Youth ACT Standards of Care	
SOC 1. Administration (P&P should be reviewed in accordance with Field Office Procedures)	
Youth ACT SOC 1.1: Administrative Compliance	1. Policies and procedures are developed, reviewed, and revised to reflect up-to-date compliance with part 508 regulation and service operations. 2. Policies and Procedures are modified as significant programmatic changes are implemented or as changes in requirements occur. 3. Policies and Procedures describe the requirements for establishing a legal record for, service documentation and billing, and meet standards and regulatory requirements related to proper storage and management of case records. This includes Electronic Health Records (EHR).
Youth ACT SOC 1.2: Health and Safety	1. Policies and procedures define and address prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric emergency when it occurs. 2. Policies and procedures address clinical/client emergencies, crisis events or disasters (e.g., emergency preparedness and response), prevention of abuse and/or neglect and incident reporting. 3. Policies and Procedures address medication administration and medication management.
Youth ACT SOC 1.3: Quality Management	1. Policy and procedures are in place to monitor the quality and evaluate the effectiveness of services on a systematic basis, and to implement quality improvements when indicated. a. Provider has policies and procedures that clearly describes a quality management plan, and implementation processes for that plan. This includes clear documentation of indicators and monitoring processes for those indicators.
SOC 2. Staffing	
Youth ACT SOC 2.1: Orientation and Training	1. Staff must complete all required Youth ACT training as directed by the NYS OMH. 2. Provider has a training and orientation plan in place for all staff. 3. Provider maintains a record of staff's completion of trainings to demonstrate agency requirements being met. 4. Provider ensures that staff have the required experience and training to provide care that is trauma informed, culturally competent, and appropriate to the developmental level of the population served. 5. Provider has training related to personal safety of staff and in de-escalation techniques. 6. Provider ensures the team has an effective monitoring plan and process in place for overseeing staff safety in community. 7. Provider has ensured all staff have completed required background checks.

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Youth ACT SOC 2.2 Staffing	1. Staff must have experience and capability to effectively treat children/youth with SED and severe mental, emotional and behavioral impairments. 2. Youth ACT team staffing ratios and composition conform to the model (10:1).
SOC 3. Organizational Structure	
Youth ACT SOC 3.1 Employee Administration	1. Employee/Staffing: Provider maintains documentation of administrative oversight to include hiring, retention, and supervision of qualified staff. 2. Policies and procedures include a written staffing plan that addresses the types, roles, services offered and coverage plan for staff absences or vacancies. 3. Provider maintains an Organizational Chart that provides a visual description outlining the organizational relationships in the agency. The chart clearly identifies the line of authority and is distributed to all staff (employees, contractors, volunteers and student interns). 4. Each position has a written job description. As employees are hired, they are provided with a detailed job description and clearly defined expectations of the position are communicated. 5. Agency Management clearly communicates with new staff the policies and procedures of the agency. The employee manual contains the materials that staff will refer to throughout their employment. Staff signs written attestation acknowledging review and understanding of contents and policies via employee manual. All staff are kept informed of policy changes that affect performance of duties and the provider has a written process to advise them of policy changes. 6. Provider maintains documentation that staff have current NYS licensure, certification, or registration, as appropriate, and are appropriately qualified to deliver Youth ACT services within the scope of their practice. 7. Provider maintains policies and procedures for conducting background checks in accordance with the requirements of the lead agency that has licensed, certified, authorized, or designated the provider for all staff (employees, contractors, volunteers and student interns) who has regular and substantial contact with child/youth, family/caregiver.
Youth ACT SOC 3.2: Governing Body and Quality Assurance	1. The agency has a systemic approach for self-monitoring and ensuring ongoing quality improvement (QI) for the Youth ACT team. 2. 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. 3. An agency-wide process for reviewing complex, high risk, high need cases are evident. Individuals with clinical expertise who can provide recommendations on treatment strategies are available to the Youth ACT team.

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Youth ACT SOC 3.3: Incident Management and Reporting	1. All 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 at the time of hire and on at least an annual basis. 2. The agency is compliant with their Incident Management policy consistent with NYCRR Part 524 and the Justice Center and conforms to the reporting and follow up timeframes and 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 & trends.
Youth ACT SOC 3.4 Cultural Competence	1. All facets of care are culturally and linguistically responsive. This includes but is not limited to Policies and Procedures; hiring/training; intake, assessment, and ongoing service delivery. 2. 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. 3. The plan ensures that language assistance services are available. 4. The child/youth and family/caregiver are provided care that reflects the awareness and responsiveness of cultural differences and diversity. a. Provider's assessment and interventions acknowledge, respect, and integrate the child/youth's and family/caregiver's beliefs, cultural values, and practices.
SOC 4. Admission and Assessment	
Youth ACT SOC 4.1 Intake	1. Youth ACT team members engage with a child/youth, and their family within 24 hours of referral. This may include community outreach, home visiting, and engagement of natural supports and other collaterals, such as school counselor or probation officer, if applicable. If an initial meeting with the child and family is not scheduled within 7 days of receipt of the referral the C-SPOA is notified. 2. For children or youth transitioning home from an inpatient hospitalization, children's community residence (CCR) or Residential Treatment Facility (RTF), this should include engagement of the child/youth, family through collaborative meetings that include hospital, RTF, or Community Residence (CCR) staff to encourage seamless transition and connection to Youth ACT post-discharge. 3. The child/youth and family/caregiver are oriented to services and provided with the necessary information and documentation regarding the scope of services, confidentiality and information sharing protocols. Provider ensures: a. Consent to receive services is obtained;

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	b. Orientation to service information is provided; and c. Individual's rights are explained (including the right to file grievances). 4. Upon admission, a screening and admission note is written to include: a. The reason for referral; b. Immediate clinical and other service needs to attain or maintain stability; c. Admission diagnoses; and d. Admission note is approved and signed by the Team Leader. 5. If admission is not indicated, notation should be made of the following: a. The reason(s) for not admitting; b. The disposition of the case; and c. Any recommendations for alternative services 6. Waitlist prioritization is needs-based and re-evaluated periodically.
Youth ACT SOC 4.2 Initial Assessment	1. The entire Youth ACT team meets to review clinical assessments included with the referral of new admissions to formulate multidisciplinary team review and to inform planning recommendations. 2. An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of admission. Immediate needs are defined as: a. Safety and suicidality b. Living situation and family functioning c. Medical/Health needs d. Resources- shelter, food, clothing e. Educational /vocational 3. A Comprehensive Assessment is completed within 30 days of admission. This includes assessing for services that comprehensively address the needs of the child/youth across multiple life domains, including within the family, school, medical, behavioral, psychosocial, and community domains. 4. The team reviews and develops clinical formulations under the guidance of the MD, Psych NP, team leader and/or designated clinical supervisor. 5. There is evidence that exploration of personalized recovery goal(s) occurred during the assessment.
Youth ACT SOC 4.3 Ongoing Assessment,	1. There is evidence that the team enters member data into CAIRS; the Baseline Assessment Form (BASF) is completed within 30 days of admission and the Follow-Up Assessment Form (FUAF) is completed six months thereafter as required by OMH. 2. CANS-NY is completed and documented in CAIRS within 30 days of admission.

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CAIRS and CANS-NY	3. CANS-NY is completed every six months thereafter and at discharge. 4. The comprehensive assessment is updated at least every six months, at the service plan review, as well as whenever there are significant events or changes in life circumstances. 5. Assessment of risk to determine acuity of needs is conducted whenever issues of safety or indications of risk are apparent for any child/youth or family, including changes in the child/youth's symptoms or mental status.
SOC 5. Service Planning and progress notes	
Youth ACT SOC 5.1 Service Plan	1. Service planning addresses the unique needs, preferences and strengths of the child and family/caregiver and is developmentally appropriate. 2. Service plan, developed in partnership, with documented involvement of the youth, family, prescriber, team leader and/or designated clinical supervisor The service plan identifies/includes: a. Desired goals and outcomes b. Scope, frequency, and duration of service c. Psychopharmacological treatment d. Safety and Crisis plan e. Signature of clinical supervisor; team leader; physician 3. The initial service plan is completed within 30 days of admission. 4. The service plan is shared with individual, and family, medical providers, and others, with consent.
Youth ACT SOC 5.2 Progress Notes and Service Plan Reviews	1. Services are provided as identified in the plan. 2. Notes include the date and location the service was provided, the length in minutes of contact and the signature of the person who provided the service. 3. Notes are directly linked to goals and objectives at a minimum, by summarizing the services provided, interventions utilized, the child/youth and family caregiver's response, and evidence of progress made toward goals. 4. Notes include any significant information impacting services, including child/youth and family caregivers' preferences, coordination with the multidisciplinary team, and consideration of the need for changes to the plan. 5. The service plan is reviewed and revised to include new strategies, services etc. in response to changes in individual's circumstances and functioning. 6. All plans are reviewed at least every 6 months or earlier if there is a significant change in the child's functioning and adjusted as needed. 7. Service dollars spent, and their related treatment objectives, are documented in progress notes and provided in accordance with Service Dollars Guidelines.

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Youth ACT SOC 5.3 Team Protocol/ Functioning	1. The team conducts the required minimum number of contacts to bill the full or half month rates and for those individuals hospitalized to bill the inpatient rate. 2. The team conducts a minimum of 80% of contacts in the community. 3. Daily team meetings are held a minimum of four times a week. 4. Daily team meeting reviews the status of each individual and plans for response to emerging crisis are formulated. Daily team meetings to include: a. Review of every enrolled child/family b. Review of the status of each child/family to be seen on the day of the meeting. c. Updates on contacts that occurred the day before. d. Updates and revisions to the daily staff assignment schedule. e. Service plan reviews 5. Communication boards, logs, and other devices are maintained as per the Youth ACT guidance. 6. All required services are delivered directly by the authorized program in alignment with the individual treatment plan.
Youth ACT SOC 5.4 Ongoing Risk Management	1. Each youth has a current safety and crisis plan, developed with the youth and family. 2. Crises are rapidly addressed with input from multiple team members. 3. The team operates a continuous and direct after-hours on-call system and are the first point of contact for after-hours crisis calls. 4. The team directly provides in-person after hours services where appropriate.
Youth ACT SOC 5.5 Discharge Planning	1. Discharge planning is a dynamic process throughout the course of service delivery and includes the participation of child/youth, family/caregiver and collaterals. 2. Discharge plan considers the child/youth and family/caregiver's circumstances and preferences. 3. Shared decision making occurs with the child/youth, family/caregiver, and collaterals regarding readiness for discharge and needed follow up services. Linkage to services is facilitated (e.g., identification of alternative providers, assistance with obtaining appointments, contact names and numbers provided, etc.). 4. Discharge summaries are completed that identify: a. The reason for discharge. b. Status and condition at discharge. c. A written final evaluation or summary of the individual's progress towards goals. d. A plan for treatment and/or follow-up after discharge, developed in conjunction with the individual. e. Signature of staff completing the document. 7. The discharge summary is shared with other service providers as needed and appropriate.