DRAFT Guidance on Evaluation and Discharge Practices for Comprehensive Psychiatric Emergency Programs (CPEP) and Emergency Departments (ED) - September 2023

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

Screening and Assessment

1. **Suicide:** All individuals who are brought to or present EDs/CPEPs should be screened for suicidality using a validated instrument (e.g., the Columbia-Suicide Severity Rating Scale). Positive screens should be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk.
2. **Substance Use:** All individuals over the age of 12 years that present for any reason should be screened for substance use using a validated instrument (examples here). Instruments should be age-appropriate and specifically screen for individual substances (e.g., alcohol, opioids, cannabis, tobacco, etc.) that may require different interventions or psychoeducation. Positive screens should be followed by an assessment by a licensed professional experienced in working with individuals who use substances, but may or may not meet criteria for a substance use disorder diagnosis (note: a CASAC certification is NOT a requirement). The assessment should include risk of acute withdrawal or accidental overdose. Withdrawal assessments should include objective information, such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute of Withdrawal Assessment (CIWA) instruments. Additionally, staff should check the I-STOP/PMP (Internet System for Tracking Over-Prescribing) for any individual with a positive substance use screen, any individual who reports a prescription of controlled medications, any individual with a history of overdose, and any individual with a history of withdrawal.
3. **Violence:** Violence screening (e.g. the Brøset Violence Checklist) should be universal and standardized for all individuals in CPEPs. Violence screenings should also be completed with all individuals with behavioral health presentations in EDs. Individuals who present to EDs with non-behavioral health chief complaints should be screened for violence if presentation includes dementia, delirium, acute change in mental status, transfer from carceral settings, police transport, history of violence, or if they exhibit agitation, aggression, threatening behaviors, and violent ideation in the ED. The assessment should include a detailed review of the history of present illness,

history from electronic health records and other exchanges such as PSYCKES and SHIN-NY/QE, and high-quality collateral information from family, friends, and community providers. Individuals who have a positive violence screen should be asked about access to firearms or other weapons.

4. **Complex Needs and Social Determinants:** All individuals admitted to inpatient psychiatric units should be screened to determine if they have complex needs related to their ability to successfully transition to community-based care following discharge. Individuals with multiple chronic comorbid diagnoses, high utilization of acute care services, extensive adverse childhood experiences or trauma histories, and/or high levels of social determinant needs known to impact health outcomes should be considered complex. These individuals require more intensive care management to coordinate discharge planning needs and ensure connections with outpatient treatment, support, and residential resources. Hospital staff should invite care managers working with individuals with complex needs into the hospital to meet with the patient and collaborate with the inpatient team, even when the care manager is not an employee or otherwise affiliated with the hospital. Social determinant screening should include assessment of housing status, particularly homelessness or insecure housing, food insecurity, transportation needs, communication/linguistic needs, family and community support, adverse childhood experiences, experiences of discrimination, exposure to threats or violence, criminal justice involvement, employment, and education, and military/veteran status. These should be considered when making disposition decisions as they will have a large impact on the success or failure of any discharge plan.
5. **Level of Care Determination**: CPEP/ED staff should always ask what the patient's goals are for coming to the hospital. When deciding to admit or discharge, it is outside the standard of care to only take into consideration current symptoms and current level of risk based on immediate or short-term observation in an ED or CPEP setting; rather, multiple domains, as well as the availability of existing services in the patient's community, should be considered. The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) by the American Associations for Community Psychiatrists (AACP) and the Child and Adolescent Service Intensity Instrument (CASII) by the American Academy of Child and Adolescent Psychiatrists (AACAP) are peer-reviewed, evidence-based instruments that hospitals should consider adopting to navigate this complexity and standardize admission decisions. Individuals who are at elevated risk for harming themselves, harming others, or who are functionally impaired to the point of being unable to meet their basic needs may need an involuntary admission. The NYS Office of Mental Health has previously issued interpretive guidance on involuntary and emergency admissions and certain situations where they are appropriate. There are times when ED/CPEP practitioners may determine that an inpatient admission would be beneficial to an individual even if the individual does not meet involuntary or emergency admission criteria. In these cases, the individual should be offered a voluntary 9.13 admission.
6. There are individuals who present to EDs/CPEPs due to difficulty establishing social connections or unmet basic needs, such as food, safety, housing, etc. (i.e., primary or secondary gain). While these individuals may be familiar to CPEP/ED staff, there is always the possibility of new or worsening medical, psychiatric, or other conditions. They need to be assessed at each presentation so CPEPs/EDs do not miss treatable conditions. These individuals should not be reflexively discharged based on the findings of evaluations in prior visits.

Communication and Collaboration with Non-Hospital Providers

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1. Hospitals should look up in PSYCKES all patients enrolled in Medicaid to review their prior psychiatric and medical history and obtain contact information for outpatient treatment teams and care managers.
2. All patients should be reviewed in any other available information network databases (e.g., SHIN-NY/QE or EPIC Care Everywhere). For individuals who report using controlled medications, their prescription histories should be reviewed in the prescription monitoring program. Staff should ask if patients have a Psychiatric Advanced Directive.
3. When assessing individuals who are brought in by the police due to behavioral disturbances in the community or individuals who are involuntarily removed from the community (i.e., pursuant to MHL §9.41, 9.45, or 9.58), clinical staff should obtain collateral (within legal requirements for consent) from the party that initiated the involuntary removal and other important sources of information, including but not limited to, family members and friends, outpatient providers, staff at residential or long-term care programs, health home care managers, children's single point of access(C-SPOA), schools, child welfare, parole/probation/persons in need of supervision(PINS) officers, and/or MCO care managers.
4. Hospitals should obtain collateral information (within legal requirements for consent) on all individuals with a behavioral health presentation. It is insufficient and outside the standard of care to make a disposition decision solely based on behavioral observation in the ED/CPEP setting. Staff should assess whether the initial source of collateral information is able to provide sufficient high-quality information to determine risk, symptomatology and functioning in the community, treatment history, engagement in treatment, and ongoing stressors. If the initial source of collateral information is not able to provide sufficient high-quality information, additional sources should be contacted.

Coordinated Discharge Planning

1. For patients with complex needs and repeated admissions, the discharging treatment team should provide (within legal requirements for consent) a verbal clinical update to the receiving outpatient treatment program and residential or long-term care program. The ED/CPEP should forward a written discharge note that includes lab results and pharmacological interventions to the outpatient providers within two business days.
2. Prior to discharge, all patients should have an appointment for psychiatric aftercare with an identified provider scheduled and confirmed to take place within 7 days following discharge. Patients who are leaving the hospital against medical advice, or who state they do not wish to receive aftercare services, should always be provided information about available treatment options and have an appointment scheduled whenever possible. Offering appointments and information about treatment resources significantly increases rates of successful care transitions, even among those patients who resist aftercare, who are the greatest risk for readmission and other poor outcomes.
3. For patients with complex needs enrolled in outpatient care management (e.g. Health Home Care Management or Health Home Non-Medicaid Care Management) or who have a residential care manager, CPEP/ED staff should coordinate plan details and timing with care managers (within legal requirements for consent.) Existing care managers may be able to meet the patient prior to their leaving the ED/CPEP. For patients with complex needs who are not enrolled in intensive care management, ED/CPEP staff should make a referral to an intensive care management provider such as Health Home Plus, a Specialty MH Care Management Agency, or Children's Single Point of Access for youth who can meet the patient prior to their leaving the CPEP/ED.

4. The discharge plan should address psychiatric, substance use disorder, chronic medical, and social needs. The plan should also address relevant concerning information obtained from collateral sources of information.

Pre-Discharge Interventions to Improve Discharge Outcomes

1. Individuals with a potentially elevated risk of self-harm or suicide should have a community suicide safety plan completed before discharge. This plan should be shared by the hospital with outpatient, residential or long-term care providers.
2. Discharge of individuals with a potentially elevated risk of violence and who report access to firearms or other lethal means should include safety planning with key collaterals (e.g., current outpatient, residential or long-term care provider, care managers, shelter/residence staff, school staff, police, etc.), within legal requirements for consent.
3. ED or CPEP physicians, RNs, LCSWs, and psychologists are required to complete a SAFE Act report (MHL §9.46) for individuals who are "likely to engage in conduct that will cause serious harm to self or others," even if the patient is ultimately admitted to an inpatient unit.
4. Individuals at risk for an opioid overdose or who live with someone at risk should be dispensed or prescribed naloxone and given education on how to use it. These individuals should also be educated on how to obtain more naloxone in the community. Additional education about harm reduction strategies, such as never using alone, using fentanyl test strips, and information about contaminants should be provided to individuals at risk or living with someone at risk of overdose.
5. Individuals who meet criteria for opioid use disorder should be offered buprenorphine (or long-acting naltrexone, if appropriate) induction, referred to an outpatient provider that can continue the treatment, and given a bridge prescription until the appointment. Similarly, individuals who meet criteria for alcohol or tobacco use disorders should be started on appropriate pharmacological interventions and referred to a new or existing provider can continue the treatment.

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