Headway

Headway's Training Guide – Military OneSource Risk Assessment

Scope: This training guide applies to all Headway providers delivering behavioral health services through the Military OneSource (MOS) program.

Providers will be required to submit the Case Activity Report (CAR) form in Military OneSource's Secondary Data System (SDS) for each session. **The note submitted in the CAR form's free text section titled "Case Note" must be in line with Headway's template below.** This facilitates consistent, high-quality documentation, risk assessment, and patient safety compliance.

Please refer to the documentation guide and template below that providers must use to fill out their respective CAR forms.

General Requirements:

- **Quality & Compliance:** As a Headway provider, you are expected to uphold quality and compliance standards set and reviewed through Headway audits, no matter which health plans you may be working with and regardless of separate instructions on documentation received from that health plan or the format of the documentation platform available.
- **Headway Providers in MOS:** Appropriate charting documentation must take place for each new client intake assessment and subsequent follow-up sessions as outlined below. Documentation must be completed within **72 hours** of each session. Providers will submit the CAR form on Military OneSource's SDS to bill the session. They will then confirm the session on Headway to trigger immediate payout.
- **Provider Attestation:** At the point of session confirmation in Sigmund, providers must attest to using the below Headway-approved documentation template for completeness and adherence to Headway standards.

Procedure Overview:

- All patient encounters will be documented in Military OneSource's SDS through a CAR form, and must adhere to the Headway-approved template shared below.
- Please find here a training guide, followed by the note templates.
- All session notes according to the below instructions must be submitted in the **free text section of the CAR form, titled, "Case Notes."** This text box has a total character limit of 4,000.

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All of the below documentation sections must be completed and submitted for every intake session note.

Training Guide:

- **Reason for visit / HPI**: Document client's presenting concerns and history of present illness. Describe the individual's presenting concerns and the symptoms, stressors, and life events that led them to seek support. Include:
    - Onset: When the concern or symptoms began
    - Duration: How long the issue has been occurring
    - Severity and impact: How the concern affects daily functioning, work, relationships, or overall well-being
    - Context: Any recent events, changes, or triggers that may have contributed.
    - Associated symptoms: Other emotional, psychiatric, behavioral, or physical symptoms that they are experiencing
    - *Note: Keep the tone objective and clinical, focusing on observable or reported information*
- **Behavioral Health History**: Include prior diagnoses, treatments, therapy history, suicide attempts, hospitalizations, and mental health interventions.
- **Medical History**: Document relevant physical health conditions, medications, and treatments.
- **Substance Use Assessment**: Capture all current and past alcohol and substance use, treatment, and associated impacts.
- **Risk Variables Analysis:**
    - **Step 1: Document Risk of Harm to Self**
        - ***A. Universal Questions (Ask every client)***
            - 1. "Do you have thoughts of hurting yourself?"
            - 2. If yes, follow up with:
                - "Do you have a plan to act on those thoughts?"
                - "Do you intend to act on those thoughts?"
        - ***B. Assess for Risk Factors (Document for every client)***
            - Ask about and categorize each of the following factors as *negative (denied)* or *positive (present)*:
                - ***Static Risk Factors:***
                    - Past suicide attempt(s) or self-harm
                    - Mental or physical illness
                    - Family history of suicide
                    - Past trauma or violence
                    - Antisocial behaviors
                    - Poor response to prior treatment
                - ***Dynamic Risk Factors:***
                    - Current or chronic pain
                    - Hopelessness

        - Insomnia or sleep problems
        - Job or financial stress
        - Active depression, anxiety, or psychosis
        - Active substance use
        - Relationship problems
        - Poor social support
    - ***C. Document Findings in Chart:***
        - Client Denies: (List all relevant factors from above that were denied)
        - Client Endorses: (List all relevant factors endorsed or present)
- **Step 2: Document Protective Factors**
    - Include protective factors that reduce overall risk, such as:
        - Strong religious or cultural beliefs
        - Supportive family or friends
        - Ongoing therapy or treatment engagement
        - Motivation for recovery
        - Fear of death
        - Hope for the future
        - No prior suicide attempts or violence
- **Step 3: Document Risk of Harm to Others**
    - ***A. Universal Questions (Ask every client)***
        - 1. “Do you have thoughts of hurting anyone?”
        - 2. If yes, follow up with:
            - “Do you have a plan to act on those thoughts?”
            - “Do you intend to act on those thoughts?”
    - ***B. Assess for Risk Factors (Document for every client)***
        - Ask about and categorize each of the following factors as *negative (denied)* or *positive (present)*:
            - Static Risk Factors:
                - History of violence
                - Young age at first violent act
                - Antisocial personality or psychopathy
                - Prior supervision failure
                - History of major mental illness
            - Dynamic Risk Factors:
                - Relationship instability
                - Employment problems
                - Substance use problems
                - Lack of insight or negative attitudes
                - Active psychiatric symptoms
                - Impulsivity or poor self-control
                - Noncompliance with treatment

        - Lack of support system
        - Recent exposure to destabilizing stressors
    - ***C. Document Findings in Chart:***
        - Client Denies: (List all relevant factors from above that were denied)
        - Client Endorses: (List all relevant factors present)
- **Step 4: Document Access to Firearms or Other Lethal Means**
    - A. Universal Questions (Ask every client)
        - 1. "Do you have access to any firearms or other lethal means?"
        - If *yes*, gather details about type, location, and current safety/storage practices and document:
            - Who owns and has access to the firearm(s)
            - How firearms are stored (e.g., locked, unloaded, ammunition stored separately)
            - Whether the patient perceives firearms as a safety concern
            - Any steps taken to limit access during periods of elevated risk
        - If *no*, document absence of access:
            - "Client reports no access to firearms or other lethal means."
    - If risk is present, document actions taken (e.g., safety planning, referral, involvement of family/supports to secure firearms).
        - Example documentation: "Client reports access to a personal firearm stored locked and unloaded. No current suicidal or violent ideation. Reviewed safe storage practices; Client verbalized understanding. Overall risk for firearm safety concerns remains low."
- **Step 5: Document Actions Taken for Positive Risk Findings**
- If any risk factors are *positive*, for both harm to self or others, document both the factors present and your response.
    - ***Examples of Actions Taken:***
        - Referred to higher level of care
        - Created or updated a safety plan
        - Increased session frequency
        - Contacted emergency or crisis resources
        - Discussed safe firearm/lethal means storage
        - Engaged family or support persons
- **Step 6: Assign and Document Overall Risk Level (low/moderate/high)**
    - Low: Minimal risk, strong protective factors
    - Moderate: Some risk factors present, mitigated by supports

        - High: Significant risk with limited protective factors
    - ***Provide a brief summary to support your risk level determination:***
        - Example Documentation (Low Risk): "Client denies any current suicidal ideation, intent, or plan; denies homicidal ideation or urges to harm self or others. No access to firearms. No acute safety concerns identified at this time."
    - **Key Documentation Expectations**
        - Always assess *both* self-harm and harm-to-others risk, even if denied.
        - Always ask about access to lethal means.
        - Always document relevant risk factors, even if denied.
        - Use professional, objective language.
        - If no risk factors are identified, document that a full assessment was completed and findings were negative.
        - Reassess and update risk status whenever clinical presentation changes.
- **Mental Status Exam (MSE)**: Include orientation, alertness, speech, affect, mood, thought process, thought content (presence/absence of hallucinations/delusions), insight, judgment, and cognitive status.
- **Interventions**: Document specific interventions applied during the session, such as goals made. If referral to higher level treatment or a safety plan is made, they must be documented.
- **Response or Progress**: Summarize how the patient responded and progress toward goals.
- **Follow-Up Plan**: Document recommended next steps, referrals, or upcoming session frequency.

Follow-Up Sessions

For all follow-up encounters, providers must use the Headway-approved follow up note template. Follow-up notes should build upon the initial assessment, focusing on interval changes, ongoing progress, and any new or emerging risks.

All below documentation sections must be completed for every follow up session note.

- Reason for Visit / Interval Update: Document the patient's stated reason for the visit, progress toward previously established goals, and any interval changes in symptoms, functioning, or circumstances since the last session.
- Behavioral Health, Medical, and Substance Use Update: Note any relevant updates to behavioral health symptoms, medical status, medications, or substance use. If unchanged, document "No interval changes reported since prior visit."

- Risk Assessment: For routine follow-up visits where no new risk indicators are present, a concise risk statement is sufficient.
    - Example: “No changes to risk status since prior assessment; patient continues to deny suicidal or homicidal ideation, urges to self-harm or harm others, or other safety concerns.”
    - If any change in risk is identified, or new risk factors are disclosed, complete a full risk reassessment using the same structure as in the initial visit, documenting both the risk factors and actions taken.
- Mental Status Exam: Document a full mental status examination. Include updated observations if there is a noted change since the prior visit or as clinically indicated.
- Interventions and Response: Describe interventions or therapeutic approaches used during the session and summarize the patient’s response or progress toward goals.
- Follow-Up Plan: Outline next steps, including treatment plan updates, follow-up intervals, referrals, or safety planning adjustments as appropriate.

Template 1: Initial Session

Below is the Headway-approved documentation template for your use.

- Reason for visit / HPI:
- Behavioral Health History:
- Medical History:
- Substance Use Assessment:
- **Risk Variables Analysis:**
    - **Step 1. Document Risk of Harm to Self**
        - Document responses regarding suicidal ideation with plan, intent, means
        - Document associated risk factors
            - Client endorses...
            - Client denies...
    - **Step 2: Document Protective Factors**
    - **Step 3: Document Risk of harm to others**
        - Document responses regarding homicidal ideation with plan, intent, means, identified victim
        - Document responses regarding urges for violent behavior with plan, intent, means, identified victim
        - Document associated risk factors
            - Client endorses...
            - Client denies...
    - **Step 4: Document Access to Firearms or Other Lethal Means**

        - If *yes* to access, gather details about type, location, and current safety/storage practices (see further instructions below).
    - **Step 5: Document Actions Taken for Positive Risk Findings**
    - **Step 6: Assign and Document Overall Risk Level (low/moderate/high)**
    - ***Provide a brief summary to support your risk level determination:***
- Mental Status Exam (MSE):
- Interventions:
- Response or Progress:
- Follow-Up Plan:

Template 2: Follow-Up Session

- Reason for Visit / Interval Update:
- Risk Assessment:
- Mental Status Exam:
- Interventions and Response:
- Follow-Up Plan:

References:

- **Course:** ***Compliant Clinical Documentation***
- ***Course:*** ***Mastering Assessments: Key Components of the Diagnostic Clinical Interview***
- **Course:** ***How to complete risk assessments and safety planning***