OUTPATIENT DOCUMENTATION REQUIREMENTS

Definitions:

DSM: diagnostic and statistical Manuel
DTO: danger to others
DTS: danger to self
PCP: primary care physician
SIB: self-injurious behavior
DUI: driving under the influence
RX: prescription medication
HEDIS: healthcare effectiveness data and information set
ECG: electrocardiogram
EPS: emergency psychiatric services
AIMS: abnormal involuntary movement scale
BARS: barns akathisia rating scale
MSAS: modified Sympson-Angus scale
PHQ9: Patient Health Questionnaire-9
CURES: controlled substance utilization review and evaluation system
MSE: mental state exam
MR: medical record
DOB: date of birth
ADL: activities of daily living

I. Initial psychiatric evaluation:

The initial psychiatric evaluation should contain the following information:

- Identifying data: age gender, sexual orientation/gender identity, preferred pronoun, ethnicity, spoken/preferred language.

- Living arrangement, marital status, pregnancy/contraceptive status or planning to conceive.

HPI/Reason for visit/Chief Complaint: Reasons that the patient is presenting for evaluation:

- Psychiatric review of symptoms including but not limited to symptoms related to anxiety, depression, panic attacks, eating disorder, sleep disturbance/sleep apnea, impulsivity.

Past Psychiatric History

- Past/current psychiatric diagnoses.

- Prior h/o of psychotic symptoms, aggressive behaviors (i.e. homicide, domestic or workplace violence, other physical or sexual aggressive threats or acts).

- Prior h/o SI, plans, attempts that were aborted or interrupted as well as the details of each attempt including h/o overdose, and the substance(s) involved.
- History of SIB, DTS, DTO (include details).
- Past psychiatric outpatient, EPS, and psychiatric hospitalizations.
- Past psychotropic trials (type, dose, duration, adherence, side effect, and response)

Substance Use History

- Document substance use history per DSM 10 classes: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics, stimulants, and tobacco, and any misuse of prescribed, over-the-counter medications, and supplements (i.e. St Johns wart, Valerian, Kava Kava, …). Include the amount of use, frequency and date of last use.
- Current or past diagnoses of substance use disorder(s), withdrawal symptoms, change in use of alcohol or other substances and past inpatient or outpatient substance use treatment.

Social and legal History

- Presence of psychosocial stressors (i.e. financial, housing, legal, school/occupational or inter-personal/relationship problems; social/family support).
- Past or current family history including psychiatric history, treatment and response.
- Review of the patient's trauma history.
- Exposure to violence or aggressive behavior, including combat exposure or childhood abuse.
- Legal or disciplinary consequences of past aggressive behaviors.
- Cultural factors related to the patient's social environment.
- Personal/cultural beliefs and cultural explanations of psychiatric illness.
- Legal history (i.e. DUI).

Education, occupational, developmental and neurocognitive functioning:

- Developmental history.
- Educational history.
- Occupational History.
- Prior/current neurocognitive functioning including any attentional or hyperactivity disorders including past psychiatric tests/results and treatments.

Medical, surgical history and the name of PCP and other providers. include:

- Allergies.
- Past physical diagnoses.
- Other providers' name, specialty and contact information.
- Current medication list: physical and psychotropic medications.
- Medication adherence.
- Side Effects.

Current/active medications: include RX name, dose, frequency, response, side effects and adherence.

- Percent adherence to antipsychotics for the treatment of Schizophrenia and Schizoaffective disorder is one of the HEDIS measures that the external review organizations look for. Brief Adherence Rating Scale is one method of assessing percent medication adherence. In addition to this rating scale, simple and pointed questions such as: the number of days out of a week or a month the patient misses taking their medication or does not take it as prescribed can provide an estimated percent adherence. Documentation of full or partial adherent or non-adherent does not provide a way to calculate a percent adherence. (Link attached in the reference section).

Vitals: include the values, date and source of vitals if taken previously.

Labs, Exams, and ECG: include the values, provider's assessment of the results, date labs were done and source of the results if ordered by other providers.

Rating scales: AIMS, BARS, MSAS, PHQ9, include the date rating scales were completed.

CURES: Document the date it was run and your observations. CURES report is legally required at the time of initiating a controlled substance and every 6 months thereafter.

MSE: MSE can be partial for telepsychiatry appointments and must be complete and up to date for the face-to-face appointments. MSE must reflect what is observed at each appointment (Minimize cloning).

Assessment:

- Assessment of current symptoms.
- Treatment compliance.
- Safety assessment/plan including possession/access to weapons and protective factors.
- Review the emergency contact procedures.

DSM Diagnoses/rule out:

Document all of patient's diagnoses: psychiatric & substance use disorder(s) including the rule out diagnoses.

Plan:

- Treatment including drug name, dose, route, and frequency for all prescribed medications.
- Psychosocial interventions.
- Follow up date/frequency.

Medication Consent:

- The consent can be documented in accordance with the purpose section of the medication practice guidelines item #18.

II. Progress notes for each medication support visit should contain the following: (Note: Be sure to Minimize cloning)

- Service Documentation: Needs to reflect Service Provided, Individual duration, Documentation Time.
- Patient identifiers: Name, MR number, DOB, Age, Gender.
- Name of Provider.

➢ **HPI/Interval/interim history/subjective: Document the patient's reported symptoms and treatment response since the last appointment. Include:**

- Assessment of medication adherence and side effects including the nature of the side effects and plan to address them.
- Assessment of treatment response in context of patient's DX and prescribed RXs.
- Social functioning, ADLs, DTO, DTS, suicidality, and homocidality.
- Assessment of substance use since the last appointment.
- Medical conditions and appointments: Changes in the medical conditions since the last appointment.
- Active/current medication list.
- MSE: A complete MSE must be done at both telepsychiatry/face to face. Phone appointments: Everything except for eye contact, appearance, and movement disorders can be obtained.
- Labs: specify lab results since the last appointment, date and source (if results obtained from other providers).
- Imaging:
- Rating scales/psychiatric testing results

History carried over from the Initial Psychiatric Evaluation.

Assessment: Diagnosis, assessment of current symptoms, treatment response. Document side effects, and adherence if not documented above.

Plan:

- Treatment including drug name, dose, route, and frequency for all prescribed medications. If there is a section dedicated to an Up-To-Date active medication list, then continue the medications as above is sufficient.

- Psychosocial interventions.
- Follow up date/frequency.
- Suicide/homicide risk assessment performed; consider exacerbating and protective factors
- Review of the emergency contact procedures.

References:

- The American Psychiatric Association Practice Guideline for the Psychiatric Evaluation of Adults. https://doi.org/10.1176/appi.books.9780890426760

- Brief Adherence Rating Scale. https://www.nppsychnavigator.com/Clinical-Tools/Psychiatric-Scales/Scale-1-(3)