
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 (supervisors, 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


CalMHSA 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 because after this date, you will not be able to access any old drafts. You will lose access to the old template at that point and will not be able to finish your note.
 - List of outstanding/pending notes using the psychiatric note template has been sent out to county EHR admins to follow up with their providers.
 - Your EHR admin can set up an announcement on the log in page to help also remind your providers.
- The procedure codes being associated to the Psych Medical Note Template will happen on 08/05/24 in early morning. The SmartCare system may be down anytime between **12:00am – 6:00am on Monday 8/5**. During these hours we recommend implementing downtime procedures (paper documentation) to ensure current work is not lost, when the system becomes unavailable while this change is made in your production systems.

THIS IS WHERE YOU CAN SEE YOUR PENDING DOCUMENTS AND ANY OUTSTANDING NOTES

Assigned Document(s) 

	Notes	ISP	Assessment	ALL
Due Now	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
In Progress	<u>9</u>	<u>0</u>	<u>0</u>	<u>17</u>
Due in 14	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Co-Sign	<u>2</u>	<u>0</u>	<u>0</u>	<u>2</u>
To-Sign	<u>1</u>	<u>0</u>	<u>0</u>	<u>1</u>

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



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

The screenshot shows a software interface for generating a 'Client Abbreviated Notes Report'. On the left, there are two filter menus. The top one is for 'ProgramIDs' with options: (Select All), MH Access, and MH Adult Outpatient. The bottom one is for 'AuthorIDs' with options: (Select All), Watson, Chris; Nurse, Test; Huang, Prescriber; Huang, Nurse; Huang, Delphine; Fitzgerald, John; and Caraveo, Sabrina. The main area contains a search bar with '1 of 27' and a 'Find Next' button. Below the search bar, the report title 'Client Abbreviated Notes Report' is displayed, followed by the client name 'Delphine, David (1024)'. A table lists the notes with columns: Author Name, Procedure Code, Service Date, FTF, Program, and Status Desc. The notes include progress notes and care plans from various authors like Caraveo, Sabrina and Huang, Delphine.

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 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					

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.

The screenshot shows a web browser window with the address bar displaying "Delphine, Child (1027)". The page title is "Client Medication Reconciliation List Page (3)". The main content area contains a table with the following data:

Med Name	Quantity	Form	Route	Schedule	Special Instructions	Start Date	End Date	Taking Med	Date Last Taken	Comments	Reconciled By	Last Reconciled Date
sertraline 25 mg tablet	1	Tab	Oral	Once A Day	N/A	06/28/2024	07/27/2024	?	N/A	N/A	N/A	07/16/2024
Tylenol 325 mg tablet	1	Tab	Oral	Once A Day	N/A	06/28/2024	N/A	?	N/A	N/A	N/A	07/16/2024
Ritalin 5 mg tablet	1	Tab	Oral	Once A Day								

A modal window titled "Medication Reconciliation Questions" is open over the first row of the table. It contains the following fields:

- Actively Taking Medication?** with radio buttons for Yes (selected), No, and Unknown.
- Date Last Taken:** a date picker showing 07/16/2024.
- Medication Reconciliation Comments:** a text area containing the text "Pt is taking medication but having side effects."

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 800005538 DOB: 02/22/00	acetaminophen 325 mg capsule 1.00 Cap, Oral, Once A Day As Needed Medication ~ Active															

Page 1 of 1 v2

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	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

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. <i>(This excludes the individual sections of the MSE's radio buttons and/or their associated comments section)</i>	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)***

Psych/Medical Note

Effective 07/22/2024  Status New Author Huang, Delphine

Service Note Billing Diagnosis Add-On Codes Warnings

Service

Status	Show	▼	Start Date	07/22/2024	
Program	MH Adult Outpatient	▼	Start Time	10:30 AM	
Procedure	 Prescriber New E/M (OP)	▼	Travel Time		Minutes
Location	Office	▼	Documentation Time		Minutes
Clinician	Huang, Delphine		Service Time	30	Minutes
Mode Of Delivery	Face-to-face	▼	Attending	Huang, IPCalMHSA	▼
Cancel Reason		▼	Referring		▼
Evidence Based Practices		▼			
Transportation Service	No	▼			

Interpreter Services Needed

Custom Fields

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.

Psych/Medical Note

Effective: 07/22/2024 Status: New Author: Huang, Delphine

Service: **Note** Billing Diagnosis Add-On Codes Warnings

Show PDF Sections Hide PDF Sections Select ALL "Do not include in PDF"

* Subjective/CC/HPI/Visit Notes

Client History & Pertinent Information Do not include in PDF

Recent Labs/Tests Do not include in PDF

Labs	Date	Flag	Value	Range	Comments	Reviewed
------	------	------	-------	-------	----------	----------

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

Type/Drug	Severity	Reaction	Comments
Allergies			
orange	High		
dog dander	High		
Penicillins			severe hives, DO NOT GIVE
Strawberry			client informed of reactions
cat dander	Severe	Wheezing	anaphylaxis allergy
Intolerances			
Failed Trials			

Current Medications Do not include in PDF

Medication Consent?	Drug Name	Instructions	Start Date	Refills	Ordered By
---------------------	-----------	--------------	------------	---------	------------

Current Self-Reported Medications Do not include in PDF

Drug Name	Instructions	Start Date	Comments	Source
-----------	--------------	------------	----------	--------

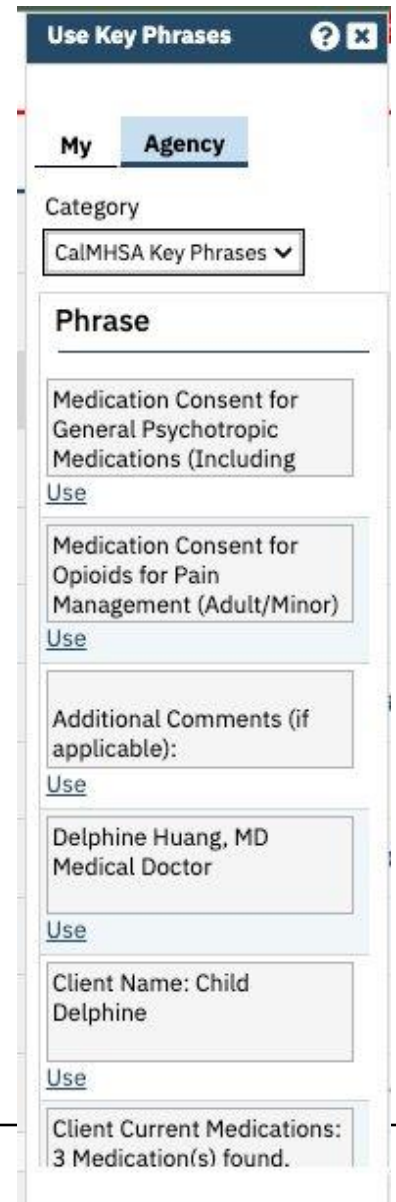
Vitals Do not include in PDF

Vital

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

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](#)



The screenshot shows a software interface titled "Use Key Phrases". At the top, there are tabs for "My" and "Agency". Below the tabs is a "Category" dropdown menu set to "CalMHSA Key Phrases". The main area displays a list of key phrases, each with a "Use" button below it. The visible key phrases are:

- Medication Consent for General Psychotropic Medications (Including)
- Medication Consent for Opioids for Pain Management (Adult/Minor)
- Additional Comments (if applicable):
- Delphine Huang, MD Medical Doctor
- Client Name: Child Delphine
- Client Current Medications: 3 Medication(s) found.

SUBJECTIVE SECTION

Service	Note	Billing Diagnosis	Warnings
<input type="button" value="Show PDF Sections"/>		<input type="button" value="Hide PDF Sections"/>	
<input type="checkbox"/> Select ALL "Do not include in PDF"			
* Subjective/CC/HPI/Visit Notes			
<p>The patient is a 32-year-old male presenting with a two-month history of worsening depression, characterized by pervasive sadness, anhedonia, fatigue, and feelings of hopelessness. The patient reports frequent crying spells and significant difficulty in maintaining daily activities and responsibilities. Over the past two weeks, he has experienced increasing thoughts of self-harm, including specific plans to cut himself. The patient admits to feeling overwhelmed and unable to cope, stating, "I don't see a way out of this." He has a history of depression but denies previous suicide attempts. The patient also reports poor sleep, reduced appetite, and weight loss of approximately 10 pounds in the past month. He denies current substance use. Social support appears limited, with strained relationships with family and friends. The patient expresses a desire for help but feels uncertain about the effectiveness of treatment</p>			

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

Client History & Pertinent Information [Last Updated On: 06/28/2024](#) Do not include in PDF

Psychiatric History:
Medical History:
Substance Use History:
Social History:
Family History:

Recent Labs/Tests Do not include in PDF

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		
HEMOGLOBIN	6/14/2024	L	10.0	13.2-17.1		

ADD ALLERGIES

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

Type/Drug	Severity	Reaction	Comments
<u>Allergies</u>			
Amoxicillin	Low	Hives	as a child
Tylenol	Low	Low blood pressure	
<u>Intolerances</u>			
NSAIDS (Non-Steroidal Anti-Inflammatory Drug)	Mild to Moderate	Abdominal cramps	no GI bleed
pollen extracts	Low	Other	
<u>Failed Trials</u>			
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						<input checked="" type="checkbox"/> Do not include in PDF
Medication Consent?	Drug Name	Instructions	Start Date	Refills	Ordered By	
<input type="checkbox"/>	Sertraline	25mg, Tab, Oral each Once A Day	6/28/2024	0.00	Huang, Delphine MD Medical Doctor	
<input type="checkbox"/>	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
<input checked="" type="checkbox"/>	Sertraline	25mg, Tab, Oral each Once A Day	6/28/2024	0.00	Huang, Delphine MD Medical Doctor
<input type="checkbox"/>	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.

Print List... Change Order Re-order Complete Order Patient Consent General Medication

Medication List

<input type="checkbox"/>				Medication	Date Initiated
<input type="checkbox"/>	X	IP	i	Bupropion HCl	07/02/2024
<input type="checkbox"/>	X	Rx	i	Bupirone	03/14/2024
<i>Take with food</i>					
<input type="checkbox"/>	X	Rx	i	Ritalin	06/28/2024
<input type="checkbox"/>	X	Rx	i	Sertraline	06/28/2024
	X	+	i	Tylenol	06/28/2024

View Consent History Print X

Delphine, Child (1027), DOB/AGE: 3/5/2019 (5), Sex: M, Height: 50 In, Weight: 100 lb

Start Date: 07/22/2023 End Date: [] Medication: ...Medications... Apply Filter

Consent List

Medication Name	Active	Dosages/Directions	Consent Start Date	Consent End Date
Sertraline	No	Any	07/22/2024	07/22/2025

Current Medications

Medication Consent?	Drug Name	Instructions	Start Date
<input checked="" type="checkbox"/>	Sertraline	25mg, Tab, Oral each Once A Day	6/28/2024
<input type="checkbox"/>	Ritalin	5mg, Tab, Oral each Once A Day	6/28/2024

REMINDER: MEDICATION CONSENT KEYPHRASES

The screenshot displays a medical software interface with two main panels. The left panel, titled 'My Agency', shows a 'Category' dropdown set to 'CalMHSA Key Phrases' and a 'Phrase' section with three options: 'Medication Consent for General Psychotropic Medications (Including Opioids for Pain Management (Adult/Minor))', 'Medication Consent for Opioids for Pain Management (Adult/Minor)', and 'Medication Consent for MAT (OTP/NTP)'. Each option has a 'Use' link. The right panel shows a 'Psych/Medical Note' for a patient named Carlos Delphine. The note includes fields for 'Effective' date (07/22/2024), 'Status' (New), and 'Author' (Huang, Delphine). The note content is divided into sections: 'MSE/PE', 'Service', 'Note', 'Billing Diagnosis', 'Add-On Codes', and 'Warnings'. The 'Note' section contains the following text: '38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.' Below this, there is a red-bordered box containing the text: 'Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms: 6 Medication(s) found. Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024. Medication #2: dexamethasone 0.5 mg tablet, 1.00 Tab- Oral, Once A Day, N/A, No Medication Start Date - No Medication End Date. Medication #3: lisinopril 10 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024. Medication #4: ibuprofen 400 mg tablet, 1.00 Tab- Oral, Once A Day, N/A, No Medication Start Date - No Medication End Date. Medication #5: amoxicillin 250 mg capsule, 1.00 Cap- Oral, Once A Day, N/A, 07/01/2024 - No Medication End Date. Medication #6: Tylenol 325 mg tablet, 1.00 Tab- Oral, Once A Day, N/A, No Medication Start Date - No Medication End Date.' Below the red box, there is a green-bordered box containing the text: 'Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.' The note also includes a section for 'Additional Comments (if applicable):' with the text: 'Additionally, we reviewed the nature of the patient's medical condition; the reasons/goals for taking such medication(s), including the likelihood of improving or not improving without such medication(s), and that consent, once reasonable alternative treatments available, if any; the probable side effects which may occur to patients taking such medication beyond three months. The patient was advised to return to the clinic for follow-up.' The note concludes with: '38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.' Below this, there is a green-bordered box containing the text: 'Medication Consent for General Psychotropic Medications (Including Antipsychotics)'. The note also includes a section for 'Additional Comments (if applicable):' with the text: 'Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms: Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024. Additionally, we reviewed the nature of the patient's medical condition; the reasons/goals for taking such medication(s), including the likelihood of improving or not improving without such medication(s), and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff. The patient was advised to return to the clinic for follow-up. Reasonable alternative treatments available, if any; the probable side effects which may occur to patients taking such medication beyond three months. The patient was advised to return to the clinic for follow-up. Side effects include: nausea, diarrhea, constipation, dry mouth, loss of appetite, weight changes, sexual issues. [Patient verbally indicated understanding the nature and effect of the medications noted above and consents to administration of the medication(s) noted above.] Additional Comments (if applicable):'

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		<input type="checkbox"/> 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

Use Key Phrases

My Agency

Category
MSE/PE Key Phrases

Phrase

General/Appearance: Well-groomed
Attention: Normal Attention
[Use](#)

General/Appearance:
Attention and Perception:
Mood and Affect:
[Use](#)

Tylenol	325mg, Tab, Oral each Once A Day	Spanish Speaker	Patient Verbal
Vitals <input type="checkbox"/> 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 <input type="checkbox"/> AIMS completed during visit <input type="checkbox"/> 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					<input type="checkbox"/> Do not include in PDF
Addressed Today?	ICD10	Description	Date	Program	
<u>Diagnoses</u>					
<input checked="" type="checkbox"/>	F41.0	Panic disorder	3/13/2024	MH Access	
<input type="checkbox"/>	F32.A	Depression, unspecified	3/12/2024	MH Adult Outpatient	
<u>Problems</u>					
<input type="checkbox"/>	Z59.01	Sheltered homelessness	3/14/2024	MH Adult Outpatient	

ASSESSMENT AND PLAN

* Assessment and Plan

CURES reviewed during visit

Add to Shared Care Plan

38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.

Medication Consent for General Psychotropic Medications (Including Antipsychotics)

Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms:

Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.

Additionally, we reviewed the nature of the patient's medical condition; the reasons/goals for taking such medication(s), including the likelihood of improving or not

- 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://calmhsacct.smartcarenet.com/CalMHSA5martcareSandbox/ShowReport.aspx?ReportId=1ykcJmOPzk%3D&ReportServerId=RUNPkrIID3Q%3D&StaffId=undefined

1 of 1 Find | Next

Shared Care Plan of Medical Providers' Assessment and Plan



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

Service	Note	Billing Diagnosis	Add-On Codes	Warnings
Billing Diagnosis				
ICD 10...				
Order		ICD/ DSM - Description		
1		F32.A - Depression, unspecified		
Re-Order Diagnosis		Refresh 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 :

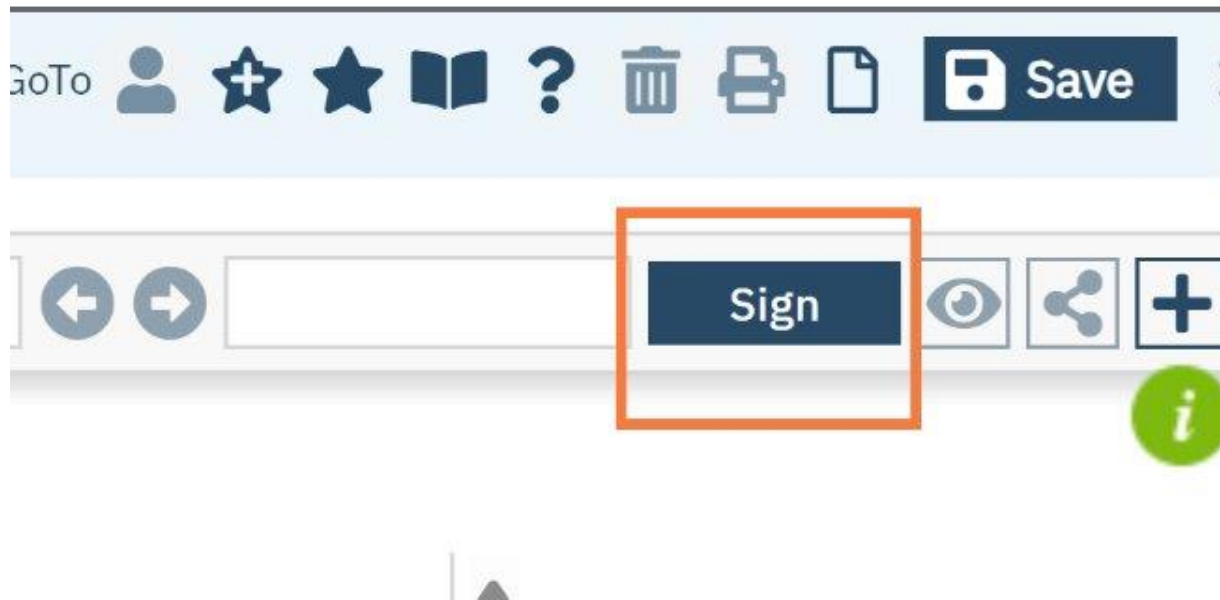
- 1) To appease lumpers and splitters writers and give agency to end users about what type of note they want to use.
- 2) Can choose because having a comprehensive note with multiple sections or less sections depending on the user and type of visit.
- 3) Can preview ahead of time the pdf by toggling 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.

"Do Not Include in PDF" Functionality

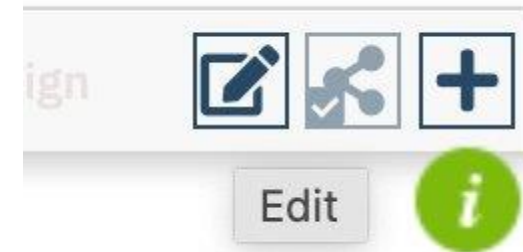
The screenshot displays a software interface with a tabbed menu at the top containing 'Service', 'Note', 'Billing Diagnosis', and 'Warnings'. The 'Note' tab is selected. Below the tabs, there is a control bar with three elements: a 'Show PDF Sections' button, a 'Hide PDF Sections' button, and a checkbox labeled 'Select ALL "Do not include in PDF"'. The checkbox is currently unchecked. Below this control bar is a large text area with a vertical scrollbar on the right. The text area contains the text '* Subjective/CC/HPI/Visit Notes'.

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

CalMHSA 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 because after this date, you will not be able to access any old drafts. You will lose access to the old template at that point and will not be able to finish your note.
 - List of outstanding/pending notes using the psychiatric note template has been sent out to county EHR admins to follow up with their providers.
 - Your EHR admin can set up an announcement on the log in page to help also remind your providers.
- The procedure codes being associated to the Psych Medical Note Template will happen on 08/05/24 in early morning. The SmartCare system may be down anytime between **12:00am – 6:00am on Monday 8/5**. During these hours we recommend implementing downtime procedures (paper documentation) to ensure current work is not lost, when the system becomes unavailable while this change is made in your production systems.

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.

Outpatient Medical - Smartcare User Group

Overview List Board Timeline Calendar Workflow Dashboard Messages Files

+ Add task Filter Sort Hide

Task name	Assignee	Due date
★ CalMHSA - Updates/Information/Upcoming ★		
Build a Client Abbreviated Notes Report 1d 11	Matthew J. ...	
FEEDBACK: How to improve this Project?		
Add task...		
★ Services/Notes/Documents ★ - Discussion		
Add task...		
★ Orders (Rx, Quick Orders, Client Orders) ★ - Discussion		
Add task...		
★ Documentation/Billing ★ - Discussion		
Add task...		
★ CalMHSA seeking feedback on... ★ -		
Issues with prescribing with height/weight requirement Ticket #29243	Delphine H...	Oct 27 - 28
Ventura: Medications Widget seems to include discontinued and voided 1	Delphine H...	

Inpatient - SmartCare User Group

Overview List

+ Add task Filter Sort Hide

Task name	Assignee	Due date
★ CalMHSA - Documentation/Upcoming ★		
https://2023.calmhsa.org/inpatient-documentation/		
Questions/FAQ		
FEEDBACK: How to improve this Project?		
Add task...		
★ INPATIENT ★ - Discussion		
Add Daily Progress Note to the Client Abbreviated Note Report 6	Delphine H...	
Retrieving Medication History for Inpatient Clients 1		
Add task...		
★ CSU ★ - Discussion		
Add task...		
★ RESIDENTIAL ★ - Discussion		
Add task...		
★ MAR ★ - Discussion		

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!