

SLO Behavioral Health Department
Quality Support Team

Documentation Tips

June 16, 2016

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- FAQs about follow up for assessment, post hospital appointments and crisis contacts

Question: Why is outreach to a person who missed an assessment or post hospital follow up appointment so important?

Answer:

Potential clients who contact us for intake assessment often have beliefs and feelings that interfere with follow through. Sometimes a personal connection will be enough to resolve the concern and allow the person to get the help he or she needs. Potential clients often have environmental barriers to access (lack of childcare or transportation, for example) that may be easily removed by rescheduling.

Persons who were recently discharged from an inpatient level of care are at a high risk for readmission or other negative outcome. Numerous studies show that a person-to-person contact is a great way to improve attendance for clients who are transitioning from inpatient to outpatient levels of care and may reduce the risk for negative outcomes.

Action Needed: (See P&P 3.20, page 5. Applies to assessment and post hospital follow ups)

- ✓ Telephone the client to discuss the missed appointment and then attempt to reschedule.
- ✓ If not able to reach the consumer by phone, mail a contact/close letter to the client.
- ✓ Write a brief progress note to document the FTS and the outreach effort.

Question: I know why documenting a crisis contact is important – what is the best way to do it?

Answer:

1. Clearly state the presenting problem. Use client quotes, when appropriate, to illustrate. When known, document precipitating events and stresses.
2. Clearly state clinical/behavioral observations in an objective, nonjudgmental manner.
 - Document the presence or absence of SI/HI and other risk factors, including:
 - The presence of mental illness

- Access to means/lethality of means
 - Current plan/intent/preparatory behavior
 - Drug and alcohol use
 - Recent stressors
 - Past attempts
 - Hopelessness/lack of future orientation
 - Lack of social support
 - Demographic factors, including age and gender, which may increase or reduce risk
3. Clearly document your interventions and how the client responded to you
 4. Consider medical issues. Consult with BH medical staff and/or refer the client to Primary Care or Emergency Department for evaluation/medical clearance if needed.
 5. Document all discussions/consultations!
 6. Clearly document the follow up/safety plan.

Question: What do I do after I make a safety plan with a client?

Answer: When you develop a safety plan with a client, be sure to implement the plan!

Action Needed: (See Documentation Guidelines_6/16/16, page 18 &19):

1. Document all your follow-up contacts
2. Communicate with your whole team to improve outcome and to reduce risk:
 - ✓ Be sure that everyone on the team is alerted to the crisis situation, including FSP staff. You may find that another team member is able to respond or follow up sooner than you are able to, which may improve the results for the client.
3. Work with MHET
 - ✓ When you contact MHET, you've added a valuable resource to the client's treatment team, but you have not given away responsibility for ongoing follow-up.
 - ✓ Expect to hear from the MHET evaluator regarding outcome, but if you don't hear back, call to request information – the evaluator may be on another call and may be delayed in getting back to you.
4. Follow up with your client promptly. If you were concerned enough to contact MHET or to complete a crisis service, follow up the next day by phone or (even better) face-to-face.
5. Consider scheduling an urgent appointment with the psychiatrist or NP – having additional input can be very helpful!