Delivering Better Care

Effective management of chronic health conditions such as depression and diabetes requires a coordinated team and shared information. CMTS is a web-based application that facilitates a shared care plan to collaboratively treat common medical and behavioral health conditions.

CMTS supports the core principles of effective integrated care that result in better clinical outcomes, higher patient satisfaction, and lower healthcare costs.

Patient-Centered Team Care
CMTS facilitates collaboration between providers and patients using shared care plans that incorporate patient goals.

Population-Based Care
CMTS tracks patient populations to prevent patients from falling through the cracks.

Measurement-Based, Treatment to Target
CMTS tracks clinical outcomes to cue providers when a consultation or systematic change in treatment is needed.

Evidence-Based Care
CMTS structures clinical workflows and uses validated measurement instruments to track patient progress.

Accountable Care
CMTS creates transparency and accountability among treating providers and payers.

AIMS CENTER
W UNIVERSITY *of* WASHINGTON
Psychiatry & Behavioral Sciences

The AIMS Center offers user guides, video demonstrations, and one-on-one consultations to help clinicians and administrators use CMTS most effectively with the ultimate goal of providing better patient care.

Contact your program manager for more information.

Care Management Tracking System

A web-based registry that supports Collaborative Care

CMTS Quick Start Guide

General Information

Required fields are always marked with an * and must be completed. There are very few required fields.

When a patient's record is selected, their name appears in the top right corner.

ToolTips ⓘ contain helpful information.

To protect patient information, CMTS will log you out after 30 minutes of inactivity.

Any note in progress when CMTS closes will be autosaved. It can be accessed on the Reminders page. To resume and continue editing, click on the Date/Time of the Autosave.

To transfer information from CMTS to an EMR or other platform, click the "Export as Text" button at the top of the page when viewing any Contact Note. This will strip all formatting from the note and allow you to easily copy and paste.

Facilitating Psychiatric Consultations

Flags

To flag a patient you want to discuss, go to the bottom of Initial Assessment or Follow-Up Note and check *"Would you like to discuss this patient with the Psychiatric Consultant."* You can also flag patients from Caseload List by clicking the yellow flag in the leftmost column. Flags can be seen by the psychiatric consultant.

Notes for Psychiatric Consultations

When a patient is flagged for consultation, you can write information in the Notes for Psychiatric Consultant text box at the bottom of Clinical Assessments and F/U notes. Your comments appear in the consultant's note template and Clinical Dashboard.

Supporting Patient Care

For all actions below, begin at the Navigation Toolbar at the top of the screen.

Enrolling a new patient

Select type of contact note. Be sure you've selected the correct patient by looking in the top right corner. Select *Patient > New*.

Entering Contact Notes

Select type of contact note. Be sure you've selected the correct patient by looking in the top right corner. Select *Patient > New Contact*.

Initial Assessment
Completed during the first encounter with the patient and used to collect information about current mental health status and treatment history.

Follow Up
Used for in-depth monitoring of patient progress.

Relapse Prevention Plan
Completed when a patient is moved from active treatment to maintenance or when the patient is being discharged from treatment.

Discharge
Once added, patients move from the Active Patients Caseload list to the Inactive Patient list. You'll no longer receive reminders, but can still enter Follow Up notes.

Re-enrollment

Select *Patient > New Episode* and create a second Episode of Care. The patient will return to your Active Caseload. You must update Patient Information before entering Contact Notes.

Clinical Dashboard

Select *Patient > Clinical Dashboard* or click on a patient's name from your Caseload List. All information for the patient is contained within this page! Use the Customize Dashboard View panel on the left side of the screen to filter the information that is displayed on the right (click on or off by each heading). Each section has expand/update/history buttons to edit information or to see more.

Caseload Management

Caseload List

Select *Caseload > Caseload Lists*.

New: patients with no clinical assessesment

Active: all pending and active patients

Inactive: all discharged patients

Sort by clicking on any column header. Use to view patients who haven't been seen for a while, or sort by symptom severity. Colored indicators let you easily see if patients are improving (green), staying the same (yellow), or declining (red) in appropriate columns (ex. PHQ-9).

Caseload Statistics

Use to compare caseload activity between different providers or clinics. A summary report can be aggregated using the menu in the top right. Patients who are not improving AND haven't had a psychiatric consultation note entered can be viewed by clicking the number next to your name. This can help identify patients you should discuss with your psychiatric consultant.

Reminders

Select *Tools > Reminders* to display a list of patients that need attention. Use this list as a prompt to reach out to patients who need to be seen or followed up on.

Provider Assignments

Select *Patient > Provider List* or *Update* on the Clinical Dashboard in the Program Information section. Click the update button, select a New Provider and the appropriate Provider Name from the drop down menu, then click "Assign." The patient will appear on the Caseload List for all providers to which they are assigned.