Electronic Health Record Documentation Tips

Set Up for Screening

- Set up the EHR to track performance and collect data from the start of your screening implementation
- Remove any symptom, diagnosis or adjective that is not used by your practice, particularly under History of Present Illness and Review of Systems
- Ensure that the screening questions, score and follow-up options exist outside of the visit note or are in a discrete/structured data field for data tracking and reporting. Ensure that the answers to each screening question can be reviewed at a later date (not just the score)
- Identify metrics needed to be captured (Quality Payment Program etc.)
- Add drop-down box with follow-up options for tracking
- Consider the following basic metrics: % of active patients screened within 12 months completed by provider; % of patients with positive screener by provider team; % of patients with positive screen receiving follow up; and type of follow-up received by patients with positive screen
- Map screener and referral process to align with existing referral processes
- Train staff on how and why to use the screener and process
- Create follow-up methods that are easy to implement/follow through (check boxes or drop-down box)
- Organize layout of EHR to match clinical workflow and resources

During the Screening

- Ensure that each question has an answer
- Check for patient understanding of the questions, especially if the answers are positive
- Capture any relevant history: family or personal history of mental health or substance use issues; treatment history; the patient's management strategies; barriers to treatment. Ask the patient to sign a Release of Information if the patient has past or current treatment for mental health or substance use disorders
- Capture current symptoms and any observations, such as current mental status
- Document diagnosis (if any)

After the Screening

- Follow-up for a positive screening must include one (1) or more of the following: additional evaluation; brief intervention/education; suicide risk assessment; referral; pharmacological intervention
- Include any specific information about follow up plan (date, time and or referral information)