PRISM

Psychiatric Consultant EHR Documentation Workflow

This guide outlines the documentation process for the psychiatric consultant (PC) within the Collaborative Care (CoCM) EHR workflow. This includes EHR templates and specific documentation requirements. This document is intended for EHR/IT staff. PCs may wish to review **PC EHR Documentation**[1], which provides guidelines for verbiage for PCs as they document in the EHR.

Note: This document is tailored toward PCs who have access to the site's EHR. If the PC does not have EHR access, they will typically send the note to the behavioral health care manager (BHCM), who will then require the ability to complete similar processes on behalf of the PC.

Required Documentation

- Specified documentation type
  - The PC will need a specified type of documentation within the EHR. They will use this type of documentation consistently throughout their work in the CoCM program.

- Location
  - The PC will need to specify the clinic for which they're documenting.

- Visit Information
  - The PC will need to specify a "chief complaint" or visit information for their documentation. Reasons for the visit might include "medication management" or "care coordination."
    - Some sites choose to create a "Collaborative Care" option for visit information. This can enhance the ease of locating CoCM-related notes within the health record.

- Templates
  - The PC will require a standardized template for their documentation. This includes recommended verbiage to support the documentation. The details of the template can be documented per the preferences of the PC and/or the site. See **EHR Documentation Template Guide**[1] for examples.

- Routing
  - The PC will require the ability to route the note to the patient's treating provider, the behavioral health care manager (BHCM), as well as any other pertinent care team members.

[1]Located via the PRISM resource library

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