Oct. 5, 2023

Colorado State Board of Human Services
Colorado Department of Human Services
Via email to kyle.zinth@state.co.us

Members of the Colorado State Board of Human Services:

On behalf of Colorado Hospital Association (CHA) and its more than 100 member hospitals and health systems statewide, I am writing to provide feedback on the Behavioral Health Administration (BHA) Provider Rules. The following comments and suggestions that CHA has submitted to the BHA in the past to support implementation and operational success.

CHA appreciates the BHA's collaborative nature on both regulatory processes and procedural guidance necessary to ensure a smooth implementation of House Bill (HB) 22-1256, HB 22-1278, and HB 23-1236. CHA especially commends the BHA staff on their thoughtful approach and willingness to work with hospitals to find solutions. While CHA is grateful that the BHA accepted a great many of CHA's and other stakeholders' feedback and suggestions over the last several months, the below comments reflect remaining recommendations that are important to address for the well-being of patients, providers, and the communities they serve.

I ask that the Colorado State Board of Human Services consider CHA's recommendations. Overall, CHA notes 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 the Association knows 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. I sincerely appreciate the BHA's and the State Board of Human Services attention to these areas as we all work toward the successful reform of the state's behavioral health safety-net system.

All licensed providers involved in an individual's care should be able to deny individual rights. Section 11.14.3.A.23 states that only the "professional person" may deny an individual's rights. CHA recommends that all licensed providers involved in an individual's care be allowed to deny rights as appropriate in the interests of safety or patient stabilization, as described in C.R.S. § 27-65-106(10)(b). Particularly in smaller, rural facilities, a professional person might not be immediately available and rights may need to be denied in order to preserve the safety of the patient. CHA understands that the statue has conflicting information that the BHA is working with the attorney general (AG) on and awaits a final determination.

Information about how to establish a psychiatric and medical advance should be provided separately from the safety plan at discharge.
Section 11.7.3.E requires facilities to develop a safety plan that includes information about psychiatric and medical advance directives. C.R.S. § 27-65-106(8) requires facilities to provide upon discharge either a psychiatric and medical advance directive or information on how to establish a psychiatric and medical advanced directive if one is not presented. However, the statute does not require such information to be included in the safety plan and including such in a safety plan runs counter to current practice as it is clinically inappropriate to discuss advance directives during the crisis period. Rather, advance directive information should be included in materials separate from the safety plan at discharge. Advance directives are best done when an individual is in recovery, not in crisis. The safety plan is meant to be the patient's resource during crisis. 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.

Age of consent for treatment and medication should be identical to and mirror statute.
Both C.R.S. § 27-65-104 and the proposed rule packet allow for a minor 15 years and older to consent to their own behavioral health treatment without the consent of a parent or guardian. However, section 11.8.1.A of the rule packet says that minors 15 to 17 years old cannot consent to medications – part of their behavioral health treatment – unless a minor is "living separately and apart from the minor's parents or legal guardians and is managing the minor's own financial affairs, regardless of the minor's source of income, or who is married and living separately and apart from the minor's parents or legal guardians." If a patient aged 15 to 17 can consent to behavioral health treatment without a parent or guardian's consent, the same requirement should apply when consenting to medication.

Seclusion, restraint, and physical management requirements should reference existing regulation to ensure continued alignment.
Section 11.9 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. CHA recommends cross-referencing regulation to ensure continued alignment. CDPHE regulations could change at some point in the future, causing misalignment and therefore potentially two conflicting standards for facilities to follow.

Individual rights provided to patients should not go above or beyond those listed out in statute.
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. While these rights are listed in regulation [2 CCR 502-1 (21.280.26.C.2)], there is no statutory basis for providing these rights and thus they should be removed from the proposed regulation.

Hospitals should not be required to report on data involving transportation holds.
Section 11.5.2.9 requires 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.

I request consideration of these recommendations to ensure operational success and welcome further dialogue with the BHA on these issues.

Regards,

/S/ Adeline Ewing
Adeline Ewing
Policy Analyst