

This guide will help you complete a chart for a mental health visit.

Note: The following procedures should be considered **required to complete a patient's chart**. Providers are encouraged to add additional information as needed in the chart.

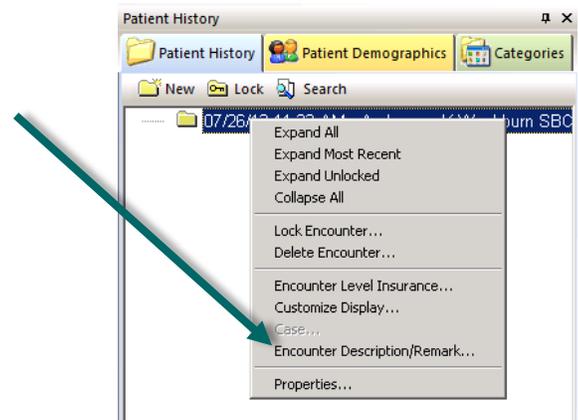
I. Opening the Encounter

A. Perform the 6-Point Check See EHR How-to Guide 2

Note: Only chart on encounters that have already been created from a visit check-in. Do not create an encounter in the EHR for a visit.

B. Create Remark

1. Right-click on the encounter and select *Encounter Description/Remark*

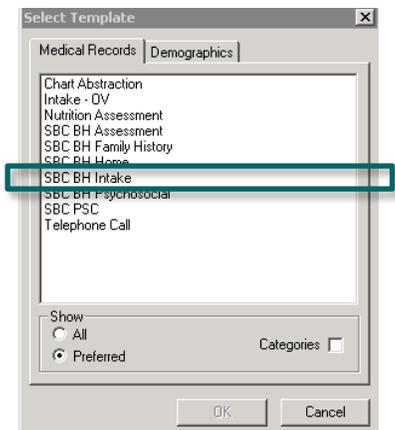


2. Depending on the type of visit, enter one of the following codes:

Type of Visit	Code
Explanation of Services	EOS
Group Activity	GRP
Mental Health – Established	MHE
Mental Health – New	MHN

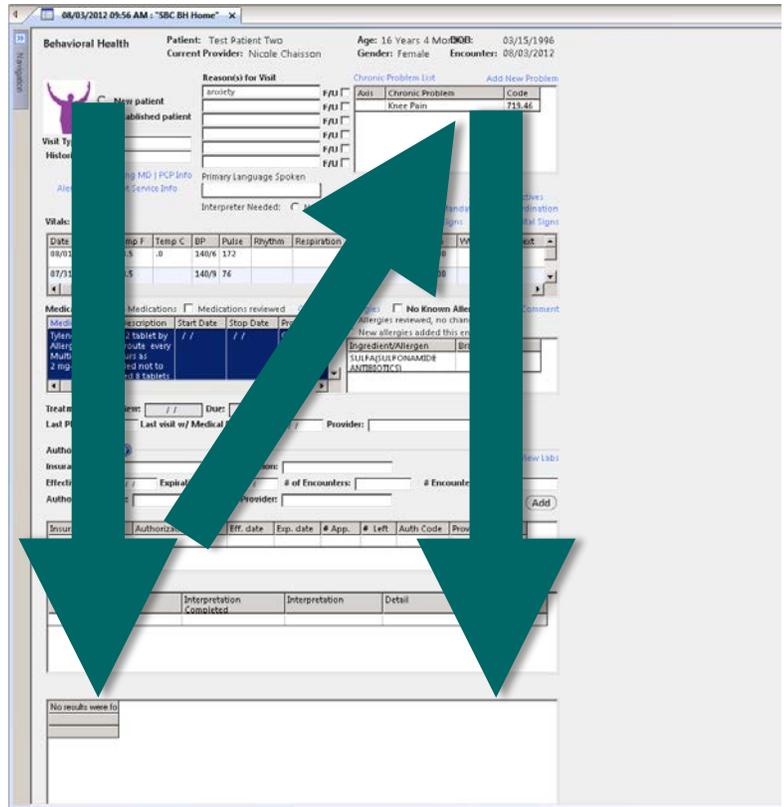
C. Open SBC BH Home Template

1. Click on the *Template*  button either at the bottom of the *Patient History* window or on the EHR toolbar.
2. Choose *SBC BH Home* from the *Select Template* window.



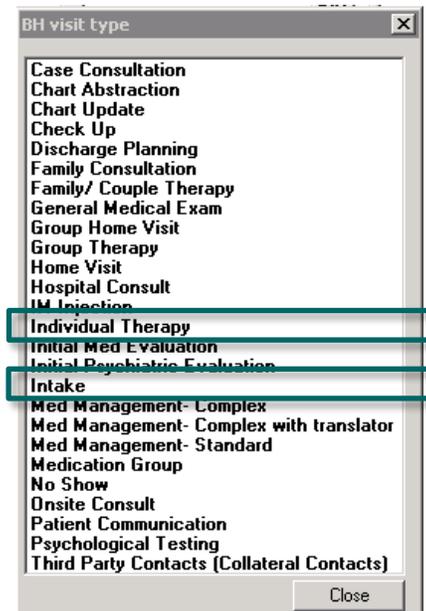
II. SBC BH Home Screen

In any template, you always work in columns – left column top to bottom, then right column top to bottom.



A. Visit Type

Select a visit type from the pick list.



B. Patient Type

Select *New* or *Established Patient*

C. Reason for Visit

1. Click on the first blank field.

2. Select at least one reason for visit from the pick list.

Note: You can free-text in the fields provided, but it is strongly recommended to select one from the picklist.

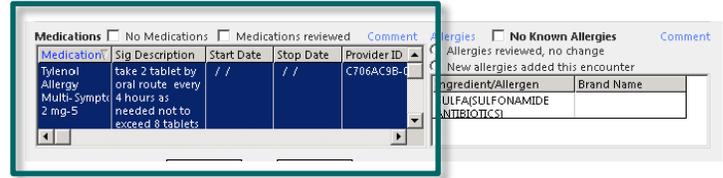
3. If this is a follow-up visit for a reason, check the *F/U* box.

D. Alerts

If a health alert has been established for this patient, the *Alerts* link will be red. Click on it to view or add alerts.

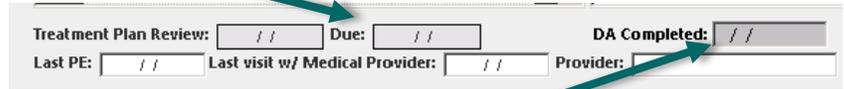
E. Medications

Review to see if patient is taking any related medications.



F. Treatment Plan

Enter a *Treatment Plan Review Due* date.



G. DA Completed

Enter the date the last Diagnostic Assessment was completed.

H. Intake vs. Progress Note



1. *New Intake* button: Click on this if this is a pre-diagnostic assessment appointment.
2. *Progress Note* button: Click on this if this is an Explanation of Services or post-diagnostic assessment appointment.



Skip to section VI: SBC BH Progress Note Screen

INTAKE

Follow Sections III - V for an intake/pre-diagnostic appointment.

III. SBC BH Intake Screen

Follow these steps for an Intake appointment.

- A. Click on the *Comments* link to add any necessary comments for each reason for visit.



B. HPI Details

For each reason for visit, click on the *HPI Detail* button and complete the questions you would normally ask in an appointment.



Hint: See the Advanced Training section of this guide on how to make this screen easier to use.

C. Patient Demographics

Review the patient demographics

Race Ethnicity Religion

D. Social History

1. Click on the *Cultural Activities* link.

a. Select *Reviewed, no change* or *Reviewed, updated*

b. If updating, click on Cultural Practice: and either select one from the pick list or type one in the field.

c. Enter the estimated *Start Date*.

d. Click on the *Add* button.

e. Repeat process for each activity.

f. When finished, click on the *Save & Close* button.

2. Click on the *Social History* link.

a. If this section has not yet been filled in from the Personal Health History form, complete it now.

- b. Click on the *Confidential Info* link to view or add sexual practices, alcohol and drug use.

E. Mental Health History

1. Click on either *Reviewed, no changed* or *Patient reports no relevant med/surg/psych Hx* or the *Add* button

Note: Mental Health History is the only history screen that is not shared with the medical templates.

F. Cultural Contextual Info

Add any contextual information on the patient.

G. Psychiatrist/Therapist Info

If the patient is currently seeing either of these, enter his/her info here.

- H. Click on the *Next* button at the bottom of the screen or the *Family History* tab at the top.

IV. Family History Screen

A. Family History

Click on either *Reviewed, no changed* or *No relevant family history* or the *Add* button.

B. Family Relationships

Interactions with family members: Supportive Strained Dysfunctional No family Estranged [Comments](#) Genogram

Family resources/strengths:

Comments:

1. Check the proper *Interaction with family members* box
2. Enter *Family resources/strengths*

Note: At this time we will not be using the NextGen Genogram.

C. Click on the *Next* button at the bottom of the screen or the *Psychosocial* tab at the top.

V. Psychosocial Screen

A. Client Strengths/Coping Skills/Resources/Support Network

Client Strengths/Coping Skills/Resources/Support Network: [Comments](#)

How does the client handle anger?

How does the client handle sadness?

Who comprises the client's current support network? Add

What are the client's resources?

1. Click the *Add* button for *Who compromises the client's current support network?*
2. Enter information for *What are the client's resources* field.

B. Significant Life Events

Complete these fields.

C. Significant Life Events (continued)

Complete these fields on the next column.

Significant Life Events: [Alert](#)

History of trauma:

History of emotional abuse:

Risk issues: Add

History of pain:

Where does client see self in 5 years?

Significant Life Events (continued): Alert

What was the best time in the client's life?

How does client rate his/her life now on a scale of 1-10, where ten is best?
 1 2 3 4 5 6 7 8 9 10

D. Mental Status

Mental Status: _____
 Safety contract in place **Safety Contract** [Mental Status Exam](#)

1. Click on the *Mental Status Exam* link.
 - a. Click the *All Normal* button.
 - b. Change any fields that should not be scored normal for this patient and add any necessary comments.

Mental Status Exam - BH

All Normal

Self care: Sleeping problems Eating problems

Appearance: Appropriate Inappropriate Disheveled Well groomed Reflective of poor hygiene

Orientation: Person Place Time Situation

Behavior: Unremarkable Agitated Limp Rigid Regressive

Psychomotor: Unremarkable Hyperactive Hypoactive Tremors Tics

Speech: Appropriate Pressured Slurred Loud Soft

Delayed Excessive Monofone Absent

Affect: Appropriate Inappropriate Flat Constricted Labile Expansive

Mood: Euthymic Labile Anxious Irritable Depressed Elevated

Memory: Intact Impaired

Sensorium: Clear consciousness Clouded consciousness

Intellect: Very superior Superior Bright Average Below average

Attitudes: Cooperative Uncooperative Hopeful Discouraged Hopeless

Thought process: Logical Tangential Blockd Incoherent Circumstantial

Vague Concrete Perseveration Flight of ideas Loose associations

Thought content: Unremarkable Paranoia Obsessions Compulsions Ideas of reference

Confabulations Delusions Phobias Dissociation Somatic preoccupations

Hallucinations

Attention: Gained Maintained Distracted Directed Poor concentration

Reasoning: Excellent Good Fair Poor Very poor

Impulse control: Excellent Good Fair Poor Very poor

Judgment: Excellent Good Fair Poor Very poor

Insight: Excellent Good Fair Poor Very poor

Self perception: Realistic Abasing Aggrandizing

Suicidal ideation: No Yes

Homicidal ideation: No Yes

able to understand and agree to refrain from harmful actions: No Yes

To clear all fields, right click on template and select clear

Save & Close **Cancel**

- c. When finished, click on the *Save & Close* button.

E. Safety Contract

1. Click on the *Safety Contract* button if applicable to print the form.
2. Have the student sign the contract and scan it into the ICS.

Mental Status: _____
 Safety contract in place **Safety Contract** [Mental Status Exam](#)

3. Check the *Safety contract in place* box.

F. Biopsychosocial Formulation

Complete this section.

- G. Click on the *Next* button at the bottom of the screen or the *Assessment/Plan* tab at the top.

STOP Skip to section VII. SBC BH Assessment Screen.

Biopsychosocial Formulation:

Previous **Next**

PROGRESS NOTE

Follow Section VI for an Explanation of Services or any post-diagnostic appointment.

VI. SBC BH Progress Note Screen

A. Direct Service

1. Select the correct type of service.
2. Select the correct *Length of service*.

B. Change in Mental Status

Complete the appropriate status information.

C. Safety Contract

1. Click on the *Safety Contract* button if applicable to print the form.
2. Have the student sign the contract and scan it into the ICS.
3. Check the *Safety contract in place* box.

D. Change in Stressors and/or Supports Progress

Complete the appropriate progress information.

E. Treatment Is Necessary to

Complete the appropriate treatment information if applicable.

F. Specific therapeutic interventions targeting the above mentioned issues and treatment objectives

Check all that apply.

Specific therapeutic interventions targeting the above mentioned issues and treatment objectives:

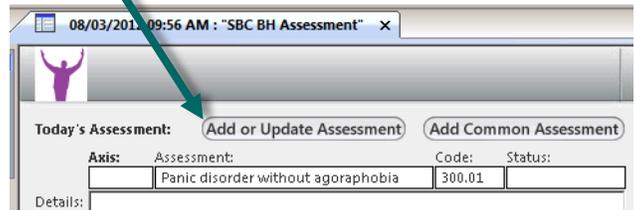
- Assertiveness and interactive skill training
- Assist with problem solving
- Cognitive behavioral

G. Click on the *Next* button at the bottom of the screen or the *Assessment/Plan* tab at the top.

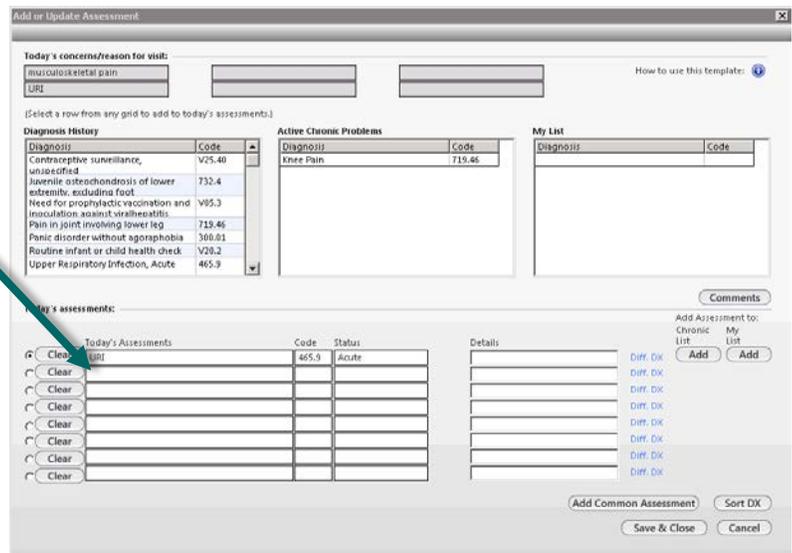
VII. SBC BH Assessment Screen

A. Assessment

1. Click on the *Add or Update Assessment* button.

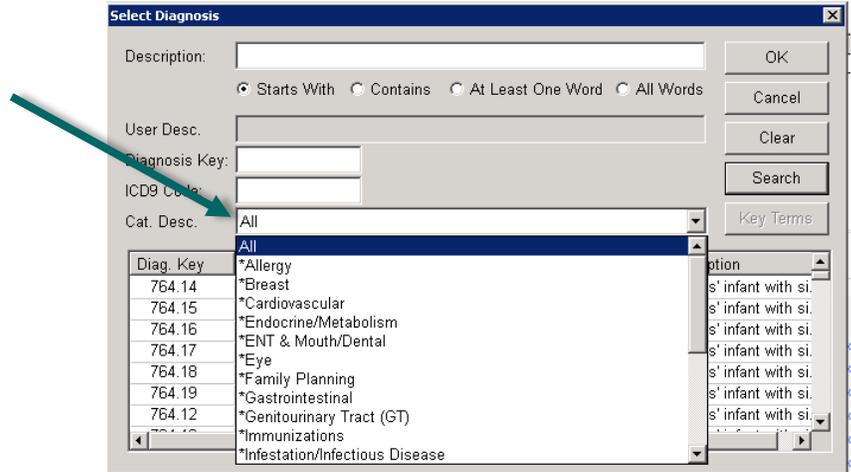


2. Click on an empty *Today's Assessments* field

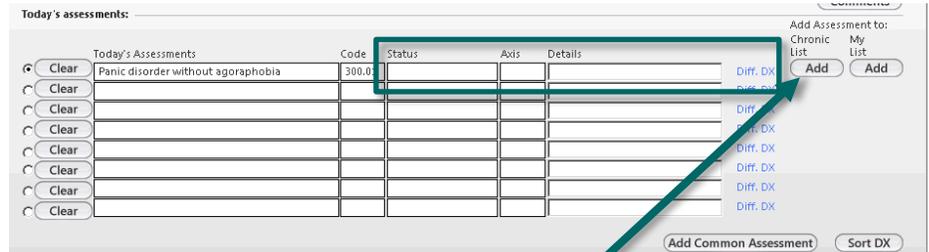


3. In the *Cat. Desc.* dropdown field, you will find several categories with an * in front of them. These are the SBC diagnosis categories on the Encounter Fee Ticket.

- Select the appropriate category and double-click on the diagnosis from the list.



- Add the *Status*, *Axis* and *Details* for the assessment.



- Click on the *Diff. Dx.* link to enter a Differential Diagnosis.
- If the assessment is chronic, click on the *Add* button.

Hint: If you selected a diagnosis you use frequently, click on the *Add* button under *My List*.

- Repeat these steps until all diagnoses have been entered.
- Click on the *Save & Close* button.

B. Treatment Plan

1. Click on the *Treatment Plan* button.

Plan/Instructions: **Treatment Plan** Add Plan Instructions My Plan

Client will be referred for medication evaluation: No Yes Not yet determined **Task**

Plan comments:

- a. Add problems and goals for each.

08/03/2012 09:56 AM : "BH - Treatment Plan 1" x

Initial Subsequent

Problem 1: Eating Disorder: Rapid consumption of large quantities of food in a short period of time

Goal: Normal body weight, fluid and electrolyte balance

Target date: / / Resolved date: / / [Detail](#)

Clear

Problem 2:

Goal:

Target date: / / Resolved date: / / [Detail](#)

- b. Click the *Return* button.

Note: Do not click on the *Next* button or *Assessment/Plan* tab from the *Treatment Plan* screen.

C. My Plan

1. Click on My Plan/Orders

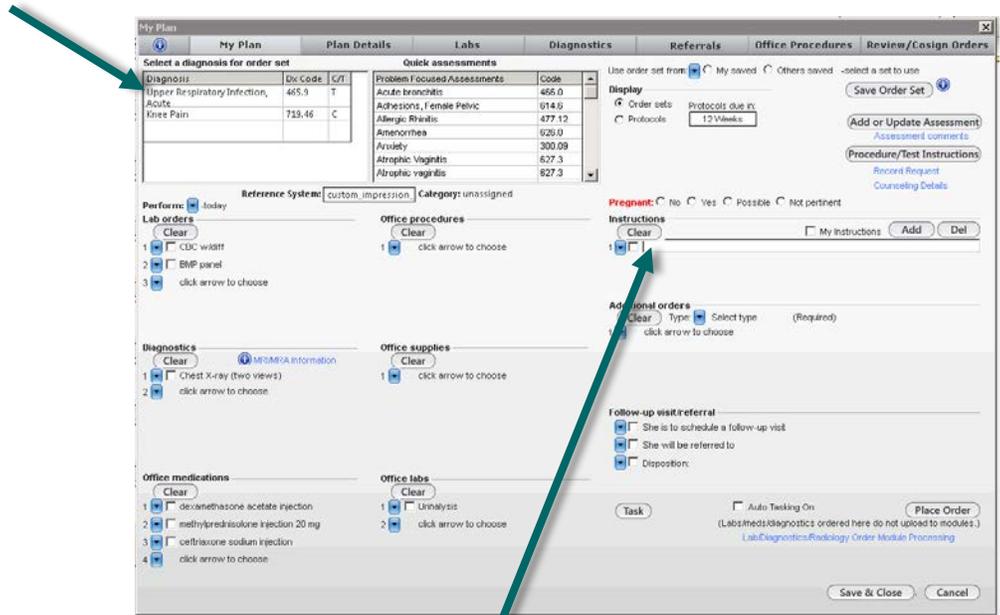
Plan/Instructions: **Treatment Plan** Add Plan Instructions **My Plan**

Client will be referred for medication evaluation: No Yes Not yet determined **Task**

Plan comments:

2. Instructions

- a. Click on a diagnosis



- b. Enter Instructions for each diagnosis if applicable.

Hint: Click the *My Instructions* box and click the *Add* button to save any common instructions for this diagnosis to use for future encounters.

3. My Phrases

- a. Click on the *Plan Details* tab.



- b. Add either *My Phrases* or *Common Phrases* to each diagnosis

Hint: See the Advanced Training section of this guide on how to make this screen easier to use.

4. Referrals

If you need to refer the patient to another provider either within or outside of the SBC, follow these steps.

- a. Click on the *Referrals* tab.



- b. Select the correct To: category (most likely *Specialty/specialist name/site*)
- c. Select the Specialty.
- d. Select or type in the provider you are referring.
- e. Add any other pertinent information

5. Click on *Save & Close*

D. Axis III

Click in a black white field under (*reported by patient*) or on the *Add* button

E. Axis IV

Check the appropriate boxes and add any necessary comments.

F. Axis V

1. Click on the *GAF Scale* button to view the scale.
2. Enter the *Current GAF* and *Date*.
3. Enter the current *CASII Score* and *Date*.

Axis V: **GAF Scale**

Current GAF: Date:

CASII Score: Date:

G. Patient Plan

Click this button to run the document to print and give to the patient.

Timeframe	*	Diagnosis Code

Previous Patient Plan Chart Note Next

H. Chart Note

1. Click this button to run the Diagnostic Assessment.
2. View the note to ensure everything is complete. If you are a Rendering Provider, you can click on the checkmark button to sign-off on the note.

09/05/2012 01:41 PM: "Immunization - Pediatric" 09/05/2012 01:41 PM: "E&M History" 09/05/2012 01:41 PM: Document "Chart_Note"

TX Text

Segue UI 10 B / U 100%

MINNEAPOLIS SCHOOL BASED CLINICS program

Patient: Test Patient Two
Date of Birth: 03/15/1996

3. Close the note when finished.

- I. Click on the *Next* button at the bottom of the screen.

VIII. Finalize OV

A. Provider Sign-off

1. If you are an Intern, check the *Submit to supervising physician* for review box.

Provider Sign Off:

Physician sign off request:

Submit to supervising physician for review

Supervising physician sign off:

I have reviewed and agree with the diagnosis and treatment plan

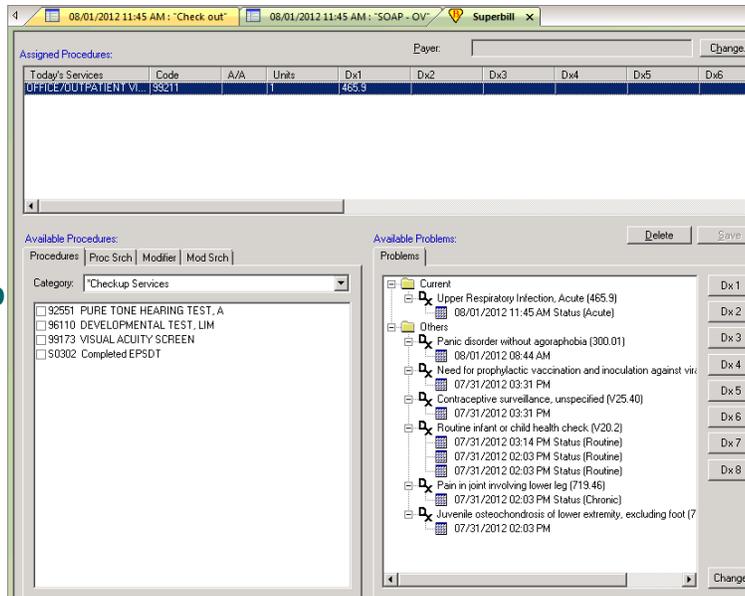
Note: If you are a Rendering Provider and received this chart in your tasks, this is where you would sign off on the chart (this is a separate process from approving the Chart Note in your PAQ).

IX. Superbill

A. Go to *File* and select *Superbill*.

B. Assigned Procedures

1. Ensure the proper office coding and diagnosis appear here.
2. If the proper diagnosis doesn't appear, select it from the *Available Problems* section.



C. Available Problems

1. The diagnosis history for the patient is listed here. If a diagnosis is missing from a service in the *Assigned Procedures* list, first click on the service in the *Assigned Procedures*.
2. Then under *Available Problems*, find the diagnosis you want to add and click on the *Dx 1*, *Dx 2* or *Dx 3* buttons depending on where you want the diagnosis to appear.
3. You should now see the diagnosis in the *Assigned Procedures* section.

D. Available Procedures

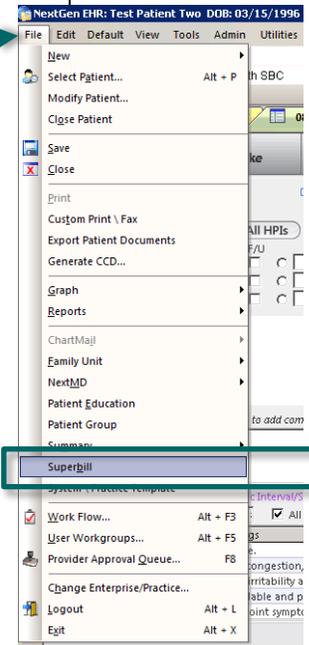
You will want to add any special visit CPT codes that are typically found on the front of the Encounter Fee Ticket.

1. Select the proper category with an * in front of it (these are the same categories listed on the front of the Encounter Fee Ticket).
2. Click on the box next to the code you want to add.
3. The selected procedures should now appear in the *Assigned Procedures* section.

E. Click on the *Save* button on the EHR toolbar.

F. Click on *File* and select *Close Patient*

Note: You have 10 days to complete these steps before the encounter locks.



Advanced Training: Memorizing Templates

This section is not required, but offers extra tips on how to customize certain templates for easier use.

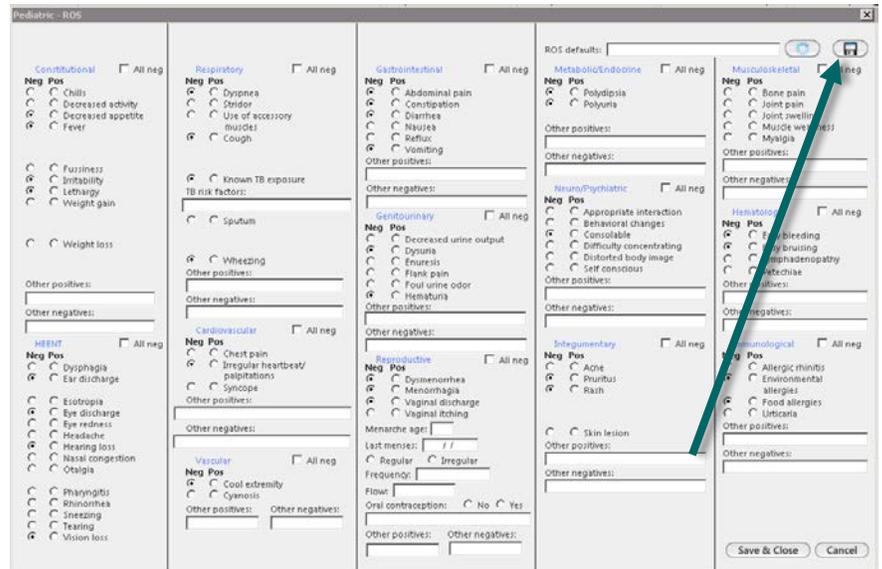
I. Template Memorization



If a template or screen has these icons in the upper right-hand corner, you can save the data you've entered as a memorized data set. You can then use this set on any patient without having to reenter the data.

A. Enter the data.

Hint: If you want to set up some data sets up without charting on an actual patient, search for *Patient, Test* or *Patient, Test Two* and create your data sets under one of these fake patients.



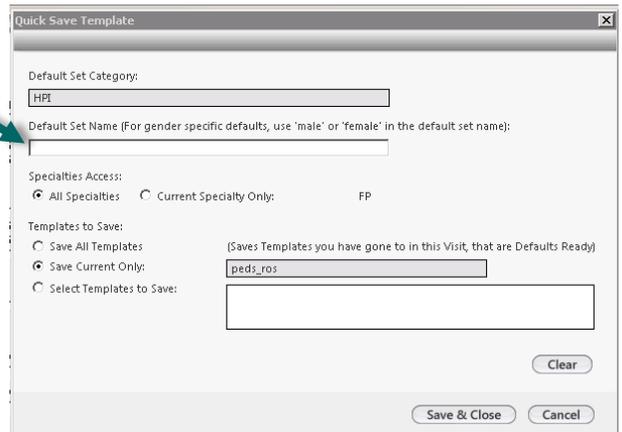
B. Click on the Quick Save button

- C. In the Default Set Name, enter the name of your data set**
Examples: Typical Anxiety, Typical Depression, Typical Mental Health Exam.

D. Click on Save & Close

- E. The next time you chart on a patient and want to use your memorized data set, click on the  button and double-click on the set you want to use. The data will then automatically fill in the template.**

F. Review and change any data that does not apply to the patient.



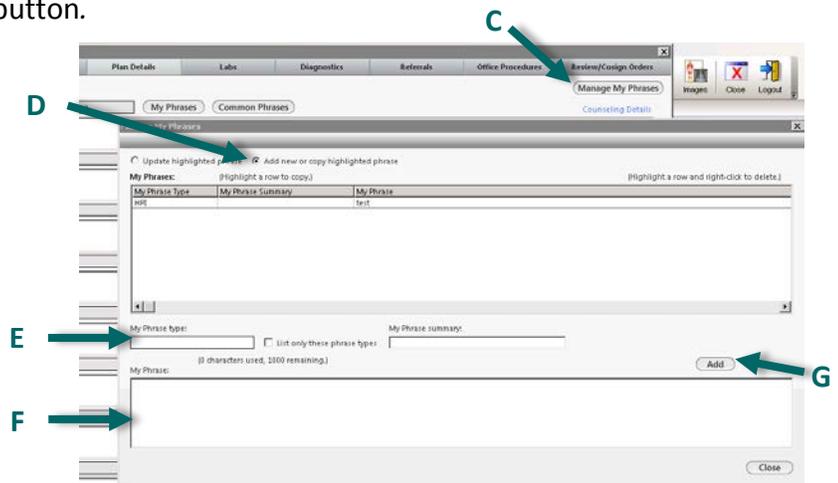
II. My Phrases

Instead of re-typing the same notes and recommendations repeatedly, you can create saved phrases relevant to a diagnosis.

- A. Open *My Plan* under the *SBC BH Assessment* screen.
- B. Click on the *Plan Details* tab.



- C. Click on the *Manage My Phrases* button.



- D. Click on *Add new or copy highlighted phrase*.
- E. Click on *My Phrase Type* and choose the appropriate type (usually HPI).
- F. In the *My Phrase* field, type the phase you want to use.
- G. Click on *Add*.

Congrats! You are now done with this How-to Guide.