

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
COMMITTEE ON CODES, REGULATIONS AND LEGISLATION MEETING

December 5, 2024, 9:30 AM

90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC TRANSCRIPT

Mr. Holt Good morning. I'm Tom Holt, the Chair of the Committee on Codes, Regulations and Legislation. I have the privilege to call to order the Codes Committee and welcome members, participants and observers. I'd like to remind council members, staff and the audience that this meeting is subject to the Open Meeting Law and is broadcast over the internet. The webcast is accessed at the Department of Health's website. The On Demand webcast will be available no later than seven days after the meeting for a minimum of thirty days, and a copy will be retained by the department for four months. There are some suggestions or ground rules to follow to make this meeting successful. Because there are synchronized captioning it's important that people do not talk over one another. Captioning cannot be done correctly with two people speaking at the same time. The first time you speak, please state your name and briefly identify yourself as a council member or DOH staff. This will be of assistance to the broadcast company who is recording this meeting. Please note that the microphones will be hot mics, meaning that they pick up every sound. Therefore, I ask that you avoid rustling papers next to the microphone and also be sensitive about the personal conversations or sidebars as the microphones can pick up this chatter. As reminder for the audience there's a form that needs to be filled out before you enter the meeting room which records your attendance at these meetings. It's required by the Commission on Ethics and Lobbying in Government, and it is in accordance with the Executive Law 166. The form is also posted at the Department of Health's website under Certificate of Need. In the future you can fill out this form prior to these council meetings. Thank you for your cooperation in fulfilling these duties as prescribed by law. We do have an individual signed up to speak. I just put this into the record. You need to limit your comments to three minutes or less. Presenters are limited to one per organization. Please be prepared to deliver your comments promptly after your name is called. Your name will be called in order. Move close to the front and deliver remarks. This morning there is one regulation on the agenda for adoption and that's the General Hospital Emergency Services. Behavioral Health.

Mr. Holt Can I have a motion for recommendation of the adoption of this regulation to the full Public Health and Health Planning Council?

Mr. Holt And second?

Mr. Holt Dr. Stephanie Shulman and Jonathan Karmel from the Department are available and will provide us with information on this proposal.

Dr. Shulman Good morning, everyone. I'm Stephanie Shulman. I'm going to talk to you this morning about 10 NYCRR 405.19. This is the revision that the regulation establishing the operational standards for the emergency services of general hospitals. This regulation amendment would require the emergency departments of general hospitals to screen patients for behavioral health presentations and to take additional actions when patients have complex needs as defined in companion regulations that are being established by the Office of Mental Health OMH. A general hospital emergency department must already refer emergency department patients for appropriate follow up care after discharge from the hospital, including individuals with documented substance use disorders or who appear to be at risk for substance use disorders. The current regulations also already require emergency departments to screen for domestic violence, sexual offense,

substance use disorder and human trafficking. In addition, hospital emergency departments are already required in conjunction with discharge planning program of the hospital to specify the circumstances for actions to be taken and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services, but not in need of inpatient care. However, the regulations current regulations do not specifically reference discharges of patients with other behavioral health presentations and complex needs from the emergency department. This regulation amendment would expand the requirement that all emergency departments screen patients to include all behavioral health presentations, including by checking for records in electronic health information systems and by attempting to obtain collateral information from family and friends. Emergency departments must also screen for suicide risk, violence risk and to determine whether a patient has complex needs as defined by OMH and OMH's regulations. General hospitals with inpatient psychiatric units must take additional actions for patients with complex needs presenting to their emergency departments. The intended purpose of this is to create a continued linkage to care for persons with complex needs who might otherwise be lost to follow up without additional assistance in obtaining care after discharge from the emergency department. Paragraph 5 of Subdivision C of Section 405.19 is amended to read as follows. The Emergency Service shall develop and implement policies and procedures for the identification, assessment and referral of patients with behavioral health presentations, including A, the review of records, if any and any available information network databases, including the Psychiatric Services and Clinical Knowledge Enhancement System, PSYCKES and the Statewide Health Information Network for New York. With the patient's consent we are required by law identifying and contacting the individual's family members or close friends who interact with the patient to obtain collateral information, including any psychiatric advance directive. C, screening for suicide risk, which shall require positive screens be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk. D, screening for violence risk, which shall include a process for subsequent assessment and intervention in the case of a positive screen. As part of the screening, all patients must be asked about access to firearms or other weapons, a screening to determine whether an individual has complex needs. Social determinants must be considered in such discharge planning. For purposes of this paragraph individual with complex needs shall have the meaning as determined by the Commissioner of Health and 14 NYCRR 580.3E. Note that there has been a minor modification in this area since this regulatory revision was posted in the Public Health and Health Planning Council's agenda. Previously, for purposes of this paragraph, individual with complex needs was defined as determined by the Commissioner of Mental Health in Title 14 of NYCRR. The new statement is individuals with complex needs shall have the meaning as determined by the Commissioner of Health in 14 NYCRR 580.3E. In general hospitals with inpatient psychiatric units under 14 NYCRR Part 5E to accomplish adequate discharge planning for individuals with complex needs in need of post emergency treatment or services. The Emergency Service shall develop and implement policies and procedures for the discharge of an individual with complex needs, including a for patients in care management programs, coordinating discharge planning with care managers and such programs. B, scheduling and confirming an appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge and sending summary detailing the presenting mental health history, hospital course and other relevant information to the outpatient, residential or long-term care treatment program for a patient who wishes to receive psychiatric aftercare services. If, after making diligent efforts, a hospital cannot identify an after-care provider with an available appointment within seven calendar days, the hospital shall document its efforts, including efforts to schedule the appointment or as soon as possible thereafter. In the extraordinary event an appointment

for psychiatric after care cannot be secured at all the hospital shall document its efforts before discharging the patient and provide such documentation to the department upon request. Individuals who are leaving the hospital against medical advice or who state who do not wish to receive services must be offered information about available treatment options. Thank you.

Mr. Holt Thank you, Dr. Shulman.

Mr. Holt I do want to make note the council received several correspondences from various associations prior to the meeting. Those were received and distributed to the full council for the review and consideration of this proposal.

Mr. Holt Do we have any questions from the members of the council or the committee?

Mr. Holt There is one public comment.

Mr. Holt If I could, Carol Hunt from New York State Office of Attorney General signed up to speak in support of this regulation.

Ms. Hunt I'm sorry. I just signed up to sit here and view. No comment. Just in support of the regulation. Thank you.

Mr. Holt Thank you very much.

Mr. Holt I'll call again then to see if there are questions or comments from the members of the committee or council.

Mr. Kraut I think the letters we received we received from Greater New York, the American College of Emergency Room Physicians. I think both organizations recognize the benefit and the beneficial nature of a regulation like this. Just to put it out there, that there were concerns expressed about operationalizing this and essentially perfecting it. There were a couple of very good recommendations here. Dealing with patients with complex needs, even though the state in its regulatory kind of guidance and evaluation, they recognize that this is going to cost between a half \$1,000,000 and \$2,000,000 for supplemental funding that is not provided here when this regulation is passed. I'm not going to go over the history of the underfunding of the mental health system, but I think we're deceiving ourselves of passing a regulation like this. Let me just start. I'm supportive of this. I want the Codes Committee to vote affirmatively so we can go to the council, and we can have a broader discussion. I think there is much room for improvement here. I think we need to clarify some of that. In the comments page, I note that the state had acknowledged in its response that the requirements in the regulation are consistent with the goals of the 1115 waiver. I just want to be clear. If these goals are consistent with the waiver the institutions that implement programs and services in furtherance of this regulation will also qualify for funding from the waiver through their SCNs. Am I correct in that assumption that the state will support program development that is consistent with the 1115 waiver for essentially dealing with social determinants, follow ups, warm handoffs? That's a question I just want clarified from the state so it's clear to the providers that have to implement this. I have a few other points and then you could decide who can respond. This is going to be based on a determination of the Commissioner for OMH on defining a patient with complex needs. Those definitions have not been finalized. I just want clarification. One of the things that I'm struck by is the operational changes that we need to make to implement these regs. I want to make sure there's some pathway for the

hospitals, you know, 90, 120 days. If anybody from OMH or from the department could give us an idea of this reg will not go into effect until those definitions are approved and go through a regulatory approval process. The other issue I identify here is the data burden.

on the institutions to collect and analyze the data. When you're in the middle of an emergency room, which is overburdened in a different way. I want to look at it at two points. I would like the department to come forward with a code change following this that will require the PSYCKES Database to be integrated into our electronic medical record systems. The fact that we have to sign into multiple platforms in this day and age when we are trying to get a uniform, consistent holistic view of patient care, I would like to see a code change that permits the integration of that data into electronic medical records. I think that would be a beneficial thing. It would actually integrate more mental health and acute care, health emergency health, if you will. Look, I think for some places this will be less problematic. I'm concerned about rural hospitals. This is only applying to hospitals that have Psych Units. I'm concerned about safety net in rural hospitals the burden here. I don't have to remind everybody of the mental health workforce shortage we have. The staffing issues we're addressing. The back up in the emergency departments is just challenging. I think as the department is looking to implement this is to really work with the industry to give them time to listen to how we may have to come back and revise this regulation in order to meet its objectives in its goals. Three things I raised. One, I just want affirmation that this will be eligible for funding from the 1115 waiver based on what we wrote in the response. Two, come back on the code to integrate the PSYCKES Database, give them permission into the EMR. Just clear about that, this does not become effective until OMH finalizes that. I don't know if we have anybody from OMH that could give us some insight into that. I don't know who would like to respond.

Mr. Holt Jeff, we do have representatives from OMH here today as well.

Mr. Kraut Okay.

Mr. Kraut Just pull it a little closer.

Mr. Kraut Thank you.

Dr. Casoy Hi. My name is Flavio Casoy. I'm a Psychiatrist. I'm the Medical Director of Acute Hospital Care Community Transitions and Managed Care at the Office of Mental Health. I want to say thank you for letting us be here and present on this important topic. To Dr. Fish and Stephanie Shulman for all the work that's been put into this. It's really exciting. It's a real honor to serve speak before all of you. I mean, it's everyone here is really inspirational. Mr., Kraut, I really hear the points that you're making. Just to speak to some of these pieces. The definition of individuals with complex needs in Part 580, the regulations that govern inpatient psychiatric units have gone through the regulatory process and are close to being finally promulgated. It will happen shortly. When we were developing these definitions in the discussions for modifying Parts 580 and 582 and 590 of NY 14, there was a lot of public feedback on the definitions. What we worked to do was make sure that the definition was based on available administrative databases, which we could then use to create a flag in PSYCKES for Medicaid users. That would make it easier for hospitals to know whether or not individuals met that definition to help reduce the burden on hospitals of having to sort of track this information on their own. We absolutely understand that it's difficult sometimes to access PSYCKES, logging in to multiple databases. I'm an emergency room Psychiatrist. I know what it's like to have a packed waiting room and sort of log into all these systems. We are working with a particular hospital now to try to figure out how to integrate. PSYCKES is an application, not a

database. An application that brings administrative databases together to display it in an easy way for people to understand. We're working to figure out how to integrate that into one hospital. As I understand that there's technical and sort of legal questions that need to be sort of overcome, but that's in the process and it's something we would like to do. In terms of just the volume with a definition as is going forward in Part 580, we're looking at data that ended on June 1st the preceding year to June 1st. Out of almost 2.8 million presentations for all causes in emergency rooms with 939 emergency rooms, there were about 43,000 that were discharged to the community who presented with a mental health complaint and met the complexity of the definition. If we average it over the year across all 939 hospitals, it's about 118 patients per day across our hospital. For each individual hospital it's just a handful of individuals who would need sort of this increased sort of discharge planning, the appointment, the notification of the care manager. We know that about 70% of the hospitals that this would impact have their own Article 31 OMH mental health outpatient treatment or rehabilitation program. A lot of these hospitals do have their own sort of clinics that can sort of with coordination, can help take some of these discharges. I mean, there's several other measure. This is not being done in isolation, right? There are several other measures that are being put in place to help facilitate this and help make it easier for hospitals to discharge individuals. There's been a significant investment in expanding the number of programs in general, CCBHCs in particular, which are the types of outpatient programs that can accept individuals with multiple co-occurring disorders. We've given guidance to the existing programs that they have to prioritize discharges from hospitals. That is already in the clinic regs that these clinics have to prioritize discharge from hospitals. In addition, in early 2025 to help with individuals and commercial insurance, there is new regulations that will come into place and network adequacy to help expand the number of individuals on Medicaid and covered insurance plans their access to different types of programs to make it easier. We're excited about that. Hopefully, sort of with these efforts, with the creation of the flag, we want to reduce that data burden to make it easier for individuals. We think that this will not be as big a lift as might have seemed when the initial definitions sort of first went out. It was a much broader, more expansive definition that has been narrowed over the course of modifying. 580. All of these hospitals are also implementing similar processes for discharges from their inpatient units because of the changes to 580 that are going to take into effect. I just want to see if my colleagues in Albany have anything else to add on this question.

Ms. Perazzo Janine Perazzo, Assistant Commissioner at OMH over the Office of Hospital Care and Community Transitions. I would just add that also in 2025, we're going to be seeing a number of other services rolling out, including critical time and prevention teams, which are really going to be built to be working with the individuals when they're in the hospitals and helping them transition, as well as our S.O.S. teams.

Mr. Moon When we RFP those services, we require that there be an MOU with the hospital. It's actually to promote the communication, to promote the teamwork. We hope that what this will do in addition will help people with their recovery and reduce their need to be in EDs or an inpatient service so that they're on a better path. I'm Bob Moon. I'm Deputy Commissioner for Community Services. I want echo what Janine and Flavio were saying. We are so pleased to be here. This is great. This is a really wonderful opportunity to hear the feedback. I think you bring up a good issue. We can carry that message back to our partner at DOH and talk to them about how we see that as it relates to this work as well. I certainly think you're right to raise it. There's probably a lot of synergy is because it is going to support people's social care needs, social determinants of health, housing. There are obviously dollars for safety net hospitals that are a part of that too. You raised that important issue about the variability across the state and what hospitals can be able to

do. We understand that. Thank you for this opportunity to be here and hear your feedback.

Mr. Kraut Just to recap what I heard, you know, the finalization of that reg is imminent. My understanding is once that's finalized if we approve today, the regulation becomes a requirement immediately. Am I correct? Just the Department of Health, folks? That's correct. Once OMH goes through and finalizes the definition and if we pass it today, it starts, it's implemented. I guess you'll have to give notice to the hospitals and give some sort of Dear Administrator Letter. Let's just say it's imminent in the next thirty days or so. I got that. I heard you say that you would be supportive of integrating the PSYCKES. I know it's an application. In this day and age, I got a 22-year-old that knows. I got a whole bunch of data scientists that will know how to integrate it into Epic or to those things. I know there are some legal issues there. We also have powers in this council where we can create certain code requirements around some of those issues. If there's commitment at both DOH and OMH that's something I think we'd put on the agenda of the Public Health Council to have a code written that permits that to occur. I have heard you say you would support that, the department would support the integration. You know, within there will be legal issues and we'll deal with that.

Dr. Fish I just to say, I can't commit.

Mr. Kraut No, no, I'm not asking you to commit, but you're supportive of it. The department is supportive and recognizes the benefit of doing so.

Dr. Fish OMH has started to explore with a hospital system on how to do this.

Mr. Kraut The point on the SCN, I'm sure the department will give out guidance on that if it makes sense to do that. We'll look forward to that.

Mr. Kraut The only thing I would suggest... Again, I'm going to vote for this. I'm supportive of it. I know what the objective is. I think the data you provided provides better context about how many people, how much we're talking about. I thought we lacked that. That was tremendously helpful. All I would say is that if providers have unintended consequences, I will hope that you would return back to this venue to see how we might be able to modify that regulation if it's required. That's all. That's really what I heard a willingness to do. I really appreciate you joining us today. I wish you would hear more often on these issues. Thank you.

Ms. Perazzo Can I just jump in?

Mr. Kraut Yes.

Ms. Perazzo I just want to address something that you said earlier that I realize I didn't address, which was the operationalizing of this, right, and the challenges for the hospitals. Our office is new to OMH. We are developing regional teams. Our teams we've been going out. We've been introducing the office to the hospitals. Our teams will be working in each of the regions working with the hospitals. Our hope is that when we are in those hospitals, we can assist and answer questions and be on the ground providing that technical assistance and support while they are working to operationalize all these new regulation changes. I just think that's really important.

Mr. Kraut That's going to be so beneficial in ways we can't both imagine. Just leave plenty of time when you come, because this is not the only thing they're going to talk to you about.

Ms. Perazzo No, not at all.

Mr. Kraut A couple of hours for each visit.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Any other questions from the members of the committee or the council?

Mr. Holt Dr. Lim.

Dr. Lim Hi, Sabina Lim. I'm a member of the council, not of the committee. It's so good to see my colleagues; Dr. Casoy, Bob Moon, Jeanine Perazzo. I just want to say I really appreciate all of OMH's efforts as well as the Governor's investment to really this amazing focus on people with behavioral health conditions. I know you're doing tremendous work to help open up access and make sure people get into care. I hope my comments are taken in the right spirit. I think at the end of the day we want to do the right thing. We want to make sure that people get into care. I just have some points. Forgive me if it's a little bit long. Some comments and possibly some suggestions for the Codes Committee to consider, as is that many touched already on the operational issues. I guess when I saw this regulation, I sort of saw it in two parts. There's this overarching identification, assessment and referral for people with behavioral health presentations and then the subset for a specific group of very vulnerable people, those with complex needs. If I take those two apart, I think part of the daunting task of implementing this is really that larger bucket of which is defined by people with behavioral health presentations. I know that we were comments and suggestions to further define that. I actually think that would be helpful to further define, particularly because there are these companion regulations similar for people with substance use disorders. I think many people, when they hear the term behavioral health, they think of both mental illness and substance use disorders. I really do think it would be helpful to further refine that phrase or if not in the actual code, in the guidance document about which population that this is referring to basically. I also do want to say this may be the first-time people have heard of PSYCKES. I just want to say as Bob knows, I am the biggest fan of PSYCKES. PSYCKES is fantastic. No other state has this. I do think part of the operational ramp up has to take into account that essentially this is sort of more than screening is sort of additively when you take all the components that are added, it's actually almost like a mini sort of pre or almost a brief assessment. It's way beyond screening. You have to understand and interpret the information that's in there. It's important, for example, for the clinicians to understand what's in and what's not in PSYCKES, right? You have to be able to interpret that information and use it appropriately. I think there's that sort of and have an understanding of the mental health system and the different programs. I think for those reasons, I think it would really be helpful if that there was a little bit of a ramp up time for providers to get used to this. To help them understand, get signed up, change their EMR to have the appropriate templates to do all the screening and identification so that they're given a couple of months to be able to adequately do this. I think that's the first part. Because that in and of itself is a huge, huge component. I think the second piece, which is really that focus on the complex needs. I'm glad to hear that the definition of the complex needs has shrunk. My biggest concern was actually the identification piece. It would be very challenging for people to identify whether they met criteria because they're so disparate, right? There isn't a single source. I think it would be really important if this were to go into effect that people could rely on the PSYCKES flag. To denote that they meet one of those eleven plus criteria so that otherwise they would have to go through multiple sources and multiple collateral pieces of information just to even identify and then to do all of those other things. I think.

the last piece is just to mention, and I understand this is limited for the complex needs just for those with inpatient Psychiatric Units. Yes, that many of them do have outpatient clinics. It's important to recognize that people who come to the emergency rooms come from all over. There's not a defined geographic catchment for all EDs. That one clinic may not be the right geographic location for ongoing care for every patient, right? We just want to take that into account. The fact that we also want to be careful about making sure that we don't hold people too long in an emergency room setting, particularly if they're not on an involuntary hold or an emergency psychiatric evaluation, basically. I think at the end of the day, what I would also sort of put forth and suggest is that essentially it would be very helpful if there was intensive training, support, guidance, very clear guidance about what this practically means. Give providers time to gain familiarity and expertise and understanding of the system, including the providers. This will be new for them. There's an adequate ramp up time so that we think about perhaps put careful thought into the effective date of this regulation and possibly even separating out the effective dates of the two provisions. I think that would be really helpful. I think at the end of the day, we want to do the right thing, but we want to make sure that we do it right and we do it well because there might be more confusion and more difficulties if not. Sorry for the long comment.

Mr. Holt Thank you, Dr. Lim. It's helpful.

Mr. Holt Yes, Dr. Boufford.

Dr. Boufford Thanks.

Dr. Boufford I want to follow up really on the context that Dr. Lim just laid out. I'm curious about why these regulations are... It feels like it's being rushed in the context of. I think everyone shares the goal. The comments by colleagues in OMH really helped a lot, as Jeff said, to contextualize what's going on. I think I understood you to say that you are working currently with a pilot in a hospital system to get the kinks out, if you will, that you had some consultation up to now and that it sounds like the Office within OMH, which will provide the technical assistance at the regional level is very welcome but may be new as well. It just feels to me as sort of reading the materials why not? I was just kind of referring to a part of that was in the Greater New York Letter that sort of indicated a request for further consultation with the hospital system to further refine perhaps the sets of issues that people see as potential problems. Why not take, you know, sort of defer this until that's happened, come back, focus in, etc.? I'm just trying to understand the speed, the desire to get this in, given the fact that when regulations go into effect in hospitals... You know, people start being concerned about being inspected, being given dings, etc.. It just feels like that's not the spirit of what you're trying to do here. I'm just trying to understand that, if you would. Thanks.

Dr. Fish Thank you for the questions.

Dr. Boufford If I may, it's a bit like the cart before the horse, just to make it simple, my intervention a little bit more so.

Dr. Fish That just to say, Dr. Lim, that we do have planned upcoming intensive trainings on the use of the new flag, that the new complexity flag is live. We are rolling out trainings to CPEP, ERs, inpatient units. And, of course, that's the beginning. This new office that Janine is leading up will be able to provide more sort of individualized training to different hospitals as we have the staff hired and trained to sort of be there. Absolutely. People

need to understand what to see in the application. In terms of why now, I think the reason why now is that I think the Governor has recognized that the crisis is unprecedented in terms of what New Yorkers need in terms of accessing mental health services. We know that we have a group of individuals that are not large, but that are coming very frequently to acute services. There's the Office of Mental Health over the years, but especially with the Governor raising this issue as a priority is thinking what can we do across all different systems to interrupt the cycle of sort of continuous presentations to acute settings and help facilitate integrate these individuals into sort of ambulatory longitudinal care where they can get sort of better and get the services that they need?

There have been efforts with the managed care plans and with inpatient hospitals and with the outpatient behavioral health providers. For these individuals' complex needs, oftentimes they come to emergency rooms, right? Not just CPEP. I think it's really important. You know, along with making changes to the requirements for the OMH services to give opportunity for these individuals to be able to sort of connect with their care managers if they are connected so that they sort of are part of that conversation for discharge planning and then have an appointment to go to. If they don't these individuals usually just fall through the cracks. They will not call the number on the paper, right? We need to do a little bit more. In terms of integration of PSYCKES, you know, we're exploring with one hospital system on the possibility of integrating. It's not a pilot. It's sort of an exploration of what are the technical issues/legal issues? As I understand it, it's very complicated. It's something to explore.

Dr. Boufford Just if I may, just one follow up again. I mean, obviously, since, you know, for the last thirty years since the institutionalization and mental health there's been a lack of investment, as Jeff alluded to in community mental health. One of the issues here is putting a focus on an emergency room situation. I mean, the issue of identification and referral, referral to. Will the receptors be there? It reminds me a little bit of saying we have a crisis in mental health. We're going to have the primary care doctor take care of it. I mean, this has been going on for a very long time in terms of primary care. I mean, as a primary care pediatrician, I can tell you how many things have been put into the responsibility of the primary care physician. I just worry about adding what sounds like, as Dr. Lim mentioned, a very complex set of activities in the emergency room potentially. I appreciate the pressure to look at the mental health issues. Maybe that's a second presentation to us. I don't know about really looking at the state of community based mental health services and the robustness of the system that these 43,000 people would be referred to if they're identified in the emergency room. I just feel like it's kind of going to one particular part of the problem, which we keep recycling many of these issues, frankly, and not necessarily having sustainable solutions. I sort of applaud the initiative, but I'm a little concerned that it's... The focus of it is not sufficient to address the problem you're raising.

Mr. Moon One thing that I can add, Dr. Boufford, is that we have done a guidance for community providers of all types of community providers, housing. You're right. It has to be a partnership as you and Dr. Lim are raising. It can't just be the burden of the hospitals. It's the system. It's the continuum as a whole that needs to be more responsive. We are going to hold them equally as accountable. I worked with health and hospitals. I know that sense of being dinged and how unpleasant that is. I will tell you that we will be as collaborative as we can be because we have to start now. I mean, this is when we have the investment. These services are coming up. We need to create the communication that will, I think, reassure people that this is doable, and it can actually improve the lives of New Yorkers.

Dr. Casoy If I could just add.

Dr. Casoy I could just add the Office of Mental Health and the department have been working very closely on the development of these regulations. We will continue to work also with people in the hospital sector, hospital associations to work with them and on the guidance documents are put together. We are deeply committed to making sure that that's going to be the case. We've had a very good working relationship with all those parties.

Inaudible