NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Department of Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

October 20, 2023

Good Afternoon,

Please find attached joint guidance from the New York State Office of Mental Health and New York State Department of Health regarding evaluation and discharge practices for individuals who present with behavioral health conditions within psychiatric inpatient programs, emergency departments, and Comprehensive Psychiatric Emergency Programs (CPEPs).

We thank you for your feedback in the development of these guidance documents, and for your continued service to the people of New York State.

Sincerely,

Dr. Ann Sullivan
Commissioner
New York State Office of Mental Health

Dr. James McDonald
Commissioner
New York State Department of Health

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health | Department of Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

Guidance on Evaluation and Discharge Practices for Comprehensive Psychiatric Emergency Programs (CPEP) and §9.39 Emergency Departments (ED)

October 2023

The goal of this document is to offer guidance to CPEP/ED settings regarding evaluation and discharge planning for individuals who present with behavioral health conditions. These are the evaluations that should be completed at each patient encounter and interventions that will improve patient outcomes; reduce the risk of overdose, self-harm, and violence; and reduce the risk of readmission and disconnection from care. These standards are not intended to replace clinical judgment but rather to help ensure that clinical staff in CPEPs/EDs routinely gather all possible information when making disposition or inpatient admission decisions. There are complicated systemic, legal, and regulatory issues that make it difficult for hospital staff to coordinate and collaborate with colleagues in residential and outpatient programs. Nonetheless, for many patients, there are possible interventions that can lengthen community tenure and help patients achieve meaningfully improved outcomes without repeatedly returning to acute settings. Hospitals should welcome care managers into hospital spaces to facilitate care integration.

Screening and Assessment

1. **Suicide Risk:** All individuals who are brought to or present to CPEPs/EDs should be screened for suicide risk using a validated instrument (e.g., the Columbia-Suicide Severity Rating Scale). Positive screens should be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk.
2. **Substance Use:** All individuals over the age of 12 that present for any reason should be screened for substance use through a validated instrument (examples here). Instruments should be age-appropriate and specifically screen for individual substances (e.g., alcohol, opioids, cannabis, tobacco/nicotine, etc.) that may require different interventions or psychoeducation. Positive screens should be followed by an assessment conducted by a licensed professional who is experienced in working with individuals using substances but not necessarily meeting the criteria for a substance use disorder diagnosis (note: a CASAC certification is NOT a requirement). The assessment should include risk of acute withdrawal and risk of accidental overdose. Assessment of acute withdrawal symptoms should include objective information, such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute of Withdrawal Assessment (CIWA) instruments. Any individual determined to be at risk of overdose or of acute withdrawal should be evaluated by a physician, and appropriate orders placed. Additionally, a physician, nurse practitioner, or physician assistant should check the I-STOP/PMP (Internet System for Tracking Over-Prescribing/Prescription Monitoring Program) for any individual with a positive substance use screen; any individual

who reports a prescription of controlled medications; any individual with a history of overdose; and any individual with a history of withdrawal.

3. **Violence Risk:** Violence risk screening should be universal and operationalized for all individuals in CPEPs. Violence screenings should also be completed for all individuals with behavioral health presentations in EDs. Individuals who present to EDs with non-behavioral health chief complaints should be screened for violence if the presentation includes dementia; delirium, acute change in mental status; transfer from carceral settings; police transport; history of violence; or if the individual exhibits agitation, aggression, threatening behaviors, and/or violent ideation in the ED. The violence risk screening should be repeated as individuals are reassessed throughout their stay in the CPEP/ED. The screening should include the individual's self-report; a detailed review of the history of present illness; history from electronic health records and other exchanges such as PSYCKES and SHIN-NY/QE; and high-quality collateral information from family, friends, and community providers (within legal requirements for consent). Positive screens should lead to a more comprehensive clinical assessment that considers risk and protective factors and that is specifically considered in the decision to admit or discharge. All individuals should be asked about access to firearms or other weapons.
4. **Complex Needs and Social Determinants:** All individuals admitted to CPEP/EDs psychiatric units should be screened to determine if they have complex needs related to their ability to successfully transition to community-based care following discharge. Individuals with multiple chronic comorbid diagnoses, high utilization of acute care services, extensive adverse childhood experiences or trauma histories, and/or high levels of social determinant needs known to impact health outcomes should be considered complex. These individuals require more intensive care management to coordinate discharge planning needs and ensure connections with outpatient treatment, care coordination, and residential resources. Hospital staff should invite care managers working with individuals with complex needs into the hospital to meet with the patient and collaborate with the CPEP/ED team, even when the care manager is not an employee or otherwise affiliated with the hospital. Social determinants critical to the individual's ability to be safe in the community - including having a safe place to be housed, criminal justice involvement, and exposure to threats or violence - should be considered in discharge planning. When billing for CPEP/ED services, hospitals should include the ICD-10 Social Determinants of Health Z codes in the claims, as appropriate.
5. **Level of Care Determination**: CPEP/ED staff should ask what the patient's goals are for coming to the hospital. When deciding to admit or discharge, it is important to consider existing symptoms and level of risk based on observation in an ED or CPEP setting as well as the individual's overall clinical history, engagement in care, and availability of existing services in the patient's community. The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) by the American Associations for Community Psychiatrists (AACP) and the Child and Adolescent Service Intensity Instrument (CASII) by the American Academy of Child and Adolescent Psychiatrists (AACAP) are peer-reviewed, evidence-based instruments that hospitals should consider adopting to navigate this complexity and standardize admission decisions. Individuals at an elevated risk for harming themselves or others, or who are functionally impaired to the point of being unable to meet their basic needs may need an involuntary admission. The state Office of Mental Health has previously issued interpretive guidance on involuntary and emergency admissions and certain situations where they are appropriate. There are times when CPEP/ED practitioners may

determine that an inpatient admission is beneficial to an individual even if the individual does not meet involuntary or emergency admission criteria. In these cases, the individual should be offered a voluntary 9.13 admission.

6. There are individuals who present to CPEPs/EDs due to difficulty establishing social connections or unmet basic needs, such as food, safety, housing, etc. (i.e., primary or secondary gain). While these individuals may be familiar to CPEP/ED staff, there is always the possibility of new or worsening medical, psychiatric, or other conditions. These individuals should be assessed at each presentation so CPEPs/EDs do not miss treatable conditions. These individuals should not be reflexively discharged based on the findings of evaluations in prior visits.

Communication and Collaboration with Non-Hospital Providers

1. Authorized hospital personnel should look up individuals in PSYCKES to review their prior psychiatric and medical history and obtain contact information for outpatient treatment teams and care managers. In emergency settings, staff may temporarily access a PSYCKES clinical profile even if the individual does not have capacity for consent.
2. Individuals should be reviewed in any other available information network databases (e.g., SHIN-NY/QE or EPIC Care Everywhere). For individuals who report using controlled medications, their prescription histories should be reviewed in the I-STOP/PMP. Staff should ask if individuals have a Psychiatric Advance Directive.
3. When assessing individuals who are brought in by the police due to behavioral disturbances in the community or individuals who are involuntarily removed from the community (i.e., pursuant to MHL §9.41, 9.45, 9.58, or 9.60), clinical staff should obtain collateral information (within legal requirements for consent) from the party that initiated the involuntary removal and other important sources of information, including family members and friends, outpatient providers, staff at residential or long-term care programs, health home care managers, Children's Single Point of Access (C-SPOA), schools, child welfare, parole/probation/persons in need of supervision (PINS) officers, and/or MCO care managers.
4. Hospitals should obtain collateral information (within legal requirements for consent) about individuals with a behavioral health presentation where possible unless the presentation is due to a non-emergent reason, such as an asymptomatic patient presenting for a medication refill. It is insufficient to make a disposition decision solely based on behavioral observation in the CPEP/ED setting. Staff should assess whether the initial source of collateral information is able to provide sufficient high-quality information to determine risk, symptomatology and functioning in the community, treatment history, engagement in treatment, and ongoing stressors. If the initial source of collateral information is not able to provide sufficient high-quality information, attempts should be made to identify and contact additional sources of collateral information.

Coordinated Discharge Planning

1. For patients with complex needs and repeated admissions, the discharging treatment team should provide a verbal clinical update within legal requirements for consent to the receiving outpatient treatment program and residential or long-term care program. The CPEP/ED should forward a written discharge note that includes lab results and pharmacological interventions to the outpatient providers within two business days.
2. As a best practice, all patients should have a confirmed, scheduled appointment for psychiatric aftercare with an identified provider scheduled within seven calendar days

following discharge. A referral to a walk-in intake clinic is insufficient. Patients who are leaving the hospital against medical advice, or who state they do not wish to receive aftercare services, should always be provided information about available treatment options, and have an appointment scheduled whenever possible. Offering appointments and information about treatment resources significantly increases rates of successful care transitions, even among those patients who resist aftercare, who are the greatest risk for readmission and other poor outcomes.

3. For patients with complex needs or AOT orders enrolled in outpatient care management (e.g., Health Home Care Management or Health Home Non-Medicaid Care Management) or who have a residential care manager, CPEP/ED staff should coordinate plan details and timing with care managers within legal requirements for consent. Existing care managers may be able to meet the patient prior to their leaving the CPEP/ED.
4. For eligible patients with complex needs who are not enrolled in care management, CPEP/ED staff should make a referral to an intensive care management provider such as Health Home Plus for AIDS/HIV population, an OMH Designated Specialty Mental Health Care Management Agency, or Health Homes Serving Children for youth who can meet the patient prior to their leaving the CPEP/ED. For patients enrolled in Medicaid Managed Care, particularly HARP plans, the MCO Care Manager may be able to provide additional discharge planning resources and assist with care coordination.
5. The discharge plan should reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs - as well as consider all available services in the particular community. The plan should also address relevant concerning information obtained from collateral sources of information.

Pre-Discharge Interventions to Improve Discharge Outcomes

1. Individuals with an elevated risk of self-harm or suicide should have a community suicide safety plan completed before discharge. This plan should be shared by the hospital with outpatient, residential or long-term care providers.
2. Discharge of individuals with an elevated risk of violence should include close collaboration with key community partners (e.g., current outpatient, residential, or long-term care provider, care managers, shelter staff, school staff, police, etc.) to incorporate in the overall strategies to address violence risk factors and access to weapons into the overall discharge plan.
3. Individuals at risk for an opioid overdose or who live with someone at risk should be dispensed or prescribed naloxone and given education on how to use it. These individuals should also be educated on how to obtain more naloxone in the community. Additional education about harm reduction strategies, such as never using alone, using fentanyl test strips, and information about contaminants should be provided to individuals at risk or living with someone at risk of overdose.
4. Individuals who meet criteria for opioid use disorder should be offered buprenorphine or long-acting naltrexone, if appropriate, referred to an outpatient provider that can continue the treatment, and given a bridge prescription until the appointment. Similarly, individuals who meet criteria for alcohol or tobacco use disorders should be offered appropriate pharmacological interventions and referred to a new or existing provider who can continue the treatment.

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health | Department of Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

Guidance on Evaluation and Discharge Practices for Article 28 and Private Article 31 Psychiatric Inpatient Units

October 2023

The goal of this document is to offer guidance to inpatient psychiatric settings regarding evaluation and discharge planning for individuals who present with behavioral health conditions. These are the evaluations that should be completed within 72 hours of admission and interventions that will improve patient outcomes; reduce the risk of post-discharge overdose, self-harm, and violence; and reduce the risk of readmission and disconnection from care. These standards are not intended to replace clinical judgment but rather to help ensure that hospital clinical staff routinely gather all possible information when making treatment or disposition decisions. There are complicated systemic, legal, and regulatory issues that make it difficult for hospital staff to coordinate and collaborate with colleagues in residential and outpatient programs. Nonetheless, for many patients, there are possible interventions that can lengthen community tenure and help patients achieve meaningfully improved outcomes without repeatedly returning to acute settings. Hospitals should welcome care managers into hospital spaces to facilitate care integration.

Screening and Assessment

1. **Review Screenings and Assessments conducted in EDs and CPEPs:** Inpatient clinical teams should also review documentation of prior visits to the hospital and attempt to obtain medical records from other hospitals where the patient was admitted.
2. **Suicide risk:** All individuals should be screened for suicide risk using a validated instrument (e.g., the Columbia-Suicide Severity Rating Scale). Positive screens should be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk. Suicide risk should also be evaluated prior to discharge.
3. **Substance Use:** All admitted adults and children over the age of 12 should be screened for substance use using a validated instrument (examples here). Instruments should be age-appropriate and specifically screen for individual substances (e.g., alcohol, opioids, cannabis, tobacco/nicotine, etc.) that may require different interventions or psychoeducation. Positive screens should be followed by an assessment by a licensed professional experienced in working with individuals who use specific or multiple substances and may or may not meet criteria for a substance use disorder diagnosis (note: a CASAC certification is NOT a requirement). The assessment should include risk of acute withdrawal and risk of accidental overdose. Assessment of acute withdrawal symptoms should include objective information, such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute of Withdrawal Assessment (CIWA) instruments. Any individual determined to be at risk of injury from overdose or acute withdrawal should be evaluated by a physician and appropriate orders placed. Additionally, a physician, nurse practitioner, or physician assistant should check the I-STOP/PMP (Internet System for Tracking Over-Prescribing/Prescription

Monitoring Program) for any individual with a positive substance use screen; any individual who reports a prescription of controlled medications; any individual with a history of overdose; and any individual with a history of withdrawal.

4. **Violence Risk:** Violence risk screening should be universal and operationalized for all individuals in inpatient psychiatric settings both on admission and during discharge planning. The screening should include the individual's self-report; a detailed review of the history of present illness; history from electronic health records and other exchanges such as PSYCKES and SHIN-NY/QE; and high-quality collateral information from family, friends, and community providers (within legal requirements for consent). All individuals should be asked about access to firearms or other weapons. If the violence risk screening warrants further assessment, the individual should receive a comprehensive clinical assessment that includes consideration of historical events; clinical factors surrounding those events; risk and protective factors that may impact future violence risk; imminency, and seriousness of harm. The assessment should be incorporated into the inpatient treatment plan and discharge planning.
5. **Complex Needs and Social Determinants:** All individuals admitted to inpatient psychiatric units should be screened to determine if they have complex needs related to their ability to successfully transition to community-based care following discharge. Individuals with multiple chronic comorbid diagnoses, high utilization of acute care services, extensive adverse childhood experiences or trauma histories, and/or high levels of social determinant needs known to impact health outcomes should be considered complex. These individuals require more intensive care management to coordinate discharge planning needs and ensure connections with outpatient treatment, care coordination, and residential resources. Hospital staff should invite care managers working with individuals with complex needs into the hospital to meet with the patient and collaborate with the inpatient team, even when the care manager is not an employee or otherwise affiliated with the hospital. Social determinant screening should include assessment of housing status, particularly homelessness or insecure housing; food insecurity; transportation needs; communication/linguistic needs; family and community support; adverse childhood experiences; experiences of discrimination; exposure to threats or violence; criminal justice involvement; employment; education; and immigration and military/veteran status. These factors should be considered when making disposition decisions as they will have a large impact on the success or failure of any discharge plan. Referrals to social services agencies should be made as part of discharge planning if they are available in the community. When billing for inpatient services, hospitals should include the ICD-10 Social Determinants of Health Z codes in the claims, as appropriate.
6. **Level of Care Determination**: Staff should ask what the patient's goals are for coming to the hospital. When determining whether a patient is ready for discharge and the most appropriate discharge setting, it is important to consider existing symptoms and the level of risk based on observation during the hospital admission as well as the individual's overall clinical history, engagement in care, and availability of existing services in the patient's community. The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) by the American Associations for Community Psychiatrists (AACP) and the Child and Adolescent Service Intensity Instrument (CASII) by the American Academy of Child and Adolescent Psychiatrists (AACAP) are peer-reviewed, evidence-based instruments that hospitals should consider adopting to navigate this complexity and standardize level-of-care decisions.

7. **Appropriateness for Assisted Outpatient Treatment (AOT):** Individuals who have an elevated risk or frequent admissions due to non-compliance should be evaluated to determine if AOT would be beneficial. In August 2023, OMH issued new guidance for physicians on conducting an AOT evaluation. Additional guidance on AOT can be found here.

Communication and Collaboration with Non-Hospital Providers

1. Authorized mental health personnel should look up individuals in PSYCKES to review their prior psychiatric and medical history and obtain contact information for outpatient treatment teams and care managers. A consent form can be downloaded from the PSYCKES application for the individual's signature and inclusion in the hospital's medical record. Attestation of consent is provided through the PSYCKES application.
2. Individuals should be reviewed in any other available information network databases (e.g., SHIN-NY/QE or EPIC Care Everywhere). For individuals who report using controlled medications, their prescription histories should be reviewed in the I-STOP/PMP. Staff should ask if individuals have a Psychiatric Advance Directive.
3. Hospitals should attempt to obtain collateral information (within legal requirements for consent) on all individuals. It is insufficient to make a disposition decision solely based on behavioral observation in the inpatient setting. Staff should assess whether the initial source of collateral information is able to provide sufficient high-quality information to determine risk; symptomatology and functioning in the community; treatment history; engagement in treatment; and ongoing stressors. If the initial source of collateral information is not able to provide sufficient high-quality information, attempts should be made to identify and contact additional sources of collateral information.

Coordinated Discharge Planning

1. For patients with complex needs and/or repeated admissions, the discharging treatment team should provide (within legal requirements for consent) a verbal clinical sign-out to the receiving outpatient treatment program and residential or long-term care program around the day of discharge. This is in addition to a comprehensive written discharge summary (explained below).
2. As a best practice, all patients should have a confirmed, scheduled appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge. A referral to a walk-in intake clinic is not sufficient. Patients who are leaving the hospital against medical advice or who state they do not wish to receive aftercare services should always be provided information about available treatment options and have an appointment scheduled whenever possible. Offering appointments and information about treatment resources significantly increases rates of successful care transitions, even among those patients who resist aftercare, who are the greatest risk for readmission and other poor outcomes.
3. For patients with complex needs or AOT orders enrolled in outpatient care management (e.g., Health Home Care Management or Health Home Non-Medicaid Care Management) or who have a residential care manager, inpatient staff should coordinate plan details and timing with care managers (within legal requirements for consent). Existing care managers may be able to meet the patient prior to their leaving the inpatient unit and possibly pick them up on the day of discharge.
4. For eligible patients with complex needs who are not enrolled in intensive care management or enrolled and in need of more complex care management, hospital staff should make a

referral to an intensive care management provider such as Health Home Plus for AIDS/HIV population, an OMH Designated Specialty Mental Health Care Management Agency, or Health Homes Serving Children for youth. For patients enrolled in Medicaid Managed Care –particularly HARP plans –the MCO Care Manager may be able to provide additional discharge planning resources and assist with care coordination.

5. Hospital staff should send a summary detailing the presenting history of present illness (HPI), hospital course, and other relevant information to the outpatient, residential, or long-term care treatment program(s) within seven days of discharge.
6. The discharge plan should reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs – as well as consider all available services in the particular community. The plan should also address relevant concerning information obtained from collateral sources of information.

Pre-Discharge Interventions to Improve Discharge Outcomes

1. Individuals with an elevated risk of self-harm or suicide should have a community suicide safety plan completed before discharge. This plan should be shared with outpatient, residential or long-term care providers.
2. Discharge of individuals with an elevated risk of violence should include close collaboration with key community partners (e.g., current outpatient, residential, or long-term care provider, care managers, shelter staff, school staff, police, etc.) to incorporate in the overall discharge plan strategies to address violence risk factors and access to weapons into the overall discharge plan. The receiving community partners should agree to the plan and have the resources in place to receive the individual and implement the discharge plan prior to the actual discharge.
3. Individuals at risk for an opioid overdose or who live with someone at risk should be dispensed or prescribed naloxone and given education on how to use it. These individuals should also be educated on how to obtain more naloxone in the community. Additional education about harm reduction strategies, such as never using alone, using fentanyl test strips, and information about contaminants should be provided to individuals at risk or living with someone at risk of overdose.
4. Individuals who meet criteria for opioid use disorder should be offered buprenorphine or long-acting naltrexone induction, if appropriate, referred to an outpatient provider that can continue the treatment, and given a bridge prescription until the appointment. Similarly, individuals who meet criteria for alcohol or tobacco use disorders should be offered appropriate pharmacological interventions and referred to a new or existing provider who can continue the treatment.
5. Individuals who need treatment with antipsychotic medication who have a known history of having difficulty consistently taking medications post-discharge should be considered for treatment with a long-acting injectable antipsychotic medication. If appropriate, the induction dose(s) should be administered prior to discharge. Similarly, individuals who may benefit from Sublocade or long-acting naltrexone should receive their induction dose prior to discharge.