

**New York State Office of Mental Health  
Bureau of Inspection and Certification  
Clinic Standards of Care Anchor Element  
Effective May 2021**

Standard of Care Focus	Exemplary (In addition to Adequate)	Adequate	Needs Improvement
<b>ASSESSMENT</b>			
<p>1.11 Requests for services are addressed appropriately and in a timely manner</p>	<p>1) There is evidence that recipients have received same-day initial assessments following screening. <b>OR</b> 2) The program provides a walk-in, same-day service which has designated staff scheduled on a regular basis. <b>OR</b> 3) There is evidence of follow-up to assist individuals screened but referred elsewhere to connect with appropriate services.</p>	<p>1) Requests for services are screened and triaged same business day and this process is overseen by supervisory staff. <b>AND</b> 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. <b>AND</b> 3) Recipients referred from inpatient, forensic, or emergency settings, or those at high risk receive initial assessment within 5 business days; priority access is given to recipients enrolled in AOT. <b>AND</b> 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. <b>AND</b> 5) Interpreter services are made available as needed. <b>AND</b> 6) There is documentation of the rationale for recipients who have not been admitted to the program. The</p>	<p>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. <b>OR</b> 2) Priority access is not given as required by regulations. <b>OR</b> 3) Admission notes are not present or are incomplete. <b>OR</b> 4) There is no rationale for non-admissions and no referrals are provided. <b>OR</b> 5) Individuals requesting services are not consistently offered intake appointments within a reasonable time frame.</p>

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<p>1.12 Assessment process is responsive and coordinated</p>	<p>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.</p>	<p>program provides other referral sources, as needed.</p> <p>1) Face-to-face assessment for all recipients is routinely completed within 30 days and expedited based on clinical presentation and need for medication. Reasons for exceptions are documented. <b>AND</b> 2) A single clinician oversees the assessment process with the recipient. <b>AND</b> 3) Clinicians completing assessments are appropriately licensed and trained. <b>AND</b> 4) There is evidence of effective “hand-off” of recipient information between clinicians. <b>AND</b> 5) Recipients are admitted within regulatory time frames.</p>	<p>1) Multiple clinicians are involved in a recipient’s assessment without explanation or clinical justification. <b>OR</b> 2) Information is lost or the assessment process is delayed due to poor coordination or communication among staff.  <b>OR</b> 3) Assessments are routinely not completed within 30 days of first appointment. <b>OR</b> 4) Psychiatric assessment is not coordinated with other assessments or psychiatrist is not available for timely or expedited evaluations as needed.</p>
<p>1.21 The assessment is comprehensive.</p>	<p>1) Assessment includes the recipient’s view of past successes, difficulties, desired outcomes and potential barriers in each area. <b>OR</b> 2) For children and</p>	<p>1) Assessment should include evaluation of history and current status, needs, goals and desires in the following areas (<i>Additional required areas are listed under other Anchors</i>):</p> <ul style="list-style-type: none"> <li>• Recipient’s reasons for seeking services</li> </ul>	<p>1) There is no documentation of assessments. <b>OR</b> 2) There is documentation of assessment in all areas, but only minimal information is included. <b>OR</b> 3) One or more assessments</p>



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	<p>adolescents, the clinic consistently obtains written reports and/or verbal communication from school to assist with the assessment.</p> <p><b>OR</b></p> <p>3) Evidence-based screening tools are used.</p> <p><b>OR</b></p> <p>4) A standardized instrument such as the DSM-5 Cultural Formulation Interview is used.</p>	<ul style="list-style-type: none"> <li>• Recipient and family’s current strengths, supports, and stressors</li> <li>• Mental status</li> <li>• Physical health (see 1.25)</li> <li>• Mental health services</li> <li>• Traumatic experiences</li> <li>• Perception of own risks and safety</li> <li>• Legal and/or forensic involvement</li> <li>• Family, significant others, social function, finances, housing</li> <li>• Education, employment, and other community roles</li> <li>• Literacy needs</li> </ul> <p>Additionally, for children:</p> <ul style="list-style-type: none"> <li>• Developmental history</li> <li>• Documented evidence of assessment of academic achievement, school performance, and social issues</li> <li>• CPS involvement, foster care, placements, contact with abuser(s), and/or domestic violence</li> </ul> <p><b>AND</b></p> <p>2) The assessment results in a clinical formulation and recommendations which inform the treatment plan.</p>	<p>relevant to treatment are missing.</p>



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<p>1.22 Screening and Assessment of Co-Occurring Disorders</p>	<p>Individuals evaluated for admission are screened for co-occurring substance use disorders using a standardized screening instrument recommended by OMH &amp; OASAS or SAMHSA</p>	<p>1) Individuals evaluated for admission are screened for co-occurring substance use disorders using a standardized screening instrument; <b>AND</b> 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; <b>AND</b> 3) Staff who administer screening instruments, review scores, or conduct clinical assessments have the training or experience to do so. <b>AND</b> 4) For children, information is sought from the child or family concerning alcohol or substance use in the home environment(s).</p>	<p>1) Individuals evaluated for admission are not screened for co-occurring substance use disorders using a standardized screening instrument. <b>OR</b> 2) Positive screening instrument scores or clinical judgment rarely trigger a comprehensive clinical assessment.</p>
<p>1.23 The assessment should include an initial risk of self-harm.</p>	<p>1) Additional information or corroboration from collateral sources is routinely sought and utilized in making the assessment. <b>OR</b> 2) There is evidence that clinicians use the Chronological Assessment of Suicide</p>	<p>1) Initial self-harm risk screening for all recipients is part of the clinic's assessment process. Both suicidal and self-injurious behavior are assessed. <b>AND</b> 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</p>	<p>1) No initial suicide or self-harm screening or assessment has been completed. <b>OR</b> 2) The record contains only minimal documentation, with conclusions such as "No SI" (suicidal ideation). <b>OR</b> 3) Significant risk factors are ignored or missed.</p>



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	<p>Events (CASE) Approach in conjunction with the Columbia Suicide Severity Rating Scale (C-SSRS) for conducting risk assessment.</p>	<p>means/weapons is emphasized. <b>AND</b> 3) Information is synthesized and incorporated into an assessment of the recipient which informs the treatment plan. <b>AND</b> 4) Determination of moderate/high potential for self-harm prompts clinical consultation and/or other immediate interventions to include means restriction, as indicated.</p>	
<p>1.24 The assessment should include an initial risk of harm to others.</p>	<p>1) Additional information or corroboration from collateral sources is routinely sought and utilized in making the assessment. <b>OR</b> 2) There is evidence that clinicians use a validated process for conducting risk assessment.</p>	<p>1) Initial violence risk screening for all recipients is part of the clinic's assessment process. <b>AND</b> 2) At a minimum, violence risk screen includes direct inquiry into the following: <ul style="list-style-type: none"> <li>• History of fights or hurting others</li> <li>• Any recent plans or intention to hurt others</li> <li>• 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.</li> <li>• History of not taking medication as prescribed, in the context of</li> </ul> </p>	<p>1) No initial violence screening or assessment has been completed. <b>OR</b> 2) The record contains only minimal documentation, with conclusions such as "No HI" (homicidal ideation). <b>OR</b> 3) Significant risk factors are ignored or missed.</p>



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		<p>past violence</p> <p><b>AND</b></p> <p>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.</p> <p><b>AND</b></p> <p>4) Information is synthesized and incorporated into an assessment of the recipient which informs the treatment plan.</p> <p><b>AND</b></p> <p>5) Determination of moderate/high potential for violence toward others prompts clinical consultation or other immediate interventions, as appropriate.</p>	
<p>1.25 Health Screening and Monitoring</p>	<p>1) Upon admission, the clinic assesses health and medical status, whether through a physical by the recipient's medical provider not more than 12 months prior to the intake, or by completing a Health Physical within 3 months of admission.</p> <p><b>OR</b></p>	<p>1) Upon admission, the clinic gathers information concerning recipient's medical history and current physical health status.</p> <p><b>AND</b></p> <p>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.</p> <p><b>AND</b></p>	<p>1) The clinic does not attempt to gather recipient health information.</p> <p><b>OR</b></p> <p>2) Health information is not reviewed by appropriate staff with medical training.</p> <p><b>OR</b></p> <p>3) Reviews are routinely signed with no recommendations about impact or service needs.</p>



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Table with 4 columns: Standard of Care Focus, Exemplary (In addition to Adequate), Adequate, Needs Improvement. The table contains detailed criteria for health monitoring, diabetes education, and medical hospitalizations.

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	(nutrition, med management, blood sugar monitoring) are addressed with the primary care provider. <b>OR</b> 5) Primary care services are offered through the clinic.		
1.27 Screening and Assessment of Tobacco Use	1) The clinic uses one of the screening instruments recommended by OMH Tobacco Dependence Treatment workgroup. <b>OR</b> 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 clinic screens all recipients for tobacco use and dependence and assesses readiness to reduce or quit using tobacco at intake and every three months for active smokers. <b>AND</b> 2) For children, information is sought from the child or family concerning tobacco use in the home environment(s).	1) The clinic does not screen for tobacco use and dependence. <b>OR</b> 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 recipient the value of including family members and significant others	1) Assessment seeks to identify significant others as well as past and current service providers and agencies involved with the recipient. This may include courts, DSS, schools, etc. in addition to mental health services.	1) There is no documentation that the clinician attempted to identify significant others or service providers in completing the assessment. <b>OR</b> 2) No contact was attempted with





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	<p>involved in the recipient's life in completing a comprehensive assessment. <b>OR</b></p> <p>2. In addition to contacting recent providers, clinicians actively pursue potentially relevant information regarding the recipient from all available sources (for instance, substance services, probation, housing, OPWDD, etc.).</p>	<p><b>AND</b></p> <p>2) With appropriate consent, family and significant others are contacted to participate in the assessment. <b>AND</b></p> <p>3) For children and adolescents, assessment should always include input from parents or other caregivers, OR there is documentation regarding why there has been no contact. <b>AND</b></p> <p>4) There is documentation that recent providers of mental health service have been contacted to obtain discharge summaries and other pertinent information.</p>	<p>any family or other persons involved in the recipient's life, with no documented explanation. <b>OR</b></p> <p>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. <b>OR</b></p> <p>4) Significant information from collateral sources has not been incorporated into the assessment.</p>
<b>TREATMENT PLAN</b>			
<p>2.11 Every recipient has a person/family-centered, treatment plan that is developed with input from the recipient/family/collaterals/supports as appropriate</p>	<p>1) The treatment plan identifies evidence-based methods to address needs and goals related to chosen community roles, as appropriate; <b>OR</b></p> <p>2) Treatment plans reflect tailored approaches which incorporate:</p> <ul style="list-style-type: none"> <li>o Culturally relevant information from recipients;</li> </ul>	<p>1) Treatment plan goals, objectives, and services are linked to assessment and reflect the individual's/family's preferences and priorities; <b>AND</b></p> <p>2) The rationale for deferring any needs identified during assessment are documented; <b>AND</b></p> <p>3) The plan shows evidence (e.g., language, written comments, etc.) of being co-authored by the recipient as well as by the family/collaterals/supports, as</p>	<p>1) The treatment plan does not appear related to the recipient's/family's identified preferences and priorities; <b>OR</b></p> <p>2) The treatment plan emphasizes symptom reduction, treatment compliance, or attendance, etc. despite these not being reflected in the input from the recipient/family/collaterals/supports; <b>OR</b></p> <p>3) Needs identified in the</p>

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	<ul style="list-style-type: none"> <li>○ Cultural and/or spiritual practices &amp; traditions and community involvement as areas of strength and support;</li> </ul> <p><b>OR</b></p> <p>3) Discharge criteria and/or desired accomplishments of the individual and family/caregiver/supports to be achieved prior to discharge are clearly documented in the treatment plan.</p> <p><b>OR</b></p> <p>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.</p>	<p>appropriate. For children, the involvement of caregivers in the development of the plan is clearly evident.</p>	<p>assessment are not addressed and the rationale for deferring those needs is not documented;</p> <p><b>OR</b></p> <p>4) Documentation is general or vague-there is little or no evidence (e.g., language, written comments, etc.) of being co-authored by the recipient as well as by the family/collaterals/supports, as appropriate;</p> <p><b>OR</b></p> <p>5) There is no evidence that family or collateral input is sought when available.</p>
<p>2.13 The Initial Treatment Plan is developed according to regulatory requirements.</p>		<p>1) The Initial Treatment Plan is developed within 30 calendar days of admission or according to any other payor requirements;</p> <p><b>AND</b></p> <p>2) Measurable and attainable steps toward the achievement of goals are</p>	<p>1) The Initial Treatment Plan is developed more than 30 calendar days past admission with no explanation for delays;</p> <p><b>OR</b></p> <p>2) The Initial Treatment Plan is missing signatures or is not</p>



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		identified, with target dates; <b>AND</b> 3) The treatment plan includes the specific interventions and services that will be utilized, the clinician(s) providing services, and the frequency and duration of services; <b>AND</b> 4) All required signatures are completed as per regulations. <sup>i</sup>	signed within the regulatory time frame.
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); <b>AND</b> 2) Treatment Plan Reviews include evidence of the recipient's input, and where appropriate, the family's/collateral's/support's input on progress. For children there is evidence of recipient/caregiver/family input; <b>AND</b> 3) Treatment Plan Reviews include modifications to goals and/or objectives to address progress/lack of progress; <b>AND</b> 4) The Treatment Plan is reviewed no less than annually; <b>AND</b> 5) The Treatment Plan is reviewed when needed, as determined by the recipient/family and treating clinician	1) Gaps between Treatment Plan Reviews exceed regulatory requirements; <b>OR</b> 2) The Treatment Plan Review does not reflect where progress has been made or when progress is lacking, with no rationale; <b>OR</b> 3) The Treatment Plan is not reviewed when there is significant clinical change; <b>OR</b> 4) The Treatment Plan is modified with no rationale; <b>OR</b> 5) Family or collateral input is not sought when available.

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		<p>based on need to address clinical changes (e.g., behavioral or medical diagnosis/condition, risk level, increased/new symptoms, functioning, stressors, needs, circumstances, etc.); <b>AND</b> 6) All required signatures are completed as per regulations.<sup>ii</sup></p>	
<p>2.14.1 Treatment Plan Updates reflect service increases and are made timely in accordance with recipient's/family's changing needs, as are all other Treatment Plan changes (adjustments).</p>	<p>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.); <b>OR</b> 2) Treatment Plan Updates are aligned with recipient's/family's changing needs.</p>	<p>1) Treatment Plan Updates reflect service additions or increases in frequency/duration; <b>AND</b> 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); <b>AND</b> 3) Changes are made with input from recipient/family; <b>AND</b> 4) All required signatures are completed as per regulations.<sup>iii</sup></p>	<p>1) Services are added or increased without a Treatment Plan Update; <b>OR</b> 2) Services are added or increased without input from the recipient, or for children, without input from family/parent; <b>OR</b> 3) A change is made without any rationale <b>OR</b> 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; <b>OR</b> 4) Changes are made without input from recipient/family, or for children, without input from family/parent; <b>OR</b> 5) Treatment Plan Updates/changes do not include required signatures.</p>

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<p>2.15 Documentation of Treatment Services</p>	<p>1) There is evidence that Collaborative/Concurrent Documentation is being utilized whenever possible. <b>OR</b> 2) Psychiatric notes consistently go beyond symptom management, demonstrating attention to individualized recovery needs and goals.</p>	<p>1) There is documentation in progress notes or elsewhere that issues are attended to and services provided as identified in the treatment plan. <b>AND</b> 2) Progress notes are linked to goals and objectives by summarizing services provided/interventions utilized, the recipient's response, and progress toward goals. <b>AND</b> 3) Notes record any significant new information impacting treatment, contacts with collaterals, and consideration of the need for changes to the treatment plan. <b>AND</b> 4) Notes of appointments with psychiatrist or prescriber contain a report of mental status and explanation of changes in medications prescribed.</p>	<p>1) There is no documentation that issues are addressed, and services provided as identified in the treatment plan. <b>OR</b> 2) Notes consist of a summary of session dialogue without reference to treatment plan goals or services.</p>
<p>2.21 Safety Plan</p>	<p>1) The clinic has criteria for identifying a recipient at risk, has a safety plan developed with each of these recipients, and administration/supervisor or closely monitors</p>	<p>1) The clinic actively assists recipients to consider, and when desired, to develop an individualized safety plan that contains at least the following elements:</p> <ul style="list-style-type: none"> <li>• Identification of triggers</li> <li>• Warning signs of increased symptoms</li> </ul>	<p>1) Not all at-risk recipients have a safety plan. <b>OR</b> 2) Safety plans are not individualized or created with the input of the recipient. <b>OR</b> 3) Safety plans are not reviewed</p>



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	<p>those so identified. <b>OR</b> 2) The clinic actively assists recipients to consider and, when desired, to develop Wellness Self Management Plans, WRAP™ plans, Behavioral Advance Directives (BAD), or other mechanisms to support wellness and self determination. <b>OR</b> 3) The clinic uses the NYSCRI Relapse Prevention Plan or Safety Planning Guide by Stanley and Brown.</p>	<ul style="list-style-type: none"> <li>• Management techniques or calming activities</li> <li>• Contact information for supportive persons</li> <li>• Plan to get emergency help if needed</li> </ul> <p><b>AND</b> 2) Safety plans are reviewed with the recipient periodically and when utilized; revisions are made as needed. <b>AND</b> 3) Recipients are given a copy of their safety plan. <b>AND</b> 4) All at-risk recipients have a safety plan developed with their input. <b>AND</b> 5) The clinic routinely educates recipients and families about community supports and crisis services.</p>	<p>with the recipient periodically. <b>OR</b> 4) Safety plans are not revised when warranted.</p>
<b>ONGOING CARE</b>			
<p>3.11 The clinic attends to the recipient and family.</p>	<p>1) Peer/family advocates are available to provide information, advocacy, and support. <b>OR</b> 2) The participation by family members in psycho-educational,</p>	<p>1) Flexibility in scheduling to meet the needs of recipients is in evidence. <b>AND</b> 2) Quality improvement tools (such as surveying Perception of Care) are used and results are utilized to shape clinic operations. <b>AND</b></p>	<p>1) There is no evidence of communication with families/other significant people. <b>OR</b> 2) The clinic has no means to solicit family or collateral opinions regarding the services provided.</p>



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	<p>support, and advocacy groups is facilitated by the clinic. <b>OR</b> 3) There is an active recipient advisory group providing ongoing input to clinic administration which is comprised of recipients from prevalent cultural groups served.</p>	<p>3) A notice of recipient rights is provided at admission. <b>AND</b> 4) There is evidence of a responsive complaint resolution process. <b>AND</b> 5) Information about advocates and advocacy organizations is available to recipients and families.</p>	<p><b>OR</b> 3) There is little evidence of complaints being accepted or adequately addressed. <b>OR</b> 4) Scheduling does not allow for flexibility to meet recipient needs.</p>
<p>3.12 Identification of a Primary Clinician</p>	<p>1) There is evidence of reassignment of clinician or prescriber to better meet the recipient's needs at the request of the recipient or family. <b>OR</b> 2) The clinic periodically assesses the adequacy of staff performance regarding evidence-based practice expertise, cultural competency, linguistic abilities, etc. in relation to the population served, and takes action to better meet their needs.</p>	<p>1) A primary clinician is assigned at the time of admission. <b>AND</b> 2) Recipient request or clinical consideration for change of primary clinician is reviewed, with rationale for resolution documented. <b>AND</b> 3) Recipients are given appropriate opportunities to process changes of clinician, whenever possible.</p>	<p>1) No primary clinician has been established. <b>OR</b> 2) The primary clinician has been changed more than once to meet the staffing of the clinic rather than the preferences of the recipient. <b>OR</b> 3) The clinic disregards the recipient's or family's request for a change in clinician.</p>



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





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



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	implemented Consumer 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. <b>OR</b> 2) Over 50% of clinicians have earned the IMHATT certificate for completing FIT distance learning modules on integrated treatment. <b>OR</b> 3) The clinic employs or regularly accesses the services of a physician certified in addiction psychiatry or addiction	1) For recipients who meet the clinic'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. <b>AND</b> 2) Treatment planning and interventions are consistent with and determined by the recipient's stage of change/treatment. <b>AND</b> 3) Treatment of co-occurring disorders is provided by staff trained in delivering such services (IDDT, FIT, or equivalent).	1) The clinic 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. <b>OR</b> 2) The clinic does not provide basic appropriate mental health and substance use interventions to recipients with co-occurring disorders. <b>OR</b> 3) Staff members lack the training and/or experience to deliver integrated treatment interventions.

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	medicine.		
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 recipient disengagement.	1) When recipients discontinue, refuse services, or are lost to contact, a review of recipient’s history, current circumstances and degree of risk is conducted. <b>AND</b> 2) Efforts to re-engage are commensurate with the degree of risk assessed. <b>AND</b> 3) Reviews include contact with significant others/collaterals and consultation with clinical supervisor or team prior to a case being closed. <b>AND</b> 4) Written correspondence indicates that recipient 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 recipient. <b>OR</b> 2) A significant proportion of closed cases indicate that recipients were lost to contact. <b>OR</b> 3) There is no individualized review of cases of disengagement. <b>OR</b> 4) Re-engagement efforts are minimal or not related to level of assessed risk.
3.17 Treatment of Tobacco Use	1) The clinic develops and reviews with the recipient, and caregivers for children, a plan to address tobacco use and dependence. <b>OR</b> 2) The program supports employees in seeking tobacco treatment. <b>OR</b>	1) The clinic delivers a strong, personalized advice statement about the negative impact of smoking and the benefits of cessation to identified tobacco users. <b>AND</b> 2) The clinic provides information on tobacco treatment options, including pharmacotherapy and referral to counseling programs, and documents tobacco treatment interventions in the treatment plan,	1) The clinic does not offer advice about the negative impact of tobacco use and the benefit of cessation. <b>OR</b> 2) The clinic does not offer assistance or information on tobacco treatment options, including pharmacotherapy and referral to counseling programs, and does not arrange for follow-up.



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	3) The clinic uses data including ongoing metrics of smokers, interventions, successful quit rates, and population incidence of smoking, and uses those metrics to assess clinic success in disseminating treatment.	as appropriate. <b>AND</b> 3) Tobacco dependence medications are accessible and offered by clinic prescribers, and recipients are monitored for interaction of tobacco use with current medications or impact of smoking cessation on other medication the recipient is taking as part of a comprehensive tobacco dependence treatment plan.	<b>OR</b> 3) The clinic does not document tobacco dependence or treatment interventions in the treatment plan.
3.21 Discharge	The clinic utilizes a system to follow up with recipients 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 recipient and significant others prior to planned discharge. <b>AND</b> 2) Discharge summaries identify services provided, the recipient's response, progress toward goals, circumstances of discharge and efforts to re-engage if the discharge had not been planned. <b>AND</b> 3) The discharge summary and other relevant information is made available to receiving service providers prior to the recipient's arrival (or within two weeks of discharge, whichever comes first) when that provider is known.	1) Recipients are discharged with no assessment of needs or plan for follow-up services. <b>OR</b> 2) Discharge summaries are missing or do not summarize the course of treatment.

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<b>CLINICAL ADMINISTRATION</b>			
<p>4.11 Caseload</p>	<p>The clinic 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.</p>	<ol style="list-style-type: none"> <li>1) Clinic leadership can demonstrate a systematic process used to assign recipients to a clinician based on presenting needs, acuity, preferences, clinician expertise as well as caseload size. <b>AND</b></li> <li>2) A systematic process, and the concomitant policies and procedures, to monitor, review and track clinician caseloads by size, risk levels of recipients and other factors can be demonstrated. <b>AND</b></li> <li>3) Productivity standards which allow for appropriate clinical care and address fiscal viability are established. <b>AND</b></li> <li>4) Sufficient prescriber coverage is available to meet the needs of recipients without undue delay, or a process is in place to assure recipients have access to prescription services when needed. <b>AND</b></li> <li>5) The clinic 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).</li> </ol>	<ol style="list-style-type: none"> <li>1) No processes have been established to assign cases to clinicians reflective of client need and clinician expertise and caseload size. <b>OR</b></li> <li>2) There is no evidence that procedures are utilized to monitor, review and track caseload size or risk levels of clients per clinicians' caseload. <b>OR</b></li> <li>3) Number or mix of staff does not support appropriate clinical care. <b>OR</b></li> <li>4) There is evidence of high staff turnover related to unrealistic caseload demands. <b>OR</b></li> <li>5) Frequency of services appears to be based on clinician availability rather than identified treatment needs.</li> </ol>

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<p>4.12 Treatment Services</p>	<p>1) The clinic 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; <b>OR</b></p> <p>2) The clinic can demonstrate implementation of two or more evidence-based practices. <b>OR</b></p> <p>3) All youth who are prescribed antipsychotic medication or are being considered for same have received an evaluation by a child and adolescent psychiatrist, either in person or via telemental health.</p>	<p>1) There is evidence that the clinic provides all required services and approved Optional Services in a consistent and clinically appropriate manner. <b>AND</b></p> <p>2) Optional Services (and appropriate staff, if necessary) are added if the clinic identifies a need among its population. <b>AND</b></p> <p>3) Administration identifies and utilizes mechanism(s) for insuring that appropriate services are provided to each recipient based on current clinical need and documented processes (for instance, UR). <b>AND</b></p> <p>4) All services are provided by appropriately trained and credentialed staff. (Including services provided at integrated MH/OASAS/DOH clinic sites.) <b>AND</b></p> <p>5) Documented procedures for identifying, monitoring, and re-assessing recipients receiving only medication treatment services are known and adhered to by clinic staff.</p>	<p>1) The clinic does not provide all required services or utilize all available clinical modalities such as Clozaril treatment, when indicated. <b>OR</b></p> <p>2) There is no evidence of changes to services offered in response to needs of the population served. <b>OR</b></p> <p>3) Recipients receive medication only service without appropriate screening, monitoring, reassessing or treatment plan changes based on significant events or decline in stabilization or progress.</p>



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	<p align="center"><b>OR</b></p> <p>4) The clinic demonstrates awareness of issues specific to foster children and monitors prescribing practices for this population.</p>		
<p>4.13 Crisis Services</p>	<p>1) The clinic provides 24/7 availability to speak with a licensed professional who is familiar with the recipient. <b>OR</b> 2) Clinic staff provide face-to-face after-hours service to recipients in crisis when clinically indicated.</p>	<p>1) The clinic has an ability to accommodate crisis intakes and walk-ins during normal program hours. <b>AND</b> 2) There is a plan in place which results in contact with a licensed professional by recipients and their collaterals who need assistance when the program is not in operation. <b>AND</b> 3) The primary clinician at the clinic is informed on the next business day of information from clinicians providing after hours services. <b>AND</b> 4) The process for after hours contact is explained to all recipients, and significant others where appropriate, during the intake process and given to them in an information packet describing the services offered by the clinic. This information is also posted and reviewed with the recipient throughout the course of care. Additionally, where indicated, the information is included in the</p>	<p>1) After hours calls go to an answering machine or answering service which refers recipients to go to an emergency room or call 911. <b>OR</b> 2) Recipients 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. <b>OR</b> 3) Information regarding after-hours contacts is not available to the clinic. <b>OR</b> 4) Crisis calls are not followed up by the clinic.</p>



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		<p>recipient's crisis plans. <b>AND</b> 5) The clinic demonstrates consistent follow-up on crisis calls received.</p>	
<p>4.14 Cultural Competence</p>	<p>1) Meeting cultural, linguistic, and other special needs is emphasized by the clinic and embedded in policy and practice: The agency has a cultural competency plan, staff have received training to increase awareness, including cultural competence training, and the program has enlisted appropriate individuals to provide guidance in engaging and attending to recipients and groups served. <b>OR</b> 2) Materials are available in languages accessible to LEP persons and in formats and media acceptable to persons from prevalent cultural groups served. <b>OR</b></p>	<p>1) There is evidence that the clinic seeks to eliminate disparities in mental health care for people of diverse backgrounds by:</p> <ul style="list-style-type: none"> <li>• Making all reasonable efforts to provide care in a culturally competent manner to its prevalent populations through all stages of screening, treatment, and discharge</li> <li>• Ensuring that assessments capture individual/family cultural, linguistic, and literacy needs, ethnic and/or racial identification, sexual orientation, etc., and any impact on treatment</li> <li>• Assigning multicultural/multilingual clinicians to recipients from matching cultural groups wherever possible</li> </ul> <p><b>AND</b> 2) For individuals with Limited English Proficiency (LEP), the clinic:</p> <ul style="list-style-type: none"> <li>• Uses language translation services as needed and as required by law</li> </ul>	<p>1) There is little or no evidence of attention to ensuring cultural competence among clinicians. <b>OR</b> 2) Screening forms, assessment forms, or correspondence templates are available in only one language. <b>OR</b> 3) Cultural, linguistic or other special needs are not routinely addressed as needed.</p>





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	3) Perception of Care surveys are administered in ways that maximize ability of prevalent cultural groups served to communicate areas which may need improvement. <b>OR</b> 4) There is evidence that individuals screened but referred elsewhere are connected with culturally competent services.	<ul style="list-style-type: none"> <li>Makes reasonable efforts to provide written correspondence and other documents to be used by the recipient in their preferred language wherever possible</li> </ul>	
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. <b>OR</b> 2) The clinic demonstrates an ongoing training program in evidence-based practices (EBPs), and a majority of staff have received training in one or more	1) Clinical supervision by appropriate leadership staff on a regular basis for all clinicians is provided and documented. <b>AND</b> 2) The frequency of supervision is increased for new vs. experienced staff. <b>AND</b> 3) Provision is made for prompt supervision in times of crisis or increased need, clinicians demonstrate knowledge of the method to request <i>ad hoc</i> supervision, and there is evidence that this has been used. <b>AND</b>	1) Clinical supervision is not provided on a regular basis. <b>OR</b> 2) All clinicians, regardless of experience, have the same level of supervision. <b>OR</b> 3) Supervisory sessions appear to deal more with administrative than clinical matters. <b>OR</b> 4) Clinical supervision occurs only in groups, not individually. <b>OR</b> 5) There is minimal evidence of staff training. <b>OR</b>

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	<p>EBPs. <b>OR</b> 3) All clinicians who treat co-occurring disorders have completed FIT or equivalent training. <b>OR</b> 4) For non-state-operated clinics, regular cultural and linguistic training is conducted.</p>	<p>4) Issues or needs identified related to staff performance are addressed in supervision, training, or by other methods. <b>AND</b> 5) Regularly scheduled clinical in-service training is provided by the agency and staff attendance is documented. <b>AND</b> 6) Required staff clearances are maintained. <b>AND</b> 7) Staff licenses and registrations are current. <b>AND</b> 8) For state-operated clinics, mandatory annual cultural and linguistic training is conducted.</p>	<p>6) Staff credentials and clearances are not reviewed. <b>OR</b> 7) No performance evaluation system or other methods to assess and evaluate staff performance are evident. <b>OR</b> 8) Annual cultural and linguistic training has not been completed by a significant number of staff at state-operated clinics.</p>
4.31 Information Sharing	<p>Training and supervision include the importance and understanding of coordination, collaboration, and partnership with other agencies, families, collaterals and other systems involved with the recipients served.</p>	<p>1) The clinic 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 recipients. <b>AND</b> 2) Recipients are informed of the clinic's privacy policies, including circumstances where written consent is not required. <b>AND</b></p>	<p>1) Staff do not understand the parameters for sharing information with other providers. For example, the clinic or clinicians believe HIPAA laws always require written consent for information sharing. <b>OR</b> 2) Few if any charts show documentation of information sharing (e.g., with PCP, other providers in the OMH nexus of care, including AOT). <b>OR</b></p>



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		3) The value of sharing information with other parties is discussed and the recipient's consent is sought and documented as appropriate. <b>AND</b> 4) There is evidence of sharing of treatment information in order to better integrate services for recipients, particularly at admission, discharge, or periods of crisis or hospitalization, and for recipients with an AOT order.	3) There is evidence of the improper withholding of information.
4.41 Clinical Risk Management	The clinic 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. <b>AND</b> 2) The IRC reviews incidents, makes recommendations, and ensures implementation of action plans with program's administrator. <b>AND</b> 3) The IRC membership composition is appropriate; members meet qualifications and are properly trained. <b>AND</b> 4) The clinic compiles and analyzes incident data for the purpose of	1) The IRC does not meet the requirements of Part 524 for review, analysis, and monitoring of incidents. <b>OR</b> 2) No policies or procedures are evident regarding risk management.



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		identifying and addressing possible patterns and trends. <b>AND</b> 5) The clinic enters incident data into NIMRS.	
4.51 Responsive to recipients 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. <b>OR</b> 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 clinic to better address the needs of at-risk or complex recipients and their collaterals. <b>OR</b>	1) The clinic identifies, tracks, monitors, assesses, and reassesses the treatment of at-risk and high-need recipients. <b>AND</b> 2) There is evidence that the identification of recipients at moderate to high risk results in psychiatric and other clinical consultation and interventions appropriate to the degree of risk assessed. <b>AND</b> 3) For at-risk and high-need recipients, an updated risk assessment is completed prior to planned discharge.	1) The agency cannot demonstrate an effective system for identifying, monitoring, or responding to recipients at risk. <b>OR</b> 2) Identification of moderate to high risk does not result in clinical consultation or appropriate interventions.



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	3) The clinic has implemented an ongoing, comprehensive approach to suicide prevention.		
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. <b>OR</b> 2) The premises is decorated and furnished in a welcoming manner specific to the prevalent cultural groups served at the facility. <b>OR</b> 3) A waiting area is available for children/families. <b>OR</b> 4) The clinic has materials promoting recovery and sharing success stories available in the waiting	1) The premises are maintained in a clean condition, free of fire and safety risks. <b>AND</b> 2) Individual and group space is sufficient, comfortable and private. <b>AND</b> 3) Records are maintained confidentially. <b>AND</b> 4) Medications are stored and disposed of appropriately. <b>AND</b> 5) Sign-in procedures and therapy rooms promote confidentiality. <b>AND</b> 6) A sufficient number of restrooms are available for use by recipients and staff. <b>AND</b> 7) Rights and advocacy information are prominently posted. <b>AND</b> 8) Proper exit signs visible and working and evacuation signage posted. <b>AND</b> 9) Comfortable temperatures are maintained in all areas of the clinic.	1) The premises are unsafe due to fire or safety hazards. <b>OR</b> 2) The premises need extensive maintenance to ensure a comfortable place to receive services. <b>OR</b> 3) Literature, photos, reading material and toys are not reflective of the population served and those using the waiting area. <b>OR</b> 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. <b>OR</b> 5) Proper signage for exits and evacuation routes are not evident.



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Table with 4 columns: Standard of Care Focus, Exemplary (In addition to Adequate), Adequate, Needs Improvement. Row 1 contains specific criteria for signage and waiting area items.

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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 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 PNP if medication is prescribed
    - psychiatrist, other physician, licensed psychologist, PNP, 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 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 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 PNP if medication is prescribed
    - psychiatrist, other physician, licensed psychologist, PNP, 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.