

OnTrackNY Observation Guide for Team Meeting

Team/Agency:

OTNY Rater:

Length of Team Meeting:

Observation Date:

Attendees:

2a. Supervision: TL provides administrative supervision which can include managing staff time on the team, making sure there is seamless communication strategies across team members, finding coverage, and ensuring that program elements are compatible with agency requirements.

Who is running the meeting? How is it structured e.g. is there an agenda, are materials reviewed?

3c. Staff Meets as Team: Each client's status (clinical status and recovery goals progress) is reviewed at least briefly at each team meeting i.e. at least 12 times per each quarter in the past year.

Is each client reviewed? In how much depth (description of new clients, review of goals, treatment plans, support person involvement, interventions used, discharge plans)? How is the review of all clients ensured e.g. going through a list, having a time keeper, etc.?

5a. Team (led by ORC) conducts outreach: The team conducted outreach and recruitment activities to mental health settings (including inpatient units, outpatient clinics, mobile crisis teams and emergency rooms) at least once each quarter in the past year.

If outreach and recruitment is reviewed, how is this done?

5b. Team (led by ORC) conducts outreach: In addition, the ORC conducted outreach and recruitment activities to community settings (including community organizations, schools, colleges, law enforcement setting) for at least two community settings each quarter in the past year.

If outreach and recruitment is reviewed, how is this done?

4a. Eligibility: OnTrackNY client records indicate that there is a consistent process for screening incoming referrals and enrollment decisions follow explicit OnTrackNY inclusion/exclusion criteria.

If outreach and recruitment is reviewed, how is this done? E.g. referrals, screenings, eligibly evaluations, re-directed referrals

9a. Assertive Outreach: Team has a concrete strategy to promote client engagement when clients miss appointments or show disinterest in services, which includes reaching out to people by various methods (e.g., phone, text, email, and home visits) to promote engagement in the past year.

What methods of communication or strategies are being utilized to increase engagement? Does the team have a policy about what to do if a client has not been heard from in the past month? Are Primary Clinicians going into the community to meet clients? Are support people contacted to help support engagement? What creative activities do they offer to increase engagement?

10b. Crisis Services: Team is involved in providing live (in-person/phone) crisis support or and coordinating linkages to crisis services, including access to medical back-up, to manage crises on a timely basis for each quarter in the past year.

Are safety concerns and plans are discussed, how is this done? Is a “high-risk” list identified?

11c. Care Processes: The team is delivering person-centered care, using recovery principles, shared-decision making and cultural competency in the past year.

If care processes and interventions are reviewed, how is this done? Are there particular clinical concepts that underline the approach to working with clients? Are client goals discussed? Are strategies identified that are tailored to client needs/goals? How is the team working with a participant/family that are on different pages in regard to treatment goal or next steps for goals? Is recovery oriented/person centered language used; how is this done?

12e. Case Management: Primary Clinicians provide case management services to help clients and families with concrete needs in the past year.

Are Primary Clinicians providing case management services e.g. benefits, housing, transportation, etc.? How is this done?

13a. Safety Planning: For those who meet or exceed the specified threshold indicating a risk of suicide based on a screening assessment, a safety plan is created, revised, and used during that same assessment period for each quarter in the past year.

Is the clinical staff assessing for risk of suicidality? If so, what screening tool is used? Has the PC developed a safety plan intervention for suicide risk with the client? How are the PCs ensuring that clients are using the safety planning intervention?

16c. Psychotropic Medications: Prescribers and clients use SDM and client preferences are considered when exploring medication decisions in the past year.

If medication and side effects are discussed, how is this done? (review of client medication goals, medication prescriptions, discussion of how they are taking it, reports of efficacy and side effects, other challenges to taking medication)

16c. Nurse works with clients to promote wellness: At least 50% of clients meet individually (i.e., not as part of a group) with the nurse for the purpose of medication education or support, health care coordination, nutrition/ exercise, smoking cessation, substance abuse, or sexual health or resources *at least once within 12 months of their admission.*

Is the nurse providing individual services? How are they doing this?

17b. Psychoeducation: The Primary Clinicians are providing psychoeducation routinely in care in the past year.

Are PCs providing psychoeducation in care? What topics are covered e.g. psychosis, co-occurring mental health problems, stress management?

18d. CBT Interventions: Interviews with Primary Clinicians, clients and client records indicate that Primary Clinicians are using empirically-validated CBT-based interventions to match client problems based on client preferences *in the past year.*

What strategies are PCs using for helping clients manage persistent positive psychotic symptoms, depression or anxiety? Are behavioral experiments used in the clinic or community? How are PCs helping clients come up with ways to manage and cope with symptoms?

19a. Substance Use Treatment: Of clients using substances, at least 50% of such clients are provided substance use treatment (includes skill-building or other interventions, such as motivational interviewing) by at least one clinician *at any time during each quarter in the past year.*

***Possible provisional item* 20b. Trauma Intervention:** Interventions for trauma PTSD such as the Brief PTSD intervention are delivered based on client preferences in the past year.

Probing questions for staff: Ask primary clinicians if they are familiar with the Brief PTSD intervention and whether they have used it with any clients. Are there other PTSD interventions that are used? Ask primary clinician if client who is being interviewed received the PTSD intervention. If yes, ask clients if they were offered PTSD treatment and whether their preferences were considered.

21a. Family Participation: Interviews (with PCs, clients and families) and client records indicate that cClient preferences are discussed (at admission and follow-ups) and the PC offers meetings with the families. For those who agree frequency and content reflect client and family preferences in the past year.

Are the Primary Clinicians offering meetings for families? Are materials for family work being used e.g. the Family Needs Assessment, psychoeducation, discharge planning? How is the Primary clinician determining clients' and families' preferences and the various ways in which family meetings are

arranged? Are clients preferences respected regarding how the team is working with their family? Has the team offered to meet with families and has assessed their preferences?

22a. SEES Services: SEES primarily provides employment and education services. At least 90% of the SEES' meetings with clients are devoted to assisting clients with working on employment or education goals (including providing follow-along supports) for each quarter in the past year.

How is the team assisting the clients in finding competitive jobs or returning to obtain an education? Is the SEES providing follow-along supports; how so?

23a. Peer Specialist Services: The Peer Specialist works with clients using their own recovery story and providing support and uses OnTrack Maps individually and in groups in the past year.

How is the PS using their recovery story and providing support to participants? Are they using a tool, such as OTNY Maps to help facilitate this? If so, how is the tool being used?

23b. Peer Specialist Services: At least 50% of participants meet with the peer specialist for each quarter in the past year.

Does the team have conversations with clients about their preferences for working with the Peer Specialist? Are clients and families being offered opportunities to meet with the peer specialist? How often does the Peer Specialist meet with clients or families?

23c. Peer Specialist Services: Peer Specialist is engaged with team outreach activities, initial and continued client engagement, discharge and linkage to resources in the past year.

What methods of communication or strategies is the PS using to increase engagement? Is the PS going into the community to meet clients? Is the PS working with participants' support people? What creative activities do they offer to increase engagement?

24c. Discharge: There is a protocol for outreaching participants who are non-responsive (e.g. team is unable to contact client) and steps are taken to refer non-responsive participants to appropriate treatment providers and appropriate follow up (e.g., sending a letter with referral information).

24d. Discharge: Interviews with Primary Clinicians, clients and a review of client records (when possible) indicate that Primary Clinicians identify and provide linkages to community supports that clients and families may need for a successful transition (e.g., NAMI, social-groups/activities, school support) in the past year.

Are steps are being taken to help with setting up a successful discharge? Are the Primary Clinicians connecting clients and families to community resources? What is the transition-planning process?

24e. Discharge: Interviews with Primary Clinicians, clients and review of client records indicate that discharges are planned and documented: teams use SDM to plan and perform discharges and have a system for following-up to make sure clients attend initial appointments with new provider in the past year.

Is there a discharge protocol that is being carried out regularly? What methods or strategies does the PC use to make sure clients attend their initial appointments with new providers? Are the PCs using the transition planning tool and how are they using that tool?

25b. Time-Limited Services: Providers communicate to clients and family members that this is a time-limited service, beginning at the time of enrollment in the past year.