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), the Statewide Health Information Network for New York (SHIN-NY), and the Prescription Monitoring Program (PMP).

(*b*) With the patient's consent, 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 Title 14 of the NYCRR.

(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*) With the patient's consent, sending a discharge summary detailing the presenting mental health history, hospital course, and other relevant information to outpatient, residential, or long-term care treatment programs.

(*b*) Referring patients to care management programs or coordinating discharge planning with care managers in such programs.

(*c*) Confirming an appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge. 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 and schedule the appointment for as soon as possible thereafter. 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.