INTEGRATED MENTAL HEALTH
WORKFLOW and DOCUMENTATION

Entering and Leaving Service

- **Answering calls**
  - "Hello this is the on-call Care Manager or Psychiatrist - how can I help?"
  - Always attempt to provide some assistance - in person if possible
  - If they ask you to come see the patient, always come to see the patient if you can
- **Criteria for offering services**
  - Patient of ACC - or willing to become one through Family Medicine **.IMHESTABLISHCARE**
  - Does not have an outside provider already established
  - PHQ-9 10 or greater or if below 10 there needs to be a compelling reason for treatment (recent trauma or severe chronic med/psych illness)
- **Criteria for discontinuing services**
  - PCP: not wanting psych treatment, issues resolved according to patient, greater than 50% improvement on rating scales
  - MediCal therapist: very low acuity (<10) and no severe recent trauma or serious chronic medical or mental health issues, having finished therapy here, or can't seem to do BA or PST after 1 sessions of each
  - Fresno County DBH: unstable bipolar or psychosis, chronic mental illness with recent 5150/admit, unimproved after full course of our treatment, or specialty needs that we cannot address at ACC

Types of Intervention

- **CURBSIDE: INFORMATION ONLY**
  - Activity: basic information needed from provider w/out needing to see patient (< 5 minutes)
  - Outcome: leading to either D/C or EVAL which we will schedule immediately and inform patient and/or provider
  - Documentation: **A few lines** on other provider note saying what we recommend and if we will move on to EVAL or D/C
  - **NOTE**: then open a **telephone call**, type "**advice**" for reason, and **.IMHSEECURB** in documentation, then close – this will allow the registry to track the patient

- **CURBSIDE: BRIEF CONSULT**
  - Activity: consultation requested from provider w/ or w/out patient contact (5-15 minutes)
  - Outcome: leading to either D/C or EVAL which we will schedule immediately and inform patient and/or provider
  - Documentation: **.IMHBRIEF** or if adding to CM/Psych MD note can just add **a few lines** saying what we recommend and if we will move on to EVAL or D/C
  - **NOTE**: then open a **telephone call**, type "**advice**" for reason, and **.IMHSEECURB** in documentation, then close – this will allow the registry to track the patient

- **EVALUATION**
  - Activity: consultation requested from provider w/ patient contact needed (30-45 minutes)
  - Outcome: leading to either D/C or ASSIGN/FOLLOW-UP which we will schedule immediately and inform patient and/or provider
  - Documentation: **.IMPACT EVALUATION** and then if needed D/C by adding **.IMHSIGNOFF**
  - *If other branch of team is needed - page them and involved at that time or put on their schedule if unavailable*

REASON FOR CONSULT - fill in blanks (no additional text)
HISTORY OF PRESENT ILLNESS: give patient 5-10 minutes to talk before going down the list below Age, most serious medical diagnoses, any psychiatric diagnosis, and reason for consult. Main psychosocial stressors in 2-3 lines.

Mood symptoms ... fill in blanks (no additional text needed unless "severe")

PSYCHIATRIC HISTORY 5-10 minutes of mostly closed questions
Psychiatric hospitalizations: how many? when was first and last? reasons for each?
Suicide/self-harm/harm to others: how many? when was first and last?
Medication trials: what worked well and what did they not like?
Psychotherapy: when and was it helpful?
Abuse/assault: any? when? where they the abuser or abused? Do they relive it (PTSD)?
Past diagnosis: what have they been told they have?
Psychological testing/Eating Disorder/ECT/Other: any?

MENTAL STATUS EXAMINATION
Use the terms in the checklist whenever possible, if needed use "other" and type in

DIAGNOSIS: make sure you updated the problem list with the SPECIFIC psychiatric diagnoses (if you forgot to do this before writing the note, go do it, then come back here and "refresh smarlinks"

ASSESSMENT - do not add any test to this (it should be elsewhere in note)

Brief case summary including working diagnoses: 1-2 lines of likely diagnosis and whether or not we will recommend meds, therapy, or outside resources
Patient strengths: 2-3 if possible

PLAN: 5-10 minutes describing what our preliminary recs are and discussing with pt

Medication: just say continue, will see psych MD, or make a note if MD is involved
Labs/Testing: n/a
Therapy/Education: whether we will start or not - ex: "schedule for brief therapy here"
Referral/Follow-up: schedule at time of visit - MD and/or CM

- **FOLLOW-UP**
  - Activity: meds, therapy, case management/linkage, or collateral (15-45 minutes)
  - Outcome: leading to either D/C or more FOLLOW-UP which we will schedule immediately and inform patient and/or provider
  - Documentation: **.IMPACT FOLLOW-UP** and then if needed D/C by adding **.IMHSIGNOFF**
  - *If other branch of team is needed - page them and involved at that time or put on their schedule if unavailable*
  - NOTE: **Group therapy:** use **.WRAP** for group

INTERVAL HISTORY: give patient 5 minutes to talk about how they have been doing - then re-introduce them to the type of therapy you are about to do - then go to the handout and walk them through the steps - ask them to do their homework (or f/u on the homework they did/did not do) - Note the main psychosocial stressors in **1-2 lines** then document what sessions this was of what kind of therapy and how it went overall using **.IMHBA, .IMHPST., .IMHRPPLAN**

OTHER SMARTPHRASES: **.IMHAVS, .IMHAVSSPANISH, .IMHREFER, .IMHREFERSPANISH, .IMHSUICIDEEVAL**