AMH Minimum Standard Chart Review Guidance for Review

1. General Record:	Source	Absent	Partial	Present	N/A
A. Record is current, organized and legible	CMS	No record	Record is not complete	Record is current, organized and legible	
B. Financial and benefit eligibility is reviewed annually	CRT Manual Admin Rule 4.7.6	Documentation not in client's chart	Documentation is unclear or incomplete, or noted as not applicable	Clear documentation of source(s) of income such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or income from employment, etc. AND Medicaid/Medicare eligibility (current coverage or application in process) or other insurance coverage, housing subsidies, food stamps, other income, entitlements or benefits	
C. Initial eligibility determination or review of ongoing CRT eligibility (required every two years)	CRT Manual Admin Rule 4.7.6	Eligibility determination/review of ongoing CRT eligibility is absent or out of date	Documentation of criteria for enrollment or ongoing enrollment is unclear or incomplete, or criteria are not met	Documentation of eligibility criteria for ongoing CRT eligibility is present and up to date	
2. Clinical Evaluation of Presenting Challenges, Symptoms and History:		**Absent**	**Partial**	**Present**	**N/A**
A. Timely -- completed within 30 days of intake or re-evaluation within 2 years.	CRT Manual Admin Rule 4.7.6	Documentation not in client's chart	Documentation may be partially completed or completed late	Completed within required time-period	
B. Presenting conditions	CRT Manual Admin Rule 4.7.6	Documentation not in client's chart	Components are unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs)	Clear information on standard is present, clearly and completely defined and explained	
C. Target symptoms	CRT Manual Admin Rule 4.7.6				
D. History of presenting issues	CRT Manual Admin Rule 4.7.6				

<table>
<tr><td>E. Treatment goals in client’s words (checkbox version or refusal documented is acceptable)</td><td>CRT Manual
Admin Rule 4.7.6</td><td></td><td>Documentation lacks or inconsistently incorporates client voice</td><td>Clear documentation in client’s own words</td><td></td></tr>
<tr><td>F. Trauma screen noted with follow up documented if clinically indicated</td><td>CMS</td><td>Documentation not in client’s chart</td><td>History of trauma documented, but review of trauma symptoms missing from documentation and/or no trauma follow-up noted.</td><td>Documentation of trauma screening as part of initial assessment as well as reassessment and documentation of clinically indicated follow up noted.</td><td></td></tr>
<tr><th>3. Functional Capacity and Support Systems (Psychosocial Assessment)</th><th>Source</th><th>Absent</th><th>Partial</th><th>Present</th><th>N/A</th></tr>
<tr><td>A. Legal complications (criminal)</td><td>CRT Manual</td><td rowspan="4">Documentation not in client’s chart</td><td rowspan="4">Documentation is unclear or incomplete or marked as not applicable</td><td>Clear documentation that legal issues have been explored and none are present—or, if they are present, they are documented so that someone not familiar with the client/situation can easily understand them</td><td></td></tr>
<tr><td>B. Employment Information</td><td>CRT Manual</td><td>Clear documentation of current status as employed (full-time/part-time) or unemployed (seeking employment or not seeking employment, and why), so that someone not familiar with the client/situation can easily understand</td><td></td></tr>
<tr><td>C. Information on activities of daily living</td><td>CRT Manual
4.7.6</td><td>Clear documentation of degree of difficulty client has with ADLs—or, if no difficulty, clear documentation to that effect so that someone not familiar with client/situation can easily understand service needs</td><td></td></tr>
<tr><td>D. Description of housing/ living situation</td><td>CRT Manual</td><td>Clear documentation of where client lives (for example, owns or rents own home, lives with parents or other relatives, lives independently in apartment, lives in supported apartment, group home, etc.)</td><td></td></tr>
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E. Hobbies/ leisure interests/ involvement	CRT Manual			Clear documentation about client's interests and involvement in any number of activities that can be undertaken either individually or in groups	
F. Special status situations, for example violence, and/or suicide risk assessment, considered and included in treatment plan if necessary	CRT Manual Admin Rule 4.9.9			ONHs, treatment needs related to enhanced DMH funding authorized for difficulty of care	
G. Support/ value system	CRT Manual Admin Rule 4.9.6			Clear documentation of client's relationships with family and friends (past and present), to include information about any interpersonal abuse issues and/or significant losses/ recent changes in relationships	
H. Education Information (highest level achieved)	CRT Manual			Clear documentation of current status (student/non-student) and highest grade or degree achieved	
4. Substance Abuse Services	**Source**	**Absent**	**Partial**	**Present**	**N/A**
A. Documentation of screening for substance use/ abuse is present	CRT Manual	Documentation not in client's chart	Documentation is unclear or incomplete, or noted as not applicable, or assessment is absent despite positive screening result.	Clear documentation of use of standardized screening tool and documentation of referral for full assessment when clinically indicated and copy of assessment in chart, incorporation of assessment results into client diagnoses and IPC goals/services.	
B. Substance abuse assessment present if indicated	CRT Manual				
5. Diagnosis: Listed, if partial note missing areas		**Absent**	**Partial**	**Present**	**N/A**
Mental Health Diagnosis	CRT Manual Admin Rule 4.7.6	Documentation not in client's chart	Documentation is unclear or incomplete	Clear documentation of diagnoses supported by assessment and/or reassessment of client or outside provider's documentation included in chart.	
6. Formulation/Interpretive Summary:		**Absent**	**Partial**	**Present**	**N/A**

A. Consumer strengths and/ or treatment preferences are listed	CRT Manual Admin Rule 4.9.6	Documentation not in client's chart	Documentation lacks or inconsistently incorporates patient preferences, strengths and needs into interpretive summary	Clear documentation in client's own words leading into clinical formulation	
B. Clinical formulation (summary of conclusions)	CRT Manual	Documentation not in client's chart	Documentation is unclear or incomplete	Clear documentation/summary of conclusions leading into treatment recommendations	
C. Clinician's signature with degree and title	CRT Manual	All three components are absent	Components are absent	Signature and degree are present, or complete list of current staff and degrees is made available during chart review	
7. Individual Plan of Care (IPC)	**Source**	**Absent**	**Partial**	**Present**	**N/A**
A. Date of last IPC review or update	CRT Manual Admin Rule 4.7.6 and 4.9.7	Documentation not in client's chart	Documentation is unclear or incomplete	Documentation is clear and complete	
B. Goals reflect assessment/evaluations	CRT Manual Admin Rule 4.9.7	No connection between assessment formulation and goals	Unclear connection between assessment formulation and goals	Clear connection between assessment formulation and goals discernible by a person unfamiliar with the client	
C. Client input is evident in goals (clinically interpreted into mental health goals)	CRT Manual Admin Rule 4.9.6 and 4.9.7	Clinical interpretation is absent	Unclear clinical interpretation of client's needs into clinical mental health goals	Clear concise clinical interpretation of client's needs into mental-health goals	
D. Clinical interventions documented in daily, weekly, monthly notes or contact notes (including group notes)	CRT Manual Admin Rule 4.9.7	Clinical interventions not documented	Documentation incomplete	Documentation includes date of service, length of service, and type of service along with description of client's participation in, response to service, and how service contributes to IPC goal(s).	
E. Strategies indicate client activities and strengths	CRT Manual Admin Rule 4.9.7	Plan does not indicate client activities	Plan is unclear about client activities	Plan is clear and identifies easily understandable client activities	
F. Documentation includes all providers	CMS	Service plan does not identify provider/staff person	Service plan's identification of provider/staff person is unclear	Service plan clearly identifies provider/staff person	

G. Frequency range of services given (including groups as active treatment)	CRT Manual Admin Rule 4.9.7	Frequency range of services is missing from service plan	Frequency range of services is unclear or incomplete	Frequency range of services is clear and complete	
H. Plan articulates expected outcomes	CRT Manual Admin Rule 4.9.7	Service plan does not articulate expected outcomes	Expected outcomes are unclear	Expected outcomes are clearly articulated	
I. Client or guardian signature is present	CRT Manual Min Std 4.9.2	Absent	Signatures are incomplete with no documented explanation or follow up	Present	
J. LIP's signature on the treatment plan	CRT Manual Admin Rule 4.9.7	Absent	Signatures are incomplete, e.g., missing credentials, missing role of provider	Present	

K. Plan Reviews or Updates are required annually, in the event of a significant change of life circumstance, or need for change in services. **Please circle Y/N for each of the following situations if they have changed since the last plan** (not scored) • **Y / N** New, complicating or worsening symptoms (mental or physical health) • **Y / N** Development of new goals/services or revisions of old goals/services • **Y / N** Failure to progress in skill building or mental health treatment over a period of 6 months • **Y / N** Major life changes that are upsetting/dysregulating to the person • **Y / N** Changes in legal status for the client, family member or significant other **If the answer was yes for any of the situations above, then was the Plan of Care updated to reflect these changes in circumstances, goals or treatment needs?**	CRT Manual Admin Rule 4.9.9 and 4.9.7	No evidence of update annually, in the event of any significant change of life circumstance, or need for change in services.	Plan reviews are inconsistently updated	Plans are consistently updated annually, in the event of any significant change of life circumstance, or need for change in services.	No evidence of applicable situations for the client
8. Progress Notes and Outcomes	**Source**	**Absent**	**Partial**	**Present**	**N/A**
A. Notes reflect treatment interventions/ objectives in IPC	CRT Manual Admin Rule 4.7.6	No connection between progress notes and IPC	Missing or inconsistent documentation, “canned” or photocopied progress notes from month to month, or only partial implementation of treatment plan	Clear reflection of IPC treatment interventions/objectives in progress notes	
B. Notes reflect planned range of services as prescribed in IPC	CRT Manual Admin Rule 4.7.6	Progress notes do not reflect IPC range (frequency) of services	Progress notes only partially reflect IPC range (frequency) of services	Clear reflection of IPC range (frequency) of services in progress notes	

C. Monthly notes or contact notes are comprehensive review of services provided	CRT Manual Admin Rule 4.7.6	No connection between printout and progress notes	Progress notes state modality only, or notes are vague (for example, “processed with client” or “supported client”), or notes address client activity only, or notes fail to explain fluctuations in service pattern	Documentation of services specifies the services provided, explains fluctuations, and identifies clinician’s role	
D. Notes evaluate the plan’s effectiveness of outcomes	CRT Manual Admin Rule 4.7.6	Progress notes do not evaluate plan’s effectiveness or outcomes	Documentation of plan’s effectiveness or outcomes is unclear or incomplete	Documentation clearly evaluates plan’s effectiveness or outcomes	
E. There is evidence of consultation for complex and treatment-refractory cases	CRT Manual Admin Rule 4.9.8	Evidence of consultation is absent from documentation	Evidence of consultation is incomplete	Evidence of consultation is present in documentation	Documentation does not suggest a need for consultation
F. Changes in Progress Notes are reflected in IPC	CRT Manual Admin Rule 4.9.8	Absent	Notes too general and lacking detail	Present	No changes in services noted in progress notes
G. Progress notes are not repetitive and are individualized to the client’s service interactions	CRT Manual Admin Rule 4.7.6	Notes are repetitive and generic	Notes too general and lacking detail	Notes reflect individual treatment interactions between client and clinician and document client’s response to service	
H. Clinician’s signature is present	CRT Manual	Absent	Incomplete, missing credentials and/or role	Present	
I. If the client has been admitted to the hospital or hospital diversion, there is evidence of discharge planning and participation from the DA (client being seen within 24 hours of D/C)	CRT Manual Admin Rule 4.7.5	Absent	Some documentation indicates that the client was in a higher level of care, but it is does not demonstrate active participation in the client’s treatment d/c planning from the higher level of care by the DA staff.	Documentation clearly indicates DA staff is involved in treatment in and discharge planning from the higher level of care.	

9. Primary Care Integration	Source	Absent	Partial	Present	N/A
A. Primary care physician identified	CRT Manual Admin Rule 4.9.10 and 4.9.11	Absent		Present	
B. Release to collaborate with primary care?	CRT Manual Admin Rule 4.9.10 and 4.9.11	Absent	Incomplete	Present	
10. Psychiatric Review (by DMH Med Dir)	**Source**	**Absent**	**Partial**	**Present**	**N/A**
11. Crisis Management Plan	**Source**	**Absent**	**Partial**	**Present**	**N/A**
A. There is a crisis management plan, e.g. WRAP "Wellness Recovery Action Plan" in chart, or evidence of refusal when clinically indicated (if N/A or Absent, all other standards in this section are N/A)	CRT Manual Admin Rule 4.9.6 Admin Rule 4.9.9	Crisis management plan is not in record	Incomplete	Crisis management plan is in record	Pattern of service use does not indicate a need for a crisis plan
B. The plan addresses precursor symptoms	Admin Rule 4.9.9	Not identified	Incomplete	Identified	Only if A is N/A
C. The plan addresses multiple domains of wellness	Admin Rule 4.9.9	Not addressed	Incomplete	Addressed	
D. The plan includes stabilization methods	Admin Rule 4.9.6 Admin Rule 4.9.9	Not identified	Incomplete - methods are impractical or unrealistic	Identifies an array of stabilization methods or options	
E. The plan promotes consumer illness self-management strategies	Admin Rule 4.9.6 Admin Rule 4.9.9	Crisis management plan offers no consumer illness self-management strategies or deals only with what others can do	Crisis management plan is impractical or unrealistic, or offers solutions outside the person's control	Crisis management plan promotes consumer illness self-management strategies that are realistic and practical	
F. The plan considers outside social supports	Admin Rule 4.9.6 Admin Rule 4.9.9	Crisis management plan does not consider outside social support	Consideration of outside social support relates only to the role of the community mental health center	Crisis management plan considers outside social support other than the CMHC	

G. The plan offers strategies for crisis intervention	Admin Rule 4.9.6 Admin Rule 4.9.9	Crisis management plan does not offer strategies for clinical intervention	Documentation of strategies for clinical intervention is too narrow (for example, listing medications as the only clinical option available)	Crisis management plan offers a range of options for clinical intervention	
12. Utilization Review	**Source**	**Absent**	**Partial**	**Present**	**N/A**
A. Service levels are consistent with IPC	CRT Manual Admin Rule 4.9.8	There is a void in the documentation evaluating service need in relation to services delivered in month-to-month progress notes	There is some evidence of consideration given to evaluating the IPC services prescribed, the services needed, and the decision to deliver amount of services in month-to-month progress notes	There is documented evidence of evaluation of the client's need for services prescribed and services delivered in month-to-month progress notes	
B. Intensity of services matches the documentation of need (right amount)	CRT Manual Admin Rule 4.9.8	Services provided do not seem to be related at all to the frequency range of each type of services prescribed in the IPC.	Services are being provided but they are only partially consistent with the frequency range of each type of services prescribed in the IPC	Intensity of services are consistent with the frequency range of each type of service prescribed in the IPC	
13. Advanced Directives		**Absent**	**Partial**	**Present**	**N/A**
A. In Chart (or evidence of refusal)	CRT Manual Admin Rule 4.9.6	Not documented in chart	Incomplete	Documentation of advance directive in chart (or evidence of refusal)	

CRT Manual - http://mentalhealth.vermont.gov/manuals

Centers for Medicare and Medicaid Services (CMS) - https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf