DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF HEALTH

NOTICE OF ADOPTION
OF AMENDMENTS TO ARTICLE 11
OF THE NEW YORK CITY HEALTH CODE

In compliance with § 1043(b) of the New York City Charter (the "Charter") and pursuant to the authority granted to the Board of Health by §558 of said Charter, a notice of intention to amend Article 11 of the New York City Health Code (the "Health Code") was published in the City Record on September 19, 2013. A public hearing was held on October 22, 2013. Four people testified and nine written comments were received. At its meeting on December 11, 2013 the Board adopted the following resolution.

Statutory Authority

These amendments to the Health Code are promulgated pursuant to § §556, 558 and 1043 of the Charter. Pursuant to section 556(b) of the Charter, the Department must determine the needs of the mentally ill in the city and plan for and coordinate the delivery of services to them. Sections 558(b) and (c) of the Charter empower the Board of Health to amend the Health Code and to include in the Health Code all matters to which the authority of the Department of Health and Mental Hygiene (the "Department" or "DOHMH") extends. Section 1043 grants the Department rule-making authority.

Statement of Basis and Purpose

Background

The Department is responsible under the Charter for supervising matters affecting the health of New Yorkers. This includes supervision of the reporting and control of chronic diseases and conditions hazardous to life and health.[1] The Department also has specific responsibilities with regard to mental health. Pursuant to section 552 of the Charter, the Department's Division of Mental Hygiene (MHy) is the local government unit (LGU) for the City of New York under New York State Mental Hygiene Law, and the executive deputy commissioner who directs the Division is the City's director of community services. As the LGU, MHy is responsible for administering, planning, contracting, monitoring, and evaluating community mental health and substance abuse services within the City of New York. It also is charged with identifying needs and planning for the provision of services for high-need individuals, such as persons with schizophrenia and other psychotic illnesses.

Overview of Psychotic Illness

Schizophrenia and other psychotic illnesses include symptoms such as hallucinations, delusions, confused and disturbed thoughts, and a lack of self-awareness.[2,3] These illnesses usually begin in young adulthood[4,5] and often place a significant quality of life and financial burden on both the individual with

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[1]Charter §556(c)(2).
[2]Barbato, A. (1998) WHO/MSA/NAM/97.6
[3] New York State Office of Mental Health (NYS OMH)(2012). Schizophrenia. Retrieved August 22, 2013 from: http://www.omh.ny.gov/omhweb/booklets/schizophrenia.html.
[4]Lewine RR. Amer J Orthopsychiat 1980;50:316-322.

the illness as well as their families and loved ones.[6] While previously thought to be chronically impairing, evidence now shows that early, high-quality treatment can reduce the risk of relapse, decrease the likelihood of debilitation, and increase chances for long-term remission for affected individuals.

DOHMH estimates that approximately 60,000 New Yorkers currently have psychotic illnesses.[7] Despite evidence that treatment improves outcomes, we estimate only 40-50% of these New Yorkers receive ongoing psychiatric care following discharge from a psychiatric hospitalization.[8,9] Approximately 2,000 new cases of psychotic illness are expected to develop annually in New York City.[10,11] Without follow-up treatment, more than one quarter of these individuals will be expected to relapse and to be re-hospitalized within one year.[12,13,14,15] With treatment, the risk of relapse can be reduced by approximately 50%.[16,17]

Impact of Duration of Untreated Psychosis and Early Intervention on Psychotic Illness

The 'duration of untreated psychosis' (DUP), the period from the first onset of psychotic symptoms to the start of treatment, is associated with both treatment effectiveness and long-term outcomes.[18,19,20] Wespite the fact that shorter DUP is associated with better response to antipsychotic treatment, indicated by reduction in symptoms and better overall functioning, the average DUP is long (between one and three years in national studies).[21,22,23,24] In the medium and longer term (6 month, 12 month and multi-year follow-ups), longer DUP is associated with poorer outcomes for overall functioning, symptoms, and quality of life.[25] [26]

DUP can be reduced by enhancing early detection, treatment and referral. Early detection programs can bring people to treatment sooner, at lower symptom levels, and reduce DUP.[27,28]

Implementing an early intervention model is also associated with better clinical and functional outcomes for individuals experiencing psychotic illness. This model involves a team-based approach (psychiatrists, social workers, peers) that includes community treatment, cognitive behavioral therapy, low-dose medication, family counseling, social skills training and vocational strategies.[29,30,31] The effectiveness of early intervention programs has been demonstrated in a growing body of research.[32,33,34,35,36]

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[5]Kleinhaus K et al. J Psych Res 2011;45:136-141.
[6] Wu EQ, et al. J Clin Psych 2005;66:1122-1129.
[7]NYC DOHMH analysis of NYS OMH Patient Characteristics Survey, 2011.
[8] NYC DOHMH analysis of NYS Medicaid claims data, 2012.
[9] Buchanan RW, et al. Schiz Bull. 2010;36(1):71-93.
[10]Kirkbride JB et al. Int J Epi. 2009; 38-1255-64.
[11]Bladwin P et al. Schiz Bull 2005 31;3, 624-38.
[12]NYC DOHMH Medicaid analysis.
[13]Zhomitsky S, et.al. Schiz Res Treatment. doi:10.1155/2012/407171
[14] Ram R, et al. Schiz Bull 1992;18:185-207.
[15]NYC DOHMH analysis of NYS Statewide Planning and Research Cooperative System, 2009.
[16]Alvarez-Jimenez M, et al. Schiz Bull. 2011:37:619-630.
[17] Marshall M et al. Arch Gen Psych 2005; 62:975-983.
[18]Marshall M et al. Arch Gen Psych 2005; 62:975-983.
[19] Perkins D, et. al. Am J Psych 2005;162:1785–1804
[20]AddingtonJ. Early Interv Psych 2007;1:294-307.
[21]Marshall M et al. Arch Gen Psych 2005; 62:975-983.
[22] Perkins D, et. al. Am J Psych 2005;162:1785–1804
[23] Hass G, et al. Schiz Bull. 1992; 18:373-386.
[24]Ho B, et al. Am J Psych 2000;157:808-815.
[25]Perkins D, et. al. Am J Psych 2005;162:1785–1804
[26]Petersen L, et al. BMJ 2005;331:602.
[27]Melle I, et al. Arch Gen Psych 2004;61:143–150.
[28]Hegelstad W, et al. Am J Psych 2012;169:374-380.
[29]Grawe RW, et al. Acta Psych Scand 2006;114:328-336.
[30]Mental Health Network NHS Confederation.2011 Issue 219.
[31] Singh SP. Br J Psych 2010; 196:343-345.
[32]Alvarez-Jimenez M, et al. Schiz Bull. 2011:37:619-630.
[33]Hastrup LH, et al. Br J Psych 2013;2002:35-41.

Adequacy of Current Links to Care

New Yorkers with psychotic illnesses often do not seek care or become disengaged from care. This is due, in part, to:

- fragmentation in the current mental health treatment system (patients being lost to care in transitions from hospitalization;
- exchange of patient information unsupported by technology infrastructure or current administrative practices);
- mental health treatment providers lacking resources to ensure links are established between patients and community supports; and
- challenges such as stigma, denial, fear, lack of support, and confusion related to benefits and insurance.

As a result, there are many people who do not become engaged in care until years after the early stages of their illness.[37]

It is well-established that linking patients to care improves both health and economic outcomes for the individual and their loved ones and reduces the burden on the healthcare system. Numerous studies, conducted with a variety of patient populations, highlight the importance and efficacy of linkage-to-care programs in improving post-hospitalization outpatient engagement, reducing the rate of re-hospitalization and decreasing associated costs.[38,39,40]

Amendment of Article 11

To improve linkages to care and outcomes for New Yorkers experiencing first episodes of psychosis, the Board of Health is amending Article 11by requiring hospitals to report when persons over 18 and under 30 years of age are admitted with a first episode of psychotic illness.

Reporting will be required within 24 hours of admission and will include hospital name, patient name, age, gender, address, telephone, date of admission, insurance type and diagnosis. All patient information will be confidential and used only for the purposes of linking patients to care. Patient name, address, date of admission and telephone number will not be retained by the Department for longer than 30 days. Information about patients agreeing to participate in the linkage-to-care program will subsequently be maintained in a program chart that is separate and apart from the information received from the reporting hospital.

Epidemiologic analysis

The de-identified data (hospital name, age, gender, month of admission, insurance type and diagnosis)in the reporting database will be used to describe characteristics of the aggregate population admitted with first-episode psychosis, in order to guide mental health system planning efforts.

The resolution is as follows:

"Shall" and "must" denote mandatory requirements and may be used interchangeably in the text below, unless otherwise specified or unless the context clearly indicates otherwise.

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[34]Mihalopoulos C, et al. Schiz Bull 2009; 35:909-918.
[35] Norman RMG, et al.SchizResearch 2011;129: 111-115.
[36] Lieberman J, et al. JAMA 2013;310:689-690.
[37]Thornicroft G, (Commentary) Epi and Psych Sci. 2012;21:59-61
[38] Jack BW, et al. Ann Intern Med. 2009; 150(3): 178-87.
[39] Coleman EA, et al. Arch Intern Med. 2006; 166(17):1822-8.
[40] Naylor MD, et al. JAMA. 1999; 281(7):613-20.

New text is underlined; deleted text is in [ ] brackets.

RESOLVED, that Article 11 of the New York City Health Code, found in Title 24 of the Rules of the City of New York is being amended by adding a new §11.04 and will be printed together with explanatory notes, to read as follows:

§11.04 **Report of First-Episode Psychosis**

(a) *Required reports.* A hospital must report to the Director of the Division of Mental Hygiene of the Department by telephone or in an electronic transmission format acceptable to the Department, the admission of any person over 18 and younger than 30 years of age with a psychosis diagnosis as defined in paragraph (1) of this subdivision within 24 hours of such admission. A report shall not be required if such person was previously hospitalized with a psychosis diagnosis as defined in paragraph (1) of this subdivision when he or she was over the age of 18.

(1) *Psychosis diagnosis* shall mean:

(A) Schizophrenia (any type);

(B) Psychosis NOS (not otherwise specified);

(C) Schizophreniform Disorder;

(D) Delusional Disorder;

(E) Schizoaffective Disorder;

(F) Brief Psychotic Disorder;

(G) Shared Psychotic Disorder;

(H) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder;

(I) Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

(2) *Reports* must include patient's:

(A) Full Name

(B) Gender

(C) Date of birth

(D) Address

(E) Telephone

(F) Hospital admission date

(G) Diagnosis

(H) Insurance type

(b) *Reports to be confidential.* The Division of Mental Hygiene will only use the information reported to it to offer care and services to the patient who is the subject of the report. Identifying information shall be confidential and shall not be subject to inspection by persons other than authorized personnel of the Division of Mental Hygiene. Such information may not be disclosed without the consent of the person who is the subject of such report or someone authorized to act on such person's behalf, except pursuant to a federal or state law that compels such disclosure. The director may not keep patient-identifying information reported to him or her for more than thirty days. Within 31 days of receiving information reported to it pursuant to this section, the Division shall cause such information to be destroyed.