



Standard of Care Focus	EXEMPLARY (In addition to CORE)	CORE (Failure to achieve substantial compliance may require a performance improvement plan or regulatory enforcement actions)
SCREENING AND ASSESSMENT		
1.1 Psychiatric Emergency Services	1) The majority of triage and referral visits are completed within 3 hours of being received by the CPEP.	1) Any person receiving a triage and referral visit must be examined by a staff physician or psychiatric nurse practitioner as soon as practicable and in any event within 6 hours after being received into the emergency room of the CPEP. 2) If a triage and referral visit is not conducted, and/or it is determined that a full evaluation is needed, a full emergency visit must be initiated within six hours.
1.2 Screening and Assessment – Ensuring Language and Cultural Needs are Met		1) Preferred language, including sign language, is identified for all individuals. 2) Screening, assessment, and other CPEP services reflects the cultural and linguistic needs of the individual.
1.3 Screening and Assessment – Medical	1) The CPEP employs a general physician to complete any necessary medical screenings and examinations. 2) Individuals with identified medical issues that cannot be addressed in the CPEP are transferred to the appropriate setting as soon as is determined to	1) All individuals are screened for medical stability, including vital signs and level of cognition. 2) Individuals with identified medical issues that cannot be addressed in the CPEP are transferred to the appropriate setting as soon as determined to be medically necessary but no longer than 8 hours. 3) All full emergency visits include a medical examination as part of their comprehensive CPEP assessment. A full visit includes a psychiatric assessment, psychosocial assessment, and medical examination. It may include other examinations and assessments as clinically indicated by the individual's presenting problems.



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	be medically necessary but no longer than 2 hours.	
1.4 Screening and Assessment	<ol style="list-style-type: none"> 1) If individuals are identified as at risk for high utilization/readmission, then CPEPs assess for contributing factors, including all core components as well as health-related social needs. 2) A single clinician or professional staff coordinates the assessment process with the individual to ensure a well-coordinated CPEP visit. 	<ol style="list-style-type: none"> 1) All individuals must be screened for suicide risk using a validated instrument. 2) Positive suicide and non-suicidal self-harm screens must be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk. The assessment of risk factors includes static and dynamic factors, mental status, supports, protective factors, access to means of self-harm, and any means pursued in past self-injurious episodes or suicide attempts. 3) All individuals over 12 years old must be screened for substance use using a validated instrument. When clinically indicated, screening for substance use for youth under 12 should be performed. 4) Positive screens must be followed by an assessment for high-risk substance use and substance use disorder by a licensed professional or CASAC working within their scope of practice. 5) CPEPs must have policies regarding violence risk and screening. All individuals must be screened, and the CPEP policy must describe a process for subsequent assessment and intervention in the case of a positive screen. As part of the screening, all individuals must be asked about access to firearms or other weapons. A positive screen of risk of harm to others results in an assessment of risk factors that includes static and dynamic factors, mental status, supports, protective factors, access to means of violence, and any past acts of violence.



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		<ul style="list-style-type: none"> 6) Staff collaborate with family, collaterals, and residential/other providers, as appropriate, in completing risk screenings and assessments. See 2.1 for further details. 7) For individuals with an existing wellness and safety plan or with a psychiatric advance directive, determined via self-report, EHR, PSYCKES, or other sources, the plan is reviewed and utilized.
GATHERING INFORMATION AND ENSURING CONTINUITY OF CARE		
<p>2.1 Consent for Information Gathering</p>		<ul style="list-style-type: none"> 1) The program will attempt to obtain the authorization of the individual (or someone authorized to make health care decisions on the individual's behalf) from people familiar with the individual collaterals, or other sources of information, such as PSYCKES, to access and disclose personal health information. 2) If an authorization of the individual cannot practicably be obtained due to incapacity or emergency circumstance, program staff may, in the exercise of professional judgment, determine whether the access, use, or disclosure is necessary to prevent imminent, serious harm to the individual. If so, only that personal health information that is necessary to protect the individual from the anticipated harm or which is in the best interest of the individual may be accessed, used, or disclosed. Information may be disclosed to arrange appropriate aftercare services. 3) In the event of incapacity or emergency circumstance, staff may temporarily access a PSYCKES clinical profile, for limited purposes and in accordance with PSYCKES Policies and Procedures. 4) The reasons for access, use, or disclosure must be



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		appropriately documented in the clinical record when authorization is not able to be obtained.



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<p>2.2 Gathering Information and Collaterals</p>	<ol style="list-style-type: none"> 1) The CPEP consistently and proactively seeks and incorporates information from a wide variety of sources. 2) The CPEP uses an EHR that links to other provider/service EHRs or RHIO/Health Information Exchanges (HIE) and information from these sources is integrated into assessments and clinical determinations. 3) The CPEP has policies and procedures in place to ensure communication with entities and individuals involved in referral for emergency services (e.g.: police, residential/ shelter programs, family) to assess safety concerns associated with the referral. 	<ol style="list-style-type: none"> 1) The program must access the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other available electronic health records (SHIN-NY/QE), database(s), and/or other sources to identify the individual's prior history of treatment and service utilization, including current providers and their contact information. 2) The program must check PSYCKES to see if the individual has a wellness plan, psychiatric advance directive, and/or preferred individuals to contact. The program must review information contained in the Internet System for Tracking Over-Prescribing - Prescription Monitoring Program (I-STOP/ PMP) for prescription histories of individuals who report using controlled medications. 3) The program must gather information about access to housing, food, clothing, and shelter. 4) The program must attempt to obtain collateral information for all individuals unless the presentation is due to a non-emergent reason, including but not limited to an asymptomatic individual presenting for a medication refill. When contacting collateral sources of information, the goal is to obtain high quality information to help with the assessment. If the source of collateral information is not able to provide sufficient high-quality information, the program must attempt to identify and contact additional sources of collateral information. 5) The program must pursue, as appropriate, multiple sources of collateral information, including from people close to the individual, other treatment providers, housing providers, Health Home care coordinators, AOT coordinators, Managed Care Organizations, mobile crisis teams, crisis residences, state-operated mobile integration teams, and



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		<p>other sources of information, as applicable. For CPEPs serving children or adolescents, input from school, caretakers, home based crisis intervention, and other social service agencies is sought, as appropriate.</p> <p>6) Communication with collateral sources of information must be documented in the case record.</p> <p>7) Individuals with developmental disabilities have possible OPWDD eligibility verified, and effort is made to identify and contact any involved providers.</p>
<p>2.3 Wellness and Safety Plans and Psychiatric Advance Directives</p>	<p>1) The program develops or updates a wellness and safety plan for any individual when useful, regardless of their risk level. The CPEP communicates the plan to other providers, including the individual’s primary clinician, if applicable, and uploads it into</p>	<p>1) For individuals determined to be of moderate to high risk, a wellness and safety plan is to be obtained, initiated, or developed.</p> <p>2) If the individual does not have a psychiatric advance directive (PAD), the program must provide information regarding-PADs, once the individual is no longer in crisis. If the individual chooses to complete a PAD, it must be placed in their chart and uploaded to PSYCKES.</p>



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	PSYCKES. 2) Certified Peer Specialists collaborate with the individual to develop/review wellness and safety plans.	
CLINICAL DETERMINATION		
3.1 Clinical Formulation		<ol style="list-style-type: none"> 1) Information collected from the individual, collaterals, chart review, screening, assessment, and individual examination are used to complete a formulation, differential diagnosis, risk assessment, and plan. 2) The formulation must include treatment recommendations, and a disposition decision. 3) A disposition decision must include consideration of whether an individual and/or their involved caregivers are able to safely care for themselves in the community. 4) Using information from screening, assessment, clinical interview, collateral contacts and/or found in PSYCKES, a determination must be made as to whether an individual has complex needs as defined in 14 NYCRR Part 590.
3.2 Legal Status		<ol style="list-style-type: none"> 1) After the initial assessment, the CPEP must give a mental hygiene legal status to all individuals not being discharged. 2) When the CPEP attending determines an EOB or inpatient admission is recommended, the CPEP must document that the individual was assessed for the appropriateness of a voluntary admission. If it is determined a voluntary admission is appropriate, this option should be clearly communicated to the individual. 3) Any legal status associated with an involuntary removal to



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		<p>the emergency department is documented (e.g., 9.41, 9.43, 9.45, 9.37, 9.57, 9.58 or AOT removal order).</p> <p>4) Individuals who are admitted to the CPEP are not retained for more than 24 hours, starting from when the individual is first received in the CPEP. If the CPEP determines an individual needs further observation or inpatient treatment, then the person must be admitted to an Extended Observation Bed (EOB) or an inpatient psychiatric unit.</p> <p>5) The CPEP may not retain individuals in an EOB for longer than 72 hours, starting from when the individual is first received in the CPEP.</p> <p>6) The CPEP must attempt to move individuals into the EOB or inpatient unit, as appropriate, based on bed and transportation availability. The reason for delays in EOB transfers or inpatient admissions must be documented.</p>
TREATMENT AND SUPPORT		
<p>4.1 Person-centered and recovery-oriented</p>	<p>1) Certified Peer Specialists, qualified per state plan, orient the individual to the unit, assist the individual in addressing their health-related social needs, and provide necessary connections and referrals upon discharge.</p> <p>2) The CPEP provides the individual with information regarding the PSYCKES My Collaborative Health Outcomes Information</p>	<p>1) To provide for a person-centered process, to the maximum extent possible, an individual participates in the planning of their services and makes informed choices about the services they receive.</p> <p>2) Services are collaborative in nature with shared decision-making based on the individual's interests, preferences, strengths, and needs. Services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect and that the individual is satisfied with activities, supports, and services.</p> <p>3) Clinical and peer staff make frequent attempts to engage the individual throughout the course of treatment</p> <p>4) When appropriate and with consent, CPEP staff involves</p>



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	<p>System (MYCHOIS) application.</p> <p>3) The CPEP allows legal guardian and caregivers to stay for extended periods of time to provide support when clinically justified and appropriate.</p>	<p>the individual’s family in treatment. Inclusion of significant people in the individual’s life, outpatient providers, and peer support is encouraged.</p> <p>5) The CPEP displays notices on the availability of on-site peer support and self-help resources. Notices must also include the address and telephone number of local off-site peer support and self-help resources.</p> <p>6) The CPEP allows for the accompaniment of legal guardians and caregivers when it is deemed to be clinically appropriate.</p> <p>7) Certified Peer Specialists provide support services including individual advocacy, outreach, engagement, information and referral, self-help, safety/crisis planning, planning for prevention of setbacks, development of psychiatric advance directives, relaxation, resource brokering, and discharge planning/identifying supports in the community, as well as health and wellness coaching.</p>
4.2 Medication and Support Services	<p>1) The CPEP has available and offers all forms of Nicotine Replacement Therapy (NRT) accessible to all individuals who use nicotine. Individuals receive instructions on how to properly use the product(s). The CPEP</p>	<p>1) Medication treatment is used, if appropriate, to stabilize acute symptoms. Medication treatment is initiated, if appropriate, to treat underlying psychiatric illness.</p> <p>2) Individuals who meet criteria for any substance use disorder must be offered pharmacological interventions, if appropriate.</p> <p>3) Individuals identified with Opioid Use Disorder or at risk of overdose (e.g., receiving opioid pain medication or using other substances that may be altered with opioids), receive:</p>



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	<p>also offers to initiate treatment for tobacco use disorder, including options for combined long- and short-acting NRT, varenicline, and/or bupropion. Information about the NYS Quitline is displayed in a common area.</p> <p>2) When appropriate, the CPEP offers additional medical care to help meet the overall health needs of each individual.</p>	<p>a. Naloxone kit or prescription and education on how to use it.</p> <p>b. Personalized Harm Reduction Plan developed collaboratively with the individual.</p> <p>4) For those individuals who screen positive for nicotine use, at least one form of Nicotine Replacement Therapy (NRT) is accessible and offered by CPEP staff as soon as possible to help prevent individuals from experiencing nicotine withdrawal symptoms such as anxiety and agitation while they are receiving care in the CPEP. Individuals receive instructions on how to properly use the product(s).</p> <p>5) The CPEP is able to provide Long-Acting Injectable medications when indicated.</p>
4.3 Psychotherapeutic and Rehabilitative Treatment	<p>1) The CPEP offers Individual and/or group therapy.</p> <p>2) The CPEP provides and discusses materials and information with individuals regarding recovery and harm</p>	<p>1) CPEP clinicians demonstrate the use of psychotherapeutic techniques when appropriate, including but not limited to crisis counseling, brief psychotherapy, motivational interviewing, psychoeducation, and/or family counseling.</p>



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4.4 Activities in EOB	<p>reduction upon discharge.</p> <ol style="list-style-type: none"> 1) For CPEPs serving children, youth- and/or family advocates (YPA/FPA) are available to provide encouragement and support. 2) Trained staff, such as creative arts therapist or rehabilitation counselors are available to provide activities and creative arts therapy, both group and individual, as needed. Certified Alcoholism and Substance Abuse Counselors (CASAC) and/or Certified Recovery Peer Advocates (CRPA) assess individuals regarding substance use, misuse, or abuse and engage them in harm-reduction strategies. 	<ol style="list-style-type: none"> 1) Activities are available for individuals throughout the EOB stay, offering opportunities for self-directed, meaningful activities and skill development. 2) Meetings are held with family, case managers, treatment providers, ACT teams, HBCI teams, CTI Case Managers, and other providers as needed. 3) Employees, including peer staff, provide encouragement and support for the individual's recovery.
DISCHARGE		



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5.1 Discharge Planning	1) CPEPs partner with ambulatory providers to access shared calendars for appointments to provide timely linkage to appointments after discharge. 2) The CPEP arranges a pre-discharge meeting with the identified providers and the individual.	1) The CPEP conducts discharge planning for all individuals determined to require additional mental health services in the community, in accordance with 590.8(h): <ul style="list-style-type: none"> a) consideration for the whole clinical presentation and history, as well as the availability of existing services and supports in the individual’s community (This includes if an individual resides in a residential program licensed by the office or supportive housing). b) The discharge plan is developed through shared decision-making in a person-centered process and reflects individual strengths and level of social support and addresses psychiatric, substance use disorder, chronic medical, and social needs. c) The plan addresses relevant information obtained from collateral sources of information and documents any objections to the plan. 2) If a CPEP cannot identify an aftercare provider with an available appointment within seven calendar days, the CPEP must document its efforts and schedule the appointment for as soon as possible thereafter. 3) Individuals who are leaving the CPEP against medical advice, or who state they do not wish to receive aftercare services, must be provided information about available treatment options and have an appointment scheduled whenever possible. 4) The CPEP completes referrals to other community services providers, including peer support services, in collaboration with the individual, to address any identified needs.



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		5) All individuals are screened for suicidality prior to their discharge. Individuals with an elevated risk of self-harm or suicide have a community suicide safety plan completed before discharge. Lethal means are identified and a plan for restriction addressed in the Safety Plan. The CPEP documents their work with collaterals to implement the plan to restrict lethal means and confirm completion prior to discharge. 6) Discharge of individuals with an elevated risk of violence includes close collaboration with current and new outpatient treatment providers, residential providers if applicable, and the county DCS if applicable to incorporate strategies to address violence risk factors and access to weapons into the overall discharge plan in accordance with section 33.13 of the Mental Hygiene Law. 7) Individuals who meet criteria for any substance use disorder are offered pharmacological interventions, if appropriate, and referred to a new or existing provider who can continue treatment for their substance use disorder.
5.2 Discharge Communication	1) The discharge summary is provided to all current behavioral health providers, including residential programs, and Health Home Care Coordinators as applicable, within 1	1) For discharges of individuals with complex needs, the CPEP provides verbal clinical sign-out on the day of discharge, or as soon as possible thereafter, to the receiving outpatient behavioral health treatment program and, if applicable, the residential program licensed or funded by OMH, OASAS, OPWDD, or DOH where the individual will reside after discharge. The CPEP staff will document that the verbal sign-out occurred in a progress note or other note in the medical record. This must be done in accordance with



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	<p>calendar day.</p> <p>2) For individuals initiated on a buprenorphine formulation, CPEPs provide a bridge prescription to cover the individual until their appointment with a community provider for on-going care. CPEPs should utilize prescription voucher programs and other options (e.g., in-house pharmacy) so there are no out-of-pocket expenses for the bridge medications.</p> <p>3) If a wellness and safety plan is developed by the CPEP, it will be communicated to other providers including a child's school, as appropriate.</p>	<p>section 33.13 of the Mental Hygiene Law.</p> <p>2) The CPEP sends a discharge summary detailing the presenting history of present illness (HPI), hospital course, and other relevant information to the outpatient, residential, or long-term care program within seven days of discharge, in accordance with section 33.13 of the Mental Hygiene Law.</p> <p>3) The CPEP makes efforts to coordinate prior to discharge with the person or organization who referred the individual, when appropriate.</p> <p>4) If the individual is enrolled in outpatient (e.g., Health Home Care Coordination or Specialty Mental Health Care Management (Health Home Plus or High Fidelity Wrap), residential care management (e.g., OMH licensed or funded supportive housing or residential treatment), or has an active AOT order, CPEP staff coordinate discharge plan details and timing with care managers.</p> <p>5) For individuals with complex needs enrolled in a Managed Care Organization (MCO) Plan who are eligible but not enrolled in intensive care management or are enrolled in care management but need intensive care management, CPEP staff call the MCO and inform the MCO of the discharge.</p>



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5.3 Follow Up After Discharge and Linkage to Care	1) CPEPs have memoranda of understanding (MOU) with community providers and use technology, including shared calendars, to facilitate connection and verification if appointments were kept. 2) For individuals determined to be at elevated risk of suicide, the CPEP makes at least two contacts to the individual within 90 days. 3) The CPEP notifies the local SPOA of the need to consider Health Home Plus specialty care management or High Fidelity Wrap.	1) The CPEP follows up with individuals to verify that after-care appointment(s) occurred and there is satisfactory linkage to care. CPEPs must continue to provide crisis outreach until linkage to care is completed or until other clinically indicated reasons are resolved. Crisis outreach ensures individuals are safe and stable in the community and provides support, care and assistance with linkage to follow up care.
CRISIS OUTREACH		
6.1 Crisis Outreach	1) Crisis outreach teams respond within 2 hours to a referral. 2) Certified Peer Specialists play an	1) Crisis Outreach Team works with the local community to support diversion from EDs and CPEP. 2) For individuals across the lifespan (children, adolescents, transitional-age youth, adults, seniors) discharged from the CPEP, crisis outreach is provided for a period of time that allows for linkage to services.



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	<p>important and valued role as a member of the crisis outreach team utilizing their expertise in engagement, resource brokering and bridging.</p> <ul style="list-style-type: none"> 3) Crisis Outreach services are provided for extended hours, up to and including 24/7. 4) Crisis Outreach teams incorporate telehealth to expand the scope of services available in the community. 	<ul style="list-style-type: none"> 3) Established policies delineate required hours of operation of Crisis Outreach Teams and protocol for response 7 days per week during day and evening hours. 4) For an initial crisis outreach visit, a member of the professional staff may respond alone if such need is determined. 5) For crisis outreach provided as a follow up to an initial crisis outreach visit or CPEP admission, a member of the staff may respond alone if such need is determined. This service may be provided by professional staff, staff possessing a bachelor's degree or a Certified Peer Specialist. 6) Psychoeducation is provided to collaterals as needed.
6.2 Crisis Outreach Follow Up	<ul style="list-style-type: none"> 1) Uses mobile technology, including the PSYCKES mobile app, to facilitate rapid response and information gathering. 2) When an individual misses an attempt by CPEP crisis outreach for follow up services, there is a follow up visit conducted the day after the attempt. 	<ul style="list-style-type: none"> 1) Until linkage to care is completed, or for other clinically indicated reasons, the CPEP provides crisis outreach services to ensure individuals are safe and stable in the community and provide support, care, and assistance with linkage to follow up care. 2) Crisis Outreach Follow up services are provided in the community or at a location within the hospital outside of the emergency department. 3) When an individual misses an attempt by CPEP crisis outreach for follow up services, where possible a rapid follow up visit should be conducted.



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STAFFING		
7.1 Staffing	<ol style="list-style-type: none"> 1) The program has recruited individuals with expertise to provide guidance in engaging and attending to cultural and demographic populations served. 2) A child psychiatrist is on call 24/7. 3) Peer staff are available or on-call to the CPEP 24/7. 4) Certified Peer Specialists provide services in all CPEP programming areas including emergency room and outreach. 5) The CPEP has a variety of peer staff as a part of their staffing plan which may include Certified Peer Specialists (NYCPS), Certified Recovery Peer Advocates (CRPA), Family Peer Advocates (FPA), and/or Youth Peer Advocates (YPA). 	<ol style="list-style-type: none"> 1) An adequate proportion of the clinical staff hours are provided by full-time employees. 2) At least one full-time equivalent psychiatrist who is a member of the psychiatric staff of the program must be on duty and available at all times. <ol style="list-style-type: none"> a. For CPEPS within rural areas and which have 3,000 or less presentations per year, the commissioner may waive the requirement that one full-time equivalent psychiatrists be on duty and available if: <ol style="list-style-type: none"> I. The CPEP can demonstrate that the volume of service does not require such level of staff coverage; II. The CPEP can demonstrate that it can provide adequate 24-hour coverage by other professional staff; and III. the CPEP can demonstrate the availability of a psychiatrist on-call for face-to-face interaction via audio visual telehealth for consultation, supervision, an admission to or discharge from an extended observation bed or treating minors without guardian consent. 3) at least one full-time equivalent registered nurse must be on duty at all times and s be responsible for the supervision of the nursing care and



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	<p>6) The CPEP identifies which staff/discipline supervises peer staff and the competencies to so. The CPEP and the supervisor ensure role clarity and communication between all disciplines and roles in the CPEP.</p> <p>7) CPEPs serving children have Youth Peer Advocates and Family Peer Advocates (YPA/FPA) provide peer support.</p> <p>8) A general medical provider is on staff and available within the CPEP to specifically provide medical evaluation and care.</p> <p>9) Additional staff (beyond core requirements) are trained for leading individual and group therapy.</p>	<p>treatment provided in the extended observation beds of the comprehensive psychiatric emergency program;</p> <p>4) at least one full-time equivalent licensed master social worker or licensed clinical social worker must be on duty and available, at a minimum, during the day and evening hours;</p> <p>5) At least one FTE credentialed alcoholism and substance abuse counselor (CASAC) or clinical staff person with experience in the counseling or treatment of individuals with a substance use disorder is available or on call 24 hours a day.</p> <p>6) EOBs are staffed by at least one clinical staff person, 24 hours a day, seven days a week.</p> <p>7) For CPEPs that serve children and adolescents, the CPEP has at least one staff member on duty, by virtue of training and/or experience, is competent to treat children and adolescents.</p> <p>8) Staff are competent in the identification of risk factors for harm to self and/or others.</p> <p>9) Staff are expected to recognize, understand, respond to and treat the effects of trauma for individuals receiving CPEP services.</p>
ADMINISTRATION		



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8.1 Safety	<ol style="list-style-type: none"> 1) There is evidence that the program’s quality assurance (QA) activities result in improved outcomes (e.g., reduction in restraints, completion of TRUST training) 2) The CPEP’s crisis response team result in improved outcomes (e.g., reduction in restraints). 3) Restraints are not utilized within the CPEP. Seclusion is not utilized within the CPEP. 4) CPEP staff do not need to call security staff, including hospital police, to respond within the CPEP. 5) Documentation demonstrates that CPEP staff consistently attempt the least restrictive interventions when managing crisis situations. 	<ol style="list-style-type: none"> 1) Staff are trained in strategies to prevent and manage crisis situations, and if needed, how to safely use manual and physical restraints. CPEPs have evidence of QA and monitoring of these strategies. 2) The CPEP has policies and procedures for the use of restraint and seclusion, for both children and adults. 3) The CPEP’s use of restraint or seclusion is in accordance with requirements of 14 NYCRR Part 526.4. 4) Mental Health staff take the lead in restraint application, with security staff as perimeter support. 5) Specific training is provided to security staff on how to address crisis situations for individuals diagnosed with mental illness and their role in participating in restraint application. 6) The CPEP has policies and procedures to describe standards for staff collaboration with law enforcement. 7) Security staff, including hospital police, respond as infrequently as possible within the CPEP. 8) The CPEP follows guidelines for managing aggression and promoting workplace safety, including: <ol style="list-style-type: none"> I. De-escalation: verbal and environmental interventions II. An individualized approach that understands and addresses underlying conditions (e.g. psychosis, developmental delay, intoxication, trauma, personality factors) III. Medication management of acute agitation aggression based on a working hypothesis of the underlying condition.



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8.2 Incident Management		9) Programs employ practices to prevent/resolve overcrowding and avoid diversion. 1) All new staff receive training regarding the definition of incidents, reporting procedures, an overview of the review process, and the role of risk management. 2) Staff are informed about the Incident Review Committee (IRC) process and the importance of risk management in maintaining safety and improving services. 3) Refresher incident reporting training is conducted at least annually, and staff records indicate evidence of annual completion. 4) The Incident Review Committee (IRC) membership composition is appropriate; members meet qualifications and are properly trained. 5) The IRC reviews incidents, makes recommendations, and ensures implementation of action plans with program's administrator. 6) The program uses NIMRS or other available reports systems to assist in risk management activities including compilation and analysis of incident data for the purpose of identifying and addressing possible patterns and trends to improve service delivery. 7) The program engages in quality improvement activities to reduce the occurrence of serious incidents. Proactive risk reduction strategies are used to identify potential problems and implement preventive measures.
8.3 Data Collection, Reporting, and Performance	1) Analyzed data is used in a continuous document quality improvement	1) The Program actively and systematically collects and reports all required data to the Office of Mental Health, including but not limited to CPEP data reports,



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Improvement	<p>process.</p> <p>2) Additional metrics are collected and analyzed by the hospital to assist in quality improvement such as an emphasis on special populations.</p> <p>3) The CPEP provides reports utilizing data to individuals, peer organizations, and collaterals and solicits feedback.</p>	<p>restraint/seclusion data, utilization of EOBs, and re-admission.</p> <p>2) Information is collected, analyzed, and utilized on a routine basis to change and improve services, in response to identified trends.</p> <p>3) The Program seeks feedback from individuals, peer organizations and collaterals regarding services and integrates program recommendations.</p>
CASE RECORDS		
9.1 Case Records	<p>1) CPEP does not use handwritten notes/documentation, and all information is in the EHR.</p> <p>2) The CPEP's EHR supports the tracking and collection of key quality and data metrics, including those submitted for OMH CPEP data</p>	<p>1) There is a complete, legible case record maintained for every individual receiving triage/referral, full visit, EOB or mobile crisis.</p> <p>2) Delays in services are recorded.</p> <p>3) The person(s) who refer or transport an individual (including law enforcement) are interviewed and identified in the case record.</p> <p>4) Case records include reports of all mental and physical diagnostic exams, assessments, tests, consultations, notes which relate to special circumstances and untoward incidents, and dated and signed orders for all medications when applicable.</p>



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	reports.	5) The case record must be available to all clinical staff, including Certified Peer Specialists, Certified Recovery Peer Advocates (CRPA), Family Peer Advocate (FPA) or Youth Peer Advocates (YPA), of the CPEP who are participating in the treatment of the individual consistent with 45 C.F.R. part 160. 6) For individuals receiving a triage/referral, full visit, and/or EOB; <ul style="list-style-type: none"> a) The case record includes a presentation note with a brief description of the presenting problem, critical needs, initial examination, overall conditions, attempts to contact collaterals; and care/treatment required to address the individual’s needs during CPEP services. b) Case records include the individual’s identifying information, available psychiatric and medical history, relevant social history, diagnoses, assessment of the individual’s treatment needs based upon psychiatric, physical, social, and functional evaluations, mental status exam, and progress notes which describe services provided. c) Discharged case records must include a discharge summary detailing the presenting history of present illness (HPI), hospital course, and other relevant information.
ADVANCING BEHAVIORAL HEALTH EQUITY		
10.1	1) Demonstrable progress is	1) The CPEP reviews demographic data for the program’s



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Behavioral Health Equity	<p>achieved in reducing disparities in access, quality of care and treatment outcomes for underserved/unserved populations and/or CPEP staffing to match the demographic profile of the persons served.</p> <p>2) CPEP demonstrates routine excellence or special programs/ initiatives in meeting the cultural and linguistic needs of the catchment area.</p>	<p>catchment area to determine the cultural and linguistic needs of the population and to identify disparities of access to treatment.</p> <p>2) CPEPS implement policies and procedures to address disparities identified in review of demographic data.</p> <p>3) Efforts are made to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved populations.</p> <p>4) CPEPS ensure that no individual is denied access to services solely based on diagnoses of HIV infection, other chronic medical comorbidity, history of suicide attempt, history of violence, criminal and juvenile justice system involvement, ability to pay, personality disorder, substance use disorder, or intellectual or developmental disability.</p> <p>5) Efforts are made for CPEP staffing to match the demographic profile of the persons served.</p> <p>6) Staff are trained to be aware and respond appropriately to the cultural and linguistic needs of the catchment area.</p>
10.2 Language Access	<p>1) The CPEP offers all necessary documents available in the individual's preferred language (e.g., releases).</p>	<p>1) The CPEP ensures provision of language assistance services at no cost to individuals with Limited English Proficiency and/or individuals with other communication needs.</p> <p>2) The program informs all individuals of their right to receive language assistance services clearly and in their preferred language, verbally and in writing.</p> <p>3) The CPEP arranges to offer documents in the individual's preferred language (e.g., releases).</p> <p>4) The CPEP provides easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.</p>



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		5) Efforts are made to provide people identified as sources of collateral information with language assistance services to translate information into their preferred language, verbally and in writing. 6) Efforts are made to employ staff that are proficient in the most prevalent languages spoken by the service users. 7) The CPEP ensures the competence of individuals providing language assistance recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. 8) The CPEP provides a description of patients’ rights and patient grievance procedure in the individual’s preferred language; which is accessible to youth, those with Limited English Proficiency (LEP) and the blind and visually impaired.
ENVIRONMENT		
11.1 Environment	1) The CPEP space is used creatively to foster a healing environment. 2) The CPEP utilizes a comfort room. 3) CPEPs have a cart/cabinet with sensory items offered to individuals as calming/soothing techniques.	1) The CPEP space allows for sufficient privacy during interviews between staff members and individuals served, and for bathing, toilets, and treatment procedures. 2) The CPEP is free of self-injury, ligature, fire, and safety risks. 3) The comfort and convenience of those waiting for and receiving services is maintained (including temperature) and compliant with relevant life safety/building codes. No one waiting for or receiving services is placed in a hallway or other area not approved by OMH. 4) The CPEP space accommodates routine activities and



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	<p>4) The Program uses dashboard technology, visual management, or white board technology as a visual summary of all individuals receiving services in the CPEP.</p>	<p>regularly used equipment.</p> <p>5) The premises are maintained in a clean condition.</p> <p>6) Records are maintained confidentially.</p> <p>7) Medications are stored in accordance with all regulatory requirements and the Hospital’s medication storage policies.</p> <p>8) Recipient rights and advocacy information are prominently posted.</p> <p>9) CPEPs have secure gun storage for law enforcement.</p> <p>10) All signage is positive, welcoming, helpful, and respectful.</p> <p>11) For CPEP that serve children and/or adolescents, patient care area(s) separate from adults are maintained, and waiting areas reasonably limit co-mingling between those children/adolescents and adults.</p> <p>12) For CPEPs that serve children and adolescents, guardians are allowed regular access to the recipient seven (7) days a week.</p> <p>13) Extended observation beds are humane and safe environments which includes appropriate sleeping quarters, toilet, bath, and dietary facilities.</p>