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 needing 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.


Currently, there are 19 licensed CPEPs in New York State providing emergency observation, evaluation, care, and treatment 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
- NYCHHC – Bellevue Hospital Center, New York, NY, Adult CPEP
- NYCHHC – Bellevue Hospital Center, New York, NY, Children’s CPEP
- NYCHHC – Elmhurst Hospital Center, Elmhurst, NY
- NYCHHC – Harlem Hospital Center, New York, NY
- NYCHHC – Jacobi Medical Center, Bronx, 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. The data presented represents aggregate self-reported CPEP data that covers the time period of October 2011 through September 2012.

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 2011 through September 2012, there were 109,128 visits to CPEP emergency rooms throughout the State, an overall monthly average of 9,094 visits. The total number of CPEP ER visits exceeded 100,000 for the third time in the program’s 22-year history.

<table>
<thead>
<tr>
<th>Emergency Room Services</th>
<th>10/08-9/09</th>
<th>10/09-9/10</th>
<th>10/10-9/11</th>
<th>10/11-9/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Monthly Visits</td>
<td>8,077</td>
<td>8,735</td>
<td>9,054</td>
<td>9,094</td>
</tr>
</tbody>
</table>

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 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 that gave the hospitals operating them more flexibility. As a result, staff were often able to provide more appropriate and safer environments for children, youth, and geriatric recipients. 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. In addition, the availability of extended observation beds assists in easing inappropriate and often short term inpatient admissions. 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 2011 through September 2012, there were 12,925 admissions to extended observation beds throughout the State. This represents 11.8 percent of all CPEP visits to the emergency room.

<table>
<thead>
<tr>
<th>Extended Observation Bed Services</th>
<th>10/08-9/09</th>
<th>10/09-9/10</th>
<th>10/10-9/11</th>
<th>10/11-9/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Monthly Admissions</td>
<td>909</td>
<td>1,021</td>
<td>1,062</td>
<td>1,077</td>
</tr>
<tr>
<td>Average Monthly Admissions Per CPEP Site</td>
<td>48</td>
<td>54</td>
<td>55</td>
<td>57</td>
</tr>
<tr>
<td>Percentage of Emergency Room Recipients Admitted to Extended Observation Beds</td>
<td>11.2%</td>
<td>11.7%</td>
<td>11.7%</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

*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 2011 through September 2012, there were 21,222 crisis outreach services visits throughout the State, an overall monthly average of 1,769 visits.
Crisis Outreach Services

<table>
<thead>
<tr>
<th>Crisis Outreach Services</th>
<th>10/08-9/09</th>
<th>10/09-9/10</th>
<th>10/10-9/11</th>
<th>10/11-9/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Monthly Visits</td>
<td>1,864</td>
<td>1,909</td>
<td>2,006</td>
<td>1,769</td>
</tr>
</tbody>
</table>

*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 2011 through September 2012, there were 127 admissions to crisis residence beds throughout the State, a decrease of 35 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 to the hospital not reimbursed by Medicaid.

**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 2011 through September 2012, 85 percent of the psychiatric emergency care visits to CPEP emergency rooms throughout the State were triaged within an hour, and 71 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. Nearly half of the recipients admitted to CPEP emergency rooms (49 percent) were discharged within six hours, and most recipients admitted to extended observation beds (68 percent) stayed 48 hours or less.

**Recipient Characteristics**

From October 2011 through September 2012, 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 (4 percent), organic disorder (1 percent), or one of a number of other
disorders (21 percent). Regarding age, 18 percent of the recipients served were under 18 years old; 36 percent were 18-34 years old; 42 percent were 35-64 years old; and 4 percent were 65 years old or older. Fifty-eight (58) percent of the recipients were male, and 42 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 (39 percent), non-State psychiatric inpatient services (26 percent), and substance use outpatient services (6 percent) from October 2011 through September 2012. From crisis outreach services and crisis residence services, recipients were most frequently referred or discharged to mental health outpatient services (59 percent), CPEP emergency rooms (7 percent), and non-State psychiatric inpatient services (3 percent).

**Financing**

OMH has historically provided CPEPs net deficit financing through State aid, the State share of Medicaid, and – until January 2012 – disproportionate share hospital (DSH) payments to offset additional costs associated with the development and operation of specialized and intensive program services. Reinvestment monies have been allocated for the implementation of several CPEPs. In accordance with Chapter 723 of the Laws of 1989, CPEPs are eligible for limited capital funding support, but this is subject to appropriation.

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 NYCRR Part 591. Medicaid fees previously in effect for these services were increased 115 percent in July 2012 as a result of the elimination of DSH. The new Medicaid fees are shown below.

<table>
<thead>
<tr>
<th>CPEP Medicaid Reimbursable Service</th>
<th>Place of Service</th>
<th>Medicaid Fee</th>
<th>Rate Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Emergency Visit</td>
<td>CPEP ER</td>
<td>$181.00</td>
<td>4007</td>
</tr>
<tr>
<td>Full Emergency Visit</td>
<td>CPEP ER</td>
<td>$1,060.00</td>
<td>4008</td>
</tr>
<tr>
<td>Crisis Outreach Service Visit</td>
<td>Community</td>
<td>$1,060.00</td>
<td>4009</td>
</tr>
<tr>
<td>Interim Crisis Service Visit</td>
<td>Community</td>
<td>$1,060.00</td>
<td>4010</td>
</tr>
</tbody>
</table>
**Future Directions**

Consistent with data in this annual report, the most recent statewide review of CPEP programs confirmed that the CPEP model has succeeded in addressing the problems that led to its creation in 1989. Specifically, the quality of crisis intervention assessments appears good; the emergency department environment is improved; and there is more ability to serve those in the community who present to emergency departments with a wider range of treatment options and alternatives to lengthy hospitalization.

OMH remains committed to ensuring a systematic response to psychiatric emergencies in New York State through the agency’s local assistance budget 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:

- Continued 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.

  Each individual CPEP provider receives a copy of their report. In addition, OMH field offices receive statewide CPEP data and individual provider reports of the CPEPs in their region. OMH’s Division of Quality Management, which includes the Bureau of Inspection and Certification, receives statewide CPEP data and all individual provider reports.

- For 2013, OMH simplified the data set that CPEPs use to self-report their data to OMH on a quarterly basis. The new data set reduces the amount of data CPEPs are required to report, reducing reporting categories from 17 to 11, for example, and combining length-of-stay time frames to make it easier for CPEPs to collect and report their data. The overarching goal is to facilitate the routine use of data to support CPEP licensure, quality improvement, and outcome management.