Youth Assertive Community Treatment (ACT)

Program and Billing Guidance Document

February 2024

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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 youth ages 10 up to 21,[1] 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 and youth with significant psychiatric needs, who are at risk of institutional level of care, who require intensive interventions to adequately support the child's and family's complex needs, in order to avoid high end services or support a successful transition back to community, would benefit from Youth ACT.

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 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] Youth ACT services can be delivered with no limitation in the month of a client's birthday. An enrolled youth can receive all Youth ACT services, and all will be billable for the month in which they turn 21 and would be discharged at the end of the month.

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:

1. All ACT programs must be certified (licensed)[2] by NYS OMH
2. Certification as an ACT program requires a comprehensive application for PAR pursuant to The Official Compilation of the Codes, Rules and Regulations of the State of New York, 14 NYCRR Part 551.
3. These guidelines are the NYS OMH standards for licensed ACT programs. The Commissioner of the NYS OMH must approve any waivers to these standards

Information about licensing, PAR, and relevant laws and regulations can be found on the NYS Office of Mental Health Bureau of Inspection and Certification website.

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

[2] In order for a Youth ACT team to be licensed the following staff must be hired and onboarded: team lead, prescriber, one licensed mental health professional and program assistant.

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 connection 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, and 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. Additional screening or assessment tools can be used based on diagnostic indicators or other areas of need identified for the child/youth.

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 as 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. The Youth ACT program is expected to collaborate with other providers of service for care coordination purposes. 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 during operating hours and are the first contact for after-hours crisis calls. 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 the after-hours on call number.

The Youth ACT team must operate a continuous and direct after-hours on-call procedure with staff members who are experienced in behavioral health crisis intervention procedures. The on-call staff must be able to respond rapidly by phone or in person as needed. Of note, the Program Assistant, and Family and Youth Peer Advocates are not included in the after-hours on call Procedure.

If a Youth ACT team is using an alternate on call procedure outside of the Youth ACT team, the agency must first receive approval from OMH Central Office prior to changing procedures. In addition, if a team is experiencing staffing shortages that result in an inability to meet the requirements of the after-hours crisis response and need to temporarily utilize an alternate on call procedure outside of the Youth ACT team, the agency must first receive approval from OMH Central Office prior to changing procedures. Approval will be granted for intervals no longer than three months at a time.

When responding to crisis during operating hours teams are encouraged to include a range of team members, including the Family and/or Youth Peer Advocates to promote the multi-disciplinary team approach.

Crisis situations often arise with some amount of forewarning and planned interventions should be discussed through ACT team meetings. In addition, as part of the comprehensive service plan development, an individualized crisis plan must be developed in collaboration with the child/family. The plan should 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 hard or diffusion of dangerous situations.

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 Youth Peer Advocate 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 28 or 36 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.

Note: It is expected that the team, with the exception of the Psychiatrist/Nurse Practitioner of Psychiatry (NPP), conducts a *minimum of 80% of contacts* in the community.

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. 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

Youth ACT team composition should include 10 or fewer individuals per team member (10:1), this ratio excludes psychiatric practitioners and program assistants.

28 Slot Youth ACT Team Model:

The multidisciplinary team works with 28 children/youth and their families. The total allocated FTE for the Team is 7 FTE staff as outlined below:

1. 0.5 FTE Team Leader (Team Management): (Licensed professional)
2. 0.5 FTE Psychiatrist or NNP that equals 0.5 FTE. Or a combination of Psychiatrist/NPP that equals 0.5 FTE
3. 5 FTE- Clinical/Professional/Clinical Support staff
    - 2 FTE MH Professional (Licensed Professional)
    - 2.5 FTE Peer Advocate and Clinical Support
        - 1 FTE Advocate- Either Family Peer Advocate or Youth Peer Advocate. Required to be a New York State Credentialed Family or Youth Peer
        - 1 FTE Clinical Support- BA with experience or MA preferred
        - 0.5 FTE- Youth ACT teams will determine the remaining 0.5 - either additional Family Peer Advocate OR Youth Peer Advocate OR additional Clinical Support
    - 0.5 FTE Team Leader (Licensed Professional)
4. 1 FTE Program Assistant (Office Assistant)

36 Slot Youth ACT Team Model:

The multidisciplinary team works with 36 children/youth and their families. The total allocated FTE for the Team is 8.67 FTE staff as outlined below:

1. 0.5 FTE Team Leader (Support): (Licensed professional)
2. 0.67 Psychiatrist or NPP that equals 0.67 FTE. Or a combination of Psychiatrist and NPP that equals 0.67 FTE.
3. 6.5 FTE clinical staff
    - 3 FTE MH Professional (Licensed Professional)
    - 3 FTE- Peer Advocate and Clinical Support Staff
        - 1 FTE- Advocate- Either Family Peer Advocate or Youth Peer Advocate. Required to be a New York State Credentialed Family or Youth Peer
        - 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 OR Youth Peer OR additional Clinical Support
    - 0.5 FTE Team Leader (clinical)
4. 1 FTE Program Assistant (Office Assistant)

The slot size of the Youth ACT team takes into account the nature of serving youth and their families with complex needs. Effective treatment services for children/youth with SED are predicated on collaboration and support being provided to the parents/caregivers of the youth and family unit as a whole. Further, since children/youth are engaged with a variety of other child serving systems, by the nature of their age and the system involvement that often accompanies complex needs, the team is expected to also have a wider variety of collateral contacts with other individuals serving or regularly engaged with the child/youth.

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 mental health professional 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 of 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 for medical and psychiatric purposes which may include long-acting injectables.

Nurse Practitioner of Psychiatry (NPP) (in lieu of Dr or offsetting Dr. hours) must be currently licensed as a Nurse Practitioner of Psychiatry by the NYS Education Department. The Nurse Practitioner of Psychiatry (NPP), under the supervision of a psychiatrist and in conjunction with the team leader, has clinical responsibility for monitoring recipient treatment and staff delivery of clinical services. The NPP provides psychiatric and medical assessment and treatment; clinical supervision, education and training of the team; and development, maintenance, and supervision of medication administration for medical and psychiatric purposes which may include long-acting injectables. The NPP must practice in accordance with NYS practice requirements . Any supporting documentation must be available for review.

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.

Once a team is licensed[3] OMH allows flexibility in staffing for the remaining Mental Health Professional roles. OMH will allow limited permit holders to be hired as Mental Health Professionals for the second and third FTE, depending on the staffing model of the team. Limited Permit Holders are allowed to practice under a qualified supervisor while working to obtain the experience and/or examination requirement for licensure based on their degree. Limited Permit Holders will follow State Education (Office of the Professions) requirements surrounding their Limited Permit. Further, agencies will be expected to have a plan in place to support the Limited Permit Holder in obtaining their license.

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.

[3] In order for a Youth ACT team to be licensed the following staff must be hired and onboarded: team lead, prescriber, one licensed mental health professional and program assistant.

- 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.

If the individual applying for either role is not Credentialed, either full or provisional, the agency is responsible for ensuring the individual is qualified for the credential. The individual should submit an application to Families Together of NYS, which is the NYS recognized credentialing body, to determine eligibility. If the individual is approved to apply this can be used as a pre-qualification for hire. The individual must then complete the full credentialing process.

The process to become credentialed can be found here: Family Peer Advocate Credential - Families Together in NYS (ftnys.org) and YPA Credential - Families Together in NYS (ftnys.org).

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. Teams 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. Brief review of prior on-call contacts since the last staff meeting
e. Updates and revisions to the daily staff assignment schedule.
f. Service plan reviews and revisions, as needed.

To optimize teamwork, communication and individual services, Youth ACT teams keep pertinent information in a central location that can be easily updated and is rapidly accessible by all staff. Tools that can be used for this Centralized Communication System include, but not limited to, white/smart boards or electronic platforms in a central location easily accessible by all staff. Information to be accessible should include:

- 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. In partnership with the child/family the team develops a person-centered plan 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.

Immediate Needs Assessment: An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of an admission; any reason for delay should be documented. 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-NY 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 plan must be signed by a LMHP. If the person completing the service plan is not a LMHP, both they and an LMHP must sign the service plan
- 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 Progress Notes

Service contacts and attempted contacts are documented in the record. Progress notes shall identify the particular services provided and specify their relationship to a particular goal or objective documented in the service plan.

Youth ACT teams should ensure that reimbursement is made for services identified and provided in accordance with an individual's goals and needs. In practice, the nature and intensity of Youth ACT services and goals are continuously adjusted through the process of daily team meetings and review of individual needs. Based on the individual's current needs and circumstances, services may be altered in order to avoid hospitalization or increase stability in the community. In these circumstances, the rationale should be clearly documented in the case record as to why the service was provided and is not identified in the service plan.

Progress notes should include date; location the service was provided; length in minutes of contact; documentation of service provided and specify their relationship to a particular goal or objective documented in the service plan or rationale why a service was needed that is not identified in the

service plan; progress or lack of progress toward goals; address significant events, as applicable; contact with collateral, as applicable; Service dollars spent and their related treatment objectives, as applicable; and signature of the person who provided the service and if the service was provided via telehealth.

4.8 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 and is accessible to children/families during the daytime/evening hours. Since most youth will be engaged with school or employment, service provision must be available outside of the standard Monday to Friday, 9:00am-5:00pm hours. NYS OMH requires teams to have flexible work hours allowing for better engagement and

accommodation of schedules, (i.e., 10:00am-6:00pm, 11:00am-7:00pm, weekends.) 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 (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; 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.

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

Please note – Medicaid eligibility is NOT an admission criteria or requirement for admission for Youth ACT. Youth ACT serves both children with Medicaid and Non-Medicaid as the fiscal model includes OMH Net Deficit Funding to support serving children/youth without Medicaid.

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 need and diagnosis, are not appropriate for Youth Act.

Youth ACT is not appropriate for youth with a moderate or severe co-occurring intellectual developmental disorder.

5.2 Referral and Admission Process

The admission process for Youth ACT is unique and distinct from other mental health programs. It is designed to be more assertive and recognizes that continuous engagement is a key component in this process

1. Referral to Youth ACT is managed through a local children's single point of access (C-SPOA) process. Referral sources may include inpatient psychiatric units, mental health outpatient programs, families and/or individuals, and Health Home Care Management agencies. Referrals are submitted to C-SPOA in the individual's county.

2. C-SPOA will manage the process, from the point of receipt of a complete application to assignment to Youth ACT or placement on a waitlist (if applicable). C-SPOA will confirm the youth is eligible for Youth ACT. If the youth is eligible and the Youth ACT has capacity C-SPOA will forward the referral to the Youth ACT team. If the youth is eligible but the Youth ACT team does not have openings the youth will be put on a waitlist. When an individual is assigned to a wait list, the SPOA will communicate with the referral source and other service providers (e.g., Health Home care manager) as needed to ensure adequate care coordination while waiting for ACT services. If a youth is determined ineligible C-SPOA will work with the referral source on referral and linkage to other services and/or supports.

3. The number of admissions per month should not exceed the range of 4-6, unless otherwise approved by the state, 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,

individuals will need the most intense services and that significant initial effort will be required to complete the assessment and to begin to address many unmet needs.

4. Assertive engagement must begin immediately upon receipt of the referral from LGU/C-SPOA. Assertive engagement entails well thought out strategies to locate and keep individuals connected with the team. The team must reach out to the child/youth/family within 24 hours of receiving the referral. If an initial meeting with child and family is not scheduled within 7 days of receipt of the referral the C-SPOA will be notified and in collaboration with the referral source and Youth ACT provider will determine next steps.

5. An admission decision should be made as soon as possible after meeting with the child/youth and family. Upon the decision to admit an individual to Youth ACT, 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 individual to attain or maintain stability;
    c. Admission diagnoses; and
    d. The admission note is approved and signed by the Team Leader.

6. When an admission is not indicated, notation shall be made of the following:
    a. The reason(s) for not admitting (an individual's decision to not take medication is not a sufficient reason to deny admission to Youth ACT)
    b. The disposition of the case; and
    c. Any recommendations for alternative services, as appropriate.

Note – The C-SPOA must be notified of the decision of whether a youth has been admitted to Youth ACT or not.

There are special referral considerations for transition age youth (TAY ages 18-21), as both Youth, Young Adult 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, the C-SPOA should take into consideration individual choice and the developmental and clinical needs of the individual to determine appropriateness and fit into Youth ACT.

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 Referrals for Children transitioning to Youth ACT 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.

5.4 Waitlist Management and Prioritization

Prioritization is needs-based and is re-evaluated periodically as new children are placed on the waitlist or as the mental health status of children on the wait list changes. In addition to meeting all Youth ACT criteria, the following should be considered in the prioritization process:

- Residing or being discharged from an inpatient bed, an OMH licensed residential treatment facility (RTF), a children's community residence (CCR) or boarding in an emergency room or pediatric unit. Youth ACT is needed for a successful transition to home/community.
- Child/youth has been deemed eligible for RTF or residential setting but has been placed on a waitlist awaiting a bed and requires clinically intensive community services to avoid hospitalization.
- Clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., CCR, psychiatric hospital, or RTF) without intensive community services. The child/youth has utilized multiple intensive alternative community mental health services and requires Youth ACT to remain in the community.

C-SPOA and the Youth ACT provider should work collaboratively on understanding capacity and managing the waitlist.

5.5 Discharge Process and Planning

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 that adequately meets the child and family's level of need for services (e.g., higher or lower level of care)
- 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.

- Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including all local policies and procedure related to reporting individuals as "missing persons"

Upon the decision to discharge the team should begin to work with the child and family on a discharge plan to ensure a successful discharge from the program. Discharge planning includes identifying the resources and supports needed for transition of an individual to another program and making the necessary referrals. This also includes linkages for treatment, rehabilitation, and supportive services as needed. Discharge planning should be done collaboratively with staff, the individual and significant others involved with the individual's recovery, and should align with goals, needs and desires of the individual.

For all children/families discharged from Youth ACT the team should maintain contact with the youth/family until they are engaged in the new services. If contact is not possible, youth/family is unresponsive, the team should document attempts and reason for no contact.

For 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. If a Youth ACT client is re-enrolling within the three-month transfer period, there is no need to treat as a new opening. Be clear in the progress notes that this is a re-opening within the three- month transfer period, update the service plan and identify new goals with the youth and family as needed. The team must notify the C-SPOA of the re-opening.

Notification must be made to the local C-SPOA for all individuals being discharged. If the individual is enrolled in a Managed Care Organization (MCO), the MCO must also be notified. The following is required for the completion of a discharge summary from Youth ACT:

a. A discharge summary must be completed and included in the case record. The discharge summary should include: The reasons for discharge (using the discharge categories outlined above).
b. The individual's status and condition at discharge.
c. A written final evaluation or summary of the individual's progress toward the goals set forth in the service plan.
d. A plan developed in conjunction with the individual for treatment after discharge and for follow-up
e. The discharge summary must be signed by the staff completing the document.
f. The signature of the individual on the discharge summary is encouraged, but not required.

The discharge summary is transmitted to the receiving program prior to the arrival of the individual. When circumstances interfere with a timely transmittal of the discharge summary, notation shall be

made in the record of the reason for delay. In such circumstances, a copy of all clinical documentation is forwarded to the receiving program, as appropriate, prior to the arrival of the individual

6. Billing

6.1 General Billing Rules

Reimbursement shall be made only for services identified and provided in accordance with an individual's plan of care. A comprehensive plan of care is developed with specific objectives and planned services necessary to facilitate achievement of identified goals. The plan of care is strengths-based, culturally relevant and responsive to the individual's preferences and choices.

6.2 Reimbursement Standards and Rates

Youth ACT billing is a bundled monthly rate and reimbursed at the following rate: full; partial/step down and inpatient. Reimbursement is both based on team size and geographical location within the State.

The allowable billing rate is based on the number of contacts made in a given month to the enrolled individual and/or a collateral. 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.

Only one rate code may be billed per month for an individual. Two contacts per day can be billed as long as one contact is with the youth and the other contact is with a collateral. The two contacts must occur separately.

1) Full rate- Youth ACT must provide a minimum of six contacts in a month, up to three of which may be collateral contacts.
    - Rate code: 4508
    - Modifiers: none

2) Partial step/down rate- -Youth ACT must provide a minimum of two, but fewer than six, contacts in a month. Two of which must be with the individual
    - Rate Code: 4509
    - Modifiers: U5

3) Inpatient Reimbursement for services to Youth ACT clients who are admitted for treatment to an inpatient facility and are anticipated to be discharged within 180 days of admission shall be with the inpatient rate.
    - Rate Code: 4511
    - Modifiers: U1, U5

The ACT inpatient rate is reimbursed in months that a minimum of two contacts with the individual are provided in the inpatient setting, regardless of the number of community based or collateral contacts.

For the purpose of discharge planning, reimbursement is permitted for up to five calendar months of service during an inpatient episode without regard to the duration of the inpatient episode as follows:

- The ACT full rate is reimbursed in the month of admission or discharge when there are four or more community-based contacts combined with inpatient contacts equals six or more. Up to three of the total contacts may be with collaterals

- The ACT partial/stepdown rate is reimbursed in the month of admission or discharge when there is a minimum of two community-based contacts, with the enrolled individual, in a month. Or when a minimum of one community-based contact, combined with a minimum of one inpatient contact is provided, with the enrolled individual.

- Any episode of inpatient care is considered a continuous hospital or other medical facility stay if the youth's discharge is followed by a readmission to a hospital on or before the tenth day following the date of discharge. For example, a youth is admitted on 1/1/21, discharged 2/15/21 and readmitted 2/20/21 would be considered a single continuous inpatient episode.

- Providers will not receive reimbursement beyond five calendar months of an inpatient stay. A Youth ACT client should be placed on inactive status. While on inactive status the youth/child remains enrolled in Youth ACT, but billing is not allowed. The Youth ACT Team should notify the local C-SPOA of the inactive status; and upon discharge from the inpatient setting, the client may return to active status on the same Youth ACT team for continuing community-based service. The Youth ACT team must notify the local C-SPOA of the reactivated status.

6.3 Groups

Group services are allowed and reimbursable per the ACT regulations 508.5 (b) (9) (ii): “contacts by ACT team members with a group composed of collaterals of more than one client, for the purpose of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting a client in the management of his or her illness. No more than one collateral contact for any recipient shall be allowed as a billable service regardless of how many of his or her collaterals participate in the session. The total number of individuals in any group shall not exceed six.”

6.4 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.

Co-enrollment in Youth ACT and the following are not allowed:

- Licensed Children’s Day Treatment program

- Residential Treatment Facilities (RTF)
- Children's Community Residence (CCR),
- Licensed Mental Health Outpatient Treatment and Rehabilitative Services (MHORTS) (also known as Clinic)- except for up to three preadmission visits
- Children's Home and Community Based Services (HCBS)- except for allowances outlined below in 6.5
- Children and Family Treatment Supports and Services (CFTSS)- expect for allowances below in 6.5

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, Youth ACT recipients can receive non-residential services rendered by substance abuse providers and Youth ACT teams simultaneously and, as appropriate, these providers can bill Medicaid for such services.

In addition, it is not expected that Youth ACT programs will provide specialized eating disorder treatment. Therefore, ACT recipients can receive non-residential services rendered by substance abut provider and ACT teams simultaneously and, as appropriate, these providers can bill Medicaid for such services.

6.5 Transition from Youth ACT to a lower level of Community Based Services

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 30 days prior to discharge from Youth ACT. The Youth ACT team should make referrals and linkages to CFTSS based on family choice of service(s) and provider(s). Reimbursement for services provided to clints who are receiving both Youth ACT and CFTSS will be limited to the Youth ACT Partial Payment.

A child/youth may also be referred to Clinic as part of a discharge plan. Youth ACT programs are permitted to bill Medicaid for up to three preadmission visits to clinic.

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 HCBS 30 days prior to discharge from Youth ACT. The Youth ACT team should make referrals and linkages to HCBS based on family choice of service(s) and provider(s). Reimbursement for services provided to clints who are receiving both Youth ACT and HCBS will be limited to the Youth ACT Partial Payment.

7 Required Organizational Processes

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

7.1 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.

7.2 Responsibilities for Hospitalized Youth 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.

7.3 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.

7.4 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.

1. The need for an ACT participants continued stay with the program shall be documented by the agency.

2. Documentation should reference back to the reason for admission and goal achievement.

3. Documentation of the review should occur for each client a minimum of every 12 months

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: Pre-Employment Checks 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 data, follow- up date and discharge data in the CAIRS system as indicated below. The agency is responsible to develop and maintain a procedure that ensures the timely entry of this information by the Youth ACT team.

- Baseline data must be entered into CAIRS within 30 days of individual's admission to the Youth ACT team.
- Follow up data must be entered in 6-month intervals from the date of admission.
- The discharge data must be completed at the time of discharge from Youth ACT.
- Teams should run the "Follow ups by program unit report" to assist in timely completion. This report will provide due dates for data entry.

CANS-NY (Child and Adolescent Needs and Strengths – New York):

CANS-NY is required within 30 days of admission, every six months thereafter and at discharge. The CANS-NY must be entered in CAIRS. 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 https://omh.ny.gov/omhweb/finance/main.htm

9. MCO Utilization Management

The agency will participate in any State, Managed Care, or LGU utilization management process.

Utilization Management (UM) Guidelines for NYS Medicaid Managed Care Organizations (MMCO) and Health and Recovery Plans (HARP) regarding ACT should be followed by ACT teams and MCOs

10 Appendices

A. Training, Staff Development and Core Competencies

At hire, all clinical staff on a Youth 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. It is the responsibility of agency to monitor CANS-NY certification status.

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 ccoordination 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

B. 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 Collaterals are members of the individual's family or household, or others who regularly interact with the individual (e.g., landlord, criminal justice staff, employer) and are directly affected by or can affect the individual's condition and who are identified in the Service Plan as having a role in the individual's treatment. Collateral contacts with the recipient's family or others significant in their life, are provided for the direct benefit of the recipient and are conducted in accordance with, and for the purpose of advancing the recipient's Service Plan, and for coordination of services with other community mental health 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 a Youth ACT team staff member and a client or collateral.

Discharge Planning means the process of planning for successful discharge from a program. Discharge planning includes identifying the resources and supports needed for transition of an individual to another program and making the necessary referrals. This also includes linkages for treatment, rehabilitation, and supportive services as needed. Discharge planning should be done collaboratively with staff, the individual and significant others involved with the individual's recovery, and should align with goals, needs and desires of the individual

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.

C. Accessing CANS-NY Training

CANS-NY training can be accessed here: CANS-NY Training

Complete the following steps to create an account and access the training:

1. Complete the registration
    a. Enter NY under "Choose Regional Designation".
    b. Enter your agency name under "Choose Agency"-

2. Download the NYS Bundle- hover over the training" tab and click on "bundles" and then enroll in the NYS bundle. This will be free as long as you listed NY as your jurisdiction.

3. Access the training by hovering over the “training” tab and click on “courses”, this will bring you to a new page with the full list of courses. Youth ACT requires the 6-21 CANS

   Of note, there is an Introductory training that runs on zoom that can be registered for by clicking on the Introductory Training (2022) course and clicking on step 1.