CLINICAL RECORD REVIEW (CRR)

ACCESS LOG (for DHHS BPQ USE ONLY)		
Name	**Date**	**PURPOSE**

CLIENT NAME:	0	0
SAMPLE CATEGORY:		
CMHC STAFF NAME:	0	0
STAFF POSITION:	0	
CMHC:	0	
PERIOD UNDER REVIEW:	1/0/1900 to	1/0/1900
RECORD REVIEW COMPLETED BY:		
DATE(S) OF REVIEW:		

ASSESSMENT, TREATMENT PLANNING, AND SERVICES

CRR Q1 Was a case management assessment completed? Yes or No Evidence? (Please record the most recent and complete the chart.)

	Assessed	Need Identified	List the Needs
Housing/Living Skills			
Employment			
Social/Family			

Name of Document:

Date of Document:

CRR Q2 Was a case management plan completed? Yes or No Evidence? (Please record the most recent and complete the chart.)

	Plan/Goal in this area	List the Plans/Goals/Explanations
Housing/Living Skills		

CLINICAL RECORD REVIEW (CRR)

Employment		
Social/Family		

Name of Document:

Date of Document:

CRR Q3 Was an annual treatment plan/ISP completed? Yes or No Evidence? (Please record the most recent and complete the chart.)

[**REVIEWER**: If there is anything in the ISP that supports the CMHC not having addressed the need via an ISP goal or objective, still select "NO" in Column D, but provide the support for why there is not an ISP goal or objective in Column F, such as barrier, functional impairment, or SE screening. Be specific.]

	Goal/Objective in this area	List the Goals/Objectives
Housing/Living Skills		
Employment		
Community Integration /Social Support		

Name of Document:

Date of Document:

CRR Q4 Was the comprehensive assessment, Adult Needs and Strengths Assessment (ANSA), completed during the period under review? Yes, No Evidence, or CMHC Does Not Use ANSA? (Please record the most recent and complete the scoring section below along with any narrative comments found.)

If CMHC DOES NOT USE ANSA or If NO EVIDENCE is selected, SKIP to CRR Q7

Need	Score	Comments	Function/Strength	Score	Comments

CLINICAL RECORD REVIEW (CRR)

Psychosis (Thought Disorder)			Physical/Medical		
Impulse Control			Family Relationships		
Mania			Employment/Educ.		
Depression			Social Functioning		
Anxiety			Recreational		
Interpersonal Problems			Living Skills		
Antisocial Behavior			Residential Stability		
Adjustment to Trauma			Living Situation		
Anger Control			Isolation		
Substance Use			Family/Family Strengths/Support		
Eating Disturbances			Interpersonal/Social Connectedness		
			Community Connection		
			Natural Supports		

Name of Document:

Date of Document:

CRR Q5 Were all the BEHAVIORAL/EMOTIONAL NEEDS, FUNCTIONING, AND RISK BEHAVIORS DOMAIN areas on the most current ANSA assessed and scored as 0, 1, 2, or 3? Yes or No?

If NO, as evidenced by (list the needs that were not assessed):

CRR Q6 Were the STRENGTHS DOMAIN areas on the most current ANSA assessed and scored as 0, 1, 2, or 3? Yes or No?

If NO, as evidenced by (list the strengths that were not assessed):

CLINICAL RECORD REVIEW (CRR)

CRR Q7 If an ANSA was not completed, was a similar current assessment of behavioral health needs and life functioning completed on a comparable document, i.e., the DLA-20? Yes or No Evidence?

As evidenced by:

Name of Document:

Date of Document:

CRR Q8 If an ANSA was not completed, was a similar ASSESSMENT OF STRENGTHS COMPLETED in a comparable document, i.e., DLA-20? Yes or No Evidence?

As evidenced by:

Name of Document:

Date of Document:

Please complete the below table with the most recent DLA-20 scores and comments:

Activities	Score	Comments	Activities	Score	Comments
Health Practices			Leisure		
Housing Stability & Maintenance			Community Resources		
Safety			Social Network		
Managing Time			Productivity		
Managing Money			Was employment assessed in Productivity?		
Nutrition			Coping Skills		
Problem Solving			Behavior Norms		
Communication					
Family Relationships					
Alcohol/Drug Use					

CRR Q9 Please complete the following chart for all Behavioral/Emotional Needs in the ANSA or comparable assessment document. *For the ANSA, ratings of 2 or 3 are considered a need* and are autofilled below. *For the DLA-20, ratings of 1, 2, or 3 are considered a need* and must be manually entered. Refer to the scoring key in the assessment to determine how needs are identified if using another assessment.

CLINICAL RECORD REVIEW (CRR)

[**REVIEWER**: If the CMHC used the DLA-20 or other comparable assessment rather than the ANSA, and MH needs were identifed, manually change "NO" to "YES" in the "Needs Identified" column.]

Mental/ Behavioral Health Needs	Needs Identified YES/NO	Addressed in the ISP/CM PLAN? YES /NO	How so? What is the Goal/Objective/ Plan in the ISP or CM Plan?	Select Either TX Plan/CM Plan	TYPE [goal/obj/plan or barrier]
Psychosis (Thought Disorder)	NO	N/A	N/A	N/A	N/A
Impulse Control	NO	N/A	N/A	N/A	N/A
Mania	NO	N/A	N/A	N/A	N/A
Depression	NO	N/A	N/A	N/A	N/A
Anxiety	NO	N/A	N/A	N/A	N/A
Interpersonal Problems	NO	N/A	N/A	N/A	N/A
Antisocial Behavior	NO	N/A	N/A	N/A	N/A
Adjustment to Trauma	NO	N/A	N/A	N/A	N/A
Anger Control	NO	N/A	N/A	N/A	N/A
Substance Use	NO	N/A	N/A	N/A	N/A
Eating Disturbances	NO	N/A	N/A	N/A	N/A

In the box below, list **1)** the BH Need that was changed from a NO to a YES, **2)** the source that identified it as a need if using an assessment other than the ANSA, and **3)** the score and text that identified it as a need to support its inclusion above:

CRR Q10 Please complete the following chart based on the individual's current treatment plan ***goals*** and their relation to an identified ***need*** in the **ANSA, Case Management Assessment**, or **comparable assessment document (e.g. DLA-20)**:

CLINICAL RECORD REVIEW (CRR)

GOALS IN THE CURRENT UNEXPIRED ISP	Assessed as an Identified **NEED** in ANSA, DLA-20, CM Assessment, or Other Assessment? (YES/NO) In ANSA, 2s or 3s = a need; In DLA-20, 1s, 2s, or 3s = need	Identify **1)** the **Assessment Used** (ANSA, DLA-20, CM Assessment, or specific other assessment used), **2)** the Need Identified, and **3)** the Score or Narrative

CRR Q11 Complete the tables based upon the individual's current annual ISP/ treatment plan and the frequency of services received/offered **since the following date** (date of ISP): **01/00/00**

TABLE A SERVICE	ON ISP/ TX PLAN (YES/NO)	Frequency	Received/ Offered (Y/ N/NA)	Received/ Offered (Date)	Received/Offered at Prescribed Frequency (YES/NO/NA)	CPC	CPD

CLINICAL RECORD REVIEW (CRR)

Individual Therapy						1/0/00	1/0/00
Case Management						1/0/00	1/0/00
Functional Support Services (FSS)						1/0/00	1/0/00
Group Therapy (DBT, etc.)						1/0/00	1/0/00
Prescriber Services						1/0/00	1/0/00
Supported Employment						1/0/00	1/0/00
Substance Use Disorder Treatment						1/0/00	1/0/00
Nursing Services (Assessments, etc.)						1/0/00	1/0/00
Peer Support Services						1/0/00	1/0/00
InSHAPE						1/0/00	1/0/00
Other:							
						1/0/00	
						1/0/00	
						1/0/00	

TABLE B Below, please explain **issues** with frequency, gaps in service provision, etc. **Include the name of the service, the frequency at which the service is prescribed, and the issue with frequency.** This information will assist the reviewer during the staff interview:

TABLE C (Only complete when it's PRN intent but not prescribed as PRN)
In the yellow-highlighted boxes, enter the actual PRN frequency prescribed.

	Indv Tx:	*FSS:*	*Prescriber:*	*SUD:*
#DIV/0! :RECEIVED/OFFERED 70% or more of Services on TX Plan	*Case Mgmt:*	*Group Tx:*	*SE:*	*Nursing:*
#DIV/0! :RECEIVED/OFFERED 70% or more of Services on TX Plan at Frequency Prescribed	*Peer:*		*InSHAPE:*	

CRR Q12 Is there documentation of the individual's involvement in ISP/treatment planning, such as a signature on the current ISP/Treatment plan, verbal acknowledgement, or documentation that a discussion of the ISP/goals on the ISP occurred? Yes or No Evidence?

Date of signature, verbal acknowledgement, or note containing the discussion:

CLINICAL RECORD REVIEW (CRR)

CRR Q13 Were the individual's strengths Included in the current ISP/treatment plan? Yes or No?

As evidenced by:

CRR Q14 Is the current ISP/treatment plan easy to understand (e.g., in the individual's words or written in a way that could be understood easily by anyone reading it)? Yes or No?

As evidenced by:

CRR Q15 Complete the chart entering all ISP reviews occuring during the PUR (most recent first, unless the most recent ISP review is not yet complete and the CMHC is still within their due date, then list the previously due ISP review first in the chart).

ISP Review dates (**actual date range of doc being used**)	ISP Review Completed (Yes/No Evidence)	Summary of Progress (yes/no)	Individual Progress was Made (yes/no)	Indication of Change in Service Needed (Yes/No)	Treatment Plan ***AND/OR*** Service(s) Modified (Yes/No)	Explain Modifications that were needed and made/not made

CRR Q16 Were ISP reviews (the specific document) completed following each review period that has fallen all or in part within the PUR? Yes or No?

HOUSING/LIVING SKILLS

CRR Q24 Was the individual assisted by the CMHC with his/her housing/living skills related needs and goals (related to residential stability as well as living skills/ADLs) in the past 12 months? Yes or No Evidence? [**Reviewer**: ***Review needs & goals in Q26 below before answering this question.***]

If NO EVIDENCE, SKIP to Q26

Name of Document(s):

CLINICAL RECORD REVIEW (CRR)

Date(s) of Document(s):

CRR Q25 Describe the type(s) of housing/living skills services and supports the individual received based on the document(s) listed in the previous question.

CRR Q26 Complete the reviewer codes below based on the information in the table.

Housing/Living Skills Needs:
Housing/Living Skills Goals:
Housing/Living Skills Services and Supports Received:
0

EMPLOYMENT

CRR Q27 Has the individual been enrolled in Supported Employment during the period under review? Yes or No?

As evidenced by:

Name of Document:

Date of Document:

Was the individual's first day of enrollment in Supported Employment at least 30 days prior to the QSR start date? Yes or No?

Enrolled prior to: ##########

Did the individual participate in Supported Employment for at least 30 days during the PUR? Yes or No?

If NO, explain:

CRR Q30 Were employment *needs* identified in either the ANSA, Case Management assessment, or other assessment? Yes or No?

If the ANSA, DLA20, or other assessment ids an employment need despite the score entered, enter YES here and the need in the blue cell below before skipping to EMPLOYMENT SERVICES/SE IDENTIFIER below. If nothing found, enter NO and skip to the Identifier.

CLINICAL RECORD REVIEW (CRR)

CRR Q31 List those identified needs as identified on the ANSA, Case Management assessment, or other assessment.

CM Assessment:	
ANSA:	
DLA-20 or OTHER:	

CRR Q35 Was an employment assessment (a.k.a. Vocational Profile or Vocational Assessment) completed? Yes or No Evidence?

If NO EVIDENCE, Skip to Employment Needs/Goals Identifier above Q37.

Name of Document:

Date of Document:

CRR Q36 Complete the chart below based upon the employment assessment identified in Q35. The "As evidenced by" field must include evidence from the assessment that supports any "Yes" entered into the chart.

REVIEWER GUIDANCE: Use any narrative in the assessment to complete the chart.

Skills & Strengths Included? (Y/N)	Interests & Preferences Included? (Y/N)	Work History/Experience	Barriers to Employment Included? (Y/N)

As evidenced by:

CRR Q37 Was the individual assisted by ***ANY MEMBER*** of the treatment team with his/her employment related needs, goals or plans? Yes or No Evidence? [**Reviewer**: ***Review needs & goals in Q39 below before answering this question.***]

If NO EVIDENCE, SKIP to CRR Q39

Name of Document(s) [***NOTE*** : Employment-related supports and services may be offered via SE, CM, FSS, Peer Support, Med, Prescriber, and/or Nursing services, and/or assessment and monitoring may be found in ISP Reviews]:

Date of Document(s):

CRR Q38 Describe the types of assistance or support provided to the individual related to his/her employment needs and goals based on the document(s) referenced in the previous question.

COMMUNITY INTEGRATION AND SOCIAL SUPPORTS

CRR Q43 Were social/community integration STRENGTHS and/or social/community integration NEEDS assessed anywhere else in the clinical record? Yes or No evidence?

Only address the area that is blank. If YES is pre-filled in the 'Strengths Assessed' or 'Needs Assessed' cell, do not alter that cell. If one of the areas is blank, select an option in the drop-down menu for that cell after checking other assessments in the EHR to see if the identified area was assessed. Note: *Strengths or needs do not have to be identified, just assessed.*

Strengths Assessed Needs Assessed

As evidenced by:

Name of document(s):

Date of document(s):

CRR Q48 Was the individual assisted by the CMHC with his/her community integration and/or social support related needs and/or goals? Yes or No Evidence? [**Reviewer**: ***Review needs & goals in Q50 below before answering this question*** **.]**

If NO EVIDENCE, SKIP to Q50

CRR Q49 Describe the types of assistance provided by the CMHC to the individual related to his/her community integration and/or social support needs and goals.

Name of Document(s):

Date of Document(s):

CRR Q50 Complete the reviewer code below based on the information in the table:

Community/Social Needs/Goals:

Community/Social Services and Supports Received:
0

CRISIS

CRR Q51 Was a current crisis plan completed? Yes or No Evidence?

If NO EVIDENCE, SKIP to CRISIS IDENTIFIER

Name of Document:

Date of Document:

CRR Q52 Was the current crisis plan written specifically for the individual and his/her situation (i.e., references his/her experiences, symptoms, people in his/her life as supports, interventions)? Yes or No?

As evidenced by:

CRR Q53 Did the ***individual*** access or receive crisis/emergency (psychiatric) services ***provided by the CMHC*** ? Yes, No, or No Evidence?

If NO or NO EVIDENCE, SKIP to ACT Section

CRR Q54 How many times did the ***individual*** access or receive crisis/emergency (psychiatric) services ***provided by the CMHC*** ? Count the note unless text in the documentation states the incident was NOT a crisis.

As evidenced by:

CRR Q55 Complete the chart below for the **most recent** PSYCHIATRIC crisis/emergency service accessed by the ***individual*** and ***provided by the CMHC*** , and provide a narrative summary of the contact below the chart:

	Date		Location/Type
	Risk Assessed?		Protective Factors Assessed?
	Plan was made?		Coping Skills Assessed?
	Staff Discussed Plan/Next Steps with Indv?		Crisis service ended with Indv remaining in or returning to Home/Community Setting (versus hospitalization)?

CLINICAL RECORD REVIEW (CRR)

Summary of Crisis Contact: **REVIEWER GUIDANCE**: Narrative must include information that supports all the responses provided in the table above.

Name of Document:

Date of Document:

ACT

CRR Q56 Was an ACT screening completed? Yes or No Evidence?

Name of Document:

Date of Document

CRR Q57 Has the individual been on ACT? Yes or No?

As evidenced by (include team name and date assigned):

CRR Q58 Is the individual currently on ACT? Yes or No? If YES, also complete the chart below regarding the past 4 weeks of ACT services:

If NO, SKIP to TRANSITIONS/DISCHARGE

Date range used to answer chart (see instructions*, **MONDAY THROUGH SUNDAY**):

8/12/2024 - 9/8/2024

		Week 1	Week 2	Week 3	Week 4	Total	Average
	Date Range (Mon to Sun):	8/12/24-8/18/24	8/19/24-8/25/24	8/26/24-9/1/24	9/2/2024 - 9/8/2024		
ACT STAFF	**How many distinct ACT staff did client have contact with? (CRR Q60)**					0	0
ACT STAFF	**How many minutes of service with ACT Staff? (CRR Q61)**					0	0
ACT STAFF	**How many total contacts with ACT Staff? (CRR Q62)**					0	0
ACT STAFF	**How many contacts with ACT Staff in which the client was in the home or community? (CRR Q63)**					0	#DIV/0!

CLINICAL RECORD REVIEW (CRR)

NON-ACT STAFF	**How many distinct NON-ACT staff did client have contact with?**	0.00	0.00	0.00	0.00	0	0
	How many minutes of service with NON-ACT Staff?	0.00	0.00	0.00	0.00	0	0
	How many total contacts with NON-ACT Staff?	0.00	0.00	0.00	0.00	0	0
	How many contacts with NON-ACT Staff in which the client was in the home or community?	0.00	0.00	0.00	0.00	0	#DIV/0!

Below, list each **NON-ACT** Staff used in the chart above, along with his/her title

CRR Q59 How long have **ACT** services been provided to the individual?

CRR Q60 During the past 4 complete weeks (Mon-Sun), did the individual have contact with more than 1 different **ACT Team staff** each week, on average? Yes or No?

As evidenced by (if response is NO):

CRR Q61 During the past 4 complete weeks (Mon-Sun), did the individual have a minimum of 85 minutes of service with **ACT Team staff** each week, on average? Yes or No?

As evidenced by (if response is NO):

CRR Q62 During the past 4 complete weeks (Mon-Sun), did the individual have 3 or more total contacts with **ACT Team staff** per week, on average? Yes or No?

As evidenced by (if response is NO):

CRR Q63 What is the percentage of **ACT services** received in which the individual was in the home or community in the past 4 complete weeks?

:THIS IS >/= 60%

As evidenced by (if response is NO):

CRR Q64 Complete the following table:

ACT Team Roles	CMHC filled
Psychiatrist/APRN	

For CMHCs with multiple ACT teams, please indicate the name/location of the individual's ACT Team:

CLINICAL RECORD REVIEW (CRR)

Psychiatric Nurse	
Employment Specialist	
Master's Level Clinician	
Subst. Abuse Specialist	
Team Leader	
Peer Specialist	

PSS First Names:

TRANSITIONS/DISCHARGES

CRR Q65 Has the individual experienced a transition/discharge from an inpatient psychiatric facility that **started** while the individual was enrolled at **this** CMHC? Yes, No, or No Evidence?

If NO or NO EVIDENCE, SKIP to COMPLETION TRACKING CHART

As evidenced by:

Date of Document:

CRR Q66 How many times was the individual discharged from an inpatient psychiatric facility during the PUR?

CRR Q67 Please complete the following chart for any inpatient psychiatric admission and discharges the individual experienced during the PUR, ***most recent first*** *:*

Facility	DOA	DOD

For the following questions, please complete using the most recent inpatient psychiatric admission and discharge from:

CRR Q68 Does the clinical record include the discharge summary and/or discharge instructions from the inpatient facility? Yes or No evidence?

Name of Document:

CLINICAL RECORD REVIEW (CRR)

Date of Document:

CRR Q69 Was there in-reach/communication with the inpatient facility or the individual during the individual's admission? Yes or No evidence?

If NO EVIDENCE, SKIP to Q72

CRR Q70 Describe the in-reach/communication:

Name of Document(s):

Date of Document(s):

CRR Q72 Describe the type(s) of service(s) and summarize the focus of the first day of CMHC appointment(s) following transition/discharge and include the date of appointment where indicated:

First Appointment Date:

Name of Document:

Date of Document:

CRR Q73 Did the individual start or continue ACT following transition/discharge, within 30 days? Yes or No?

As evidenced by:

CRR Q74 How was the individual involved in his/her discharge planning process? **Select all that apply.**

	Indv Attended a Discharge Planning meeting		Prior to Discharge, Indv Discussed Risk Factors/Things that Might be Difficult Following Discharge
	Indv Devp'd Safety/Wrap Plan During Stay		Prior to Discharge, Indv Talked with Staff About Meds/Med Changes

CLINICAL RECORD REVIEW (CRR)

	Prior to Discharge, the Indv's Follow-up Treatment Appointments in the Community were Discussed with Him/Her		Indv Participated in therapeutic groups/activities to Help Plan Indv's Return Home
	Prior to Discharge, Where the Indv Was Going to Live Was Discussed with Indv		NO EVIDENCE was found of indv's Involvement in Discharge Planning

Summary of Discharge Planning Activities: **REVIEWER GUIDANCE**: Narrative must include information that supports all the responses provided in the table above.

Name of Document(s):

Date(s) of Document(s):