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MEMORANDUM

TO: NYS Article 28/31 Hospital Psychiatry Providers

FROM: Dr. Thomas Smith, Chief Medical Officer, NYS Office of Mental Health

DATE: March 25, 2020

SUBJECT: Treatment planning and documentation standards for article 28/31 hospital psychiatry providers during emergency period

The New York State Office of Mental Health (OMH) is providing guidelines to support article 28/31 hospitals' efforts to continuing providing hospital-based mental health care during the declared state of emergency. OMH will share the following recommendations with the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission, which establish and maintain standards of care for inpatient mental health care. Given the urgency of the present situation, OMH supports easing of regulations, statutes and hospital policies immediately for NYS article 28/31 hospital psychiatry providers.

Mental Health Treatment Standards

During the COVID-19 crisis emergency period, hospital-based mental health programs may modify their inpatient treatment programming as follows:

1. Hospital mental health programs should follow their hospital-wide policies regarding visitors.
2. Programs should cancel all therapeutic, rehabilitative, and recreational groups that do not align with physical distancing and other mitigation recommendations.
3. During individual sessions, if in-person, clinician and patients should remain six feet apart.
4. Patients should be allowed to remain in their rooms during the day and should not be asked to remain in shared settings. Programs should maximize the space patients can occupy while on the unit.
5. Programs should continue to provide and even increase, where feasible, time for outside activities. Patients should be reminded to maintain at least six feet distance from all other individuals while outside.

Documentation Requirements

During the COVID-19 crisis emergency period, hospital mental health programs may modify their documentation requirements as follows:

1. A separate written treatment plan is no longer required provided a treatment plan is described in the psychiatric admission note and updated as needed.

2. Documentation by psychiatrists, nurses, psychologists, rehab staff, social workers, and other members of the treatment team may be limited to admission notes, discharge notes detailing course of treatment, and brief progress notes detailing changes in treatment plan, clinical emergencies, and other clinically relevant events.
3. For each patient, there should be a minimum of one medical record notation per day summarizing the patient's clinical status, risk status, and key elements of the treatment plan.

Discharge Planning

During the COVID-19 crisis emergency period it may be difficult for psychiatric inpatient teams to arrange for timely appointments with community-based providers following discharge. During this period, the inpatient team should continue the following discharge planning practices:

1. Attempt to schedule post-discharge outpatient appointments within 7 days of discharge. Outpatient mental health providers licensed by OMH are expected to remain operational during this emergency period and accept both returning patients and new referrals from hospitals.
2. If an outpatient mental health provider is not responding to requests or is refusing to accept new referrals, the OMH Field Office should be contacted to review the outpatient provider's policies and availability.
3. If the inpatient team remains unable to identify an outpatient mental health provider able to assume responsibility for the patient's care within 7 days, the inpatient provider may discharge the patient with the following considerations:
 - a. Ensure that the patient has continuity of medication treatment following discharge. The inpatient team should remain in touch with the patient and ensure an ongoing supply of medications until an outpatient prescriber is identified. Inpatient treatment teams may use discretion to provide more than a 30-day supply of medication.
 - b. Document a comprehensive risk assessment immediately prior to discharge to identify patients at heightened risk for adverse outcomes including suicide and violence. For identified high-risk patients, the inpatient team should remain in contact and continue to assess risk and follow-up as indicated until a community-based provider can assume responsibility for the patient.

Use of Telemental Health for Removal and Retention Pursuant to Article 9 of the Mental Hygiene Law

In response to the COVID-19 public health crisis and until further notice, any evaluation or examination required as part of an involuntary removal from the community, involuntary retention in a hospital or Assisted Outpatient Treatment order pursuant to Article 9 of the Mental Hygiene Law can be conducted via telemental health.

Evaluations or examinations conducted via telemental health must comply with the current guidance issued by the Office of Mental Health posted at:

<https://omh.ny.gov/omhweb/guidance/>

This use of telemental health for Article 9 removals will be considered equivalent to face-to-face evaluations or examinations for purposes of meeting statutory requirements. However, this guidance does not alter applicable clinical or legal standards, and the provisions of Article 9 remain in effect.

The following scenarios can be considered:

1. For Article 9 voluntary admission paperwork, an off-site psychiatrist can explain the legal paperwork to the patient via telehealth and an on-site clinician can scribe the signature for the off-site psychiatrist.
2. For Article 9 involuntary paperwork, an off-site psychiatrist can print and complete paperwork and then send electronically to an on-site clinician to be placed in the patient's record. Original copies of the patient's legal paperwork should be retained and placed in the patient's medical record as soon as possible.

Seclusion and Restraint

During the declared state of emergency, the requirements in NYCRR 526.4 (Restraint and Seclusion) requiring a physician for the order and the in-person, face-to-face examination of the patient for restraint or seclusion may temporarily be fulfilled by an order and an in-person, face-to-face examination by a licensed nurse practitioner or physician assistant.

NOTE: telehealth orders for seclusion and restraint are not permitted at this time.

Use of Video and Telephone Technology for Treatment of Patients

Telemental health should also be used to support routine treatment planning on hospital inpatient mental health units. For example:

1. Hospitals may consider plans in which one psychiatrist is on-site during regular work hours to manage duties that require in-person evaluations while allowing other psychiatrists to complete evaluations, treatment, and daily rounds via video connections (or via telephone when clinically appropriate and if video is not available).
2. Hospital Psychiatric Consult-Liaison teams should also consider using telemental health when clinically appropriate from within the hospital in order to help preserve the hospital's supply of personal protective equipment.

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