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Standard of Care Focus	Exemplary (In addition to Adequate)	Adequate	Needs Improvement
ASSESSMENT			
1.11 Requests for services are addressed appropriately and in a timely manner	1) There is evidence that individuals have received same-day initial assessments following screening. **OR** 2) The program provides a walk-in, same-day service which has designated staff scheduled on a regular basis. **OR** 3) There is evidence of follow-up to assist individuals screened but referred elsewhere to connect with appropriate services. **OR** 4) There is availability of Peer Support Services for pre-admission encounters.	1) Requests for services are screened and triaged same business day and this process is overseen by supervisory staff. **AND** 2) Calls, walk-ins or referrals for services are screened for risk by appropriately trained staff and mechanisms are in place for alerting professional staff when risk is identified. **AND** 3) Individuals referred from inpatient, forensic, or emergency settings, or those at high risk receive initial assessment within 5 business days; priority access is given to individuals enrolled in AOT and individuals receiving and transitioning from ACT. **AND** 4) A note is written upon decision to admit which includes reason for referral, primary clinical needs, services to meet those needs, and admission diagnosis. **AND** 5) Interpreter services are made available as needed. **AND** 6) There is documentation of the rationale for individuals who have	1) Criteria for screening and triaging requests for service are inappropriate or inconsistently applied, or certain required treatment modalities are not offered, or process is not reviewed by supervisory staff. **OR** 2) Priority access is not given as required by regulations. **OR** 3) Admission notes are not present or are incomplete. **OR** 4) There is no rationale for non-admissions and no referrals are provided. **OR** 5) Individuals requesting services are not consistently offered intake appointments within a reasonable time frame.

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		not been admitted to the program. The program provides other referral sources, as needed. **AND** 7) Documentation for all services delivered during pre-admission are completed and retained.	
1.12 Assessment process is responsive and coordinated	1) Assessments, including psychiatric assessments, are completed within 2 weeks of first appointment, and are expedited if indicated by clinical presentation and need for medication. Reasons for exceptions are documented. **OR** 2) If preferred by the individual, or clinically appropriate for engagement, an off-site assessment is offered. **OR** 3) Applicable staff meet to conduct a multidisciplinary team review of assessment(s) to inform planning recommendations.	1) Assessment for all individuals is routinely completed within 30 days of admission and expedited based on clinical presentation and need for medication. Reasons for exceptions are documented. **AND** 2) A single clinician oversees the assessment process with the individual/family. **AND** 3) Clinicians completing assessments are licensed, trained, and supervised, as appropriate. **AND** 4) There is evidence of effective "hand-off" of individual information between clinicians/staff. **AND** 5) Individuals are admitted within regulatory time frames.	1) Multiple clinicians are involved in an individual's assessment without explanation or clinical justification. **OR** 2) Information is lost or the assessment process is delayed due to poor coordination or communication among staff. **OR** 3) Assessments are routinely not completed within 30 days of admission. **OR** 4) Psychiatric assessment is not coordinated with other assessments or psychiatrist is not available for timely or expedited evaluations as needed.

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1.21 The assessment is comprehensive.	1) Assessment includes the individual's view of past successes, difficulties, desired outcomes and potential barriers in each area. **OR** 2) For children and adolescents, the MHOTRS program consistently obtains written reports and/or verbal communication from school to assist with the assessment. **OR** 3) Evidence-based screening tools are used. **OR** 4) When peer services are identified, Peer Specialist/Advocate is engaged in the assessment process to further inform treatment planning and guide a person-centered/family-centered perspective and service interventions. **OR** 5) A standardized instrument such as the DSM-5 Cultural Formulation Interview is used.	1) Assessment should include evaluation of history and current status, needs, goals and desires, in the following areas *(Additional required areas are listed under other Anchors)*: • Individual's reasons for seeking services • Individual and family's current strengths, supports, and stressors • Mental status • Physical health (see 1.25) • Co-occurring conditions • Mental health services • Traumatic experiences • Perception of own risks and safety • Legal and/or forensic involvement • Family, significant others, social function, finances, housing • Education, employment, and other community roles • Literacy needs Additionally, for children: • Developmental history • School performance, and interpersonal/social issues • Family history which may impact child's mental health • Relationship between child-parent/caregiver and other family	1) There is no documentation of assessments. **OR** 2) There is documentation of assessment in all areas, but only minimal information is included. **OR** 3) One or more assessments relevant to treatment are missing.

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		• Parent's/caregiver's perception of, and capacity to manage the child's specific needs • CPS involvement, foster care, placements, contact with abuser(s), and/or domestic violence **AND** 2) The assessment results in a clinical formulation and recommendations which inform the treatment plan.	
1.22 Screening and Assessment of Co-Occurring Disorders		1) Individuals evaluated for admission are screened for co-occurring substance use disorders using a population (age/development) appropriate standardized screening instrument. **AND** 2) Based on positive screening instrument scores or on clinical judgment, individuals are clinically assessed to determine the presence or absence of independently diagnosable mental health and substance use disorders. **AND** 3) Staff who administer screening instruments, review scores, or conduct clinical assessments have the training or experience to do so. **AND** 4) For children, information is sought from the child or family concerning alcohol or substance use in the home environment(s).	1) Individuals evaluated for admission are not screened for co-occurring substance use disorders using a standardized screening instrument. **OR** 2) Positive screening instrument scores or clinical judgment rarely trigger a comprehensive clinical assessment.

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1.23 The assessment should include an initial risk of self-harm.	1) Additional information or corroboration from collateral sources is routinely sought and utilized in making the assessment. **OR** 2) There is evidence that clinicians use the Chronological Assessment of Suicide Events (CASE) Approach in conjunction with the Columbia Suicide Severity Rating Scale (C-SSRS) for conducting risk assessment.	1) Initial self-harm risk screening for all individuals is part of the MHOTRS program's assessment process. Both suicidal and self-injurious behavior are assessed. **AND** 2) A positive screen results in a discrete assessment that considers both static and dynamic factors in conjunction with current mental status, supports and protective factors. Access to means/weapons is emphasized. **AND** 3) Information is synthesized and incorporated into an assessment of the individual which informs the treatment plan. **AND** 4) Determination of moderate/high potential for self-harm prompts clinical consultation and/or other immediate interventions to include means restriction, as indicated. For children/youth this includes notification and involvement of parents/guardian unless otherwise indicated.	1) No initial suicide or self-harm screening or assessment has been completed. **OR** 2) The record contains only minimal documentation, with conclusions such as "No SI" (suicidal ideation). **OR** 3) Significant risk factors are ignored or missed.

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1.24 The assessment should include an initial risk of harm to others.	1) Additional information or corroboration from collateral sources is routinely sought and utilized in making the assessment. **OR** 2) There is evidence that clinicians use a validated process for conducting risk assessment.	1) Initial violence risk screening for all individuals is part of the MHOTRS program's assessment process. **AND** 2) At a minimum, violence risk screen includes direct inquiry into the following: • History of fights or hurting others • Any recent plans or intention to hurt others • Critical events such as past hospitalizations, arrests, domestic violence, orders of protection, child abuse, fire setting, abuse of animals, etc. that suggest a history of violence • History of not taking medication as prescribed, in the context of past violence • For children, additional information or corroboration from parents/caregivers or other collateral sources is routinely sought **AND** 3) A positive screen results in a more comprehensive assessment that considers both static and dynamic factors in conjunction with current mental status, supports and protective factors. Access to means/weapons is emphasized.	1) No initial violence screening or assessment has been completed. **OR** 2) The record contains only minimal documentation, with conclusions such as "No HI" (homicidal ideation). **OR** 3) Significant risk factors are ignored or missed.

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		AND 4) Information is synthesized and incorporated into an assessment of the individual which informs the treatment plan. **AND** 5) Determination of moderate/high potential for violence toward others prompts clinical consultation or other immediate interventions, as appropriate. For children/youth this includes notification and involvement of parents/guardian unless otherwise indicated.	
1.25 Health Screening and Monitoring	1) Upon admission, the MHOTRS program assesses health and medical status, whether through a physical by the individual's medical provider not more than 12 months prior to the intake, or by completing a Health Physical within 3 months of admission. **OR** 2) Upon admission, and quarterly, the MHOTRS program provides Health Monitoring by assessing the following health indicators: • Adults: Blood pressure, BMI, and risk for diabetes	1) Upon admission, the MHOTRS program gathers information concerning individual's medical history and current physical health status. **AND** 2) Health information is reviewed by a physician, NPP, RN, or PA who documents review of health information, potential impact on mental health diagnosis and treatment, and any need for additional health services or referrals. **AND** 3) Any medical hospitalizations are reviewed, and issues are incorporated into mental health treatment where appropriate. Recommendations from review are acted upon. Reasons for exceptions	1) The MHOTRS program does not attempt to gather individual health information. **OR** 2) Health information is not reviewed by appropriate staff with medical training. **OR** 3) Reviews are routinely signed with no recommendations about impact or service needs.

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	• Children and Adolescents: BMI percentile, activity level/exercise, and risk for diabetes **OR** 3) On a quarterly basis, the MHOTRS program develops and reviews with the individual, and caregivers for children, a plan to address any identified health issues. This should be in collaboration with the primary care provider when possible. **OR** 4) Diabetes education is provided where appropriate. Issues of non-cooperation or non-effectiveness of diabetes treatment (nutrition, med management, blood sugar monitoring) are addressed with the primary care provider. **OR** 5) Primary care services are offered through the MHOTRS program.	are documented. **AND** 4) Abnormal Involuntary Movement Scale (AIMS) testing or equivalent is conducted on a regular basis for individuals taking psychotropic medications with a known potential side effect of tardive dyskinesia (TD) or other extra-pyramidal symptoms (EPS) and for all individuals with a diagnosis of TD regardless of current medication regimen.	

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1.27 Screening and Assessment of Tobacco Use	1) The MHOTRS program uses one of the screening instruments recommended by OMH Tobacco Dependence Treatment workgroup. **OR** 2) Assessments are conducted and reviewed by staff who completed a specialized training program on tobacco dependence treatment for individuals with SMI (FIT training modules).	1) The MHOTRS program screens all individuals for tobacco use and dependence and assesses readiness to reduce or quit using tobacco at intake and every three months for active smokers. **AND** 2) For children, information is sought from the child or family concerning tobacco use in the home environment(s).	1) The MHOTRS program does not screen for tobacco use and dependence. **OR** 2) Some staff who administer screening instruments, review scores, or conduct clinical assessments lack the training or experience to do so.
1.31 The clinician should pursue information from other available sources, particularly family members, significant others, and recent providers of services.	1) There is documentation that the clinician discussed with the individual the value of including family members and significant others involved in the individual's life in completing a comprehensive assessment. **OR** 2) In addition to contacting recent providers, clinicians actively pursue potentially relevant information regarding the individual from all available sources (for instance, substance	1) Assessment seeks to identify significant others as well as past and current service providers and agencies involved with the individual. This may include courts, DSS, schools, etc. in addition to mental health services. **AND** 2) With appropriate consent, family and significant others are contacted to participate in the assessment. **AND** 3) For children, assessment should always include input from parents or other caregivers, OR there is documentation regarding why there has been no contact. **AND** 4) There is documentation that recent providers of mental health service	1) There is no documentation that the clinician attempted to identify significant others or service providers in completing the assessment. **OR** 2) No contact was attempted with any family or other persons involved in the individual's life, with no documented explanation. **OR** 3) There is no evidence that current or past providers of mental health service have been contacted to obtain information to contribute to the evaluation. **OR** 4) Significant information from collateral sources has not been

	services, probation, housing, OPWDD, etc.).	have been contacted to obtain discharge summaries and other pertinent information.	incorporated into the assessment.
TREATMENT PLAN			
2.11 Every individual has a person/family-centered, treatment plan that is developed with input from the individual/ family/ collaterals/ supports as appropriate	1) The treatment plan identifies evidence-based methods to address needs and goals related to chosen community roles, as appropriate. **OR** 2) Treatment plans reflect tailored approaches which incorporate: o Culturally relevant information from individuals/family o Cultural and/or spiritual practices and traditions and community involvement as areas of strength and support **OR** 3) Discharge criteria and/or desired accomplishments of the individual and family/caregiver/supports to be achieved prior to	1) Treatment plan goals, objectives, and services are linked to assessment and reflect the individual's/family's preferences and priorities. **AND** 2) The rationale for deferring any needs identified during assessment are documented. **AND** 3) The plan shows evidence (e.g., language, written comments, etc.) of being co-authored by the individual as well as by the family/collaterals/supports, as appropriate. For children, the involvement of caregivers in the development of the plan is clearly evident. **AND** 4) When applicable or as requested by the individual, the treatment plan identifies need for ongoing Peer Support Services, if available, to support the goals in the treatment plan. **AND** 5) The treatment plan identifies if there is a need for off-site services to be provided, if available, and identifies	1) The treatment plan does not appear related to the individual's/family's identified preferences and priorities. **OR** 2) The treatment plan emphasizes symptom reduction, treatment compliance, or attendance, etc. despite these not being reflected in the input from the individual/family/collaterals/ supports. **OR** 3) Needs identified in the assessment are not addressed and the rationale for deferring those needs is not documented. **OR** 4) Documentation is general or vague - there is little or no evidence (e.g., language, written comments, etc.) of being co-authored by the individual as well as by the family/collaterals/supports, as appropriate.

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	discharge are clearly documented in the treatment plan. **OR** 4) The treatment plan shows evidence of input from others (e.g., collaterals such as community providers) involved in the individual's/family's treatment, as appropriate.	which services will be provided off-site, and how this assists with meeting the treatment goals/objectives.	**OR** 5) There is no evidence that family or collateral input is sought when available.
2.13 The Initial Treatment Plan is developed according to regulatory requirements.		1) The Initial Treatment Plan is developed within 30 calendar days of admission or according to any other payor requirements. **AND** 2) Measurable and attainable steps toward the achievement of goals are identified, with target dates. **AND** 3) The treatment plan includes the specific interventions and services that will be utilized, the clinician(s)/ staff providing services, and the frequency and duration of services. **AND** 4) All required signatures are completed per regulations. [i]	1) The Initial Treatment Plan is developed more than 30 calendar days past admission with no explanation for delays. **OR** 2) The Initial Treatment Plan is missing signatures or is not signed within the regulatory timeframe.

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2.14 Treatment Plan Reviews reflect ongoing appraisal of progress and lack of progress towards all goal(s) and objective(s).	There is evidence that up-to-date information is regularly shared among the treatment team (e.g., treatment team meetings, clinical supervision, huddles, etc.).	1) The Treatment Plan Review includes an appraisal of progress/lack of progress towards each goal(s) and objective(s). **AND** 2) Treatment Plan Reviews include evidence of the individual's input, and where appropriate, the family's/collateral's/support's input on progress. For children there is evidence of individual/caregiver/family input. **AND** 3) Treatment Plan Reviews include modifications to goals and/or objectives to address progress/lack of progress. **AND** 4) The Treatment Plan is reviewed no less than annually. **AND** 5) The Treatment Plan is reviewed when needed, as determined by the individual/family and treating clinician based on need to address clinical changes (e.g., behavioral or medical diagnosis/condition, risk level, increased/new symptoms, functioning, stressors, needs, circumstances, etc.). **AND** 6) All required signatures are completed as per regulations. [ii]	1) Gaps between Treatment Plan Reviews exceed regulatory requirements. **OR** 2) The Treatment Plan Review does not reflect where progress has been made or when progress is lacking, with no rationale. **OR** 3) The Treatment Plan is not reviewed when there is significant clinical change. **OR** 4) The Treatment Plan is modified with no rationale. **OR** 5) Family or collateral input is not sought when available.

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2.14.1 Treatment Plan Updates reflect service increases and are made timely in accordance with individual's/family's changing needs, as are all other Treatment Plan changes (adjustments).	1) There is evidence that up-to-date information is regularly shared among the treatment team (e.g., treatment team meetings, clinical supervision, huddles, etc.). **OR** 2) Treatment Plan Updates are aligned with individual's/family's changing needs.	1) Treatment Plan Updates reflect service additions or increases in frequency/duration. **AND** 2) All other treatment plan changes (adjustments) are made in real time as a need changes and/or progress is made (e.g. change to a particular goal, objective(s) or intervention(s), time period or change in staff); **AND** 3) Changes are made with input from individual/family. **AND** 4) All required signatures are completed as per regulations. [iii]	1) Services are added or increased without a Treatment Plan Update. **OR** 2) Services are added or increased without input from the individual, or for children, without input from family/parent. **OR** 3) A change is made without any rationale OR no change is made when a goal(s) or objective(s) has already been met, or a new goal, objective, intervention is being addressed, new time period or staff. **OR** 4) Changes are made without input from individual/family, or for children, without input from family/parent. **OR** 5) Treatment Plan updates/changes do not include required signatures.
2.15 Documentation of Treatment Services	1) There is evidence that Collaborative/ Concurrent Documentation is being utilized whenever possible. **OR** 2) Psychiatric notes consistently go beyond symptom management, demonstrating attention to individualized recovery	1) There is documentation in progress notes or elsewhere that issues are attended to and services provided as identified in the treatment plan. **AND** 2) Progress notes are linked to goals and objectives by summarizing services provided/interventions utilized, the individual's response, and progress toward goals.	1) There is no documentation that issues are addressed, and services provided as identified in the treatment plan. **OR** 2) Notes consist of a summary of session dialogue without reference to treatment plan goals or services.

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	needs and goals.	**AND** 3) Notes record any significant new information impacting treatment, contacts with collaterals, and consideration of the need for changes to the treatment plan. **AND** 4) Notes of appointments with psychiatrist or prescriber contain a report of mental status and explanation of changes in medications prescribed.	
2.21 Safety Plan	1) The MHOTRS program has criteria for identifying an individual at risk, has a safety plan developed with each of these individuals, and administration/ supervisor closely monitors those so identified. **OR** 2) The MHOTRS program actively assists individuals to consider and, when desired, to develop Wellness Self Management Plans, WRAP™ plans, Psychiatric Advance Directives (PAD), or other mechanisms to support wellness and self-determination.	1) The MHOTRS program actively assists individuals/families to consider, and when desired, to develop an individualized safety plan that is appropriate to their age/development, and contains at least the following elements: • Identification of triggers • Warning signs of increased symptoms • Management techniques or calming activities as appropriate to the age/developmental capacity of the individual • Contact information for supportive persons • Plan to get emergency help if needed. **AND** 2) For young children, the	1) Not all at-risk individuals have a safety plan. **OR** 2) Safety plans are not individualized or created with the input of the individual. **OR** 3) Safety plans are not reviewed with the individual periodically. **OR** 4) Safety plans are not revised when warranted.

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	OR 3) The MHOTRS program uses the Safety Planning Guide by Stanley and Brown.	parent's/caregiver's role in implementing elements of the plan is clearly identified. **AND** 3) Safety plans are reviewed with the individual/family periodically and when utilized; revisions are made as needed. **AND** 4) Individuals/families are given a copy of their safety plan. **AND** 5) All at-risk individuals have a safety plan developed with their input. For children, this includes input from parent/caregiver unless otherwise indicated. **AND** 6) The MHOTRS program routinely educates individuals and families about community supports and crisis services.	
ONGOING CARE			
3.11 The MHOTRS program attends to the individual and family.	1) Peer Specialists and Advocates are available to provide information, advocacy, support, and other interventions as outlined in the MHOTRS program Peer Support Services Guidance. **OR** 2) The participation by	1) Flexibility in scheduling to meet the needs of individuals is evidenced. **AND** 2) Quality improvement tools (such as surveying Perception of Care) are used and results are utilized to shape MHOTRS program operations. **AND** 3) A notice of individual rights is provided at admission.	1) There is no evidence of communication with families/other significant people. **OR** 2) The MHOTRS program has no means to solicit family or collateral opinions regarding the services provided. **OR** 3) There is little evidence of complaints being accepted or

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	family members in psycho-educational, support, and advocacy groups is facilitated by the MHOTRS program. **OR** 3) There is an active individual advisory group providing ongoing and actionable input to MHOTRS program administration which is comprised of individuals from prevalent cultural groups served. This should include youth, family, adults, and older adults served by the MHOTRS program.	**AND** 4) There is evidence of a responsive complaint resolution process. **AND** 5) Information about advocates and advocacy organizations is available to individuals and families. **AND** 6) If utilized, the implementation and ongoing review of peer services is consistent with the MHOTRS program Peer Support Services Guidance.	adequately addressed. **OR** 4) Scheduling does not allow for flexibility to meet individual needs.
3.12 Identification of a Primary Clinician	1) There is evidence of reassignment of clinician or prescriber to better meet the individual's needs at the request of the individual or family. **OR** 2) The MHOTRS program periodically assesses the adequacy of staff performance regarding evidence- based practice expertise, cultural responsiveness, linguistic abilities, etc. in relation to the population served, and	1) A primary clinician is assigned at the time of admission. **AND** 2) Individual request or clinical consideration for change of primary clinician is reviewed, with rationale for resolution documented. **AND** 3) Individuals are given appropriate opportunities to process changes of clinician, whenever possible.	1) No primary clinician has been established. **OR** 2) The primary clinician has been changed more than once to meet the staffing of the MHOTRS program rather than the preferences of the individual. **OR** 3) The MHOTRS program disregards the individual's or family's request for a change in clinician.

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	takes action to better meet their needs.		
3.13 Engagement and Retention	1) Actively utilizes Complex Care Management where appropriate to better engage individuals. **OR** 2) Clinicians seek out persons and information that can expand their understanding of and responsiveness to the cultural perspective of the individual/family. **OR** 3) Confirmation phone calls are made prior to appointments or other effective methods are consistently used to reduce "no-shows" and offer the individual alternatives and choice. **OR** 4) There is consistent, personalized follow-up by the assigned clinician for missed appointments. **OR** 5) The MHOTRS program utilizes Peer Specialists and Advocates to engage individuals in informed decision making about their treatment options	1) MHOTRS program procedures and staff contacts demonstrate respect for individuals/families served and concern for confidentiality. **AND** 2) Potential barriers and current difficulties in participating in treatment are identified and addressed at intake and throughout course of treatment. **AND** 3) Service delivery reflects an understanding of the cultural perspective of the individual and/or family. **AND** 4) There is evidence of follow-up on missed appointments. **AND** 5) Information is provided to individual/family about services available at the MHOTRS program, the treatment process, and shared decision making. **AND** 6) Staff training has been provided on topics such as engagement, motivational interviewing, shared decision-making, collaborative documentation, etc.	1) Initial contacts emphasize agency attendance and billing rules or are focused solely on paperwork requirements. **OR** 2) There is no evidence of follow-up on missed appointments. **OR** 3) Interactions between staff and individuals are perceived as impersonal or disrespectful. **OR** 4) Service delivery is not congruent with the cultural needs and perspective of the individuals served.

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	and their recovery process.		
3.14 Communication with Families/Other Significant People	1) Documentation and interviews with family members/significant others indicate consistent, ongoing and collaborative contacts with MHOTRS program. **OR** 2) The clinician reviews the potential involvement of family/significant others with individual on a periodic basis and as opportunities arise. **OR** 3) Communication with family/significant others is documented as addressed in clinical supervision meetings. **OR** 4) A majority of staff have completed training in Consumer Centered Family Consultation by the Family Institute for Education, Practice and Research. **OR** 5) There is evidence that the MHOTRS program has implemented Consumer	1) Families or significant others have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis. **AND** 2) Staff can explain the parameters and policies concerning confidentiality, including the ability to receive information from family and others. **AND** 3) Clinicians seek to identify others involved in individual's care and recovery and discuss benefits of their involvement with individual. **AND** 4) There is documentation of efforts to communicate in person or by telephone with significant others involved in the individual's treatment and recovery, as appropriate. **AND** 5) For children, ongoing communication and service involvement with caregivers and other collaterals is documented.	1) There is no evidence of efforts to coordinate or communicate with family or other collaterals. **OR** 2) Staff does not understand the parameters for communicating with family members/others involved in the recovery of the individual. **OR** 3) Family or other collaterals are not provided with information necessary to contact the MHOTRS program when needed.

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	Centered Family Consultation.		
3.15 Co-occurring Mental Health and Substance Use Disorders	1) The same clinician or team of clinicians, working in one setting, provide additional mental health and substance use interventions, including: a. Health Promotion b. Family Psychoeducation c. Efforts to involve and encourage participation in self-help groups. **OR** 2) Over 50% of clinicians have earned the IMHATT certificate for completing FIT distance learning modules on integrated treatment. **OR** 3) The MHOTRS program employs or regularly accesses the services of a physician certified in addiction psychiatry or addiction medicine.	1) For individuals who meet the MHOTRS program's mental health admission criteria, have a co-occurring substance use disorder, and are able to participate in the program, the same clinician or team of clinicians, working in one setting, provide basic appropriate mental health and substance use interventions such as pharmacological treatment and individual and group counseling/therapy. **AND** 2) Treatment planning and interventions are consistent with and determined by the individual's stage of change/treatment. **AND** 3) Treatment of co-occurring disorders is provided by staff trained in delivering such services (IDDT, FIT,or equivalent), as appropriate to age and population.	1) The MHOTRS program is reluctant to admit or keep individuals with co- occurring mental health and substance use disorders on its caseload or delays admission of such individuals until a chemical dependence agency sees or treats them first. **OR** 2) The MHOTRS program does not provide basic appropriate mental health and substance use interventions to individuals with co-occurring disorders. **OR** 3) Staff members lack the training and/or experience to deliver integrated treatment interventions.

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3.16 Disengagement from Treatment	There is a system-wide effort to track and reduce disengagement, including efforts to identify salient factors leading to disengagement and an action plan implemented to address individual disengagement. Efforts include Peer Specialists and Advocates, as appropriate.	1) When individuals discontinue, refuse services, or are lost to contact, a review of individual's history, current circumstances and degree of risk is conducted. **AND** 2) Efforts to re-engage are commensurate with the degree of risk assessed. **AND** 3) Reviews include contact with significant others/collaterals and consultation with clinical supervisor or team prior to a case being closed. **AND** 4) Written correspondence indicates that individual is encouraged and welcome to re-engage in services at any time in the future.	1) There is minimal or no documentation of follow-up efforts to re-engage the individual. **OR** 2) A significant proportion of closed cases indicate that individuals were lost to contact. **OR** 3) There is no individualized review of cases of disengagement. **OR** 4) Re-engagement efforts are minimal or not related to level of assessed risk.
3.17 Treatment of Tobacco Use	1) The MHOTRS program develops and reviews with the individual, and caregivers for children, a plan to address tobacco use and dependence. **OR** 2) The program supports employees in seeking tobacco treatment. **OR** 3) The MHOTRS program uses data including ongoing metrics of smokers, interventions, successful quit rates, and	1) The MHOTRS program delivers a strong, personalized advice statement about the negative impact of smoking and the benefits of cessation to identified tobacco users. **AND** 2) The MHOTRS program provides information on tobacco treatment options, including pharmacotherapy and referral to counseling programs, and documents tobacco treatment interventions in the treatment plan, as appropriate. **AND** 3) Tobacco dependence medications	1) The MHOTRS program does not offer advice about the negative impact of tobacco use and the benefit of cessation. **OR** 2) The MHOTRS program does not offer assistance or information on tobacco treatment options, including pharmacotherapy and referral to counseling programs, and does not arrange for follow-up. **OR** 3) The MHOTRS program does not document tobacco dependence

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	population incidence of smoking, and uses those metrics to assess MHOTRS program success in disseminating treatment.	are accessible and offered by MHOTRS program prescribers, and individuals are monitored for interaction of tobacco use with current medications or impact of smoking cessation on other medication the individual is taking as part of a comprehensive tobacco dependence treatment plan.	or treatment interventions in the treatment plan.
3.21 Discharge	The MHOTRS program utilizes a system to follow up with individuals or other providers post- discharge and, where applicable, to confirm appointment was kept, and provides assistance in linking to new services as needed.	1) Arrangements for appropriate services (appointment dates, contact names and numbers, etc.) are made and discussed with the individual and significant others prior to planned discharge. **AND** 2) Discharge summaries identify services provided, the individual's response, progress toward goals, circumstances of discharge and efforts to re-engage if the discharge had not been planned. **AND** 3) The discharge summary and other relevant information is made available to receiving service providers prior to the individual's arrival (or within two weeks of discharge, whichever comes first) when that provider is known.	1) Individuals are discharged with no assessment of needs or plan for follow-up services. **OR** 2) Discharge summaries are missing or do not summarize the course of treatment.

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CLINICAL ADMINISTRATION			
4.11 Caseload	The MHOTRS program can demonstrate an ongoing system for evaluating caseload assignments and service utilization incorporating a variety of information sources and data elements such as lengths of stay, UR, IRC, and Perception of Care surveys.	1) MHOTRS program leadership can demonstrate a systematic process used to assign individuals to a clinician based on presenting needs, acuity, preferences, clinician expertise as well as caseload size. **AND** 2) A systematic process, and the concomitant policies and procedures, to monitor, review and track clinician caseloads by size, risk levels of individuals and other factors can be demonstrated. **AND** 3) Productivity standards which allow for appropriate clinical care and address fiscal viability are established. **AND** 4) Sufficient prescriber coverage is available to meet the needs of individuals without undue delay, or a process is in place to assure individuals have access to prescription services when needed. **AND** 5) The MHOTRS program systematically recruits staff to better meet the clinical and other needs of the population served (for instance, bilingual staff or staff with particular expertise or training).	1) No processes have been established to assign cases to clinicians reflective of client need and clinician expertise and caseload size. **OR** 2) There is no evidence that procedures are utilized to monitor, review and track caseload size or risk levels of clients per clinicians' caseload. **OR** 3) Number or mix of staff does not support appropriate clinical care. **OR** 4) There is evidence of high staff turnover related to unrealistic caseload demands. **OR** 5) Frequency of services appears to be based on clinician availability rather than identified treatment needs.

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4.12 Treatment Services	1) The MHOTRS program conducts ongoing monitoring of racial, ethnic, cultural or other service needs of populations served (via UR, IRC trends, Perception of Care surveys, measurement of outcomes related to life role goals, etc.) and develops new or revised programs, procedures, or linkages to address identified needs. **OR** 2) The MHOTRS program can demonstrate implementation of two or more evidence- based practices. **OR** 3) If preferred by the individual, or clinically appropriate, off-site services are offered. **OR** 4) The MHOTRS program demonstrates awareness of issues specific to foster children. **OR** 5) All youth who are prescribed antipsychotic	1) There is evidence that the MHOTRS program provides all required services and approved Optional Services in a consistent and clinically appropriate manner. • Intensive Outpatient Program (IOP) services are delivered in accordance with design and plan approved by OMH and IOP Program Guidance. **AND** 2) Optional Services are added if the MHOTRS program identifies a need among its population. **AND** 3) Administration identifies and utilizes mechanism(s) for ensuring that appropriate services are provided to each individual based on current clinical need and documented processes (for instance, UR). **AND** 4) All services are provided by appropriately trained and credentialed staff (including services provided at integrated MH/OASAS/DOH MHOTRS program sites). **AND** 5) For children: Family/parent-child treatment approaches are consistently provided, as needed and appropriate. **AND** 6) All youth who are prescribed	1) The MHOTRS program does not provide all required services or utilize all available clinical modalities such as Clozaril treatment, when indicated. **OR** 2) There is no evidence of changes to services offered in response to needs of the population served. **OR** 3) Individuals receive medication only service without appropriate screening, monitoring, reassessing or treatment plan changes based on significant events or decline in stabilization or progress.

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	medication or are being considered for same have received an evaluation by a child and adolescent psychiatrist.	antipsychotic medication or are being considered for same have access to consultation by a child and adolescent psychiatrist. **AND** 7) Documented procedures for identifying, monitoring, and re-assessing individuals receiving only medication treatment services are known and adhered to by MHOTRS program staff.	
4.13 Crisis Services	1) The MHOTRS program provides 24/7 availability to speak with a licensed professional who is familiar with the individual. **OR** 2) MHOTRS program staff provide face-to-face after-hours service to individuals in crisis when clinically indicated. **OR** 3) Availability of MHOTRS program Peer Specialists and Advocates to support individuals or families in crisis alongside clinicians.	1) The MHOTRS program has an ability to accommodate crisis intakes and walk-ins during normal program hours. **AND** 2) There is a plan in place which results in contact with a licensed professional by individuals and their collaterals who need assistance when the program is not in operation. **AND** 3) The MHOTRS program has a written policy for the availability of crisis intervention services at all times. **AND** 4) After-hours coverage includes the ability to provide brief crisis intervention services. **AND** 5) The primary clinician at the MHOTRS program is informed on the next	1) After hours calls go to an answering machine or answering service which refers individuals to go to an emergency room or call 911. **OR** 2) Individuals in need are not aware of an after-hours contact system or experience significant wait times before contact with a professional staff member, with no explanation. **OR** 3) Information regarding after-hours contacts is not available to the MHOTRS program. **OR** 4) Crisis calls are not followed up by the MHOTRS program.

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		business day of information from clinicians providing after hours services. **AND** 6) The process for after hours contact is explained to all individuals, and significant others where appropriate, during the intake process and given to them in an information packet describing the services offered by the MHOTRS program. This information is also posted and reviewed with the individual throughout the course of care. Additionally, where indicated, the information is included in the individual's crisis plans. **AND** 7) The MHOTRS program demonstrates consistent follow-up on crisis calls received. **AND** 8) If after-hours services are provided pursuant to a Clinical Services Contract, the contract includes, at a minimum, provisions assuring that in the event of a crisis, the nature of the crisis and any measures taken to address such crisis are communicated to the primary clinician or other designated clinician involved in the individual's treatment on the next business day.	

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4.14 Diversity, Equity and Inclusion (DEI)	1) Meeting cultural, linguistic, and other special needs is emphasized by the MHOTRS program and embedded in policy and practice: The agency has a cultural and linguistic diversity plan, staff have received training to increase awareness, including diversity, equity and inclusion training, and the program has enlisted appropriate individuals to provide guidance in engaging and attending to individuals and groups served. **OR** 2) Perception of Care surveys are administered in ways that maximize ability of prevalent cultural groups served to communicate areas which may need improvement. **OR** 3) There is evidence that individuals screened but referred elsewhere are connected with culturally competent services.	1) There is evidence that the MHOTRS program seeks to eliminate disparities in access to health care for people of diverse backgrounds by: • Making all reasonable efforts to provide care via culturally sensitive and responsive practices that recognize and respect the diverse cultural beliefs, practices, languages and communication needs of staff and service recipients through all stages of screening, treatment, and discharge. • Ensuring that assessments capture individual/family cultural, linguistic, and literacy needs, ethnic and/or racial identification, sexual orientation, etc., and any impact on treatment. • Recruiting and assigning multicultural/multilingual clinicians to individuals from matching cultural groups wherever possible. **AND** 2) For individuals with Limited English Proficiency (LEP), the MHOTRS program: • Uses language interpretation and translation services as	1) There is little or no evidence of attention to ensuring cultural competence among clinicians. **OR** 2) Screening forms, assessment forms, or correspondence templates are available in only one language. **OR** 3) Cultural, linguistic or other special needs are not routinely addressed as needed.

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		needed and as required by law. • Materials are available in languages accessible to LEP persons and in formats and media acceptable to persons from prevalent cultural groups served. • Makes reasonable efforts to provide written correspondence and other documents to be used by the individual in their preferred language wherever possible.	
4.21 Supervision and Training	1) Individual and group supervision sessions result in the identification of individual and agency-wide training needs, policy and procedure reviews, etc. **OR** 2) The MHOTRS program demonstrates an ongoing training program in evidence- based practices (EBPs), and a majority of staff have received training in one or more. **OR** 3) Professional Staff supervising Peer Specialists and Advocates have completed training in peer support services and the role of	1) Clinical supervision by appropriate leadership staff on a regular basis for all clinicians is provided and documented. **AND** 2) The frequency of supervision is increased for new vs. experienced staff. **AND** 3) Provision is made for prompt supervision in times of crisis or increased need, clinicians demonstrate knowledge of the method to request *ad hoc* supervision, and there is evidence that this has been used. **AND** 4) Issues or needs identified related to staff performance are addressed in supervision, training, or by other methods. **AND**	1) Clinical supervision is not provided on a regular basis. **OR** 2) All clinicians, regardless of experience, have the same level of supervision. **OR** 3) Supervisory sessions appear to deal more with administrative than clinical matters. **OR** 4) Clinical supervision occurs only in groups, not individually. **OR** 5) There is minimal evidence of staff training. **OR** 6) Staff credentials and clearances are not reviewed. **OR** 7) No performance evaluation system or other methods to

Standard of Care Focus	Exemplary (In addition to Adequate)	Adequate	Needs Improvement
	credentialed/certified peers EBPs. **OR** 4) MHOTRS program ensures Peer Specialists/Advocates have access to in-discipline supervision, mentoring and support. This is accomplished by connecting Peer Specialists/Advocates within the organization and supporting regular convenings. **OR** 5) Agency leadership meet regularly with Peer Specialists/Advocates and treatment team leaders to ensure successful implementation of Peer Support Services and address challenges in a timely manner. Peer Specialists/Advocates are afforded opportunities to participate in external peer networking, training and conferences, and other activities dedicated to support their continued educational and professional development.	5) Regularly scheduled clinical in-service training is provided by the agency and staff attendance is documented. **AND** 6) Required staff clearances are maintained. **AND** 7) Staff licenses, certifications, credentials, and registrations are current. **AND** 8) Mandatory annual cultural and linguistic training is conducted. **AND** 9) The MHOTRS program has policies in place to address personal safety and safety in the community of all relevant staff. **AND** 10) The MHOTRS program provides training in de-escalation techniques.	assess and evaluate staff performance are evident. **OR** 8) Annual cultural and linguistic training has not been completed by a significant number of staff at state-operated MHOTRS programs.

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	OR 6) All clinicians who treat co-occurring disorders have completed FIT or equivalent training.		
4.31 Information Sharing	Training and supervision include the importance and understanding of coordination, collaboration, and partnership with other agencies, families, collaterals and other systems involved with the individuals served.	1) The MHOTRS program has procedures, policies and clearly delineated protocols in place which describe and support the importance of appropriate information sharing within the agency and with outside agencies, families, and other collaterals in providing coordinated services for individuals. **AND** 2) Individuals are informed of the MHOTRS program's privacy policies, including circumstances where written consent is not required. **AND** 3) The value of sharing information with other parties is discussed and the individual's consent is sought and documented as appropriate. **AND** 4) There is evidence of sharing of treatment information in order to better integrate services for individuals, particularly at admission, discharge, or periods of crisis or hospitalization, and for individuals with an AOT order.	1) Staff do not understand the parameters for sharing information with other providers. For example, the MHOTRS program or clinicians believe HIPAA laws always require written consent for information sharing. **OR** 2) Few if any charts show documentation of information sharing (e.g., with PCP, other providers in the OMH nexus of care, including AOT). **OR** 3) There is evidence of the improper withholding of information.

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4.41 Clinical Risk Management	The MHOTRS program engages in activities to reduce the occurrence of serious incidents through proactive risk reduction strategies which identify potential problems and implement preventive measures.	1) All new staff receive training regarding the definition of incidents and reporting procedures for incidents; they are informed about the Incident Review Committee (IRC) process and the importance of risk management in maintaining safety and improving services. **AND** 2) The IRC reviews incidents, makes recommendations, and ensures implementation of action plans with program's administrator. **AND** 3) The IRC membership composition is appropriate; members meet qualifications and are properly trained. **AND** 4) The MHOTRS program compiles and analyzes incident data for the purpose of identifying and addressing possible patterns and trends. **AND** 5) The MHOTRS program enters incident data into NIMRS within the required timeframes.	1) The IRC does not meet the requirements of Part 524 for review, analysis, and monitoring of incidents. **OR** 2) No policies or procedures are evident regarding risk management.

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4.51 Responsive to individuals at risk	1) The agency utilizes a process and/or committee that includes individuals with clinical expertise (psychiatrists, QA and clinical administrators) charged with reviewing complex, high-risk, high-need cases and providing recommendations on treatment or treatment-related strategies. **OR** 2) There is evidence of an agency-wide or multi-program risk management or review process and/or committee that includes QA personnel and clinical administrative staff that assists the MHOTRS program to better address the needs of at-risk or complex individuals and their collaterals. **OR** 3) The MHOTRS program has implemented an ongoing, comprehensive approach to suicide prevention.	1) The MHOTRS program identifies, tracks, monitors, assesses, and reassesses the treatment of at-risk and high-need individuals. **AND** 2) There is evidence that the identification of individuals at moderate to high risk results in psychiatric and other clinical consultation and interventions appropriate to the degree of risk assessed. **AND** 3) For at-risk and high-need individuals, an updated risk assessment and safety plan is completed prior to planned discharge.	1) The agency cannot demonstrate an effective system for identifying, monitoring, or responding to individuals at risk. **OR** 2) Identification of moderate to high risk does not result in clinical consultation or appropriate interventions.

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4.61 Premises	1) The environment is welcoming and attractive (for example: comfortable furniture, beverages in the waiting area, up to date reading materials, and decorated offices) to the age groups and cultural groups served at the facility. **OR** 2) The premises is decorated and furnished in a welcoming manner specific to the prevalent cultural groups served at the facility. **OR** 3) A waiting area is available for children/families. **OR** 4) The MHOTRS program has materials promoting recovery and sharing success stories available in the waiting area. **OR** 5) Outcomes from Perception of Care surveys, suggestion boxes and complaints are displayed prominently including the actions taken	1) The premises are maintained in a clean condition, free of fire and safety risks. **AND** 2) Individual and group space is sufficient, comfortable and private. **AND** 3) Records are maintained confidentially. **AND** 4) Medications are stored and disposed of appropriately. **AND** 5) Sign-in procedures and therapy rooms promote confidentiality. **AND** 6) A sufficient number of restrooms are available for use by individuals and staff. **AND** 7) Rights and advocacy information are prominently posted. **AND** 8) Proper exit signs visible and working and evacuation signage posted. **AND** 9) Comfortable temperatures are maintained in all areas of the MHOTRS program. **AND** 10) All signage is positive, welcoming, helpful and respectful. **AND** 11) Literature, photos, reading material	1) The premises are unsafe due to fire or safety hazards. **OR** 2) The premises need extensive maintenance to ensure a comfortable place to receive services. **OR** 3) Literature, photos, reading material and toys are not reflective of the population served and those using the waiting area. **OR** 4) Negative messages such as “all cell phones will be confiscated” or “arriving late may mean loss of appointment privileges” are posted in the waiting and reception areas. **OR** 5) Proper signage for exits and evacuation routes are not evident.

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	by the MHOTRS program to improve services based on this customer feedback. **OR** 6) Trainings and resources are administered to staff providing services in the home and community to address de-escalation and environmental safety of the staff person.	and toys are reflective of the populations served as well as those using the waiting area. **AND** 12) Sanitizing or proper care of toys and all other commonly shared items occurs. **AND** 13) The determination of off-site service provision by the multidisciplinary team accounts for clinical appropriateness, the individual's preferences and addresses issues of safety and accessibility. **AND** 14) If off-site services are provided, they must be in settings that are conducive to meeting treatment goals and objectives and assure privacy for the delivery of services. **AND** 15) A written protocol is followed to address personal safety of staff providing services in the home and community including assessing for safety risks.	

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Treatment Planning Signature and Timeframe Requirements Summary:

Programs shall develop a policy which indicates the location of treatment plan related documentation and the mechanism for identifying it within the case record/EMR.

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i [i] **Initial Treatment Plans:**

- Medicaid Fee-for-service **Initial Treatment Plans** must be signed off by a psychiatrist, Nurse Practitioner of Psychiatry (NPP), or other physician.
- However, Medicaid Managed Care (MMC) or Commercial Insurance **Initial Treatment Plan** signature requirements depend on whether or not medications are prescribed:
  - psychiatrist, other physician, or NPP if medication is prescribed
  - psychiatrist, other physician, licensed psychologist, NPP, LCSW, or other licensed practitioner if NO medication is prescribed

* Please consult other payors such as Medicare, Medicaid Managed Care and other Commercial Insurance to verify treatment plan related signature and time frame requirements.

ii [ii] **Treatment Plan Reviews:**

- **Treatment Plan Reviews**, which are completed **no less than annually**, are signed by the clinician.

[iii] **Treatment Plan Updates: Service increases** (adding a service or increasing the frequency and/or duration of a service) require the following:

- Medicaid Fee-for-service **service increases** must be signed off by a psychiatrist, Nurse Practitioner of Psychiatry or other physician.
- However, Medicaid Managed Care (MMC) or Commercial Insurance service increase signature requirements depend on whether or not medications are prescribed:
  - psychiatrist, other physician, or NPP if medication is prescribed
  - psychiatrist, other physician, licensed psychologist, NPP, LCSW, or other licensed practitioner if NO medication is prescribed

* Please consult other payors such as Medicare, Medicaid Managed Care and other Commercial Insurance to verify treatment plan related signature and time frame requirements.

All Other Treatment Plan Changes:

- Changes which include goals, objectives, interventions, time periods and staff are signed by the clinician.