Part 590. Operation of Comprehensive Psychiatric Emergency Programs

Section 590.1. Background and intent

(a) The purpose of comprehensive psychiatric emergency programs for those individuals with a known or suspected mental illness is to provide emergency observation, evaluation, care, and treatment in a safe and comfortable environment.

(b) The purpose of this Part is to establish standards for a comprehensive psychiatric emergency program which provides a full range of psychiatric emergency services within a defined geographic area. Comprehensive psychiatric emergency program services will include crisis intervention services within an emergency room setting, crisis outreach services, beds for extended observation of individuals [~~patients~~], and triage and referral services.

(c) The purpose of this Part is to describe requirements for the establishment and operation of a comprehensive psychiatric emergency program; establish requirements for admission and discharge; and specify requirements for staffing, services, treatment planning, recordkeeping and appropriate community linkages.

Section 590.2. Legal base

(a) Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health the powers and responsibility to adopt regulations that are necessary and proper to implement matters under [~~his or her~~] their jurisdiction and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for mentally ill individuals pursuant to an operating certificate.

(b) Section 9.40 of the Mental Hygiene Law provides for emergency psychiatric admission to a comprehensive psychiatric emergency program.

(c) In accordance with Mental Hygiene Law Sec. 9.13 voluntary patients may seek admission to a comprehensive psychiatric emergency program. Voluntary treatment means that a person has a mental illness for which care and treatment as a patient in a comprehensive psychiatric emergency program is essential to such person's welfare and such person understands and consents to the need for such care and treatment.

(d) Section 31.02 of the Mental Hygiene Law prohibits the operation of programs providing services for persons with mental illness unless an operating certificate has been obtained from the appropriate commissioner of an office within the Department of Mental Hygiene.

(e) The Mental Hygiene Law, sections 31.05, 31.07, 31.09, 31.13, 31.19 and 31.27 further authorize the commissioner or his or her representative to examine and inspect such programs to determine their suitability and proper operation. Sections 31.16 and 31.17 authorize the commissioner to suspend, revoke or limit any operating certificate.

Section 590.3. Applicability

This Part applies to any general hospital which is operated by State or local governments or voluntary agencies, is authorized to receive and retain patients pursuant to section 9.39 of the Mental Hygiene Law and operates or proposes to operate a comprehensive psychiatric emergency program.

Section 590.4. Definitions

(a) General.

(1) Commissioner means the Commissioner of Mental Health.

(2) Individual with Complex Needs shall mean individuals who have one or more of the following:

(a) High utilization of inpatient, crisis or emergency services, including Residential Treatment Facility (RTF) services.

(b) High intensity outpatient service utilization or eligibility for high intensity outpatient services in the year prior to current psychiatric admission including, Assertive Community Treatment (ACT), Assisted Outpatient Treatment (AOT), Health Home Plus (HH+) eligibility or services, Critical Time Intervention (CTI), Pathway Home, Safe Options Support (SOS), Intensive Mobile Treatment (IMT), or other service utilization

characteristics determined by the Office as meeting criteria for Complex Needs designation;

(c) Discharge from inpatient level care at an Office operated Psychiatric Center or Office licensed RTF in the past year; or

(d) Inadequate connection to ambulatory or residential services and, have co-morbidities that require intensive supports for treatment and stabilization , or who have social needs that are determinants of poorer mental health outcomes, including but not limited to homelessness or insecure housing, food insecurity, transportation needs, communication/linguistic needs, insufficient family and community support, adverse childhood experiences, experiences of discrimination, exposure to threats or violence, criminal justice involvement, insufficient employment or education, immigration status, and military/veteran status and other individual characteristics determined by the Office as meeting criteria for Complex Needs designation.

(3[~~2~~]) General hospital shall be defined as in article 28 of the Public Health Law.

(4) Office means the Office of Mental Health.

(5[~~3~~]) Rural areas, for the purposes of this Part, means any city, town, village, community, organization or other group in a county with a population under 200,000.

(6[~~4~~]) Voluntary agency shall be defined as in article 41 of the Mental Hygiene Law.

(b) Services.

(1) 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, and shall also include any Psychiatric Advance Directive.

(2) 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 comprehensive psychiatric emergency program. Crisis outreach does not have to result in a visit or admission to the comprehensive psychiatric emergency program. For individuals discharged from the comprehensive psychiatric emergency program, 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.

(3) Extended observation bed means a bed located in or adjacent to the emergency room of a comprehensive psychiatric emergency program 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.

(4) 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 comprehensive psychiatric emergency program services are completed. It may include other examinations and assessments as clinically indicated by the patient's presenting problems. Full emergency visit [~~should~~]shall be provided to patients whose presenting symptoms are initially determined to be serious and where the clinical staff determine commencement of treatment [should]shall begin immediately, and/or where staff are evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit.

(5) I-STOP/PMP shall mean internet System for Tracking Over-Prescribing/Prescription Monitoring Program.

(6*)* Intensive Care Management shall mean a care management program that provides mobile, community-based support, with duration and frequency of visits meeting client needs. Services are provided in home or residences, community settings, health care settings including emergency department, hospital, and primary care settings to support access, engagement, quality, and coordination of care to meet clients' health care and basic needs. Examples of Intensive Care Management include Critical Time Intervention, Assertive Community Treatment, and Health Home Plus services, and other services designated by the Office as meeting criteria for Intensive Care Management services.

(7[~~5~~]) Medical examination means an examination conducted as part of a comprehensive psychiatric emergency program's full emergency visit, conducted by an appropriately credentialed professional employed by the comprehensive psychiatric emergency program or emergency department. Such medical examination shall include:

(i) 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.

(ii) Where clinically indicated:

(a) a targeted physical exam, and

(b) orders for laboratory and other diagnostic studies.

(8[~~6~~]) On duty means the professional is physically present in the building and accessible.

(9) PSYCKES shall mean the Psychiatric Services and Clinical Knowledge Enhancement System, a secure, HIPAA-compliant web-based platform developed by the Office of Mental Health (OMH) for sharing Medicaid billing claims and encounter data, other health-related data, and other data and documents entered by providers and individuals.

(10) PSYCKES MYCHOIS shall mean the My Collaborative Health Outcomes Information System (MYCHOIS), which is a PSYCKES application for individuals receiving behavioral health services.

(11) Psychiatric advance directive shall mean a legal document that details a person's preferences for future mental health treatment decisions and names an individual to make treatment decisions if the person is in a crisis and unable to make decisions.

(12[~~7~~]) Received means the individual has completed all required registration materials upon entry to the comprehensive psychiatric emergency program, and a record has been created for such individual.

(13[~~8~~]) Restraint means the term restraint as such term is defined in section 526.4 of this Title.

(14[~~9~~]) 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 comprehensive psychiatric emergency program and is located away from the central campus of the general hospital. A satellite facility at minimum must provide crisis intervention services including triage and referral and full emergency visits and/or extended observation bed services.

(15[~~10~~]) Seclusion means the term seclusion as such term is defined in section 526.4 of this Title.

(16) SHIN-NY/QE shall mean the Statewide Health Information Network for New York, which facilitates the secure electronic exchange of individual health information, connects healthcare professionals statewide and connects New York's Qualified Entities (QE), regional health information organization networks (RHIO) that store and share protected health information.

(17[~~11~~]) Triage means a determination upon presentation by a staff member that an individual [should]shall receive an evaluation, or when appropriate, referral to other nonmental health services.

(18[~~2~~]) Triage and referral means a face to face interaction between an individual [~~patient~~] and a staff physician, preferably a psychiatrist, or psychiatric nurse practitioner to determine the scope of emergency service required. This interaction [~~should~~]shall include a psychiatric diagnostic examination. It may result in further comprehensive psychiatric emergency program evaluation or treatment activities on the individual's [~~patient's~~] behalf or discharge from the comprehensive psychiatric emergency program. For those persons who are discharged from the comprehensive psychiatric emergency program and who require additional mental health services triage and referral must include a discharge plan.

(c) Staffing.

(1) 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.

(2) 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 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.~~] Credentialed Alcoholism and Substance Abuse Counselor (CASAC) means an individual who has a current valid credential issued by the New York State Office of Addiction Services and Supports (OASAS), or a comparable credential, certificate or license from another recognized certifying body as determined by the OASAS.

(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

(iv) 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.

(3) Certified peer specialist means an individual who is [~~credentialed~~] certified as a peer in New York State from a certifying authority recognized by the Commissioner of OMH.

(4) Certified recovery peer advocate means an individual who holds a certification issued by an entity approved and recognized by the Commissioner of the Office of Addiction Services and Supports (OASAS).

(5) Certified or credentialed family peer advocate means and individual who is credentialed as a peer in New York State from a certifying authority recognized by the Commissioner of OMH or OASAS.

(6) Certified or credentialed youth peer advocate means an individual who is credentialed as a peer in New York state from a certifying authority recognized by the Commissioner of OMH or OASAS.

(7[~~4~~]) Other professional disciplines may be included as professional staff, provided that the discipline is approved as part of the staffing plan submitted to the Office of Mental Health. The discipline shall be from a field related to the treatment of mental illness. For rural areas, individuals who have obtained at least a master's degree in psychology may be considered professional staff for the purposes of calculating professional staff but may not be assigned supervisory responsibility.

Section 590.5. Certification

(a) Any general hospital that intends to operate a comprehensive psychiatric emergency program must be issued an operating certificate by the Office of Mental Health prior to the operation of the program.

(b) An operating certificate may be limited, suspended, or revoked by the Office of Mental Health in accordance with the provisions of section 31.16 of the Mental Hygiene Law and Part 573 of this Title. Operating certificates shall remain the property of the Office of Mental Health, and revoked operating certificates shall be returned to the Office of Mental Health.

(c) In order to receive and retain an operating certificate, a comprehensive psychiatric emergency program shall:

(1) submit an application on such forms and with supporting documentation as shall be required by the Office of Mental Health. Such application shall include an emergency services plan which complies with section 590.7 of this Part and which, as approved, shall be the program and community plan for the licensed comprehensive psychiatric emergency program and an integral part of the certificate;

(2) frame and display the operating certificate within the comprehensive psychiatric emergency program in a conspicuous place which is readily accessible to the public;

(3) cooperate with the Office of Mental Health during any review, evaluation or inspection of the facility or program;

(4) make available to the Office of Mental Health upon request all documents, files, reports, patient records, accounting records or other materials required by this Part or requested by the Office of Mental Health in the course of visitation, audit or inspection;

(5) undertake changes in the operation of the hospital or program as required by the operating certificate; and

(6) obtain prior approval of the Office of Mental Health to:

(i) change the physical location of the program or utilize additional physical locations;

(ii) initiate major changes in the services provided by the program;

(iii) terminate the program or services in the program; and

(iv) change the powers or purpose set forth in the certificate of incorporation.

Section 590.6. Organization and administration

(a) The governing body of the hospital shall be responsible for the overall operation and management of the comprehensive psychiatric emergency program. 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. No individual shall serve as both member of the governing body and of the paid staff of the comprehensive psychiatric emergency program without prior approval of the Office of Mental Health.

(b) The hospital shall assure that the comprehensive psychiatric emergency program has space, program, staff, policies and procedures that are sufficient to meet the requirements of this Part and are separately identifiable from any other programs which may be operated by the providers.

(c) The governing body shall comply with all requirements set forth in 10 NYCRR Part 405 as well as requirements established by appropriate local, State and Federal standard-setting bodies. In addition, the governing body shall be responsible for the following duties:

(1) to develop an organizational plan which indicates lines of accountability and the qualifications required for staff positions. Such plan may include the delegation of the responsibility for the day-to-day management of the program to a program director who shall be a member of the professional staff employed by the comprehensive psychiatric emergency program. The program director shall report to the director of the host hospital or to the Director of Psychiatry;

(2) Ensure efforts to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved marginalized populations, including but not limited to: people of color, members of the LBGTQ 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. Such policies and procedures shall include, but are not limited to the following:

(i) written personnel policies which shall prohibit discrimination on the basis of race or ethnicity, religion, color, creed, disability, gender identity, sexual orientation, sex, marital status, age or national origin, as well as, written policies on affirmative action which are consistent with the affirmative action and equal employment opportunity obligations imposed by title VII of the Civil Rights Act, Federal Executive Order 11246, the Rehabilitation Act of 1973, section 504, as amended, and the Vietnam Era Veteran's Readjustment Act;

(3) to develop, approve, periodically review and revise as appropriate all programmatic and administrative policies and procedures. Such policies and procedures shall include, but are not limited to the following:

(i) written policies and procedures governing patient records [~~which~~]that ensure confidentiality consistent with the Mental Hygiene Law, sections 33.13, 33.14 and 33.16, 45 C.F.R. parts 160 and 164 and which provide for appropriate retention of such records pursuant to section 590.12 of this Part; and

(ii) written policies that ensure the protection of patients' rights. At a minimum these policies shall establish and describe a patient grievance procedure. The provider shall post a statement of patients' rights in a conspicuous location easily accessible to the public pursuant to section 590.15 of this Part. This statement shall be provided in the patient's preferred language, and be accessible to the blind and visually impaired.

(4) To make an effort that the comprehensive psychiatric emergency program's staffing matches the demographic profile of the persons served, the program regularly uses data to set workforce

recruitment targets. Efforts to recruit a diverse workforce [~~should~~]shall include all levels of the organization's workforce, including management.

(d) Comprehensive psychiatric emergency programs 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.

(e) Comprehensive psychiatric emergency programs review available demographic data to identify disparities of access to treatment and [~~should~~]shall implement policy and procedures to address such disparities.

(f) Comprehensive psychiatric emergency programs shall ensure provision of language assistance services to individuals who are Limited English Proficient and/or have other communication needs (e.g., deaf or hard of hearing) at no cost to them to facilitate timely access to all health care and services. Language access services will be made available in such a way that assessment or treatment activities will not be delayed.

(1) The comprehensive psychiatric emergency program shall make all necessary documents available in the individual's preferred language (e.g. releases). The program shall inform all individuals of their right to receive language assistance services clearly and in their preferred language, verbally and in writing.

(2) The comprehensive psychiatric emergency program provides 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.

(3) Efforts are made to provide the individuals identified as collaterals with language assistance services translated into their preferred language, verbally and in writing.

(4) Efforts are made to employ staff that are proficient in the most prevalent languages spoken by services users.

(5) Ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters [~~should~~]shall be avoided.

(g) Incidents

(1) The hospital shall ensure the timely reporting, investigation, review, monitoring and documentation of incidents pursuant to the Mental Hygiene Law and Part 524 of this Title. Additionally, such records and any related information shall be made available to the Department of Health, at their request.

(a) The comprehensive psychiatric emergency program shall 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.

(2) Incident Training

(a) All new staff shall receive training which must include at a minimum, the definition of incidents, reporting procedures, an overview of the review process, and the role of risk management.

(b) Refresher incident reporting training shall be conducted at least annually for all staff and evidence of such training must be recorded in the staff personnel file;

(3) The Hospital's incident review committee shall review incidents, make recommendations and ensure implementation of action plans with the comprehensive psychiatric emergency program's administrator.

(h) The hospital shall ensure that no otherwise appropriate individual [~~patient~~] is denied access to services solely on the basis of multiple diagnoses or a diagnosis of HIV infection, AIDS, or AIDS-related complex.

(i) The hospital shall participate with the local governmental unit in local planning processes pursuant to sections 41.05 and 41.16 of the Mental Hygiene Law. At a minimum, such participation shall include:

(1) provision of budgeting and planning data as requested by the local governmental unit;

(2) identification of the population being served by the program;

(3) identification of the geographic area being served by the program; and

(4) description of the program's relationship to other providers of service, including but not limited to a description of all written agreements entered into pursuant to this Part.

(j) In programs which are not operated by State or local government, there shall be an annual audit, pursuant to a format prescribed by the Office of Mental Health, of the financial condition and accounts of the program performed by a certified public accountant who is not a member of the governing body or an employee of the program. Documents and fiscal information provided by the certified public accountant shall be relied upon by the Office of Mental Health in determining whether to issue, modify or renew the program's license and any associated contracts. Government-operated programs shall comply with applicable laws concerning financial accounts and auditing requirements. The audit may be program specific or may be performed as a part of any overall hospital audit.

(k) The hospital shall ensure the posting of notices of recipients' rights pursuant to section 527.5 of this Title.

(l) The comprehensive psychiatric emergency center shall ensure the posting of 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.

Section 590.7. Emergency service plan

(a) Each comprehensive emergency service program must submit an emergency services plan which shall be approved by the Commissioner of Mental Health prior to the issuance of an operating certificate.

(b) The emergency services plan shall include:

(1) a description of the program's catchment area;

(2) a description of the program's psychiatric emergency services, including crisis intervention services, crisis outreach services, extended observation beds, and triage and referral services, whether provided directly or through written agreement with other providers of services;

(3) written agreements or affiliations with the host hospital and, if appropriate, other hospitals, as defined in section 1.03 of the Mental Hygiene Law, to receive and admit persons who require inpatient psychiatric services;

(4) written agreements or affiliations with the hospital and as appropriate with other general hospitals to receive and admit persons who have been referred by the comprehensive psychiatric emergency programs and who require medical or surgical care which cannot be provided by the comprehensive psychiatric emergency program;

(5) a description of the program's linkages with mental health, substance abuse, alcohol, intellectual and developmental disabilities, social services, peer counseling and self help services, State and local police agencies, emergency medical services, and ambulance services or other transportation agencies;

(6) written discharge criteria and guidelines for discharge planning for persons in need of post emergency treatment or services in accordance with the requirements set forth in section 590.8 of this Part;

(7) a statement indicating that the program has been included in an approved local or unified service plan pursuant to article 41 of the Mental Hygiene Law for each local government located within the program's catchment area;

(8) the qualifications and duties of each staff position by title. Proposed staffing shall take into account the population to be served and the services provided, and shall include, at minimum, an adequate number of psychiatrists, registered nurses, licensed master and/or licensed clinical social workers, and security personnel;

(9) the rationale and justification for the specific number of extended observation beds which are being requested pursuant to section 590.9(e) of this Part. Hospitals are prohibited from operating extended observation beds above the approved number of beds which appear on the operating certificate of the program. <u>The total number extended observation beds must be approved by the Office</u>.[~~In no case shall a comprehensive psychiatric emergency program operate more than six extended observation beds;~~] and

(10) any other information or agreements required by the commissioner.

Section 590.8. Admission and discharge procedures

(a) Each comprehensive psychiatric emergency program shall maintain admission and discharge criteria which are consistent with its goals and objectives, and which are subject to the approval of the Office of Mental Health. Each admission shall be conducted in accordance with the provisions of section 9.40 of the Mental Hygiene Law and on the forms prescribed therefor.

(b) Admission and retention of individuals.

(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 six hours after being received into the emergency room.

(2[~~1~~]) Any person receiving a full emergency visit[~~admitted into the emergency room of the comprehensive psychiatric emergency program~~] must be examined by a staff physician, as soon as practicable and in any event within six hours after being received into the emergency room.

(3[~~2~~]) The director of the comprehensive psychiatric emergency program may, in accordance with section 9.40 of the Mental Hygiene Law, involuntarily receive and retain in an extended observation bed any person alleged 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 comprehensive psychiatric emergency program is appropriate. Retention in an extended observation bed shall not exceed 72 hours, which shall be calculated from the time such person is initially received into the emergency room of the comprehensive psychiatric emergency program.

(4[~~3~~]) No person may be involuntarily retained in a comprehensive psychiatric emergency program for more than 24 hours unless the person is admitted to an extended observation bed in accordance with section 9.40 of the Mental Hygiene Law.

(5[~~4~~]) Any person with a need of medical or surgical care or treatment which cannot be provided in the comprehensive psychiatric emergency program, shall not remain in the comprehensive psychiatric emergency program for a period exceeding eight hours. Within eight hours such person shall be accepted by the host hospital or a hospital with an affiliation agreement pursuant to section 590.7(b)(3) of this Part for appropriate observation or treatment in accordance with applicable regulations of the Department of Health (10 NYCRR section 405.19).

(c) Information gathering

(1) The program shall access the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other available electronic health records or database(s) to identify the individual's [~~patient's~~] treatment providers and prior medication use and/or treatment engagement history.

(2) The program shall document efforts to identify and contact with the individual's consent, the individual's treatment team and other relevant providers (e.g., housing providers, care coordination, managed care organizations), and collaterals. In accordance with HIPAA and section 33.13 of the Mental Hygiene Law, the program shall attempt to obtain the authorization of the individual or someone authorized to make health care decisions on the individual's behalf to access, use and disclose PHI from collaterals or other data sources as outlined in this

subdivision. If the 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 patient. If so, only that PHI that is necessary to protect the patient from the anticipated harm or which is in the best interest of the patient may be accessed, used, or disclosed. The reasons for the access, use, or disclosure must be appropriately documented in the clinical record.

(3) The program shall attempt to obtain collateral information on all individuals:

(i) When contacting collaterals staff shall assess whether the 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 source of collateral information is not able to provide sufficient high-quality information, attempts shall be made to identify and contact additional sources of collateral information.

(iii) Where the presentation is due to a non-emergent reason, including but not limited to an asymptomatic individual presenting for a medication refill, the program is not required to contact collaterals.

(4) The program shall access the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other available electronic health records or database(s) to identify the individual's treatment providers and prior medication use and/or treatment engagement history with consent as required. In the event of incapacity or emergency circumstance, staff may temporarily access a PSYCKES clinical profile, for the limited purposes authorized by this section and in accordance with PSYCKES Policies and Procedures.

(5) The program shall access all other available information network databases (e.g., SHIN-NY/QE or EPIC Care Everywhere) to review relevant information on the individual with appropriate consent as may be required. In the event of incapacity or emergency circumstance, staff may temporarily access a clinical profile, for the limited purposes authorized by this section and in accordance with SHIN-NY policy or as authorized by other policy, law or regulation.

(6) The program shall review information contained in the I-STOP and PMP databases including but not limited to prescription histories related to individuals who report using controlled medications.

(7) The program shall check PSYCKES to see if the individual has a Psychiatric Advance Directive (PAD), Wellness Plan, or preferred contacts. The program shall obtain appropriate consent as required to access the full view of the Psychiatric Advance Directive, Wellness Plan, or preferred contacts. In the event of incapacity or emergency circumstance, staff may temporarily access a PSYCKES clinical profile, for the limited purposes authorized by this section and in accordance with PSYCKES Policies and Procedures. If the individual does not have a PAD, the Program shall provide a copy and explanation of the PAD. If the individual chooses to complete a PAD, it shall be placed in their chart.

(d) Screening and assessment

(1) All individuals must be screened for suicide risk using a validated instrument. Positive screens must be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk.

(2) Each CPEP 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 patients must be asked about access to firearms or other weapons.

(3) All individuals over 12 years old must be screened for substance use using a validated instrument. Positive screens shall be followed by an assessment by a licensed professional who is familiar with working with individuals who have a substance use disorder or CASAC.

(4) A determination must be made as to whether an individual has complex needs. Social Determinants must be considered when making treatment and disposition decisions.

[~~(1) all presenting individuals shall be screened for risk of harm to self and others;~~

~~(2) staff shall collaborate with collaterals as appropriate and available;~~

~~(3) for individuals determined to be of moderate to high risk, efforts shall be made to obtain or develop a safety plan;~~

~~(4) all presenting individuals shall be screened for alcohol and substance use, high risk use [and]substance use disorder;~~

~~(5) screening tools shall be evidence based and validated where possible; and]~~

(5[~~6~~]) [a]Assessments shall be strength-based and person-centered.

(e) The commissioner or his or her designee may prevent new admissions to the comprehensive psychiatric emergency program emanating from emergency medical services, ambulance services and law enforcement if a conclusion is reached that the ability of the program to deliver quality service would be jeopardized.

(1) The commissioner or his or her designee shall review the continued necessity for such prevention at least once every 24 hours according to a mutually developed plan.

(2) The comprehensive psychiatric emergency program shall develop a contingency plan with other local affiliated hospitals, emergency medical services and law enforcement for the prevention of new admissions during periods of high demand and overcrowding.

(3) Where a comprehensive psychiatric emergency program prevents new admissions pursuant to this paragraph, the comprehensive psychiatric emergency program must notify the appropriate OMH Field Office according to a mutually developed plan.

(f) Discharge criteria.

The provisions of section 29.15 of the Mental Hygiene Law shall not apply to the discharge of an individual from a comprehensive psychiatric emergency program, however:

(1) Discharge planning shall be conducted for all persons discharged from a comprehensive psychiatric emergency program who have been determined to require additional mental health services after triage and referral or full emergency visit and for those persons admitted to extended observation beds who require additional mental health services.

(2) Discharge planning criteria shall include at least the following activities prior to discharge from the comprehensive psychiatric emergency program:

(i) When determining whether an individual is ready for discharge and the most appropriate discharge setting, the whole clinical presentation and history, as well as the availability of existing services and supports in the individual's community, must be considered. This includes if an individual resides in a residential program licensed by the Office or supportive housing.

(ii[~~i~~]) The discharge plan must reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. The plan must also address relevant information obtained from collateral sources of information. [~~a review of the person's psychiatric and physical needs;~~]

(iii) For discharges of individuals with complex needs, active AOT orders and/or repeated admissions, the CPEP must provide a verbal clinical sign-out to the receiving outpatient treatment program and the residential or long-term care program licensed or funded by the Office or another Office within the Department or the Department of Health where the individual will reside after discharge on the day of discharge, or as soon as possible thereafter, in accordance with section 33.13 of the Mental Hygiene Law.

(iv) The CPEP must send 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.

(v) If the individual is enrolled in outpatient (e.g., Health Home Care Coordination or Specialty Mental Health Care Management (Health Home Plus)), residential care management (e.g., OMH licensed or funded supportive housing or residential treatment), or has an active AOT order, CPEP staff must coordinate discharge plan details and timing with care managers.

(vi) For individuals with complex needs who are eligible for but not enrolled in intensive care management or are enrolled in care management but need intensive care management, CPEP staff must make a referral to an intensive care management provider, in accordance with Office guidance.

(vii) Prior to discharge, and in accordance with section 33.13 if the Mental Hygiene Law, the CPEP shall contact aftercare providers to schedule and confirm a follow up appointment to occur within seven calendar days following discharge. A referral to a walk-in intake clinic is insufficient to meet this requirement. Individuals who are leaving the CPEP against medical advice, or who state they do not wish to receive aftercare

services, shall be provided information about available treatment options and have an appointment scheduled whenever possible. When an appointment for mental health services cannot be made within seven calendar days, crisis outreach teams or other available comprehensive psychiatric emergency program staff shall provide crisis outreach until the initial appointment occurs and such services shall be reimbursed pursuant to section 591.4.

(viii) [~~c~~]Completion of referrals to other community services providers, including peer support services, in collaboration with the individual receiving services and comprehensive psychiatric emergency program staff, to address the person's identified needs.[;]

[~~(iii) in collaboration with the individual receiving services, the comprehensive psychiatric emergency program shall arrange for appointments with community providers which shall be made as soon as possible after discharge from the emergency room of the comprehensive psychiatric emergency program. When an appointment for mental health services cannot be made within a reasonable period of time, crisis outreach teams or other available comprehensive psychiatric emergency program staff may provide crisis outreach until the initial appointment occurs and such services shall be reimbursed pursuant to section 591.4(f); and~~]

([~~iv~~]ix) Each individual shall be given the opportunity to participate in the development of his or her discharge plan. Absent the objection of the person and when clinically appropriate, reasonable attempts shall be made to contact [~~family members~~] collaterals for their participation in the discharge planning program. However, no person or family member shall be required to agree to the person's discharge. A notation shall be made in the person's record if such person objects to the discharge plan or any part thereof[.];

(x) All individuals must be screened for suicidality prior to their discharge. Individuals with an elevated risk of self-harm or suicide must have a community suicide safety plan completed before discharge. Lethal means shall be identified and a plan for restriction addressed in the Safety Plan. The CPEP shall document their work with collaterals to implement the plan to restrict lethal means and confirm completion prior to discharge.

(xi) Discharge of individuals with an elevated risk of violence must include, to every extent possible, close collaboration with key community partners to incorporate strategies to address violence risk factors and access to weapons in the overall discharge plan, in accordance with section 33.13 of the Mental Hygiene Law.

(xii) Individuals who meet criteria for any substance use disorder shall be offered pharmacological interventions, if appropriate, and referred to a new or existing provider who can continue their medication assisted treatment for their substance use disorder.

(xiii) Individuals who require treatment with an antipsychotic medication but have history of non-compliance shall be considered for treatment with a long-acting injectable medication.

(3) The comprehensive psychiatric emergency program shall verify that after-care appointment(s) occurred and follow up with individuals to ensure satisfactory linkage to care. Until linkage to care is completed, or for other clinically-indicated reasons, comprehensive psychiatric emergency program staff shall provide crisis outreach services to ensure individuals are safe and stable in the community and continue to provide support, care and assistance with linkage to follow up care. Such services shall be reimbursed pursuant to section 591.4(f).

Section 590.9. Services

(a) The comprehensive psychiatric emergency program shall directly provide or ensure the provision of psychiatric emergency services, seven days per week, which shall include but not be limited to crisis intervention services in an emergency room, crisis outreach services, extended observation beds and triage and referral services as such terms as defined in section 590.4 of this Part.

(b) Crisis intervention services shall be provided in the emergency room 24 hours per day, seven days per week and shall include psychiatric and medical evaluations and assessments which are used to determine the appropriateness of admission to and retention in the comprehensive psychiatric emergency program.

(1) Triage and referral services shall be performed as soon as practicable and in any event within six hours after an individual is admitted into the comprehensive psychiatric emergency program's emergency room.

(2) if a triage and referral visit is not conducted, a full emergency service shall be performed.

(3[~~2~~]) Full emergency visit services shall be performed as soon as is practicable after an individual is determined to need such services. If a triage and referral visit is not conducted, a full emergency visit must be initiated within six hours.

(4[~~3~~]) In any case, an individual shall not be retained in the comprehensive psychiatric emergency program emergency room for more than 24 hours at which point they must be admitted to an extended observation bed or a psychiatric inpatient bed.

(c) Crisis outreach shall be provided seven days per week, during at least the day and evening hours pursuant to a staffing plan approved by the Office of Mental Health.

(1) Such services may be provided directly by the comprehensive psychiatric emergency program or through written agreement with a provider of service approved by the Office of Mental Health.

(2) 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 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 comprehensive psychiatric emergency program. Crisis outreach does not have to result in an admission to the comprehensive psychiatric emergency program. For individuals discharged from comprehensive psychiatric emergency programs, 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 a community-based provider.

(i) Crisis outreach services include but are not limited to assessment, therapeutic communication, coordination with identified supports, psychiatric consultation, safety planning, referral, linkage, peer services.

(ii) Crisis outreach referrals can be made through internal referrals, external referrals or through comprehensive psychiatric emergency program discharge referrals.

(d) Extended observation beds shall be available 24 hours per day, seven days a week to provide extended assessment and evaluation as well as a humane, safe environment which includes appropriate toilet, bath, and dietary facilities. The rationale for placement in extended observation beds shall be documented in the individual's [~~patient's~~] case record and continued stay for up to 72 hours shall be subject to a daily written documentation of the need for continued retention.

(e) Triage and referral services as defined in section 590.4(b) of this Part, shall be available 24 hours per day, seven days per week and shall be provided to all individuals who receive services from the comprehensive psychiatric emergency program.

(f) Each comprehensive psychiatric emergency program shall provide information to individuals regarding the availability of peer counseling, family support, and/or self-help services.

Section 590.10. Staffing

(a) A comprehensive psychiatric emergency program shall 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. Each comprehensive psychiatric emergency program shall submit a staffing plan which includes the qualifications and duties of each staff position by title. The staffing plan and its rationale shall be subject to approval by the Office of Mental Health. The Office of Mental Health must be notified of and approve any long-term deviations from the approved staffing plan.

(b) An adequate proportion of the clinical staff hours shall be provided by full-time employees.

(c) The comprehensive psychiatric emergency program shall, at a minimum, employ the following types and numbers of staff:

(1) except as provided in subdivision (e) of this section, 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;

(2) at least one full-time equivalent registered nurse shall be on duty at all times and shall be responsible for the supervision of the nursing care and treatment provided in the extended observation beds of the comprehensive psychiatric emergency program;

(3) 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;

(4) a sufficient number of security personnel shall be on duty and available at all times;

(5) at least one full-time equivalent credentialed alcoholism and substance use disorder counselor or clinical staff person with experience in the counseling or treatment of individuals with a substance use disorder shall be available or on call 24 hours a day;

(6) the extended observation beds component of the comprehensive psychiatric emergency program shall be staffed by at least one clinical staff person, who is supervised by the registered nurse supervisor indicated in paragraph (2) of this subdivision, 24 hours per day, seven days per week; and

(7) when providing crisis outreach at a site other than the emergency room of the comprehensive psychiatric emergency program at least two staff of the crisis outreach team, one of whom is a member of the professional staff, shall be present at all times.

(i) For an initial crisis outreach visit, a member of the professional staff may respond alone if such need is determined.

(ii) 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 maybe provided by professional staff, staff possessing a bachelor's degree or staff with a peer certification or credential working within their scope of practice.

(d[~~e~~])The commissioner may waive the requirement that one full time equivalent psychiatrist be on duty and available during the night hours, if:

(1) the comprehensive psychiatric emergency program can demonstrate that the volume of service does not require such level of staff coverage; and

(2) the comprehensive psychiatric emergency program can demonstrate that it can provide adequate coverage by other professional disciplines; and

(3) the comprehensive psychiatric emergency program can demonstrate the availability of a psychiatrist on call for consultation and supervision.

(e[~~f~~]) For comprehensive psychiatric emergency programs which are 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:

(1) the comprehensive psychiatric emergency program can demonstrate that the volume of service does not require such level of staff coverage;

(2) the comprehensive psychiatric emergency program can demonstrate that it can provide adequate 24-hour coverage by other professional staff; and

(3) the comprehensive psychiatric emergency program can demonstrate the availability of a psychiatrist on-call for face-to-face interaction, consultation, supervision, an admission to or discharge from an extended observation bed.

(g[~~i~~])In order to assure that individuals admitted to the comprehensive psychiatric emergency program are adequately supervised and are cared for in a safe and therapeutic manner, the comprehensive psychiatric emergency program shall meet each of the following requirements:

(1) appropriate professional staff shall be available to assist in emergencies on at least an on-call basis at all times.

Section 590.11. Special treatment procedures

(a) No comprehensive psychiatric emergency program shall use restraint or seclusion without a written plan for the use of restraint or seclusion, as defined in section 590.4 of this Part, which is in accordance with section 526.4 of this Title.

(b) No comprehensive psychiatric emergency program shall use extraordinary risk procedures. Extraordinary risk procedures include, but are not limited to, experimental treatment modalities and aversive conditioning.

(c) No comprehensive psychiatric emergency program shall use electroconvulsive therapy.

Section 590.12. Case records

(a) There shall be a complete legible case record maintained for each individual [~~patient~~] admitted to a comprehensive psychiatric emergency program.

(b) The case record shall be available to all clinical staff, including peer specialists, recovery peer advocates, family peer advocate or youth peer advocate, of the comprehensive psychiatric emergency program who are participating in the treatment of the individual [~~patient~~] consistent with 45 C.F.R. parts 160 and 164.

(c) All individuals receiving services from the comprehensive psychiatric emergency program must have a case record which, at a minimum, includes a presentation note which indicates:

(1) a brief description of the presenting problem, critical needs and overall conditions;

(2) 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

(3) a brief description of the comprehensive psychiatric emergency program's attempts to contact collaterals in accordance with Part 590.8 .

(d) In addition to the information called for in subdivision (c) of this section, each case record for individuals who receive a triage and referral visit, a full emergency visit, or are admitted to an extended observation bed or receive crisis outreach shall include:

(1) patient identifying information and available psychiatric medical and relevant social history, including the person's residential situation and the details of the circumstances leading to the individual's presentation at the comprehensive psychiatric emergency program, and the name of the person or persons who have referred or brought the individual to the comprehensive psychiatric emergency program, if any. In the case of individuals brought to the comprehensive psychiatric emergency program by law enforcement officers, the officers [~~should~~]shall be interviewed and identified in the case record;

(2) diagnosis;

(3) assessment of the individual's [~~patient's~~] treatment needs based upon psychiatric, physical, social and functional evaluations; and

(4) progress notes which relate to goals and objectives of treatment and document services provided.

(e) 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 and may be included in the case record for individuals who receive a triage and referral visit and/or crisis outreach:

(1) reports of all mental and physical diagnostic exams, assessments, tests, and consultations;

(2) notes which relate to special circumstances and untoward incidents;

(3) dated and signed orders for all medications;

(4) discharge summary, including referrals to other programs and services, which must be completed within five days of discharge and;

(5) documentation of attempts to contact collaterals, including housing providers.

(f) The case record shall include documentation of the individual's [~~patient's~~] status pursuant to mental hygiene law.

Section 590.13. Premises

(a) The comprehensive psychiatric emergency program and any satellite facility shall maintain premises adequate and appropriate for the safe and effective operation of the program.

(b) The space provided shall be both adequate and appropriate for:

(1) the maintenance of privacy for interviews between staff members and persons served;

(2) the comfort and convenience of those waiting for and receiving services. No individual waiting for or receiving services may be placed in a hallway or other area not approved by the Office of Mental Health as a waiting or treatment area;

(3) accommodation of routine activities and regularly used equipment;

(4) controlled access to, and maintenance of, case records; and

(5) applicable Federal standards for space requirements which are necessary to assure continued receipt of Federal reimbursement for care and services provided in the comprehensive psychiatric emergency program or the host hospital.

(c) The emergency room of the comprehensive psychiatric emergency program shall be near or adjacent to the medical emergency room of the host hospital but shall be allocated physically discrete space acceptable to the Office of Mental Health.

(d) Extended observation beds shall be located in or adjacent to the comprehensive psychiatric emergency program emergency room unless otherwise authorized by the Office of Mental Health. [~~except that a waiver of this requirement may be made when:~~

~~(1) an interim location is acceptable to Office of Mental Health; and~~

~~(2) the host hospital submits architectural plans for the establishment of the extended observation beds in space in or adjacent to the emergency room within a period of time acceptable to the Office of Mental Health~~.]

(e) The premises shall be reasonably maintained to ensure access to services by all individuals [~~patients~~].

(f) Facilities shall comply with all local zoning and building laws, regulations and ordinances.

(1) Heating, lighting and ventilation shall be adequate for the comfort and well being of the persons served and the employees.

(2) A written certificate of occupancy, or equivalent, by the local building inspection authority shall be retained in the records of the program.

(3) Copies of all local inspection reports, and other relevant inspection reports, shall be maintained and available upon request.

Section 590.14. Statistical records and reports

(a) Such statistical information shall be prepared and maintained as may be necessary for the effective operation of the comprehensive psychiatric emergency program and as may be required by the Office of Mental Health.

(b) Statistical information shall be reported to the Office of Mental Health in a manner and within time limits specified by the Office of Mental Health.

(c) Statistical reporting shall be the responsibility of an individual whose name and title shall be made known to the Office of Mental Health.