June 4, 1998

Mr. James L. Stone, M.S.W.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY  12229

Re: Oversight of Comprehensive Psychiatric Emergency Program
Report 96-S-20

Dear Mr. Stone:

Pursuant to the State Comptroller’s authority as set forth in Section 1, Article V, of the State Constitution and Section 8, Article 2, of the State Finance Law, we have audited selected aspects of the Office of Mental Health's oversight of the Comprehensive Psychiatric Emergency Program, focusing on the period of January 1, 1993 through September 1, 1996.

A.  Background

Throughout the history of New York State, psychiatric emergency care has been provided in hospital emergency rooms, while psychiatric centers operated by the Office of Mental Health (OMH) have provided treatment to patients with more serious and persistent mental illnesses. Since 1986, in a change of focus, OMH has downsized and/or closed psychiatric centers, moving many clients into community-based settings. This movement, in turn, has placed greater demands on limited community-based mental health services and has often resulted in overcrowded emergency rooms and the overuse of acute inpatient hospitalization.

Chapter 723 of the Laws of 1989 authorized OMH to develop the Comprehensive Psychiatric Emergency Program (CPEP), which is designed to provide a systematic response to psychiatric crises in urban areas. In August of 1994, Chapter 723 was amended to extend CPEP until July 1, 2000, and to authorize OMH to develop and implement a suburban/rural psychiatric emergency system. As of March 31, 1997, OMH had licensed CPEPs in 13 urban locations (including 8 in New York City) and 1 in a suburban location, all operated by local hospitals.

CPEPs are to orchestrate the delivery of a full range of psychiatric crisis and emergency
care within a defined geographic area. They are required to provide four components of service: hospital-based crisis intervention, extended-observation beds, mobile crisis outreach services, and crisis residences. This integrated program attempts to alleviate the overcrowding in emergency rooms, provide alternatives to inpatient admissions, and maintain a community-based focus. Its objectives are to provide crisis intervention in the community, consisting of timely triage, assessment, intervention, and links to other community-based mental health services; and to control inpatient admissions.

CPEPs charge patients for the services provided, and collect revenue from patients and third-party payors. They may also receive funding from other sources, such as local government agencies. OMH has a contractual agreement with each CPEP whereby it funds the CPEP’s annual net operating deficiency that is associated with the incremental costs of meeting the CPEP regulatory requirements, up to a maximum amount of $1 million. The program budget for the year ended March 31, 1997 was $11,400,000.

B. Audit Scope, Objectives, and Methodology

Our audit focused on OMH’s oversight of the CPEP for the period January 1, 1993 through September 1, 1996. Our objectives were to test the accuracy and completeness of CPEP reports of program statistics; to evaluate OMH’s efforts in determining whether CPEPs have taken adequate steps to correct deficiencies cited in a consultant’s clinical audits; and to determine whether the CPEPs have provided all required components of the program. To achieve these objectives, we interviewed the OMH staff who monitor CPEP activities and selected CPEP officials, verified a sample of program data provided by CPEPs to OMH, and reviewed program records. We also visited four New York City-area CPEPs at the Kings County Hospital Center (Brooklyn), Elmhurst Hospital Center (Queens), Columbia Presbyterian Medical Center (Manhattan), and the Bronx Lebanon Hospital Center (Bronx).

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of OMH which are included within the audit scope. Further, these standards require that we understand OMH’s internal control structures and its compliance with those laws, rules and regulations that are relevant to those operations which are included in our audit scope. An audit also includes assessing the estimates, judgments, and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions, and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an “exception basis.” This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.
C. Results of Audit

OMH needs to improve its oversight of CPEP. According to OMH officials, the newness of the CPEP program and its uniqueness warranted a multi-faceted approach to monitoring and evaluating the program. This included oversight through program evaluations, initial licensing and periodic recertifications, clinical audits, and other monitoring efforts by OMH staff. We found, however, that OMH needs to more fully evaluate the program data supplied by the CPEPs, which is to be used by OMH to monitor CPEP activities. We also found that OMH has not been following up on program deficiencies cited in clinical audits performed by a consultant under contract with OMH. OMH has also not ensured that the CPEPs provide all required components of the program.

In response to our draft report, OMH officials stated, "While CPEP has been very successful, it is both normal and appropriate to make minor adjustments to a program based on experimental data available after several years of program operation. OMH's consideration of the OSC audit recommendations will assist us in making some of these adjustments." They added that, although they are in general agreement with the audit recommendations, they do not totally agree with the report's observations and conclusions regarding the adequacy of OMH's oversight of CPEP.

1. Reports of Program Performance

CPEPs are responsible for reporting certain program information relating to their operations, including summaries of the numbers of patients treated, the types of treatment provided, patient demographics, and discharge dispositions. The OMH Director of CPEP reports that she uses this data to monitor program activities, identify concerns to be discussed at quarterly meetings with CPEP providers, and prepare an annual report that is submitted to the State Legislature. Up to and including 1994, OMH employees would visit each CPEP to compile the data required for this report and to verify the accuracy of the information provided by the CPEPs. However, since 1995, OMH has relied on unaudited data provided by the CPEPs; thus, there is no assurance that it is accurate.

We tested a limited judgmental sample of the performance information provided to OMH by three of the CPEPs we visited. Although our testing identified some inaccuracies in the reported data, we believe these inaccuracies were not material enough to affect OMH's overall conclusions regarding program performance. However, we did observe some performance indicators that OMH officials need to evaluate. If these indicators show that potential problems exist, action should be taken.

For example, an OMH study has determined that patients admitted to extended-observation beds are 12 times less likely to require inpatient admission than individuals who are not. The Commissioner of OMH is responsible for establishing the number of extended-observation beds each urban CPEP can make available. Currently, that maximum
number is six. CPEPs report the number of patients admitted to this component, as well as the number who would have benefitted from this component of the program if additional beds had been available. According to the reported data, the 13 CPEPs in existence during calendar year 1995 had admitted 8,448 patients to extended-observation beds. The CPEPs also reported that another 3,234 patients would have been admitted if additional beds had been available. Furthermore, officials at one of the CPEPs we visited stated that they occasionally keep candidates for extended-observation beds in a holding area (i.e., in cots in the hallway) until a bed becomes available.

OMH officials need to evaluate the implications of the reported number of patients who would have been admitted for extended observation if a bed had been available. Moreover, OMH staff should routinely visit CPEPs to ensure that they are not housing more than six patients in extended-observation beds at any given time or using holding areas improperly.

Performance data relating to the use of crisis residences also warrant further investigation. This component of the program, which is based on Mental Health Regulations, is to provide up to five days of temporary residential and other necessary support services to patients discharged from other components of the CPEP operation. However, the CPEPs report that patients stayed in crisis residences an average of 17.8 days during 1995. This suggests either that the five-day period does not allow enough time to deliver what the patient needs, or that crisis residence services are being used inappropriately. CPEP officials at the hospital we visited during the audit told us they believe that a five-day stay is not long enough to achieve the desired outcomes. OMH officials need to determine whether crisis residence beds are being used inappropriately, or whether the Regulations should be amended to allow CPEPs more time to provide crisis residence services.

We also noted a situation where OMH officials were not aware that important performance data was being reported inaccurately. Elmhurst Hospital staff informed us that they generally classify all mobile crisis outreach visits as initial visits, even though Elmhurst routinely provides both initial and interim types of mobile crisis services. The hospital receives the same reimbursement rate for both types of service, but prefers to use the initial visit classification to reduce paperwork. However, the two types of service are very different. An initial visit is usually made to a mentally ill patient who is either unable or unwilling to obtain treatment in the emergency room. An initial visit might also be made in response to a request from the police or a family member, who might ask the mobile team to intervene when a crisis is in progress. An interim visit is usually made to a patient who has been discharged from the CPEP, but does not have an immediate appointment with a mental health provider. The mobile crisis outreach team might make up to five interim visits to such a patient to ensure that he or she remains stable until treatment begins. Without interim visits, a discharged patient could forget to take medications or fail to begin scheduled treatment or show up for subsequent treatments. The patient’s condition might then deteriorate and, as a result, he or she might have to return to the CPEP, or even a State mental health facility, for emergency care.
We interviewed OMH officials and found that they were not aware that Elmhurst Hospital staff were not reporting outreach visits properly. This situation should have been identified by OMH and action taken to ensure that Elmhurst was providing necessary services and reporting them accurately.

2. **Consultant Clinical Audits**

OMH contracted with a consultant, Behavioral and Organizational Consulting Associates (BOCA), to perform clinical audits between August 1993 and September 1994 at the ten CPEPs existing at the time. The contract amount was $192,000. (According to OMH officials, about $55,000 of the contract amount was specifically for BOCA audits of CPEPs.) OMH’s Bureau of Data/Incident Management forwarded copies of the resulting reports to OMH’s Regional Directors, instructing them to ask each CPEP director to prepare a plan of corrective action, help the CPEP implement the plan, and keep the Bureau of Data/Incident Management informed of the CPEP’s progress in such implementation. However, follow-up on the deficiencies cited by BOCA stopped when the OMH closed its regional offices in 1995. OMH staff who currently monitor the CPEPs located in New York City told us they had never seen the BOCA reports or the CPEPs' plans for corrective action.

OMH officials told us they are aware of many of the problems BOCA identified, such as the underutilization of crisis residences and mobile crisis interim services, the lack of facilities for treating children and adolescents, and the need to have CPEP staff make appointments for discharged patients to ensure that they continue to receive treatment. However, there is no indication that OMH officials have acted upon those problems or are aware of certain other deficiencies identified by BOCA, such as a failure to document a patient's vital signs, behavior, and mental status while restraints were being used; the use of restraints that had not been approved by OMH; a length of stay in a crisis residence bed that far exceeded the five-day limit; patient areas that could not be observed by CPEP staff; staff areas that were overcrowded and noisy and lacked adequate facilities for privacy or respite; and inadequate written policies and procedures. OMH officials said that the follow up of the clinical audit deficiencies cited by BOCA was not done in all cases; they plan to contract with BOCA to revisit the CPEPs for this purpose.

3. **Utilization of Program Components**

CPEPs are required by OMH to provide all four program components. Most of the CPEPs had planned to provide the crisis residence services component by using beds located at State (OMH) psychiatric centers. However, OMH allowed the CPEPs to begin operating before specific agreements had been made with the centers regarding admission criteria, staffing, and provisions for day treatment services for patients still in crisis residence beds. In practice, few CPEP patients have been able to obtain such beds in State psychiatric centers; the 13 CPEPs we reviewed reported a total of just 239 admissions during 1995. The majority of these admissions occurred at crisis residences provided by three CPEPs (Harlem Hospital - 92 patients, Stony
Brook Hospital - 61 patients, and Erie County Medical Center - 41 patients). Four other CPEPs (Bronx Municipal Hospital, Columbia Presbyterian Hospital, Kings County Medical Center, and St. Vincent’s Hospital on Staten Island) had not admitted any patients into crisis residence beds during the entire year.

OMH officials told us they consider crisis residence beds to be an important component of the CPEP program, and said they believe such slots can be obtained most effectively through community-based providers. In fact, three CPEPs (Harlem Hospital, Bellevue Hospital Center, and Broome County Medical Center) currently have agreements with community-based providers. However, OMH must ensure that the remaining CPEPs are also able to provide the necessary comprehensive range of services.

**Recommendations**

1. Ensure program compliance by making periodic site visits to CPEPs, examining the program and verifying the accuracy of the performance data provided by the CPEPs.

   (OMH officials agreed that routine site visits are important. They stated they have monitored CPEPs through site visits in the past, and will continue to do so in the future. They also agreed that the accuracy of statistical data should be verified and that, by and large, this already occurs.)

2. Evaluate the performance data provided by CPEPs and take appropriate actions where indications of problems exist, including whether urban CPEPs should be allowed to have more than six extended-observation beds and whether the five-day limit for crisis residence services is adequate to meet current program needs.

   (OMH officials indicated that performance data is reviewed regularly. They added that plans have been made to involve field staff in reviewing the data and resolving identified issues in a routine fashion. Regarding the two issues raised in the recommendation, OMH officials stated that a workgroup will be formed to address them.)

3. Determine whether CPEPs have taken appropriate actions to correct the program deficiencies cited by BOCA.

   (OMH officials stated that field staff will review the BOCA audits and revisit each CPEP, as appropriate. They will also direct BOCA to revisit those CPEPs with the most significant deficiencies.)

4. Help CPEPs obtain crisis residence beds from community-based providers.

   (OMH officials stated they are convening a workgroup to identify contributing factors and develop strategies for implementation.)
A draft copy of this report was provided to Office of Mental Health officials for their review and comment. Their comments have been considered in preparing this report, and are included as Appendix A.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefore.

Major contributors to this report were Kenneth Spitzer, Anthony Carbonelli, David Hoffer, Legendre Ambrose, and Marticia Madory.

We wish to thank the management and staff of the Office of Mental Health for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Frank J. Houston
Audit Director

cc: Robert L. King
Mr. Frank Houston  
Audit Director  
Management Audit  
Office of the State Comptroller  
270 Broadway  
New York, NY 10007  

Dear Mr. Houston:

The Office of Mental Health has reviewed draft audit report 96-S-20 resulting from the Office of the State Comptroller's review of selected aspects of OMH’s Oversight of the Comprehensive Psychiatric Emergency Program. Our comments to the findings and recommendations contained in the report are enclosed.

The Office of Mental Health appreciates the Office of the State Comptroller's continuing efforts to recommend improvements in our operations.

Many thanks for your continued help and cooperation.

Sincerely yours,

James L. Stone  
Commissioner

Enclosure  
cc: Diana Jones Ritter
OFFICE OF MENTAL HEALTH
RESPONSE TO OFFICE OF THE STATE COMPTROLLER’S
DRAFT AUDIT REPORT - 96-S-20
OVERSIGHT OF THE COMPREHENSIVE
PSYCHIATRIC EMERGENCY PROGRAM

Overall OMH Comments

As part of the implementation process for the Comprehensive Psychiatric Emergency Program (CPEP), OMH established procedures to ensure that the program was well monitored. As detailed in this response, OMH takes several steps to ensure that CPEP program objectives are achieved and that the program is operating successfully through licensing and certification efforts, clinical audits, program evaluations and Central Office and field staff site visits.

The CPEPs were strategically implemented as a mechanism that would have a significant positive impact on the mental health system. Emergency settings are the point of entry into the mental health system for many clients, and the link used to engage clients in other mental health services following discharge. By establishing such a comprehensive program, it was the intent of OMH to provide careful assessments, timely treatment and appropriate discharges. This has been done by leveraging hospital and community resources.

Based on reported data and OMH evaluations, the CPEPs have definitely met the goals the program set out to achieve. Overcrowding has been reduced and more appropriate dispositions are being made. The CPEPs tend to manage well the psychiatric crises presented. Overall, triage and assessments are timely, and dispositions are appropriate. Additionally, each CPEP component offers a unique means for accessing services, thereby increasing availability of care.

While CPEP has been very successful, it is both normal and appropriate to make minor adjustments to a program based on experiential data available after several years of program operation. OMH’s consideration of the OSC audit recommendations will assist us in making some of these adjustments.

Although OMH is in general agreement with the audit recommendations, we do not totally agree with the observations and conclusions in the OSC audit report. Further, much has changed since the OSC audit work was completed in August 1996, over 18 months ago. While we understand that OSC audit reports are written on an exception basis, it is unfortunate that OSC had nothing positive to say about this program which has been so successful.
The following OMH comments provide additional background information regarding CPEP and provide clarification for some of the OSC statements in each section of the report.

**Program Background**

The Community Mental Health Centers Act of 1963 required a full array of psychiatric emergency services. Yet, as late as 1983, the psychiatric literature contended that “most psychiatric emergency care was provided by police officers, [medical] emergency department personnel and other non-mental health professionals” (McClelland, 1983, p. 225). Who was to provide emergency care and where it was to be provided were problems compounded by a dramatic rise in the demand for psychiatric emergency services.

The burgeoning of emergency room presentations resulted in overcrowded emergency rooms where patients waited extraordinarily long periods of time to be evaluated and discharged. The problem at the front door of the emergency room also created problems that were observed at the time of discharge. Particularly for individuals who were homeless or who were abusing substances, discharge alternatives were limited. Inpatient admission was often the most readily available option for these individuals, so the high volume of activity in the emergency rooms frequently overburdened inpatient units and precipitated problems throughout the mental health system.

It was recognized that a well-coordinated, comprehensive emergency program was needed for people in psychiatric crises — a program that could alleviate overcrowding in emergency rooms, provide alternatives to inpatient admission, and maintain a community-based focus. A program meeting these objectives would support the overall mental health system by stabilizing patients, decreasing the reliance on inpatient care, and linking patients to community services within and outside the mental health system (Surles, Petrilia and Evans, 1994).

In response, OMH developed CPEP to assure the overcrowding in emergency rooms and the gridlock that was a consequence of the congestion. Since the problems facing emergency room staff were complex, the program that addressed the problems had to be multifaceted.

**Program Description**

By 1996, 14 CPEP emergency room sites were certified to provide services. The CPEPs were organized into four components that included the emergency, extended observation beds (EOBs), crisis outreach, and crisis residence. The intent of this design was to provide an integrated continuum of emergency care as a support to, not a substitute for, other community service alternatives.

During 1996, there were over 63,400 presentations at the 14 CPEP emergency rooms. This represents a 16 percent increase in such presentations since the inception of the program in 1990-91. The crisis outreach program component reported 15,341 visits in 1996.
A large percentage of the clients were diagnosed with a major mental illness (i.e., schizophrenia, delusional disorders, psychotic disorders, mood disorders). As noted in the OMH evaluation, there were an increasing number of clients who were experiencing a myriad of social problems, such as chemical abuse, alcohol abuse, homelessness, etc. The complex needs of these clients have implications for dispositions and augments the need for linkages with providers of service and supports.

**CPEP Objectives**

The integrated program attempted to alleviate the over crowding in the emergency rooms, provide alternatives to inpatient admissions and maintain a community-based focus. The CPEP program objectives are to:

- provide crisis interventions in the community;
- provide timely triage, assessment and intervention;
- provide linkages; and
- control inpatient admission.

Based on reported data and OMH evaluation, the CPEPs have definitely met the goals the program set out to achieve. Overcrowding has been reduced and more appropriate dispositions are being made. The CPEPs tend to manage well the psychiatric crises that are presented. Overall, triage and assessments are timely, and dispositions are appropriate. Additionally, each CPEP component offers a unique means for accessing services, thereby increasing availability of care.

(Excerpts taken from Oldham and DeMasi, 1995)

**OMH Comments to OSC Observations and Findings**

**Results of Audit**

There are some statements in this section of the report which need clarification. The second sentence asserts that “OMH does not evaluate the program data supplied by the CPEPs …” That statement is not correct. OMH has evaluated the program as stated in our response to the preliminary findings and again in this response. Part of this process was to confirm the accuracy of the data which was accomplished prior to the evaluation.

OMH concurs that the follow up of clinical audit deficiencies cited by Behavioral and Organizational Consulting Associates (BOCA) was not done in all cases. However, CPEP is monitored through many different processes, only one of which are the BOCA audits. As later discussed in this response and previously provided to OSC in response to their preliminary audit finding in May 1996, OMH monitors and provides oversight through program evaluations, required inspections by certification staff and quarterly meetings among CPEP staff, consultants...
and OMH Central Office and field staff.

**Monitoring/Oversight of CPEPs — Consultant Clinical Audits**

While OSC accurately states that OMH’s contract with BOCA was for $192,000, it should be clarified that the amount of the contract specifically for BOCA audits of CPEPs totaled $55,227.

Additional OSC comments related to BOCA findings again focus on OMH’s follow up of the BOCA visits. As stated in response to OSC’s Results of Audit section, the BOCA audits were only one of several monitoring efforts OMH employed to ensure that the program was successful.

The OSC audit initially focused on the effectiveness of OMH’s monitoring of CPEPs. OSC is now focusing largely on the BOCA clinical audits. OMH reiterates that the BOCA audits were and are only part of the monitoring/oversight provided for the CPEPs.

**Evaluation**

At the outset, OMH designed a multi-faceted approach to monitoring the program. The newness of the program and its uniqueness warranted not only traditional monitoring, but evaluation of the program as well. A formal evaluation design was developed and instruments created to gather a multitude of data on various aspects of the program. Data collected through the evaluation component of the program allowed OMH staff to review critical data on a continuous basis and to provide feedback to the programs even in the course of their development.

**Inspection and Certification**

Another very important component of OMH’s monitoring protocol is that of initial licensing and periodic recertification following regular inspections. Each CPEP must meet certain standards prior to licensure and recertification thereafter on a regular basis. After initial licensing, each CPEP is visited on a regular basis and the program management and operations are reviewed by OMH certification staff who ensure that the programs are in compliance with relevant State regulations. Any deficiencies discovered are routinely brought to the attention of the management of the CPEPs and plans of correction are required.

Currently, OMH licenses 14 CPEPs throughout the State, including 8 in New York City. During 1996, part of the time period OSC reviewed, OMH certification staff conducted nine recertification visits and two special visits to CPEPs. Once a survey is completed, an exit conference is conducted with CPEP staff, and a statement of deficiencies is sent to the provider. Each program is required to respond to the statement of deficiency with a plan of corrective action. When the plan of corrective action is received at a Bureau of Inspection and Certification Field Unit, it is reviewed by certification staff for appropriateness and follow up, as necessary.
Clinical Audits

In addition to routine monitoring of the program by licensing and certification staff and OMH evaluators, OMH implemented a series of clinical audits to assess the quality of the clinical services provided. Through a contract with an independent consulting firm (BOCA), OMH secured the services of skilled clinicians to review the clinical practices of each of the CPEPs. The results of the clinical audits were forwarded to OMH field staff, as well as to Central Office program and licensing staff. Each of the CPEPs was required to submit a plan of corrective action in response to deficiencies cited. OMH Operations Division staff conducted a follow-up review with each program. This included a review of the plan of corrective action and on-site assistance to each CPEP in correcting identified deficiencies. They also met with CPEP providers monthly to maintain positive communications. OMH plans to continue these consultant clinical audits, and will direct the consultant to revisit those CPEPs where the most significant issues were noted during the original clinical audits (not all CPEPs as OSC has reported).

Other Monitoring Efforts

OMH staff reviewed relevant data available from the evaluation, licensing and clinical audits and providing continuous feedback and technical assistance. Quarterly meetings were routinely held with key CPEP staff and principal Central Office, field office, and consultant staff. In essence, a formal feedback loop, as well as professional and peer group assistance, was undertaken.

Reports of Program Performance

As the OSC report indicates, prior to 1995, OMH Central Office staff visited the CPEPs and gathered data that was used for annual reporting. This offered a baseline to measure the accuracy of data. As explained to OSC, from 1995 through the end of 1996 quarterly reports were sent to Central Office staff, reviewed for accuracy, and compiled. Part of the data review process identified any inconsistencies and follow-up calls were made to the CPEP Director who submitted the original data. Whenever necessary, revisions were made and the corrected data was used in the quarterly report summaries. The CPEP data was also shared with OMH field staff who were able to discuss the statistics with CPEP staff during CPEP Director meetings or recertification visits.

As OSC noted, this continual feedback process worked well, and while it resulted in "some inaccuracies in the reported data, we [OSC] believe these inaccuracies were not material enough to affect OMH's overall conclusions regarding program performance."

This section of the report highlights three areas of concern: use of extended observation beds, crisis residence stays and reporting of mobile crisis visits. A response to each follows.

Admissions to Extended Observation Beds - As discussed with OSC, clients may be admitted to EOBs for up to 72 hours. The purpose of these beds is to allow staff to assess and treat clients
while avoiding inappropriate admissions to inpatient units. According to CPEP evaluation findings, these beds have been successful in diverting admissions and have been credited by staff and clients as providing an alternative hospitalization. Since EOBS were a new feature to CPEPs and limited to 6 beds per site (for urban CPEPs), the quarterly report garnered information pertaining to the number of individuals who would have been admitted to an EOB. This statistic was then used to: (1) better understand whether the demand for such beds could justify an increase of the 6-beds-per-site; and (2) provide the program evaluator with a comparison group to study the impact of EOBS on inpatient admissions.

**Crisis Residence Length of Stay** - The statistics reported in quarterly reports have provided an opportunity for extensive discussion among CPEP Directors regarding strategies they should use to help improve discharge alternatives for clients who could benefit from crisis residence services. For example, some CPEPs have developed linkages with providers that have available housing capacity so they can immediately begin treatment while assuring the client has housing. Further, CPEP staff report that clients often are not discharged from the crisis residence earlier due to a variety of clinical and system reasons (e.g., clients are not stable, appropriate placements are not available in the community, etc.).

**Mobile Crisis Visits** - As part of the CPEP quarterly report, CPEPs submitted statistics regarding the type of services provided. Two such services included mobile crisis initial visits and mobile crisis interim visits. The OSC finding noted that Elmhurst Hospital only reported initial visits. As noted, Elmhurst Hospital carefully tracked all visits made to clients following the initial visit and will correctly report those visits as interim contacts in future reporting.

**Utilization of Program Components**

The creation of CPEP, an innovative program, was in response to a host of serious problems experienced in general emergency rooms. Some components have proved more appropriate and successful than others. This is not an unusual outcome with any new program. Clearly, the structure of the crisis residence component needs to be reviewed and modified. OMH is committed to reviewing this aspect of the program and working with the hospitals to fully implement functional crisis residence services in all CPEPs. OMH’s goal is to correct the problem or redesign this program component, if needed. As part of our overall review, OMH will examine the reasons associated with the specific cases where the length-of-stay was longer than expected.
OMH Comments To OSC Recommendations

OSC Recommendation No. 1

Ensure program compliance by making periodic site visits to CPEPs, examining the program and verifying the accuracy of the performance data provided by the CPEPs.

OMH Response

OMH agrees that routine site visits are an important component in monitoring program performance. OMH has continuously monitored the CPEPs through site visits in the past, and will continue to do so in the future. As required by regulation, certification staff routinely conduct site visits to CPEPs to ensure regulatory compliance. Programs are notified by OMH of areas of non-compliance during exit conferences and by written statements of deficiencies thereafter. Where significant areas of non-compliance are found, plans of corrective action are required. In addition, field office staff periodically visit the CPEPs within their respective geographic areas, and central office staff also sometimes visit service locations. In-depth clinical audits were conducted at all CPEPs several years ago and will be conducted again at those CPEPs suspected of having more serious deficiencies. In addition, bi-monthly meetings with CPEP Program Directors will continue. These meetings serve as a forum to discuss issues of mutual concern. At these meetings, data reflecting program performance and associated issues is always discussed.

OMH also agrees that the accuracy of statistical data provided by CPEPs should be verified and, by and large, this already occurs. The OSC audit report acknowledged that the inaccuracies discovered were minor and did not distort the overall picture of program performance.

OSC Recommendation No. 2

Evaluate the performance data provided by CPEPs and take appropriate actions where indications of problems exist, including whether urban CPEPs should be allowed to have more that six extended-observation beds and whether the five-day limit for crisis residence services is adequate to meet current program needs.

OMH Response

Each CPEP is required to submit a quarterly report which addresses a variety of areas including the following:

- monthly summary of services provided in each of the four program components;
- timeliness of service delivery;
- discharge and dispositional data;
- demographic profiles of individuals served;
- diagnostic data; and
- housing data.

The data reported is reviewed regularly. Any discrepancies or outliers prompt further questions and disposition through telephone contact or site visits. Plans have been made to involve field staff in reviewing the data and resolving identified issues in a routine fashion.

Also included in Recommendation No. 2 are two questions of a policy nature. They are the following:

- Whether CPEPs should be allowed to have more than six extended observation beds; and
- Whether the five-day limit for crisis residence services is adequate to meet current program needs.

OMH initiated an analysis of these two questions and discussed their implications with the downstate CPEP directors. As a result, a workgroup will be formed to address these issues in greater detail, since changes may have an impact on space, licensing, and Medicaid costs. One matter under consideration is the elimination of the limit on the number of extended observation beds each CPEP may have.

The establishment of time limits for the provision of any kind of service in a new and innovative program is based on the best information available at the time of program implementation. This was especially challenging for OMH in establishing the parameters of operation for a new statewide program with different clientele, community resources, and other variations across the State. OMH plans to study the five-day limitation for crisis residence services to determine more precisely the program experience to date and make appropriate revisions based on the results of the evaluation of the data.

**OSC Recommendation No. 3**

Determine whether CPEPs have taken appropriate actions to correct the program deficiencies cited by BOCA.

**OMH Response**

OMH generally follows up on audit recommendations to determine whether deficiencies have been corrected. Field staff will review the BOCA audits and revisit each CPEP, as appropriate. OMH will direct BOCA to revisit those with the most significant deficiencies.
OSC Recommendation No. 4

Help CPEPs obtain crisis residence beds from community-based providers.

OMH Response

A wide range of crisis residence program models exists, however, underutilization remains an issue. Certainly, the lack of geographic proximity has played a major role in underutilization. As previously mentioned, OMH is convening a workgroup to identify the contributing factors and to develop strategies for implementation. A strategy promoting the use of crisis residence beds from community-based providers in close proximity to the CPEP will be a cornerstone of the workgroup’s recommendations. In anticipation of this recommendation, plans are being made for OMH Central Office and field staff to work in conjunction with the NYC CPEPs and with NYCDMMHR&AS to assist them in developing mechanisms to obtain crisis residence services from community-based providers in close proximity to each of the CPEPs. The model will be initiated in NYC and, subsequently, will be implemented upstate with appropriate modifications. OMH plans to fully implement crisis residence services within all CPEPs.