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14 NYCRR Part 590

"Comprehensive Psychiatric Emergency Programs"

9-01-2021

This document is intended to provide interpretive/implementation guidance with respect to certain provisions of # NYCRR Part 590. Because this guidance document addresses only selected portions of regulations and does not include or reference the full text of the final and enforceable part 590, it should not be relied upon as a substitute for these regulations.

Table of Contents

A. Part 590 CPEP Regulations

The New York State Office of Mental Health (OMH) published CPEP regulations, 14 NYCRR Part 590 on May 19th, 2021. The purpose of this Part is to establish standards for a CPEP which provides a full range of psychiatric services within a defined geographic area and establish requirements for the establishment and operation of a CPEP.

B. Purpose of this Guidance

The purpose of this document is to provide an overview of program and billing requirements for CPEPs This document provides guidance for the implementation of services within these programs. This guidance:

a. Defines services
b. Describes standards for the operation of CPEP services; and
c. Describes guidelines for CPEP and expectations for documentation, performance, and services delivery.

C. CPEP Services

CPEPs provide triage, observation, evaluation, care, treatment and referral in a safe and comfortable environment for those individuals with a known or suspected mental illness. They provide a full range of psychiatric emergency services and crisis outreach services within a defined geographic area to individuals experiencing symptoms of a behavioral health crisis including co-occurring disorders. These co-occurring disorders may include substance use disorders, intellectual and developmental disabilities, and medical conditions.

Individuals may present to the CPEP in a variety of ways including but not limited to referrals from providers, emergency medical services transport, police transport, and walk-ins. The CPEP staff will make a reasonable effort to obtain as much information from the individual(s) accompanying them to the CPEP.

1. Psychiatric emergency services

Psychiatric emergency services are provided in the emergency room 24 hours per day, seven days per week and include:

a) Triage and referral services

Triage and referral services are performed in the CPEP and must include a face-to-face interaction in person between an individual and a staff physician or psychiatric nurse practitioner. Other disciplines including but not limited to nurses, social workers, and mental health aides, may assist the physician or psychiatric nurse practitioner with triage and referral services.

Triage and referral services are performed to determine the scope of emergency service the individual requires. Determination of the scope would be based on the acuity and intensity of an individual's symptoms and/or distress and would determine the most appropriate next step in treatment. Triage and referral services include a psychiatric diagnostic examination and may result in either further evaluation, treatment activities, a full emergency visit, or discharge planning and referral to community treatment providers.

Triage and referral services are initiated as soon as possible and in any event within six hours after an individual is received into the CPEP's emergency room. The goal is to connect people to care and services expeditiously. The CPEP's workflow should be organized to facilitate rapid completion of triage and referral services. If the psychiatrist or nurse practitioner conducting a triage and referral service makes the clinical determination that a full evaluation is needed, they should proceed accordingly. For complex situations, nurse practitioners are encouraged to collaborate with a CPEP physician to make a clinical determination for the course of treatment.

Various activities and services may be performed during triage and referral services including but not limited to:

- psychiatric diagnostic assessments are performed by a staff physician, preferably a psychiatrist, or a psychiatric nurse practitioner;
- basic health screening, vitals, other screenings and emotional support as necessary may be performed by a nurse;
- emotional support, orientation to the unit, reassurance for the individual receiving services may be performed by a mental health aide and/or peer specialist;
- communication by CPEP staff with collaterals including but not limited to family, family of choice, and/or guardians of the individual receiving services. This is an essential aspect of the service for children; and
- discharge planning and linkage to services in the community may be performed by licensed social workers, other licensed professionals, and peer specialists.
- If a more specialized assessment is required, it may be provided by relevant trained staff, e.g., a substance use evaluation may be provided by a credentialed alcoholism and substance abuse counselor.

- Risk assessments including suicide and violence assessment are performed as needed. CPEPs are encouraged to use standardized or validated risk assessment tools to assist in their assessment of suicide and violence risk.
- Supportive services and resource brokering may be provided by peer specialists.

Triage and referral services results in discharge from the CPEP or initiation of full emergency visit services. For those Individuals discharged from the CPEP who require additional services, a discharge plan must be developed in collaboration with the individual, and upon discharge must be shared with the individual in the format of discharge instructions (see section 1. Admissions and Discharge for further details).

CPEP staff will work in collaboration with the individual to arrange a successful discharge by discussing treatment preferences and community supports. Completing a viable discharge plan with known appointments is expected. CPEP outreach services can be utilized for follow-up and support until connections are made.

Situations that may require triage and referral services include but are not limited to the following:

- an individual may present to the CPEP requiring stabilization of crisis symptoms that can be resolved quickly;
- an individual may present to the CPEP requesting or requiring a prescription or refill for medication;
- an Individual may present to the CPEP requesting or requiring an intramuscular injection;

For individuals presenting to the CPEP requiring assistance with food, housing issues and/or for individuals who frequently present to the CPEP in search of social interaction, in order to be able to bill for a Triage and Referral visit, individuals would need to be exhibiting symptoms of a behavioral health crisis and the services provided would need to meet the definition of a triage and referral visit.

b) Full emergency visit services

Full emergency visit services are performed in the psychiatric emergency room of a CPEP and require a face-to-face interaction in person between an individual and a psychiatrist. Other clinical staff may perform full emergency visit services in collaboration with a psychiatrist to assist in assessment and treatment.

Full emergency visit services are initiated as soon as possible after an individual is determined to need such services. Full emergency visit must be initiated within six hours of the individual being received into the CPEP. A full emergency visit consists of an in-depth evaluation and

determinations for next steps for treatment. Those determinations may include but are not limited to admission to an extended observation bed, admission to an inpatient bed, or discharge to community programs.

Full emergency visit is indicated for an individual whose presenting symptoms are initially determined to be serious and where the clinical staff believe commencement of treatment should begin immediately, and/or where staff are evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit. Serious symptoms are those that have the potential to substantially impact an individual's safety to self or others, or ability to care for oneself in the community.

Situations that may require a full emergency visit include but are not limited to:

- individual transported by Emergency Medical Services to the CPEP;
- individual transported by Law enforcement to the CPEP;
- Individual brought in against their will by family member or collateral; and
- individual requiring de-escalation or crisis intervention.

Full emergency visit services include:

- a psychiatric or mental health diagnostic examination;
- a psychosocial assessment;
- a medical examination;
- a comprehensive psychiatric emergency treatment plan; and
- discharge planning, which results in a discharge plan and discharge summary and may result in a Wellness and Safety plan when indicated; and
- full emergency visits may include other examinations and assessments as clinically indicated by the individual's presenting problems and as requested by the psychiatrist.

Various activities and services may be performed during a full emergency visit including but not limited to:

- basic health screening, vitals, de-escalation, crisis intervention and other screenings as necessary performed by a nurse; and
- emotional support, orientation to the unit, reassurance for the individual receiving services, de-escalation and crisis intervention may be provided by psych techs, mental health aides, patient care associates, and/or peer specialists.
- communication by CPEP staff with collaterals including but not limited to family, family of choice, and/or guardians of the individual receiving services. This is an essential aspect of the service for children; and
- Licensed Social workers and/or other licensed professionals may provide the same services as mental health aides, and may also provide counseling, discharge planning using a network of services available in the community and perform a variety or

problem-solving activities to ensure the success of the individual post discharge. In some instances, social workers and other licensed professionals may provide clinical assessments in conjunction with the treatment team.

- If a more specialized assessment is required, it may be provided by relevant trained staff, e.g., a substance use evaluation may be provided by a credentialed alcoholism and substance abuse counselor.
- Risk assessments including suicide and violence assessment are performed as needed. CPEPs are encouraged to use standardized or validated risk assessment tools to assist in their assessment of suicide and violence risk.
- Supportive services and resource brokering may be provided by peer specialists.

c) Extended Observation Bed (EOB)

An EOB is a bed located in or adjacent to the emergency room of a CPEP which provides a safe environment for an individual who, in the opinion of the examining physicians, requires extensive evaluation, observation, assessment, or stabilization of the person's acute psychiatric symptoms for a period up to 72 hours.

72 hours begins when the individual is received into the CPEP. Received means the individual has completed all required registration materials upon entry to the CPEP, and a record has been created for such individual.

In addition, individuals may also benefit from admission to an EOB to assist with any of the following:

- the gathering of collateral and longitudinal observation to assist in a comprehensive psychiatric assessment and plan;
- metabolism of substances that may be contributing to an individual's acute psychiatric symptoms or crisis;
- treatment of acute intoxication or withdrawal to support safety and stability if discharged back to the community;
- coordination with family or outpatient care providers, including family meetings; and
- discharge planning (see section 1. Admission and Discharge – J. Discharge Planning).

Extended observation beds are operated 24 hours per day, seven days a week. EOBs provide extended assessment, observation and evaluation, therapeutic programming as well as a humane, safe environment which includes appropriate sleeping quarters, toilet, bath, and dietary facilities.

Staffing
EOBs should have a comprehensive staffing plan to ensure that an individual's psychiatric assessment, medical, treatment and discharge planning needs are met during their stay. The staffing plan may include the following:

- Psychiatrists, psychiatric nurse practitioners, Registered Nurses (RN), social workers, and other licensed clinicians and trainees, including psychiatry residents. Medical providers may work with individuals during an EOB stay to ensure that medical needs are being assessed and met. These staff may vary based on the program's and individuals' needs.
- Psych techs, mental health aides, behavioral health associates and/or patient care assistants engage with the person throughout their stay and may be involved in the monitoring and/or assessment of individuals, as well ensuring a safe and therapeutic milieu. They may also be involved in crisis de-escalation and intervention when needed.
- Activities and creative arts therapists may be available to provide appropriate activities and creative arts therapy, both group and individual modalities as needed.
- Certified Alcoholism and Substance Abuse Counselors (CASAC) and/or Certified Recovery Peer Advocates assess and engage individuals regarding substance use, misuse or abuse and harm-reduction strategies.
- Peer specialists are recommended to be a part of the staff attending to individuals admitted to EOB to assist with engagement, resource brokering and other peer services.

Services include but are not limited to the following:
- Individuals are observed frequently throughout their stay in an EOB. Observation levels are determined by the treatment team and ordered by the CPEP physician.
- Nursing assessment is performed by a RN every shift.
- Minimum daily psychiatric assessment performed by the attending psychiatrist or a nurse practitioner in psychiatry under supervision of a staff psychiatrist.
- Meetings occur with the treatment team throughout an EOB stay. Meetings are dependent on the individual's needs, clinical course and possible family or outpatient care providers/case managers meetings.
- Opportunities to engage in activity therapy are offered daily.
- Risk assessments including suicide and violence assessments are performed. CPEPs are encouraged to use standardized or validated risk assessment tools to assist in their assessment of suicide and violence risk.
- For individuals admitted into an extended observation bed, a safety plan for the EOB stay is developed for anyone determined to be at moderate to high risk of harm to their self or others.

- Short-term recovery-oriented counseling focused on the identified crisis to re-establish baseline functioning is provided. This service includes individual, family, and group therapy. It also can include peer support in groups and 1:1.
- Discharge planning in collaboration with the individual is provided. (see section 1. Admission and Discharge – J. Discharge Planning)

Individuals may be discharged from an EOB back to the community or may need more intensive treatment provided in an inpatient psychiatric hospital.

2. Additional CPEP Services

In addition to psychiatric emergency services, the following services are included in the array of CPEP services:

a) Crisis Outreach Services

Crisis outreach services are evaluation, assessment and stabilization services provided in person outside of an emergency room. They may be provided in the community or at a location within the hospital, outside of the emergency department. They include:

i. Mobile Crisis Outreach

Mobile Crisis Outreach services are voluntary services provided to individuals in the community who are exhibiting symptoms of mental illness and/or acute stress that significantly impairs the capacity to cope with normal life circumstances. There may be a risk for an escalation of psychiatric symptoms that cannot reasonably be managed without intervention.

ii. Crisis Outreach Follow Up

Crisis Outreach Follow Up services are provided to individuals who may be considered high risk, disconnected from care or other factors, and are identified through CPEP psychiatric emergency services at discharge or by Mobile Crisis Outreach teams. These services may be provided in the community or at a location within the hospital outside of the emergency department. If provided within the hospital, this service is not intended to replace clinic services but are intended to provide opportunities for individuals where making connections in the community are too difficult and providing a space within the hospital walls provides better access and greater opportunity for making connections with the individual and linkages within the community.

Crisis Outreach Follow Up is not a service that is provided to individuals being discharged from psychiatric inpatient units.

iii. Referrals

Mobile Crisis outreach referrals can be made through hospital internal referrals, community referrals or through CPEP discharge referrals. Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) as well as local Electronic Health Records (EHR) and Regional Health Information Organizations (RHIO)/ and Qualified Entities (QE) resources can be used to gather treatment history which may be helpful in making decisions about referrals.

Crisis Outreach Follow Up service referrals are made through CPEP psychiatric emergency service discharge referral and after mobile crisis service referrals.

iv. Services

Crisis outreach services include, but are not limited to, therapeutic communication, coordination with identified supports, psychiatric consultation, safety planning, referral, linkage, and peer services. Medications to treat psychiatric symptoms or substance use/withdrawal should be prescribed to individuals receiving crisis outreach services when appropriate.

Crisis outreach services allow for direct linkage to community and treatment programs as well as the ability to maintain connection with individuals after discharge from CPEP to facilitate and support a successful transition to and appropriate engagement in ongoing services and supports identified in the discharge plan.

Communication between CPEP crisis outreach services and outpatient treatment programs regarding risk and need for crisis services are critical to provide the right service at the right time. Crisis outreach services should not replace an outpatient provider's own responsibility to ensure engagement and continuity of care. Balancing this responsibility will allow crisis outreach teams to maintain the ability to both support outpatient programs and respond rapidly to community crisis calls.

Crisis outreach must be provided seven days per week, during at least the day and evening hours. A CPEP may determine and plan for further availability of crisis services in coordination with the local government unit.

Crisis outreach services may be provided directly by the CPEP or through written agreement with a provider of service approved by the Office of Mental Health.

Telephonic mobile crisis follow-up services may be reimbursed for individuals enrolled in Medicaid Managed Care through the 1115 Crisis Intervention benefit.

v. Duration of follow up

OMH removed a prior limit to how long crisis outreach follow up services may be provided. Instead, OMH expects providers to make appropriate, person-centered

determinations for how long crisis outreach follow-up may be provided. An individual may receive crisis outreach services for a sufficient period of time that allows for linkage to and engagement in services after an initial crisis service visit in the community or discharge from the emergency room of the CPEP. Keep in mind that these are crisis services and are transitional in nature. Crisis outreach services should not take the place of ongoing treatment and support services in the community.

vi. Staffing

When providing crisis outreach services in the community, at least two staff of the crisis outreach team, one of whom is a member of the professional licensed staff, must be present. Certified peer specialists play an important and valued role as a member of the crisis outreach team and their inclusion in crisis outreach service provision is strongly recommended, due to their expertise in engagement, resource brokering and bridging, among other specialties. When peer specialists are not available, other clinical staff may be included in the crisis outreach team. For the definitions of staff please see section F. Definitions.

b) Peer services

Peer support services include but are not limited to individual advocacy, prevention, outreach, engagement, hospital diversion, information and referral, self-help, safety/crisis planning, planning for prevention of setbacks, development of psychiatric advance directives, relaxation, resource brokering, as well as health and wellness coaching.

Peer Specialists are integral to crisis response and stabilization. Availability of peer services within the CPEP and connection with community peer programs to individuals who request these services is required. CPEPs must post notices displaying the availability of on-site peer counseling/self-help services and the address and telephone number of local off-site peer counseling/self-help services.

c) Telehealth

Telehealth is allowed in CPEPs with proper approvals. For details on how Telehealth may be implemented in CPEPs, please review the most current telehealth guidance at:

https://omh.ny.gov/omhweb/guidance/

D. CPEP Operations

1. Admissions and Discharge

Each CPEP must maintain admission and discharge criteria consistent with goals and objectives of psychiatric emergency care.

a) Presentation

Individuals may present to the CPEP in a variety of ways including but not limited to referrals from providers, emergency medical services transport, police transport, and walk-ins. The mode of presentation to the CPEP will inform the initial services provided to the individual. The CPEP staff will make a reasonable effort to obtain as much information from these modes of presentation as possible.

b) Information Gathering

Gathering information from multiple sources, in addition to the individual's self-report, is a key aspect of conducting a thorough emergency behavioral health evaluation. The CPEP should obtain information about an individual's history from databases including PSYCKES, local EHRs, QE/ RHIO and/or other relevant database(s).

Information obtained should include but not be limited to identification of information regarding the individual's involvement and contacts in the system of care (e.g., presence of Assisted Outpatient Treatment (AOT) orders, treatment providers, etc., see below); to clarify clinical characteristics including prior medication use, substance use and treatment, medical issues; as well as successes and challenges with treatment engagement.

Efforts must be made to identify and contact family members (family of origin and/or family of choice) to better understand the individual's current living situation, history, and treatment preferences. Multiple sources are pursued for obtaining information and input from collaterals. For programs serving children and adolescents, input from schools, caretakers and social services agencies are pursued, as appropriate.

CPEPs should also make concerted efforts to contact treatment providers, including but not limited to Assertive Community Treatment (ACT) teams, shelter or residential staff, health home care coordinators, Managed Care Organizations (MCOs), state-operated facilities mobile integration teams, etc. to better understand treatment history, current crisis situation, personal strengths, and barriers to care and engagement. Every effort should be made by the CPEP to ensure a clinician can receive information from collaterals 24 hours a day, seven days a week.

c) Screening and Assessment

- All presenting individuals are assessed for primary language, including sign language, and services should be provided to meet language access needs (including addressing age/ developmentally appropriate language);
- All presenting individuals are screened for alcohol and substance use.
- CPEP assessments must be strength-based and person-centered and reflect the cultural and linguistic needs of the individual.
- In addition to assessment of suicidality and homicidality, assessment of presenting symptoms and risk for violence is performed.
- CPEPs assess social determinants, including but not limited to primary care, dental, food access, living situation, personal safety, heat/electricity;
- OMH recommends using standardized, evidence- based, risk screening tools to inform clinical decision-making. Screening tools should address symptoms, risk for violence, substance use/misuse, and risk of harm to self and others. For commonly used measures see section G. Appendix.
- Positive screens of risk of harm to self or others should results in an assessment of risk that includes static and dynamic factors together with mental status, supports, protective factors, and means and access to weapons.

d) Examination

When clinically indicated, individuals receiving CPEP services may require the following exams and/or procedures including but not limited to:

- a mental status exam;
- a medical exam which includes at a minimum a past medical history, review of physical systems, review of medications and allergies, and assessment of vital signs;
- a targeted physical exam;
- orders for laboratory and other diagnostic studies; and
- review of the individual's current engagement in treatment, support groups, and coping skills.

e) Formulation and Plan

The information collected from a conversation with the individual, collaterals, chart review, screening, assessment, and patient examination should be used to complete a formulation. The formulation should guide decision-making for next steps. An individual's formulation should include a discussion of the individual's presenting complaints, description of crisis, differential diagnosis, and a risk assessment.

Based on this formulation, a comprehensive psychiatric emergency treatment plan is developed, tailored to the individual. The plan includes, at a minimum, treatment recommendations and a disposition decision (inpatient admission, EOB admission, discharge, transfer to medicine, etc.). When applicable, the plans for other interventions should be described. These may include safety planning, any needed follow-up collateral, care coordination or family meetings.

f) Wellness and Safety Plan

OMH strongly recommends that CPEPs use, prepare and share Wellness and Safety Plans. "Wellness and Safety Plan" is a blanket term referring to a range of tools which can be helpful in engaging individuals in care and preventing future negative outcomes. A Wellness and Safety Plan can refer to a suicide prevention plan, a relapse prevention plan, a violence prevention plan, psychiatric advanced directives, a Wellness and Recovery Action Plan (WRAP ®) as well as other types of plans. These plans typically have common elements, including an individual's self-identified and preferred ways of coping with events in their lives. These can include coping mechanisms, calming techniques, preferred crisis stabilization strategies (e.g., oral vs. injectable PRN medications, preferred PRN medications, use of calming techniques instead of restraint and seclusion), contact information for people who should be involved in decisions about care, preferred harm reduction techniques, etc. An individual's Wellness and Safety Plan should be attached to their discharge plan and provided to the individual. See section G. Appendix for commonly used templates that can be helpful in examples of such plans.

i. Accessing and Sharing Wellness and Safety Plans

For the last several years, PSYCKES has included a section where providers can upload Safety Plans and can view and download such plans that have been uploaded by other providers. We strongly encourage CPEPs to look for and utilize these plans when reviewing PSYCKES on a routine basis and even more so to upload plans that you develop so other providers can access plans. In addition, CPEPs should review their own internal hospital information systems to review uploaded Wellness and Safety Plans where included.

g) CPEP Flow

CPEP Admission – An individual may be admitted to the CPEP if the staff physician, preferably a psychiatrist, determines that the person may have a mental illness or co-occurring disorder for

which immediate observation, care, and treatment in a CPEP is appropriate, and which is likely to result in serious harm to person or others (See OMH Form 476 for further details). In the case of a CPEP Admission, the front page of OMH Form 476 is to be completed, and the individual should be provided their notice of status and rights form.

Triage and Referral visit- If the staff physician or nurse practitioner conducting a triage and referral service makes the clinical determination that a full evaluation is needed, they should proceed accordingly. For complex situations, nurse practitioners are encouraged to collaborate with a CPEP physician to make a clinical determination for the course of treatment. Please note that only one service, either triage and referral or full, can be billed in a single CPEP episode of care

CPEP Full Emergency Visit – An individual must be examined by a staff psychiatrist of the CPEP as soon as is practicable, and in any event no later than six hours after the person is received in the CPEP emergency room.

*Reassessmen*t - An individual may be retained for no more than 24 hours, before they are to be reevaluated by a staff psychiatrist. Based on the reassessment, an individual may be discharged, or they may be admitted to an EOB bed if further observation, care, and treatment in the CPEP is needed. In this case, the back page of OMH Form 476 should be completed.

EOB Admission – An individual may spend up to 72 hours receiving care in the EOB. 72 hours is calculated from the time the individual is received in the CPEP. Received means the individual has completed all required registration materials upon entry to the CPEP, and a record has been created for such individual.

Inpatient Admission - At any time during the individual's CPEP or EOB stay, an individual may be reassessed and converted to a 9.13, 9.39 or 9.27 admission, should the appropriate criteria be met.

Discharge - At any time during the individual's CPEP or EOB stay, an individual may be reassessed and if clinically appropriate, may be discharged.

Please see appendix page 39 for a detailed illustration

h) Requests to leave CPEP

From the time of arrival in the CPEP, until a complete assessment has been performed and a disposition decision has been made, an individual has the right to request to leave the CPEP. In response to this request, a staff psychiatrist (or psychiatric nurse practitioner) should assess the individual for their safety and stability to leave the CPEP prior to a complete assessment. Please

note in the case of minors receiving services in a CPEP, a minor cannot choose to the leave the CPEP without agreement from the parent/guardian.

This brief examination to assess the individual for their safety and stability to leave the CPEP should, at a minimum, include a review of the individual's presentation, as well as their safety to self and to others. To the best of the clinician's ability, a determination that the individual is safe to return to the community without a complete assessment or treatment should be made. If this determination cannot be made via said brief examination and an individual needs to be retained against their will for a complete assessment, a justification for this should be provided to the individual, as well as documented in the chart. The individual's complete assessment should be completed as soon as possible, resulting in either discharge or being placed on a mental hygiene legal status (see section I. CPEP Mental Hygiene Law Sec. 9.13 below).

The following is a case note example that documents the brief examination that was done prior to an individual leaving voluntarily prior to completion of an assessment:

Mr. Jones self-presented to CPEP requesting a refill of his "depression medication". After approximately 1 hour in the CPEP waiting room, Mr. Jones requested to leave - saying that he would rather follow-up with his primary care doctor. On brief discussion with this writer, patient denies suicidal ideation (SI) / homicidal Ideation (HI), and does not show evidence of any acute mood or psychotic symptoms. While in CPEP, he was observed to be calm and in no distress. He was future oriented, denied any acute medical complaints and did not present as acutely intoxicated or in withdrawal. As such, he did not demonstrate evidence of acute dangerousness to self or others and will be permitted to walk out, with the plan that he will follow up with his primary care provider (PCP).

The CPEP ensures all required admission forms are completed and additionally are reviewed by the individual (see Appendix H. Form)

i) CPEP Mental Hygiene Law Sec. 9.13

In accordance with Mental Hygiene Law Sec. 9.13, individuals may seek voluntary admission to a CPEP and a CPEP's extended observation bed. Voluntary treatment means that a person has a mental illness for which care and treatment as a patient in a CPEP is essential to such person's welfare and such person understands and consents to the need for such care and treatment.

i. Involuntary Retention

In order to be retained in a CPEP over an individual's objection, an involuntary legal status must be in place.

CPEP Emergency (9.40)
CPEP emergency standard: A person may have a mental illness for which immediate observation, care and treatment in a CPEP is appropriate and which is likely to result in serious harm to him/herself or others.

“Likelihood of serious harm" is defined in Mental Hygiene Law 9.01 and includes:

- a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to him/herself; or
- a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

A staff physician, preferably a psychiatrist, must, within 6 hours after the person is received in the CPEP emergency room, examine and determine that the individual meets the CPEP emergency standard. If an individual requests to leave the CPEP, a CPEP staff physician, preferably a psychiatrist, must, within 6 hours after the person is received in the CPEP emergency room examine and determine that the individual meets the CPEP Emergency Standard (see Request to Leave section Page number above).

ii. EOB Involuntary Admissions

In order to admit an individual to an EOB involuntarily, the staff psychiatrist must, within 24 hours after the individual is received in the CPEP emergency room, examine the individual and confirm the first staff physician’s finding that the individual meets the CPEP emergency standard and would benefit for extended observation and treatment. At that point, the individual must be moved to an extended observation bed.

iii. EOB Retention

Individuals admitted to EOB under 9.40 or 9.13 legal status may continue stay up to 72 hours from admission to the CPEP, after which the individual must be discharged from CPEP. Ongoing assessment must be conducted to ensure that the individual continues to meet the requirements for CPEP emergency admission. If it is determined that the person is likely to continue meeting the requirements for CPEP emergency standard beyond the 72-hour period, the person shall be evaluated and, if appropriate, admitted to a psychiatric service pursuant to MHL section 9.39. If the person is determined to no longer meet CPEP emergency standard requirements but is in need of continued inpatient care and treatment and is not suitable for a voluntary admission, they may be admitted on an involuntary basis under MHL section 9.27.

iv. Inpatient Retention

At any point in a CPEP stay in the emergency room or EOB, an individual may subsequently be held involuntarily if he/she meets the Involuntary Standard (§9.27) or emergency standard (§9.39) and is admitted to an appropriate facility in accordance with the processes described above. An individual must be transferred to inpatient services as soon as possible, and in no cases, should be retained in a CPEP longer than 24 hours from admission, unless admitted to an EOB. This does not imply that individuals who are awaiting admission should automatically be admitted to an EOB bed. Admission to EOB should be reserved for individuals who require

extended observation to clarify their clinical status. For more information see section C. CPEP Services- 1. Psychiatric Emergency Services- c. Extended Observation Beds and section iii. EOB Retention above.

j) Discharge Planning

i. Triage and Referral Visit

An individual may be discharged from the emergency room of a CPEP following determination of a CPEP physician or nurse practitioner.

Full Emergency Service Visit

An individual may be discharged from the emergency room of a CPEP or an EOB following the determination of a CPEP psychiatrist.

Prior to an individual's discharge from the CPEP the following activities should be performed, including but not limited to:

- identifying services that have been previously provided to the individual;
- asking the individual's preference for services in the community following discharge;
- checking the individual's health insurance to ensure compatibility with services referred;
- contacting the insurance company to discuss services;
- referral to CPEP crisis outreach services if need is determined (for information on making this determination see section C. CPEP services – 2. Additional CPEP services- a. Crisis Outreach Services) ;
- notification to the individual's Health Home care manager if the individual is enrolled, or referral to a Health Home if the individual is not enrolled;
- collaboration with referral sources or other involved collateral as part of the discharge planning process;
- if applicable, collaboration with the individual's residential team, ACT team, and/ or case manager;
- plan to address social determinants that were identified in the assessment, including but not limited to primary care, dental, food access, living situation, personal safety, heat/electricity;
- ensuring the person has a prescription or supply of medication adequate to meet their needs until their next appointment;
- individual's discharge instructions are provided and reviewed with the individual;
- a child's discharge instructions are provided and reviewed with the child and family;
- individual's Wellness and Safety plan is provided and reviewed with the individual; and
- a child's Wellness and Safety plan is provided and reviewed with the child and family.

Peer Specialists and discharge planning

Peer specialists may be utilized as an important part of discharge planning and may work to broker resources and identify supports in the community

ii. Discharge Instructions

Discharge instructions (also known as discharge plan or an after-visit summary) must be completed for every individual who is discharged from the CPEP or EOB, and is to be completed prior to an individual's discharge. An individual must have the opportunity to participate in the development of their discharge plan. The written record should explain any circumstance in which the individual refuses or is not able to participate in the discharge planning process.

The discharge instructions must include the services and supports that are appropriate to the individual's needs, and be composed of person-centered, age- and developmentally-appropriate language. The discharge instructions shall minimally include:

- a summary of findings;
- treatment recommendations;
- any lab or testing results that are pending at time of discharge and when and how these results will be provided to the individual;
- medication reconciliation;
- prescription information;
- information regarding peer services; and
- dates and times of follow up appointments including address and contact information.
- The discharge instructions shall include the name(s) of all provider contacts and telephone numbers at the discharging facility, to allow the recipient opportunities to ask questions.

The discharge instructions shall be provided to the individual, prior to their exit from CPEP. A copy should also remain as part of the individual's case record. The discharge instructions shall also be promptly provided to current providers including housing providers, appropriate Health Home care coordinators and managed care organizations, prior to the individual's next appointment.

iii. Discharge Summary

Triage and Referral

In the event there is key information that is not otherwise captured in the psychiatric assessment or discharge instructions related to hospital course or discharge planning a discharge summary should be completed as indicated.

Full Emergency visits and Extended Observation Beds

A comprehensive discharge Summary is required for all Full emergency visits and EOB stays and should be completed within five days of discharge. An individual's discharge summary shall Include all the components of the discharge instructions and additionally includes:

- a hospital course, including a summary of all services and treatments received in the CPEP;
- a summary of collateral involvement;
- results of any relevant lab testing, examinations and/or imaging (Please note that discharge instruction and summaries for all CPEP services must include a plan for when and how pending lab or testing results will be reviewed and provided to the patient);
- condition at discharge, including the results of a recent mental status examination and risk assessment; and
- discharge diagnosis.

A copy of the Discharge Summary should remain as part of the individual's case record. The Discharge Summary should be provided to all current treatment providers and housing providers. The discharge summary may also be provided to Health Home care coordinators, managed care organizations, and to others per an individual's approval and with HIPAA Consent. Discharge summaries should be shared prior to the individual's next appointment but no later than five days after discharge. CPEPs should take all necessary steps to follow hospital policies regarding the sharing of information and confirm all information sent is secure and confidential.

Discharge-related Case Record Summary:

	Discharge Instructions	Discharge Summary	Wellness and Safety Plan	Additional info
Triage and Referral Visit	Required	When indicated	Strongly Encouraged	
Full Emergency Visit -> Discharge (w/in 6hrs of individual being received in CPEP)	Required	Required	Strongly Encouraged	*Given that there may be a limited hospital course in these cases, individual's discharge summary information may be documented within other parts of the case record (for example, as part of the individual's discharge plan, their comprehensive psychiatric assessment or as a separate follow-up note).

Full Emergency Visit -> CPEP Admission (individual in CPEP ER 6hrs-24hrs) -> Discharge	Required	Required	Strongly Encouraged	
Full Emergency Visit -> EOB -> Discharge	Required	Required	Strongly Encouraged	

iv. Follow Up After Discharge and Linkage to Care

In the updated CPEP regulations, OMH included language about expectations to follow up with individuals after discharge to verify that after-care appointment(s) occurred and follow up with individuals to ensure satisfactory linkage to care. Each CPEP should develop policies and procedures for this requirement. Below is guidance to help clarify these expectations.

After care appointments, including those made with open access centers, require a specific appointment date and time which must be provided to the individual, in advance of the appointment. If such an appointment is not able to be obtained prior to discharge, the CPEP must outreach the individual to ensure they have the appointment information. CPEPs should also share discharge instructions or discharge summaries with after-care providers.

The following is an example of a CPEP using partnerships and technology to facilitate linkage to care:

Stony Brook University Hospital has partnered with ambulatory providers both within the Stony Brook system and with community providers to provide timely and definitive linkage to appointments after discharge from our hospitals. Stony Brook entered into Memorandums of Understanding with partners allowing access to a shared calendar for appointments. Stony Brook is able to book an appointment with community partners and give that day/time to patients before they leave the hospital, increasing the likelihood of follow-up with aftercare. Additionally, Stony Brook staff have begun using Direct Messaging to transmit patient information (with consent) to the ambulatory provider to ensure the provider has all discharge and diagnostic information. Lastly, and just as importantly, community providers have a system to follow-up with Stony Brook to close the loop as to whether or not the patient attended the follow up appointment.

For individuals receiving such an appointment, CPEP staff shall verify that after-care appointment(s) occurred. Such follow up may be completed by review of EHR for referrals internal to your facility or network. Where access is available to Regional Health Information Organization (RHIO)/Qualified Entity (QE) systems, these can be used as well. If electronic access is not available, CPEPs should follow up with the next provider, care coordinator, housing or shelter provider, collateral and/or the discharged individual to ensure satisfactory connection to care.

To manage workload, CPEPs should develop clinical or other risk-based protocols to determine which individuals should receive follow up and the necessary extent of such follow up. If reasonable attempts to confirm after-care attendance as above are unsuccessful, no further follow up is needed.

If it is confirmed that an after-care appointment was not completed the CPEP should reach out to the individual to review the discharge plan and identify alternative resources if needed. A referral to crisis outreach services may be used to connect with the person, review the discharge plan, and to facilitate linkage to care**.**

In cases where no after care appointment was made due to either lack of clinical necessity or refusal of services, decisions about need for follow up should be made based on clinical considerations.

Until linkage to care is completed, or for other clinically-indicated reasons, CPEPs should make a reasonable effort to:

- ensure individuals are safe and stable in the community;
- provide support, care and assistance with linkage to follow up care;
- provide crisis outreach services to support an individual's stability in the community;

It is the expectation that follow up outreach services are offered to recipients of services at CPEP based on clinical necessity or recipient preference. Prioritization of services and partnership with community providers is the responsibility of the CPEP. For more detailed information regarding crisis outreach services please see C. CPEP Services- iv. Crisis Outreach Services.

v. Considerations for follow up services:

- Crisis outreach services are time limited, but in the revised regulations, we removed specific timeframes limiting duration of follow up.
- CPEPs should develop policies and guidelines to ensure individuals do not receive follow up services in excess of a reasonable amount of time.
- Follow up crisis outreach services are designed to ensure linkage to care for individuals discharged from a CPEP.
- Follow up services are not designed to place CPEPs in the role of case manager or to carry an ongoing clinical caseload.
- Efforts should be made to transition individuals to other providers including to but not limited to housing shelters, housing providers, case managers, etc.

vi. Alternative Funding Options

CPEPs approved under the Medicaid Managed Care Crisis Intervention Benefit may bill MMCOs for mobile and telephonic follow-up services provided to a recipient of a qualifying crisis service. Please refer to section 7. Billing.

k) Diversion

When a CPEP requests a temporary cessation of Emergency Medical Technicians (EMT) visits (diversion), the appropriate OMH Field Office must be notified according to a mutually developed and agreed upon plan. CPEPs should contact their local field office for details.

l) Crisis Residences

Effective October 7, 2020, CPEPs are no longer required to provide Crisis Residence services under Part 590. However, with the development of Crisis Residential Services under OMH Part 589, CPEPs should develop close linkages working with crisis residences in the area. CPEPs should refer appropriate individuals to Crisis Residential programs as clinically indicated and consistent with individual preference.

2. Staffing

A CPEP must continuously employ an adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision. All staff working in the CPEP should be oriented in, and having ongoing access to, all relevant hospital policies and OMH regulations. All staff working in a CPEP must be competent in the identification of risk factors for harm to self and/or others.

A CPEP must, at a minimum, employ the following types and numbers of staff:

- At least one full-time equivalent psychiatrist, who is a member of the psychiatric staff of the program, shall be on duty and available at all times.
- At least one full-time equivalent registered nurse shall be on duty at all times to oversee nursing triage, assessment, care and treatment of all individuals receiving CPEP services.
- At least one full-time equivalent licensed master social worker or licensed clinical social worker shall be on duty and available, at a minimum, during the day and evening hours.

Please note: *On duty* means the professional is physically present in the building and accessible.

- A sufficient number of security personnel shall be on duty and available at all times. Ideally clinical staff trained in Preventing and Managing Crisis Situations (PMCS), such as Behavioral Health Associates and Psychiatric Technicians, are the primary staff ensuring a safe milieu, and liaising with other hospital security staff as necessary.

  Staffing Case Example – Behavioral Health Associates (BHA):

  The New York City Health + Hospitals system has developed and implemented an alternate approach incorporating crisis de-escalation and safety management in a clinical framework, the Behavioral Health Associate (BHA). BHAs report to nursing leadership and are incorporated into the staffing pattern and milieu of CPEPs and inpatient services. BHAs perform crisis and/or de-escalation interventions, therapeutic observations, engagement, patient supervision and other behavioral health related duties, including assisting in the implementation of seclusion/restraints for patients presented to behavioral health services for psychological assessment and treatment.

  BHAs are typically experienced psychiatric technician staff who have worked in acute emergency or inpatient settings, and may also have experience in security-related settings, such as law enforcement. BHAs receive enhanced training on patient engagement, crisis prevention and de-escalation, and are looked to as experts and leaders in these domains.

- At least one full-time equivalent credentialed alcoholism and substance abuse counselor or clinical staff person with experience related to the counseling or treatment of individuals with a substance use disorder shall be available or on-call 24 hours a day.

While at a minimum, the extended observation beds component of the CPEP must be staffed by at least one clinical staff person, who is supervised by the registered nurse supervisor, 24 hours per day, seven days per week; the entirety of the CPEP should be adequately staffed with clinical staff to ensure appropriate levels of observation of patients, as well as a safe and therapeutic milieu. In addition to those mentioned above and below, CPEPs may employ clinical staff including, but not limited to, behavioral health associates, psych techs, mental health aides, patient care associates, and nurse support staff to ensure appropriate delivery of treatment and a therapeutic milieu.

For CPEPs that serve children and adolescents, a child psychiatrist is on call 24/7 and the CPEP will have at least one clinical staff member (OMH recommends a licensed clinical staff member). The identified clinical staff member, by virtue of training or experience, is competent to treat children and adolescents.

Other specialists and/or consultants should be available to assist in patient care as needed.

Individuals in the CPEP must have timely access to medical care by a medical provider who is available 24/7. CPEPs may employ a medical provider as part of their staff, or utilize the services provided within their hospital, as long as timely assessment and intervention can be assured.

CPEP regulations have been expanded to allow for the potential of more autonomous care to be provided by Psychiatric Nurse Practitioners for lower acuity and low complexity triage and referral visits. Close collaboration between Psychiatric Nurse Practitioners and the CPEP Psychiatrist is strongly encouraged. Ultimately, a Nurse Practitioner's roles and responsibilities within a CPEP should be guided by the policies and procedures of the hospital.

The inclusion of certified peer specialists in a CPEP staffing model is expected. Certified peer specialist includes any peer specialist certified or credentialed by the state of New York and includes but is not limited to certified peer specialists, family peer advocates, youth peer advocates, or certified recovery peer advocates depending on the populations served.

Students and trainees may qualify as CPEP clinical staff if they are participating in a program leading to a degree or certificate appropriate to the goals, objectives, and services of the CPEP and are supervised in accordance with the policies governing the training program and are included in the staffing plan approved by the Office of Mental Health. Peers who have not yet been certified or credentialed may be included in a CPEP staffing pattern if they also qualify as students or trainees.

3. Case Records

a) Case Record Requirements

There must be a complete legible case record maintained for each individual admitted to a CPEP. The case record should be available to all clinical staff of the CPEP who are participating in the treatment of the individual. The case record must include documentation of the individual's mental hygiene legal status.

The case record must include a presentation note which, at minimum, indicates:

- a brief description of the presenting problem, critical needs and overall conditions;
- a brief description of the care and treatment required to safely and effectively address the individual's needs during the initial period after admission; and
- a brief description of the CPEP attempts to contact collaterals. This includes other treatment providers, including but not limited to Health Home care coordinators, managed care organizations, and residential providers as applicable.

Each case record for individuals who receive CPEP services must include:

- patient identifying information;
- available psychiatric and medical history;
- relevant social history, including the person's residential situation and the details of the circumstances leading to the individual's presentation at the CPEP;
- the name of the person or persons who have referred or brought the individual to the CPEP, if any;
- In the case of individuals brought to the CPEP by law enforcement officers, the officers should be interviewed and identified;
- assessment of the individual's treatment needs based upon psychiatric, physical, social and functional evaluations; and
- progress notes which relate to goals and objectives of treatment and document services provided.

The following information is required for each case record for individuals who receive a full emergency visit and/or is admitted to an extended observation bed. When applicable, the following may be included in the case record for individuals who receive a triage and referral visit and/or crisis outreach:

- reports of all mental and physical diagnostic exams, assessments, tests, and consultations;
- notes which relate to special circumstances and untoward incidents;
- dated and signed orders for all medications;
- discharge summary, including referrals to other programs and services, which must be completed within five days of discharge;
- documentation of attempts to contact collaterals; and
- documentation if services are refused.

Additionally, case records for individuals receiving extended observation bed services must include the rationale for placement in the EOB. Daily written documentation of the need for continued retention must be included for those receiving services up to 72 hours.

Wellness and Safety plans are strongly encouraged when applicable. For more information see D. CPEP Operations- 1. Admission and Discharge- f. Wellness and Safety Plan.

b) Treatment Plans

A treatment plan for those individuals admitted to the CPEP or the EOB may be documented by a psychiatrist or psychiatric nurse practitioner where appropriate within the case record. This plan should include the treatment goals for the individual's admission, and plans for any of the following:

- standing and/or prn medications;
- non-pharmacological interventions such as individual or group counseling;
- family meetings or other collateral involvement;
- an individualized plan to address risk of harm to self or others;
- level of observation and frequency of reassessments;
- plans for medical care, including any needed procedures, lab testing and vital signs;
- recommendations for activity therapies, peer services, and/or involvement of an alcoholism and substance abuse counselor; and
- linkages to social services and supports.

For information regarding discharge summary and discharge plan requirements see D. CPEP Operations-1. Admissions and Discharge.

4. Organization and Administration

a) Governing body

The governing body of the hospital is responsible for the overall operation and management of the CPEP. The governing body may delegate responsibility for the day-to-day management of the program to appropriate staff pursuant to an organizational plan approved by the Office of Mental Health.

b) Policies and procedures

The CPEP's written policies ensure the protection of patient's rights. These policies establish and describe a patient grievance procedure. The provider must post a statement of patients' rights in a conspicuous location easily accessible to the public.

c) Incident Reporting

The hospital must ensure the timely reporting, investigation, review, monitoring, and documentation of incidents. Such records and any related information must be made available to the Department of Health and Office of Mental health at their request.

CPEPs will:

- ensure all new staff receive training regarding the definition of incidents and reporting procedures for incidents;
- ensure staff are informed about the incident review process and the importance of risk management in maintaining safety and improving services;

- ensure refresher incident reporting training shall be conducted at least annually, and staff records indicate evidence of annual completion;
- ensure hospital staff reviewing incidents shall meet qualifications and are properly trained;
- ensure incident review results in recommendations action plans with program's administrator;
- the program must utilize New York Incident Management Reporting System reports, or other available incident/data analysis program reports, to assist in risk management activities and compile and analyze incident data for the purpose of identifying and addressing possible patterns and trends to improve service delivery.

d) Advancing Behavioral Health Equity

CPEPs will have written personnel policies which prohibit discrimination on the basis of race, color, creed, disability, sex, marital status, age or national origin, as well as written policies on ensuring a diversified workforce.

CPEPs must ensure efforts are made to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved marginalized populations. Efforts may include outreach and education about services and access, linkages to advocacy organizations, and policies.

Underserved/unserved marginalized populations may include but are not limited to: people of color, members of the LGBTQ community, older adults, Veterans, individuals who are deaf & hard of hearing, individuals who are Limited English Proficient, immigrants, and individuals re-entering communities from jails and prisons.

i. Staffing Demographics

CPEPs must make an effort to hire and retain staff that mirrors the demographic profile of the community and persons that are served. The program must use available data to set workforce recruitment targets to meet this goal. Efforts to recruit a diverse workforce should include all levels of the organization’s workforce, including management.

ii. Utilization of Demographic Data

CPEPs must review demographic data for the program’s catchment area to determine the cultural and linguistic needs of the population. Staff is trained to be aware and respond appropriately to the cultural and linguistic needs of the catchment area.

CPEPs must review available demographic data to identify disparities of access to treatment and should implement policy and procedures to address such disparities.

iii. Language Access

CPEPs must ensure provision of language assistance services to Limited English Proficient (LEP) Individuals and/or have other communication needs (e.g., Deaf or Hard of Hearing) at no cost to the individual to facilitate timely access to all health care and services. Language access services must be made available in such a way that assessment or treatment activities will not be delayed. For more information about Limited English proficiency please see www.lep.gov .

In addition, CPEPs must:

- make all necessary documents available in the individual's preferred language (e.g. releases, documents pertaining to rights);
- inform all individuals of their right to receive language assistance services clearly and in their preferred language, verbally and in writing;
- provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area, with a focus on the varied reading levels among the service user population;
- make efforts to provide the individuals identified as collaterals with language assistance services in their preferred language, verbally and in writing;
- make efforts to employ staff that are proficient in the most prevalent languages spoken by services users; and
- ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

For more information regarding culturally and linguistically appropriate services please visit https://thinkculturalhealth.hhs.gov/clas .

e) Local Government

The hospital must participate with the local governmental unit in local planning processes. At a minimum, such participation must include:

- provision of budgeting and planning data as requested by the local governmental unit;
- identification of the population being served by the program;
- identification of the geographic area being served by the program; and

- description of the program's relationship to other providers of service.

f) Quality Improvement

CPEPs should collect, analyze, and utilize information on a routine basis to change and improve services in response to identified trends. In addition, the CPEP should seek feedback from individuals, peers, and collaterals regarding services and integrates program recommendations.

5. Premises

The CPEP must maintain an environment adequate and appropriate for the safe and effective operation of the program. The premises must be reasonably maintained to ensure access to services and the physical space by all individuals including but not limited to individuals with developmental and intellectual disabilities, physical disabilities, communication needs, and individuals who are blind.

In an effort to provide space for healing, the CPEP should be a welcoming and comfortable environment.

Considerations for the CPEP environment include the following:

- Individuals should be greeted, engaged by CPEP staff, observed, and provided appropriate personal space while awaiting CPEP services;
- Individuals that present to the CPEP via means other than ambulance and police are considered voluntary until a determination is made to retain an individual under a mental hygiene legal status;
- creating an environment that is safe, therapeutic, and comfortable for the individual is important in stabilizing mental health emergencies;
- the maintenance of privacy for interviews between staff members and individuals served;
- when seclusion or restraint is performed, CPEPs should be mindful of safety and privacy considerations;
- the comfort and convenience of those waiting for and receiving services;
- individuals waiting for or receiving services may not be placed in a hallway or another part of the hospital not approved by the Office of Mental Health as a waiting or treatment area;
- accommodation of routine activities and regularly used equipment;
- adequate control for medications and controlled substances;
- controlled access to, and maintenance of, case records; and
- appropriate monitoring of the entrance and exit to the CPEP.

6. Statistical Records and Reporting

Consistent with 590.14, CPEPs must report data to OMH on a regular basis. OMH is transforming the data reporting requirement from the prior practice of reporting summary data to an expectation for reporting individual patient level data as available from the Agency's Electronic Health Record consistent with the CPEP Reporting Data dictionary.

CPEPs should use collected data to improve the quality of care provided and improve individual satisfaction.

7. Billing

CPEP is claimed on a daily basis. An individual may receive one triage and referral visit or one full emergency visit service in one calendar day. If an individual receives one of each, the CPEP will receive reimbursement for the full emergency visit. A provider may be reimbursed for one crisis outreach service and either one triage and referral visit or one full emergency visit per individual, per one calendar day. If more than one service is provided, then more than one claim must be submitted (one claim for each rate code). Each CPEP service has a combination of rate code/procedure code/modifier code.

Triage and Referral visit (4007) – Face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, or Psychiatric Nurse Practitioner to determine the scope of emergency service required. This interaction should include a mental health diagnostic examination. It may result in further CPEP evaluation or treatment activities on the patient's behalf or discharge from the CPEP. For those persons who are discharged from the CPEP and who require additional mental health services triage and referral must include a discharge plan.

Note: Services provided in a medical/surgical emergency or clinic setting for comorbid conditions are separately reimbursed.

Full Emergency Visit (4008) – A face-to-face interaction between a patient and a psychiatrist and other clinical staff as necessary to determine a recipient's current psychosocial and medical condition. It must include a psychiatric or mental health diagnostic examination; psychosocial assessment; and medical examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when CPEP or services are completed. It may include other examinations and assessments as clinically indicated by the recipient's presenting problems. Full

emergency visits should be provided to recipients whose presenting symptoms are initially determined to be serious and where the clinical staff determines commencement of treatment should begin immediately, and/or where staff is evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit. No person may be involuntarily retained in a CPEP for more than 24 hours unless the person is admitted to an extended observation bed. (See extended observation beds below.)

Crisis Outreach Service (4009) - A face-to-face psychiatric emergency services provided outside an emergency room setting which includes clinical evaluation, assessment, and stabilization services. Crisis outreach services include but are not limited to therapeutic communication, coordination with identified supports, psychiatric consultation, safety planning, referral, linkage, peer services. Crisis outreach services may be provided outside the emergency room of the hospital, in the community or in other clinical areas within the hospital, for purposes of face-to-face visits with individuals discharged from the CPEP. Crisis outreach does not have to result in a visit or admission to the CPEP. For individuals discharged from the CPEP, crisis outreach includes face-to-face contact with a mental health professional for purposes of facilitating an individual's community tenure prior to engagement or re-engagement with community-based providers.

Note: An individual may receive crisis outreach services for a period of time that allows for linkage to services after discharge from the emergency room of the CPEP.

Extended Observation Bed (4049) - No person may be involuntarily retained in a CPEP for more than 24 hours unless the person is admitted to an extended observation bed. The director of the CPEP may involuntarily receive and retain in an extended observation bed any person known or suspected to have a mental illness which is likely to result in serious harm to the person or others and for whom immediate observation, care and treatment in the CPEP is appropriate. Retention in an extended observation bed shall not exceed 72 hours (voluntarily, or involuntarily), which shall be calculated from the time such person is initially received into the emergency room of the CPEP.

Claiming for Extended Observation Beds –

- Admission to the extended observation bed is, for billing purposes, the calendar day after the calendar day in which the full or brief visit is completed.
- The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
- A triage and referral or full visit claim is submitted for the calendar day in which the visit is completed, and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the individual's initial arrival in the CPEP.

- If the individual is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed.

a) Alternative funding

CPEPs approved under the Medicaid Managed Care Crisis Intervention Benefit may bill MMCOs for mobile and telephonic follow-up services provided to a recipient of a qualifying crisis service. Follow-up services are eligible for reimbursement if provided within 14 days of the qualifying crisis episode. More information can be found at https://omh.ny.gov/omhweb/bho/crisis-intervention.html .

Follow-up services may be delivered face-to-face or through telephonic contact and may include, but are not limited to, the following types of activities:

- therapeutic communication and interactions to maintain stabilization following a crisis episode and prevent escalation of BH symptoms;
- facilitation of engagement in outpatient BH services, care coordination, medical health or basic needs related to the original crisis service;
- confirmation with service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services;
- contact with the individual's existing primary care and BH treatment providers, adult or children's Single Point of Access (SPOA) where applicable, and and/or care coordinator of the developed crisis plan;
- contact with the individual's natural support network with consent;
- referral and engagement/re-engagement with health homes and appropriate BH community and certified peer services to avoid more restrictive levels of treatment, including crisis respite; and
- follow-up with the individual and the individual's family/support network to confirm enrollment in care coordination, outpatient treatment, or other community services has occurred or is scheduled.

E. CPEP Satellites

As the Hospital-based health system has evolved over the last several years from individual, stand-alone hospitals to integrated systems comprised of multiple hospitals, OMH recognizes the need for CPEP satellite facilities. A CPEP satellite facility is a medical facility that must provide psychiatric emergency services and is managed and operated by a general hospital who holds a valid operating certificate for a CPEP. A CPEP satellite is located away from the central campus of the general hospital. A satellite facility, at minimum, must provide psychiatric emergency services including triage and referral and full emergency visits and/or extended observation bed services.

The vision for CPEP satellites is to allow hospital systems that have at least one CPEP to be able to enhance the behavioral health care emergency services they currently provide elsewhere in their hospital network by adding components of a CPEP, including CPEP emergency room and/or EOB that meet CPEP standards for staffing and premises. This allows systems to identify crisis service needs within their system and meet them flexibly.

Satellite Staffing

CPEP Satellites must have the appropriate staffing complement to be able to provide the specific services and to meet the projected volume for any approved CPEP satellite site. Telehealth may be implemented in CPEP satellites, but must be consistent with current OMH guidance for telehealth in CPEPs. For details, please review the most current telehealth guidance at:

https://omh.ny.gov/omhweb/guidance/

F. Definitions

Collaterals means an individual who is a member of the patient's family or household, or other individual who interacts with the patient and is directly affected by or has the capability of affecting their condition and is identified in the comprehensive psychiatric emergency plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the recipient prior to admission.

Co-occurring disorder means the diagnosis of at least one disorder in both of the following areas: substance use disorder (e.g., addiction, alcoholism, chemical dependency, and drug abuse), mental health disorder (e.g., personality disorder; a mood disorder like depression, anxiety, or bipolar; schizophrenia; post-traumatic stress disorder).

Crisis outreach means face-to-face psychiatric emergency services provided outside an emergency room setting which includes evaluation, assessment, and stabilization services. Crisis outreach services include but are not limited to therapeutic communication, coordination with identified supports, psychiatric consultation, safety planning, referral, linkage, peer services. Crisis outreach services may be provided outside the emergency room of the hospital, in the community or in other clinical areas within the hospital, for purposes of face-to-face visits with individuals discharged from the CPEP. Crisis outreach does not have to result in a visit or admission to the CPEP. For individuals discharged from the CPEP, crisis outreach includes face-to-face contact with a mental health professional for purposes of facilitating an individual's community tenure prior to engagement or re-engagement with community-based providers.

Extended observation bed means a bed located in or adjacent to the emergency room of a CPEP designed to provide, for a period up to 72 hours, a safe environment for an individual who, in the

opinion of the examining physicians, requires extensive evaluation, assessment, or stabilization of the person's acute psychiatric symptoms.

Full emergency visit means a face-to-face interaction between a patient and a psychiatrist and other clinical staff as necessary to determine a patient's current psychosocial and medical condition. It must include a psychiatric diagnostic examination; psychosocial assessment; and medical examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when CPEP services are completed. It may include other examinations and assessments as clinically indicated by the patient's presenting problems. Full emergency visit should be provided to patients whose presenting symptoms are initially determined to be serious and where the clinical staff [believe] determine commencement of treatment should begin immediately, and/or where staff are evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit.

Medical examination means an examination conducted as part of a CPEP's full emergency visit, conducted by an appropriately credentialed professional employed by the CPEP or emergency department. Such medical examination shall include:

1. A History and Physical which may be obtained either from the individual or systems including but not limited to the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or Electronic Health Records (EHR) and includes at a minimum:
    a. past medical history,
    b. review of systems (physical systems),
    c. review of medications and allergies, and
    d. assessment of vital signs.
2. Where clinically indicated:
    a. a targeted physical exam, and
    b. orders for laboratory and other diagnostic studies.

On duty means the professional is physically present in the building and accessible.

Received means the individual has completed all required registration materials upon entry to the CPEP, and a record has been created for such individual.

Restraint means the term *restraint* as such term is defined in section 526.4 of this Title.

Satellite facility means a medical facility providing psychiatric emergency services that is managed and operated by a general hospital who holds a valid operating certificate for a CPEP and is located away from the central campus of the general hospital. A satellite facility at minimum must provide psychiatric emergency services including triage and referral and full emergency visits and/or extended observation bed services.

Seclusion means the term *seclusion* as such term is defined in section 526.4 of this Title.

Serious symptoms means symptoms that have the potential to substantially impact an individual's safety to self or others, or ability to care for oneself in the community.

Triage means a determination upon presentation by a staff member that an individual should receive an evaluation, or when appropriate, referral to other nonmental health services.

Triage and referral means a face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, or Psychiatric Nurse Practitioner to determine the scope of emergency service required. This interaction should include a psychiatric diagnostic examination. It may result in further CPEP evaluation or treatment activities on the patient's behalf or discharge from the CPEP. For those persons who are discharged from the CPEP and who require additional mental health services triage and referral must include a discharge plan.

Staffing Definitions:

Clinical staff are all staff members who provide services directly to patients. Students and trainees may qualify if they are participating in a program leading to a degree or certificate appropriate to the goals, objectives and services of the comprehensive psychiatric emergency program and are supervised in accordance with the policies governing the training program and are included in the staffing plan approved by the Office of Mental Health.

Professional staff, for the purpose of this Part, are individuals who are qualified by credentials, training, and experience to provide supervision and direct service related to the treatment of mental illness in a comprehensive psychiatric emergency program and [shall] may include the following:

> (i) Creative arts therapist is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.
> (ii) Credentialed alcoholism and substance use counselor is an individual who is credentialed by the New York State Division of Alcoholism and Alcohol Abuse.
> (iii) Licensed practical nurse is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department
> (iiiv) Licensed psychoanalyst is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.
> (v) Marriage and family therapist is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.
> (vi) Mental health counselor is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.

(vii) Nurse practitioner is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.
(viii) Nurse practitioner in psychiatry (referred to as Psychiatric Nurse Practitioner in statute) is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.
(ix) Physician is an individual who is currently licensed as a physician by the New York State Education Department.
(x) Physician assistant is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.
(xi) Psychiatrist is an individual who is currently licensed as a physician by the New York State Education Department and who is certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology.
(xii) Psychologist is an individual who is currently licensed as a psychologist by the New York State Education Department.
(xiii) Registered professional nurse is an individual who is currently licensed as a registered professional nurse by the New York State Education Department.
(xiv) Rehabilitation counselor is an individual who has either a master's degree in rehabilitation counseling from a program approved by the New York State Education Department or current certification by the Commission on Rehabilitation Counselor Certification.
(xv) Social worker is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department.

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G. Appendix

Forms:

CPEP admission form:
https://omh.ny.gov/omhweb/forensic/manual/html/mhl_admissions.htm
https://omh.ny.gov/omhweb/forensic/manual/html/chapter7.htm

OMH 474A/476A Emergency of CPEP Emergency Admission (custody transport – signed by DCS)
https://omh.ny.gov/omhweb/forensic/manual/pdf/474a476a.pdf

OMH 476 CPEP Emergency Admission (9.40)
https://omh.ny.gov/omhweb/forensic/manual/pdf/7_29.pdf

Status and rights form:

https://omh.ny.gov/omhweb/patientrights/inrtsweb.pdf
To order forms please visit:

https://omh.ny.gov/omhweb/email/compose_mail.php?tid=IT_printshop_1

Recommended Violence Screening and Assessments Tools:

- Behavior Activity Rating School (BARS)
- Brøset Violence Checklist
- Dynamic Appraisal of Situational Aggression – Inpatient Version
- Historical Clinical Risk-20
- Overt Aggression Scale
- Staff Observation Aggression Scale/Revised
- Short Term Assessment of Risk and Treatability (START)

Recommended Screening Tools for Suicidality:

- Ask Suicide Screening Questions (ASQ)
- PHQ 9
- ED -Safe patient Safety Screener
- Columbia Suicide Severity Rating Scale – Triage Version (C-SSRS)
- Suicide Behavior Questionnaire Revised (SBQ-R)

Recommended Assessment Tools for Suicidality:

- Suicide Assessment 5-step Eval. And Triage
- Scale for suicide ideation
- Beck Scale for suicide ideation
- Child suicide potential scale
- Decision Support tool
- Behavioral Health Screening- ED

CPEP FLOWSHEET