PSYCH MEDICAL NOTE TEMPLATE

+ MEDICAL STAFF DOCUMENTATION WORKFLOW

07.25.24

CalMHSA

HOW DID WE GET HERE

We started with endeavor back in Fall 2023.

We designed with visual prototypes with end users/focus groups through Sept 2023 –March 2024 .

We met with medical directors, nurses (supevisors, LVNs/PT/RNs), prescribers, pharmacists, dieticians, internists, inpatient/CSU teams in different counties to understand their workflows, talk about what they struggled with the current templates, and get feedback.

PREMISE OF THIS NOTE TEMPLATE:

We designed this new note template because end-users desired the following:

- Ability to push from certain sections of the previous “Psychiatric Note” template.
- Ability to retain previous note’s information so that authors can review what was written previously and push important medical information without having to retype.
- Pull real-time objective data such as vitals, allergies, labs and medications/orders.
- Key Phrase functionality can be leveraged to create custom text template.
- Flexibly select relevant sections pertinent to the visit and document efficiently via customized text templates by individual or clinic/unit.
- Allow for documentation of medication consent.
- Other tools have been built to aid in documentation

WHAT NEEDS TO HAPPEN BETWEEN TODAY AND GO-LIVE

*C*alMHSA is focused on...

- We are changing the "Display As" Names
- Deployment script to assign this template its' procedure codes
- We are fixing high priority bugs

Recommendations for counties to focus on...

- Make sure your providers are aware (Nurses, Prescriber, Dieticians, Pharmacists) of change and have the information to help them write a note.
  - The Display As" Name change will happen 07/26/24, 4:30 PM PST.
  - Finish all outstanding notes that use the old psychiatric note template by 08/04/24 11:59 AM
  - List of outstanding/pending notes using the psychiatric note template has been sent out to county EHR admins to follow up with their providers.
  - You will lose access to the old template at that point and will not be able to finish your note.
  - Your admin can set up an announcement on the log in page.
- The procedure code being associated to the Psych Medical Note Template will happen on 08/05/24 in early morning.

AGENDA

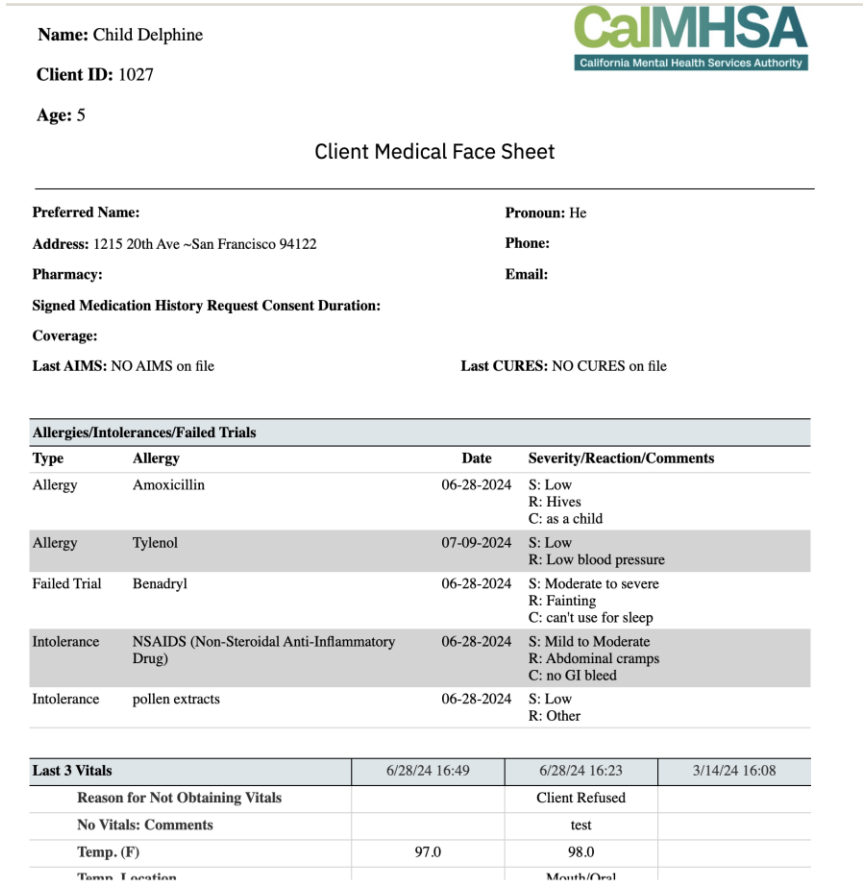
- Intro
- Looking at historical data
- Inpatient Supporting Documents
- Transitioning from the Old Psych Note
- Filling out the Psych Note Template
- Leveraging Key Phrases
- Adding Allergies
- Adding Vitals
- Adding Medications and their consents
- Diagnosis
- A/P and Shared Care Plan
- Additional information
- Billing Diagnosis
- Show and Hide PDF Section Fxn
- Completing Note
- Procedure Codes New Names
- Discharge / Aftercare Summary
- What needs to happen between today and go – live
- Links to Training Material
- Future State

LOOKING AT HISTORICAL DATA : WHY THIS IS IMPORTANT

- The medical / psych note is not meant to have ALL of the client's history. We purposely chose to include on most recent and relevant data.
- We created filterable reports that allow for historical data can be used, sit as a pseudo split screen to your note, and be able to review specific historical data while writing your note.
- Can also print historical reports for transfers or discharges.

LOOKING AT HISTORICAL DATA: USING REPORTS

- Client Medical Facesheet:
  high level overview of a patient's medical information



Name: Child Delphine

Client ID: 1027

Age: 5

CalMHSA
California Mental Health Services Authority

Client Medical Face Sheet

Preferred Name:

Pronoun: He

Address: 1215 20th Ave ~San Francisco 94122

Phone:

Pharmacy:

Email:

Signed Medication History Request Consent Duration:

Coverage:

Last AIMS: NO AIMS on file

Last CURES: NO CURES on file

Allergies/Intolerances/Failed Trials

Type	Allergy	Date	Severity/Reaction/Comments
Allergy	Amoxicillin	06-28-2024	S: Low R: Hives C: as a child
Allergy	Tylenol	07-09-2024	S: Low R: Low blood pressure
Failed Trial	Benadryl	06-28-2024	S: Moderate to severe R: Fainting C: can't use for sleep
Intolerance	NSAIDS (Non-Steroidal Anti-Inflammatory Drug)	06-28-2024	S: Mild to Moderate R: Abdominal cramps C: no GI bleed
Intolerance	pollen extracts	06-28-2024	S: Low R: Other

Last 3 Vitals	6/28/24 16:49	6/28/24 16:23	3/14/24 16:08
Reason for Not Obtaining Vitals		Client Refused	
No Vitals: Comments		test	
Temp. (F)	97.0	98.0	
Temp. Location		Mouth/Oral	

LOOKING AT HISTORICAL DATA

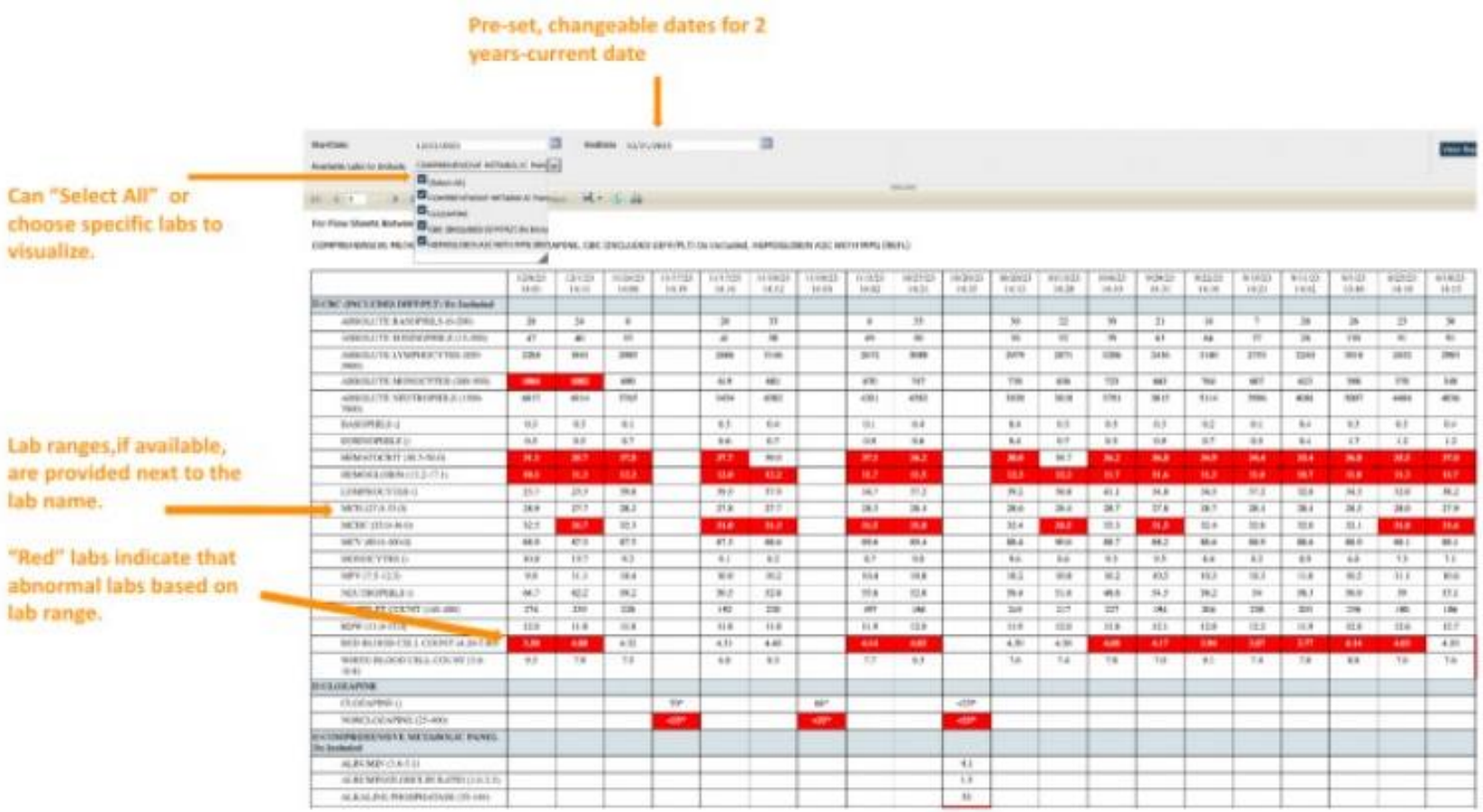
Abbreviated Notes Report- compilation of all notes from all clinicians and primarily where people would write their "plans" for a client.

Most of the information in the client abbreviated notes report will NOT pull into the medical / psych note, primarily just the subjective and A/P sections

Author Name	Procedure Code	Service Date	FTF	Program	Status Desc
Caraveo, Sabrina	Psychosocial Rehabilitation Group	11/26/23	60.00	MH Adult Outpatient	In Progress
Progress Note Information	test				
Progress Note Care Plan	plan to have pt talk with his daughter and set up time with group therapy on Tuesdays				
Huang, Delphine	Crisis Intervention/Mobile Crisis	10/09/23	30.00	MH Access	Signed
Progress Note Information	Pt is feeling more agitated and concerned about his well being though no SI. Talked with family including daughter who states that she will stay with pt until morning and call the psychiatrists				
Progress Note Care Plan	sent to psychiatrist and therapist a message to f/u				
Huang, Delphine	Medical Team Conference,Participation by Physician. Pt and/or Family Not Pr	10/09/23	30.00	MH Adult Outpatient	Signed
Narrative	met with team and discussed pt change in behavior and discussed with therapist ,nurse and case manager that he may need more frequency engagements				
Huang, Delphine	Individual Therapy	10/09/23	60.00	MH Adult Outpatient	Signed
Progress Note Information	Discussed with pt how he has been having a lot of anger towards his family.				
Progress Note Care Plan	plan to have pt talk with his daughter and set up time with group therapy on Tuesdays				
Huang, Delphine	Medication Support Existing Client	10/09/23	30.00	MH Adult Outpatient	Signed
Psych Note Chief Complaint	Patient came in today bc he he has issues with controlling his anger at his family and feels out of control				
Psych Note Plan	Plan to start pt on lexapro and risperadone to help with his depression. Follow up with his therapist and call his daughter				

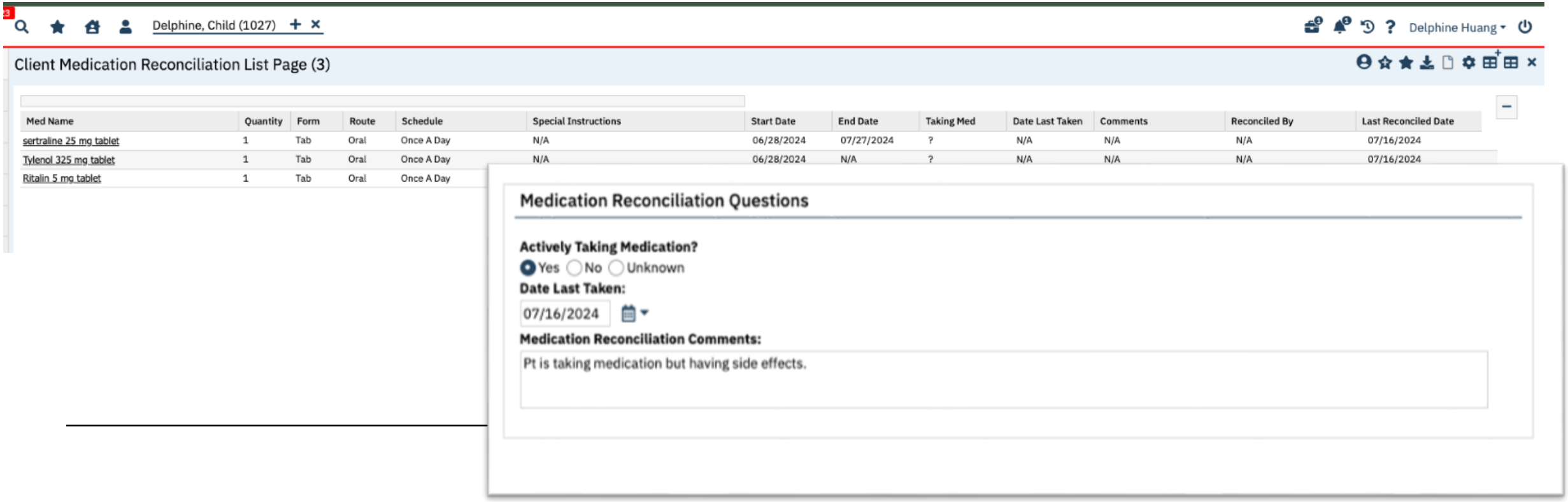
LOOKING AT HISTORICAL DATA

- Cumulative Lab Report- *cumulative report of labs results across time for a client*
- Psych / Medical note will pull in last 2 months of labs, to view historical report of labs, please see the cumulative lab report.



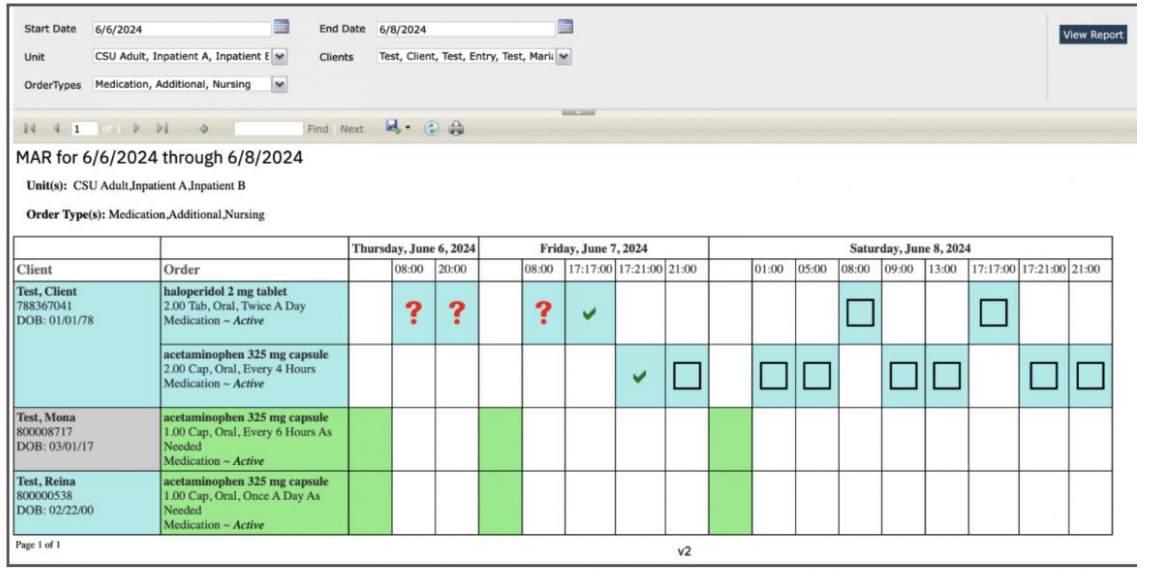
MEDICATION RECONCILIATION

This tool is helpful to capture if a patient is taking medications or not. It will pull current medications or expired medications within last 1 year.



INPATIENT SUPPORTING DOCS

- CalMHSA MAR Report
- Medication Reconciliation - *pending digital instructions, live in PROD*
- Shift Report (coming soon!)



Start Date 6/6/2024 End Date 6/8/2024 View Report
Unit CSU Adult, Inpatient A, Inpatient E Clients Test, Client, Test, Entry, Test, Mari
OrderTypes Medication, Additional, Nursing

MAR for 6/6/2024 through 6/8/2024

Unit(s): CSU Adult,Inpatient A,Inpatient B

Order Type(s): Medication,Additional,Nursing

Client	Order	Thursday, June 6, 2024			Friday, June 7, 2024					Saturday, June 8, 2024								
			08:00	20:00		08:00	17:17:00	17:21:00	21:00		01:00	05:00	08:00	09:00	13:00	17:17:00	17:21:00	21:00
Test, Client 788367041 DOB: 01/01/78	**haloperidol 2 mg tablet** 2.00 Tab, Oral, Twice A Day Medication ~ *Active*		?	?		?	✔						☐			☐		
	acetaminophen 325 mg capsule 2.00 Cap, Oral, Every 4 Hours Medication ~ *Active*							✔	☐		☐	☐		☐	☐		☐	☐
Test, Mona 800008717 DOB: 03/01/17	**acetaminophen 325 mg capsule** 1.00 Cap, Oral, Every 6 Hours As Needed Medication ~ *Active*																	
Test, Reina 800000538 DOB: 02/22/00	**acetaminophen 325 mg capsule** 1.00 Cap, Oral, Once A Day As Needed Medication ~ *Active*																	

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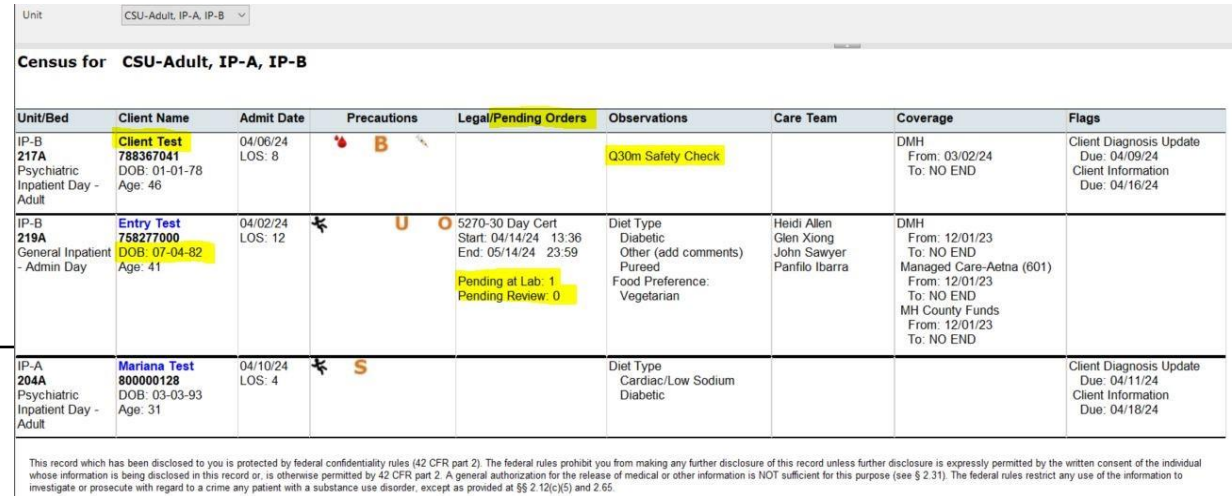


Unit CSU-Adult, IP-A, IP-B

Census for CSU-Adult, IP-A, IP-B

Unit/Bed	Client Name	Admit Date	Precautions	Legal/Pending Orders	Observations	Care Team	Coverage	Flags
IP-B **217A** Psychiatric Inpatient Day - Adult	**Client Test** **788367041** DOB: 01-01-78 Age: 46	04/06/24 LOS: 8	B		Q30m Safety Check		DMH From: 03/02/24 To: NO END	Client Diagnosis Update Due: 04/09/24 Client Information Due: 04/16/24
IP-B **219A** General Inpatient - Admin Day	**Entry Test** **758277000** DOB: 07-04-82 Age: 41	04/02/24 LOS: 12	U O	5270-30 Day Cert Start: 04/14/24 13:36 End: 05/14/24 23:59 Pending at Lab: 1 Pending Review: 0	Diet Type Diabetic Other (add comments) Pureed Food Preference: Vegetarian	Heidi Allen Glen Xiong John Sawyer Panfilo Ibarra	DMH From: 12/01/23 To: NO END Managed Care-Aetna (601) From: 12/01/23 To: NO END MH County Funds From: 12/01/23 To: NO END	
IP-A **204A** Psychiatric Inpatient Day - Adult	**Mariana Test** **800000128** DOB: 03-03-93 Age: 31	04/10/24 LOS: 4	S		Diet Type Cardiac/Low Sodium Diabetic			Client Diagnosis Update Due: 04/11/24 Client Information Due: 04/18/24

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

NOTE TEMPLATE AGENDA

- Create a new service note
- Fill out Service Tab
- Filling out Note Tab
  - SOAP note template: each section
  - Associated Tables and Refreshing Tables
  - Show and Hide Toggle
- Leveraging Key Phrases
- Adding Allergies
- Adding Vitals
- Adding Medications and their consents
- Diagnosis
- A/P and Shared Care Plan
- Additional information
- Billing Diagnosis
- Show and Hide PDF Section Fxn
- Completing Note
- Procedure Codes New Names

TRANSITION FOR THE OLD PSYCHIATRIC NOTE

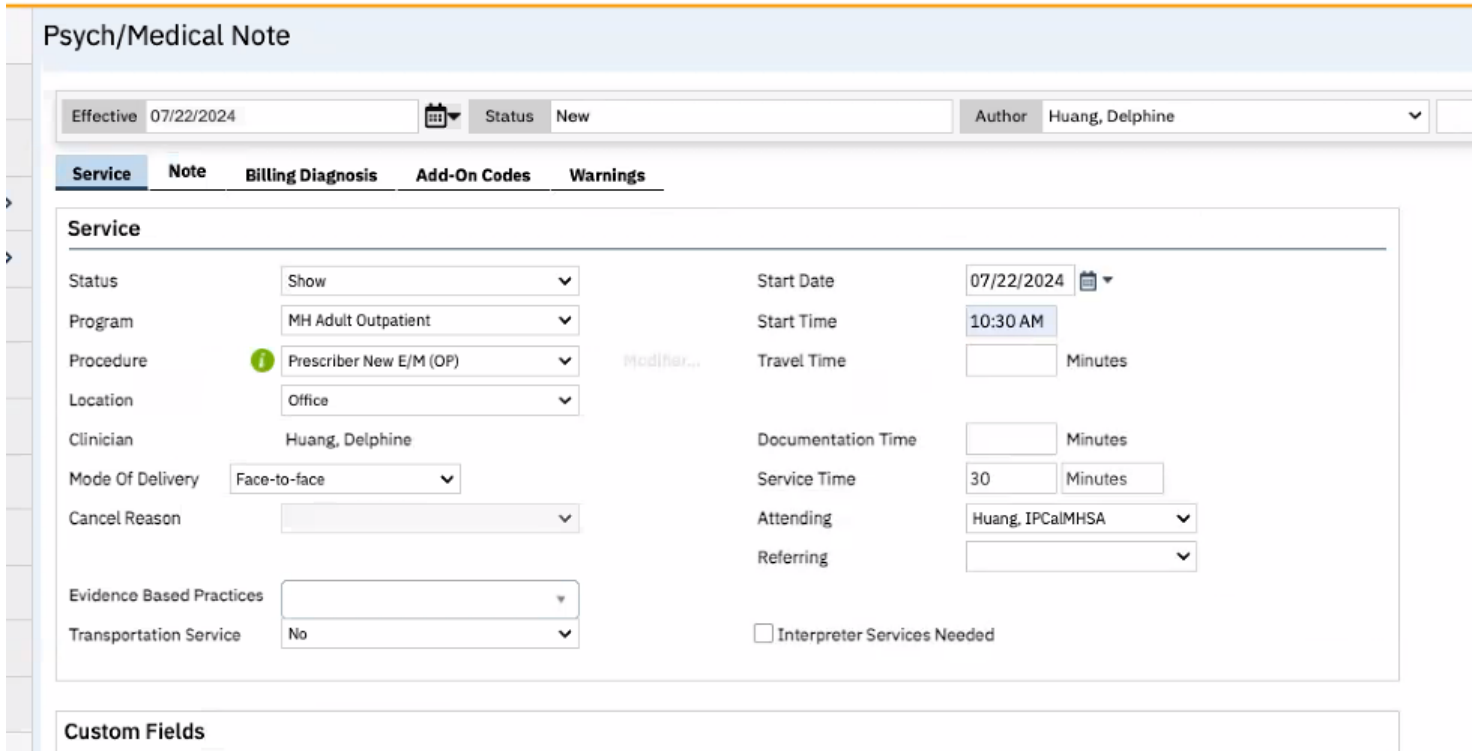
If there are any information in the following sections from the old “Psychiatric Note Template,” there will be a one-time push for each client regardless of procedure code to the new “Psych/Medical Note,” if it is the same author, same program and same CDAG.

Psychiatric Note Template (OLD)	**Psych/Medical Note Template (NEW)**
Today’s Chief Complaint	**Subjective/CC/HPI/Visit Notes**
History of Present Illness	**Client History & Pertinent Information**
Mental Status Exam Additional Comments, Descriptions. *(This excludes the individual sections of the MSE’s radio buttons and/or their associated comments section)*	**MSE/PE**
Plan	**Assessment and Plan**

SERVICES TAB

What will show up on the final PDF

- Status*
- Program*
- Procedure*
- Location*
- Mode of Delivery
- StartDate*
- Start Time*
- Travel Time (if needed)
- Documentation Time
- Service Time*
- **Attending (if needed)***



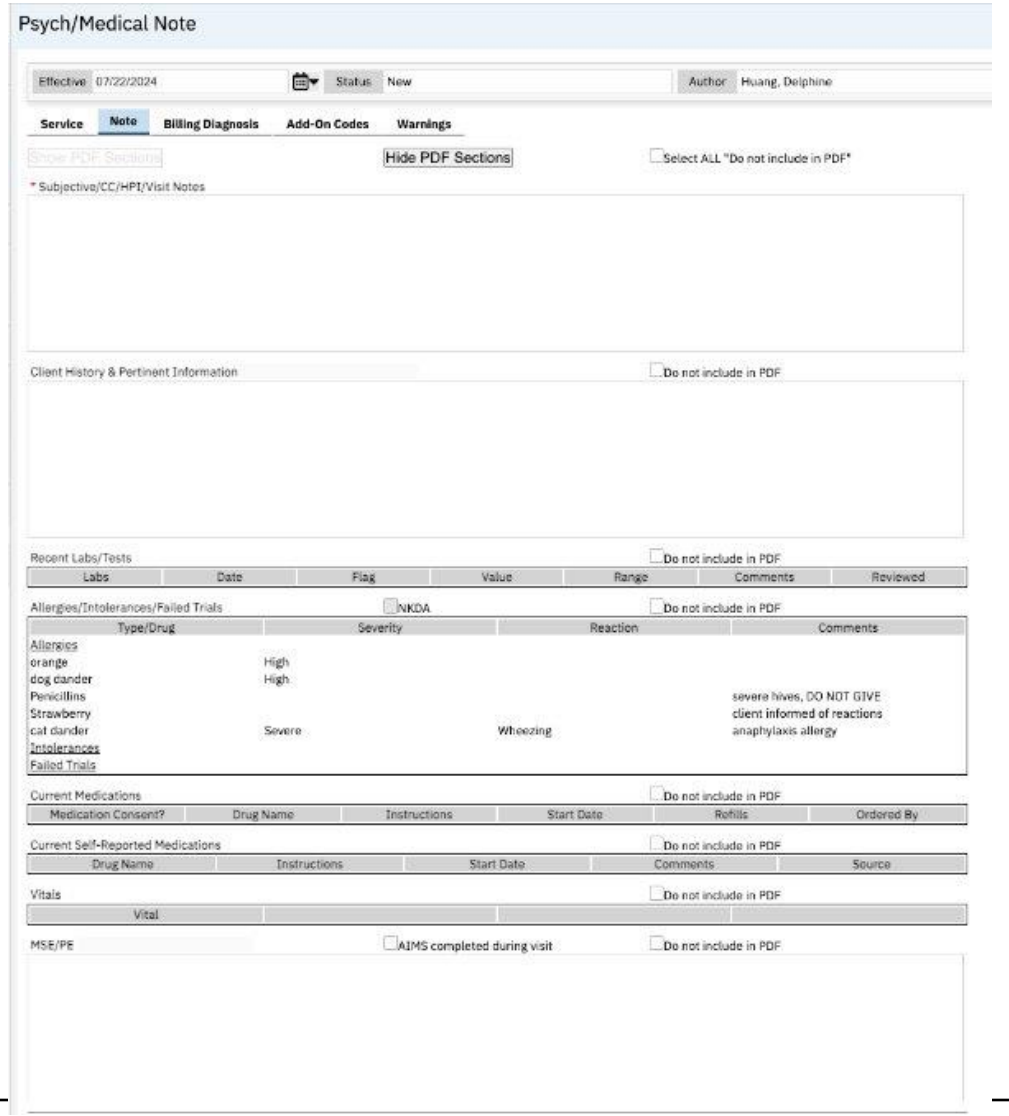
NOTE TEMPLATE

Textbox Data will only initialize If:

- Same Client
- Same Author
- Same Program

Within the Program, different procedures (that also meet the same client, same author, same program criteria) and use the psych medical note template, will initialize from last signed.

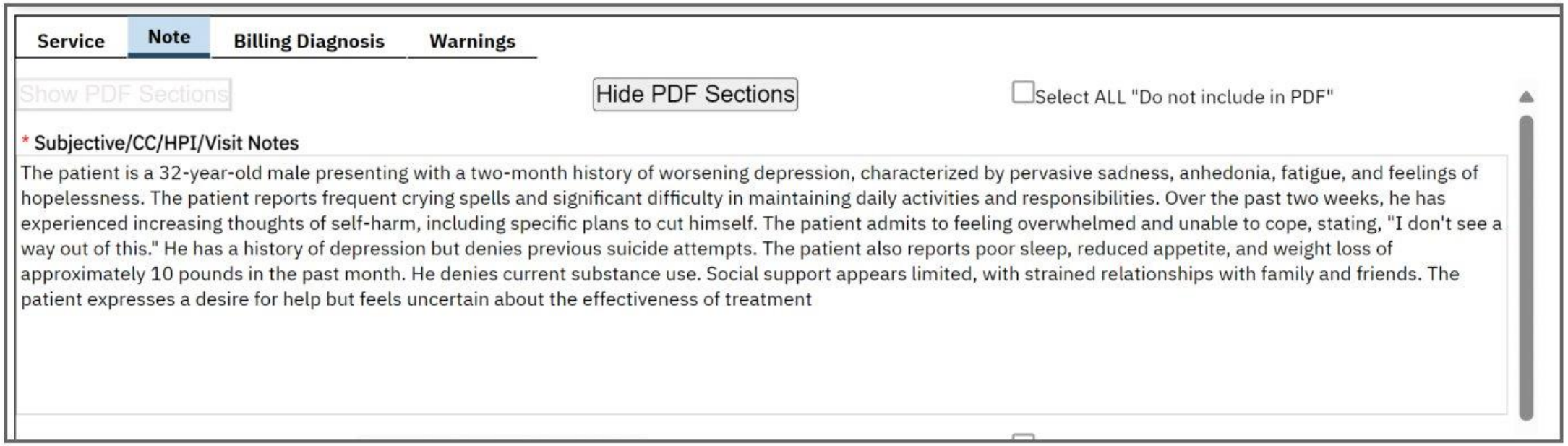
If you go to a different screen that data will hold if you don't close out the note, BUT we highly recommend that you also "Save" often.



LEVERAGING KEY PHRASES

- Keyphrases can be used to take preset text and autoload into their note
- It allows customization of the template
  - Creating Assessment as Key Phrases
  - Functional Keyphrases are available for use to pull in specific data *(digital instructions pending for end users)*
  - Counties should make and organize county level/agency level key phrases to support their end users and standardize as they see necessary.
  - End users should learn how to create key phrases to expedite their documentation.
  - Instructions
    - *Keyphrases Set up for Admin*
    - *Users with Edit Agency Key phrases*
    - *How to Add, Edit, and Use Key Phrases: w/ Permission Only*
    - *How to document verbal medication consent in notes*

SUBJECTIVE SECTION



This section can be used to capture the subjective part of a patient visit.
It can also be used to record visit notes, and if you choose to not document using any other sections.
This is mandatory to fill out.

CLIENT HISTORY

This section can be used to capture the patient's history such as their previous psychiatric, medical, medication, or program history. It can also be used to capture any social, substance use, family history, pertinent tests. The "Do Not Include in PDF" functionality can be utilized.

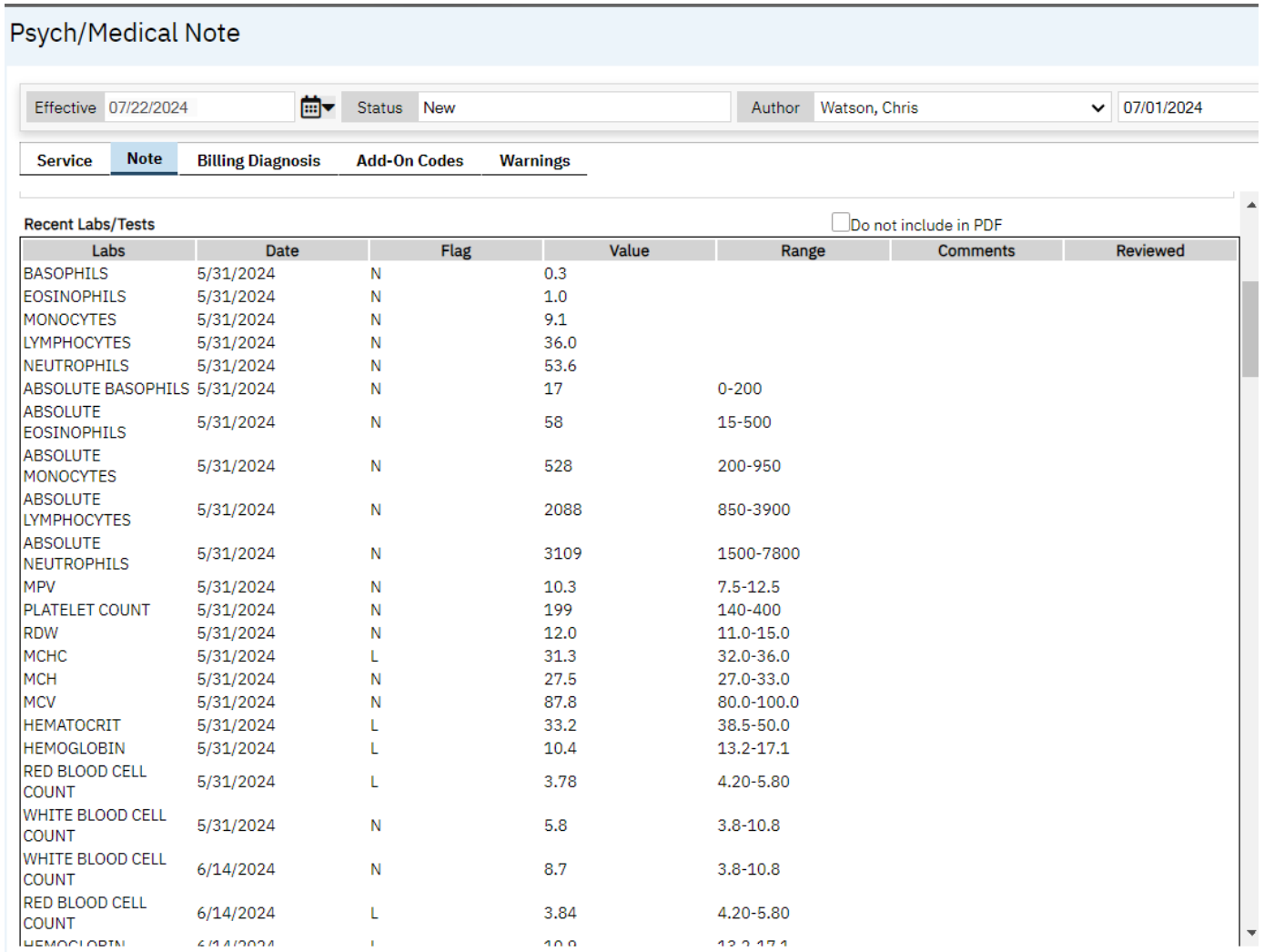
We highly recommend creating Key Phrase Templates to assist with what client history you want your staff to collect. It is different for every user, clinic, and county.

LAB RESULTS

This section pushes two months of lab data into the note.

It includes the lab name, result date, if any abnormality (H = high, L= low, N=Normal), the lab value, the range, lab comments, and if it has been reviewed by staff.

The “Do Not Include in PDF” functionality can be utilized.



Psych/Medical Note

Effective 07/22/2024 Status New Author Watson, Chris 07/01/2024

Service | Note | Billing Diagnosis | Add-On Codes | Warnings

Recent Labs/Tests

Do not include in PDF

Labs	Date	Flag	Value	Range	Comments	Reviewed
BASOPHILS	5/31/2024	N	0.3			
EOSINOPHILS	5/31/2024	N	1.0			
MONOCYTES	5/31/2024	N	9.1			
LYMPHOCYTES	5/31/2024	N	36.0			
NEUTROPHILS	5/31/2024	N	53.6			
ABSOLUTE BASOPHILS	5/31/2024	N	17	0-200		
ABSOLUTE EOSINOPHILS	5/31/2024	N	58	15-500		
ABSOLUTE MONOCYTES	5/31/2024	N	528	200-950		
ABSOLUTE LYMPHOCYTES	5/31/2024	N	2088	850-3900		
ABSOLUTE NEUTROPHILS	5/31/2024	N	3109	1500-7800		
MPV	5/31/2024	N	10.3	7.5-12.5		
PLATELET COUNT	5/31/2024	N	199	140-400		
RDW	5/31/2024	N	12.0	11.0-15.0		
MCHC	5/31/2024	L	31.3	32.0-36.0		
MCH	5/31/2024	N	27.5	27.0-33.0		
MCV	5/31/2024	N	87.8	80.0-100.0		
HEMATOCRIT	5/31/2024	L	33.2	38.5-50.0		
HEMOGLOBIN	5/31/2024	L	10.4	13.2-17.1		
RED BLOOD CELL COUNT	5/31/2024	L	3.78	4.20-5.80		
WHITE BLOOD CELL COUNT	5/31/2024	N	5.8	3.8-10.8		
WHITE BLOOD CELL COUNT	6/14/2024	N	8.7	3.8-10.8		
RED BLOOD CELL COUNT	6/14/2024	L	3.84	4.20-5.80		

ADD ALLERGIES

Allergies/Intolerances/Failed Trials ☐ NKDA ☑ Do not include in PDF

Type/Drug	Severity	Reaction	Comments
Allergies			
Amoxicillin	Low	Hives	as a child
Tylenol	Low	Low blood pressure	
Intolerances			
NSAIDS (Non-Steroidal Anti-Inflammatory Drug)	Mild to Moderate	Abdominal cramps	no GI bleed
pollen extracts	Low	Other	
Failed Trials			
Benadryl	Moderate to severe	Fainting	can't use for sleep

Authors can input or edit from the Allergies, Intolerance and Failed Trials from Medication Rx and/or the Allergies screen.

This information may NOT refresh since this Medications Rx operates in a separate window, but if you go to a different screen, it will refresh. Even if the data does not refresh, any data that is new and/or modified in the Rx module will appear in the final PDF. It will list the severity, reactions and comments.

The Do Not Include in PDF" functionality can be utilized.

ADD RX MEDICATIONS

Current Medications ☑ Do not include in PDF

Medication Consent?	Drug Name	Instructions	Start Date	Refills	Ordered By
☐	Sertraline	25mg, Tab, Oral each Once A Day	6/28/2024	0.00	Huang, Delphine MD Medical Doctor
☐	Ritalin	5mg, Tab, Oral each Once A Day	6/28/2024	0.00	Huang, Delphine MD Medical Doctor

This section will pull medications from Medication Rx module. It will only display medications that are active, and the end date has not expired within 1 year. It will include the number of refills and who prescribed the medications. This information may NOT refresh since the Rx module operates in a separate window, but if you go to a different screen it will refresh. Even if the data does not refresh, any data that is new and/or modified in Rx module will appear in the final PDF. The “Do Not Include in PDF” functionality can be utilized.

CalMHSA is aware of this issue and is working on creating a real-time refresh mechanism.

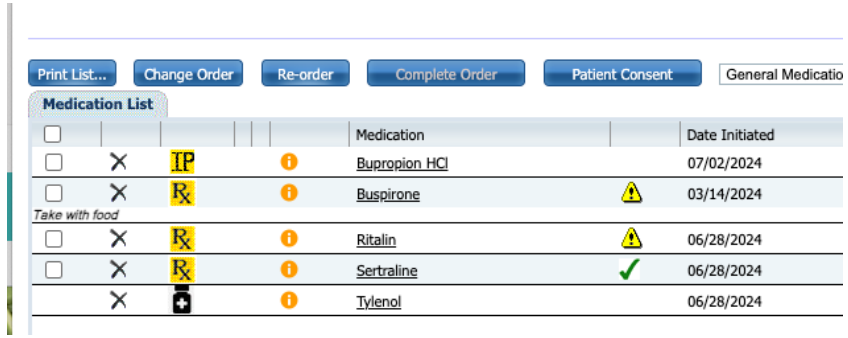
MEDICATION CONSENTS

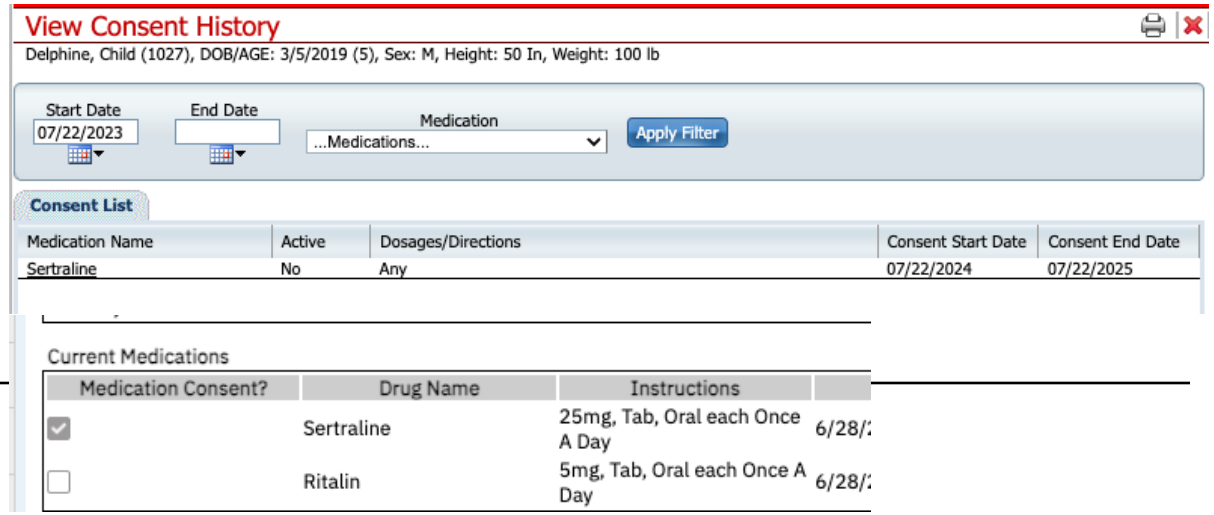
Current Medications

Do not include in PDF

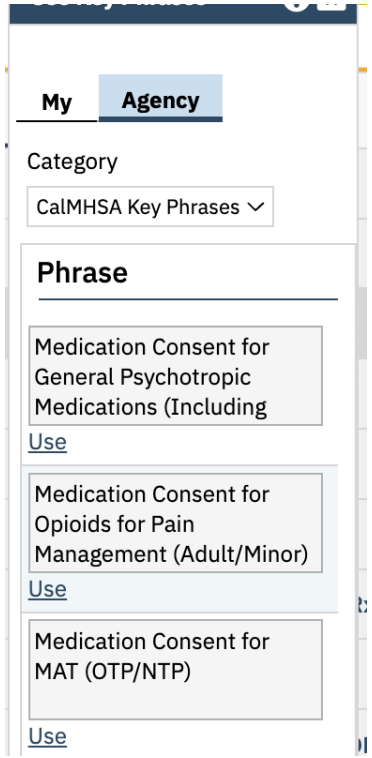
Medication Consent?	Drug Name	Instructions	Start Date	Refills	Ordered By
☑	Sertraline	25mg, Tab, Oral each Once A Day	6/28/2024	0.00	Huang, Delphine MD Medical Doctor
☐	Ritalin	5mg, Tab, Oral each Once A Day	6/28/2024	0.00	Huang, Delphine MD Medical Doctor

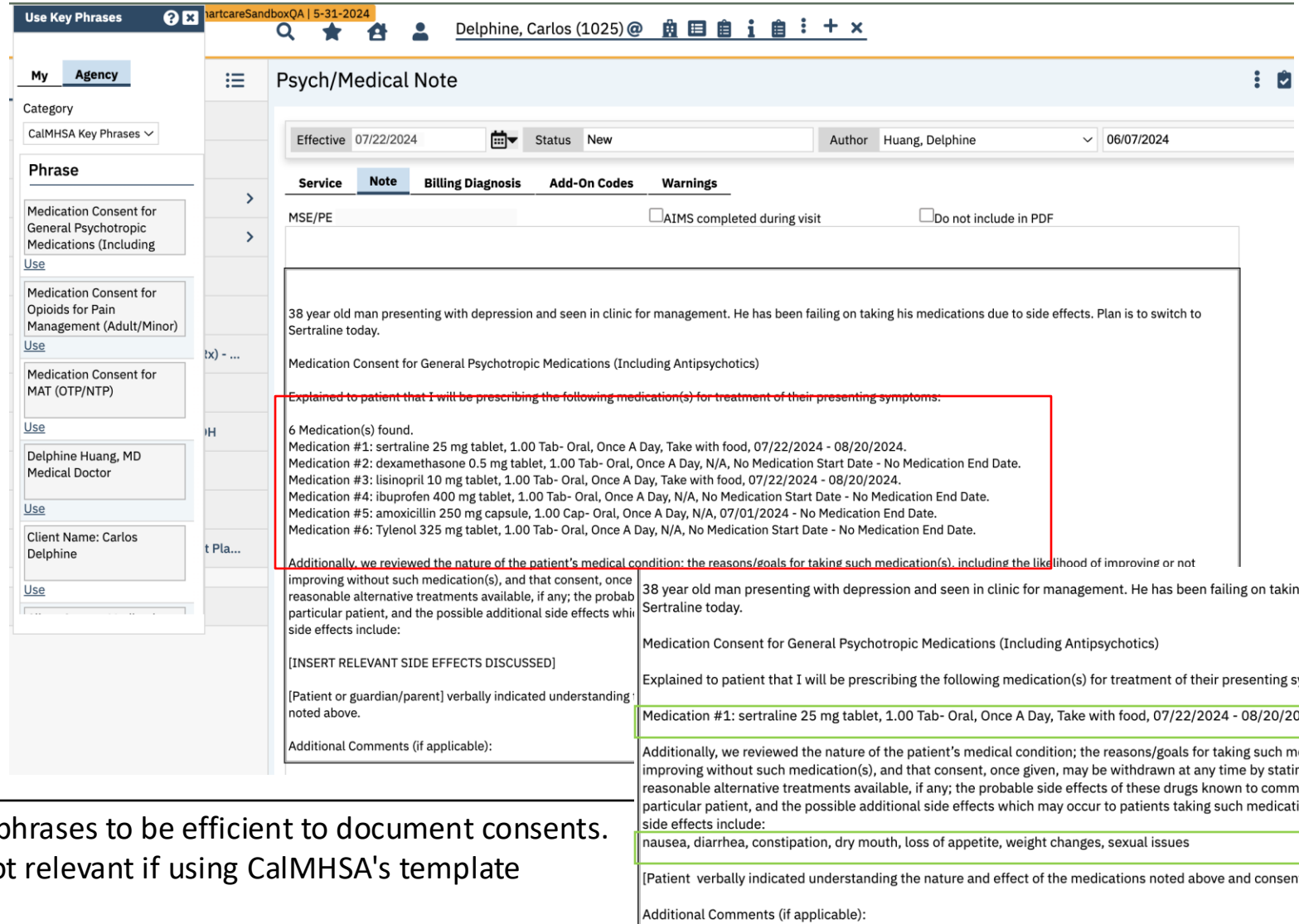
- If verbal or written consent is captured for certain medications, can check off this. This will change the icon for that specific medication within Medication Rx from a yellow warning to a green checkmark and add to the Medication Consent History.
- The subsequent note will gray out because there is a valid medication consent.





REMINDER: MEDICATION CONSENT KEYPHRASES





Use vetted Medication Consent Keyphrases to be efficient to document consents.
Remove any medications that are not relevant if using CalMHSA's template

ADD HOME MEDICATIONS

Current Self-Reported Medications ☐ Do not include in PDF

Drug Name	Instructions	Start Date	Comments	Source
Dexamethasone	0.5mg, Tab, Oral each Once A Day			Pharmacy Verbal
Ibuprofen	400mg, Tab, Oral each Once A Day		Concern for GIB so watch poop	Pharmacy Documentation
Amoxicillin	250mg, cap, Oral each Once A Day	7/1/2024		Patient Verbal
Tylenol	325mg, Tab, Oral each Once A Day		Spanish Speaker	Patient Verbal

This section will push medication from Medication Rx module's "Add Medication" section. It will only display medications that are active and the end date has not expired. It will include "Comments" and "Source". The initiated date is displayed here.

This information may not refresh since this Medications Rx operates on a separate window, but if you go to a different screen, it will refresh. Even if the data does not refresh, any data that is new and/or modified in Rx will appear in the final PDF.

The "Do Not Include in PDF" functionality can be utilized

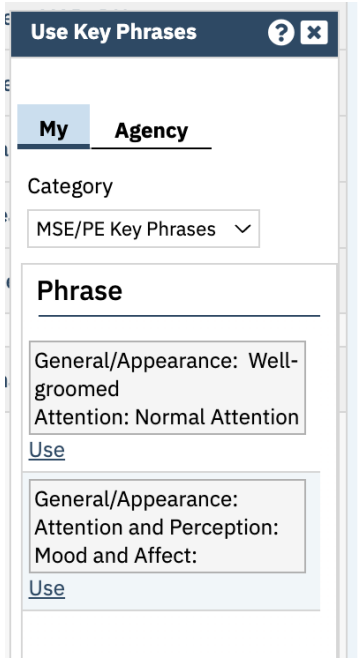
ADD VITALS

Vitals ☐ Do not include in PDF

Vital	3/14/2024	3/12/2024	
Temp. (F)	98.0 F		
Pulse (bpm)	100 bpm	80 bpm	
Blood Pressure	180 / 100 (mmHg)	120 / 80 (mmHg)	
BP Position	Standing	Sitting	
Breaths/Min	20	30	
Oxygen level	100		
Height (in)	60.00 In	60.00 In	
Weight (lbs)	200.00 lb	150.00 lb	
BMI (lbs/in2)	39.06 lbs/in2	29.29 lbs/in2	
Pain Level	5		
Pain Location	Mouth		

This section will pull the last 3 vitals within a CDAG from the “Vitals/Meaningful Use” Flowsheet or “Enter Vitals”. This information will refresh the note automatically with any added information. The “Do Not Include in PDF” functionality can be utilized.

MSE/PE



Tylenol	325mg, Tab, Oral each Once A Day	Spanish Speaker	Patient Verbal

Vitals ☐ Do not include in PDF

Vital	3/15/2024	3/15/2024	3/15/2024
Temp. (F)			98.0 F
Pulse (bpm)		90 bpm	120 bpm
Systolic BP (mmHg)		150	180
Diastolic BP (mmHg)		90	90
Breaths/Min			100

MSE/PE ☐ AIMS completed during visit ☐ Do not include in PDF

General/Appearance: Well-groomed
Attention: Normal Attention
Perception: Normal Perception
Mood and Affect: Euthymic mood, Appropriate affect
Speech: Clear and Coherent Speech
Behavior: Calm, Cooperative, Engaged, Good Eye Contact
Thought Process: Organized and Linear Thought Content
Thought Content: No Auditory Hallucinations, No Visual Hallucinations, No Delusions,
Suicidal/Homicidal: Has SI- plans shoot himself
Insight: Normal Insight

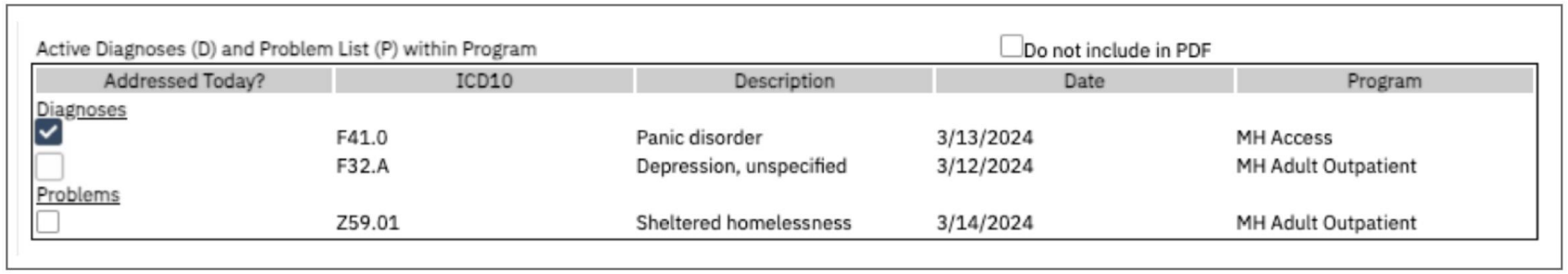
This is a section that can be used to document the Mental Status Exam or Physical Exam. We highly recommend creating Key Phrases to improve efficiency.

The "Do Not Include in PDF" functionality can be utilized.

AIMS Completed During Visit: The data collection should be done in the **AIMS Assessment Document**, and if users mark the checkbox then this information will be displayed on the **Client Medical Facesheet** This checkmark will NOT be retained for the subsequent note.

DIAGNOSES AND PROBLEMS LIST

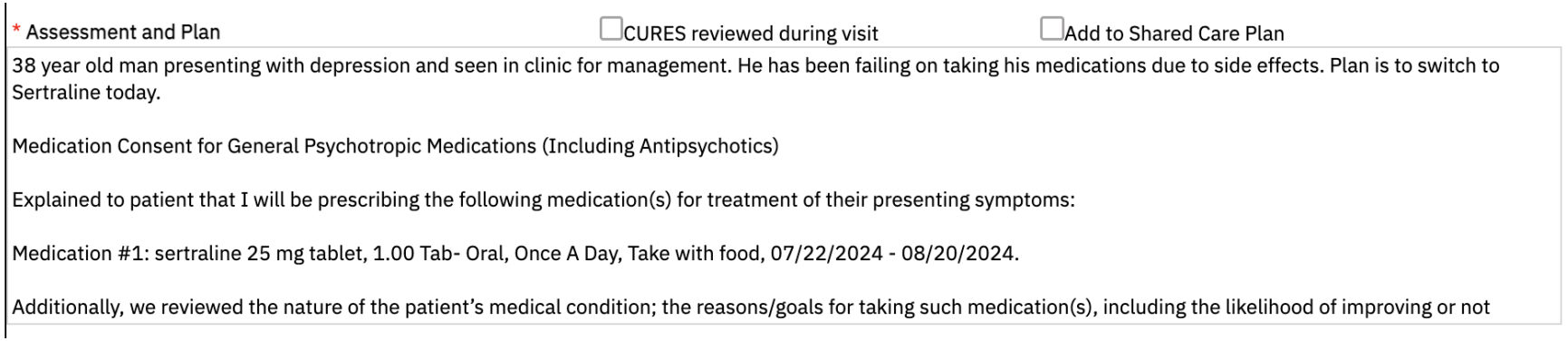
- This section captures the client's diagnoses and problem list from any programs that are within the same CDAG. The active diagnosis captured by Diagnosis Document is included in the diagnosis sub-section. Also, any problems that are documented in the Client Problem List are demarcated in the Problem's subsection.
- Any common ICD10s are grouped together.
- The date represents the most recent entry for that ICD10 code.
- You can checkmark the issues that were addressed at the visit.
- Any selection will NOT retain its checkmark for the subsequent note.



Active Diagnoses (D) and Problem List (P) within Program ☐ Do not include in PDF

Addressed Today?	ICD10	Description	Date	Program
Diagnoses				
☑	F41.0	Panic disorder	3/13/2024	MH Access
☐	F32.A	Depression, unspecified	3/12/2024	MH Adult Outpatient
Problems				
☐	Z59.01	Sheltered homelessness	3/14/2024	MH Adult Outpatient

ASSESSMENT AND PLAN

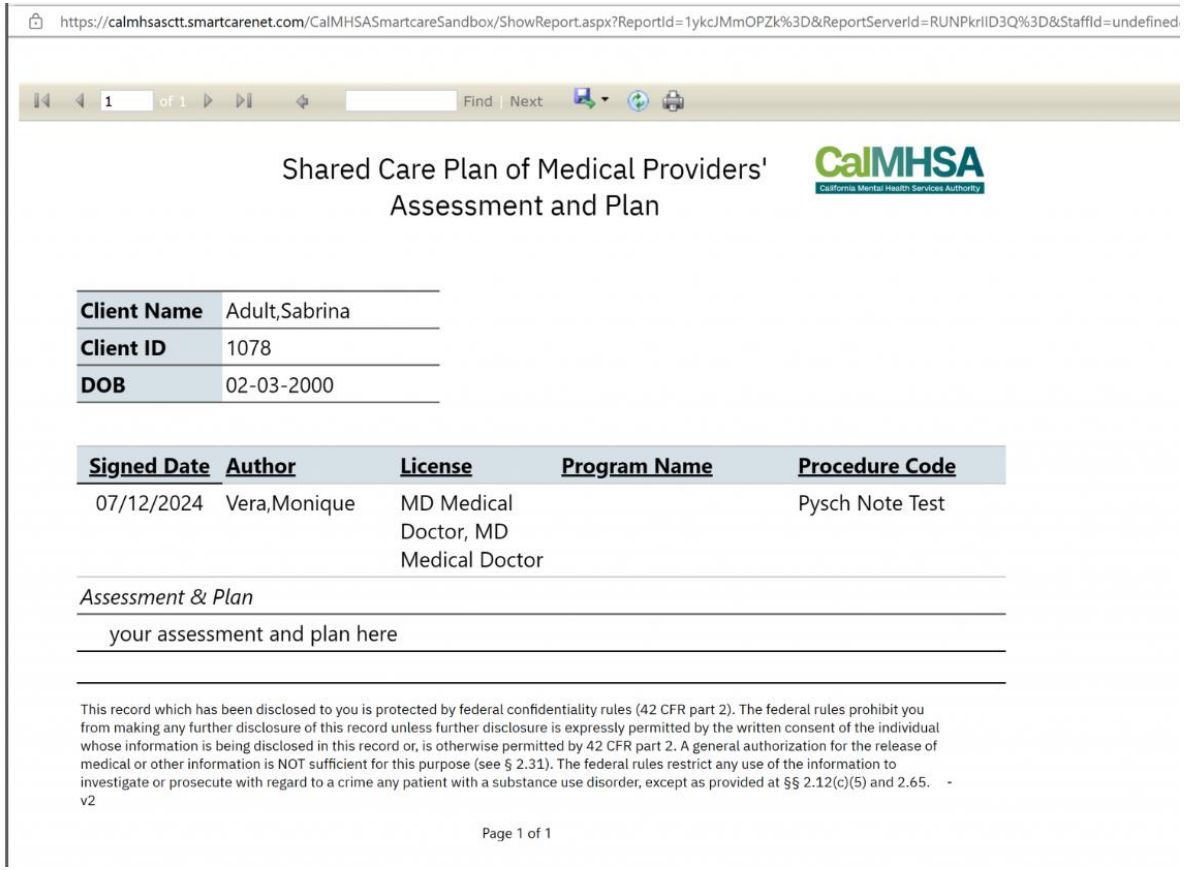


- This section can be used to capture the Assessment / Plan. It is mandatory to fill this out.
- **Documentation of CURES** being reviewed can be checked. This information will be displayed on the Client Medical Facesheet as an efficient way to see when it was last completed and by whom. This checkmark will NOT be retained for the subsequent note.
- **Add to Shared Care Plan:** This is optional as we are still building out a future-state Shared Care Plan to be more collaborative and efficient in data collecting and data sharing. The goal is that for facilities that use a shared care plan or treatment plan, individual's plans can feed into the document to reduce the need for double entry. For now, if the box is checked, this saves to the Shared Care Plan Report which is a compilation of individual's psych medical note's plans

CURES + ADD SHARED CARE PLAN

- **Documentation of CURES** being reviewed can be checked. This information will be displayed on the Client Medical Facesheet. This checkmark will NOT be retained for the subsequent note.
- **Add to Shared Care Plan:** This is optional, as we are still building out a future-state Shared Care Plan/Treatment Plan to be more collaborative and efficient in data collecting and data sharing.
    - The goal is that for facilities that use a shared care plan or treatment plan, individual's plans can feed into the document to reduce the need for double entry.
    - For now, if the box is checked, this saves to the Shared Care Plan Report which is a compilation of individual's psych medical note's A/P sections to facilitate ease of reading of all provider's A/Ps

SHARED CARE PLAN REPORT



https://calmhsasctt.smartcarenet.com/CalMHSASmartcareSandbox/ShowReport.aspx?ReportId=1ykcJMmOPZk%3D&ReportServerId=RUNPkrIID3Q%3D&StaffId=undefined

1 of 1 Find | Next

Shared Care Plan of Medical Providers' Assessment and Plan

CalMHSA
California Mental Health Services Authority

Client Name	Adult,Sabrina
Client ID	1078
DOB	02-03-2000

Signed Date	Author	License	Program Name	Procedure Code
07/12/2024	Vera,Monique	MD Medical Doctor, MD Medical Doctor		Pysch Note Test

Assessment & Plan

your assessment and plan here

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. - v2

Page 1 of 1

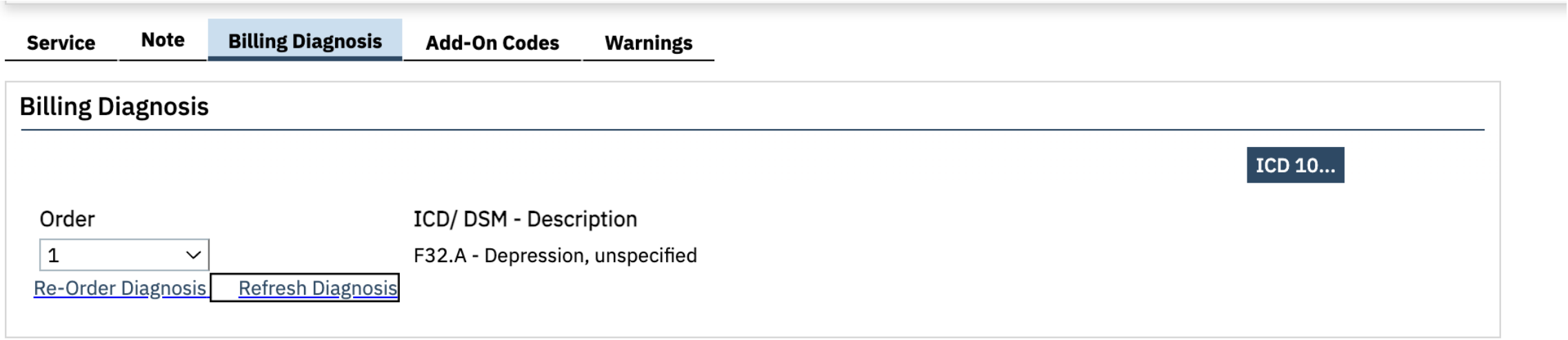
ADDITIONAL INFORMATION

This section is a flexible section for authors to capture information that does not fit in any above section but should be included. (For example: attending attestation, client's timeline within the program, family conversations, follow-up information). The "Do Not Include in PDF" functionality can be utilized.

Additional Information

☐ Do not include in PDF

BILLING DIAGNOSIS



- Autopopulates from Diagnosis Document and is program specific
- No change in functionality here, as previously done.

SHOW AND HIDE PDF SECTION

The reason why we included this functionality is :

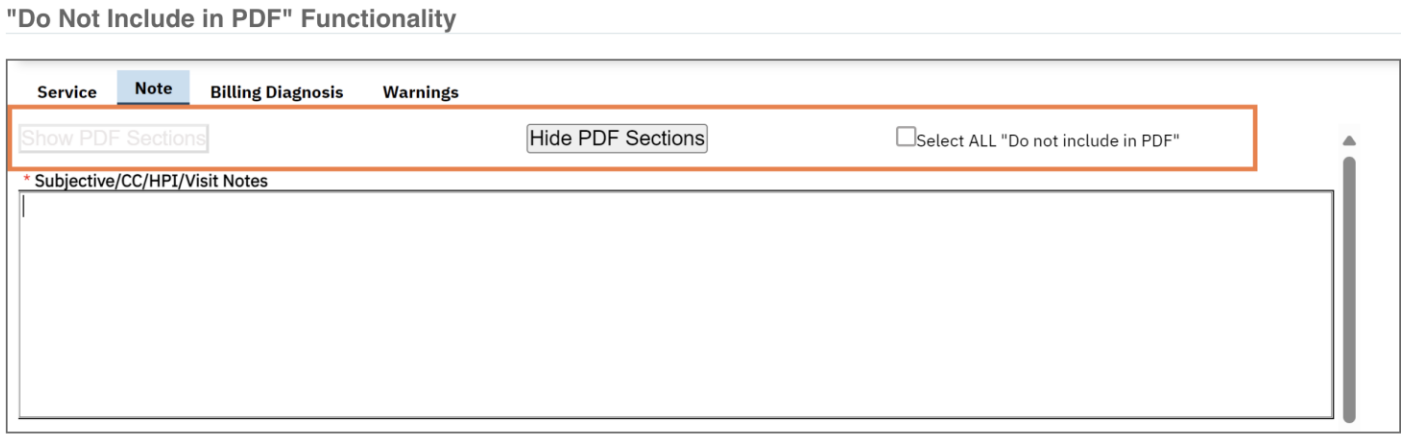
1) To appease lumpers and spliters writers and give agency to end users about what type of note they want to use.

2) Can choose because having a comprehensive note with multiple sections or less sections depending on the user and type of visit.

3) Can preview ahead of time the pdf by toggling between Show and Hide PDF Sections

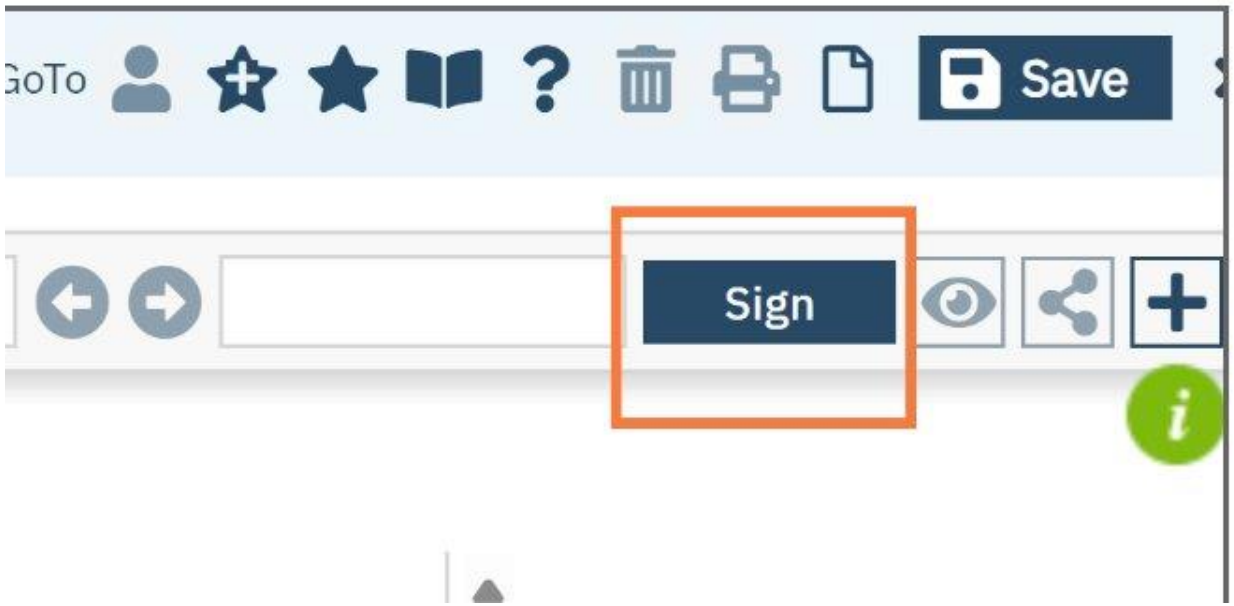
4) Remove checkbox for "Do not include in PDF" if you want have new information that was added to the section.

5) If there is no checkbox for "Do not include in PDF" then, the data in that textbox will initialize to subsequent note.
If there is a mark in the checkbox, then the data will NOT initialize to the subsequent note, only the last signed section will show up next time.

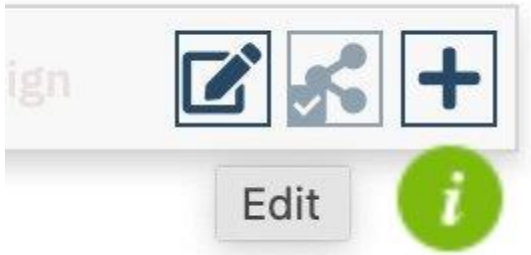


COMPLETING NOTE

Sign note and can review PDF



Amend or Assign Co-signer



PROCEDURE CODES + NEW NAMES + ASSOCIATED TEMPLATE

Psych Medical Note Template Associated to Procedure Codes- which notes will have the new template and any changes to the "Display As" name.

The Display As" Name change will happen 07/26/24, 4:30 PM PST.

The procedure code being associated to the Psych Medical Note Template will happen on 08/05/24 in early morning.

Which procedure code to use in which scenario is county dependent but we have provided recommendations.

CalMHSA Procedure Code ID	CPT	Planned Changes to the Procedure Code Label and add new Template	Current procedure code label	Suggested Facility Type/Role or License/Use Case
80	90792	Prescriber Assessment E/M (OP)	Assessment MD	Outpt: Prescriber, Initial Assessment
74	99201-99205	Prescriber New E/M (OP)	Medication Support New Client	Outpt: Prescriber
73	99212-99215	Prescriber Progress E/M (OP)	Medication Support Existing Client	Outpt: Prescriber
107	99441-99443	Prescriber Telephone E/M (OP)	Medication Support Telephone	Outpt/IP/PHF/CSU/Res: Prescriber
72	99242-99245	Prescriber Consult (OP)	Consult for New and Established Patients	Outpt: Prescriber
49	99451	Physician-to-Physician Consult	Physician Consultation	Outpt/IP/PHF/CSU/Res: only MD/DO to MD/DO Consultation

DISCHARGE/ AFTERCARE SUMMARY

How to Get a Summary of Care - very extensive

How to Complete the Discharge Instructions - pt focused

How to Complete the Discharge Summary- text based and some medical information

How to Create the Aftercare Discharge Summary Medical Report includes the Discharge Summary's text + medical relevant information (including changes to medications) , can be used for patients and/or transfer of care to other providers

WHAT NEEDS TO HAPPEN BETWEEN TODAY AND GO-LIVE

*C*alMHSA is focused on...

- We are changing the "Display As" Names
- Deployment script to assign this template its' procedure codes
- We are fixing high priority bugs

Recommendations for counties to focus on...

- Make sure your providers are aware (Nurses, Prescriber, Dieticians, Pharmacists) of change and have the information to help them write a note.
  - The Display As" Name change will happen 07/26/24, 4:30 PM PST.
  - Finish all outstanding notes that use the old psychiatric note template by 08/04/24 11:59 AM
  - List of outstanding/pending notes using the psychiatric note template has been sent out to county EHR admins to follow up with their providers.
  - You will lose access to the old template at that point and will not be able to finish your note.
  - Your admin can set up an announcement on the log in page.
  - The procedure code being associated to the Psych Medical Note Template will happen on 08/05/24 in early morning.

WEBSITE INSTRUCTIONS

- Psych Medical Note Instructions
- Psych Medical Note Template Associated to Procedure Codes
- Shared Medical Care Plan
- *Keyphrases Set up for Admin*
- *Users with Edit Agency Key phrases*
- *How to Add, Edit, and Use Key Phrases: w/ Permission Only*
- *How to document verbal medication consent in notes*
- How to Complete the AIMS Assessment
- Client Medical Facesheet
- Abbreviated Notes Report
- Cumulative Lab Report
- CalMHSA MAR Report
- How to Get a Summary of Care
- How to Complete the Discharge Instructions
- How to Complete the Discharge Summary
- How to Create the Aftercare Discharge Summary Medical Report
- Medication Reconciliation
- Shift Report- pending instructions and final testing in QA , will send announcement in our Bulletin

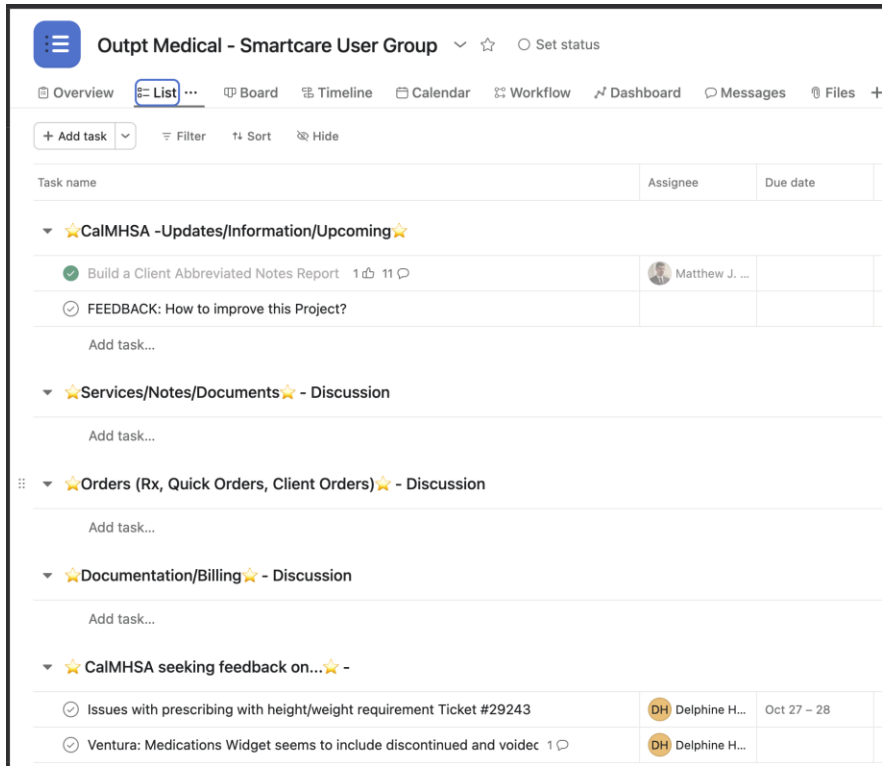
WHAT IS BEING FIXED AFTER AUGUST 5TH

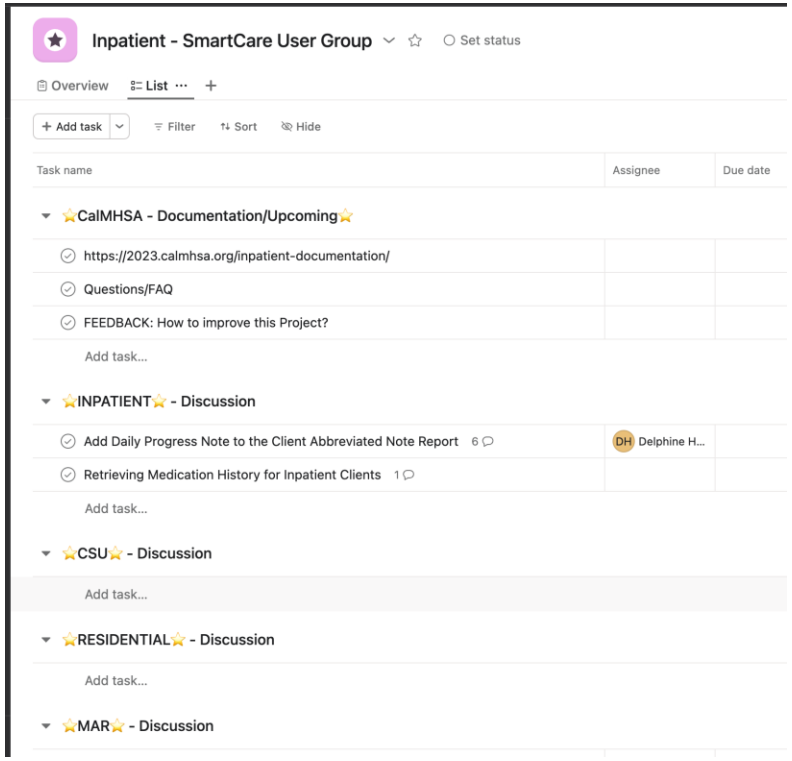
- Manual Refresh button for all tables *
- When you type in an area, undo the "Do not include in PDF" checkbox for that field *
- RDL: The "cosigner" field can be cut off *
- Tables not forcing page breaks*
- Pull-Forward: Note must be signed to be eligible to pull-forward*
- For fields that delete on Save, change it to "Delete this from the Note"
- When you uncheck a checkbox, uncheck "Select ALL" checkbox
- Hidden PDF information should be replaced with pull-forward information when delete
- Vitals not accurately displaying in Pysch/Med Note – *this is working in our systems technically but some counties are reporting that it is not consistently pulling in for them in their QA systems. We are testing*

ASANA SMARTCARE GROUPS

Benefits include:

- Hear from other counties that are in the same boat
- Share ideas/perspectives/workflows
- Give feedback to CalMHSA on an issue/prototype/prioritization
- Any enhancement request or bug should still be logged in Helix as a ticket.





SIGN UP FOR OUTPATIENT MEDICAL SMARTCARE USER GROUP: https://forms.gle/sn8ojvmAzrHpwiY77

SIGN UP FOR INPATIENT MEDICAL SMARTCARE USER GROUP: https://forms.gle/G6Uuc9fFfTSP4pKn9

Q/A

- Thank you for joining!