



IPCOM DOCUMENTATION GUIDELINES

“The joys of paperwork were phenomenal but can never be eclipsed by the sheer ecstasy of electronic documentation, and the excitement it brings to everything” (anonymous source)

1. Admit the patient to IPCOM.
Until there is time for the Avatar Team to create an IPCOM bundle, please include the following forms to your favorites, in order to access them quickly:
Admission (Outpatient)
History and Review of Systems,
Vitals entry
Physical Exam
Diagnosis
Discharge (Outpatient)
MD Progress Note
2. Make sure that you have IPCOM Primary Care forms in Word Templates.
If you have not received these files to save on your laptop, or if there is any problem with them, please contact Elizabeth Bartmess. These are exact Word versions of the IPCOM forms on Avatar. They may be printed and put into records in programs when Avatar is not accessible.
3. When Avatar is not accessible, use the Word Template on your laptop. Open a template (Word document) for the form you want to use (e.g., ROS) and save it as a new file with a name indicating the date and the patient. For example, you could name a record as “10/22/15_ROS_Mary”.

When the form is completed, save the file and print a paper copy for the chart in the program. Ideally, the saved Word document should be copied and pasted into Avatar, when the system becomes available.

4. This procedure described above for entering Avatar information after the fact (“back-entry”) is consistent with DCBHS policy*. It was designed for the Avatar transition in community programs, where most providers remain on site for the day and are provided with time to copy and paste templates into the EHR.

Our situation is very different because NPs may not be in the programs Avatar becomes accessible and certainly don’t have time to wait. For this reason we have made a request to the Avatar team to develop an alternate procedure for back entry of IPCOM data. This would allow other IPCOM staff to paste your completed template into the patient’s record. We will let you know when and if this happens. *However, early or late, the MD Progress Note can only be entered by you.*

5. Why is the MD Progress Note so important?

When you can’t use Avatar, you can use the NP progress note to alert other NPs and MDs. IPCOM records cannot be accessed by anyone but MDs and NPs. All mental health providers can see the MD Progress Note. Therefore entries should be brief and refer to where health information is rather than repeating it, for example: 4/4/2015, “Mrs. Smith had a complete history and physical exam, see in Loso House record”

MOST IMPORTANT in terms of goals of the HRSA Grant:

The MD Progress Note is the place we have selected to put information on referrals to ongoing primary or specialty care, after discharge. In contrast to IPCOM records that are visible to medical personnel, the MD progress note is accessible to the mental health providers who coordinate care after the patient’s discharge (e.g., counselors, case managers, social workers, therapists, nursing staff).

6. When provide a patient with a referral or appointment, please do the following:
Fill out the “Appointment & Referral form” (attached) and give the patient a copy.
Also, offer the patient the option of taking business sized cards to copy this information and a pocket-size “IPCOM” card wallet to hold it. If you need some cards and wallets please let Pat Mejia know.

Finally, let the patient that this information is also in their health record. If they forget or lose information, they can ask a mental health provider to find it in their record.

7. At the appropriate time please discharge the patient from the IPCOM episode.

*Everything you wanted to know about DBH documentation but were afraid to ask:

https://www.sfdph.org/dph/files/CBHSdocs/SFDPHDocumentationManual_REVISED_121112.pdf