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DRAFT Guidance on Evaluation and Discharge Practices for Article 28 and Private Article 31 Psychiatric Inpatient Units - September, 2023

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

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Screening and Assessment

1. **Review Screenings and Assessments conducted in EDs and CPEPs.** Inpatient clinical teams should also review documentation of prior presentations to the hospital and attempt to obtain medical records from other hospitals where the patient was admitted.
2. **Suicide:** All individuals 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. Suicide risk should also be evaluated prior to discharge.
3. **Substance Use:** All admitted adults and children 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 specific or multiple substances and may or may not meet criteria for a substance use disorder diagnosis (note: a CASAC certification is NOT a requirement). The assessment should include an assessment for risk of acute withdrawal and of 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..
4. **Violence:** Violence screening (e.g. the Brøset Violence Checklist) should be universal and standardized for all individuals in inpatient psychiatric settings. 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.

5. **Complex Needs and Social Determinants:** All individuals admitted to inpatient psychiatric units should be screened to determine if they have complex needs related to their ability to successfully transition to community-based care following discharge. Individuals with multiple chronic comorbid diagnoses, high utilization of acute care services, extensive adverse childhood experiences or trauma histories, and/or high levels of social determinant needs known to impact health outcomes should be considered complex. These individuals require more intensive care management to coordinate discharge planning needs and ensure connections with outpatient treatment, 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. Referrals to social services agencies should be made as part of discharge planning if they are available in the community.
6. **Level of Care Determination**: When determining whether a patient is ready for discharge and where would be the most appropriate discharge setting, it is outside the standard of care to only take into consideration current symptoms and current level of risk based on observation during the hospital admission; 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 level of care decisions.

Communication and Collaboration with Non-Hospital Providers

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. Hospitals should attempt to obtain collateral information (within legal requirements for consent) on all individuals. It is insufficient and outside the standard of care to make a disposition decision solely based on behavioral observation in the inpatient setting. Staff should assess whether the initial source of collateral information is able to provide sufficient high-quality information to determine risk, symptomatology and functioning in the community, treatment history, engagement in treatment, and ongoing stressors. If the initial source of collateral information is not able to provide sufficient high-quality information, inpatient teams should attempt to contact additional sources.

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Coordinated Discharge Planning

1. For patients with complex needs and/or repeated admissions, the discharging treatment team should provide (within legal requirements for consent) a verbal clinical sign-out to the receiving outpatient treatment program and residential or long-term care program on the day of discharge. This is in addition to a comprehensive written discharge summary (below).
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, inpatient staff should coordinate plan details and timing with care managers (within legal requirements for consent). Existing care managers may be able to meet the patient prior to their leaving the inpatient unit and possibly pick them up on the day of discharge. For patients with complex needs who are not enrolled in intensive care management or are enrolled but need more complex care management, hospital 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.
4. Hospital staff should 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 treatment program(s) within 7 days of discharge.
5. The discharge plan should address psychiatric, substance use disorder, chronic medical, and social needs – although many communities may have limitations on what services are available. The plan should also address relevant concerning information obtained from collateral sources of information.

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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 with outpatient and residential 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 staff, school staff, police, etc.), within legal requirements for consent.
3. Inpatient 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." Inpatient staff should complete a SAFE Act report for individuals who are admitted due to serious self-harming behaviors or aggression.
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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