Appendix A (Online). New York State Office of Mental Health Bureau of Inspection and Certification Clinic Standards of Care Anchor Elements

Standard of Care Focus	Exemplary (In addition to Adequate)	Adequate	Needs Improvement
Assessment			
1.11 Requests for services are addressed appropriately and in a timely manner	1. Following screening, individuals are offered same day appointments for initial assessment. 2. There is evidence that supervisory staff oversees the decisions for non-admissions. 3. Evidence of follow-up to assist individuals screened but referred elsewhere to connect with appropriate services.	1. Requests for services are screened and triaged same business day and this process is overseen by supervisory staff. **and** 2. Calls, walk-ins or referrals for services are screened for risk by staff that has been appropriately trained and mechanisms are in place for alerting professional staff when risk is identified. **and** 3. Individuals referred from inpatient, forensic, or emergency settings, or those at high risk receive initial assessment within 5 business days; priority access is given to individuals enrolled in AOT. Note- Until Part 599 is adopted, the specific five day standard applies to individuals referred from inpatient and emergency settings to COPS providers. **and** 4. A note is written upon decision to admit which includes reason for referral, primary clinical needs, services to meet those needs, and admission diagnosis. **and** 5. There is documentation of the rationale for recipients who have not been admitted to the program. The program provides other referral sources, as needed.	1. Criteria for screening and triaging requests for service are inappropriate, inconsistently applied, or process is not reviewed by supervisory staff. **or** 2. Priority access is not given as required by regulations. **or** 3. Admission notes are not present or are incomplete. **or** 4. There is no rationale for non admissions and no referrals provided.
1.12 Assessment process is responsive and coordinated	1. Assessment, including psychiatric assessment, is completed within 30 days of first appointment; however, assessments are completed sooner if indicated by clinical presentation and need for medication. Reasons for exceptions are documented.	1. Face to face assessment for all recipients is timely based on the recipient's clinical presentation and need for medication. **and** 2. A single clinician oversees the assessment process with the recipient. **and** 3. Clinicians completing assessments are appropriately licensed and trained and provide culturally competent service. **and** 4. There is evidence of effective "hand- off" of recipient information between clinicians. **and**	1. Multiple clinicians are involved in a recipient's assessment without explanation or clinical justification. **or** 2. Information is lost or the assessment process delayed due to poor coordination or communication among staff.

		5. Recipients are admitted within the required timeframes of the regulations.	
1.21 The assessment is comprehensive.	1. Assessment includes recipient's view of past successes, difficulties, desired outcomes and potential barriers in each area.	1. Assessment should include evaluation of history and current status in the following areas: ◦ Recipient's reasons for seeking services ◦ Recipient/family current strengths, supports, and stressors ◦ Mental status ◦ Physical health (reviewed by MD, NPP, RN, or PA) ◦ Mental health services ◦ Episodes of trauma legal, forensic involvement ◦ Family, significant others, social function finances, housing; culture and language ◦ Developmental history for children ◦ Note: Additional elements of comprehensive assessment are listed separately **and** 2. The assessment results in a clinical formulation which informs the treatment plan.	1. There is no documentation of assessments. **or** 2. There is documentation of assessment in all areas, but only minimal information is included.
1.22 Assessment includes current or past use, abuse or dependence on alcohol or other substances	1. The clinic uses one of the screens recommended by OMH/OASAS Task Force on Co-Occurring Disorders: Modified Simple Screening Instrument for Substance Abuse (MSSI-SA) CAGE Adapted to Include Drugs (CAGE-AID) Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) Or, for children/adolescents: CRAFFT Global Appraisal of Individual Needs (screening version) (GAINS-SS) Problem Oriented Screening Instrument for Teenagers (POSIT); Problem Oriented Screening Instrument for Parents (POSIP) 2. Assessments are conducted or reviewed by staff with experience or training in co-occurring disorders.	1. The clinic screens all individuals for alcohol and substance use, abuse, and dependence. **and** 2. Positive screens result in in-depth assessment. **and** 3. Staff administering screens or conducting assessments have received training in their use. **and** 4. For children, information is sought concerning alcohol/substance use in the home environment(s).	1. The clinic does not screen for use, abuse or dependence on alcohol or other substances. **or** 2. Positive screens do not result in more detailed assessment.

1.23 The assessment should include an initial risk of harm to self.	1. Additional information or corroboration from collateral sources is routinely sought and utilized in making the assessment. 2. Evidence that clinicians use the Chronological Assessment of Suicide Events (CASE) Approach or other validated process for conducting risk assessment.	1. An initial self harm screening for all recipients is part of the clinic's assessment process. **and** 2. A positive screen results in a more comprehensive assessment that considers both static and dynamic factors in conjunction with current mental status, supports and protective factors. Access to means/weapons is assessed. **and** 3. Information is synthesized and incorporated into an assessment of the recipient which informs the treatment plan. **and** 4. Determination of moderate/high potential for self harm prompts the development of a Safety Plan, clinical consultation or other immediate interventions.	1. No initial suicide screening or assessment has been completed. **or** 2. The record contains only minimal documentation, with conclusions such as "No SI" (suicidal ideation). **or** 3. Significant risk factors are ignored or missed
1.24 The assessment should include a sequential screening of risk for violence to others.	1. Additional information or corroboration from collateral sources is routinely sought and utilized in making the assessment.	1. Violence risk screening for all recipients is part of the clinic's assessment process. **and** 2. The violence risk screen includes at minimum: Direct inquiry whether recipient has ever fought with or hurt another person and whether he/she has recently thought about hurting another person. Additional inquiry into critical events such as past hospitalizations, arrests, domestic violence, orders of protection, child abuse, fire setting, abuse of animals etc. that raise the possibility of past violence. **and** 3. A positive screen results in a more comprehensive assessment that explores details and context of past violence and considers additional historic factors as well as current circumstances. Access to means/ weapons is assessed. **and** 4. Information is synthesized and incorporated into an assessment of the recipient which informs the treatment plan. **and** 5. Determination of moderate/high potential for violence prompts the development of a Safety Plan, clinical consultation or other immediate interventions.	1. No violence screening has been completed. **or** 2. The record contains only minimal documentation, with conclusions such as "No HI" (homicidal ideation). **or** 3. Significant risk factors are ignored or missed.
1.25 Health Screening	1. Upon admission, and on a quarterly basis, the clinic	1. Upon admission, the clinic gathers information concerning	1. The clinic does not attempt to gather

and Monitoring	assesses the following health indicators, whether through a physical by the individual's primary care physician not more than 12 months prior to the intake, or by completing the assessment at the clinic: ◦ Adults-blood pressure, BMI and smoking status ◦ Children and Adolescents-BMI percentile, activity level/exercise and smoking status. 2. Quarterly, the clinic develops and reviews with the recipient, and caregivers for children, a plan to address any identified health issues. This should be in collaboration with the primary care physician when possible.	recipient's medical history and current physical health status. **and** 2. Health screening information is reviewed by a physician, NPP, RN, or PA to determine potential impact on mental health diagnosis and treatment, and the need for additional health services or referrals. **and** 3. Recommendations from review are acted upon, or there is documentation as to why not.	recipient health information. **or** 2. Health information is not reviewed by appropriate staff with medical training **or** 3. Reviews are routinely signed-off, with no recommendations about impact or service needs.
1.26 Employment, education, community roles	1. Assessment explores past and present successes and barriers to achieving desired roles. 2. For children, the clinic consistently obtains written reports and/or verbal communication from school to assist with the assessment.	1. Recipient's history of education, employment, and other community roles is obtained. **and** 2. For children, there is documented evidence of assessment of academic achievement, school performance, and social issues. **and** 3. Recipient's interest, goals, and needs re. education, employment, and other community roles are assessed.	1. The clinic does not assess history/ interest in employment, education, or other community roles. **or** 2. For children, the clinic does not assess or address academic achievement or school performance issues.
1.31 The clinician should pursue information from other available sources, particularly family members, significant others, and recent providers of services…	1. There is documentation that the clinician discussed with the recipient the value of including family members and significant others involved in the recipient's life in completing a comprehensive assessment. In addition to contacting recent providers, clinicians actively pursue potentially relevant information regarding the individual from all available sources (e.g. substance services, probation, housing, OMRDD etc.)	1. Assessment seeks to identify significant others as well as past and current service providers and agencies involved with the recipient. This may include courts, DSS, schools etc in addition to mental health services. **and** 2. With appropriate consent, family and significant others are contacted to participate in the assessment. **and** 3. For children/adolescents, assessment should always include input from parents or other caregivers. **or** There is documentation regarding why there has been no contact. **and** 4. There is documentation that recent providers of mental	1. There is no documentation that the clinician attempted to identify significant others or service providers in completing the assessment. **or** 2. No contact was attempted with any family or other persons involved in the individual's life with no documented explanation. **or** 3. There is no evidence that current or past providers of mental health service have been contacted to obtain information to contribute to

		health service have been contacted to obtain discharge summaries and other pertinent information.	the evaluation. **or** 4. Significant information from collateral sources has not been incorporated into the assessment.
Treatment Plan			
2.11 Every recipient has a comprehensive treatment plan.	1. There is a clear linkage between the assessment, treatment plan and discharge criteria. Ways in which the services provided will assist the recipient to reach their desired outcomes are identified. The plan addresses needs and goals related to work, education or other chosen roles, as appropriate.	1. Treatment plan goals, objectives, and services are clearly based on a comprehensive assessment. **and** 2. Measurable and attainable steps toward the achievement of goals are identified, with target dates. **and** 3. Plan includes the specific interventions and services that will be utilized, the clinician(s) providing services, and the frequency of services.	1. The treatment plan focuses only on symptom reduction. **or** 2. Needs identified in the assessment are not addressed and no explanation is provided. **or** 3. There are no methods or interventions identified to assist the recipient with meeting the objectives.
2.12 Developed with recipient/family/ collaterals	1. The plan shows evidence of being co-authored by the recipient and treatment team through use of recipient's language, written comments, etc. For adults, input from and role of collaterals are reflected in the plan.	1. Plan is person centered as evidenced by goals, objectives and services that are individualized and reflect the recipient's circumstances and preferences. **and** 2. Plan identifies and utilizes recipient's strengths. **and** 3. For children, the involvement of caregivers in the development of the plan is clearly evident.	1. The treatment/care plan appears to be comprised primarily of boilerplate/ stock goals that are not individualized. **or** 2. The treatment plan has no involvement with activities meaningful to the recipient. **or** 3. Family or collateral input is not sought when available.
2.13 Responsive to cultural linguistic , and other special needs	1. The treatment plan reflects culturally tailored engagement strategies, incorporates culturally relevant information from the recipient, and uses the recipient's cultural and /or spiritual practices and traditions and involvement in the community as areas of strength and support.	1. The treatment plan addresses cultural, linguistic, or other special needs as identified in the assessment. This can include special linguistic arrangements, need for off-site services or physical accommodations, documentation of home bound status etc.	1. The treatment plan has minimal or no evidence of identifying and responding to the recipient's and family's cultural, linguistic, or other special needs.
2.14 Treatment Plan Reviews reflect active and ongoing reappraisal of goals, objectives	1. Changes in recipient's symptoms, stressors, needs or circumstances result in updated assessments as needed. **and** 2. Changes prompt immediate re-evaluation and updating of the treatment plan. 3. Treatment reviews indicate recipient/ family's view of progress, current needs, and services.	1. Review of the treatment plan includes an assessment of recipient's progress on each goal and objective. **and** 2. Plan is reviewed at least every 90 days and when goals, objectives, and/or services are changed in response to changes in recipient's symptoms, stressors, needs or circumstances; **and** 3. As progress is made, or when there is an ongoing lack of	1. The treatment plan has gaps between updates which exceed regulatory requirements. **or** 2. The treatment plan doesn't change as stressors change, goals are attained or no progress is made, and no rationale is provided. **or**

and discharge plan.		progress.	3. The treatment changes with no explanation or rationale.
2.15 Documentation of Treatment Services	1. There is evidence that Collaborative/ Concurrent Documentation is being utilized whenever possible.	1. There is documentation in progress notes or elsewhere that issues are attended to and services provided as identified in the treatment plan. **and** 2. Progress notes are linked to goals and objectives by summarizing services provided/interventions utilized, the recipient's response, and progress toward goals. **and** 3. Notes record any significant new information impacting treatment, contacts with collaterals, and consideration of the need for changes to the treatment plan. **and** 4. Notes of appointments with psychiatrist or prescriber contain a report of mental status and explanation of changes in medications prescribed.	1. There is no documentation that issues are attended to and services provided as identified in the treatment plan. **or** 2. Notes consist of a summary of session dialogue without reference to treatment plan goals or services.
2.21 Safety Plan	1. The clinic has criteria for identifying a recipient at risk, has a safety plan developed with each of these recipients, and administration/ supervisor closely monitors those so identified. 2. Safety plans are reviewed with the recipient periodically and when utilized; revisions are made as needed. 3. The clinic actively assists recipients to consider and, when desired, to develop Wellness Self Management Plans, WRAP™ plans, Behavioral Advance Directives (BAD), or other mechanisms to support wellness and self determination.	1. The clinic actively assists recipients to consider, and when desired, to develop an individualized safety plan that contains at least the following elements: ◦ Identification of triggers ◦ Warning signs of increased symptoms ◦ Management techniques or calming activities ◦ Contact information for supportive persons ◦ Plan to get emergency help if needed **and** 2. Recipients are given a copy of their safety plan. **and** 3. All at risk recipients have a safety plan developed with their input. **and** 4. Clinic routinely educates recipients/ families about community supports as well as crisis services.	1. No at risk recipients have a safety plan. **or** 2. Safety plans are not individualized or created with the input of the recipient.
2.31 The comprehensive treatment is developed in a timely manner; the plan and	1. The recipient, therapist, collaterals and other treatment team members discussed or reviewed the treatment plan/reviews and signed them concurrently.	1. The comprehensive treatment plan is developed in coordination with the recipient within 30 days of admission or prior to the fourth visit. **and** 2. The recipient and the primary clinician reviewed and signed the treatment plan/reviews on the same date, and all members of the treatment team required to sign did so within the regulatory time frame.	1. The comprehensive treatment plan is developed more than 30 days past admission. **or** 2. The plans/reviews are missing signatures, or not signed within required timeframe without explanation. **or**

subsequent reviews are signed by all individuals participating in the person's care			3. The signatures are not dated.
		Ongoing Care	
3.11 The clinic attends to the recipient and family	1. Peer/family advocates are available at the clinic. 2. There is an active recipient advisory group providing ongoing input to clinic administration. 3. The participation by family members in psycho-educational, support, and advocacy groups is facilitated by the clinic.	1. Flexibility in scheduling to meet the needs of recipients is in evidence. **and** 2. Satisfaction surveys are conducted and results are utilized to shape clinic operations. **and** 3. A notice of recipient rights is provided at admission. **and** 4. There is evidence of a responsive complaint resolution process. **and** 5. Information about advocates and advocacy organizations is available to recipients and families.	1. There is no evidence of communication with families/other significant people. **or** 2. The clinic has no means to solicit family or collateral opinions regarding the services provided. **or** 3. Little evidence of complaints being accepted or adequately addressed. **or** 4. Scheduling does not allow for flexibility to meet recipient needs.
3.12 Identification of a Primary Clinician	1. Evidence of reassignment of clinician/prescriber to better meet recipient's needs at recipient's or family's request. 2. Clinic demonstrates periodic assessment of the adequacy of staff performance regarding Evidence Based Practice expertise, cultural competency, linguistic abilities, etc in relation the population served and takes action to better meet their needs.	1. A primary clinician is assigned at the time of admission. **and** 2. Recipient request or clinical consideration for change of primary clinician is reviewed, with rationale for resolution documented. **and** 3. Recipients are given appropriate opportunities to process changes of clinician, whenever possible.	1. No primary clinician has been established. **or** 2. The primary clinician has been changed more than once to meet the staffing of the clinic rather than the preferences of the recipient. **or** 3. The clinic disregards the recipient's or family's request for a change in clinician.
3.13 Engagement And Retention	1. Clinic actively utilizes Outreach services, off-site visits, and Complex Care Management where appropriate to better engage recipients. 2. Clinicians seek out persons and information that can expand their understanding of and responsiveness to the cultural perspective of the recipient/family.	1. Clinic procedures and staff contacts demonstrate respect for individuals served and concern for confidentiality. **and** 2. Potential barriers and current difficulties in participating in treatment are identified and addressed at intake and throughout course of treatment. **and** 3. Service delivery reflects an understanding of the cultural	1. Initial contacts emphasize agency attendance and billing rules or are focused solely on paperwork requirements. **or** 2. There is little evidence of consistent follow up on missed appointments. **or**

	3. Confirmation phone calls are made prior to appointments or other effective methods are consistently used to reduce "no-shows" and offer the recipient alternatives and choice. 4. There is consistent, personalized follow up by the assigned clinician for missed appointments. 5. Staff training has been provided on topics such as engagement, motivational interviewing, shared decision making, collaborative documentation etc.	perspective of the recipient/ family. **and** 4. There is evidence of follow up on missed appointments. **and** 5. Information is provided to recipient/ family about services available at clinic, the treatment process, and shared decision making.	3. There are a high percentage of closed cases due to loss of contact. **or** 4. Interactions between staff and recipients are perceived as impersonal or disrespectful. **or** 5. Service delivery is not congruent with the cultural needs and perspective of the individuals served.
3.14 Communication with Families/Other Significant People	1. Documentation and interviews with family members/significant others indicate consistent and collaborative contacts with clinic. **or** 2. Clinician reviews the potential involvement of family/significant others with recipient on a periodic basis and as opportunities arise. 3. Communication with family/significant others is documented as addressed in clinical supervision meetings.	1. Families or significant others have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis. **and** 2. Staff can explain the parameters and policies concerning confidentiality, including the ability to receive information from family and others. **and** 3. Clinicians seek to identify others involved in recipient's care and recovery and discuss benefits of their involvement with recipient. **and** 4. There is documentation of efforts to communicate in person or by telephone with significant others involved in the recipient's treatment and recovery, as appropriate. **and** 5. For children, ongoing communication with caregivers and other collaterals is documented.	1. There is no evidence of efforts to coordinate or communicate with family or other collaterals. **or** 2. Staff does not understand the parameters for communicating with family members/others involved in the recovery of the individual. **or** 3. Family or other collaterals are not provided with information necessary to contact the clinic when needed.
3.15 Attention to Co-Occurring Disorders	Evidence of "no wrong door" practice in terms of treatment of co-occurring disorders by providing integrated treatment, an evidence-based practice in which the same clinician or team of clinicians, working in one setting, provide appropriate mental health and substance use interventions in a coordinated fashion, is being implemented in the clinic. Integrated treatment includes taking into account the stages of change/treatment, individualized treatment,	1. The clinic demonstrates an understanding of OMH and OASAS guidance documents, MOA and training resources. **and** 2. Agency can identify steps taken or planned to move toward integrated treatment. **and** 3. At present, when co-occurring disorders are identified, there is documentation of recommendations and services provided.	1. Co-occurring disorders are documented in the record but no additional recipient-specific actions are taken to provide treatment for both/all disorders.

	and the following services: • Pharmacological treatment • Counseling • Group treatment • Family psycho education • Self-help/community support groups		
3.16 Disengagement from Treatment	1. System wide effort to track and reduce disengagement, including efforts to identify salient factors leading to disengagement and an action plan implemented to address recipient disengagement.	1. When individuals discontinue, refuse services, or are lost to contact, a review of recipient's history, current circumstances and degree of risk is conducted. **and** 2. Efforts to re-engage are commensurate with the degree of risk assessed. **and** 3. Reviews include contact with significant others/collaterals and consultation with clinical supervisor or team prior to a case being closed. **and** 4. Written correspondence indicates that individual is encouraged and welcome to re-engage in services at any time in the future.	1. There is minimal or no documentation of follow-up efforts to re-engage the recipient. **or** 2. Significant proportion of closed cases indicates that recipient was lost to contact. **or** 3. There is no individualized review of cases of disengagement. **or** 4. Re-engagement efforts are minimal or not related to level of assessed risk.
3.21 Discharge	1. Documentation that discharge plan was developed collaboratively by recipient, clinician, and significant others involved with individual's recovery. The plan is updated as needed. 2. Clinic utilizes a system to follow-up with recipients or other providers post discharge and, where applicable, to confirm appointment was kept, and provides assistance in linking to new services as needed. 3. Based on the treatment plan, the recipient and clinician should both be clear on when the recipient is ready to be discharged from the clinic. 4. Updated Safety Plans are developed with recipients prior to planned discharges.	1. Discharge criteria reflect recipient's and, for children, family's desired accomplishments as well as clinical assessment of individual's service needs. **and** 2. Arrangements for appropriate services are made (appointment dates, contact names and numbers etc.) and discussed with recipient and significant others prior to planned discharge. **and** 3. Discharge summaries identify services provided, recipient's response, progress toward goals, circumstances of discharge (and efforts to re-engage if not planned) **and** 4. Discharge summary and other relevant information is made available to receiving service providers prior to the recipient's arrival (or within two weeks of discharge, whichever comes first) when that provider is known.	1. Discharge criteria are unrelated to recipient's desired outcomes or are clearly unrealistic for recipient to attain. **or** 2. Recipients are discharged with no assessment of needs or plan for follow up services. **or** 3. Discharge summaries are missing or do not summarize the course of treatment.
Clinical Administration			
4.11	1. Policies and procedures reflect current practices for	1. The clinic leadership can demonstrate a systematic	1. No systematic policies, procedures and

Caseload	reviewing and monitoring the effectiveness of caseload assignments. The Clinic can demonstrate changes made based on the established system for caseload assignment and monitoring. 2. The Clinic can demonstrate an ongoing system for evaluating caseload assignments and service utilization which incorporates a variety of information sources such as UR, ICR and Satisfaction Surveys.	process used to assign recipients to a clinician based on presenting needs, acuity, preferences, clinician expertise as well as caseload size. **and** 2. A systematic process, and the concomitant policies and procedures, to monitor, review and track clinician caseloads by size, risk levels of recipients and other factors can be demonstrated. **and** 3. Productivity standards are established and allow for appropriate clinical care and addresses fiscal viability. **and** 4. Sufficient prescriber coverage is available to meet the needs of recipients without undue delay, or a process is in place to assure recipients have access to prescription services when needed. **and** 5. The Clinic meets the staffing requirements of current regulations. **and** 6. Clinic systematically recruits staff to better meet the clinical, cultural, and other needs of the population served.	processes have been established to assign cases to clinicians reflective of client need and clinician expertise and caseload size. **or** 2. No evidence that procedures are utilized to monitor, review and track caseload size or risk levels of clients per clinicians' caseload. **or** 3. Number or mix of staff do not support appropriate clinical care. **or** 4. Evidence of high staff turnover related to unrealistic caseload demands.
4.12 Treatment Services	1. Clinic shows evidence of ongoing monitoring of the current service needs of populations served and development of new or revised programs, procedures, or linkages to address those needs. 2. Clinic can demonstrate implementation and staff training in one or more evidence-based practice. 3. All youth who are prescribed antipsychotic medication or are being considered for same have received an evaluation by a child and adolescent psychiatrist, either in person or via telepsychiatry. 4. Training and service initiatives relate to data obtained from ICR trends, UR and Satisfaction Surveys.	1. Evidence that Clinic provides all required services and approved optional services in a consistent and clinically appropriate manner. **and** 2. Administration identifies and utilizes mechanism(s) for insuring that appropriate services are provided to each recipient based on current clinical need and documented processes, e.g. utilization review. **and** 3. Services are provided by staff that are credentialed and trained to provide them. **and** 4. Documented procedures for identifying, monitoring, and re-assessing recipients receiving only medication treatment services are known and adhered to by clinic staff.	1. Clinic does not provide all required services. **or** 2. No evidence of changes to services offered in response to needs of population served. **or** 3. Recipients receive medication only service without appropriate screening, monitoring, reassessing or treatment plan changes based on significant events or decline in stabilization or progress.

4.13 Crisis Services	1. The clinic provides 24/7 availability to speak with a licensed professional who is familiar with the recipient. And/Or Clinic staff provide face to face after hours service to recipients in crisis, when clinically indicated.	1. The Clinic has an ability to accommodate crisis intakes and walk-ins during normal program hours. **and** 2. There is a plan in place which results in contact with a licensed professional by recipients and their collaterals who need assistance when the program is not in operation. **and** 3. The primary clinician at the clinic is informed on the next business day of information from clinicians providing after hours services. **and** 4. The process for after hours contact is explained to all recipients, and significant others where appropriate, during the intake process and given to them in an information packet describing the services offered by the clinic. This information is also posted and reviewed with the client throughout the course of care. Additionally where indicated, the information is included in the client's crisis plans. **and** 5. The Clinic demonstrates consistent follow-up on crises calls received**.**	1. After hours calls go to an answering machine or answering service which refers recipients to go to an emergency room or call 911. **or** 2. Individuals in need are not aware of an after hours contact system or experience significant wait times before contact with a professional staff member, with no explanation. **or** 3. Information regarding after hours contacts is not available to the clinic. **or** 4. Crisis calls are not followed up by the clinic.
4.21 Supervision and Training	1. There is evidence of increased psychiatrist involvement with high risk clients and during emerging instability or crisis. 2. Individual and group supervision sessions result in the identification of individual and agency wide training needs, policy and procedure reviews, etc. 3. Regularly scheduled clinical in-service training is provided by the agency and staff attendance is documented. 4. Agency has a cultural competency plan, staff have received training to increase awareness, and the program has enlisted appropriate individuals to provide guidance in engaging and attending to individuals and groups served.	1. Clinical supervision by appropriate leadership staff on a regular basis for all clinicians is provided and documented. **and** 2. The frequency of supervision is increased for new vs. experienced staff. **and** 3. Provision is made for prompt supervision in times of crisis or increased need, clinicians demonstrate knowledge of the method to request ad hoc supervision, and there is evidence that this has been used. **and** 4. Issues or needs identified related to staff performance are addressed in supervision, training, or by other methods. 5. Documentation of periodic staff trainings is maintained. **and** 6. Required staff clearances are maintained. **and** 7. Staff licenses and registrations are current.	1. Clinical supervision is not provided on a regular basis. **or** 2. All clinicians, regardless of experience, have the same level of supervision. **or** 3. Supervisory sessions appear to deal more with administrative than clinical matters. **or** 4. Clinical supervision occurs only in groups, not individually. **or** 5. Minimal evidence of staff training. **or** 6. Staff credentials and clearances are not reviewed. **or** 7. No procedures are in place for supervision. **or** 8. No performance evaluation system or

			other methods to assess and evaluate staff's performance is evident.
4.31 Information Sharing	1. Training and supervision includes the importance and understanding of coordination, collaboration, and partnership with other agencies, families, collaterals and other systems involved with the recipients served.	1. The clinic has procedures, policies and clearly delineated protocols in place which describe and support the importance of appropriate information sharing within the agency and with outside agencies, families and other collaterals in providing coordinated services for recipients. **and** 2. Recipients are informed of the clinic's privacy policies, including circumstances where written consent is not required. **and** 3. The value of sharing information with other parties is discussed and the recipient's consent is sought and documented as appropriate. **and** 4. Evidence of sharing of treatment information in order to better integrate services for recipients, particularly at admission, discharge, or periods of crisis or hospitalization.	1. Staff does not understand the parameters for sharing information with other providers. For example, the clinic or clinicians believe HIPAA laws always require written consent for information sharing. **or** 2. Few if any charts show documentation of information sharing (e.g., with PCP, or other providers in the OMH nexus of care). **or** 3. There is evidence of the improper withholding of information.
4.41 Clinical Risk Management	1. The clinic engages in activities to reduce the occurrence of serious incidents through proactive risk reduction strategies which identify potential problems and implement preventive measures. The clinic uses NIMRS reports to assist in risk management activities.	1. All new staff receives training regarding the definition of incidents and reporting procedures for incidents; they are informed about the Incident Review Committee process and the importance of risk management in maintaining safety and improving services. **and** 2. The Incident Review Committee reviews incidents, makes recommendations, and ensures implementation of action plans with program's administrator. **and** 3. The Incident Review Committee membership composition is appropriate; members meet qualifications and are properly trained. **and** 4. The clinic compiles and analyzes incident data for the purpose of identifying and addressing possible patterns and trends.	1. The Incident Review Committee does not meet the requirements of Part 524 for review, analysis, and monitoring of incidents. **or** 2. No policies or procedures are evident regarding risk management. **or** 3. A Risk Management Plan has not been developed.
4.51 Responsive to recipients at risk	1. The Agency utilizes a process/ committee that includes individuals with clinical expertise	1. Current policies, procedures and protocols are in place regarding the identification, tracking, monitoring,	1. Agency cannot demonstrate an effective system for identifying,

	(psychiatrists, quality assurance administrators, clinical administrators) charged with reviewing complex, high risk, high need cases and providing recommendations on treatment or treatment-related strategies. 2. There is evidence of an agency-wide or multi-program risk management or review committee/process that includes quality assurance personnel and clinical administrative staff that assist the clinic to better address the needs of at risk or complex recipients and their collaterals.	assessment and treatment of at risk and high need recipients. **and** 2. Evidence that the identification of individuals at moderate/high risk results in clinical consultation and interventions appropriate to the degree of risk assessed.	monitoring, or responding to at risk recipients. **or** 2. Identification of moderate/high risk does not result in clinical consultation or appropriate interventions.
4.61 Premises	1. The environment is welcoming and attractive (for example: comfortable furniture, beverages in the waiting area, up to date reading materials, and decorated offices) to all of the age and cultural groups served and using the facility. 2. Waiting area available for children/family. 3. The clinic has materials promoting recovery and sharing success stories available in the waiting area. 4. Suggestion/complaint receptacles are prominently displayed and invite ongoing and spontaneous feedback. 5. Outcomes from satisfaction surveys, suggestion boxes and complaints are displayed prominently including the actions taken by the Clinic to improve services based on this customer feedback.	1. The premises are maintained in a clean condition, free of fire and safety risks. **and** 2. Individual and group space is sufficient, comfortable and private. **and** 3. Records are maintained confidentially and medications are stored appropriately. **and** 4. Sign-in procedures and therapy rooms promote confidentiality. **and** 5. A sufficient number of restrooms are available for use by recipients and staff. **and** 6. The literature, photos, reading material and toys are reflective of the population served as well as those using the waiting area. **and** 7. Rights and advocacy information are prominently posted. **and** 8. Proper exit signs visible and working and evacuation signage posted. **and** 9. Comfortable temperatures are maintained in all areas of the clinic. **and** 10. All signage is positive, welcoming, helpful and respectful. **and** 11. Sanitizing or proper care of toys and all other commonly shared items occurs.	1. The premises are unsafe due to fire or safety hazards. **or** 2. The premises need extensive maintenance to ensure a comfortable place to receive services. **or** 3. The literature, photos, reading material is not reflective of the population served and using the waiting area. **or** 4. Some bathrooms are labeled solely for staff use. **or** 5. Signs with negative messages are posted in the waiting and reception areas (e.g. all cell phones will be confiscated; arriving late may mean loss of appointment privileges). **or** 6. Proper signage for exits and evacuation routes are not evident

Available: http://www.omh.state.ny.us/omhweb/clinic_standards/care_anchors.html