Colorado Hospital Association

Comments Regarding BHA Rule Packets

June 23, 2023

CHA appreciates the Behavioral Health Administration (BHA)'s willingness to collaborate on both regulatory processes and procedural guidance necessary to ensure a smooth implementation of HB 22-1256. We would note that the provisions included in both statute and subsequent proposed regulation (2 CCR 501-1, Chapter 15) include significant operational, procedural, and regulatory changes and that guidance and training from the BHA will be critically important to ensure that facilities are able to safely able to make these transitions in a way that supports both access to care for the communities they serve and patient safety.

We appreciate the BHA's attention to these areas and would note specific requirements that will require immense guidance from the regulator in coordination with hospital operational teams:

- General timing/ procedural changes
    - Specifically, we recommend that a clear flow chart in the procedure manual that documents the evaluation and screening timelines, relevant locations, and required procedures at each step (denoting who completes those procedures) would be incredibly helpful to support implementation of these changes coupled with trainings provided by the BHA as early as possible before Jan. 1, 2024.
- Reporting
    - Any changes to reporting take a significant amount of time to change in a hospital's electronic health record – we appreciate the BHA's recognition that any reporting changes will likely require regulatory flexibility to ensure that facilities are not being penalized for failing to track/ report data for data requests that will not be finalized until November 2023 at the earliest (meaning at least four months to build the capability into an electronic health record to begin tracking the data).
- Discharge planning
    - The medication management section in 15.7.3.E.4 is another area that will require significant procedural support from the BHA. Emergency medical services facilities do not often change/ prescribe new medications and there are also instances where facilities do not have pharmacies available at the time of discharge, nor would the facility know when the individual was able to access another provider.
    - We appreciate the BHA's commitment to assisting with this section. Under C.R.S. § 27-65-128, in addition to proactively training providers and facilities on the procedure under Title 27, Article 65, the BHA is required to provide suggested templates and resources to be used by facilities to meet the requirements of 27-65-106(8)(a)(III) and (8)(a)(VII). These are the requirements for the discharge instructions for each person detained on an emergency mental heal hold for:

        - A safety plan for the person and, if applicable, the person's lay person where indicated by the person's mental health disorder or mental or emotional state,
        - Information on how to establish a psychiatric advance directive if one is not presented.
- Individual rights
    - Particularly around the area of individual rights, hospitals and providers always strive to prioritize patient autonomy when balanced with the safety of the patient, staff, and other patients. These provisions, particularly the requirement surrounding cellphones, could cause a significant safety risk to both the patient, staff, and both the health and privacy of other patients. We request guidance and guard rails to ensure that facilities and providers have the clarity they need to implement these policies in a way that does not inadvertently place either patients or staff in danger.

We also request that the BHA evaluation and the crisis assessment form operate through one process as possible and appreciate clarification on how this will work. Similarly, we request that there is one set of criteria for critical incident reports and appreciate the BHA's ongoing work to streamline requirements in this space.

Section	Background	Question/ Recommendation
15.3 27-65 Designation Requirement (p. 6)	The following statement in section D, read in context with the definitions in 15.2, could inappropriately and unintentionally be interpreted to require any facility that provides "involuntary services" to receive a designation: D. In order to provide involuntary services described in Ch. 15 a facility must receive a designation based on their substantial compliance with the service standards described in this chapter. The definition of "27-65 services" or "involuntary services" means "services provided pursuant to Title 27, Article 65, C.R.S." A "facility" is defined broadly to include a public hospital or a licensed private hospital that "provides treatment for individuals with mental health disorders." That would include emergency medical services facilities that provide care for patients meeting the criteria for an M-1 hold pursuant to C.R.S. § 27-65-106.	Section D could be clarified as follows: D. In order to provide involuntary services described in this Chapter 15, a facility, other than an emergency medical services facility, must receive a designation based on their substantial compliance with the service standards described in this chapter.
15.4.1 Application Process	15.4.1.C allows a facility to seek to exclude Saturdays, Sundays, and holidays from the 72-hour limitation on detaining persons for evaluation and treatment. However, that exception will no longer be in C.R.S. § 27-65-106(5) when the HB 22-1256 changes go into effect January 1, 2024. A plain reading of the amended version of 27-65-106 is that the 72-hour time limit continues on arrival at a	Strike 15.4.1.C

	designated facility and that, if the designated facility cannot complete the evaluation before the M-1 hold expires, it may place the person on a subsequent M-1 hold and must immediately notify the BHA and lay person.	
15.5.2, 15.5.3, 15.5.9 Reporting Requirements	Federal privacy law and subsequent regulation requires covered entities to limit the use or disclosures of protected health information to the minimum necessary standard intended for the purpose (45 CFR 164.502(b)).	CHA strongly recommends that the BHA consult legal counsel to avoid a conflict with patient privacy protections in the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. Federal law's preference is always to submit de-identified data. Clarify wording in 15.5.2 and 15.5.3 to apply only to designated facilities. The same clarification should be made in the following sections that apply to data sets for designated facilities, not emergency medical facilities that only have reporting obligations under C.R.S. § 27-65-106(9)(a): The designated facility is required to maintain a data set sufficient to report the following disaggregated numbers to the BHA annually by July 1 . . . **15.5.3 Short and long-term certifications** The designated facility is required to maintain a data set . . . **15.5.4 Voluntary individuals** The designated facility is required to maintain a data set . . .

		15.5.5 Involuntary medications The designated facility is required to maintain a data set . . . **15.5.6 Involuntary treatments** The designated facility is required to maintain a data set . . . **15.5.7 Electroconvulsive therapy (ECT) procedures** As defined in section 13-20-401, C.R.S., the designated facility is required to maintain data sets . . . **15.5.8 Imposition of legal disability or deprivation of a right** The designated facility is required to maintain data sets . . .
	Additionally, EHR builds can only happen once all procedures and forms are finalized and take at minimum four months.	Provide reporting guidance and hold trainings utilizing finalized data elements at least six months prior to any expectation of data

	While most of these provisions would require EHR updates 15.5.2.8 (challenges encountered with placement) and 15.5.2.9 (reason behind the hold) would both require significant, complex EHR builds and administrative changes. Additionally, these items are both incredibly subjective and documentation could include many scenarios that are not articulated.	Strike section 15.5.2.8 and 15.5.2.9.
	Transportation holds become void when a patient crosses the receiving facility threshold – this was recently reaffirmed by HB 23-1236 in 27-65-107(b) and the receiving facility should not be responsible for reporting on them.	Strike section 15.5.2.10
15.6 Staffing Requirements	15.6.1.C sets forth strict staffing requirements for designated facilities.	CHA would request additional information on the regulatory justification for these staffing requirements.
15.7.3 Documentation	15.7.3.C while CHA recognizes the need for uniformity in the type of crisis form assessment, facilities should be able to build this form into their EHR. The wording of this section implies facilities must use a separate, BHA form outside of existing channels for patient documentation.	Add to 15.7.3.C The elements from this form can be integrated into a facility's electronic health record.
	The 15.7.3.D.1 safety plan documentation requirement wording appears to go beyond far beyond the standard established by HB 22-1256 and also appears to incorrectly apply the requirement to individuals who were not placed on emergency mental health holds.	15.7.3.D.1 emergency services facilities will develop crisis safety plans with individuals who are detained for an emergency mental health hold prior to discharge ~~with individuals who are not placed on emergency mental health holds prior to discharge or transfer~~
	15.7.3.D.2 places requirements on collaboration with family/ other social supports, but does not establish clear standards for how to determine if that action is desired by the individual in crisis or how	Strike 15.7.3.D.2

	to identify those other social supports. While facilities often do this if desired by the patient/ available, it should not be in regulation. 15.7.3.D.3 should note that often facilities do not have information on psychiatric and medical advance directives.	 Add to 15.7.3.D.3 The safety plan should include information about psychiatric and medical advance directives if available and desired by the individual
Follow Up	This process will be incredibly burdensome for facilities to comply with.	CHA requests significant education and training as well as procedural guidance updates throughout this summer and fall to ensure compliance.
15.9 Seclusion and Restraint	This section is consistent with existing requirements that facilities follow pursuant to standards for hospitals and health facilities; however, CHA notes that it is possible for these regulations to shift in the future, which could cause a misalignment – we would recommend cross referencing regulation to ensure continued alignment.	Cut this section and cross reference existing regulation in 6 CCR 1011-1:2-8.1
15.13 Procedures for involuntary transportation holds	As noted above, transportation holds end when the individual gets to the receiving facility. Additionally, the timelines in this section appear to be out of alignment.	Insert following 15.13.2.A: If a person detained pursuant to this section is transported to an emergency medical services facility, the involuntary transportation hold expires upon the facility receiving the person for screening by an intervening professional.
15.14.2 Court Orders for Screening and Evaluation	There's a typo in line three of section H. "Detail" should be "detain." CHA would also recommend re-titling this section as it refers to non-court ordered provisions of C.R.S. § 27-65-106 as well.	15.14.2 Court Orders and Emergency Mental Health Hold Procedures ~~Court Orders for Screening & Evaluation~~ 15.14.2.H The facility may detain ~~detail~~ the individual. Section N.3 should include a second sentence consistent with C.R.S. § 27-65-

		106(7)(b) that "The BHA is responsible for actively assisting the facility in locating appropriate placement for the person."
15.14.3 Individual Rights	The title of this section refers to rights "for emergency mental health holds" but it goes beyond the statutory requirements of C.R.S. § 27-65-106(10)(a). There is no requirement in that statute that requires the rights to be explained and provided in written form. In addition, provisions in A.1 (which appear to be taken from C.R.S. § 27-65-103), are not required to be provided in writing to patients on an emergency mental health hold in an emergency medical services facility. As noted above, CHA has significant concerns with this section. Good cause needs to be clearly defined as subjectivity in this area can be incredibly harmful for patient and staff safety as it is open to interpretation. For example, 15.14.3.A.17 and 15.14.3.A.18 contradict each other as patients have a right to their phone, but also a right to not be photographed. Facilities would not be able to control if a patient photographed another patient while they had their phone. *Some specific points of clarification:* For emergency medical services facilities, where patients are detained on an M-1 hold typically in an emergency department	Strike 15.14.3.A ~~and must be explained to the individual and provided in written form~~ We request significant updates to the procedural manual and stakeholder work with both hospitals, patient safety experts, emergency department staff, and organizations representing mental health to work on procedures and regulatory language in this section that does not inadvertently harm patient or staff safety. We also recommend that the BHA's council review this section closely against Medicare Conditions of Participation to ensure that these regulations do not conflict with federal requirements. Strike 15.14.3.A.15, 15.14.3.A.16, 15.14.3.A.21, and 15.14.3.A.24

	setting, there is nothing in C.R.S. § 27-65-106(10)(a) that gives patients the right under 15 to receive and send sealed correspondence, or under 16 to have access to letter-writing materials and postage. There is no right to petition the court under 21, in the ED setting for release to a less restrictive setting. The voting rights in section 24 are also not in C.R.S. § 27-65-106 and would not be appropriate for a patient on an M-1 hold in an emergency medical services facility. In addition, C.R.S. § 27-65-106(10)(a)(XVII) limits the right to visitors "in accordance with the facility's current visitor guidelines," not as under 22 to have "frequent and convenient opportunities to meet with visitors." The safety of all patients and staff is paramount in the ED setting. Subsection 23, states that only the "professional person" (physician or psychologist) may deny one of these rights. C.R.S. § 27-65-106(10)(b), however, allows any "licensed provider involved in the person's care" to deny a right as appropriate in the interests of safety or patient destabilization. A physician may not be immediately available, particularly in smaller rural facilities, and a nurse, PA, or APRN may need to make this decision in an urgent situation. The regulation should not place restrictions beyond language that was agreed to by stakeholders in statute.	Edit 15.14.3.A.22 to include "to have frequent opportunities to meet with visitors in accordance with the facilities guidelines." Edit 15.14.3.A.23 to read "An individual's rights may be denied for good cause by any licensed provider involved in the person's care ~~only by the professional person providing treatment.~~"
15.14.2.K Evaluations	This section establishes that the evaluation must be completed by someone with two years of experience in behavioral health safety and risk assessment working in a health care setting; however, under these new standards it would be impossible to get two years of experience and thus be able to complete the evaluation.	CHA requests that the BHA work with council to either remove this language in legislation or address a necessary statutory fix to avoid a shortage of staff able to complete evaluations.
15.14.6 Court Notification	Facilities do not have a process or communication pipeline with the courts to make the type of notification being requested.	CHA requests that the BHA develop a process wherein the facility notifies the BHA who makes the appropriate

		notification to the court and establishes that process directly with the courts.
15.16.2.A Involuntary Emergency Services Designation	Emergency medical services facilities are frequent and necessary locations for M-1 holds given the nature of the services they provide. This currently occurs without a voluntary new designation type. As these services already occur in emergency medical services facilities, adding a new voluntary designation type would be unnecessarily confusing without providing patient or facility value.	Strike 15.16.2.A

Additional Feedback on Other Rule Chapters Included Below:

Chapter 2:

- CHA appreciates the clarification in the past that hospitals are not BHEs.
- To that end, it would be helpful to specifically clarify in this section that they are not BHEs.

Chapter 3:

- On pg. 13 and pg. 18, are the "standard criteria" referencing the above section or the 3 subpoints of B?
- On pg. 14 and pgs. 19-20, the data collection is only made available upon request by the BHA. This data should be required to be reported to the BHA quarterly and required to be used by the BHA to inform how to strengthen the safety net
- Is there a difference between a "comprehensive BH safety net provider" and a "comprehensive community behavioral health provider"? Different terms are used in the statute and the rules.
- CHA would recommend removing the language when a comprehensive provider is not able to provide services to an individual because we see this as the goal of the safety net.
- This language could be used as a back door to violating the exclusion criteria included in HB 22-1278.
- The chapter states that you must obtain approval from the BHA before referring a priority population individual. Why is this not the case for all individuals trying to seek safety net services?

Chapter 4:

- All safety net providers should be required to plan to prevent disengagement from services or following up after discharge from a hospital for people in their care. This endorsement should be required for safety net providers.

Chapter 5:

- All safety net providers should be required to outreach to the community and proactively try to engage individuals. This endorsement should be required for safety net providers.

Chapter 9:

- Mobile crisis (or some other function within the safety net) should continue to support a crisis wherever it occurs, including hospitals that do not have full-time behavioral health staff or locations like residential child care facilities. If we do not allow dispatch to those locations, police will continue to be a part of the crisis system which is inappropriate and harmful to individuals.
- This is a crucial function of the existing safety net and without BHA support communities and facilities will be at significant risk of loss of access.

Chapter 11:

- We request clarity surrounding the frequency of the comprehensive assessments.