Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by section 2803 of the Public Health Law, section 405.19 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Paragraph (5) of subdivision (c) of section 405.19 is amended to read as follows:

(5) (i) The emergency service shall provide for the identification, assessment and referral of individuals with documented substance use disorders or who appear to have or be at risk for substance use disorders, as that term is defined in section 1.03 of the Mental Hygiene Law, as described in subdivision (f) of section 405.9 of this Part.

(ii) The emergency service shall develop and implement policies and procedures for the identification, assessment and referral of patients with behavioral health presentations, including:

(*a*) The review of records, if any, in any available information network databases, including the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), and the Statewide Health Information Network for New York (SHIN-NY).

(*b*) With the patient's consent where required by law, identifying and contacting the individual's family members or close friends who interact with the patient to obtain collateral information, including any psychiatric advance directive.

(*c*) Screening for suicide risk, which shall require positive screens be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk.

(*d*) Screening for violence risk, which shall include a process for subsequent assessment and intervention in the case of a positive screen. As part of the screening, all patients

must be asked about access to firearms or other weapons.

(*e*) Screening to determine whether an individual has complex needs. Social determinants must be considered in such discharge planning. For purposes of this paragraph, "individual with complex needs" shall have the meaning as determined by the Commissioner of Mental Health in 14 NYCRR section 580.3(e).

(iii) In general hospitals with inpatient psychiatric units under 14 NYCRR Part 580, to accomplish adequate discharge planning for individuals with complex needs in need of post emergency treatment or services, the emergency service shall develop and implement policies and procedures for the discharge of an individual with complex needs, including:

(*a*) For patients in care management programs, coordinating discharge planning with care managers in such programs.

(*b*) Scheduling and confirming an appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge and sending a discharge summary detailing the presenting mental health history, hospital course, and other relevant information to the outpatient, residential, or long-term care treatment program for a patient who wishes to receive psychiatric aftercare services. If, after making diligent efforts, a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the hospital shall document its efforts, including efforts to schedule the appointment for as soon as possible thereafter. In the extraordinary event an appointment for psychiatric aftercare cannot be secured at all, the hospital shall document its efforts before discharging the patient and provide such documentation to the department upon request. Individuals who are leaving the hospital against medical

advice, or who state they do not wish to receive aftercare services, must be offered information about available treatment options.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (PHL) § 2803 authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner, to implement the purposes and provisions of PHL Article 28, and to establish minimum standards governing the operation of health care facilities.

Legislative Objectives:

The legislative objectives of PHL Article 28 include the protection of the health of the residents of the State by promoting the efficient provision and proper utilization of high-quality health services at a reasonable cost.

Current Requirements:

General hospital emergency services are required by 10 NYCRR § 405.19(c)(7), in conjunction with the discharge planning program of the hospital, to develop policies and procedures that specify the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services, but not in need of inpatient hospital care. A general hospital emergency department must refer emergency department patients for appropriate follow-up care after discharge from the hospital, including individuals with documented substance use disorders or who appear to have or be at risk for substance use disorders. However, the current regulations do not specifically reference discharges of patients with other behavioral health presentations and complex needs from the emergency department.

Needs and Benefits:

The proposed rule will require general hospital emergency services to develop policies and procedures for intake and discharge of patients with behavioral health presentations. The proposed rule will also add new screening requirements for risk of suicide and violence.

In addition, emergency departments in hospitals with inpatient psychiatric units must follow a more person-centered discharge plan for patients with complex needs. To accomplish adequate discharge planning for these individuals, general hospitals with inpatient psychiatric units must create and implement a discharge plan that addresses the patient's complex needs. These changes ensure that discharge plans will address the post-emergency needs of the patient, including confirmation of appointments for psychiatric follow-up after a hospital visit, moving clinicians away from treating only the medical emergency.

These new requirements for emergency departments will help improve patient outcomes, reduce the risk of post-discharge self-harm and violence, and reduce the risk of readmission and disconnection from care.

COSTS:

Costs to Private Regulated Parties:

The new screening requirements will increase staffing needs to accomplish this screening. Hospitals may need to hire more social workers, discharge planners, and administrative support staff to implement discharge plans that address the patient's complex needs. Cost to the regulated parties will be dependent upon the number of staff hired and the prevalent wages in the community where the regulated party is located. It is estimated that these costs will range from $500k per year for a small hospital, to up to $2.5M a year for a large

hospital. The Department will provide guidance to hospitals and will work with hospitals and hospital associations on the development of policies and procedures to implement the requirements of this regulation.

Costs to Local Government:

There are 13 hospitals owned by counties and municipalities which will be affected by this regulation and the costs associated with it. If the regulated party is owned by a local government, the costs will be comparable to the costs to private regulated parties.

Costs to the Department of Health:

It is estimated that at least 100 new complaints per year will be received after the implementation of this regulation. These complaints will result in approximately 75 onsite investigations at a cost of approximately $2.1M per year to the Department. This cost considers the number of hours that will be incurred by the surveillance team to investigate the complaint, collaborate with the Office of Mental Health (OMH) if needed, write up the statement of deficiency and review the plans of correction.

Costs to Other State Agencies:

OMH will also incur costs if they perform investigations into complaints and issues alleged or identified.

Local Government Mandate:

Hospitals owned by counties and municipalities are required to comply with the

requirements of this regulation.

Paperwork:

General hospitals are already required to establish written policies and procedures related to various operational requirements, train staff in such policies and procedures, and refer patients to appropriate follow-up care. Therefore, the proposed regulations increase their paperwork to the extent that existing policies and procedures need to be updated to conform to these regulations.

Duplication:

While existing regulations require hospitals to make appropriate referrals, those regulations do not specifically reference patients with behavioral health presentations and complex needs. There otherwise are no relevant State regulations which duplicate, overlap, or conflict with the proposed regulations.

Alternatives:

The Office of Mental Health and the Department on Health, on October 20, 2023, issued joint guidance regarding evaluation and discharge practices for individuals who present with behavioral health conditions within psychiatric inpatient programs, emergency departments, and Comprehensive Psychiatric Emergency Programs (CPEPs). The Department opted to codify the guidance through these regulations, in part, for general hospitals with psychiatric inpatient programs to further strengthen evaluation and discharge requirements and to help improve patient outcomes, reduce the risk of post-discharge self-harm and violence, and reduce the risk of

readmission and disconnection from care. This regulation is necessary to turn provisions in the guidance into rules that general hospitals must follow.

Federal Standards:

The proposed regulations do not duplicate or conflict with any federal regulations.

Compliance Schedule:

The regulations will be effective upon publication of a Notice of Adoption in the New York State Register.

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REGULATORY FLEXIBILITY ANALYSIS
FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

The proposed regulatory provisions related to discharges from hospital emergency departments will apply to all general hospitals in New York State. This proposal will not impact local governments unless they operate one of the 13 general hospitals owned by counties and municipalities. Such local governments will be affected by this regulation and the costs associated with it. The general hospitals with emergency departments required to comply with these regulations are not small businesses.

Compliance Requirements:

These regulations will require general hospitals to develop new policies and procedures for intake and discharge of patients with behavioral health presentations and complex needs from emergency departments. Hospitals will be required to train their licensed and certified clinical staff members in such policies and procedures.

Professional Services:

While the current regulations do not specifically refer to intake and discharge of patients with behavioral health presentations or complex needs from hospital emergency departments, hospitals are already required to establish written policies and procedures related to various operational requirements, train staff in such policies and procedures, and refer patients to appropriate follow-up care. Hospitals are not likely to need outside professional services to comply with the requirements of this regulation.

Compliance Costs:

While the current regulations do not specifically refer to intake or discharge of patients with behavioral health presentations or complex needs from emergency departments, hospitals are already required to establish written policies and procedures related to various operational requirements, train staff in such policies and procedures, and refer patients to appropriate follow-up care. The proposed regulations do require additional effort to ensure that the policies and training encompass the policies and procedures for patients who have behavioral health presentations or complex needs. However, these efforts are expected to assist individuals in obtaining treatment that will help them avoid future emergency room visits and hospital admissions. Costs to regulated parties will be dependent upon the number of staff hired and the prevalent wages in the community where the regulated party is located. It is estimated that these costs will range from $500k per year for a small hospital, to up to $2.5M a year for a large hospital. The Department will provide guidance to hospitals and will work with hospitals and hospital associations on the development of policies and procedures to implement the requirements of this regulation.

Economic and Technological Feasibility:

This proposal is economically and technically feasible. While existing regulations do not specifically refer to intake or discharge of patients with behavioral health presentations or complex needs from emergency departments, hospitals are already required to establish written policies and procedures related to various operational requirements, train staff in such policies and procedures, and refer patients to appropriate follow-up care.

Minimizing Adverse Impact:

The regulations afford general hospitals flexibility to develop and implement their own policies and procedures that meet the minimum requirements of the regulations, which is expected to minimize the costs of compliance. In addition, if after making diligent efforts, a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the regulations provide flexibility to allow a hospital to document its efforts and schedule the appointment for as soon as possible thereafter.

Small Business and Local Government Participation:

Development of these regulations included input from organizations including those whose members include general hospitals that are operated by local governments or that constitute small businesses. The essential requirements of this regulation were announced in the Governor's State of the State address on January 9, 2024. This regulation was on the agenda of the meeting of the Public Health and Health Planning Council (PHHPC) that took place on February 8, 2024, in accordance with the Open Meetings Law. At that meeting, the regulation was reviewed and discussed by PHHPC members. In addition, the public, including the affected parties to this regulation, were afforded an opportunity to ask questions and provide comments.

In addition, there were conference calls made to associations representing the hospital industry to inform them of the regulation and to provide an opportunity to ask questions.

The regulation must be presented a second time at an open meeting of PHHPC, with another opportunity for public comment, and the regulation cannot be established unless and until PHHPC approves adoption of the regulation.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 44 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2020 (https://www.census.gov/quickfacts/). There are 55 general hospitals in rural areas.

Allegany County	Greene County	Schoharie County
Broome County	Hamilton County	Schuyler County
Cattaraugus County	Herkimer County	Seneca County
Cayuga County	Jefferson County	St. Lawrence County
Chautauqua County	Lewis County	Steuben County
Chemung County	Livingston County	Sullivan County
Chenango County	Madison County	Tioga County
Clinton County	Montgomery County	Tompkins County
Columbia County	Ontario County	Ulster County
Cortland County	Orleans County	Warren County
Delaware County	Oswego County	Washington County
Essex County	Otsego County	Wayne County
Franklin County	Putnam County	Wyoming County
Fulton County	Rensselaer County	Yates County
Genesee County	Schenectady County	

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2020.

Albany County	Niagara County	Orange County
Dutchess County	Oneida County	Saratoga County
Erie County	Onondaga County	Suffolk County
Monroe County		

Reporting, Recordkeeping, Other Compliance Requirements and Professional Services:

The proposed regulation is applicable to those general hospitals located in rural areas and is expected to impose only minimal costs upon hospitals, which are already required to establish written policies and procedures related to various operational requirements, train staff in such policies and procedures, and refer patients to appropriate follow-up care. However, the proposed regulatory requirements can be incorporated into existing processes, which should help to minimize the administrative burden on these entities.

Costs:

While the current regulations do not specifically refer to discharges of patients with behavioral health presentations or complex needs from hospitals emergency departments, hospitals are already required to establish written policies and procedures related to various operational requirements, train staff in such policies and procedures, and refer patients to appropriate follow-up care. The proposed regulations do require additional effort to ensure that the policies and training encompasses the policies and procedures for patients with behavioral health presentations or complex needs discharged from emergency departments. However, these efforts are expected to assist individuals in obtaining treatment that will help them avoid future emergency room visits and hospital admissions. Costs to regulated parties will be dependent upon the number of staff hired and the prevalent wages in the community where the regulated party is located. It is estimated that these costs will range from $500k per year for a small hospital, to up to $2.5M a year for a large hospital. The Department will provide guidance to hospitals and will work with hospitals and hospital associations on the development of policies and procedures to implement the requirements of this regulation.

Minimizing Adverse Impact:

The regulations afford general hospitals flexibility to develop and implement their own policies and procedures that meet the minimum requirements of the regulations, which is expected to minimize the costs of compliance. In addition, if after making diligent efforts, a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the regulations provide flexibility to allow a hospital to document its efforts and schedule the appointment for as soon as possible thereafter.

Rural Area Participation:

Development of these regulations included input from organizations including those that include as members general hospitals located in rural areas.

The essential requirements of this regulation were announced in the Governor's State of the State address on January 9, 2024. This regulation was on the agenda of the meeting of the Public Health and Health Planning Council (PHHPC) that took place on February 8, 2024, in accordance with the Open Meetings Law. At that meeting, the regulation was reviewed and discussed by PHHPC members. In addition, the public, including the affected parties to this regulation, were afforded an opportunity to ask questions and provide comments.

In addition, there were conference calls made to associations representing the hospital industry to inform them of the regulation and to provide an opportunity to ask questions.

The regulation must be presented a second time at an open meeting of PHHPC, with another opportunity for public comment, and the regulation cannot be established unless and until PHHPC approves adoption of the regulation.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

No job impact statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. No adverse impact on jobs and employment opportunities is expected as a result of these proposed regulations.

SUMMARY OF ASSESSMENT OF PUBLIC COMMENT

A Proposed Rule was published on February 21, 2024. The New York State Department of Health ("Department") received comments from the New York American College of Emergency Physicians, Greater New York Hospital Association, the Healthcare Association of New York State, Fountain House, NYS Coalition for Children's Behavioral Health, and the New York State Conference of Local Mental Hygiene Directors.

Comment: Commenters requested that the Department of Health clarify the applicability of this regulation.

Response: This regulation applies to general hospital emergency department patients.

Comment: A commenter requested that the Department explain how a general hospital emergency department should determine whether a patient has a "behavioral health presentation."

Response: This regulation does not define behavioral health presentation, and clinicians may use their professional judgment to determine if the patient presents with a behavioral health need.

Comment: Commenters expressed concern that the definition of complex needs is overly broad.

Response: This regulation incorporates the definition of complex needs from Office of Mental Health regulations.

Comment: Commenters requested clarification regarding methods general hospitals must use to screen for suicide and violence risk and asked whether the regulation requires general hospitals to screen for all social determinants of health.

Response: The additional screenings are intended to help ensure that hospital clinical staff routinely gather all possible information when making treatment or disposition decisions and are a key component to accomplishing adequate discharge planning for persons in need of post

emergency treatment or services. The Department will provide guidance to hospitals and will work with hospitals and hospital associations on the development of policies and procedures to implement the requirements of this regulation. Screening for suicide and violence risk should be aligned with existing CMS Conditions of Participation. This regulation does not contain any general requirement to screen patients for social determinants of health. The new requirement to screen patients with behavioral health presentations for suicide and violence risk is consistent with existing requirements. For example, the emergency service of a general hospital is already required to have policies and procedures which provide for the assessment, treatment, and management of patients when there is a suspected or confirmed case of domestic violence, and the emergency department is also already required to have a protocol for survivors of sexual offenses.

Comment: A commenter stated that hospitals may have difficulty in reviewing data in the SHIN-NY and PSYCKES and expressed concerns regarding the security of data.

Response: The Department and the Office of Mental Health welcome new SHIN-NY and PSYCKES users, and training materials are available. Security is a critical concern for all health information system applications, and the SHIN-NY and PSYCKES comply with applicable requirements to safeguard privacy and security.

Comment: One commenter stated that prescribers in emergency departments are not required to review the PMP when controlled substance prescriptions do not exceed a five-day supply under PHL § 3343-a and 10 NYCRR § 80.63(c)(2)(v).

Response: The Department agrees that under PHL § 3343-a(2) and (5), an emergency department of a general hospital is not required to consult the PMP unless the emergency department is prescribing more than a five day supply of controlled substances. The requirement

to review the PMP was intended to be consistent with existing requirements. To avoid confusion, the Department has revised the language to remove the requirement to review the PMP; however, hospitals must continue to review the PMP as required under PHL Article 33 and 10 NYCRR Part 80.

Comment: A commenter stated that section 405.19(c)(5)(iii)(*b*) requires hospitals to refer individuals with complex needs to care management programs or coordinate discharge planning with care managers in such programs. The commenter asked how general hospitals can coordinate discharge planning with care managers in care management programs, and what happens if it's not possible to coordinate discharge planning with care managers outside of business hours and on weekends and holidays.

Response: The provision about which the commenter is inquiring is now in Section 405.19(c)(5)(iii)(*b*), and it has been changed to read: "For patients in care management programs, coordinating discharge planning with care managers in such programs." Individuals with complex needs include individuals enrolled in a Medicaid program health home with intensive care management services such as Health Home Plus. To the extent practicable, the hospital should coordinate discharge planning with care managers in care management programs such as Health Home Plus. Hospitals that are part of a Health Home network must coordinate discharge planning with care managers in the Health Home network. Such coordination may include an alert using the SHIN-NY to the care manager that is sent to the care manager in the Health Home network.

Comment: One commenter stated concern that emergency departments will be unable to secure outpatient behavioral health provider appointments for individuals with complex needs in the prescribed time frames.

Response: Several efforts are underway to address scarcity and perceived scarcity. The Office of Mental Health will continue working to support the collaboration between hospital emergency departments and outpatient mental health providers.

If after making all diligent efforts, an appointment for psychiatric aftercare cannot be secured, the provider shall document its effort and schedule an appointment as soon as possible thereafter. The language in the regulation has been revised to make it clear that the hospital is required to document its efforts to schedule and confirm an appointment for as soon as possible, but the patient may be discharged without an appointment when scheduling an appointment is not possible.

Comment: A commenter inquired whether telehealth could be considered an appropriate option for follow-up care.

Response: This regulation does not prohibit the use of telemedicine to provide the services required by this regulation.

Comment: A commenter asked whether this regulation is consistent with the Department's proposed behavioral health network adequacy requirements.

Response: The Department's proposed network adequacy regulations would add a new 10 NYCRR § 98-5.5(a)(3) that would require that a managed care organization ensures that its network has adequate capacity and availability of health care providers of behavioral health services to offer enrollees appointments within "seven days for an appointment following a discharge from a hospital or an emergency room visit." The proposed 10 NYCRR § 98-5.5(a)(3) and this regulation's requirement to make an appointment within seven days are consistent.

Comment: A commenter expressed concern about the requirement that information be obtained "with the patient's consent" and stated that consent is not always required.

Response: The regulation has been revised in 10 NYCRR § 405.19(c)(5)(ii)(*b*) to make clear that hospitals must obtain collateral information with the patient's consent "where required by law." The regulation was also revised in 10 NYCRR § 405.19(c)(5)(iii) to eliminate the phrase "with the patient's consent" while retaining the language indicating that an appointment for psychiatric aftercare is for patients who wish to receive such services.

Comment: Commenters pointed out that significant additional resources would be necessary to implement these regulations.

Response: Most of this proposal is limited to hospitals with inpatient psychiatric units that are designated under Section 9.39 of the Mental Hygiene Law. The majority of such providers also operate licensed outpatient mental health programs, which creates significant efficiencies in discharge planning and outpatient appointments.

The intent of this rule is to improve patient outcomes by connecting individuals to appropriate outpatient care, which can ultimately reduce both emergency room visits and readmissions for behavioral health concerns, creating additional efficiencies.

Comment: Several commenters described that implementation of the revisions to 10 NYCRR § 405.19 would lead to further delays and increased length of stay in the already overburdened emergency rooms. One of these commenters stated that the delays would negatively impact patient care for patients with acute illness.

Response: The intention is to engage patients with complex needs in outpatient treatment to reduce utilization of emergency departments and prevent readmissions. The short-term impact for emergency departments will be offset by a long-term reduction in patients who present in emergency departments with behavioral health complex needs.

Comment: A commenter stated that the standard of care for patients receiving emergency care should be defined by board-certified emergency physicians.

Response: This regulation does not create a standard of care and is not intended to replace clinical judgment. Rather, this regulation helps ensure that clinical staff routinely gather all possible information when making treatment or disposition decisions.

Comment: One comment urged the Department to defer the amendment, which they believe will burden emergency department and behavioral health providers.

Response: Emergency departments are intended to serve individuals experiencing a medical emergency, which includes behavioral health crises. Nearly all individuals with complex needs, as defined in the proposed rule, are already receiving outpatient behavioral health services, and therefore emergency departments must primarily identify those providers and support reengagement during discharge.

The SFY 2023-24 enacted Budget included a $1 billion transformative, multi-year investment to overhaul the State's continuum of mental health care and drastically expand mental health services. The plan expands access, reduces wait times, and ensures appropriate levels of care are provided to those who struggle with mental health issues. These regulations build on the Governor's initiative to help ensure appropriate levels of care are provided to those who struggle with behavioral health issues.

ASSESSMENT OF PUBLIC COMMENT

A Proposed Rule was published on February 21, 2024. During the public comment period, the New York State Department of Health ("Department") received comments from the New York American College of Emergency Physicians, Greater New York Hospital Association, the Healthcare Association of New York State, Fountain House, NYS Coalition for Children's Behavioral Health, and the New York State Conference of Local Mental Hygiene Directors.

Applicability

Comment: Commenters requested that the Department of Health clarify the applicability of this regulation.

Response: This regulation applies to general hospital emergency department patients who have not been admitted to the hospital's inpatient psychiatric unit, and includes additional requirements before patients with complex needs may be discharged from a hospital emergency department. These regulations do not amend the requirements for discharge of inpatients, which can be found in 10 NYCRR § 405.9.

Under 10 NYCRR § 405.19(c)(5)(ii), all emergency departments will be required to develop and implement policies and procedures for the identification, assessment, and referral of patients with behavioral health presentations. In addition, emergency departments of general hospitals that operate an inpatient psychiatric unit will be required to provide individuals with complex needs with a discharge plan that complies with 10 NYCRR § 405.19(c)(5)(iii).

Emergency departments of general hospitals that do not have an inpatient psychiatric unit will continue to follow policies and procedures, including written patient criteria and guidelines, for transfer of patients as needed to accomplish adequate discharge planning for persons in need of post emergency treatment or services.

Note that inpatient psychiatric units licensed by the Office of Mental Health must also comply with 14 NYCRR Part 580, and Comprehensive Psychiatric Emergency Programs (CPEPs) licensed by the Office of Mental Health must also comply with 14 NYCRR Part 590.

Behavioral Health Presentation

Comment: A commenter requested that the Department define the term "behavioral health presentation" and explain how a general hospital emergency department should determine whether a patient has a behavioral health presentation.

Response: This regulation does not define behavioral health presentation. These regulations are not intended to replace clinical judgment, and clinicians may use their professional judgment to determine if the patient presents with a behavioral health need. Hospitals will have flexibility to determine appropriate approaches for identifying, assessing, and referring individuals with behavioral health presentations. No changes to the regulation were made as a result of this comment.

Comment: A commenter urged the Department to create emergency service protocols that address specific behavioral health presentations, including protocols that address the needs of youth.

Response: The Department and the Office of Mental Health recognize the importance of ensuring that hospitals consider the health and developmental needs of patients of all ages. Existing emergency services regulations already require general hospitals to have policies for treating pediatric patients, and for treatment or transfer of patients needing specialized emergency care, including pediatric patients in need of a higher level of care. The Department and the Office of Mental Health have also provided guidance advising emergency departments on the importance of having age-appropriate intervention. See link here:

https://omh.ny.gov/omhweb/guidance/omh-doh-evaluation-discharge-guidance.pdf. The guidance includes references to peer-reviewed, evidence-based instruments that hospitals should consider adopting, including instruments that are specifically designed for assessing children and adolescents.

Complex Needs

Comment: One commenter stated that behavioral health presentation alone should not be the reason to require emergency departments to spend additional time identifying "individuals with complex needs." The determination whether a patient has complex needs should be based on the clinical judgment of emergency services providers.

Response: As stated in response to a previous comment, clinicians may use their professional judgment to determine if the patient presents with a behavioral health need. Patients with complex needs are a subset of patients with behavioral health presentations, and therefore only patients with behavioral health presentations must be evaluated to determine whether they are individuals with complex needs.

Comment: Commenters expressed concern that the definition of complex needs is overly broad and urged the Department to narrow the definition and ensure that there is alignment with existing requirements and guidelines.

Response: This regulation incorporates the definition of complex needs from Office of Mental Health regulations. In response to these comments and comments received by the Office of Mental Health on proposed amendments to 14 NYCRR Parts 580, 582 and 590, the Office of Mental Health has revised the definition of "individual with complex needs" in 14 NYCRR §§ 580.3, 582.3, and 590.4. An individual with complex needs includes an individual who demonstrates high utilization of emergency services as indicated by: three or more mental health

inpatient hospitalizations in the past year; or four or more mental health presentations to an emergency department or CPEP in the past year; or three or more medical/surgical hospitalizations in the last year and carrying a diagnosis of schizophrenia or bipolar disorder. Individual with complex needs also includes an individual enrolled in a Medicaid program health home with intensive care management services for individuals with mental illness such as Health Home Plus.

In addition, when a patient has a behavioral health presentation, general hospital emergency services will review any available records from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) and the Statewide Health Information Network for New York (SHIN-NY). Using these networks, the emergency department can identify patients who are individuals with complex needs. Furthermore, to assist providers in making the determination whether a patient with a behavioral health presentation has complex needs, the Office of Mental Health is developing a "complex needs flag" in PSYCKES to help with identification and care coordination for individuals with complex needs.

Screening for Suicide and Violence Risk

Comment: Regarding screening for suicide risk, a commenter expressed that general hospital emergency departments should not be held to the same standard as CPEPs.

Response: The goal of these regulations is to improve patient outcomes; reduce the risk of overdose, self-harm, and violence; and reduce the risk of readmission and disconnection from care. The additional screenings are intended to help ensure that hospital clinical staff routinely gather all possible information when making treatment or disposition decisions and are a key component to accomplishing adequate discharge planning for persons in need of post emergency

treatment or services but not in need of inpatient hospital care, whether an individual is seen at a general emergency department or a CPEP.

Comment: One commenter noted that hospitals have limited resources and urged the Department to assist stakeholders in identifying and implementing appropriate screening tools.

Response: The Department will provide guidance to hospitals and will work with hospitals and hospital associations on the development of policies and procedures to implement the requirements of this regulation.

Comment: Two commenters requested that the Department align screening for suicide and violence risk with existing Centers for Medicare and Medicaid Services (CMS) Conditions of Participation and Joint Commission standards to eliminate confusing and duplicative requirements.

Response: The Department will provide guidance to hospitals and will work with hospitals and hospital associations on the development of policies and procedures to implement the requirements of this regulation. The Department agrees that screening for suicide and violence risk should be aligned with existing CMS Conditions of Participation. No changes to the regulation were made as a result of these comments.

Comment: One commenter stated that CMS does not require or expect emergency departments to screen for social determinants of health; emergency departments do not have the resources to address social determinants of health; and additional time-consuming screenings will contribute to longer delays for treating emergency department patients.

Response: The goal of this regulation is to improve patient outcomes and linkages to care. This regulation does not contain any general requirement to screen patients for social determinants of health. Rather, patients are screened for suicide and violence risk in order to accomplish

adequate discharge planning, which must consider social determinants, for individuals in need of post emergency treatment services.

Comment: One commenter stated that the Department should allow the Department's Social Security Act Section 1115 Medicaid waiver and new Medicare requirements to be implemented and operationalized before it considers imposing requirements related to social determinants of health on general hospital emergency departments.

Response: The Department believes that the requirements in this regulation are consistent with the goals of the 1115 waiver and Medicare requirements.

Comment: One commenter stated that hospitals must have a plan to address suicide and violence risk when the risk is identified.

Response: The screening requirements are not intended to replace clinical judgment but rather to help ensure that clinical staff routinely gather all possible information when making treatment or disposition decisions. The emergency services regulation in section 405.19 already requires hospitals to adopt policies and procedures to accomplish adequate discharge planning for people in need of post emergency treatment or services.

Comment: One commenter urged the Department to reconsider the requirement to screen patients for violence risk based solely on behavioral health presentation.

Response: The new requirement to screen patients with behavioral health presentations for violence risk will help inform the appropriate level of care needed and post discharge needs and is consistent with existing requirements. For example, the emergency service of a general hospital is already required to have policies and procedures which provide for the assessment, treatment, and management of patients when there is a suspected or confirmed case of domestic

violence, and the emergency department is also already required to have a protocol for survivors of sexual offenses.

Individuals with behavioral health diagnoses in their medical history are not necessarily patients with behavioral health presentations. For example, an individual who has taken a medication for anxiety who presents with appendicitis would not necessarily have a behavioral health presentation in the emergency department. If, however, the patient exhibited agitation, aggression, threatening behaviors, or violent ideation in the emergency department, the patient may have a behavioral health presentation in addition to their emergent medical presentation.

Comment: One commenter expressed concern about screening adolescents for substance abuse and stated that a licensed substance abuse professional is not available in most emergency departments in New York State.

Response: The screening requirement for substance use disorder under Public Health Law § 2803-u and 10 NYCRR § 405.19(c)(5) is an existing requirement and is already applicable to all patients, including minors. This regulation does not change this already-existing requirement.

Comment: One commenter recommended including patient-reported outcome measures (PROMs) to address loneliness, quality of life, thriving, and potentially other key aspects of people's lived experience upon discharge from the hospital, to include within an individual's pre-discharge interventions to improve discharge outcomes.

Response: Current guidance from the Department and the Office of Mental Health is available here: https://omh.ny.gov/omhweb/guidance/omh-doh-evaluation-discharge-guidance.pdf. The Department appreciates the comment and will consider this comment as additional guidance is developed.

Review of Records and Information Gathering

Comment: A commenter stated that hospitals may have difficulty in reviewing data in PSYCKES and the SHIN-NY due to limited access and lack of integration with existing electronic medical records systems, and the commenter also expressed concern about cybersecurity issues since the soft tokens used to access PSYCKES do not always meet higher security standards.

Response: PSYCKES and the SHIN-NY were developed to support clinicians and continue to enhance content and features to increase clinical utility. The Department would not recommend hospitals limit access to these clinical applications to one or two administrators. The Department and the Office of Mental Health welcome new PSYCKES and SHIN-NY users, and training materials for leadership, administrative, and clinical staff are available here: PSYCKES Home.

Emergency Department clinicians are best served by having all needed clinical information available. Security is a critical concern for all health information system applications, and PSYCKES and the SHIN-NY comply with applicable requirements to safeguard privacy and security.

Comment: One commenter stated that effective and streamlined communication will require technology integration that is not currently the standard among community-based or hospital providers. Another commenter requested the integration of PSYCKES and the prescription monitoring program (PMP) registry into electronic medical records systems to reduce information gathering burdens.

Response: The Department supports the integration of all available information regarding a patient into the hospital patient's electronic medical record system. The Department is engaged in multiple efforts to improve the interoperability of the various databases that contain patient information.

Comment: One commenter stated that prescribers in emergency departments are not required to review the PMP when controlled substance prescriptions do not exceed a five-day supply under PHL § 3343-a and 10 NYCRR § 80.63(c)(2)(v).

Response: The Department agrees that under PHL § 3343-a(2) and (5), an emergency department of a general hospital is not required to consult the PMP unless the emergency department is prescribing more than a five day supply of controlled substances. The requirement to review the PMP was intended to be consistent with existing requirements. To avoid confusion, the Department has revised the language to remove the requirement to review the PMP; however, hospitals must continue to review the PMP as required under PHL Article 33 and 10 NYCRR Part 80.

Comment: One commenter noted that hospitals face chronic staff shortages, and the use of contract, per diem, and floating staff complicates hospital access to PSYCKES, as reliance on temporary or irregular staff makes training, maintenance of staff-level access to PSYCKES, and information retention a challenge.

Response: Temporary staff who lack permission to use electronic databases should work with other members of a patient's care team to access patient information needed to accomplish adequate discharge planning from the emergency department.

Comment: Commenters stated that hospitals report ongoing challenges and limitations using the SHIN-NY for clinical purposes. The commenter suggested that before mandating access to the SHIN-NY or any other data source, the Department should ensure access is likely to have a material benefit to providers in caring for their patients.

Response: The Department acknowledges that PSYCKES and the SHIN-NY may or may not contain information that would have a material benefit in providing care to emergency

department patients. The Department nevertheless believes that these systems will assist hospitals in making treatment or disposition decisions and are a key component for identifying and providing appropriate care.

Comment: A commenter recommended that the use of PSYCKES and the SHIN-NY should not be required, and that accessing multiple databases is burdensome and offers little benefit when widely applied to the population.

Response: Requiring the review of additional records, if available, is intended to help ensure that hospital clinical staff routinely gather all possible information when making treatment or disposition decisions and are a key component for identifying and providing appropriate care. No changes to the regulation were made as a result of this comment.

Comment: A commenter urged the Department to require that the emergency department include consultation with the patient's mental health provider in addition to performing outreach to the patient's family members or close friends.

Response: 10 NYCRR 404.19(c)(5)(ii) requires emergency departments to adopt policies and procedures for the identification, assessment, and referral of patients with behavioral health presentations, which would include the review of records in PSYCKES and the SHIN-NY if available. These databases contain mental health provider records. No changes to the regulation were made as a result of this comment.

Discharge Responsibilities and Aftercare Timeframes

Comment: This regulation requires hospital emergency departments to prepare discharge summaries that detail the patient's presenting mental health history, hospital course, and other relevant information. Modifying discharge instructions, particularly for behavioral health patients, will require clinical input, electronic medical record programming, and staff training.

Entities receiving discharge information must also develop workflows to receive and appropriately handle sensitive behavioral health information received from hospitals.

Response: To assist with the sharing of information between hospitals and behavioral health providers, the Department and the Office of Mental Health have issued guidance for coordinated discharge planning: https://omh.ny.gov/omhweb/guidance/omh-doh-evaluation-discharge-guidance.pdf. In addition, the Office of Mental Health has issued and is working on updates to Draft Guidance for Outpatient Treatment, Residential, Residential Treatment Facility, Care Management Programs on Collaborating with Hospitals on Admissions and Discharges.

Comment: Proposed Section 405.19(c)(5)(iii)(*b*) requires hospitals to refer individuals with complex needs to care management programs or coordinate discharge planning with care managers in such programs. How can general hospitals coordinate discharge planning with care managers in care management programs, and what if it is not possible to coordinate discharge planning with care managers outside of business hours and on weekends and holidays?

Response: The provision about which the commenter is inquiring is now in Section 405.19(c)(5)(iii)(*b*), and it has been changed to read: "For patients in care management programs, coordinating discharge planning with care managers in such programs."

Individuals with complex needs include individuals enrolled in a Medicaid program health home with intensive care management services such as Health Home Plus. To the extent practicable, the hospital should coordinate discharge planning with care managers in care management programs such as Health Home Plus. Hospitals that are part of a Health Home network must coordinate discharge planning with care managers in the Health Home network. Such coordination may include an alert using the SHIN-NY to the care manager that is sent to the care manager in the Health Home network.

Coordinating with care managers is important for positive patient outcomes. The intention is to link patients to outpatient treatment and to retain patients in outpatient treatment programs. Providing appropriate outpatient treatment for patients with complex needs will ultimately reduce emergency department volume and reduce readmissions on emergency departments.

Comment: One commenter stated concern that emergency departments will be unable to secure outpatient behavioral health provider appointments for individuals with complex needs in the prescribed time frames, if outpatient capacity is insufficient. A commenter expressed concerns about the complexity of some patient's needs, the difficulty in obtaining access to follow-up care, and that this regulation does not address the hospital's protocol when no appropriate psychiatric provider can be identified when the patient is discharged from the emergency department.

Response: Several efforts are underway to address scarcity and perceived scarcity. First, Governor's Hochul historic investment in the behavioral health system will bring online Critical Time Intervention teams, which will partner with hospital emergency departments to implement discharge plans and extensive new mental health outpatient treatment resources, including a two-year expansion plan, which will triple the number of Certified Community Behavioral Health Clinics (CCBHCs) statewide from 13 to 39 by July 2025. There is also expansion of Assertive Community Treatment teams (adult, young adult, youth), Crisis Stabilization Centers, and Crisis Residences, which will serve to divert individuals from going to emergency departments and can function as emergency department step-downs.

The Office of Mental Health will continue working to support the collaboration between hospital emergency departments and outpatient mental health providers. In conjunction with

these regulations, the Office of Mental Health recently issued Draft Guidance for Outpatient Treatment, Residential, Residential Treatment Facility, Care Management Programs on Collaborating with Hospitals on Admissions and Discharges. In addition, the Office of Mental Health has a regulatory requirement in 14 NYCRR 599.6(c)(7)(i) requiring outpatient clinics to ensure that patients referred from emergency settings receive services "within five business days."

If after making all diligent efforts, an appointment for psychiatric aftercare cannot be secured, the provider shall document its effort and schedule an appointment as soon as possible thereafter. The hospital may be considered in compliance with this regulation so long as the hospital has documented its efforts to schedule the appointment. If the hospital reasonably determines and documents that it is not possible to schedule an appointment *at all* as provided in these regulations, the hospital may discharge the patient without an appointment. The language in the regulation has been revised to make it clear that the hospital is required to document its efforts to schedule and confirm an appointment for as soon as possible, but the patient may be discharged without an appointment when scheduling an appointment is not possible.

Comment: A commenter inquired whether telehealth could be considered an appropriate option for follow-up care.

Response: This regulation does not prohibit the use of telemedicine to provide the services required by this regulation.

Comment: A commenter stated that the Department's behavioral health network adequacy requirements will require health plans to facilitate enrollee appointments within a 10-day timeframe and believes that the 10-day and seven-day timeframes should be aligned.

Response: The Department's proposed network adequacy regulations would add a new 10 NYCRR § 98-5.5(a)(3) that would require that a managed care organization ensures that its network has adequate capacity and availability of health care providers of behavioral health services to offer enrollees appointments within "seven days for an appointment following a discharge from a hospital or an emergency room visit." The proposed 10 NYCRR § 98-5.5(a)(3) and this regulation's requirement to make an appointment within seven days are consistent.

Comment: A commenter expressed appreciation and support for the requirement that discharge summaries be transmitted to the patient's outpatient, residential, or long-term treatment program. The commenter also recommended that the discharge summaries include documentation from the patient's medical record to ensure continuity of care.

Response: The Department agrees that the discharge summary should include documentation from the patient's medical record to the extent that such documentation is necessary to ensure continuity of care by the psychiatric aftercare provider.

Comment: One commenter appreciated the intention to create a clear and timely window for the scheduling of follow-up psychiatric appointments and encouraged the development of a mechanism for tracking whether appointments are kept.

Response: The Department appreciates this comment but believes such a mechanism would be beyond the scope of these regulations.

Comment: A commenter expressed concern about the requirement that information be obtained "with the patient's consent" and stated that consent is not required by the Mental Hygiene Law, Office of Mental Health regulations, or HIPAA and would be a barrier to care coordination. The commenter suggests that the regulation be amended to include language making it clear that under HIPAA and existing statutes, hospital emergency departments may legally share

information with community-based mental health care providers involved with the discharge plan without patient consent.

Response: The regulation has been revised in 10 NYCRR § 405.19(c)(5)(ii)(*b*) to make clear that hospitals must obtain collateral information with the patient's consent "where required by law." The regulation was also revised in 10 NYCRR § 405.19(c)(5)(iii) to eliminate the phrase "with the patient's consent" while retaining the language indicating that an appointment for psychiatric aftercare is for patients who wish to receive such services. The Department agrees that when patients wish to receive services from psychiatric aftercare providers, hospitals may share patient information with such psychiatric aftercare providers.

Resources

Comment: Commenters point out that significant additional resources to support clinical and non-clinical staffing and technology and data needs would be necessary to implement effective assessment, communication, referral, and discharge protocols in general hospital emergency departments under these regulations. Commenters also believe that the Department's regulatory impact statement significantly underestimates the resources emergency departments will need to achieve compliance with these regulations and requested that the Department provide additional resources to the emergency departments to help with implementation.

Response: Most of this proposal is limited to hospitals with inpatient psychiatric units that are designated under Section 9.39 of the Mental Hygiene Law. The majority of such providers also operate licensed outpatient mental health programs, which creates significant efficiencies in discharge planning and outpatient appointments.

The intent of this rule is to improve patient outcomes by connecting individuals to appropriate outpatient care, which can ultimately reduce both emergency room visits and

readmissions for behavioral health concerns, creating additional efficiencies. Lastly, while resources, as highlighted in the regulatory impact statement, may be needed, this requirement consists of best practices in patient-centered care, addressing essential population health needs.

Comment: Several commenters described that implementation of the revisions to 10 NYCRR 405.19 would lead to further delays and increased length of stay in the already overburdened emergency rooms. One of these commenters stated that the delays would negatively impact patient care for patients with acute illness.

Response: The intention is to engage patients with complex needs in outpatient treatment to reduce utilization of emergency departments and prevent readmissions. The short-term impact for emergency departments will be offset by a long-term reduction in patients who present in emergency departments with behavioral health complex needs.

Coordination with Community-Based Programs

Comment: A commenter recommended that the Department add clubhouses to the list of organizations that would be included within a patient's coordinated discharge plan and states that clubhouses offer a different set of services that have been shown to provide better outcomes for those living with serious mental illness.

Response: No changes to the regulation were made as a result of this comment; however, the Department will consider this comment as it develops additional guidance to implement this regulation.

Standard of Care

Comment: A commenter stated that the standard of care for patients receiving emergency care should be defined by board-certified emergency physicians.

Response: This regulation does not create a standard of care and is not intended to replace clinical judgment. Rather, this regulation helps ensure that clinical staff routinely gather all possible information when making treatment or disposition decisions.

Other

Comment: A commenter urged that routine site checks be performed and consultation with community stakeholders to ensure compliance.

Response: The Department monitors hospitals through a complaint process and an incident reporting program. These programs are intended to identify those instances in which a hospital may not have met the required standard of care. When a hospital is found not to have met either the standard of care or specific compliance requirements, the Department issues a statement of deficiency and monitors the hospital's progress in taking corrective action.

Comment: A commenter requested that the Department work with hospitals on messaging and promoting awareness of available behavioral health resources in the community.

Response: The Department and the Office of Mental Health will provide guidance regarding the implementation of these regulations, including materials promoting awareness of behavioral health resources in the community.

Comment: A commenter requested that patients' medications should not be withheld during observation unless medically necessary.

Response: The regulations are not intended to replace clinical judgment and clinicians should use their professional judgment to determine whether a patient's medications should be discontinued or withheld.

Comment: One comment urged the Department to defer the amendment, which they believe will burden emergency department and behavioral health providers.

Response: Emergency departments are intended to serve individuals experiencing a medical emergency, which includes behavioral health crises. Nearly all individuals with complex needs, as defined in the proposed rule, are already receiving outpatient behavioral health services, and therefore emergency departments must primarily identify those providers and support reengagement during discharge.

The SFY 2023-24 enacted Budget included a $1 billion transformative, multi-year investment to overhaul the State's continuum of mental health care and drastically expand mental health services. The plan expands access, reduces wait times, and ensures appropriate levels of care are provided to those who struggle with mental health issues. These regulations build on the Governor's initiative to help ensure appropriate levels of care are provided to those who struggle with behavioral health issues.