

NEW YORK STATE OFFICE OF MENTAL HEALTH
2010 ANNUAL REPORT
TO THE GOVERNOR AND LEGISLATURE OF NEW YORK STATE
ON COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS

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Introduction

Psychiatric emergency care in New York State was historically provided primarily in the emergency rooms of general hospitals and often resulted in overcrowded emergency rooms and over-utilized acute inpatient hospitalization services. An increase in the use of emergency rooms in the 1980s raised concern about the timeliness, quality, and continuity of care for people accessing psychiatric emergency services. As the Office of Mental Health (OMH) continued to concentrate the locus of mental health treatment, rehabilitation, and support services in the community, there was a recognized need to support a more coordinated and comprehensive emergency service system.

Accordingly, Chapter 723 of the Laws of 1989 authorized OMH to develop a Comprehensive Psychiatric Emergency Program (CPEP) designed to provide a systematic response to psychiatric emergencies in urban areas. In July 1994, Chapter 723 was amended to extend the legislative authorization of CPEPs to July 2000 and to authorize OMH to develop and implement suburban/rural CPEPs. A year later, Chapter 306 of the Laws of 1995 authorized a number of amendments regarding the location of extended observation beds within a CPEP. Chapter 93 of the Laws of 2000 extended the legislative authorization of CPEPs to July 2004, and Chapter 131 of the Laws of 2004 extended such authorization to July 2008. In April 2006, Chapter 57, Part M amended section 31.27 of the Mental Hygiene Law to eliminate the statutory authority to designate suburban/rural CPEPs. Chapter 58 of the Laws of 2008 extended the legislative authorization of CPEPs to July 2012.

Today, the 19 hospitals listed below are licensed to operate 20 CPEPs that provide emergency observation, evaluation, care, and treatment in safe and comfortable environments in accordance with the model:

- Beth Israel Medical Center, New York, NY
- Bronx-Lebanon Hospital Center, Bronx, NY
- Brookdale Hospital Medical Center, Brooklyn, NY
- Clifton Springs Hospital and Clinic, Clifton Springs, NY
- Erie County Medical Center, Buffalo, NY
- New York-Presbyterian Hospital, New York, NY (separate adult and children CPEPs)
- NYCHHC – Bellevue Hospital Center, New York, NY
- NYCHHC – Elmhurst Hospital Center, Elmhurst, NY
- NYCHHC – Harlem Hospital Center, New York, NY
- NYCHHC – Jacobi Medical Center, Bronx, NY
- NYCHHC – Kings County Hospital Center, Brooklyn, NY
- NYCHHC – Queens Hospital Center, Jamaica, NY
- Richmond Medical Center, Staten Island, NY
- Saint Joseph's Hospital Health Center, Syracuse, NY
- Saint Luke's-Roosevelt Hospital Center, New York, NY
- SUNY at Stony Brook University Hospital, Stony Brook, NY

- United Health Services Hospitals, Inc., Binghamton, NY
- University of Rochester Medical Center/Strong Memorial Hospital, Rochester, NY
- Westchester Medical Center, Valhalla, NY

This report, prepared in accordance with the statutory requirement that OMH submit annual reports to the Governor and the Legislature describing progress made toward implementation of CPEP legislation, provides a programmatic overview and information related to services provided, the timeliness of services, recipient characteristics, dispositions, financing, and future directions. But for Beth Israel Medical Center's newly opened CPEP, the data presented represent aggregate data submitted by all licensed CPEPs covering the time period of October 2009 through September 2010.

Programmatic Overview

CPEP program objectives include providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services. The initial CPEP evaluation completed in 1994 and subsequent monitoring and evaluation demonstrate that CPEPs are meeting these objectives and that the program has succeeded in alleviating overcrowding in general medical emergency rooms, providing alternatives to inpatient admissions, and serving individuals in crisis in their own communities.

CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. The four required components of service are:

- *Hospital-based crisis intervention services* in the emergency room, including triage, referral, and psychiatric and medical evaluations and assessments;
- *Extended observation beds* in the hospital to provide for extended evaluation, assessment, or stabilization of acute psychiatric symptoms for up to 72 hours;
- *Crisis outreach services* in the community, including clinical assessment and crisis intervention treatment; and
- *Crisis residence services* in the community for temporary residential and other necessary support services for up to five consecutive days.

In addition to providing or ensuring the provision of required services, each CPEP is also responsible for submitting quarterly reports to OMH regarding the number of visits or admissions to each of the four required components of service; timeliness/length of stay and disposition data related to emergency room evaluations and extended observation beds; disposition data related to crisis outreach and crisis residence services; discharge diagnoses; and recipient demographic characteristics.

Services Provided

Hospital-Based Crisis Intervention Services

The psychiatric emergency room is the setting for CPEP hospital-based crisis intervention services and is available 24 hours per day, seven days a week. Services offered in the emergency room include triage, referral, evaluation and assessment, stabilization, treatment, and discharge planning. These services are provided by a multi-disciplinary team consistent with CPEP regulations. Enhanced staffing is necessary for timely and thorough assessments and more appropriate clinical decision making, especially as high risk or high cost decisions are frequently made. CPEPs help ensure individual and community safety and appropriate inpatient admissions and outpatient referrals. They also play a role in controlling inappropriate hospital admissions which are costly and counterproductive.

From October 2009 through September 2010, there were 104,819 visits to CPEP emergency rooms throughout the State, with an overall monthly average of 8,735 visits. The total number of CPEP ER visits exceeded 100,000 for the first time in the program's 20-year history.

<i>Emergency Room Services</i>	<i>10/06-9/07</i>	<i>10/07-9/08</i>	<i>10/08-9/09</i>	<i>10/09-9/10</i>
Average Monthly Visits	8,197	8,120	8,077	8,735

Extended Observation Beds

Extended observation beds are intended to provide recipients a safe environment where staff can continue to observe, assess, diagnose, treat, and develop plans for continued treatment as needed in the community or in a hospital or other setting. By regulation, CPEPs may be licensed for up to six extended observation beds. The number of beds per site varies from two to six based on geographical need and the CPEP's physical plant.

Extended observation beds are usually located in or adjacent to the psychiatric emergency room, allowing recipients to remain in the emergency room area for up to 72 hours. Chapter 306 of the Laws of 1995 authorized a number of amendments regarding the location of extended observation beds in CPEPs. The amendments gave more flexibility to hospitals operating extended observation beds and often enabled staff to provide more appropriate and safer environments for children, youth, and geriatric recipients with psychiatric emergencies. The amendments included the following provisions:

- Extended observation beds may be located in or adjacent to the CPEP emergency room (previously, extended observation beds could be located only in the emergency room); and
- The Commissioner of Mental Health may approve the location of one or more extended observation beds within another unit of the hospital as long as the privacy

and safety of all hospital patients can be maintained.

Extended observation beds also enable staff to assess and treat recipients who need short term care and treatment more than inpatient hospitalization. That the availability of extended observation beds would assist in easing inappropriate and often short term inpatient admissions was a program design expectation. The most recent statewide review of CPEP programs found that only 27 percent of the recipients admitted to extended observation beds were hospitalized after their stays.

From October 2009 through September 2010, there were 12,251 admissions to extended observation beds throughout the State. This represents 11.7 percent of all CPEP visits to the emergency room.

Extended Observation Bed Services	10/06-9/07	10/07-9/08	10/08-9/09	10/09-9/10
Average Monthly Admissions	848	856	909	1,021
Average Monthly Admissions Per CPEP Site	45	45	48	54
Percentage of Emergency Room Recipients Admitted to Extended Observation Beds	10.3%	10.5%	11.2%	11.7%

Crisis Outreach Services

Crisis outreach services are designed to provide mental health emergency services in the community. The two objectives of this component of service are to provide initial evaluation and assessment and crisis intervention services for recipients in the community who are unable or unwilling to use hospital-based crisis intervention services in the emergency room and to provide interim crisis services for discharged emergency room recipients who require followup. Interim crisis services are mental health services provided in the community for recipients who are released from a CPEP emergency room and include immediate face-to-face contacts with mental health professionals to facilitate community tenure while waiting for a first visit with a community-based mental health provider.

From October 2009 through September 2010, there were 22,910 crisis outreach services visits throughout the State for an unduplicated number of 15,104 recipients.

Crisis Outreach Services	10/06-9/07	10/07-9/08	10/08-9/09	10/09-9/10
Average Monthly Visits	1,599	1,742	1,864	1,909

Crisis Residence Services

Crisis residence services were designed to offer residential and other necessary support services for up to five days to recipients who recently experienced a psychiatric crisis or were determined to be at risk of an emerging psychiatric crisis. Most CPEPs have provided crisis residence services through linkages with State psychiatric centers or other local service providers. From October 2009 through September 2010, there were 193 admissions to crisis residence beds throughout the State, an increase of 33 admissions compared to last year.

Most CPEPs have encountered difficulty providing crisis residence services because of the short duration of allowable stay and costs. Obtaining services such as supportive housing, for example, is often difficult to accomplish during a relatively short five-day length of stay, and because crisis residence beds are purchased services, they represent costs not reimbursed by Medicaid to the hospital.

Timeliness of Services

A major objective of the CPEP is to provide psychiatric emergency care recipients with timely services. The length of time that an individual remained in the emergency room was a serious problem prior to the implementation of the program as recipients often remained there for many hours, sometime even days. More rapid triage and assessment that would decrease overcrowding and reduce long waiting times was a program design expectation. From October 2009 through September 2010, 82 percent of the psychiatric emergency care visits to CPEP emergency rooms throughout the State were triaged within an hour, and 65 percent of those seeking services were seen by a physician within two hours.

CPEPs are required to discharge recipients from their emergency rooms within 24 hours of arrival unless they are admitted to extended observation beds, in which case they may remain in the emergency room area for up to 72 hours. Most recipients admitted to CPEP emergency rooms (56 percent) were discharged within 6 hours, and most recipients admitted to extended observation beds (73 percent) stayed 48 hours or less.

Recipient Characteristics

From October 2009 through September 2010, the most frequently reported discharge diagnoses of individuals who received CPEP services were major mental illnesses such as schizophrenia, psychotic disorder, delusional disorder, and mood disorder (58 percent). The remaining 42 percent of discharge diagnoses were psychoactive substance abuse disorder (16 percent), personality disorder (3 percent), organic disorder (2 percent), or one of a number of other disorders (21 percent). Regarding age, 17 percent of the recipients served were under 18 years old; 36 percent were 18-34 years old; 43 percent were 35-64 years old; and 4 percent were 65 years old or older. Fifty-seven (57) percent of the recipients were male and 43 percent were female.

Dispositions

From hospital-based crisis intervention services and extended observation beds throughout the State, CPEP recipients were most frequently referred or discharged to mental health outpatient services (38 percent), non-State psychiatric inpatient services (26 percent), and CPEP crisis outreach services (6 percent) from October 2009 through September 2010. From crisis outreach services and crisis residence services, recipients were most frequently referred or discharged to mental health outpatient services (60 percent), CPEP emergency rooms (9 percent), and non-State psychiatric inpatient services (4 percent).

Financing

OMH has historically provided CPEPs net deficit financing through State aid. Funding is provided to offset additional costs associated with the development and operation of specialized and intensive program services and includes State aid, disproportionate share income, and Medicaid. In accordance with Chapter 723 of the Laws of 1989, CPEPs are eligible for capital funding support, but this is subject to appropriation. Reinvestment monies were allocated for the implementation of several CPEPs.

While extended observation bed days are reimbursed at the host hospital's regular psychiatric inpatient per diem rate, CPEP hospital-based crisis intervention services (brief or full emergency visits) and crisis outreach services in the community (crisis outreach or interim crisis service visits) are Medicaid reimbursable in accordance with 14 New York Codes, Rules and Regulations (NYCRR) Part 591. Current Medicaid fees reflect a cost of living adjustment that increased medical assistance program reimbursement rates for these CPEP services by 3.2 percent in April 2008.

CPEP Medicaid Reimbursable Service	Place of Service	Medicaid Fee	Rate Code
Brief Emergency Visit	CPEP ER	\$84.64	4007
Full Emergency Visit	CPEP ER	\$497.06	4008
Crisis Outreach Service Visit	Community	\$497.06	4009
Interim Crisis Service Visit	Community	\$497.06	4010

Future Directions

OMH remains committed to ensuring a systematic response to psychiatric emergencies in New York State through the agency's local assistance budget, disproportionate share income funding, and the ability to continue to provide technical assistance to existing CPEPs and to counties requesting assistance to address local psychiatric emergency care issues.

Current or planned initiatives include:

- Expanded distribution of OMH calendar year tabular reports of self-reported CPEP data that compare an individual provider's CPEP data with the statewide average for a set of selected indicators: total visits; utilization of extended observation beds; time of first contact with clinical staff and physicians; and time spent in the CPEP, with and without admission to an extended observation bed.
- Provider involvement in initiatives to improve the integrity of CPEP data and simplify the CPEP data set, with the goal of using data more routinely to support CPEP certification, quality improvement, and outcome management.