

9. FEDERAL STANDARDS: There are no federal standards applicable to the licensing of gaming facilities in New York because such licensing is solely in accordance with New York State law.

10. COMPLIANCE SCHEDULE: The Board anticipates that affected parties will be able to achieve compliance with the proposed rules upon the adoption of the rules.

Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

The proposed changes do not require a Regulatory Flexibility Analysis, Rural Area Flexibility Analysis or Job Impact Statement. There will be no adverse impact on small businesses, local governments, rural areas or jobs.

The proposed rules prescribe the license fee for an additional gaming facility license issued by the New York State Gaming Commission. It is not expected that any small business or local government will apply for a gaming facility license.

The proposal imposes no adverse economic impact or reporting, recordkeeping, or other compliance requirements on small businesses in rural or urban areas or on employment opportunities. The rules apply uniformly throughout the State to any applicant seeking a license to develop and operate an additional gaming facility in the State.

The proposal will not adversely impact small businesses, local governments, jobs, or rural areas. It does not require a full Regulatory Flexibility Analysis, Rural Area Flexibility Analysis, or Job Impact Statement.

Department of Labor

NOTICE OF ADOPTION

Injury and Illness Reporting and Recordkeeping Requirements

I.D. No. LAB-18-24-00002-A

Filing No. 604

Filing Date: 2024-07-15

Effective Date: 2024-07-31

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Repeat of sections 801.39, 801.41; addition of new sections 801.39 and 801.41 to Title 12 NYCRR.

Statutory authority: Labor Law, section 21(11)

Subject: Injury and Illness Reporting and Recordkeeping Requirements.

Purpose: To adopt updates to OSHA regulations regarding reporting and recordkeeping requirements as required by law.

Text or summary was published in the May 1, 2024 issue of the Register, I.D. No. LAB-18-24-00002-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Elizabeth Robins, Department of Labor, State Office Campus, Building 12, Albany, NY 12240, (518) 485-2191, email:regulations@labor.ny.gov

Assessment of Public Comment

The agency received no public comment.

Office of Mental Health

REVISED RULE MAKING NO HEARING(S) SCHEDULED

Admission and Discharge Criteria for Psychiatric Inpatient Units of General Hospitals

I.D. No. OMH-04-24-00006-RP

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following revised rule:

Proposed Action: Amendment of Part 580 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.07, 7.09, 29.15, 31.04, 43.02; Social Services Law, sections 364 and 364-a

Subject: Admission and Discharge Criteria for Psychiatric Inpatient Units of General Hospitals.

Purpose: To standardize admissions and discharges.

Substance of revised rule (Full text is posted at the following State website: https://omh.ny.gov/omhweb/policy_and_regulations/): Part 580

In addition to technical amendments updating this regulation consistent with Title 14 and eliminating outdated terminology, the Proposed Rule amends Part 580 as follows:

Part 580.1. Background and Intent. Provides that it is the intention of this Part to provide for a person-centered process and that compliance with this Part shall ensure that services are collaborative in nature.

Part 580.2. Legal Base. No substantive edits.

Part 580.3. Definitions. Includes removing outdated references to behavioral health organizations and defines Managed Care (MCO), removes definition for concurrent review and defines utilization review. Provides uniform definition of Collateral, Credentialed Alcoholism and Substance Abuse Counselor (CASAC), creates a new definition of Individual with Complex Needs, Governing Body, Interventional Therapies, defines Intensive care management. Provides definitions for person-centered process, psychiatric advance directive, PSYCKES, shared decision making and SHIN-NY.

Part 580.4. Certification. No substantive edits.

Part 580.5. Organization and administration. Clarifies that policies and procedures must conform with confidentiality. Clarifies policies ensuring patient rights. Clarifies education programming requirements for school age children.

Part 580.6. Program.

-Clarifies that services shall be provided through a person-centered process with shared decision making and should be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals.

-When an individual is admitted clinical staff shall in accordance with HIPAA and Mental Hygiene Law 33.13: review documentation of assessments, treatment, and other services provided in referring outpatient, emergency, or program and prior presentations; attempt to obtain collateral information on all admitted individuals; review information in PSYCKES regarding prior psychiatric and medical history; review information in any other available information network databases as may be required, regarding admitted individuals; and check to see if the individual has a Psychiatric Advance Directive (PAD) or other wellness plan and preferred contacts in PSYCKES.

-The following screenings shall take place on admission and documented in the individual's chart: suicide risk using a validated instrument, violence risk screening and assessment and inquiries about access to firearms or other weapons, substance use screenings using a validated instrument and a determination shall be made as to whether an individual has complex needs.

-Discharge plans shall reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. For discharges of individuals with complex needs, the discharging unit shall provide a verbal clinical sign-out to the receiving outpatient treatment program and residential or other long-term care program on the day of discharge, or as soon as possible thereafter in accordance with section 33.13 of the Mental Hygiene Law. Prior to discharge, the hospital shall contact aftercare providers to schedule and confirm a follow up appointment to occur within seven calendar days following discharge. Where a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, after documenting diligent efforts, such appointment should be scheduled for as soon as possible. Individuals with complex needs enrolled in outpatient or residential care management, must coordinate discharge plan details and timing with care managers. For individuals in need of intensive care management, staff shall make a referral to an intensive care management provider. All individuals shall be screened for suicidality prior to their discharge. When determining whether an individual is ready for discharge and the most appropriate discharge setting, the whole clinical presentation and history, as well as the availability of existing services in the individual's community, shall be considered. Individuals who meet criteria for any substance use disorder shall be offered pharmacological interventions, if appropriate, and referred to a new or existing provider who can continue their treatment for their substance use disorder. Individuals who require treatment with an antipsychotic medication but have history of difficulty with consistently taking oral medications, shall be considered through shared decision making, for treatment with a long-acting injectable medication.

Part 580.7. Staffing. No substantive edits.

Part 580.8. Premises. Clarifies Electroconvulsive therapy (ECT) may not be used as an emergency procedure. Clarifies existing rule that no facility shall use restraint or seclusion without a written plan for the use of

restraint or seclusion in accordance with section 526.4 of this Title. No facility shall use extraordinary risk procedures. Extraordinary risk procedures include, but are not limited to, experimental treatment modalities and aversive conditioning.

Part 580.9. Records and Statistics. Clarifies case records should include: a record of communication with family, outpatient providers, and other significant sources of collateral information; notes which relate to special circumstances and untoward incidents including but not limited to, the use of any seclusion or restraints; documentation of any referrals within the hospital or to another agency; and documentation of voluntary or involuntary status and other information as requested by the Office.

Part 580.10. Community Relations. No substantive edits.

Part 580.11 Managed Care Organizations. Conforming edits relating to outdated language.

Revised rule compared with proposed rule: Substantial revisions were made in sections 580.3(e), 580.6(b)(6), (5)(vi) and (c)(3).

Text of revised proposed rule and any required statements and analyses may be obtained from Sara Paupini, Office of Mental Health, 44 Holland Ave., Albany, NY 12229, (518) 474-1331, email: regs@omh.ny.gov

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Revised Regulatory Impact Statement

1. Statutory Authority: Section 7.07(c) of the Mental Hygiene Law charges the Office of Mental Health with the responsibility for seeing that persons with mental illness are provided with care and treatment, and that such care, treatment and rehabilitation is of high quality and effectiveness.

Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under their jurisdiction, and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children diagnosed with emotional disturbance, pursuant to an operating certificate.

Section 43.02 of the Mental Hygiene Law gives the Commissioner the authority to request from operators of facilities licensed by the Office of Mental Health such financial, statistical and program information as the Commissioner may determine to be necessary.

Sections 364 and 364-a of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for medical care and services in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

Section 29.15 of the Mental Hygiene Law establishes requirements for the discharge or conditional release of patients from hospitals operated by the Office of Mental Health or from psychiatric inpatient services subject to licensure by this office.

2. Legislative Objectives: Articles 7 and 31 of the Mental Hygiene Law reflect the Commissioner's authority to establish regulations regarding mental health programs. The proposed rule furthers the legislative policy of providing high quality inpatient mental health services to individuals with mental illness and to require evidence based screenings to take place on admission and to require comprehensive discharge plans. Part 580 of Title 14 NYCRR sets forth standards for the certification, operation and organization of psychiatric inpatient units of general hospitals serving children and adults.

3. Needs and Benefits: The proposed rule will require that inpatient psychiatric units of general hospitals follow comprehensive standards for admission and discharge of individuals from psychiatric inpatient units. These amendments were considered after a multi-year quality collaborative with hospitals (the High Risk Quality Collaborative) developed consensus statements to reduce the risk of suicide, violence, and opioid overdose and extensive outreach to hospitals, ambulatory community providers and other stakeholders leading to the development of a guidance document which was shared with the field for comment. Pursuant to the Commissioner's general oversight of persons with mental illness to ensure those individuals are provided with care, treatment and rehabilitation is of a high quality and effectiveness, these changes were necessary to ensure the proper and appropriate delivery of services through fostering linkages with community care providers. These changes ensure that treatment will be provided with more of a person-centered approach, leading to more accurate treatment and successful discharges that allow individuals to prolong community tenure. The proposed rule will add new requirements for comprehensive screenings of suicide, violence, and substance use and provides a definition for complex needs. These evaluations and standards for admission, coordination with community providers, and discharge planning should help improve patient outcomes; reduce the risk of post-discharge overdose, self-harm, and violence; and reduce the risk of readmission and disconnection from care.

These amendments include provisions to: remove outdated references

to behavioral health organizations and define Managed Care (MCO), remove definition for concurrent review and define utilization review. It provides uniform definition of Collateral, Credentialed Alcoholism and Substance Abuse Counselor (CASAC), creates a new definition of Individual with Complex Needs, Governing Body, Interventional Therapies, and defines Intensive care management. The rule provides definitions for person-centered process, psychiatric advance directive, PSYCKES, shared decision making and SHIN-NY. It clarifies that policies and procedures must conform with confidentiality, clarifies that services shall be provided through a person-centered process with shared decision making and should be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals. The proposal provides admission requirements which shall include an enhanced review of documentation including assessments, treatment, and other services provided in referring outpatient, emergency, or program and prior presentations; collateral information in PSYCKES and any other available information network and a review to see if the individual has a Psychiatric Advance Directive (PAD) or other wellness plan and preferred contacts in PSYCKES. Screenings on admission and documented in the individual's chart will include: suicide risk using a validated instrument, violence risk screening and assessment and inquiries about access to firearms or other weapons, substance use screenings using a validated instrument and a determination shall be made as to whether an individual has complex needs. Discharge plans shall reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. Enhanced discharge procedures for discharges of individuals with complex needs, including communications with the receiving outpatient treatment program and residential or other long-term care program on the day of discharge, contact with aftercare providers to schedule and confirm a follow up appointment to occur within seven calendar days following discharge. Individuals with complex needs enrolled in outpatient or residential care management, must coordinate discharge plan details and timing with care managers.

4. Costs:

(a) Cost to State government: These regulatory amendments will not result in any additional costs to the State government. Hospitals already have staff that are responsible for conducting evaluation and treatment, doing discharge planning, and maintaining relationships with community agencies. These proposed regulations will not add a requirement for further staff; they clarify and standardize what is already expected of staff. Facilities can use the same electronic medical records they currently use.

(b) Cost to local government: These regulatory amendments will not result in any additional costs to local government.

(c) Cost to regulated parties: These regulatory amendments will not result in any additional costs to those regulated parties.

5. Local Government Mandates: These regulatory amendments will not result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. Paperwork: No substantial increase in paperwork is anticipated as a result of the amendments to 14 NYCRR Part 580. Hospitals have staff that are responsible for conducting evaluation and treatment, doing discharge planning, and maintaining relationships with community agencies. These proposed regulations clarify and standardize what is already expected of staff. Facilities can use the same electronic medical records they currently use.

7. Duplication: These regulatory amendments do not duplicate existing State or federal requirements.

8. Alternatives: No alternatives were considered, as these amendments seek to ensure that psychiatric inpatient settings provide safe, comprehensive, and evidence based treatment. These amendments were considered after a multi-year quality collaborative with hospitals (the High Risk Quality Collaborative) developed consensus statements to reduce the risk of suicide, violence, and opioid overdose and extensive outreach to hospitals, ambulatory community providers, and other stakeholders leading to the development of a guidance document which was shared with the field for comment. Pursuant to the Commissioner's general oversight of persons with mental illness to ensure those individuals are provided with care, treatment and rehabilitation is of a high quality and effectiveness, these changes were necessary to ensure the proper and appropriate delivery of services through fostering linkages with community care providers. These changes ensure that treatment will be provided with more of a person-centered approach, leading to more accurate treatment and successful discharges that allow individuals to prolong community tenure. New standards for discharge planning will ensure that individuals will be discharged to an appropriate setting according to their needs. Discharge planning will include confirmed, scheduled outpatient appointments. For individuals with complex needs and who have a care manager, inpatient staff will coordinate plan details and timing with care managers. All individuals should be referred for outpatient mental health services which are person-

centered, recovery-oriented designed to help individuals achieve and maintain recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community. New standards for discharge planning will ensure that individuals will be discharged to an appropriate setting according to their needs. Discharge planning will include confirmed, scheduled outpatient appointments. For individuals with complex needs and who have a care manager, inpatient staff will coordinate plan details and timing with care managers. All individuals should be referred for outpatient mental health services which are person-centered, recovery-oriented designed to help individuals achieve and maintain recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community.

9. Federal Standards: The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance Schedule: This rulemaking will be effective upon publication of a Notice of Adoption in the State Register.

Revised Regulatory Flexibility Analysis

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or other governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

Revised Rural Area Flexibility Analysis

The amendments to Part 580.14 NYCRR will require that inpatient psychiatric units of general hospitals follow comprehensive standards for admission and discharge of patients from psychiatric inpatient units. The proposed rule will add new requirements for evidence-based standards for screenings and creates standards for safe discharges. The amendments will not impose any adverse economic impact on rural areas; therefore, a Rural Flexibility Analysis is not submitted with this notice.

Revised Job Impact Statement

A job impact statement is not needed as this proposed rule requires that inpatient units of general hospitals follow comprehensive standards for admission and discharge of patients from psychiatric inpatient units in an effort to coordinate appropriate care and reduce the amount of unnecessary and reoccurring visits. There will be no adverse impact on jobs and employment opportunities as a result of the proposed amendments to 14 NYCRR Part 580.

Assessment of Public Comment

This summary reflects the responses of the New York State Office of Mental Health (OMH) to the main comments submitted by the public regarding the adoption of amendments to 14 NYCRR Part 580. The proposed rule furthers the legislative policy of providing high quality inpatient mental health services to individuals with mental illness and to require standard screenings and assessments to take place on admission, require active coordination with community and residential providers, and to require comprehensive discharge plans. The proposed rulemaking was published in the January 24, 2024, State Register on page 18 (Issue #24). The public comment period ended March 25, 2024.

During preparation of the revised rule making, OMH incorporated suggestions made by the public based on the comments received. A full Assessment of Public Comment is available for review on the OMH website.

Highlights of the public comments received include:

Requesting a revision to the definition of Individual with Complex Needs due to several commentors finding the proposed definition overbroad. In response to these comments the Office has revised this definition to narrow the scope and ease the identification of individuals identified under this definition.

Comments stating the requirement to review other sources of information where available presents challenges for hospitals and is not useful for clinical decision making purposes. The Office clarified that the regulation only obligates staff to check available databases. If front end staff do not have access to SHIN-NY, then there is no obligation to check such network. The Office respectfully disagrees with the assertion that such verification is not clinically useful. The ability to view any relevant background information about the individual will assist in coordinating discharge planning and ensures staff receives the most accurate background of the presenting individual.

A Commentor noted that the requirements of these regulations should extend to non-hospital providers and payers to avoid communication gaps and support timely information sharing. Proposed guidance relating to this

concern has been developed and has been released to stakeholders for further feedback. These will inform any proposed rulemaking issued by the Office.

A Commentor stated that the follow up care appointment requirements are a challenge for the system, and expressed concern about the proposed regulation as it relates to scheduling and confirming follow-up appointments within 7 days before discharge, particularly for weekend or evening discharges. The Office stated that communicating with outpatient, care coordination and residential providers is the current standard. Existing regulation requires licensed mental health clinics to offer appointments to individuals leaving hospitals within 5 days of discharge. The proposed network adequacy requirement is 10 days and applies to all patients, including those not presently admitted to hospitals or in CPEPs. For individuals admitted to hospitals or in CPEPs, the Office strongly believes they need to be seen within 7 days. Some flexibility is provided for within the regulation, which provides that after making diligent efforts, where a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the hospital should document its efforts and schedule the appointment for as soon as possible thereafter.

A Commentor expressed concerns that the violence screening assessment will encourage the finding of non-existent violent tendencies and have a disproportionate effect on certain populations. The Office has reviewed the comment and find the amendment to be unnecessary as the rule presently provides that all services must be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals. Additional information will be provided through guidance.

REVISED RULE MAKING NO HEARING(S) SCHEDULED

Admission and Discharge Criteria for Comprehensive Psychiatric Emergency Programs

I.D. No. OMH-04-24-00007-RP

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following revised rule:

Proposed Action: Amendment of Part 590 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.07, 7.09, 29.15, 31.04, 43.02; Social Services Law, sections 364 and 364-a

Subject: Admission and Discharge Criteria for Comprehensive Psychiatric Emergency Programs.

Purpose: To standardize admissions and discharges.

Substance of revised rule (Full text is posted at the following State website: https://omh.ny.gov/omhweb/policy_and_regulations/): Part 590

In addition to technical amendments updating this regulation consistent with Title 14 and eliminating outdated terminology, the Proposed Rule amends Part 590 as follows:

Part 590.1. Background and Intent. Provides that it is the intention of this Part to provide for a person-centered process and that compliance with this Part shall ensure that services are collaborative in nature.

Part 590.2. Legal Base. No substantive edits.

Part 590.3. Applicability. No substantive edits.

Part 590.4. Definitions. Includes removing outdated references to behavioral health organizations and defines Managed Care (MCO), removes definition for concurrent review and defines utilization review. Provides uniform definition of Collateral, Credentialed Alcoholism and Substance Abuse Counselor, (CASAC), certified recovery peer advocate, certified or credentialed family peer advocate, certified or credentialed youth peer advocate, creates a new definition of Individual with Complex Needs, Governing Body, Interventional Therapies, defines Intensive care management. Provides definitions for person-centered process, psychiatric advance directive, PSYCKES, shared decision making and SHIN-NY.

Part 590.5. Certification. No substantive edits.

Part 590.6. Organization and administration. Clarifies that services may not be denied individuals solely on the basis of multiple diagnoses or a diagnosis of HIV infection, other chronic medical comorbidity, history of suicide attempt, history of violence, criminal and juvenile justice system involvement, personality disorder, substance use disorder, or intellectual or developmental disability.

Part 590.7. Emergency service plan. Clarifies that the total number of extended observation beds must be approved by the office.

Part 590.8. Admission and discharge procedures.

-Clarifies that services shall be provided through a person-centered process with shared decision making and should be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment

and discharge planning of Black, Indigenous, People of Color and other marginalized individuals.

-Clarifies that any person receiving a triage and referral visit must be examined by a staff physician or psychiatric nurse practitioner within six hour after being received into the CPEP.

-When an individual is admitted clinical staff shall in accordance with HIPAA and Mental Hygiene Law 33.13: review documentation of assessments, treatment, and other services provided in referring outpatient, emergency, or program and prior presentations; attempt to obtain collateral information on all admitted individuals unless the presentation is due to a non-emergent reason; review information in PSYCKES regarding prior psychiatric and medical history; review information in any other available information network databases regarding admitted individuals; and check to see if the individual has a Psychiatric Advance Directive (PAD) or other wellness plan and preferred contacts in PSYCKES.

-The following screenings shall take place on admission and documented in the individual's chart: suicide risk using a validated instrument, violence risk screening and assessment and inquiries about access to firearms or other weapons, substance use screenings using a validated instrument and a determination shall be made as to whether an individual has complex needs.

-Discharge plans shall reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. When determining whether an individual is ready for discharge the whole clinical presentation and history, as well as the availability of existing services and supports in the individual's community, must be considered. This includes if an individual resides in a residential program licensed by the office or supportive housing. The discharge plan shall be developed through shared decision making in a person-centered process and must reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. For discharges of individuals with complex needs, the CPEP must provide a verbal clinical sign-out to the receiving outpatient treatment program and the residential program licensed or funded by the office or Office of Addiction Services and Supports, Office for Persons with Developmental Disabilities or the Department of Health where the individual will reside after discharge. The CPEP must send a discharge summary detailing the presenting history of present illness (HPI), hospital course, and other relevant information to the outpatient, residential, or long-term care program within seven days of discharge, in accordance with section 33.13 of the Mental Hygiene Law. If the individual is enrolled in outpatient, residential care management, or has an active AOT order, CPEP staff must coordinate discharge plan details and timing with care managers. Prior to discharge, and in accordance with section 33.13 of the Mental Hygiene Law, the CPEP shall schedule and confirm a follow up appointment with an identified provider to occur within seven calendar days following discharge or document such efforts and secure an appointment for as soon as possible thereafter. A referral to a walk-in intake clinic is insufficient to meet this requirement. When an appointment for mental health services cannot be made within seven calendar days, crisis outreach teams or other available comprehensive psychiatric emergency program staff shall provide crisis outreach until the initial appointment occurs and such services shall be reimbursed pursuant to section 591.4 of this Title. All individuals must be screened for suicidality prior to their discharge. Discharge of individuals with an elevated risk of violence must include, to every extent possible, close collaboration with current and new outpatient treatment providers, residential providers if applicable, and the county DCS if applicable to incorporate strategies to address violence risk factors and access to weapons into the overall discharge plan in accordance with section 33.13 of the Mental Hygiene Law. Individuals who meet criteria for any substance use disorder shall be offered pharmacological interventions, if appropriate, and referred to a new or existing provider who can continue treatment for their substance use disorder.

Part 590.9. Services. Clarifies that if a triage and referral visit is not conducted, a full emergency service shall be performed.

Part 590.10. Staffing. Clarifies when providing crisis outreach at a site other than the emergency room of the comprehensive psychiatric emergency program a member of the professional staff may respond alone if such need is determined for an initial crisis outreach visit. For crisis outreach provided as a follow up to an initial crisis outreach visit or CPEP admission, a member of the staff may respond alone if such need is determined. This service may be provided by professional staff, staff possessing a bachelor's degree or staff with a peer certification or credential working within their scope of practice.

Part 590.11. Special treatment procedures. No substantive edits.

Part 590.12. Case records. Clarifies that peer specialists, recovery peer advocates, family peer advocate or youth peer advocate may have access to case records. Clarifies that housing providers should be attempted to be contacted as part of collateral documentation.

Part 590.13. Premises. Provides that extended observation beds may be

located outside the CPEP upon authorization by the Office of Mental Health.

Part 590.14. Statistical records and reports. No substantive edits.

Revised rule compared with proposed rule: Substantial revisions were made in sections 590.4(a)(2), (b)(7), 590.7(b)(5), 590.8(f)(3), (4) and (h)(2).

Text of revised proposed rule and any required statements and analyses may be obtained from Sara Paupini, Office of Mental Health, 44 Holland Ave., Albany, NY 12229, (518) 474-1331, email: regs@omh.ny.gov

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Revised Regulatory Impact Statement

1. Statutory Authority: Section 7.07(c) of the Mental Hygiene Law charges the Office of Mental Health with the responsibility for seeing that persons with mental illness are provided with care and treatment, and that such care, treatment and rehabilitation is of high quality and effectiveness.

Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under their jurisdiction, and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children diagnosed with emotional disturbance, pursuant to an operating certificate.

Section 43.02 of the Mental Hygiene Law gives the Commissioner the authority to request from operators of facilities licensed by the Office of Mental Health such financial, statistical and program information as the Commissioner may determine to be necessary.

Sections 364 and 364-a of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for medical care and services in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

Section 29.15 of the Mental Hygiene Law establishes requirements for the discharge or conditional release of patients from hospitals operated by the Office of Mental Health or from psychiatric inpatients services subject to licensure by this office.

2. Legislative Objectives: Articles 7 and 31 of the Mental Hygiene Law reflect the Commissioner's authority to establish regulations regarding mental health programs. The proposed rule furthers the legislative policy of providing high quality inpatient mental health services to individuals with mental illness and to require standard screenings and assessments to take place on admission, require active coordination with community and residential providers, and to require comprehensive discharge plans. Part 590 of Title 14 NYCRR sets forth standards for the certification, operation and organization of comprehensive psychiatric emergency programs (CPEP).

3. Needs and Benefits: The proposed rule will require that CPEPs follow comprehensive standards for admission and discharge of individuals. These amendments were considered after a multi-year quality collaborative with hospitals (the High Risk Quality Collaborative) developed consensus statements to reduce the risk of suicide, violence, and opioid overdose and extensive outreach to hospitals, ambulatory community providers and other stakeholders leading to the development of a guidance document which was shared with the field for comment. Pursuant to the Commissioner's general oversight of persons with mental illness to ensure those individuals are provided with care, treatment and rehabilitation is of a high quality and effectiveness, these changes were necessary to ensure the proper and appropriate delivery of services through fostering linkages with community care providers. These changes ensure that treatment will be provided with more of a person-centered approach, leading to more accurate treatment and successful discharges that allow individuals to prolong community tenure.

The proposed rule will remove outdated references to behavioral health organizations and defines Managed Care (MCO), removes the definition for concurrent review and defines utilization review. The rule provides uniform definitions of Collateral, Credentialed Alcoholism and Substance Abuse Counselor, (CASAC), certified recovery peer advocate, certified or credentialed family peer advocate, certified or credentialed youth peer advocate; creates a new definition of Individual with Complex Needs, Governing Body, Interventional Therapies, and Intensive care management. The rule also provides definitions for person-centered process, psychiatric advance directive, PSYCKES, shared decision making and SHIN-NY and clarifies that services shall be provided through a person-centered process with shared decision making and should be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals. The proposal clarifies that any person receiving a triage and referral visit must be examined by a staff physician or psychiatric nurse practitioner within six hour after being

received into the CPEP. It provides admission requirements which shall include an enhanced review of documentation including assessments, treatment, and other services provided in referring outpatient, emergency, or program and prior presentations; collateral information in PSYCKES and any other available information network and a review to see if the individual has a Psychiatric Advance Directive (PAD) or other wellness plan and preferred contacts in PSYCKES. Screenings on admission and documented in the individual's chart will include: suicide risk using a validated instrument, violence risk screening and assessment and inquiries about access to firearms or other weapons, substance use screenings using a validated instrument and a determination shall be made as to whether an individual has complex needs. When determining whether an individual is ready for discharge the whole clinical presentation and history, as well as the availability of existing services and supports in the individual's community, must be considered. This includes if an individual resides in a residential program licensed by the office or supportive housing. The discharge plan shall be developed through shared decision making in a person-centered process and must reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. For discharges of individuals with complex needs, the CPEP must provide a verbal clinical sign-out to the receiving outpatient treatment program and the residential or long-term care program licensed or funded by the office or another office within the department or the Department of Health where the individual will reside.

If the individual is enrolled in outpatient, residential care management, or has an active AOT order, CPEP staff must coordinate discharge plan details and timing with care managers. MCO must be notified prior to discharge, of individuals with complex needs who are eligible but not yet enrolled, or who are in need of care management or intensive care management. Prior to discharge, and in accordance with section 33.13 of the Mental Hygiene Law, the CPEP shall schedule and confirm a follow up appointment with an identified provider to occur within seven calendar days following discharge or document such efforts and secure an appointment for as soon as possible thereafter. A referral to a walk-in intake clinic is insufficient to meet this requirement. When an appointment for mental health services cannot be made within seven calendar days, crisis outreach teams or other available comprehensive psychiatric emergency program staff shall provide crisis outreach until the initial appointment occurs and such services shall be reimbursed pursuant to section 591.4 of Title 14. All individuals must be screened for suicidality prior to their discharge. Individuals who meet criteria for any substance use disorder shall be offered pharmacological interventions, if appropriate, and referred to a new or existing provider who can continue treatment for their substance use disorder. Individuals who require treatment with an antipsychotic medication but have history of difficulty with consistently taking oral medications, shall be considered for treatment, through shared decision making, with a long-acting injectable medication. The proposal also clarifies that if a triage and referral visit is not conducted, a full emergency service shall be performed and that when providing crisis outreach at a site other than the emergency room of the comprehensive psychiatric emergency program a member of the professional staff may respond alone if such need is determined for an initial crisis outreach visit. For crisis outreach provided as a follow up to an initial crisis outreach visit or CPEP admission, a member of the staff may respond alone if such need is determined. This service may be provided by professional staff, staff possessing a bachelor's degree or staff with a peer certification or credential working within their scope of practice.

4. Costs:

(a) Cost to State government: These regulatory amendments will not result in any additional costs to the State government. CPEP's already have staff that are responsible for conducting evaluation and treatment, doing discharge planning, and maintaining relationships with community agencies. These proposed regulations will not add a requirement for further staff; they clarify and standardize what is already expected of staff. Facilities can use the same electronic medical records they currently use.

(b) Cost to local government: These regulatory amendments will not result in any additional costs to local government.

(c) Cost to regulated parties: These regulatory amendments will not result in any additional costs to those regulated parties.

5. Local Government Mandates: These regulatory amendments will not result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. Paperwork: No substantial increase in paperwork is anticipated as a result of the amendments to 14 NYCRR Part 590. CPEPs have staff that are responsible for conducting evaluation and treatment, doing discharge planning, and maintaining relationships with community agencies. These proposed regulations clarify and standardize what is already expected of staff. Facilities can use the same electronic medical records they currently use.

7. Duplication: These regulatory amendments do not duplicate existing State or federal requirements.

8. Alternatives: No alternatives were considered, as these amendments seek to ensure that CPEPs provide safe, comprehensive, and evidence based treatment. These amendments were considered after a multi-year quality collaborative with hospitals (the High Risk Quality Collaborative) developed consensus statements to reduce the risk of suicide, violence, and opioid overdose and extensive outreach to hospitals, ambulatory community providers, and other stakeholders leading to the development of a guidance document which was shared with the field for comment. Pursuant to the Commissioner's general oversight of persons with mental illness to ensure those individuals are provided with care, treatment and rehabilitation is of a high quality and effectiveness, these changes were necessary to ensure the proper and appropriate delivery of services through fostering linkages with community care providers. These changes ensure that treatment will be provided with more of a person-centered approach, leading to more accurate treatment and successful discharges that allow individuals to prolong community tenure. New standards for discharge planning will ensure that individuals will be discharged to an appropriate setting according to their needs. Discharge planning will include confirmed, scheduled outpatient appointments. For individuals with complex needs and who have a care manager, inpatient staff will coordinate plan details and timing with care managers. All individuals should be referred for outpatient mental health services which are person-centered, recovery-oriented designed to help individuals achieve and maintain recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community.

9. Federal Standards: The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance Schedule: This rulemaking will be effective upon publication of a Notice of Adoption in the State Register.

Revised Regulatory Flexibility Analysis

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

Revised Rural Area Flexibility Analysis

The amendments to Part 590 of title 14 NYCRR will require that operation of comprehensive psychiatric emergency programs follow comprehensive standards for admission and discharge of patients. The proposed rule will add new requirements for evidence-based standards for screenings and creates standards for safe discharges. The amendments will not impose any adverse economic impact on rural areas; therefore, a Rural Flexibility Analysis is not submitted with this notice.

Revised Job Impact Statement

A job impact statement is not needed as this proposed rule requires that comprehensive psychiatric emergency programs follow comprehensive standards for admission and discharge of patients in an effort to coordinate appropriate care and reduce the amount of unnecessary and reoccurring visits. There will be no adverse impact on jobs and employment opportunities as a result of the proposed amendments to 14 NYCRR Part 590.

Assessment of Public Comment

Part 590 Summary of the Assessment of Public Comment

This summary reflects the responses of the New York State Office of Mental Health (OMH) to the main comments submitted by the public regarding the adoption of amendments to 14 NYCRR Part 590. The proposed rule furthers the legislative policy of providing high quality inpatient mental health services to individuals with mental illness and to require standard screenings and assessments to take place on admission, require active coordination with community and residential providers, and to require comprehensive discharge plans. The proposed rulemaking was published in the January 24, 2024, State Register on page 18 (Issue #24). The public comment period ended March 25, 2024.

During preparation of the revised rule making, OMH incorporated suggestions made by the public based on the comments received. A full Assessment of Public Comment is available for review on the OMH website.

Highlights of the public comments received include:

- Requesting a revision to the definition of Individual with Complex Needs due to several commentors finding the proposed definition overbroad. In response to these comments the Office has revised this definition to narrow the scope and ease the identification of individuals identified under this definition.
- Comments stating the requirement to review other sources of information where available presents challenges for hospitals and is not useful for clinical decision making purposes. The Office clarified that the regula-

tion only obligates staff to check available databases. If front end staff do not have access to SHIN-NY, then there is no obligation to check such network. The Office respectfully disagrees with the assertion that such verification is not clinically useful. The ability to view any relevant background information about the individual will assist in coordinating discharge planning and ensures staff receives the most accurate background of the presenting individual.

- A Commentor noted that the requirements of these regulations should extend to non-hospital providers and payers to avoid communication gaps and support timely information sharing. Proposed guidance relating to this concern has been developed and has been released to stakeholders for further feedback. These will inform any proposed rulemaking issued by the Office.

- A Commentor stated that the follow up care appointment requirements are a challenge for the system, and expressed concern about the proposed regulation as it relates to scheduling and confirming follow-up appointments within 7 days before discharge, particularly for weekend or evening discharges. The Office stated that communicating with outpatient, care coordination and residential providers is the current standard. Existing regulation requires licensed mental health clinics to offer appointments to individuals leaving hospitals within 5 days of discharge. The proposed network adequacy requirement is 10 days and applies to all patients, including those not presently admitted to hospitals or in CPEPs. For individuals admitted to hospitals or in CPEPs, the Office strongly believes they need to be seen within 7 days. Some flexibility is provided for within the regulation, which provides that after making diligent efforts, where a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the hospital should document its efforts and schedule the appointment for as soon as possible thereafter.

- A Commentor expressed concerns that the violence screening assessment will encourage the finding of non-existent violent tendencies and have a disproportionate effect on certain populations. The Office has reviewed the comment and find the amendment to be unnecessary as the rule presently provides that all services must be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals. Additional information will be provided through guidance.

- A Commentor stated the proposed regulation should require outreach to homeless shelters or local agency that oversees homeless shelters for people who report that they reside in a shelter, and should require the determination of housing status prior to discharge. The Office has reviewed the comment and finds the amendments to be unnecessary as the proposed regulations the discharge plan will be developed through shared decision making in a person-centered process and reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs.

REVISED RULE MAKING NO HEARING(S) SCHEDULED

Admission and Discharge Criteria for Hospitals for Persons with Mental Illness

I.D. No. OMH-04-24-00008-RP

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following revised rule:

Proposed Action: Amendment of Part 582 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.07, 7.09, 29.15, 31.04, 43.02; Social Services Law, sections 364 and 364-a

Subject: Admission and Discharge Criteria for Hospitals for Persons with Mental Illness.

Purpose: To standardize admissions and discharges.

Substance of revised rule (Full text is posted at the following State website: https://omh.ny.gov/omhweb/policy_and_regulations/): Part 582

In addition to technical amendments updating this regulation consistent with Title 14 and eliminating outdated terminology, the Proposed Rule amends Part 582 as follows:

Part 582.1. Background and Intent. Provides that it is the intention of this Part to provide for a person-centered process and that compliance with this Part shall ensure that services are collaborative in nature.

Part 582.2. Legal Base. Removes references to Social Services Law § 365m.

Part 582.3. Definitions. Includes removing outdated references to behavioral health organizations and defines Managed Care (MCO), removes definition for concurrent review and defines utilization review. Provides uniform definition of Collateral, Credentialed Alcoholism and

Substance Abuse Counselor (CASAC), creates a new definition of Individual with Complex Needs, Governing Body, Interventional Therapies, defines Intensive care management. Provides definitions for person-centered process, psychiatric advance directive, PSYCKES, shared decision making and SHIN-NY.

Part 582.4. Certification. No substantive edits.

Part 582.5. Organization and administration. Clarifies that policies and procedures must conform with confidentiality. Clarifies policies ensuring patient rights. Clarifies education programming requirements for school age children.

Part 582.6. Program.

- Clarifies that services shall be provided through a person-centered process with shared decision making and should be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals.

- When an individual is admitted clinical staff shall in accordance with HIPAA and Mental Hygiene Law 33.13: review documentation of assessments, treatment, and other services provided in referring outpatient, emergency, or program and prior presentations; attempt to obtain collateral information on all admitted individuals; review information in PSYCKES regarding prior psychiatric and medical history; review information in any other available information network databases regarding admitted individuals; and check to see if the individual has a Psychiatric Advance Directive (PAD) or other wellness plan and preferred contacts in PSYCKES.

- The following screenings shall take place on admission and documented in the individual's chart: suicide risk using a validated instrument, violence risk screening and assessment and inquiries about access to firearms or other weapons, substance use screenings using a validated instrument and a determination shall be made as to whether an individual has complex needs.

- Discharge plans shall reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. For discharges of individuals with complex needs, the discharging unit shall provide a verbal clinical sign-out to the receiving outpatient treatment program and residential or other long-term care program on the day of discharge, or as soon as possible thereafter in accordance with section 33.13 of the Mental Hygiene Law. Prior to discharge, the hospital shall contact aftercare providers to schedule and confirm a follow up appointment to occur within seven calendar days following discharge. Where a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, after documenting diligent efforts, such appointment should be scheduled for as soon as possible. Individuals with complex needs enrolled in outpatient or residential care management, must coordinate discharge plan details and timing with care managers. For individuals in need of intensive care management, staff shall make a referral to an intensive care management provider. All individuals shall be screened for suicidality prior to their discharge. When determining whether an individual is ready for discharge and the most appropriate discharge setting, the whole clinical presentation and history, as well as the availability of existing services in the individual's community, shall be considered. Individuals who meet criteria for any substance use disorder shall be offered pharmacological interventions, if appropriate, and referred to a new or existing provider who can continue their treatment for their substance use disorder. Individuals who require treatment with an antipsychotic medication but have history of difficulty with consistently taking oral medications, shall be considered through shared decision making, for treatment with a long-acting injectable medication.

Part 582.7. Staffing. No substantive edits.

Part 582.8. Premises. Clarifies Electroconvulsive therapy (ECT) may not be used as an emergency procedure. Clarifies existing rule that no facility shall use restraint or seclusion without a written plan for the use of restraint or seclusion in accordance with section 526.4 of this Title. No facility shall use extraordinary risk procedures. Extraordinary risk procedures include, but are not limited to, experimental treatment modalities and aversive conditioning.

Part 582.9. Records and Statistics. Clarifies case records should include: a record of communication with family, outpatient providers, and other significant sources of collateral information; notes which relate to special circumstances and untoward incidents including but not limited to, the use of any seclusion or restraints; documentation of any referrals within the hospital or to another agency; and documentation of voluntary or involuntary status and other information as requested by the Office.

Part 582.10. Community Relations. No substantive edits.

Part 582.11 Managed Care Organizations. Conforming edits relating to outdated language.

Revised rule compared with proposed rule: Substantial revisions were made in sections 582.3(g), 582.6(b)(4)(vi), (5), (c)(3) and (9).

Text of revised proposed rule and any required statements and analyses may be obtained from Sara Paupini, Office of Mental Health, 44 Holland Ave., Albany, NY 12229, (518) 474-1331, email: regs@omh.ny.gov

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Revised Regulatory Impact Statement

1. **Statutory Authority:** Section 7.07(c) of the Mental Hygiene Law charges the Office of Mental Health with the responsibility for seeing that persons with mental illness are provided with care and treatment, and that such care, treatment and rehabilitation is of high quality and effectiveness.

Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under their jurisdiction, and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children diagnosed with emotional disturbance, pursuant to an operating certificate.

Section 43.02 of the Mental Hygiene Law gives the Commissioner the authority to request from operators of facilities licensed by the Office of Mental Health such financial, statistical and program information as the Commissioner may determine to be necessary.

Sections 364 and 364-a of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for medical care and services in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

Section 29.15 of the Mental Hygiene Law establishes requirements for the discharge or conditional release of patients from hospitals operated by the Office of Mental Health or from psychiatric inpatient services subject to licensure by this office.

2. **Legislative Objectives:** Articles 7 and 31 of the Mental Hygiene Law reflect the Commissioner's authority to establish regulations regarding mental health programs. The proposed rule furthers the legislative policy of providing high quality inpatient mental health services to individuals with mental illness and to require standard screenings and assessments to take place on admission, require active coordination with community and residential providers, and to require comprehensive discharge plans. Part 582 of Title 14 NYCRR sets forth standards for the certification, operation and organization of psychiatric inpatient hospitals.

3. **Needs and Benefits:** The proposed rule will require that freestanding psychiatric facilities, certified by the Office of Mental Health will follow comprehensive standards for admission and discharge of individuals. These amendments were considered after a multi-year quality collaborative with hospitals (the High Risk Quality Collaborative) developed consensus statements to reduce the risk of suicide, violence, and opioid overdose and extensive outreach to hospitals, ambulatory community providers and other stakeholders leading to the development of a guidance document which was shared with the field for comment. Pursuant to the Commissioner's general oversight of persons with mental illness to ensure those individuals are provided with care, treatment and rehabilitation is of a high quality and effectiveness, these changes were necessary to ensure the proper and appropriate delivery of services through fostering linkages with community care providers. These changes ensure that treatment will be provided with more of a person-centered approach, leading to more accurate treatment and successful discharges that allow individuals to prolong community tenure. The proposed rule will add new requirements for comprehensive screenings of suicide, violence, and substance use and provides a definition for complex needs. These evaluations and standards for admission, coordination with community providers, and discharge planning should help improve patient outcomes; reduce the risk of post-discharge overdose, self-harm, and violence; and reduce the risk of readmission and disconnection from care.

These amendments include provisions to: remove outdated references to behavioral health organizations and define Managed Care (MCO), remove definition for concurrent review and define utilization review. It provides uniform definition of Collateral, Credentialed Alcoholism and Substance Abuse Counselor (CASAC), creates a new definition of Individual with Complex Needs, Governing Body, Interventional Therapies, and defines Intensive care management. The rule provides definitions for person-centered process, psychiatric advance directive, PSYCKES, shared decision making and SHIN-NY. It clarifies that policies and procedures must conform with confidentiality, clarifies that services shall be provided through a person-centered process with shared decision making and should be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals. The proposal provides admission requirements which shall include an enhanced review of documentation including assessments, treatment, and other services provided in referring outpatient, emergency, or program and prior presentations; collateral information in PSYCKES and any other available information network and a review to see if the individual has a Psychiatric Advance Directive (PAD) or other wellness plan and preferred contacts in

PSYCKES. Screenings on admission and documented in the individual's chart will include: suicide risk using a validated instrument, violence risk screening and assessment and inquiries about access to firearms or other weapons, substance use screenings using a validated instrument and a determination shall be made as to whether an individual has complex needs. Discharge plans shall reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs. Enhanced discharge procedures for discharges of individuals with complex needs, including communications with the receiving outpatient treatment program and residential or other long-term care program on the day of discharge, contact with aftercare providers to schedule and confirm a follow up appointment to occur within seven calendar days following discharge. Individuals with complex needs enrolled in outpatient or residential care management, must coordinate discharge plan details and timing with care managers.

4. Costs:

(a) **Cost to State government:** These regulatory amendments will not result in any additional costs to the State government. Stand alone psychiatric hospitals already have staff that are responsible for conducting evaluation and treatment, doing discharge planning, and maintaining relationships with community agencies. These proposed regulations will not add a requirement for further staff, they clarify and standardize what is already expected of staff. Facilities can use the same electronic medical records they currently use.

(b) **Cost to local government:** These regulatory amendments will not result in any additional costs to local government.

(c) **Cost to regulated parties:** These regulatory amendments will not result in any additional costs to those regulated parties.

5. **Local Government Mandates:** These regulatory amendments will not result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. **Paperwork:** No substantial increase in paperwork is anticipated as a result of the amendments to 14 NYCRR Part 582. Hospitals have staff that are responsible for conducting evaluation and treatment, doing discharge planning, and maintaining relationships with community agencies. These proposed regulations clarify and standardize what is already expected of staff. Facilities can use the same electronic medical records they currently use.

7. **Duplication:** These regulatory amendments do not duplicate existing State or federal requirements.

8. **Alternatives:** No alternatives were considered, as these amendments seek to ensure that psychiatric inpatient settings provide safe, comprehensive, and evidence based treatment. These amendments were considered after a multi-year quality collaborative with hospitals (the High Risk Quality Collaborative) developed consensus statements to reduce the risk of suicide, violence, and opioid overdose and extensive outreach to hospitals, ambulatory community providers, and other stakeholders leading to the development of a guidance document which was shared with the field for comment. Pursuant to the Commissioner's general oversight of persons with mental illness to ensure those individuals are provided with care, treatment and rehabilitation is of a high quality and effectiveness, these changes were necessary to ensure the proper and appropriate delivery of services through fostering linkages with community care providers. These changes ensure that treatment will be provided with more of a person-centered approach, leading to more accurate treatment and successful discharges that allow individuals to prolong community tenure. New standards for discharge planning will ensure that individuals will be discharged to an appropriate setting according to their needs. Discharge planning will include confirmed, scheduled outpatient appointments. For individuals with complex needs and who have a care manager, inpatient staff will coordinate plan details and timing with care managers. All individuals should be referred for outpatient mental health services which are person-centered, recovery-oriented designed to help individuals achieve and maintain recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community.

9. **Federal Standards:** The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. **Compliance Schedule:** This rulemaking will be effective upon publication of a Notice of Adoption in the State Register.

Revised Regulatory Flexibility Analysis

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

Revised Rural Area Flexibility Analysis

The amendments to Part 582.14 NYCRR will require that operation of hospitals for persons with mental illness follow comprehensive standards for admission and discharge of patients from such facilities. The proposed rule will add new requirements for evidence-based standards for screenings and creates standards for safe discharges. The amendments will not impose any adverse economic impact on rural areas; therefore, a Rural Flexibility Analysis is not submitted with this notice.

Revised Job Impact Statement

A job impact statement is not needed as this proposed rule requires that hospitals for persons with mental illness, follow comprehensive standards for admission and discharge of patients in an effort to coordinate appropriate care and reduce the amount of unnecessary and reoccurring visits. There will be no adverse impact on jobs and employment opportunities as a result of the proposed amendments to 14 NYCRR Part 582.

Assessment of Public Comment

Comment 1: A Commentor recommended further review of addressing the complex needs of individuals with co-occurring disorders including Intellectual Developmental Disabilities.

Response 1: The comment was reviewed by the Office. Additional information will be provided through guidance.

Comment 2: A Commentor requested the Office broaden the definition of providers who are authorized to provide MHL 9.58 removals.

Response 2: The comment was reviewed by the Office and no amendment was determined to be necessary as the comment is outside the scope of the rule.

Comment 3: A Commentor requested the Office increase the number of teams available in the community.

Response 3: The comment was reviewed by the Office and no amendment was determined to be necessary as the comment is outside the scope of the rule.

Comment 4: A Commentor requested the Office clarify the definition of "harm to self."

Response 4: The comment was reviewed by the Office. The language proposed is consistent with other programs, and as such, no amendments were made. Additional guidance recently provided by the Office clarifying the Article 9 "harm to self" standard addresses the concern.

Comment 5: A Commentor requested the Office mandate hospitals to use the totality of a patient's history to make a determination of treatment.

Response 5: The Office has reviewed the comment and find the amendment to be unnecessary as the rule presently provides for a person-centered process with shared decision making and requires a more comprehensive review for admission and discharge determinations.

Comment 6: A Commentor requested the Office require hospitals to provide outpatient treatment programs.

Response 6: The comment was reviewed by the Office and no amendment was determined to be necessary as the comment is outside the scope of the rule.

Comment 7: A Commentor with lived experience recommended an increase in the budget for youth and young adult mental health.

Response 7: The comment was reviewed by the Office and no amendment was determined to be necessary as the comment is outside the scope of the rule.

Comment 8: A Commentor with lived experience shared their support for the proposed rule as it relates to more efficient communication between providers.

Response 8: The comment was reviewed by the Office and no amendment was determined to be necessary. The Office appreciates the comments from individuals and family members with lived experience.

Comment 9: A Commentor expressed support for the goal of improving discharge planning, screenings for social determinants of health and the presence of complex conditions, and supports the increased collaboration with community organizations, which will support more person-centered care.

Response 9: The comment was reviewed by the Office and no amendment was determined to be necessary.

Comment 10: A Commentor expressed concerns that the violence screening assessment will encourage the finding of non-existent violent tendencies and have a disproportionate effect on certain populations.

Response 10: The Office has reviewed the comment and find the amendment to be unnecessary as the rule presently provides that all services must be informed by the understanding that implicit bias may affect the assessment, diagnosis, treatment and discharge planning of Black, Indigenous, People of Color and other marginalized individuals. Additional information will be provided through guidance.

Comment 11: A Commentor recommended discharge guidance to encourage connection with per support services, housing services and referrals to a local Clubhouse program or recovery center.

Response 11: Response 51: The comment was reviewed by the Office. Additional information will be provided through guidance.

Comment 12: A Commentor recommended amendments to Part 580.6(c)(9) language concerning discharge of "individuals with elevated risk of violence" to be more general or reserved for guidance and technical assistance.

Response 12: The Office has taken the recommendation to revise the language.

Comment 13: A Commentor stated the proposed regulation should require staff to determine the person's housing status before discharge, where the individual resides in supportive housing, the hospital should be directed to contact the housing provider to determine whether the person can return there or whether alternative housing needs to be arranged. OMH should establish a point of contact at each field Office who can provide contact information for supportive housing providers, including the name of the program director.

Response 13: The comment was reviewed by the Office and no amendment was determined to be necessary as the concern is addressed by the proposed regulation. The discharge plan will be developed through shared decision making in a person-centered process and reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs.

Comment 14: A Commentor stated the proposed regulation should require outreach to homeless shelters or local agency that oversees homeless shelters for people who report that they reside in a shelter.

Response 14: The comment was reviewed by the Office and no amendment was determined to be necessary as the concern is addressed by the proposed regulation. As required in the proposed regulations, the discharge plan will be developed through shared decision making in a person-centered process and reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs.

Comment 15: A Commentor stated the regulations should require completion of a supportive housing application for persons who are unsheltered or unstably housed and agree to receive assistance as part of the discharge planning process.

Response 15: The comment was reviewed by the Office and no amendment was determined to be necessary as the concern is addressed by the proposed regulation. The discharge plan will be developed through shared decision making in a person-centered process and reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs.

Comment 16: A Commentor stated the regulations should require completion of Medicaid Transportation applications for people who report that they cannot use public transportation for medical reasons.

Response 16: The comment was reviewed by the Office and no amendment was determined to be necessary as the concern is addressed by the proposed regulation. The discharge plan will be developed through shared decision making in a person-centered process and reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs.

Comment 17: A Commentor stated the regulations should require hospitals to provide information about crisis respite centers as an option for stepdown care.

Response 17: The comment was reviewed by the Office and no amendment was determined to be necessary as the concern is addressed by the proposed regulation. The discharge plan will be developed through shared decision making in a person-centered process and reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs.

Comment 18: A Commentor stated the regulations should require care coordination referrals for people who are not already linked to a care coordination provider.

Response 18: The comment was reviewed by the Office and no amendment was determined to be necessary as the concern is addressed by the proposed regulation where it is not outside the scope of the regulation. Additional information will be provided through guidance.

Comment 19: A Commentor stated the regulations should encourage communication with criminal legal system supports when appropriate. When a person reports having a pending criminal case and requests assistance contacting their attorney or being on probation or parole supervision and requests assistance contacting the supervising officer, hospital staff should assist the person in obtaining contact information for the relevant attorney, probation officer, or parole officer.

Response 19: The Office has reviewed the comment and agrees with the assessment.

Office for People with Developmental Disabilities

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Pathway to Employment

I.D. No. PDD-31-24-00001-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Amendment of Subpart 635-10 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 13.07, 13.09(b) and 16.00

Subject: Pathway to Employment.

Purpose: To update the pathway to employment regulations as NY becomes an employment first State.

Substance of proposed rule (Full text is posted at the following State website: <https://opwdd.ny.gov/regulations-guidance/current-proposed-regulations>): • Repeal existing subdivision 635-10.4(h) and replace as follows:

(h) *Pathway to Employment.*

Pathway to Employment is a time-limited, person-centered, comprehensive career and vocational planning and support service. The goal of this service is to help individuals in developing a vocational plan with an identified career path to obtain competitive integrated employment in the future. This habilitative service uses an individualized career and vocational planning process to identify the individual's vocational strengths and goals, which includes community vocational experiences and support services.

The outcome of Pathway to Employment is a career, vocational and transition plan document which includes the next steps for achieving self-employment or competitive, integrated employment at or above the State or Federal minimum wage.

(1) *Allowable Services.*

The Pathway to Employment service consists of specific allowable services. Allowable services must be provided directly to and/or on behalf of an individual. This may include providing the services remotely if that is not the only service delivery method. Allowable Pathway to Employment services include:

(i) *vocational assessment, discovery activities, person-centered planning, job-related experiential learning, and career exploration;*

(ii) *assessment and instruction in the use of remote and assistive technology to increase independence in the workplace;*

(iii) *development and planning community-based vocational experiences (paid or unpaid), including analysis, customization, carving, and negotiating, training or orienting employers on behalf of an individual or group of individuals;*

(iv) *training, orientation, and systematic instruction including career-specific skills instruction prior to and during the community-based vocational experiences;*

(v) *job coaching;*

(vi) *planning for self-employment, including identifying skills that could be used to start a business, identifying business training and technical assistance that could be utilized in achieving self-employment goals;*

(vii) *communication and meeting with the individual, businesses, staff delivering or coordinating services for the individual, family members and the individual's circle of support and instructors to address challenges, discuss supports or coordinate Pathway to Employment services;*

(viii) *review of an individual's records and other documentation for career planning;*

(ix) *observation and assessment of an individual's interactions and routines at home, in the community and within other services or programs for the purpose of assessment and career planning;*

(x) *staff travel to and from allowable Pathway to Employment activities, including staff travel time to deliver Pathway to Employment services directly or on behalf of an individual;*

(xi) *travel training related to accessing employment;*

(xii) *development of social skills, job retention strategies, and other workplace skills that enable the individual to be successfully integrated into the vocational setting (e.g., social interactions, maintaining relationships with co-workers and supervisors, job readiness, how to attend to task, problem-solving, increasing independence, and communication skills);*

(xiii) *benefits support, advisement and asset development;*
(xiv) *planning for employment opportunities or vocational experience sites on behalf of an individual or group of individuals;*

(xv) *documentation of the delivery and support of all Pathway to Employment services, preparation of service-related documentation and completion of the comprehensive career and vocational plan;*

(xvi) *planning the delivery of all allowable Pathway to Employment services;*

(xvii) *managing the delivery of all allowable Pathway to Employment services;*

(xviii) *communication, reports or meetings with OPWDD staff regarding outcomes for individuals receiving Pathway to Employment services, report preparation, and other requested information;*

(xix) *staff time to attend and travel to OPWDD Innovations Training; and*

(xx) *other activities with prior approval from OPWDD.*

(2) *Eligibility for Pathway to Employment.*

To be eligible for Pathway to Employment services, the individual must:

(i) *require habilitative services including employment-related learning, volunteer and vocational experiences;*

(ii) *express an interest in preparing for competitive integrated employment or self-employment and have this identified in their Life Plan;*

(iii) *be enrolled in the Home and Community-based Services (HCBS) Waiver; and*

(iv) *not have met or exceeded the lifetime total of Pathway to Employment service hours cap (see paragraph (3) of this subdivision.*

(3) *Limits on Pathway to Employment.*

(i) *Pathway to Employment is time-limited. Eligible individuals may be approved for Pathway to Employment for up to 12 months or 425 hours, whichever occurs first.*

(ii) *In unique circumstances, the Pathway to Employment provider may request OPWDD approval for additional time and/or hours of this service. This request must be made in the form and format specified by OPWDD.*

(iii) *In these unique circumstances, OPWDD may consider requests for approval for additional time and/or hours of Pathway to Employment. OPWDD will determine if these requests are reasonable considering the services provided, community-based vocational experiences, best interests of the individual, and any other relevant criteria as determined by OPWDD.*

(iv) *In any event, an individual's Pathway to Employment services are capped and must not exceed a total of 24 months or 556 hours (whichever occurs first) over their lifetime.*

(4) *Pathway to Employment Service Provision Time.*

Pathway to Employment services may be provided during both the day and/or evening on both weekdays and weekends.

(5) *Individual and Group Provision of Pathway to Employment.*

Pathway to Employment may be provided to one (1) individual or a group of two – five (2-5) individuals, except for training related to gaining vocational skills or career exploration. Related training may be delivered to a group of no more than 15 individuals. Individuals may move to and from individual and group sessions based on the individual's needs.

(6) *Community-Based Vocational Experiences.*

(i) *Individuals receiving Pathway to Employment services must participate in community-based vocational experiences to inform the development of the Career, Vocational, and Transition Plan. Community-based vocational experiences must be delivered in integrated settings alongside members of the broader community.*

(ii) *Community-based vocational experiences may be paid or unpaid. Applicable Federal and/or State Department of Labor laws, rules, regulations, and guidance applies to both paid and unpaid community experiences.*

(iii) *If the individual is paid for their community-based vocational experience, then they must earn minimum wage at or above the applicable county, State or Federal minimum wage.*

(iv) *If an individual is provided 100 or more hours of Pathway to Employment services, there must be at least:*

(a) *30% of those hours must include community-based vocational experiences. This must be documented in the individual's Career, Vocational, and Transition Plan.; and*

(b) *three (3) different community-based vocational experiences.*

(v) *In exceptional circumstances where the individual is provided more than 100 hours of Pathway to Employment services, OPWDD may grant an exception to allow fewer than:*

(a) *30% community-based vocational experience hours; and/or*

(b) *three (3) community-based vocational experiences.*

(7) *Career, Vocational, and Transition Plan.*

(i) *A Career, Vocational, and Transition Plan is a comprehensive plan that identifies an individual's career path to help them obtain competitive integrated employment.*