial Encounter entered
- **In Treatment:** If the patient is in treatment
- **Recovery Support Plan:** If the patient has a Relapse Prevention Plan note with no "Plan End Date" recorded.
- **Discharged:** If a Discharge Note has been entered

Provider & Clinic List

Current providers and clinics are displayed and updated here. See the "Managing Provider and Clinic Assignments" section of this user guide for more information on changing provider and/or clinic assignments.

Appointment List

The Appointment List page gives you the ability to track and schedule your patient appointments on an appointment list and calendar.

To view upcoming appointments for a specific patient, confirm that the appropriate patient is selected in the white summary box on the upper-right corner of the screen, and navigate to *Patient > Appointment List*.

Appointments can be scheduled by clicking the "Add" icon in the Appointments section. You will be asked for the following information:

- **Date & Time:** may be entered in many formats
    - Example: Next Thursday 3pm
    - Example: 09/21/2014 3pm
- **Provider:** The list will include all providers assigned to the patient. For more information about assigning Providers, refer to the "Provider Assignments" section of this document.
- Visit Type
- Add'l Info

> TIP: To view your Appointment Calendar, including scheduled visits with ALL patients, navigate to *Tools > Appointment Calendar.*

Referral List

Patient referrals to specialty mental health and/or addictions treatment are tracked and managed on the Referral List page. To view a patient's Referral List, confirm that the appropriate patient is selected in the white summary box on the upper-right corner of the screen, then navigate to *Patient > Referral List*.

REFERRAL DATE	REFERRING PROVIDER	TYPE	REFERRAL REASON	STATUS	CLOSED DATE

Any existing referrals will be displayed with the following information:

- **Referral Date:** date referral was made
- **Referring Provider:** provider the referral is made to
- **Type:** type of referral
- **Referral Reason:** additional information about referral, including provisional diagnoses
- **Status:** options include Pending (an open referral), or Closed. Changing the Referral Status to "Closed" will prevent additional reminders from occurring for this Referral.
- **Closed Date:** date the referral was closed

New referrals can be added by clicking the "Add" icon at the bottom of the list.

A reminder will appear on the Reminders page 28 days after the Referral Date, reminding you to close the referral. This reminder will be removed once the Status question has been changed to one of the "Closed" options. The Closed Date can be entered on the date the referral was closed, but will have no effect on the reminder.

ACCOUNT PREFERENCES

The Preferences page allows you to customize several options for your CMTS account.

To view the Account Preferences page, use the navigation toolbar to select *Tools > Preferences*. Customizable options include:

- **Number of Records per Page:** how many patient records show on Caseload Lists pages
- **First Page after Login:** which page you see first each time you log in
- **Page after Clicking on Patient ID:** which page you are directed to upon clicking on any Patient ID link
- **Diagnosis Sort Method:** determines how patient diagnoses are sorted on the Clinical Dashboard: alphabetically, chronologically, or both
- **Medication Sort Method:** determines how the medication lists are sorted for Prior and Current Medication sections – alphabetically, chronologically, or both
- **Caseload List:** sort particular columns in either ascending or descending order
- **Calendar options:** manage the calendar view on the Appointment List page
- **Dashboard default selection:** which section are automatically displayed in Clinical Dashboard for all patients

SYSTEM TIMEOUT

As a security measure, you will be automatically logged out of after 30 minutes of inactivity. Any partially completed note can be retrieved using the Autosave function described in the Autosave section of this document.

USING CMTS ALONGSIDE AN ELECTRONIC HEALTH RECORD

CMTS is a standalone system and does not have the ability to automatically port data back and forth with your existing electronic health record (EHR) system. The AIMS Center recommends that Care Managers document directly in CMTS while the patient is in the room with them, and then port the essential information into the EHR afterwards.

Using "Export as Text"

After documenting a contact note in CMTS, you can export a summary of your note with all the formatting stripped out. This summary can easily be copy-and-pasted into an EHR encounter note or patient message. Follow these steps to transfer information between CMTS and your EHR:

1. Open windows for CMTS and your EHR at the same time.

2. In CMTS, navigate to the contact note you want to export.

3. Click the "export to text" button at the top of the note.

4. Highlight the text and right-click, choose copy.

5. Switch to your EHR window and paste the text into your EHR.

Note: It should take less than 15 minutes per day to port notes from registry to your EHR.

Using Screen Capture

Images from CMTS can be pasted into an EHR. A simple method of doing this uses the Microsoft Windows Snipping Tool.

1. In CMTS, navigate to the page you want to take a screenshot of.

2. In the Windows Start menu, click on All Programs

3. Select Accessories.

4. Click on Snipping Tool.

5. The Snipping Tool will open and should automatically have "New" selected.

6. Use your cursor to select the portion of the screen you would like to take a screenshot of. (Note: The Snipping Tool window will remain on your screen, but will not be in the screenshot.)

7. Once you have selected a rectangular portion of your screen, a new window will open with the screenshot in it. Save the image by going to File > Save As or copy/paste the image by going to Edit > Copy and then pasting it into the desired location.

EXPORTING AND PRINTING DATA

Export as Text

While viewing (not editing) any Contact Note, the "Export as Text" button will appear at the top of the page. Click this button to strip all formatting from the note and display the information as unformatted text. This feature allows you to easily copy-and- paste information from CMTS to an EHR or another platform.

Printing from CMTS

For best results when printing from CMTS, use the built-in "Print" function, not the print function in your browser. To access the built-in CMTS print function, navigate to *Tools > Print.*