



**Office of
Mental Health**

Youth Assertive Community Treatment (ACT)

Program Guidance Document

July 2021

Youth ACT Program

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Youth Assertive Community Treatment

I. Program Overview

Youth Assertive Community Treatment (ACT) is a program designed to address the significant needs of children ages 10 up to 21, who are at risk of entering, or returning home from high intensity services, such as inpatient settings or residential services, through the use of a multi-disciplinary team. Children with significant psychiatric needs, who are at risk of institutional level of care, require intensive interventions in order to adequately support the child and family's complex needs, to avoid high end services or facilitate and support a successful transition back to community. Youth ACT serves as a critical component in the children's continuum of care.

Youth ACT ensures the child and their family have the level of support services and access to clinical professionals they require to sustain any gains made in crisis response or other out-of-home high-intensity services. Youth ACT teams deliver intensive, highly coordinated, individualized services and skilled therapeutic interventions through an integrated, multi-disciplinary team approach to better achieve success and maintain the child in the home, school and community. Youth ACT services are delivered in the home or other community-based settings.

Team interventions are focused on improving or ameliorating the significant functional impairments and severe symptomatology experienced by the child/youth due to mental illness or serious emotional disturbance (SED). Interventions are also focused on enhancing family functioning to foster health/well-being, stability, and re-integration for the child/youth. Services are delivered using a family-driven, youth guided and developmentally appropriate approach that comprehensively addresses the needs of the child/youth within the family, school, medical, behavioral, psychosocial, and community domains.

To address the needs of children and adolescents eligible for this comprehensive service, the Youth ACT team is multi-disciplinary and expected to promote a myriad of interventions, including: the active participation of the family and other natural supports; the utilization of promising practices and evidence-based interventions focused on family and systems approaches; re-integration and meaningful connections within the home and community; and preparations for transition to adulthood; all as applicable to the population served. The Youth ACT team must also ensure that services are comprehensive, and principle driven. A reliable treatment structure that is flexible and responsive in nature is required, whereby the type and intensity of services are immediately and seamlessly adjusted to meet the individualized, changing needs of the child and family.

1.1 Outcomes:

The purpose of Youth ACT is to support children with complex mental health needs and their families so that they may remain in their homes and communities, achieve success in their educational, vocational or employment endeavors and foster positive relationships among friends and family. As such, the expected outcomes of Youth ACT include:

- Youth is stabilized and able to successfully remain in their home, school, and community
- Youth and their families are actively engaged in community-based services and have adequate supports to sustain gains achieved in the program
- Youth eliminate or reduce frequency or duration of inpatient admissions, emergency room use, crisis services use,
- Youth and families acquire effective skills such that youth can achieve age-appropriate developmental milestones
- Youth and family have enhanced capacity to sustain healthy interactions, secure emotional attachment, and functional relationships

1.2 Certification:

All ACT programs must be certified (licensed) by the New York State Office of Mental Health pursuant to 14 NYCRR Part 508.

These guidelines serve as the NYS Office of Mental Health's standards for licensed Assertive Community Treatment programs. The Commissioner of the NYSOMH must approve any waivers to these standards in accordance with Part 501 of Title 14 NYCRR.

2. Guiding Principles

Youth ACT services must be provided in accordance with the below outlined guiding principles to ensure services are person-centered and meet the needs of the youth:

Accessible and Available: Services are flexible and mobile, and adapt to the specific and changing needs of each child/family; utilize the home/community for service delivery, along with therapeutic, rehabilitative and supportive approaches that best fit the needs of each child and family

Family-Driven: Services emphasize the important role of family as the experts in their lives, their needs, and their goals. The family drives the treatment, rehabilitative and supportive delivery process for the child. Family-driven care promotes the well-being and developmental

needs of the child while supporting the relationships between the child, family, other natural supports and service providers.

Youth Guided: Services recognize that youth have the right to be empowered, educated, and given a decision-making role in the care of their own lives, including guiding the treatment, rehabilitative and supportive service delivery process.

Developmentally Appropriate: Services and interventions are provided in a manner that is not only appropriate for a child/youth's age, but anchored to their developmental, social and emotional stage, and attuned to the relationship between the child/youth and family/caregiver. As the child/youth's needs indicate, the scope of service and interventions enable the family/caregiver's active involvement and are reflected in the treatment plan.

Culturally and Linguistically Competent: Services are respectful of and responsive to the values and needs of the family and contain a range of expertise in treating and assisting families in a manner responsive to cultural and linguistic diversity. Services are delivered in a manner that recognizes and respects the culture and practices of the child/youth and family, including the awareness and understanding of different cultural groups' experiences. Such experiences include but are not limited to oppression and social diversity with respect to race, ethnicity, sex, sexual orientation, gender identity or expression, disability, religion, immigration status and its impact on engagement and perception of care.

Strength-based: Services rely upon a collaborative process between the Youth ACT team members, youth and family, enabling them to work together to determine a treatment plan that draws on their strengths and assets. This includes the identification of family members and significant others who provide support and have a meaningful role in the child/youth's ongoing care or development. This may also include interventions and activities which build upon the youth's or family's competencies, interests, beliefs, values and practices that serve as a source of support or growth.

Recovery-Oriented: Services incorporate a process of change through which the child/youth and family improves their health and wellness, lives a self-directed life, and strives to reach their full potential.

Trauma-Responsive and Trauma Specific: Services are based on an understanding of the vulnerabilities or triggers experienced by children who have experienced or witnessed trauma that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. Families are engaged in services with the assumption that trauma has occurred within their lives. Trauma specific treatment should be provided for those who have experienced trauma.

Evidence-Based/Promising Practices: Services utilize or apply core components of evidence-based and promising practices, supported by continuing education activities for staff to promote learning and implementation.

3. Youth ACT Services

Youth ACT teams are expected to make available the following range of treatment, rehabilitation and support services in a manner that is consistent with the conditions, age and developmental stage of the youth to be served, and in accordance with a person-centered and individualized service plan. The services offered may therefore vary in degree and/or focus per team. Services include:

- A. Assertive Engagement
- B. Case Management
- C. Assessment
- D. Child and Family Services Planning
- E. Individual, Group, and/or Family Counseling/Therapy
- F. Family Psychoeducation
- G. Individual Psychoeducation
- H. Psychosocial Rehabilitation
- I. Crisis Intervention Services
- J. Medication Management
- K. Health Services
- L. Peer Services (Family and Youth Peer)
- M. Vocational/Educational Services

A. Assertive Engagement:

These services include a variety of methods to promote engagement of children/youth and families who initially may not engage readily in ACT services, including community outreach, home visiting, and engagement of natural supports and other collaterals, such as school counselor or probation officer, if applicable. For children or youth transitioning home from a crisis residence, Children's Community Residence (CCR), inpatient psychiatric unit or Residential Treatment Facility (RTF), this should include engagement of the youth, family through collaborative meetings that include crisis residence, hospital, RTF or CCR staff to encourage seamless transition and connection to ACT post-discharge. Assertive Engagement is designed to foster a commitment on the part of a child/youth and family to enter into a therapeutic relationship with the ACT team that is supportive of their recovery and motivates their participation in services in order to build or enhance their functional capacities.

B. Case Management:

Case management services provide linkages to community resources and supports to help children/youth live in the community, transition home from higher levels of care and meet their personal goals. Case management uses strength-based and person-centered practices, assisting persons to achieve the goals of wellness management and recovery. Case management helps with increasing access to resources, supports and services that will promote recovery while decreasing the need for hospitalization and reliance on emergency services. Case management assists individuals and families to obtain needed medical, social, psychosocial, educational, financial, vocational, housing, and other services. Utilizing the strength-based model of service delivery, case management services empower individuals and families by engaging them in the decision-making process and encouraging them to choose among all available options that will assist them in achieving their goals.

Case management for children/youth relies on coordination of care through partnerships and collaboration among the child/family, Youth ACT team, other service providers and natural supports. Care coordination should be considered a foundational approach incorporated into all aspects of service delivery to facilitate integrated care that addresses the co-occurring needs and systems involvement in the child/youth's and family's life.

C. Assessment:

Assessments are to be conducted as a multi-disciplinary, continuous process of identifying an individual's strengths, barriers to achieving goals, and service needs, through the observation and evaluation of the individual's current mental, physical and behavioral health condition and history. The assessment is the basis for establishing a diagnosis and a person-centered, recovery-oriented service plan. An initial assessment is conducted upon admission into the Youth ACT program, with follow-up assessments every six months, or as needed. This may also include specific indicated assessments based on need, such as trauma assessment, suicide assessment or violence risk assessment.

For children/youth and families, assessment and diagnostic evaluation is intended to be a unified process inclusive of treatment planning, in order to establish a child/youth-centered, family-centered plan for service provision. The capacity to assess and/or identify co-occurring mental health and substance use conditions, as well as intellectual deficits/learning disorders is an important component of assessment in order to comprehensively inform an integrated, unified treatment planning process and a developmentally appropriate treatment plan.

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, family circumstances and upon the child/youth stepping down from a higher level of care. The regular, consistent use of standardized tools to screen, assess and monitor the level of risk severity should be part of the ongoing

assessment process. Screening for risk indicators within the child/youth and family should occur throughout the process of service delivery by the Youth ACT team to determine if/when assessment of risk is needed.

D. Child/Family Centered Service Planning:

Service Planning is a continuous process that engages each child/youth and family as active partners in developing, reviewing, and modifying a course of care that supports the child/youth's progress towards identified goals related to restoring, building or enhancing functionality as well as the development of a relapse prevention plan where appropriate.

Child/youth-centered, family-centered service planning is as significant to the care of a child/youth and family as the interventions provided. It is a therapeutic process that engages the child/youth and family in defining their desired goals and the action steps by which to achieve them. The treatment plan developed through this dynamic process is the agreement between the provider, child/youth and family as to what changes need to occur, what services and participants will help achieve those changes and how progress toward those changes will be measured. It serves as a roadmap for recovery, developed in partnership with the provider, the child/youth, family/caregiver, and significant others involved in the child's treatment.

The child/youth-centered, family-centered treatment plan should be reviewed at least every six months, or earlier if there is a significant change in the child's functioning, and adjusted as needed, in partnership with the child and family, and in consultation with collaborative providers outside of the Youth ACT team to gauge changes in status, responses to treatment, or progress toward goal achievement.

E. Individual, Group, and/or Family Counseling/Therapy:

Therapy is problem-specific and goal-oriented, using evidence-based practices such as cognitive-behavioral therapy, as appropriate. Therapy emphasizes social/interpersonal competence, addresses barriers that disrupt the developmental process, and considers an individual's strengths, needs, and cultural values.

Therapy services utilize skilled interventions to ameliorate or improve functional impairments and facilitate behavioral change related to the child's/youth's condition(s) of mental illness, emotional/behavioral disturbance. Interventions aim to reverse or change maladaptive patterns of behavior within the child/youth and family as well as to support the child's capacity to achieve age-appropriate developmental milestones and the family's capacity to sustain healthy family interactions, more secure emotional attachment and functional family relationships.

Therapy approaches should include the capacity to address individual and family trauma,

such as experiences of physical, sexual or emotional abuse, disrupted attachment, family conflict, significant loss, witness to violence, generational mental illness or substance use disorders. Trauma specific treatment or interventions should be provided when needed by the child/family.

In the event a specialized therapy service outside of the expertise within the ACT team are required, it should be made available through referral or formal arrangement with other providers. For example, for youth with an identified substance use disorder, the following therapeutic intervention may be needed:

- *Integrated Dual Disorder Treatment* is an evidence-based practice using an integrated care model involving motivational interviewing, stage-wise interventions, groups, self-help groups, cognitive-behavioral, and harm reduction techniques which are designed to restore functionality and promote recovery for youth with dual recovery substance use disorder and mental illness.

F. Family Psychoeducation:

Family Psychoeducation is a rehabilitative service involving counseling an individual's family members, caregivers, or social supports on the early warning signs of the individual's psychiatric symptomology, and how to avoid and reduce stressors on the individual to promote the individual's recovery in the community. Family Psychoeducation for families of children/youth with mental illness or serious emotional disturbance fosters a partnership between the child/youth, their family and clinician to support mental health treatment and recovery. Family Psychoeducation helps families gain greater knowledge of mental illnesses and emotional or behavioral disorders in order to reduce stress, confusion, and isolation.

G. Psychosocial Rehabilitation:

Psychosocial Rehabilitation utilizes hands on training and rehabilitative interventions to target the development, reacquisition or improvement of skills that were lost or undeveloped due to the onset of mental illness/emotional disturbance. Training is provided through direct instruction techniques including explanation, modeling, role playing, and social reinforcement interventions. Psychosocial Rehabilitation for children/youth assists in the development, reacquisition, or improvement of age-appropriate skills necessary for functioning in home, school and community settings.

Psychosocial Rehabilitation may be provided through group modalities that offer an interactive setting for skill development, restoration, or enhancement. Services may assist the child/youth with implementing strategies introduced by clinicians in therapy. Skills areas such as coping/anger management, social/relationship, recreation, and relapse prevention are often addressed to facilitate community integration. Psychosocial Rehabilitation that focuses on facilitating *community integration* includes interventions and hands-on training to develop

or rebuild developmentally appropriate skills to interact with peers, establish/maintain friendships and a supportive social network. Psychosocial Rehabilitation that focuses on the development or rebuilding of age appropriate recreational/leisure skills provides opportunities for supervised application and practice of recreational skills, in the home and community or group setting (e.g. creative arts, sports, physical activities).

For transition age youth, Psychosocial Rehabilitation should target skills needed for personal independence and community integration, within the domains of employment, education, housing and community life (e.g. daily living skills such as food preparation, money management, health, leisure, self determination, communication, relationships).

For children and younger adolescents in particular, Psychosocial Rehabilitation may assist their parents/caregivers to implement more effective behavioral interventions for the benefit of their child, in order to better support the development of positive behavior. Needed areas of skill development are those that help parents/caregivers assist their child with developing age appropriate skills in areas such as self-regulation, frustration tolerance, problem solving. Parents may also be assisted to enhance skills to better recognize and respond to their child's triggers in order to prevent problem behaviors from escalating or crises from occurring. This also includes assisting parents to implement strategies introduced by clinicians in therapy.

H. Crisis Intervention Services:

Crisis intervention services are intended to interrupt and/or ameliorate a crisis or prevent a child/youth or family from experiencing an escalation of symptoms. Interventions may also include assessment of risk, immediate crisis resolution and de-escalation and the implementation or development of a safety plan to mitigate risk. Crisis interventions should stabilize the child/youth and family, deescalate the severity of the child's/family's level of distress and need for urgent care such as ED/hospitalization.

These also include necessary crisis-oriented remedial activities and interventions, such as medication or verbal therapy, designed specifically to address acute distress and associated behaviors when the individual's condition or family circumstance requires immediate attention, and/or could lead to hospitalization.

Youth ACT teams have the primary responsibility for crisis response and are the first contact for after-hours crisis calls. The Youth ACT team must operate a continuous and direct after-hours on-call system with staff that are experienced in the program and skilled in crisis intervention procedures. The Youth ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone. To ensure direct access to the Youth ACT program, children/families must be given a phone list with the responsible Youth ACT staff to contact after hours.

I. Medication Management Services:

These include a full range of medication services including prescribing and administering medication, reviewing the appropriateness of the individual's existing medication regimen, monitoring and evaluating target symptom response, monitoring the effects of medication on the individual's mental and physical health, ordering and reviewing diagnostic studies and ongoing lab monitoring. Additionally, may include rehabilitative counseling, education and skill-development to restore, as developmentally appropriate an individual's ability to obtain and self-administer medications which has been lost due to the onset of mental illness or a parent/caregiver's understanding and ability to administer medications for their child/youth, and recognize and cope with the side effects of the individual's medications.

J. Health Services:

These services include the gathering of data concerning the individual's physical health history and any current signs and symptoms, and the assessment of the information to determine the individual's physical health status and need for referral to appropriate medical services.

For children and youth, this may include screening and monitoring key health indicators and health risk services, including screening and preventive interventions such as weight assessment and counseling for nutrition and physical activity. This service also ensures that children/youth receive age appropriate screening, preventive and treatment interventions from their pediatric care providers.

K. Peer Support Services:

These are rehabilitative in nature and include an array of formal and informal services and supports provided by a peer with lived experience:

- *Family Peer Support Services (FPSS)* are provided to families by a peer with lived experience caring for a child who is experiencing social, emotional, developmental, medical, substance-use and/or behavioral challenges in their home, placement, school, or community. These services provide a structured strength-based relationship between a New York State credentialed Family Peer Advocate and the parent, family member or caregiver for the benefit of the child/youth. FPSS assist families with developing community connections and natural supports to enhance the quality of life by integration and supports for families in their own communities, as well as helping the family to rediscover and reconnect to natural supports already present in their lives. Other activities include: helping the family learn and practice strategies to support their child's positive behavior, assisting the family to implement strategies

recommended by clinicians, providing individual or group parent skill development related to the behavioral health needs of the child (i.e., training on special needs parenting skills).

- *Youth Peer Support Services (YPSS)* are formal and informal services and supports provided to youth by a New York State credentialed peer who has lived experience with mental health and/or co-occurring behavioral health challenges in their home, school and/or community. The services provided offer support necessary to ensure engagement and active participation of the youth in the treatment planning process and the ongoing implementation and reinforcement of skills. This service provides the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

L. Vocational/Education Services:

Services individually designed to prepare a youth to engage in paid or volunteer work or continuing education, and to succeed in a work or educational environment. Services are directed at teaching skills needed to work or study and facilitating appropriate work habits, acceptable job or classroom behaviors, and learning work or school requirements. These services may be needed for youth who are not already in receipt of such services under IDEA or ACCES-VR.

- *Pre-Vocational/Educational Services* are those services individually designed to prepare a youth to engage in paid work, volunteer work or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose mental illness or emotional disturbance does not permit them access to other prevocational services. The service is directed at teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.
- *Supported Employment Services* are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting. Services may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

4. Youth ACT Team

Youth ACT uses an interdisciplinary team approach to treatment, rather than an individual treatment model approach. The Youth ACT team has two capacity models and serves either 36 or 48 youth along with their family members and collaterals, as outlined in their individualized service plans. To the greatest extent possible, youth/families enrolled in ACT are the responsibility of the collective team, and not just one or two individuals on the team. Although youth can and will form a special bond with some individual team member, all members of the team should see all of the ACT enrolled youth/families and ensure access to all identified services on the individualized service plan. It is expected that a majority of recipients will be seen by a minimum of three (3) or more different staff members in a given month.

Within the scope of Youth ACT services, the team provides all needed and preferred services for the child/family. Except at points of transition, the Youth ACT team does not refer out for mental health related clinical, rehabilitative or support services. Youth ACT team has the capacity to provide the frequency and duration of staff-to-child/family contact required by each child's individualized level of need, service plan and their immediate needs, at any given time.

It is expected that Youth ACT team provides a minimum of six (6) visits per month, of at least 15 minutes, three (3) of which may be collateral. No more than one client or collateral contact per day shall be allowed as a billable service, except that two contacts per day shall be allowed as a billable service if one contact is face-to-face with the client and the other contact is face-to-face with a collateral. The two contacts must occur separately.

It should be noted, there are two billing rates for ACT; a full rate for those recipients who receive at least 6 contacts in a month and a partial rate for those recipients who are seen less than 6 but more than 2 times per month. The Youth ACT team has the capacity to increase and decrease contacts based upon daily assessment of the child's/family clinical need(s), with a goal of enhancing family functioning to foster stability. The team has the capacity to provide multiple contacts to children/families experiencing an increase in conflict and a rapid response to early signs of crisis.

Youth ACT has the capacity to provide support and skills development services to the child's/family's others/collaterals. Collateral contacts may include additional providers (e.g. school, probation), additional family members, friends, caretakers, or employers, consistent with the service plan and for the coordination of services. Youth ACT team has the capacity to provide services through group modalities, as clinically appropriate. For example, for

recipients with common diagnostic characteristics; or for supportive skill building or family psychoeducation.

4.1 Staffing Model

36 Slot Youth ACT Team Model:

The multidisciplinary team works with 36 recipients and their families. The total allocated FTE for the Team is 7 FTE staff as outlined below:

1. .5 FTE Team Leader (Team Management): (Licensed professional)
2. .50 FTE Prescriber (Psychiatrist)¹
3. 5 FTE- Clinical/Professional/Clinical Support staff
 - 2FTE MH Professional (Licensed Professional)
 - 2.5 FTE Peer Advocate/Clinical Support
 - 1FTE Family Peer Advocate and/or Youth Peer Advocate- Required to be a New York State Credentialed Family and/or Youth Peer
 - 1 FTE Clinical Support- BA with experience or MA preferred
 - .5 FTE- Youth ACT teams will determine the remaining .5- either additional Family Peer Advocate and/or Youth Peer Advocate OR additional Clinical Support
 - .5 FTE Team Leader (Licensed Professional)
4. 1 FTE Program Assistant (Office Assistant)

48 Slot Youth ACT Team Model:

The multidisciplinary team works with 48 recipients and their families. The total allocated FTE for the Team is 8.67 FTE staff as outlined below:

1. .5 FTE Team Leader (Support): (Licensed professional)
2. .67 Psychiatrist²
3. 6 FTE clinical staff
 - 3 FTE MH Professional (Licensed Professional)

¹* Psychiatric Nurse Practitioner (PNP) may fulfill the FTE due to lack of availability of Psychiatrist with approval from OMH- see appendices for waiver requirements

² Psychiatric Nurse Practitioner (PNP) may fulfill the FTE due to lack of availability of Psychiatrist with approval from OMH- see appendices for waiver requirements

- 3 FTE- Peer Advocate/Clinical Support Staff
 - 1 FTE- Family Peer Advocate and/or Youth Peer Advocate - Required to be a New York State Credentialed Family and/or Youth Peer); Youth ACT teams will determine percentage of Family Peer Advocate and Youth Peer Advocate
 - 1 FTE- Clinical Support- BA with Experience or MA preferred must
 - 1 FTE- Youth ACT teams will determine the remaining 1 FTE - either additional Family Peer and/or Youth Peer OR additional Clinical Support
 - .5 FTE Team Leader (clinical)
4. 1 FTE Program Assistant (Office Assistant)

4.2 Youth ACT Team

Each member of the Youth ACT team contributes to the generalist practice of ACT, in addition to provision of direct service in their respective specialty and training/coaching to the rest of their team. This approach allows collaboration among the team across all dimensions of ACT work from engagement to assessment to skill development to stabilization to transition from Youth ACT to community-based services.

This collaborative approach allows for flexibility for each Youth ACT team member to provide focused services, based on their specialty, to a subset of enrolled children/families while also offering general support to the remaining enrolled children/families, with the goal of offering tailored and adaptable services/supports to each child/family based on their unique needs at any given time.

Staff must have experience and capability to effectively treat children/youth with SED and severe mental, emotional and behavioral impairments commensurate with Residential Treatment Facility (RTF) or Community Residence (CR) level of care or histories of hospitalization, and families with complex, multi-system needs. A Youth ACT team is one that functions in an integrated manner, utilizing a multi-disciplinary approach to care that supports the needs of the “whole person” and family.

Staff must complete all required Youth ACT training as directed by the NYS OMH. Please reference the appendix for additional information on Youth ACT training.

4.3 Staff Roles and Qualifications

Team Leader – A full-time licensed professional staff member who directs and supervises staff activities, leads team organizational and service planning meetings, provides clinical

direction to staff regarding individual cases, conducts side-by-side contacts with staff and regularly conducts individual supervision meetings. The team leader is also responsible for direct services as a member of the professional staff, clinical supervision for staff, and the administration and leadership of the team, on an ongoing basis.

Psychiatrist – Must be currently licensed as a physician by the NYS Education Department and certified by, or be eligible to be certified by, the American Board of Psychiatry and Neurology. The psychiatrist, in conjunction with the team leader, has overall clinical responsibility or monitoring recipient treatment and staff delivery of clinical services. The psychiatrist provides psychiatric and medical assessment and treatment; clinical supervision, education, and training of the team; and development, maintenance, and supervision of medication administration and psychiatric and medical treatment and procedures.

Psychiatric Nurse Practitioner (in lieu of Dr or offsetting Dr. hours) must be currently licensed as a Psychiatric Nurse Practitioner by the NYS Education Department. The Psychiatric Nurse Practitioner (PNP), under the supervision of the psychiatrist and in conjunction with the team leader, has clinical responsibility for monitoring recipient treatment and staff delivery of clinical services. The PNP (when functioning to offset the psychiatrist hours) provides psychiatric and medical assessment and treatment; education and training of the team; and development, maintenance, and supervision of medication administration and psychiatric and medical treatment and procedures.

Licensed Mental Health Professional is licensed by the New York State Education Department and operate within the practitioner's scope of practice as defined in NYS law. These include, but are not limited to: Licensed Psychologists, Licensed Clinical/Masters Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, or Licensed Creative Arts Therapist. The licensed mental health professional is responsible for providing treatment to the child and their family/caregivers to address the clinical needs of the child and the complex needs of the family unit. Treatment interventions are to be individualized to the child/family and evidence-based practices should be used to address identified clinical and family system needs.

Peer Advocate – Peer specialists are in a unique position to serve as role models, educate recipients about self-help techniques and self-help group processes, teach effective coping strategies based on personal lived experience, teach symptom management skills, assist in clarifying rehabilitation. ACT teams must include at least one of the following types of peer advocates (Youth ACT teams will determine percentage of each based on need up to 1 FTE)

- *Family Peer Advocates (FPA)* are parents or caregivers who are raising or have raised a child with serious mental health concerns and are personally familiar with the associated challenges and available community resources for children and families.

The FPA must possess a credential recognized by the Office of Mental Health and receive specialized training and supervision.

- *Youth Peer Advocates (YPA)* are individuals, age 18 to 30 years old, who self-identify as a person who has first-hand experience with mental health and/or co-occurring behavioral health challenges. At a minimum a youth peer must, have a high school diploma, high school equivalency or a State Education Commencement Credential and possess a credential recognized by the Office of Mental Health, and receive specialized training and supervision.

Clinical Support Staff (BA experience or MA preferred) – Clinical staff are responsible for working with the child and family in support of identified treatment goals through discrete and targeted service interventions, such as skill development or training and education. The clinical staff support the child and family in acquiring the necessary skills and abilities to manage their health, improve family relationships, and develop opportunities for prosocial activities and interactions.

- The clinical staff who, in addition to performing routine clinical support team duties, also has lead responsibility for integrating educational and/or vocational goals and services with the tasks of all team members. This staff member provides needed assistance through all phases of the vocational service.

Program Assistant – Typically, a non-clinical staff member who is responsible for managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for recipient and program expenditures; and performing reception activities (e.g., triaging calls and coordinating communication between the program and recipients).

4.4 Team Function and Communication

Youth ACT staff function collectively and collaboratively on behalf of all program recipients as a team. Therefore, organizational staff meetings are held a minimum of four times a week. The team meeting is critical to facilitate frequent communication among team members about progress of each enrolled child/family and to help teams make rapid adjustments to meet any needs of the child/youth. If programs choose to meet the minimum of 4 times weekly, they need to develop mechanisms to share information on the non-meeting day about the status (progress, needs, status and interventions), to ensure that all team members are familiar with the current status of each enrolled child/family.

The organizational meetings should be short (no longer than one hour) and include the following elements:

- 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 and revisions, as needed.

In order to maximize collaboration, ACT teams must also maintain and utilize documentation processes to further communications among team members. Examples include the following:

- A weekly or monthly schedule of contacts and activities for each child/family organized in a notebook or file and maintained in a central location.
- A child/family monthly schedule board, on which is recorded future appointments and other important dates, that are not included on the current month scheduling board.
- A daily team schedule containing a list of child/family to be contacted and the interventions planned for each contact, scheduled paperwork time, supervision meetings and other rehabilitation and service activities scheduled to occur that day, to be maintained on a log board.
- A staff monthly schedule board, on which is recorded staff appointments, training dates that impact scheduling for enrolled member contacts.
- A daily communication system, tools for organization of the daily meeting and scheduling of recipient/staff contacts, and a significant event log or other intra-team communication system to make the team aware of high-risk situations or other safety issues which may need to be addressed in providing services.
- A child/family monthly contact log, in which is individually listed all the contacts and attempted contacts, phone contacts, collateral contacts, location, duration, a brief description of the contact and plan for the next contact.
- Significant child/family issues and observations made by staff between team meetings can be recorded in the daily log prior to the end of the staff person's workday and discussed at the next team meeting.
- A child/family goal board, on which is listed the name of each child/family in the program and the goals of that individual.
- A hospitalization log, in which is listed hospitalization information for each child.

4.5 Assessment

The Core of Youth ACT is a multi-disciplinary team process for ongoing assessment and person-centered service planning, conducted under the supervision of the team leader and the psychiatrist. The team develops a person-centered plan in partnership with the child/family to address all identified needs and preferences for services and supports. This

includes services provided directly by the ACT team, as well as services and/or activities that are naturally occurring in the community and provided by other community agencies.

Preliminary Assessment: An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral; 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

A Comprehensive Assessment, is completed within 30 days of admission and must include the following information:

1. Mental health history
 - a. Diagnosis
 - b. Medications
 - c. Behavioral health history/outcomes
 - d. Current providers, services or agency involvement

2. Needs and strengths
 - a. Current functioning, including description of the current symptoms and/or behaviors
 - b. Symptoms and severity
 - c. Safety/suicidality - assessment of risk, conducted using a standardized risk assessment tool that includes assessment of risk factors and level of severity (minimally including risk of self-harm, both suicidal and self-injurious behaviors and risk of violence), and perception of own risks and safety.
 - d. Living situation, including family functioning
 - e. Educational/vocational
 - f. Legal
 - g. Trauma
 - h. Medical/health
 - i. Social Supports
 - j. Resources - shelter, food, clothing

3. The child/family's choices including:
 - a. treatment and rehabilitative goals that are consistent with the purpose and intent of the Youth ACT program related to individual and/or family functioning or educational, social or recreational pursuits

b. skills and resources needed to achieve goals

The Comprehensive Assessment is updated at least every six (6) months at the Service Plan review; as well as whenever there are significant events or changes in life circumstances. If required assessment information is not obtainable, evidence of efforts to secure the information required for the completion of the Comprehensive Assessment should be documented on the assessment form and in the progress notes. The Comprehensive Assessment is approved and signed by the Team Leader or designated clinical supervisor.

A Child and Adolescent Needs and Strengths (CANS) Assessment: The CANS-NY assessment tool is a multi-purpose tool to support decision making regarding level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS-NY is to be used as a tool for communication with the client and their family to facilitate the linkage between the assessment process and the design of individualized service plans. The CANS-NY helps to provide the assessor, the family, and team members with a common language to use in the development, review, and update of the child's care plan. Designed to give a profile of the current functioning, needs, and strengths of the child and the child's parent(s)/family, the CANS can be used to track progress and demonstrate the need for an increase or reduction of service interventions. The CANS-NY includes a wider range of domains to better identify and address the multi-systems needs of the children served in OMH intensive community-based services. Completion of the CANS-NY is required within 30 days of admission, every six months thereafter and at discharge.

4.6 Service Planning

An individualized, child centered and family focused approach to service planning and implementation should be utilized to address the unique needs, preferences and strengths of the child and family/caregiver. While service planning and implementation is centered around the developmentally appropriate needs of the child, it takes into consideration the family/caregiver's integral role in the care and recovery of the child. It emphasizes shared decision-making approaches to empower the child and family/ caregiver, provide choice, minimize stigma and establish youth and family driven goals. The family participates as full partner to the extent possible and appropriate, in all stages of planning and decision-making including treatment implementation, monitoring and discharge.

A Comprehensive Service Plan is completed within 30 days of admission, with specific objectives and planned services necessary to facilitate achievement of the identified goals and needs. The service plan is strengths-based, culturally relevant, responsive to child/family preferences and choices, and shall include:

- The child's/family treatment goals, objectives (including target dates), preferred treatment approaches, and related services
- The child's/family educational, vocational, social, wellness management, living situation/family functioning or recreational goals; associated concrete and measurable objectives; and related services
- When psychopharmacological treatment is used, the plan must/include identification of target symptoms, medication, doses, and strategies to monitor effectiveness related to identified targeted symptoms/functioning
- A crisis plan developed in collaboration with the child/family to be utilized by the child/family and provider to assist in reducing or managing crisis related symptoms; promoting healthy behaviors; addressing safety measures; and/or preventing or reducing the risk of harm or diffusion of dangerous situations
- Input of all staff involved in treatment of the child/family
- Involvement of the child/family and others of the child's/family choice
- The approval and signature of the physician and the team leader or designated clinical supervisor involved in the treatment an
- Planned use of service dollars, if applicable.

The comprehensive service plan is reviewed and updated at least every 6 months, including:

- Assessment of the progress of the child/family in regard to the mutually agreed upon goals in the service plan
- Changes in child/family status
- Adjustment of goals, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate.

The child's/family participation in service planning and approval of the service plan are evidenced in the planning process and documented by the child's/family signature. Reasons for non-participation shall also be documented in the case record.

Service contacts and attempted contacts are documented in the progress notes. Such notes shall identify the services provided and specify their relationship to a particular goal or objective documented in the service plan. Progress notes must document progress or lack of progress toward goals, significant events and the child's /family response to the service provided. Gaps in services should be documented. The progress note shall contain the date and location of contact and be signed by the person who provided the service.

Service dollars spent, and their related treatment objectives, are documented in progress notes. ACT service dollar guidance can be found here:

<https://omh.ny.gov/omhweb/guidance/service-dollar-guidance.pdf>

4.7 Case Records

There shall be a complete case record maintained at one location or electronically for each recipient. The case record shall be confidential, and access shall be governed by the requirements of sections 33.13 of the Mental Hygiene Law.

Each case record shall include:

- identifying information about the child and the child/family's support system
- a note upon admission indicating source of referral, date of admission, rationale for admission, the date service commenced, presenting problem and initial treatment needs
- summary of psychiatric, medical, emotional, and social needs
- reports obtained of any mental and physical diagnostic exams, assessments, tests, and consultations
- record and date of contact with the child, the type of service provided and the duration of contact
- record and date of all contact with collateral provider for coordination of care
- dated progress notes which relate to goals and objectives of treatment
- dated progress notes which relate to significant events and /or untoward incidents
- a comprehensive service plan
- record of service plan reviews
- a safety plan
- Consent forms; and
- a discharge summary, which includes the reasons for discharge and, if appropriate, the provision for alternative services which the child or family may require, should be available on day of discharge.

Records must be retained for a minimum period of six years from the date of the last service provided to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer.

5. Program Operations

Youth ACT is available seven days a week, 24 hours a day by direct phone link and is regularly accessible to children/families during the daytime/evening hours. Since most youth will be engaged with school or employment, service hours are expected to also be provided and staff accessible during afterschool, evening and early night hours. Teams may utilize a split staff assignment schedule to achieve this coverage.

5.1 Eligibility

A child must meet all the following admission criteria:

1. Child must be at least 10 at the time of enrollment and may be served up to the age of 21.
2. A determination of Serious Emotional Disturbance (SED) defined as:
 - A child or adolescent having a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorder AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:
 - Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
 - Family life (e.g. capacity to live in a family or family-like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
 - Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
 - Self-direction/self-control (e.g. ability to sustain focused attention for long enough to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
 - Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).
3. Have continuous high service needs that are not being met in more traditional service settings demonstrated by two or more of the following conditions:
 - Child and/or family has not adequately engaged or responded to treatment in more traditional settings.
 - High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
 - High use of psychiatric emergency or crisis services.
 - Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
 - Residing or being discharged from in an inpatient bed, residential treatment program, or in a children's community residence, or being deemed eligible for RTF, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. This may also include current or

recent involvement (within the last six months) in another child-serving system such as juvenile justice, child welfare, foster care etc. wherein mental health services were provided.

- Home environment and/or community unable to provide necessary support for developmentally appropriate growth required to adequately address mental health needs.
- Clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., children's community residence, psychiatric hospital or RTF) without intensive community services.

3. Child's County of Residence is within program catchment area (county(ies) licensed to serve).

Note - Individuals with a primary diagnosis of a personality disorder(s), or solely a substance abuse disorder without having a co-occurring and significant mental health needs and diagnosis, are not appropriate for Youth Act.

Children with Developmental Disabilities: Children with an IQ of 51 and above may be eligible for Youth ACT. Youth ACT is equipped to serve children whose IQ is 70 and above. For children whose IQ is 51-69, determinations will be made on a case by case basis.

5.2 Admission Process:

Admission to Youth ACT is managed through a local Children's Single Point of Access (C-SPOA). Inpatient psychiatric units, residential treatment facilities, children's community residences, mental health outpatient programs, children and/or families, Medicaid Managed Care plans and other referral sources submit referrals for Youth ACT to C-SPOA in their County.

There are special referral considerations for transition age youth (TAY ages 18-21), as both Youth and Adult ACT teams can serve TAY individuals. For individuals on Assisted Outpatient Treatment (AOT) C-SPOA must make a referral to an adult ACT team as they have the expertise to serve these individuals. However, for those individuals not on AOT C-SPOA should take into consideration individual choice and the developmental and clinical needs of the individual.

The number of admissions per month should not exceed the range of 4-6, particularly for newly licensed teams that are attempting to fill up to full capacity. Consideration should be given to the fact that, during the weeks following admission, children/families will need the most intense services and that significant initial effort will be required to engage the

child/family and complete the assessment process and to begin to address many unmet needs e.g. housing, entitlements, medical care and stabilizing psychiatric symptoms.

An admission decision must be made within seven (7) consecutive days of the receipt of the initial referral, unless indicated by the local municipality to be different due to the needs of that community.

Upon the decision to admit a child/family to the ACT program, a screening and admission note shall be written, to include:

- a. The reason(s) for referral
- b. Immediate clinical and other service needs for the child/family to attain or maintain stability
- c. Admission diagnoses

When an admission is not indicated, notation shall be made of the following:

- a. The reason(s) for not admitting
- b. The disposition of the case; and
- c. Any referrals or recommendations made to the referring agency, as appropriate

The child/family decision not to take medication or a history of refusal or disengagement from services is not a sufficient reason for denying admission to a Youth ACT program.

5.3 Discharge Process

Youth ACT services are youth focused and family driven with no prescribed enrollment or length of stay.

Children/Families that meet any of the following criteria may be discharged:

- the child and family no longer want to receive services through Youth ACT
- all parties involved concur that the child has met the goals of his/her Individualized Service Plan and no longer requires Youth ACT services
- the child no longer meets the definition of SED or has complex mental health needs requiring ACT level of care
- Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the Youth ACT program upon their release from the hospital or jail
- The child has been admitted to another program (Community Residence, RTF)
- The child turns 21
- The child is deceased

- The child/family moves out of the geographic area served by the Youth ACT team in which they are enrolled. The Youth ACT team is responsible for transfer of mental health service to an appropriate provider and must maintain contact with the child/family until the provider and the child/family are engaged in this new service arrangement.

For all children/families discharged from Youth ACT to another service provider within the team's primary service area or county, during the three-month transfer period, if the child/family do not adjust well to their new program; they may, in collaboration with the team, decide to voluntarily return to the Youth ACT program. Notification must be made to the local single point of access process coordinator for persons being discharged to other programs managed through the C-SPOA process.

The agency shall develop and maintain a procedure regarding discharge and transmits discharge summaries with appropriate content to receiving program.

6. Required Organizational Processes

The following sections detail the organizational processes required for Youth ACT program.

6.1 Program Site Requirement

While services under Youth ACT are provided in the home and community, programs are required to ensure office locations are compliant with the following site requirements:

- Persons (children/families, staff, and visitors) shall be safe from undue harm while they are at the program site.
- Persons (children/families, staff, and visitors) with various disabilities shall have access to appropriate program areas. Programs shall adjust service environments, as needed, for recipients who are blind, deaf, or otherwise impaired.
- Programs shall have sufficient furnishings, adequate program space and appropriate program-related equipment for the population served.
- Medications and case records shall be stored according to applicable laws to ensure only authorized access.

6.2 Responsibilities for Hospitalized ACT Enrollees

Youth ACT Teams are closely involved in hospital admissions and hospital discharges in order to ensure continuity and coordination of services, and to be a support and advocate for recipients.

When a child is hospitalized, the Youth ACT team should take the following steps to coordinate with the clinical staff at the hospital:

- a. Contact the child's responsible physician/treatment team to familiarize them with Youth ACT assessment findings and the child's individualized service plan, including medication regimen.
- b. Provide both the child and the family with support during the hospitalization, facilitating and assisting with all therapeutic interventions including family visits with the child
- c. Advocate with collaterals in the community to maintain current services and social supports
- d. Work with the discharge staff and child/family to formulate the child's discharge plan.

The Youth ACT team may receive reimbursement for services to recipients admitted for treatment to an inpatient facility, pursuant to the requirements of Part 508 Medicaid Assistance Rates of Payment for Youth ACT Services.

6.3 Quality Improvement and Leadership

Strong team leadership is critical to improving organizational performance. Clinical leadership on the Youth ACT team is provided through the direction of the physician and the team leader. Administration and team leadership is the responsibility of the team leader. Leadership will include a daily review of each child/family's progress in treatment, and barriers to achieving their goals. Leadership will also include provision and oversight of adequate and appropriate supervision.

6.4 Internal Utilization Review

The Agency shall maintain a systematic utilization review process which is conducted by individuals who are appropriately credentialed and do not provide direct care to the Youth ACT recipients he/she reviews.

The Agency will develop a process to systematically monitor, analyze and improve the performance of the Youth ACT team in assisting children/families to achieve their goals. This will include the development of a quality improvement plan consistent with the mission and values of the Youth ACT program.

7. Referrals & Discharges: Allowable Reimbursements & Exclusions

Youth ACT staff provide most of the services required by Youth ACT recipients. Therefore, Youth ACT providers are prohibited from billing the Mental Health Medicaid Program for any

costs over and above the Youth ACT case payment and other providers are excluded from billing for certain services for individuals enrolled in Youth ACT. The non-billable services for Youth ACT recipients are: licensed day treatment program for children, Residential Treatment Facilities (RTF), Children's Community Residence (CCR), and licensed outpatient clinic. Home and Community Based Services (HCBS) and Children and Family Treatment Supports and Services (CFTSS) and non-billable unless during the transition period in which Youth ACT can be billed using the partial rate (see Section 7.2).

Youth ACT programs are permitted to bill Medicaid for any month in which a recipient is receiving only pre-admission from a clinic. It is not expected that Youth ACT programs will provide substance abuse treatment. There may be instances in which Youth ACT recipients require substance abuse services (e.g. detoxification, rehab or outpatient). Therefore, ACT recipients can receive services rendered by substance abuse providers and ACT teams simultaneously and, as appropriate, these providers can bill Medicaid for such services.

Individuals on Assisted Outpatient Treatment (AOT) must be served by adult ACT team as they have the expertise to serve these individuals. Therefore, if an individual is enrolled in Youth ACT and is placed on an AOT order that individual must be transitioned to an adult ACT team.

7.1 Referrals for Children transitioning from a Higher Level of Care

Upon receipt of a referral, from C-SPOA, for a youth in an inpatient setting, including Residential Treatment Facilities, the Youth ACT team should begin engagement activities with the referral source and the child/family. Ideally, engagement should begin 30 days prior to discharge to ensure Youth ACT enrollment and service delivery as soon as the child returns to his/her home community.

7.2 Transition from Youth ACT to Child Family Treatment Supports and Services (CFTSS) and/or Home and Community Based Services (HCBS):

A child/family that has been determined ready for transition from Youth ACT to a lower level of care may be both an active Youth ACT client and enrolled in CFTSS and/or HCBS 30 days prior to discharge from Youth ACT. The Youth ACT team should make referrals and linkages to CFTSS and/or HCBS based on family choice of service(s) and provider(s).

Reimbursement for services provided to clients who are receiving both ACT and CFTSS or HCBS will be limited to the ACT partial payment rate.

8. Reporting and Compliance Requirements

8.1 Background Checks

OMH Licensed providers must adhere to the criminal background check requirements under the Justice Center in accordance with MHL Section 31.35 and 14 NYCRR 550 (see OMH Justice Center website for more information: [Justice Center Background Information \(ny.gov\)](https://www.omh.ny.gov/justice-center/background-information)) and clearance requirements under NYS Social Services Law Section 424 regarding the child abuse and neglect registry.

8.2 Incident Reporting

Incidents are reported into the NYS Incident Management Reporting System (NIMRS) immediately upon discovery of the incident. NIMRS is a web-based application that is available on the browser 24 hours a day, 7 days a week.

Guidance on incident reporting can be found here:

https://omh.ny.gov/omhweb/dqm/bqi/nimrs/regulations/inciden_management_field_guide.pdf

8.3 Mandated Reporting

All Youth ACT programs shall comply with the provisions governing the reporting of suspected child abuse or maltreatment, as set forth in sections 413-416 and 418 of the Social Services Law.

8.4 Required Data Collection - CAIRS (Child and Adult Integrated Reporting System)

NYSOMH developed the CAIRS system to collect, analyze, trend, and report recipient data and outcomes. NYSOMH requires that Youth ACT teams complete the Baseline Assessment Form (BASf) and the Follow-up Assessment Form (FUAF) and Discharge on the CAIRS system at prescribed time intervals. The CANS-NY must also be entered into CAIRS on the same time intervals. The agency is responsible to develop and maintain a procedure that ensures the timely entry of this information by the Youth ACT team.

Youth ACT teams may be required to report additional data as required by NYSOMH.

8.5 Consolidated Fiscal Reporting

Agencies with Youth ACT must complete an annual Consolidated Fiscal Report (CFR) as a licensed program under the Office of Mental Health. More information can be found here [Service Dollar Guidance](#)

9. MCO Utilization Management

MMCO members should be referred for ACT services as follows:

A referral is made to C-SPOA who, in collaboration with the referral source to ensure all relevant information is communicated, contacts the MMCO to request a Youth ACT Level of Service Determination (LOSD). C-SPOA, along with the referral source, and MMCO utilization manager review whether the member meets Youth ACT level of care admission criteria. Simultaneously, C-SPOA assesses for capacity/availability of Youth ACT slot. The MMCO notifies C-SPOA that a LOSD for Youth ACT admission has been made. The MMCO must make the Level of Service Determination within 24 hours. Once LOS is determined, and if approved, C-SPOA will process a referral to Youth ACT.

If the member is assigned to a waiting list, the C-SPOA will communicate with the referring provider, MMCO and other providers as needed to ensure adequate supportive services while waiting for Youth ACT services.

The C-SPOA will attempt to assign members to an in-network Youth ACT. If the Youth ACT slot is with an out-of-network provider, the SPOA will assign to the available Youth ACT team and the MMCO reimburse out-of-network ACT services with or without an executed out-of-network agreement.

The accepting Youth ACT team will contact the MMCO within seven (7) days prior to the date of admission to obtain the prior authorization and determine a timeframe for concurrent review.

It is the responsibility of the Youth ACT team to notify the C-SPOA and the MMCO when the individual is discharged from a Youth ACT program.

Utilization Management for ACT – Authorization and Concurrent

Pursuant to Section 10.21(a) of the Medicaid Managed Care Model Contract, MMCPs must adhere to utilization management and level of care guidelines for making initial and ongoing mental health level of care decisions and with utilization management criteria approved by the Office of Mental Health. In addition, MMCPs must utilize evidence-based, peer reviewed, and age-appropriate medical necessity criteria that has been reviewed and approved by the Office of Mental Health, in consultation with the Department of Health, as required by NYS Public Health Law §4902. When developing medical necessity criteria MMCPs must ensure alignment with service criteria outlined herein and utilization management guidance in the [Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services](#)

1. Streamlining communication between MMCOs and ACT Teams for authorization requests. To ensure delivery of appropriate care that meets the members' needs, the following is recommended:

- a) MMCOs must identify and track members who are in ACT. MMCOs are expected to use Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other internal data systems (such as claims, UM/UR) at least monthly to update their internal records to ensure MMCO staff are aware of members in ACT (refer to OMH guidance "Using PSYCKES to identify members with Assisted Outpatient Treatment (AOT) orders and/or who receive Assertive Community Treatment (ACT) services", 12/9/2016).
- b) MMCO UM staff who conduct prior authorization and concurrent reviews should have focused training in ACT principles. When possible, MMCOs should consider identifying specific UM primary staff, and a secondary staff, who will conduct all ACT prior authorization and concurrent reviews.
- c) ACT Teams should also have a primary point of contact, and a secondary contact, who is a clinician familiar with MMCO requirements, timelines and procedures around authorization requests. Scheduling reviews ahead of time is strongly recommended to ensure points of contacts from MMCO and ACT are available and prepared for the review. Scheduling reviews ahead of time is strongly recommended to ensure points of contact from MMCO and ACT are available and prepared for the review.
- d) MMCOs should develop and distribute to ACT Teams a list of required documentation that is routinely required for prior authorization/concurrent review. Additional clinical information may be required by the MMCOs on a case by case basis.

e) ACT Teams should send required documentation as referenced above (e) or if requested, assessments, service plans and POCs to the MMCOs prior to scheduled meetings so they can review them.

2. Timeframes to Begin Concurrent Review Process are listed in the Medicaid Managed Care Model Contract (Appendix F). The parameters for Service Authorization Determinations listed in the Medicaid Managed Care Model Contract are made to maintain continuity of care for individuals, and continuity of payment for service providers.

It is recommended that ACT providers and MMCOs put processes in place to identify members with expiring authorizations and begin the concurrent authorization request process no later than 14 days before the end of the current authorization period, to avoid lapses in payment and unnecessary expedited reviews.

3. Concurrent Review - OMH requires the following schedule of assessments and care planning for ACT recipients under the NYS Medicaid fee-for-service program:

- Immediate needs assessment is completed within 7 days of receipt of referral;
- Initial Comprehensive Assessment and Comprehensive Service Plan is completed within 30 days of admission;
- The Comprehensive Assessment is updated, and the Comprehensive Service Plan is reviewed at least every 6 months.

Aligning concurrent review with assessment and service plan dates (6-months) will allow MMCOs to have the most up-to-date documentation. However, this should not prevent MMCOs and ACT teams from communicating at any time to ensure provision of person-centered care. ACT documentation utilized for UM procedures may include any current documentation such as the Comprehensive Assessment, progress notes or the Comprehensive Service Plan.

4. Submitting Authorization Requests - It is recommended that ACT providers and MMCOs put processes in place for ACT Teams faxing documentation, such as an ACT team calling or emailing the MMCO contact to verify that the MMCO received the fax and/or to let the MMCO know that the fax was sent.

5. Unit of Service - Behavioral Health Billing Manual (pg7): ACT services are billed **once per month** using one rate code for the month's services. There are three (3) types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial, or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service.

ACT must therefore be reimbursed on a monthly basis using the full, partial or inpatient State rate. These rates include required contacts, as outlined in regulation. MCOs may not authorize “partial months” of ACT, or units of service defined by number of contacts within the month. ACT may only be authorized in months as each month is considered 1 unit of ACT service (1 unit = 1 month of ACT service). If the MMCO and a provider want to negotiate an alternative reimbursable approach, they will need to come to the State for approval.

Appendices

A. Youth ACT Program Guidelines Waiver for Psychiatric Coverage

The Office of Mental Health recognizes the importance of the psychiatrist's role on a Youth Assertive Community Treatment (ACT) team. The psychiatrist, in conjunction with the team leader, exercises overall clinical responsibility for monitoring treatment and staff delivery of clinical services. The psychiatrist provides psychiatric and medical assessment and treatment; clinical supervision, education, and training of the team; and supervision of medication administration

OMH is aware of the difficulties Youth ACT programs may have experienced in recruiting and retaining psychiatrists and recognizes the increasing need for flexibility when a psychiatrist is not available. Therefore, OMH will accept a Youth ACT Program Guidelines Waiver Request for a time-limited approval to allow ACT teams to utilize a licensed PNP for the team in either of the following ways:

- a. Split time between a psychiatrist and a PNP when combined equal the total scheduled psychiatric coverage - at a minimum of .50 FTE for the 36 slot model or .67 for the 48 slot model

OR

- b. A PNP scheduled .50 for the 36 slot model or .67 for the 48 slot model for psychiatric coverage, who will receive supervision from a psychiatrist, through a supervisory agreement/contract if applicable.

ACT Program Guidelines Waiver Request Procedure

To receive a waiver, Youth ACT teams will need to submit a Youth ACT Program Guidelines Waiver for Psychiatric Coverage Request Form to the local OMH Field Office. Requests will be reviewed by the Field Office, Central Office, and OMH Chief Medical Officer(s), and will also be shared with the Local Government Unit (LGU).

ACT Program Guideline Waiver Requirements

The following ACT Program Guideline Waiver Requirements must be met at time of waiver request and must continue to be met during the waiver period:

1. The PNP must be currently licensed as Psychiatric Nurse Practitioner by the NYS Education Department.
2. The PNP must be supervised by a psychiatrist on the team, from within the agency, or external psychiatric supervision may be permitted in situations where a psychiatrist is not available from within the agency. A supervisory agreement with the psychiatrist must be completed and submitted with the request (only needed for option b. above).

The supervising psychiatrist should have a clear understanding of the NYS ACT Program model, and associated guidelines and regulations. Supervision will include PNP consultations, pharmaceutical consult, and caseload supervision. The supervising psychiatrist must provide no fewer than four (4) hours of supervision per month.

- a. Examples of internal psychiatric supervision: ACT team psychiatrist, agency medical director, psychiatrist at another program within the agency.
 - b. Examples of external psychiatric supervision: OMH licensed programs in community, private psychiatrist, contract for remote supervision with a psychiatrist licensed and based in NYS.
3. The PNP in conjunction with the team leader, will have overall clinical responsibility for monitoring recipient treatment and staff delivery of clinical services. The PNP provides psychiatric and medical assessment and treatment/ clinical supervision, education and training of the team; and supervision of medication administration.
 4. PNP shall attend the daily meeting on scheduled workdays at a minimum of three (3) days/week.
 5. Consistent with ACT program guidelines, the PNP will have scheduling flexibility and, when needed, can see children/youth on a weekly basis. The PNP must provide community-based services as per the following:
 - a. The PNP must complete an initial assessment visit in the community
 - b. If the recipient will not meet the PNP at the Youth ACT office, the PNP must provide services in the community at least monthly, or as clinically indicated for that individual.
 6. PNP must complete all required trainings as identified by OMH

B. Training, Staff Development and Core Competencies

At hire, all clinical staff on an ACT team must have experience in providing direct services related to the treatment with families and children with serious emotional disturbance. Staff should be selected consistent with the Youth ACT guiding principles (See Section 2) and experience in delivering the Youth ACT services (See Section 3). Clinical staff should have demonstrated competencies in screening and assessment, clinical approaches/treatment (that may include evidence-based practices), family therapy/family system approaches, and clinical documentation.

All staff will demonstrate basic core competencies in designated areas of practice, including the Assertive Community Treatment core processes, system of care/multi-system work, family psychoeducation and motivational interviewing.

The agency ensures that the Youth ACT staff receives appropriate and ongoing professional training. Youth ACT teams will be required to complete all trainings as directed by OMH.

The Youth ACT team must also complete CANS-NY training and be CANS-NY certified.

Safety Plan for Youth ACT team

The Youth ACT team provides services in the community where children/families live, attend school, work, socialize, and recreate. Safety of the staff in the community is an important feature of the Youth ACT model. The agency must develop a comprehensive safety plan specific to the Youth ACT team and ensure that all staff are trained in community safety and routinely follow the safety plan.

Core competencies

Screening and Assessment:

- Screening for social determinants of health; understanding of ACES; knowledge of and linkage with the larger community and service system through which to address needs
- Screening for mental health- depression, anxiety, ADHD
- Trauma screens (e.g. UCLA PTSD Reaction Index scale; ACES) or other diagnostic tools where appropriate
- Risk screening and assessment (e.g. Columbia Suicide Severity Rating Scale)
- Substance use screening and assessment (e.g. Screening, Brief Intervention, and Referral to Treatment - SBIRT)
- Adaptive behavioral assessment (e.g. Vineland Adaptive Behavior Scales)
- Vocational assessments

Clinical approaches/treatment models that may include evidence based and promising practices such as:

- Motivational Interviewing for ongoing engagement of youth and families with complex needs
- System of care; multi-systems approaches to involve the active coordination of care of the child/youth and family with multidisciplinary providers, agencies, community resources and supports
- Family therapy/family systems approaches consistent with the range of developmental stages of the children/youth to be served
- Behavioral interventions for severe behavior disorders, co-occurring learning disorders or limited cognitive functioning
- CBT, DBT core competencies to treat prevalent severe symptomatology of anxiety, depression, dangerous and self-harming behaviors, hyperactivity, impulsivity/dysregulation, trauma

- Integrated treatment for co-occurring SUD; stage-wise treatment approaches (e.g. Stages of Change) using MI practice technique
- Family Psychoeducation model for families to gain greater knowledge of mental illnesses and emotional or behavioral disorders in order to reduce stress, confusion, and isolation
- Evidence-based parenting programs (e.g. Parent Management Training; Strengthening Families) for children with moderate to severe behavioral difficulties
- Family Peer support with lived experience in caring for child with mental, emotional or behavioral impairments
- Youth Peer support with lived experience with mental, emotional or behavioral impairments

C. Definitions

Children’s Single Point of Access(C-SPOA) - Lead contact in county for Children’s Mental Health Services. Manages referrals, vacancies and waitlists for high end services and community programs.

Child Family Treatment and Support Services (CFTSS) means an array of six treatment, rehabilitative and support services to assist children and youth with mental health and/or behavioral challenges to function successfully within their homes and community, primarily provided in nontraditional settings including in the home or community settings.

Collateral - A contact that shall occur with the recipient’s family, and others significant in their life, that provide a direct benefit to the recipient and is conducted in accordance with, and for the purpose of, advancing the recipient’s Service Plan; and for coordination of services with other educational, community service providers and medical providers.

Contact means a face-to-face interaction of at least 15 minutes duration where at least one ACT service is provided between an ACT team staff member and a client or collateral.

Family means those members of the recipient’s natural family, family of choice, or household who interact with the recipient and are directly affected by, or have the capability of affecting, the recipient’s condition.

Home and Community Based Services (HCBS) means services provided to individuals in the least restrictive environment possible by providing services and support to children and their families at home and in the community. HCBS are designed for people who, but for these services, would require an institutional level of care such as a long-term care facility or psychiatric inpatient care.