CHA Feedback on BHA Proposed Rule Packet, First Reading at State Board of Human Services
Sept. 8, 2023

The Colorado Hospital Association (CHA) respectfully submits the recommendations and comments below on the Behavioral Health Administration's (BHA) proposed rule packet. We appreciate the BHA's willingness to collaborate on both regulatory processes and procedural guidance necessary to ensure a smooth implementation of HB 22-1256.

While CHA is grateful that the BHA accepted many of our and other stakeholders' feedback and suggestions over the last two months, we believe many significant changes are still necessary. Our submission today reflects those outstanding recommendations and questions that are critically important to address for the well-being of patients, providers, and the communities they serve.

We ask that the Colorado State Board of Human Services consider our recommendations, revisions, and questions. Overall, we note that the rules promulgated should align with statute. CHA respects and appreciates the BHA's flexibility in crafting these rules necessary for a successful implementation, and we know the BHA recognizes that the statutory language was carefully negotiated between stakeholders over many months before and throughout the legislative process. Regulations should not be more prescriptive than what is in statute and analogous regulations regarding physical health.

We would note that the provisions included in both statute and subsequent proposed regulation (2 CCR 501-1, Chapter 11) include significant operational, procedural, and regulatory changes and that guidance and training from the BHA will be essential 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 adding 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). This 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 11.7.3.F.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, and/or,
        - 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 around cellphones, could cause a significant safety risk to the patient, staff, and the health and privacy of other patients. We request guidance and guardrails 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.

Line/Section-Specific Recommendations on Chapter 11:

Section	Background	Question/Recommendation
11.2 Definitions – Professional Person	The rule packet proposes expanding the definition of professional person as defined in CRS 27-65-102 to include advanced practice registered nurses. This issue was extensively stakeholdered for a year and agreement was reached to write "professional persons and APRNs" rather than change the definition of professional persons. BHA should not violate this agreement that was reached.	CHA recommends striking the definition of professional person and referencing the statutory definition at CRS 27-65-102. Creating two different definitions of professional person in statute and regulation will cause conflicting interpretations and is outside the BHA's statutory authority.
11.5 Data Reporting Requirements for All 27-65 Designated Facilities	Federal privacy law and subsequent regulation requires covered entities to limit the use or disclosure of protection health information to the minimum necessary standard intended for the purpose (45 CFR 164.502(b)).	The BHA stated that rules are currently under legal review by the AG to confirm that the de-identified data is compliant with the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. CHA requests technical assistance and training for providers once these reporting requirements are finalized.
	EHR builds can only happen once all procedure and forms are finalized and take at minimum four months.	CHA requests that the BHA 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, 11.5.2.7 (challenges encountered with placement) and 11.5.2.8 (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.	CHA recommends striking sections 11.5.2.7 and 11.5.2.8.
	In subsection 2, the rules would require facilities to collect data and report on the total number of involuntary transportation holds received by the facility. 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 them.	CHA recommends striking section 11.5.2.9.
11.7.3 Documentation	Subsection E.1 safety plan documentation requirement wording appears to go far beyond the standard established by HB 22-	CHA recommends the section is amended as follows: 11.7.3.E.1 emergency services facilities will develop crisis

in Individual Records	1256 and also appears to incorrectly apply the requirement to individuals who were not placed on emergency mental health holds.	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~~ The BHA stated that safety planning is necessary in order to reduce the chances of an individual escalating to the point of needing to be placed on an emergency mental health hold again. CHA understands this intent and would note that the proposed language would cover individuals who were placed on an emergency mental hold at one point.
	Subsection E.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 to identify those other social supports. While facilities often do this if desired by the patient, it should not be in regulation.	CHA recommends striking 11.7.3.E.2.
	Subsection E.3 requires facilities to develop a safety plan that includes information about psychiatric and medical advance directives. This requirement is more prescriptive than the statute and conflicts with standards put out by The Joint Commission. Upon discharge, the statute requires either a psychiatric advance directive or information on how to establish a psychiatric advance directive if one is not presented and requires this directive to be included in discharge instructions, not the safety plan (CRS 27-65-106(8)). Additionally, The Joint Commission requires hospitals to develop a safety plan with the patient (NPSG 15.01.01 EP 6) and promotes the use of the Stanley Brown Safety Plan, which does not include information on psychiatric and medical advance directives. Psychiatric and medical advance directives are	CHA recommends striking 11.7.3.E.3.

	generally provided in the "after visit summary" that a patient is discharged with.	
	Subsection F.4 requires EDs to assist in care coordination for the follow up appointment, if needed. EDs are not the right entity to assist in care coordination for follow-up care. While EDs can often serve as the best setting in a crisis, they often do not have a care coordination role or ability to schedule follow-up appointments.	CHA recommends striking "Facility must assist in care coordination for the follow-up appointment, if needed;"
	Subsection K allows facilities to facilitate follow-up care through a third-party contract and requires the facility to provide authorization from the individual. If the individual does not provide authorization, the facility should be relieved of all follow-up requirements. Many facilities contract with third-party entities to provide follow-up care as they do not have the staffing ability to provide it themselves.	CHA recommends adding language to read as follows: "…the facility shall obtain authorization from the individual to provide follow-up care. If the individual does not provide authorization for follow-up care, all follow-up requirements placed on the facility will be considered fulfilled."
	Subsection O requires follow up with the patient and authorized caregiver and/or family members within 24 hours. This is inconsistent with the statute, which requires follow up within 48 hours. The regulation should not place restrictions beyond language that was agreed to by stakeholders in statute. There are existing agreements in place in regard to follow-up timelines that would be disrupted by this requirement. Additionally, the regulation should allow the follow-up requirement to be fulfilled if a patient doesn't provide consent to receive follow up.	Modify the language as follows: "receive follow up by phone or telehealth within forty-eight (48) hours if the patient consents. If the patient does not consent, all follow-up requirements placed on the facility will be considered fulfilled."
11.9 Seclusion, Restraint, and Physical Management	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.	CHA recommends cutting this section and cross reference existing regulation in 6 CCR 1011-1:2-8.1. While the proposed regulation is currently in alignment with CDPHE regulations regarding seclusion and restraint, CDPHE regulations could change at some point in the future, causing misalignment and therefore

	Additionally, CHA recommends removing any language that is overly prescriptive and inconsistent with requirements placed on hospitals on the physical health side. For example, language was added to 11.9.10.J to require soiled adult diapers to be changed immediately, but there is no corresponding requirement to do that for patients that are seen for solely physical health issues.	potentially two conflicting standards for facilities to follow. CHA recommends cross-referencing the CDPHE regulation to prevent such misalignment.
11.14.2 Court Orders for Screening and Evaluation	11.14.2.I states that each individual detained for an emergency mental health hold must receive an evaluation as soon as possible after the individual is presented to the facility. This requirement is inconsistent with the authorizing statutory language, which states that an individual must be screened immediately or within eight hours if an intervening professional is not immediately available.	Edit 11.14.2.I to read "shall receive an evaluation as soon as possible or within eight hours if an intervening professional is not immediately available after the individual..."
	Subsection K 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 or have someone with two years of experience review and provide their signature on the evaluation. The statute requires the evaluation to be completed by an intervening professional. Therefore, in line with the spirit of the law, the sign off from someone within two years of experience should be expanded to include all intervening professionals, instead of just professional persons.	CHA appreciates the addition of language to allow for sign off on an evaluation if it is completed by a professional person without two years of experience. However, to remain consistent with the statute, CHA recommends that all intervening professionals with two years of experience be allowed to sign off on an evaluation rather than just professional persons. CHA has some operational questions that could be clarified in the regulation: • Will experience prior to obtaining a license go towards the two-year requirement? CHA recommends that, consistent with DORA, the two years of experience to obtain a clinical licensure should be sufficient to meet this requirement.
11.14.3 Individual Rights for Emergency	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	We request significant updates to the procedural manual and stakeholder work with both hospitals, patient safety experts, emergency department staff, and organizations

Mental Health Holds	interpretation. For example, 11.14.3.A.19 and 11.14.3.A.20 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.	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.
	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 (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.	Strike 11.14.3.A ~~and must be explained to the individual and provided in written form.~~
	For emergency medical services facilities, where patients are detained on an M-1 hold typically in an emergency department setting, there is nothing in C.R.S. § 27-65-106(10)(a) that gives patients the right under 17 to receive and send sealed correspondence, or under 18 to have access to letter-writing materials and postage. 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.	Strike 11.14.3.A.17, 11.14.3.A.18, and 11.14.3.A.24.
	11.14.3.A.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	Edit 11.14.3.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."~~

	restrictions beyond language that was agreed to by stakeholders in statute.	
11.14.6 Procedures for Subsequent Emergency Mental Health Holds	This section would require the facility that places an individual under a subsequent emergency mental health hold to immediately notify the court. 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.
11.16 Involuntary Emergency Services 11.16.1.A & 11.16.1.C 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.	CHA recommends striking 11.16.

Additional Points of Clarification:

- In response to a stakeholder question about individuals on medical/surgery floors needing involuntary psych treatment, the BHA stated that EDs should get designated so patients can move throughout medical floors. CHA requests clarification as facilities are the ones that get designated, not certain floors within a facility.
- The BHA stated in response to stakeholder feedback that they added a definition for "discharge summary." CHA asks for clarification on where this language is included, as we cannot find it in Chapter 11.
- The BHA stated in response to a stakeholder question that only one additional subsequent hold may be placed. CHA believes this is inaccurate. Statutory language allows for multiple subsequent holds if appropriate placement options cannot be located, and the person continues to meet the criteria for a hold. Statute also documents the process for each subsequent hold (CRS 27-65-106(7)(b)).