NYS Office of Mental Health
ACT Standards of Care Survey Tool June 2015

Standard of Care Focus	Exemplary (In addition to Core)	Core (Absence of a preponderance of core indicators may require a performance improvement plan)
Intake		
ACT SOC 1.11 Intake	ACT team members engage with a person prior to admission into ACT and well in advance of hospital discharge or jail release assisting with coordination of discharge planning.	Following referral, the ACT Team locates individuals and engages them in services.
Assessment and Evaluation		
ACT SOC 2.11 Initial Assessment	1. The entire team meets to review clinical assessments of new admissions to formulate multidisciplinary team review and to inform planning recommendations. 2. Each recipient is screened using the Columbia-Suicide Severity Rating Scale (C-SSRS).	1. An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral. 2. A Comprehensive Assessment is completed within 30 days of admission: a. Staff with appropriate expertise complete the assessments. b. The team reviews and develops clinical formulations under the guidance of the MD, team leader or designated clinical supervisor. c. Person specific risk factors and patterns are identified, as well as effective and ineffective coping strategies, level of independence in critical areas, supports and interventions. d. There is evidence that exploration of personalized recovery goal(s) occurred during the assessment. 3. Standardized screening and assessment instruments are used for: a. Risk b. Substance Use c. Health (reviewed by MD, NP or RN) d. Clinical needs form (Transition needs form)
ACT SOC 2.12 Ongoing Assessment and CAIRS	1. The team's CAIRS BASF and FUAF data is entered within 2 weeks of the due date. 2. The team uses PSYCKES to identify and monitor individuals who could benefit from clinical review, and inform treatment planning.	1. There is evidence that the team enters recipient data into CAIRS; the Baseline Assessment Form (BASF) is completed within 30 days of admission and the Follow-Up Assessment Form (FUAF) is completed timely as required by OMH. 2. The comprehensive assessment is updated at least every six months, at the service plan review. 3. Specific re-assessments are completed as needed, specifically in areas of Risk, SUD, Medical, and Psychiatric.
Service Plan		
ACT SOC 3.11 Service Plan	1. Recipients develop WRAP plans. 2. The team uses systematic tools to determine readiness for change. 3. The team uses tools that reflect a rehabilitation process: e.g.: identifying a personal goal, assessment of strengths, barriers and strategies, and timelines to achieve the goal. 4. Recipients receiving rehabilitation services actively practice and utilize social and communication skills. 5. Treatment planning and review occurs with family/supports present, if the person consents.	1. Every recipient has a comprehensive service plan developed in partnership, within 30 days of admission, with documented involvement of the recipient, physician and the team leader or designated clinical supervisor involved in the treatment. 2. The service plan reflects: a. A recovery orientation, including life goals, such as educational, vocational, residential, social or recreational pursuits. b. Evidence of shared decision making with recipient team and/or family support and/or collateral. c. Activities to be carried out from an AOT order, where applicable. d. Future orientation and documentation of specific and individualized discharge criteria. 3. The plan is shared with individual, and family, medical and other providers, with consent.

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	6. A copy of the plan is shared with family, medical and other providers with consent.	4. Clinical interventions are not solely focused on engagement and treatment adherence, but include: a. Building and testing skills, and fostering independence b. Strengthening and building community links and supports 5. There is evidence that the team and recipient have identified barriers associated with reaching goals and strategies to assist in overcoming these barriers. 6. At least one of the documented services is a care management service: a. Care coordination; b. Health promotion; c. Comprehensive transitional care from inpatient and ACT to other settings, including appropriate follow-up; d. Individual and family support, which includes authorized representatives; e. Referral to community and social support services, if relevant; f. The use of health information technology to link services, as feasible and appropriate
Ongoing Care		
ACT SOC 4.11 Progress Notes & Service Plan Reviews		1. New information, changes in individual's functioning, and lack of engagement are clearly identified and immediately communicated to team members via progress notes, logs, verbal reports etc. 2. The service plan is reviewed and revised to include new strategies, services etc. in response to changes in individual's circumstances and functioning. 3. All plans are reviewed at least every 6 months.
ACT SOC 4.12 Ongoing Risk Management	1. The team proactively addresses any issues that potentially place the recipient at risk 2. The team utilizes a tracking system to identify and monitor at-risk individuals 3. The team has QI initiative focused on reduction of harmful behaviors	1. Each recipient has a current crisis/relapse prevention plan, developed with the recipient. 2. Crises are rapidly addressed with input from multiple team members, and strategies for addressing recipient difficulties integrated across the disciplines and treatment approaches. 3. The team operates a continuous and direct after-hours on-call system with experienced staff skilled in crisis intervention procedures. 4. The team directly provides in-person after hours services where appropriate. 5. When the team identifies recipients who will not come to meet the psychiatrist/NPP, there is evidence that they provide services to that individual in the community in addition to the required community visits.
ACT SOC 4.13 Attention to Co-Occurring Medical Issues	1. There is evidence that the team is helping recipients manage their diabetes, high cholesterol, hypertension or obesity. 2. There is evidence of collaboration/ relationship building with community medical providers.	1. At least monthly, the psychiatrist and/or the PNP document the recipient's response to medication, symptoms and any side effects. 2. The record includes any recent hospitalizations and or medical treatments and team's active response. 3. The team documents efforts to coordinate services between health and behavioral health services for recipients.
ACT SOC 4.14 Attention to Co-Occurring Disorders	1. The team is fully-based in Co-occurring Disorders treatment principles, with harm reduction treatment provided by team staff. 2. Cross-discipline co-occurring treatment is utilized by the team.	1. The record includes any recent substance use and the team's active response. 2. Evidence-based substance abuse treatment is offered; recipients with substance use disorders have at least one session weekly in such treatment. 3. The record identifies efforts taken to provide integrated substance abuse treatment for recipients with co-occurring disorders and the service plan reflects active IDDT treatment.

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		4. The team facilitates access to self-help services to support the recipient outside of the ACT program.
ACT SOC 4.15 Communication with Families/Collaterals	1. The team documents outreach efforts to family/collaterals, including Health Homes, MCOs, and housing programs. 2. The team has one or more contacts per month per recipient with their support system in the community.	1. The team identifies the recipients' family and support network in the service plan, with permission from the recipient. 2. The team develops and works with recipient support networks to further integration into the community. 3. The team demonstrates use of all sources (family, friends, etc.) to contact a missing recipient.
ACT SOC 4.16 Transition Planning	1. There is evidence that a system is in place that assures early and regular post-d/c follow up with new providers and natural supports to ensure that discharge plan is being followed. 2. There is evidence of a system in place for identifying and practicing recovery skills needed for all ACT enrollees. 3. The team engages recipients in the WSM for Transition curriculum. Each recipient leaves ACT with a WSM/or WRAP plan. 4. The team uses a formalized transition model, including specific stages, groups and strategies.	1. There is evidence that discharges are consistent with recipient transitions scores in CAIRS. Individuals who score "ready for transition" are actively engaged in the transition process. 2. The team establishes a positive expectation for transition for recipients via practice of: a. Introducing the idea of transition at admission. b. Engaging long-stay ACT recipients in transition discussions (progress and goals for the future). 3. Specific activities associated with positive discharges are evident in the record.
Staffing		
ACT SOC 5.11 Staffing		1. ACT team staffing ratios and composition conform to the model. 2. Specialists on the team provide targeted interventions and collaborate with other team members.
ACT SOC 5.12 Team Protocols/ Functioning	The team utilizes TMACT or another tool to assess fidelity to the model.	1. The team conducts the minimum number (six) of required face-to-face contacts per month, three of which may be collateral contacts. 2. The team conducts a minimum of 80% of contacts in the community. 3. The team is involved in at least 70% of hospital admissions, discharges and ER visits. 4. The Physician and NPP conduct visits in community as per the guidelines. 5. Daily team meeting review the status of each individual, and plans for response to potentially elevated risk status are formulated. 6. Communication boards, logs, and other devices are maintained as per the guidelines.
ACT SOC 5.13 Training	1. The agency has a system in place for assessing staff competencies. 2. The team has a system in place for review of the team profile, including FIT data, and identifies individual staff training needs. 3. The team maintains a fully trained staff as evidenced by the team Certificate for Training Excellence issued by the ACT Institute twice per year.	1. The team provides or arranges for training in the ACT model and relevant Evidence-Based Practices for each specialist. 2. Required core training for all new hires is completed within 6 months of hire, and every five years thereafter (or as indicated on the ACT Institute website). 3. The Team Leader has a system in place for tracking the training status of all staff members. 4. Supervision is routinely provided by qualified staff.

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Organizational Practices and the Team Operations		
ACT SOC 6.11 Governing Body and Quality Assurance	1. The agency Governing Body (GB) has a subcommittee responsible for overseeing quality improvement initiatives, or attending to serious issues raised by external review agencies, recipients, or families. The subcommittee meets at least quarterly or more often as needed 2. There is evidence that the GB's quality assurance activity has reviewed data from the team Profile (comparison data across the state, region, county, etc.) and provided assistance, as needed, to the ACT team to improve performance	The agency has a systemic approach for self-monitoring and ensuring ongoing quality improvement (QI) for the ACT team: 1. The agency's QI plan involves reviewing UR findings and recommendations. Information is used to measure goal achievement, length of stay, barriers to treatment, etc. and incorporated into the team's overall QI plan 2. An agency-wide process for reviewing complex, high risk, high need cases is evident. Individuals with clinical expertise who can provide recommendations on treatment strategies are available to the ACT team. 3. The agency addresses vacancies through an effective coverage plan and active recruitment.
ACT SOC 6.12 Incident Management and Reporting	The team uses NIMRS data in conjunction with its incident trending data as it develops and implements preventive measures.	1. All new staff receive training on the definition of incidents and reporting procedures, are informed about the Incident Review Committee (IRC) process and the importance of risk management in maintaining safety and improving services. 2. The agency has an Incident Management policy consistent with NYCRR Part 524 and the Justice Center and conforms to the reporting and follow up requirements of each. 3. The IRC reviews incidents, makes recommendations, and ensures implementation of action plans with the team's administrator. 4. The IRC membership composition is appropriate; members meet the qualifications and are properly trained. 5. The committee compiles and analyzes incident data for the purpose of identifying and addressing possible patterns and trends.
ACT SOC 6.13 Cultural Competence	1. The team utilizes a Cultural Competence standardized self- assessment and uses the results in developing policies and trainings. 2. The team is trained in the use of the Cultural Formulation interview (DSM 5). 3. The team includes bilingual staff representative of the recipients enrolled.	1. The team/agency has a written, comprehensive Cultural Competence Plan based on the approved OMH outline. The plan should be reviewed annually, and when indicated, changes initiated to improve outcomes. 2. The plan ensures that language assistance services are available.