GREATER NEW YORK HOSPITAL ASSOCIATION
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RE: Parts 580 - Admission and Discharge Criteria for Psychiatric Inpatient Units of General Hospitals (I.D. No. OMH-04-24-00006-P) and 590 - Comprehensive Psychiatric Emergency Programs (I.D. No. OMH-04-24-00007-P) of Title 14 of NYCRR

To Ms. Paupini:

On behalf of the 170 voluntary and public hospitals and health systems across New York State, Greater New York Hospital Association (GNYHA) appreciates the opportunity to comment on the Office of Mental Health's (OMH) proposed admission and discharge criteria for inpatient psychiatric unit and comprehensive psychiatric emergency program (CPEP) services provided by member hospitals. GNYHA's comments herein address both proposed Parts 580 and 590—inpatient and CPEP, respectively—given the significant alignment in language.

While GNYHA member hospitals support the idea that people with complex behavioral health needs must be better and more comprehensively served across the continuum of care, we respectfully submit that the proposed regulations will not achieve that goal. The proposed rules do not clearly define the cohort of individuals requiring enhanced planning; recognize hospital operations, protocols, and workflows that need to be developed to operationalize the proposed criteria when appropriately defined, including data needs; create commensurate and simultaneous non-hospital provider requirements that need to be operationalized; establish payer responsibilities; take into consideration system capacity; and other concerns outside of hospitals' control, which are described in detail below.

Definition of Individual with Complex Needs

The proposed definition of *Individual with Complex Needs*, as written, is over-encompassing and will create significant burdens on scarce hospital and non-hospital system resources. The reality is that the continuum of care, of which hospital inpatient units and CPEPs are only a part, is already beyond its capacity to care for all the individuals in need of behavioral health services. While the State has recently taken several steps to address this problem, sustainable solutions are years away, in part because we have a chronic staff shortage. This does not mean that existing regulations and policies should not be updated and continuously improved, but when doing so, OMH should take into account this reality, not ignore it.

Hospitals and other stakeholders need a well-defined cohort of individuals who require intensive support and services to improve timely engagement with an over-burdened system with finite resources. The proposed definition includes high utilization of certain services; high intensity ambulatory service utilization *or* eligibility for high intensity ambulatory services; discharge from an OMH-operated psychiatric center (PC) or residential treatment facility (RTF); or inadequate connection to an overly broad list of services and patient characteristics that include housing insecurity, food and linguistic issues, transportation needs, adverse childhood experiences, experiences of discrimination, exposures to threats or violence, criminal justice involvement, insufficient employment or education, immigration status, military/veteran status, and other characteristics determined by OMH. This definition is overly broad, and if it is finalized as written, it will capture too many individuals, further delaying timely access to scarce resources. This would hurt the individuals the rulemaking is intended to help.

To support appropriate and timely identification of individuals with complex needs, OMH's Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is a necessary part of the solution. PSYCKES contains consensus-driven and evidence-based quality flags, which are consistent with policy priorities, and should be used to drive clinical practice. A PSYCKES quality flag will increase and improve the identification of individuals with complex needs. And this must be done *with input from the field.*

As proposed in 580.3(e)(3) and 590.4(a)(2)(c)—referring to inpatient and CPEP services, respectively—the definition of individuals with complex needs includes individuals *receiving services from or discharged from* State-operated PCs and RTFs *within the past year*.

Individuals discharged from these settings after extended episodes of care should be encouraged to return there following discharge because those PCs and RTFs are most familiar with their histories and strengths and consumer-driven care plans. To the extent that those settings are already stretched too thinly, the regulations should be phased in to address that reality and allow for some of the State's initiatives to gain the traction that will hopefully result in more capacity being built over time.

Sections 580.39(e)(2), 580.39(e)(4), 590.4(a)(2)(b), and 590.4(a)(2)(d), again, referring to inpatient and CPEP services, respectively, include overly broad inclusion criteria *in the year prior* to presenting to a hospital, which will trigger extraordinary numbers of individuals meeting the definition of individuals with complex needs. Further, inpatient and CPEP provisions also contain open-ended language—referring to individuals presenting with "other service utilization characteristics determined by the office as meeting criteria for complex needs designation"—which does not inform hospitals of their responsibilities or OMH's expectation and does not reflect that such determinations will be done with input from the field, which we think would be a missed opportunity.

OMH should spend at least the next three months—with extensive input from hospitals and other stakeholders—working to define individuals with complex needs more narrowly. In addition, OMH should share data informing hospitals of the anticipated volume of individuals that will trigger a more narrowly defined definition so that individuals most in need of intensive support are identified and receive timely follow-up.

Hospital Operations – Information Gathering and Sources

Hospitals operate 365 days a year, 24/7, unlike most ambulatory and residential providers and payers. As such, hospitals receive individuals outside of business hours, including holidays and weekends. Given hospitals' fast-paced environments, non-hospital providers, including payers, must have policies and procedures that affirmatively require all stakeholders to provide clinical information for individuals enrolled in their programs and plans in a timely manner.

One way to bridge this discontinuity within the system is through timely and easy data access. Providers continue to request the integration of PSYCKES and the New York State Department of Health's (DOH) Prescription Monitoring Program (PMP)—sources that will be required to be reviewed—into electronic medical records (EMRs) to reduce information gathering burdens. Currently, PSYCKES and the PMP require providers to exit their EMR to review clinical information. To mitigate security burdens, OMH executed data use agreements (DUAs) at the hospital/system level and designated hospital security managers who control employee access. Even with hospital-controlled security and access measures in place, hospitals continue to report significant administrative burdens associated with managing PSYCKES access at the employee level. When DOH implemented the Internet System for Tracking Over-Prescribing law mandating prescribers of controlled substances check the PMP a decade ago, GNYHA worked closely with DOH's Bureau of Narcotics Enforcement to permit mandated prescribers to designate personnel permitted to access the PMP on behalf of prescribers. This created a workflow that enabled support staff to provide PMP controlled substance histories to prescribers to be used during patient encounters. It also bears noting that hospitals are still very much affected by chronic staff shortages. The use of contracted, per diem and floating staff only further burdens hospital access to PSYCKES and the PMP. To further reduce burdens, hospitals should be able to permit all staff to access EMRs, PSYCKES, and the PMP in accordance with hospital PHI policies—until integration with EMRs can be operationalized.

The proposed regulations also mandate that providers review information in other available databases, and cite the Statewide Health Information Network for New York (SHIN-NY). Hospitals report ongoing challenges and limitations using the SHIN-NY data sources for clinical purposes. While some hospitals and health systems have a limited number of highly qualified personnel with data analytic expertise that access SHIN-NY/QE data for population health and other high-level purposes, our members report that SHIN-NY/QE data is not particularly useful for clinical decision-making purposes at the time when an individual presents to a hospital for emergency or inpatient care. Prior to mandating access to the SHIN-NY or any other data source, OMH should note such limitations and work with its State partners to ensure the SHIN-NY and all other data repositories are available for use by behavioral health providers in caring for their patients.

OMH and DOH need to prioritize efforts on integrating PSYCKES and PMP data into EMRs and remove language related to the SHIN-NY/QE until providers can use it to support clinical decision making.

Non-Hospital Providers and Payers—Commensurate Shared Responsibility

OMH's proposals specific to inpatient and CPEP settings do not extend simultaneous and commensurate requirements to non-hospital providers or payers and will perpetuate communication gaps and a fragmented care delivery system. Any new and additional mandates need to include all stakeholders to materially improve continuity of care.

While OMH distributed draft guidance for outpatient, residential, RTF, and care management programs this month, the language “expects" that outpatient and residential providers “should” develop protocols for communication and engagement with hospital providers. This language does not establish requirements that further collaboration and communication among hospital and non-hospital providers. All provider types must similarly be required to establish protocols and procedures that facilitate information sharing.

Additionally, payers are an important information source that have the timeliest details on enrolled individuals. Hospital and non-hospital providers are required to notify payers when an enrollee presents for services. Hospitals also provide an initial treatment plan. Encounter information that payers have is available long before claims are adjudicated. Adjudicated claims are the primary source of PSYCKES data. OMH acknowledges lags in its PSYCKES system. Payers must have an affirmative role in sharing treatment information when hospitals notify them that an enrollee presents for services. State agencies with payer oversight should work together to establish payer information sharing requirements that can otherwise take months to be incorporated into PSYCKES and other data sources.

OMH and State partners should swiftly establish simultaneous and commensurate requirements for non-hospital providers and payers that support timely information sharing that will inform hospital treatment and discharge planning.

Discharge Responsibilities and Aftercare Timeframes

OMH proposes to add significant additional responsibilities to inpatient units and CPEPs in Parts 580.6(c) and 590.8(h), respectively. As proposed, hospital providers will be required to “provide a verbal 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…” The proposed language also seeks to have hospitals coordinate discharge timing with care managers and make certain high intensity referrals that can take months to become available. Hospitals are fast-paced environments that often operate at or above capacity with limited resources, including, especially, staff. This is another example of how simultaneous and commensurate requirements on non-hospital providers or payers will assist individuals most in need.

As proposed, inpatient and CPEP providers will be required to schedule follow-up care appointments within seven days (580.6(c)(5) and 590.8(h)(2)(vii). Hospital and non-hospital providers have struggled to provide appointments within seven days, well before the current unprecedented mental health crisis. There is a staggering lack of capacity in the outpatient behavioral health system due to chronic underfunding and workforce shortages, among other challenges.

It also bears noting that payer and provider requirements in this area are unaligned. GNYHA recently submitted comments on proposed regulations to address DOH’s behavioral health network adequacy. GNYHA’s comments include discussion of DOH’s proposal to require plans to facilitate enrollee appointments within a 10-day timeframe. It is unclear why the 10-day and seven-day timeframes are unaligned.

OMH, DOH, and other State entities need to align follow-up appointment timeframe requirements for hospitals, non-hospital providers, and payers that take into consideration scarce resources.

Quality Assurance and Performance Improvement

GNYHA would be remiss not to convey concerns about the enforcement posture that has been taken with hospital providers. It is well established that quality assurance (QA) and performance improvement (PI) activities using the Plan-Do-Study-Act method support rapid implementation of sustainable change. A QA and PI approach will support necessary change. New York cannot enforce its way out of the behavioral health and workforce crises.

OMH should support QA and PI collaborations with hospitals and non-hospital providers to increase communication and collaboration that support behavior health consumers.

Hospital Association Access to PSYCKES

GNYHA has a long history of supporting member QA and PI initiatives with great success. In furtherance of GNYHA's expertise and deep reach into member hospital leadership, GNYHA has been strongly advocating for hospital association access to PSYCKES. The PSYCKES team built a version specifically for hospital associations that does not provide access to individual patient-level protected health information. OMH continues to raise data sharing questions and concerns about providing PSYCKES access to the associations. With DOH approval, GNYHA provided OMH with an executed DUA that DOH and the associations developed for association access to HERDS data. This agreement can easily be replicated to facilitate association access to PSYCKES aggregate data.

OMH and DOH should swiftly expedite a DUA that facilitates hospital association access to de-identified aggregate data that GNYHA can use to support hospital QA and PI activities.

Conclusion

OMH's regulatory impact statement grossly underestimates the resources that are needed to achieve compliance with proposed Parts 580 and 590. GNYHA's comments highlight the significant resources that hospital inpatient units and CPEPs need to operationalize these regulations that OMH must recognize.

GNYHA's members are ready to work with OMH and other State partners, as well as other stakeholders, to improve timely and informed connections to care for the most vulnerable. We urge OMH to make needed revisions to the proposed rule that will support rather than undercut this goal, taking into account the realities of the current system as we together seek to rebuild it under the State's initiatives.

Sincerely,

Kenneth E. Raske
President