NY ACT Record Tool

Effective Date: October 22, 2025

General Documentation

Question	
1	Each member has a separate record.
2	Treatment record that includes the member's address, telephone numbers including emergency contacts, birth and/or identified gender, relationship and legal status, and guardianship information, if relevant.
3	All entries in the record include the responsible clinician's name, professional degree/licensure/certification, and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.

Intake

Question	
4	Following the ACT referral, the ACT Team locates individuals and engages them in service.
5	There is evidence that the member is willing to participate in ACT or there is an AOT (Assisted Outpatient Treatment Order).

Initial Assessment

Question	
6	An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 business days of admission.
7	An Initial Assessment is completed within 45-60 calendar days of admission.
8	There is evidence in the initial assessment that the team develops clinical formulations under the guidance of the MD, team leader or designated clinical supervisor.
9	There is evidence in the initial assessment that member specific risk factors and patterns are identified, as well as effective and ineffective coping strategies, level of independence in critical areas, supports and interventions.
10	There is evidence in the assessment that exploration of personalized recovery goal(s) occurred during the assessment.
11	Standardized screening and assessment instruments are used for risk.
12	There is evidence in the record that standardized risk screening and assessment instruments are used.
13	There is evidence in the record that standardized screening and assessment instruments are used for health (reviewed by MD, NP or RN).

Ongoing Assessment

Question	
14	The assessment is updated at least every six months, and the service plan review.
15	Specific re-assessments are completed as needed, specifically in areas of Risk, SUD, Medical, and Psychiatric.

Service Plan

Question	
16	There is evidence that the member has a person-centered service plan developed in partnership, within 45-60 days of admission, with documented involvement of the recipient, physician and the team leader or designated clinical supervisor involved in the treatment.
17	The service plan reflects a recovery orientation, including life goals, such as educational, vocational, residential, social, or recreational pursuits.

18 The service plan reflects evidence of shared decision making with member, team and/or family support and/or collateral.

19 The service plan reflects activities to be carried out from an AOT order, where applicable.

20 The service plan reflects future orientation and documentation of specific and individualized discharge criteria.

21 The plan is shared with individuals, family, medical and other providers, with consent.

22 Clinical interventions include engagement and treatment adherence.

23 Clinical interventions include building and testing skills.

24 There is evidence that building and testing skills foster independence.

25 There is evidence that the team and member have identified barriers associated with reaching goals and strategies to assist in overcoming these barriers.

26 There is evidence of Community Integration and Re-integration of at least one of the following services: care coordination, health promotion, comprehensive transitional care from inpatient and ACT to other settings, including appropriate follow up, individual and family support (which included authorized representatives), referral to community and social support services if appropriate, the use of health information technology to like services if appropriate.

27 There is evidence that the service plan is reviewed and revised to include new strategies, services etc. in response to changes in member's circumstances and functioning.

28 There is evidence that all plans are reviewed at least every 6 months.

Progress Notes/Service Plan

Question

29 There is evidence that new information, changes in member's functioning, and lack of engagement are clearly identified and immediately communicated to team members via progress notes, logs, verbal reports or other documentation.

Ongoing Risk Management

Question

30 Crises are rapidly addressed with input from multiple team members, and strategies for addressing member difficulties integrated across the disciplines and treatment approaches.

31 There is evidence the team directly provided in-person after hours services with experienced staff skilled in crisis intervention procedures. to member where appropriate (if applicable).

32 If the member will not come to meet the psychiatrist/NPP, there is evidence that they provide services to that individual in the community in addition to the required community visits.

Co-Occurring Medical Issues

Question

33 The psychiatrist and/or the NPP document the members response to medication, symptoms, and any side effects.

34 The record includes any recent hospitalizations and or medical treatments of member and the team’s response.

35 The team documents efforts to coordinate services between health and behavioral health services for members.

Co-Occurring Disorders

Question

36 The record includes any recent substance use of the member and the team’s active response.

37 If applicable, evidence-based substance abuse treatment is offered to the member.

38 If there is an identified substance use disorder of the member, there is evidence that the member has at least one session weekly in such treatment.

39 The record identifies efforts taken to provide integrated substance abuse treatment for member with co-occurring disorders and the service plan reflects active IDDT treatment.

40	There is evidence that the team facilitates access to self-help services to support the member outside of the ACT program.

Communication

Question	
41	The team identifies the members family and support network in the service plan or absence of, with permission from the recipient (document this is declined by my member).
42	The team develops and works with member support networks to enhance integration into the community (document absence of support or declined by member).
43	The team demonstrates use of all sources (family, friends, etc.) to contact a missing recipient.

Transition Planning

Question	
44	There is evidence that a transition tool is used and individuals who score are ready for transition are actively engaged in the transition process.
45	There is evidence that the team establishes a positive expectation for transition at admission.
46	For long-stay ACT members, there is evidence of transition discussions (progress and goals for the future).
47	There is evidence that specific activities associated with positive discharges are evident in the record.
48	There is evidence that a system is in place that assures early, and regular post-d/c follow up with new providers and natural supports to ensure that discharge plan is being followed for the member.
49	There is evidence that the team completes a warm handoff with concurrent provider or in transitions in care, including discharge (if applicable). NON SCORED

Interventions & Collaboration

Question	
50	There is evidence in the record that specialists on the team provide targeted interventions to the member.
51	There is evidence in the record that specialists on the team collaborate with other team members that the member is engaged with.
52	There is evidence in the record that the team conducts face-to-face contacts based on the member's needs, with the minimum number of 2 (two) to 6 (six) face-to-face contacts per month.
53	There is evidence in the record that the team conducts most of the team contacts in the community for the member.
54	There is evidence in the record that the team is involved in hospital admissions, discharges, and ER visits (if applicable) for the member.
55	There is evidence that the Physician and NPP conduct visits in community as needed per guidelines.
56	There is evidence that the team reviews the status of member and plans for response to potentially elevated risk status are formulated.