Headway

Essential Intake Documentation

HOW HEADWAY DEFINES QUALITY

The Headway Clinical Team collaborates with providers to enhance care quality in order to provide high-quality healthcare to all patients. This includes identifying and implementing improvements within our care delivery model. Per our Documentation Policy, Headway adheres to strict documentation, coding, and billing standards, ensuring compliance with all relevant regulations and best practices.

HOW HEADWAY EVALUATES QUALITY

The Clinical Team reviews documentation to ensure patient safety, adherence to evidence-based practices, and compliance with billing requirements. We prioritize clear communication regarding documentation and clinical quality to empower providers with the knowledge and support needed to enhance their practice and minimize risks.

When necessary, the Clinical Team may contact you via email or schedule a meeting to address any documentation concerns. These interactions aim to provide support, guidance, and access to relevant resources for improvement. We are committed to supporting clinicians in achieving safe, efficient, and high-quality documentation.

A diagnostic clinical interview is where it all begins with a patient. Completing a thorough and robust interview is critical.

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RESOURCES FOR QUALITY DOCUMENTATION

☐ **Chief Complaint**
- Documented reason for seeking treatment, usually 1-2 sentences in the patient's own words. Typically a quote or brief description of the current reason the client is at the appointment.
- i.e. “I haven't been able to sleep well for months and I am hoping you can help."

☐ **History of Presenting Illness (HPI)**
- Detailed information about current symptoms (or if there are no/minimal current symptoms, then the most recent symptom specific episode must be documented).
- This section should include:
  i. Each of the symptoms currently present
  ii. Time of onset of symptoms - when did each symptom or symptom cluster start?
  iii. Duration of symptoms - how long has it been going on?
  iv. Frequency of symptoms - when are symptoms experienced (i.e. only at school)?
  v. Quality of symptoms - how does the patient describe their symptoms?
  vi. Modifying factors - what makes symptoms better or worse?
  vii. Severity and functional impairment - to meet DSM-V-TR criteria this must be addressed
  viii. Context - psychosocial or structural factors negative or positively impacting symptoms
  ix. Prior episodes of these symptoms, including prior diagnoses
- This section should provide the full symptom criteria and time course to support each billed diagnosis.

☐ **Psychiatric Review of Symptoms**
- Provides information about pertinent positive or negative psychiatric symptoms. This is where you document that you asked the patient about key symptoms to rule out/in differential diagnoses such as symptoms of mania, depression, anxiety, obsessive thoughts, trauma responses, or psychosis.
- This section provides information for the differential diagnosis discussion. There may be some overlap with the HPI or psychiatric history.

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☐ **Substance Use**

- Documentation of a patient's current and past use of or lack of use of substances must be present.
  i. Including: Alcohol, Cannabis, Amphetamine, Cocaine, Opiates, Benzodiazepines, Nicotine, and others
- Documentation should include age of first use, general timeline, amount and frequency of use, prior periods of sobriety or treatments, and the presence of tolerance, withdrawal, or other substance dependence behaviors.

☐ **Psychiatric History**

- Documentation of the patient's psychiatric history including symptom onset and course, diagnoses, treatment types, providers, duration, hospitalizations must be included.
- This information may include the patient's history of:
  i. Prior diagnoses and symptom clusters (i.e. ADHD dx at age 8 by psychiatrist due to impulsivity and difficulty sustaining attention in 2nd grade classroom and at home)
  ii. Psychotherapy treatments
  iii. Psychiatric medication treatment (dose, duration, time of use, impact, side effects)
  iv. Hospitalizations, partial hospitalizations or day programs
  v. Prior suicide attempts, self-harm, harm to others or risk behavior including treatments and outcome
  vi. Legal or custody involvement

☐ **Trauma History**

- A statement regarding the past history of trauma including time period (i.e. early childhood, adolescence, early adulthood).

☐ **Social History and Supports**

- Identification of the patient's social history and patient's social support.

☐ **Medical History**

- A summary of the patient's medical history. If there is no significant medical history, documentation must indicate that the provider asked about prior health issues such as hospitalizations, surgeries, allergies, and medical conditions.

☐ **Family History**

- Family medical and psychiatric history is important to include in your documentation. This information can point to potential biological or psychological risks (i.e. genetic conditions, family history of mania, cardiac or seizure disorders) or potential medications that have worked for other family members (i.e. sister's depression improved greatly with sertraline).

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☐ **Current Medications**
- Documentation of a list of current medications the patient is taking including name, dose, duration, reason for taking.

☐ **Collaboration with Outside Providers**
- Documentation of other outside providers and coordination if needed.

☐ **Mental Status Exam (MSE)**
- Your assessment of the patient and must be documented in every note.
- Key content areas include:
  i. General appearance
  ii. Orientation x1-4
  iii. Speech including rate, rhythm, tone
  iv. Mood, (i.e. dysthymic, depressed, euthymic, anxious, manic, hypomanic)
  v. Thought process (i.e. linear, loose associations, tangential, disorganized)
  vi. Thought content (AVH, SI, HI) - if positive, a safety plan should be documented
  vii. Judgment
  viii. Insight
  ix. Cognition

☐ **Risk Assessment**
- A risk assessment of danger to self or others must be documented.
- Current or recent suicidal or homicidal ideation should be detailed and always include documentation of any intent, plan, and means.
- A safety plan should be documented for anyone with SI, self-harm, HI or high risk factors (i.e. distorted thinking, impulsivity)
- Past history of risk to self or others should be clearly documented
- Include current protective and risk factors

☐ **Safety Plan**
- If SI, HI, or potential harm is present, a safety plan must be present. Items to consider include:
  - Warning signs
  - Coping strategies
  - Social settings and supports
  - Professionals or agencies the client can contact in crisis
  - Ways to make the environment safer (i.e. storage of medication, removal of weapons)

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☐ **Assessment and Diagnosis**

- This is where you formulate your assessment and diagnosis by synthesizing the subjective and objective data. Documentation of a rationale for your diagnosis that includes how the patient reported data, history, and your examination data meet the DSM-V-TR criteria for the diagnosis you are documenting is required. It is important to include severity and any functional impairment.
- The patient reported, subjective data should be present in greater detail in the HPI, Psych ROS, and past psychiatric history.

☐ **Evidence-Based Treatment Plan**

- An evidence-based treatment plan that is medically appropriate for the patient's condition (ie. antidepressant medication for a diagnosis of MDD). Treatment may include multiple modalities such as individual therapy, medication, or support groups.
- If off-label treatment is utilized, it must be justified in documentation with rationale and evidence-base.

☐ **Prescription**

- The prescription must include medication name, dose, frequency. Rationale for polypharmacy or multiple medication changes should be documented.
- If the prescription is a controlled substance or the patient is on a controlled substance, your state PDMP should be checked and results documented.

☐ **Informed Consent**

- For any prescribed medication, there must be either verbal or written and signed informed consent that includes specific side effects, risks, benefits, and alternatives to the recommended treatment.
- If the patient is a reproductive-aged female and is on a teratogenic medication the client should be screened for pregnancy and IC about risk specific to pregnancy should be documented. IC should take into consideration risk/benefit related to the patient's specific medical conditions and risks.

☐ **Prescription**

- The prescription must include medication name, dose, frequency, and quantity.
- Polypharmacy, off-label prescribing, or multiple medication changes must include documentation of an evidence-based justification.
- If the prescription is a controlled substance or the patient is on a controlled substance, your state PDMP should be checked and results documented. Practices should maintain a controlled substance policy.

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☐ **Labs**

- Documentation of appropriate labs in accordance with medication management guidelines or documentation of request/review of outside labs (i.e. PCP).

☐ **Telehealth Documentation**

- Include a telehealth attestation statement: “Services were provided via synchronous audio/video telehealth on a HIPAA-compliant platform. The provider was located in their office, and the patient was located at [Home/Other address]. The patient consented to telehealth services, and all standards of care were maintained.”
- Ensure the Place of Service (POS) billed matches what is documented in the note (telehealth or in-office).