FREQUENTLY ASKED QUESTIONS: BEHAVIORAL HEALTH RULES

GENERAL QUESTIONS

"Why is individual used instead of client?"

<u>Response</u>: In 2010, House Bill 10-1137 updated rule-making processes to include personcentered language mandated that any new regulations would use person-centered language. Therefore, throughout these rules, language has been updated to reflected individuals or persons receiving behavioral health services instead of using "patient", "client", "consumer", etc.

"Why are there so few definitions at the beginning of the volume?"

Response: Definitions are found at the beginning of the sections that they are specific to.

21.100 DEFINITIONS

"The definition of 'case management' does not match the definitions provided in the 2006 Deficit Reduction Act. The State's Uniform Coding Manual has been updated to reflect these changes."

<u>Response</u>: Agencies using the 2012 Uniform Service Coding Standards Manual will continue to follow it for its intended purpose. Within OBH's behavioral health rules, case management is used within many different treatment environments, therefore the definition is not meant to be specific to any one population.

Does "Inpatient" include residential?

<u>Response</u>: Yes. For the purposes of these rules, inpatient means inpatient hospitalization as well as residential levels of care unless otherwise specified.

"The definition of "professional person" should include an Advanced Practice Psychiatric Nurse (Psych APN)."

<u>Response</u>: Statutory change would be required. Within the Colorado Revised Statues, a "Professional Person" is defined as: "a person licensed to practice medicine in this state, a psychologist certified to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the United States, the United States public health service, or the United States department of veterans affairs" (27-65-102(17), C.R.S.).

21.120 BEHAVIORAL HEALTH LICENSURE AND DESIGNATION

"In the section on **Initial Licenses**, **21.120.22A**, it states: " ...applicants for an initial license to provide substance use disorder services shall... ". Should mental health agencies be included here?"

<u>Response</u>: No. OBH designates agencies to provide mental health services. It does not license mental health agencies. Agencies providing mental health services are licensed by the Colorado Department of Public Health and Environment. Parallel designation processes to licensing can be found in Section **21.120.4**, **Designation Procedures**.

"Why is the licensing process every two years?"

<u>Response</u>: Licensing and designation timeframes and processes have been aligned. The two year renewal cycle supports ensuring quality care and rights of individuals receiving services. It provides for more timely accountability and technical assistance. Moving from a three to two year licensing schedule also brings OBH more in line with other State department licensing practices.

"Why does each physical site need to be licensed to provide substance use disorder services?" [Section 21.120.21.B, Criteria]

<u>Response</u>: Licensing individual sites allows for tracking which services and levels of care are being provided and to monitor the training and credentials of staff providing those services. Not all sites serve the same populations or offer the same level of care. The license number is helpful to the public in finding what they are looking for.

In the event of a complaint or grievance, it is easier to identify the location by using the corresponding license number. Agencies that have more than one site have also found it beneficial to identify the specific site of the allegations and know exactly where to pinpoint the issue. Action on a license would then be taken at that specific location instead of sanctioning the license of the entire agency.

"In Section **21.120.3**, **Facilities Designated to Provide Mental Health Services**, is this just referencing mental health holds? Or does it also apply to substance use disorder holds, which are specifically discussed later in Section 21.260, Alcohol and Drug Emergency Commitments?"

<u>Response</u>: Section **21.120.3**, Facilities Designated to Provide Mental Health Services, refers to 4 types of facility designations: 1) facilities designated pursuant to Colorado Revised Statute 27-65-101 et seq., for seventy-two hour treatment and evaluation, short and long term mental health treatment; 2) Community Mental Health Centers, 3) mental health specialty clinics; and 4) Residential Child Care Facilities (RCCF).

This section does not include substance use disorder emergency commitments (see Section 21.260).

21.130 DATA REQUIREMENTS

"The CCAR and DACODS should be simplified into a single form and only have the minimum necessary fields to make federal reporting and give outcome /quality measures that are more consistent with measures used in physical health care settings."

<u>Response</u>: OBH has just formed a steering committee for what is currently known as the Colorado Behavioral Health Integrated Data Tool initiative. This committee is addressing the integration of CCAR and DACODS. Revisions and enhancements to the current CCAR and DACODS platforms are currently under way. A new integrated instrument is scheduled to come on line in 2015.

21.140 CRITICAL INCIDENT REPORTING

"Can state departments align and share the same form and reporting information? We already report to CDPHE and Division of Child Welfare. The process is redundant."

<u>Response</u>: OBH has and will continue to have dialogue with our state partners regarding efforts to align state reporting.

"For Critical Incident reporting to the Office of Behavioral Health, is it one (1) business day or twenty-four (24) hours?

<u>Response</u>: Within twenty-four (24) hours of knowledge of the incident, and it depends on the facility's hours of operation. If a facility operates twenty-four (24) hours per day, seven (7) days per week (i.e. hospitals, residential programs), then critical incident reporting is that same day or within twenty-four (24) hours of knowledge of the incident, including weekends and holidays.

"Where can I find the Critical Incident Form?"

<u>Response</u>: The link below will take you to the OBH website where the "Critical Incident" link can be found under Policies. .

http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDHS-BehavioralHealth%2FCBONLayout&cid=1251581927776&pagename=CBONWrapper

21.150 QUALITY IMPROVEMENT

"In Section 21.150.B.1, what are the standards of quality indicators that OBH expects?"

<u>Response</u>: Section **21.150.B.1** reads: "The agency shall adopt and implement a written quality improvement plan that includes....clinical quality measurements of performance...". These are not prescribed by OBH. The agency may determine the criteria and standards.

[&]quot;Are there any specific outlines/quidelines we need to use for a quality improvement plan"?

Response: The Office of Behavioral Health does not prescribe what form a Quality Improvement (QI) plan should take. Quality Improvement plans should take into consideration trending in grievances or critical incidents. There are websites that can provide guidance on developing and implementing a QI plan such as the federal Substance Abuse and Mental Health Administration (SAMHSA) at http://www.samhsa.gov or the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) at http://www.hrsa.gov/quality/toolbox/methodology/developingandimplementingagiplan/

21.160 PERSONNEL

"Do all volunteers and interns need background checks?"

Response: Section **21.160.2**, **Background Checks and Employee Verification**, states that background checks are to be completed for "all staff, interns and volunteers who have direct contact with individuals receiving services". Staff, volunteers, and interns providing face-to-face care, counseling, supervision, and other treatment services regardless of level of supervision, are to have a documented background check.

"Where can I find information on requesting a Trails Background Check for staff who are treating minors?" [Section 21.160.2A.3]

<u>Response</u>: Trails is the State central registry of child protection and is a child welfare automated database. Background checks can be requested through the Boards and Commissions Division, Background Investigation Unit at 303-866-4614 or directly through their website at: http://www.colorado.gov/cs/Satellite/CDHS-ExecDir/CBON/1251610438070

21.170 RECORDS CARE AND RETENTION

"How will the timeframes for record retention be phased in if we have been using different retention periods?" [Sections **21.170.1.B** and **C**]

<u>Response</u>: For persons discharged from services after November 1, 2013, outpatient records shall be kept for seven (7) years and inpatient records retained for ten (10) years.

"Does this section mean the entire record? At one point full records were kept for a period of time and discharge records for an additional period of time."

<u>Response</u>: The retention periods refer to the entire record and are implemented at the time of discharge. There is no <u>additional</u> retention period for discharge summaries.

"Why retain records for seven (7) years?"

<u>Response</u>: Records retention timeframes have been updated to align with statute 27-65-121(4), C.R.S. and the Department of Regulatory Agencies, Division of Professions and Occupations rule for record retention.

21.170.3 RELEASE OF INFORMATION

"Does the release of information (ROI) two year expiration requirement follow 42 CFR or HIPAA which allows for event, episode of care, or conditions as the expiration."

<u>Response</u>: 42 CFR and HIPAA do allow for a specific time frame expiration dates. The two-year expiration requirement upholds the appropriate minimum standard of care for the residents of Colorado and is a protective measure for consumers. OBH outreached consumers, family, and advocacy groups and heard that if releases instead had an event or condition (such as an episode of care) as the expiration date; it would be too open ended.

21.180 GRIEVANCES

"Grievances must be reported annually to OBH? Is this new?"

<u>Response</u>: Historically and currently certain groups of providers report on a quarterly basis. The integration of mental health and substance use disorder rules streamlines this standard across all licensed and designated program areas.

"Is reporting of annual grievance data to the Office of Behavioral Health specific to behavioral health grievances, or all grievances that happen in our hospital?"

<u>Response</u>: For hospitals, only report grievances related to behavioral health services.

"Can the grievance rep person be the clinical supervisor?"

<u>Response</u>: No. The grievance representative cannot be a person who is involved in the clinical care or regular care of the individual.

21.190 DOCUMENTATION IN INDIVIDUAL RECORDS

"Can a stamp be utilized to meet the requirement for signing treatment entries?" [Section 21.190.5, Treatment Progress Documentation]

<u>Response</u>: Yes, if the stamp includes first initial, last name, and professional licensure or certification credentials (or academic degree).

21.190.3 ASSESSMENT

"How are admission summaries different from assessments and screenings?" [Section 21.190.2.B.4 Content of Records]

<u>Response</u>: An admission summary is a brief review of assessments and other relevant intake data that summarizes the current status and provides a basis for individualized treatment planning.

"What does re-assessment mean? Is a full assessment instrument (i.e. ASI) completed again?" [Section 21.190.3, Assessment]

<u>Response</u>: It depends on the population. Specific assessment instruments administered at the beginning of treatment may not be applicable or be part of a re-assessment. At minimum, the reassessment should follow **Section 21.190.3**.

"If Probation is administering the ASUDS as part of their assessment, does a licensed SUD agency need to administer another assessment prior to admission into DUI education?"

<u>Response</u>: The screening conducted by probation, which includes the ASUDS, is not considered a clinical assessment. Agencies must conduct a comprehensive assessment [Section 21.190.3, Assessment], and the results of the screening can be incorporated into that assessment.

"How detailed does assessment of trauma have to be?" [Section 21.190.3.D.14, Assessment]

<u>Response</u>: Screening of trauma history should be adequately documented to inform the potential impact on service planning and treatment. If there is no noted trauma, please do not leave this blank. Make notation that the individual does not identify current or historical trauma issues.

"If Probation is administering the ASUDS as part of their assessment, does a licensed SUD agency need to administer another assessment prior to admission into DUI education?" [Section 21.190.3, Assessment]

<u>Response</u>: The screening conducted by probation, which includes the ASUDS, is not considered a clinical assessment. Agencies must conduct a comprehensive assessment, and the results of the screening can be incorporated into that assessment.

"It's unclear what it means to have advance directives as part of the clinical record. [Section 21.190.2.B, Content of Records and 21.190.3.D, Assessment] Does this just mean that the client can give us a copy for their record (if applicable) or that we have to help them create an advance directive or just document whether or not they have one?"

<u>Response</u>: The Federal Patient Self Determination Act (PSDA) addresses the rights of health care users, including behavioral health, to stipulate how s/he would like to be treated by providers when incapacitated. Advance Directives are one form of rights. Knowing and documenting a person's advance directives (psychiatric, health care proxy, medical Durable Power of Attorney, living wills) respects the person's right to behavioral health and medical treatment preferences.

Advance directives may identify emergency contacts and a health care proxy or agent who can assist in making health care decisions when the person is unable to do so. They may also identify specific names of psychotropic medication that the person does not want administered in the event of a psychiatric emergency.

If available, a copy of an advance directive should be kept in the record. Any information verbally provided by the individual to a provider with regard to an advance directive should be noted. In the event of a psychiatric or medical emergency, advance directives should be

conveyed to the entity that will be providing direct treatment (ambulance and fire emergency responders, hospital, behavioral health designated facility).

If an individual asks for more information on how to complete a psychiatric/medical advance directive, the facility can refer the person to community or internet-based resources. The facility does not have to furnish or complete an advance directive with the person.

"Acute Treatment Unit (ATU) timeframes for assessment and service planning are more restrictive than hospital level of care, why?" [21.190.3.A Assessment and 21.190.4.D Service Planning]

<u>Response</u>: Assessment within ATU settings has always been within twenty-four (24) hours. This is not a change from current rule. ATU service plan reviews were revised to be three (3) days as the average length of stay is three to five (3-5) days.

21.190.4 SERVICE PLANNING AND REVIEWS

"Signing of treatment plan reviews by clients is difficult in an Electronic Health Record. Do you have some suggestions around how to address this? Is there another way we can document client and parent involvement (on various documents) besides requiring a signature?" [Section 21.190.41.F, Service Planning and Reviews]

<u>Response</u>: Signatures in electronic health records can be captured by a signature pad, authentication known only to the individual such as PIN, or signatures on the paper document that is then scanned back into the system.

"Does a client in detox or residential treatment have to sign the service plan?"

<u>Response</u>: Yes. Clients need to be part of the service planning process and reviews and be offered a copy of the plan. If s/he refuses to sign or cannot sign a service plan, document same and the reasons.

"Can service plan reviews be considered a re-assessment?" [Section 21.190.42 Service Planning and Reviews]

<u>Response</u>: No. Service planning is guided by assessment. Service plan reviews are specific to progress made on goals and objectives and the need to change interventions or level of service based on changes in level of care or service needs.

"Why are outpatient service plan reviews every six (6) months instead of annually as they are for Medicaid?" [Section 21.190.4, Service Planning and Reviews]

<u>Response</u>: The six month timeframes are within federal CMS guidelines and what OBH believes to represent the minimum standard of care for Colorado residents in outpatient

behavioral health settings. This also aligns with the Uniform Services Coding Manual which allows for service planning every six (6) months or as needed.

"In Section **21.190.41, Service Planning and Reviews**, it states the service plan requires interdisciplinary team member's signatures. If the client has a counselor, probation officer, and/or case manager, do they all have to sign the service plan?

<u>Response</u>: The service plan shall be developed by an interdisciplinary team when applicable and all individuals who participated in developing the service plan shall sign the plan. If your interdisciplinary team came together after the assessment to discuss and develop the direction of treatment for an individual's service plan and if the individuals involved in developing the service plan were the client, counselor, and probation officer/case manager, all of these individuals would sign the service plan. If the individual has a probation officer/case manager, but this staff was not a part of the team who developed the service plan, then there is no need to have this staff sign the service plan.

"Are service plan reviews every six (6) months for medication management only clients?"

<u>Response</u>: No, service plan reviews for persons receiving psychiatric /medication services only are completed annually. **Section 21.190.7**, **Medication/Psychiatric Services Only** at Mental Health Centers and Clinics, delineates what should be included annually.

"How often should DUI service plans be reviewed?"

<u>Response</u>: Service plans are updated when there is a change in level of care, functioning, or service needs and at minimum within sx (6) months. For individuals in Level II Education and Therapy, an assessment and service plan update is conducted when the individual completes Level II education and begins Level II Therapy. [Also see Section 21.240.81.G]

21.190.6 DISCHARGE PLANNING AND SUMMARIES

"The requirement to 'discharge' patients from outpatient services is a significant conflict and barrier to ongoing access to care as well as continuity of care." [Section 21.190.6, Discharge Planning and Summaries]

<u>Response</u>: OBH has noted that the rules do not prescribe when an individual is discharged from service. Rather, the rules speak to <u>when</u> an individual is discharged, what the minimum requirements are regarding discharge planning and discharge summaries. OBH will be discussing episodes of care and transfer versus discharge in the coming year. Communication is central to continuity of care for the patient and with other service providers. Discharge information provided to the client facilitates arrangements for any follow-up services and community resources.

21.200 CARE AND TREATMENT OF CHILDREN, YOUTH AND FAMILIES

"What is the definition of youth?"

<u>Response</u>: For individuals receiving services in an OBH designated Residential Child Care Facility (RCCF), youth means ages zero to twenty-one (0-21), for all other purposes, youth means under the age of eighteen (18).

"In **Section 21.200.13**, **Rights of Children and Adolescents**, children fifteen and older can consent to treatment without parental consent. Is this consistent with consents in 42 CFR Part 2?"

Response: Yes. The Legal Action Center states: "Both HIPAA and 42 C.F.R. Part 2 leave the issue of who is a minor and whether a minor can obtain health care or alcohol or drug abuse treatment without parental consent, entirely to state laws. Although HIPAA and 42 C.F.R Part 2 have somewhat different approaches to the issue of minors, the final result is the same under both laws".

"Section 21.200.2, Minor in Possession, requires those younger than sixteen (16) be placed in a separate group from those seventeen to twenty (17-20) years old. What if that is not possible?"

<u>Response</u>: The rule states "when possible" to treat youth under sixteen (16) in separate groups from older youth.

21.210 AGENCIES LICENSED TO PROVIDE SUBSTANCE USE DISORDER SERVICES

"Why are therapeutic groups limited to a group size of twelve?" [Section 21.210.43.E, Provision of Servcies]

Response: Most literature suggests that between eight (8) and twelve (12) is an optimal group size. Groups that are not "closed" do not meet criteria to be considered "therapeutic". The state made the decision to not go that far, but to limit the group to not regularly exceed twelve (12). A limited size allows the facilitator to better engage group members and it allows the individuals to have the opportunity to discuss and practice the treatment topics.

"In **Section 21.210.5**, **Levels of Care**, why do the ASAM licensing categories have different names now and are there new categories?"

<u>Response</u>: OBH licenses to ASAM levels of care and those levels have been updated by the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R). Day treatment is now referred to ASAM Level II.5 and the modality is known as partial hospitalization. Facilities delivering ASAM Level III.1 are clinically managed low-intensity residential services, formerly known as transitional residential treatment. Facilities

delivering ASAM Level III.3 level of care is known as clinically managed medium-intensity residential services. This is not a new ASAM level, however is being included as a licensing category. ASAM Level III.5 is delivered as clinically managed high-intensity residential services and also is a SOA-R Level 4d. This level may represent a step-down from Level III.7 or therapeutic communities are also a common modality under this level of care. ASAM Level III.7 is medically monitored intensive residential treatment and a SOA-R Level 4c. The former modality equated with this level of care was intensive residential treatment.

"Why is there a twenty-to-one (20:1) resident-to-staff overnight ratio for ASAM Level III.5?"

[Section 21.210.57 Clinically Managed High-Intensity Residential Services, SOA-R Level 4d]

<u>Response</u>: ASAM Levels III.1, III.3, and III. 7 have had this requirement for years. Persons meeting this level of care (Level III.5) have extensive substance abuse disorder treatment or criminal justice histories, chaotic, non-supportive, and often abusive interpersonal relationships, and antisocial value systems. The twenty-to-one (20:1) resident to staff ratio is for resident and public safety.

21.220 GENDER RESPONSIVE WOMEN'S TREATMENT IN SUBSTANCE USE DISORDER PROGRAMS

"What does 'emotional and physical safety of individuals takes precedence over all other considerations in the delivery of services' (Section 21.220.1.D.1) mean?"

Response: This means that if you are using an intervention that is highly confrontational, you must have a "stop" mechanism in place for use when people are triggered. If a client talks about feeling unsafe, you must address that feeling before proceeding with treatment.

"Does OBH want to know every time a pregnant woman is given an initial appointment farther out than two (2) days (Section 21.220.4.D, Services to Pregnant Women)?"

<u>Response</u>: Yes. Per Block Grant requirements, any funded program should be contacting OBH if they cannot offer a woman an appointment in less than forty-eight (48) hours.

"How do you apply **21.220.1.F**: Agency policy and procedures shall include the criteria for interventions offered and expected outcomes of services delivered?"

<u>Response</u>: This is in lieu of requiring a specific curriculum be used. OBH can provide technical assistance.

21.230 SUBSTANCE USE DISORDER EDUCATION AND TREATMENT FOR PERSONS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

"Does this section apply to any behavioral health treatment for clients involved in the criminal justice system or just for clients who have substance use disorders?"

<u>Response</u>: This section was formally known as Offender Education, Treatment and Adjunct Services. Offender has been replaced with person-centered language and this section only applies to agencies licensed to provide substance use disorder services to this specific population.

"General provisions **21.230.1** states that staff shall have documented qualifications and training in forensic populations and criminal justice system. Is this all staff and how should qualifications be documented?"

<u>Response</u>: Staff working directly with these individuals need to have the qualifications and necessary training to work with persons involved in the criminal justice system.

Documentation of qualifications can be accomplished by staff submitting college transcripts, training certificates, or through a reference check of previous employment. This information should be placed in the personnel file so it is available upon request.

"Outpatient groups that must be two (2) hours long seems like too much for most curriculums. Why isn't an hour and a half (1 ½) sufficient, and long enough to require clients to be in a group?" [Section 21.230.1.H]

Response: This is not a change but rather a clarification to the current rule which states: "Frequency and intensity of education and treatment services shall be based on client assessments or as required by referring criminal justice agencies, but shall not be less than two (2) hours per week." Group sessions for the offender population for all levels of care requires the group session to be two hours in length as the curricula developed for this population are structured for the two hour length to cover the material effectively.

21.240 DUI, DWAI, BUI, FUI EDUCATION AND TREATMENT

"Why are level II therapy group sessions at least two (2) hours?" [Section **21.240.81.D, Level II Outpatient Therapy**]

<u>Response</u>: The change to two-hour level II therapy groups is intended to increase the consistency with level II education which is in a two-hour format and also to be more consistent with DUI specific curricula. This change is more consistent with the required hours, all of which are even numbers (42, 52, 68 and 86). This change also provides greater consistency and standardization throughout DUI programs in Colorado.

"If Probation is administering the ASUDS as part of their assessment, does a licensed SUD agency need to administer another assessment prior to admission into DUI education?" [Section 21.190.3, Assessment]

<u>Response</u>: The screening conducted by probation, which includes the ASUDS, is not considered a clinical assessment. Agencies must conduct a comprehensive assessment, and the results of the screening can be incorporated into that assessment.

"Are there provisions for an extra session per week if there is a holiday?"

<u>Response</u>: There is no provision for "doubling up" groups without a clinical justification based on client needs. If a group is going to be cancelled because of a holiday the agency can simply cancel, reschedule that group for a different day within that week, or allow education clients to attend a different group for that week. Attending a different group for the week for education is appropriate, but not for therapy (**Section 21.240.3.C**)

"Level 1 and 2 therapy requires face- to-face contact, but some of my DUI clients go to other agencies for groups. In the past this was able to be counted as therapy. Has that changed since it is not face-to face-with me?"

<u>Response</u>: Since the services provided by these other counseling agencies are face- to-face, credit can be given for the services received in accordance with **Section 21.240.9** - Level II Behavioral Health Services. The DUI provider does not have to personally provide every face-to-face service to the client, face-to-face services provided by non-DUI licensed clinicians can still be credited.

21.250 NON-HOSPITAL RESIDENTIAL DETOXIFICATION

"Why is the blood alcohol level (BAL) discharge changing from 0.04 to 0.00?" [Section 21.250.4.B]

Response: Requiring a BAL 0.00 prior to discharge from a detox unit decreases the liability should individuals harm themselves or others after leaving a detoxification program that was treating the person. Individuals with a high tolerance for alcohol can appear "more sober" at a 0.04 than others, which gives them a false sense of security and a perception that they could drive responsibly or behave in a manner that actually could endanger themselves or others. Anyone with a history of seizures/DT's can remain at risk for seizures/DT's long after they are at 0.00 and the longer these person is at detox, the greater accessibility to staff and medical help if needed.

"Are there specific trainings OBH requires to meet the eleven areas in Section 21.250.5?"

<u>Response</u>: The eleven training categories in this section are mandatory for all Detox staff to demonstrate a working knowledge to ensure the minimum standard of care is maintained. During licensing reviews, OBH staff will require agencies to provide documentation that staff have participated in all eleven trainings. OBH does not prescribe specific trainings to meet this requirement.

"Can a Licensed Addiction Counselor (LAC) oversee day-to-day operations?"

Response: Yes, a Licensed Addiction Counselor may oversee day-to-day operations in non-hospital residential detox facilities.

21.260 ALCOHOL AND DRUG EMERGENCY COMMITMENTS

"What type or level of funding from Managed Service Organizations (MSO's) obligates a provider to be licensed to treat individuals on involuntary commitment?"

<u>Response</u>: Licensing and Funding are two different issues. Not all the programs licensed by OBH are funded by OBH. For those that are, contracts exist that clarify obligations between the MSO and the substance use disorder treatment programs.

"Who can initiate and terminate an alcohol or drug emergency commitment?"

<u>Response</u>: **Section 21.260.B** states that the treatment facility administrator designates who can authorize and terminate Emergency Commitments. By statute, any responsible person can make an application, e.g., a law enforcement officer, physician, spouse, guardian, relative, non-relative, etc.

21.270 ALCOHOL AND DRUG INVOLUNTARY COMMITMENTS

"Is OBH looking for something specific in regard to completing fourteen (14) hours for training in interviewing and engaging clients?"

<u>Response</u>: No. It is up to the agency to determine the type of training or class to meet the requirement. During licensing reviews, OBH staff will require agencies to provide documentation that staff have participated in trainings.

21.280 CARE AND TREATMENT OF PERSONS WITH A MENTAL HEALTH DISORDER IN A DESIGNATED FACILITY

"Why have Psychiatric Advanced Practice Nurses (APNs) not been added to persons who can place a person on a mental health short or long-term civil commitment?"

<u>Response</u>: Current Colorado Revised Statute pursuant to Title 27, Article 65, limits the certification of a person for short or long-term commitment to a "Professional Person", defined as: "a person licensed to practice medicine in this state, a psychologist certified to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the United States, the United States public health service, or the United States department of veterans affairs.

"How do written orders need to be documented and who can write them?"

<u>Response</u>: Orders for seclusion, restraint, or emergency medication are documented in the medication administration record (MAR) and in the physician orders section of the chart. These orders are written by a Colorado licensed physician or psychologist (excepting ordering of medication).

"Can a BSN (Bachelor's level nurse) complete an M-1 (72-hour mental health hold)?"

<u>Response</u>: No. Under 27-65-105(1)(II)(C), C.R.S., the person would have to be a "registered professional nurse..., who by reason of postgraduate education (Master's degree or higher) and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing".

"If unable to find a bed to transfer a patient on an M-1 hold, can another M-1 be completed when the first one expires?"

<u>Response</u>: No. Multiple M-1 mental health holds do not comply with 27-65-105(4), C.R.S. Per State statute, within 72-hours of an M-1 being initiated, one of three outcomes needs to

happen: 1) the person no longer meets criteria for services and is discharged with no further follow-up; <u>OR</u> 2) the person no longer meets imminent danger/gravely disabled criteria and accepts voluntary mental health services; <u>OR</u> 3) the person continues to meet imminent danger/gravely disabled criteria and is certified for short-term treatment at a designated facility.

"What department collects and tracks placement facility agreements?" [Section 21.280.25, Placement Facilities]

Response: OBH's quality assurance section tracks placement facility agreements.

"Can you explain under what circumstances a placement facility agreement would be used?" [Section 21.280.25, Placement Facilities]

Response: Placement Facility Agreements (PFA's) are used when 27-65 Designated Facilities place someone on a short or long-term certification into a residential setting (i.e. when a person on an outpatient long-term certification held by a community mental health center is placed in a nursing home) **OR** into an in-patient medical unit (i.e. a free standing psychiatric hospital transferring a patient to an oncology unit for brief medical treatment) for continuity of care. The PFA addresses continuity of care issues such as monitoring court-ordered medications and providing psychiatric consultation. The facility holding the 27-65 certification initiates the PFA with the receiving facility.

"If the Patient Rights and the notice of patient Representative are posted on in-patient units, do they also need to be posted in in the Emergency Department?"

Response: Yes. The Rights and information on who , where, how, why to contact the Patient Representative is to be posted in prominent places frequented by patients/clients and their families and were they may be held on an M-1 application for a 72-hour Mental Health Hold.

"Do we need to advise and complete the M-2 rights when a short-term certification is terminated and the person signs in voluntarily?"

<u>Response</u>: No. **Per Section 21.280.26.D**, the M-2 rights are required when there is a change in legal status due to initiation of an M-1 or court-ordered certifications for involuntary mental health treatment. That includes when application is made from an M-1 to a short-term certification, when the court approves changes in legal status from short-term certification to short-term certification extension, extended short-term certification to long-term certification, long-term certification to extended long-term certification, and from extended long-term certification to extended long-term certification.

"What is an e-med and when should it be documented?" [Section 21.280.34, Psychiatric Emergency Conditions]

<u>Response</u>: An emergency psychiatric medication may be medications used as part of the person's usual psychiatric treatment and/or is used to manage behavior due to an emergency psychiatric condition. An emergency psychiatric condition exists if the person is determined to be in imminent danger of harming him/herself or others or by a recent overt act or threat to harm oneself or others.

Chemical restraints as defined by HHS in 42 CFR § 482.13(e)(1)(i)(B) are "A drug or medication when it used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." Chemical restraints cannot be ordered PRN and may be administered involuntarily. For person's on a 72-hour hold, short-term certification or long-term certification and are involuntary administered psychotropic medications, this is considered an involuntary emergency psychiatric medication and needs to be documented in accordance with 21.280.34 and included in 27-65 data under involuntary medications (not restraint data) submitted to the Office of Behavioral Health.

21.290 ACUTE TREATMENT UNITS

"Can health assessments be completed by a nurse practitioner or physician assistant?" [Section 21.290.43, Acute treatment Units and Section 21.280.3 in Care and Treatment of Persons with a Mental Health Disorder in a Designated Facility]

Response: Yes. The rules have been updated to include a "licensed independent practitioner".

"Acute Treatment Unit (ATU) means a facility or a distinct part of a facility for short-term psychiatric care, which may include substance abuse treatment. However, then there is this exclusion criteria: has acute withdrawal symptoms, is at risk of withdrawal symptoms, or is incapacitated due to a substance abuse disorder. This would seem to allow for the exclusion of a very large percentage of the dually diagnosed, and would contradict the vision of creating an integrated system of care."

<u>Response:</u> The exclusion criteria determines the risk of withdrawal and incapacitation due to substance use. It does not however, exclude individuals who are no longer at risk of withdrawal or incapacitated.

21.330 ADDICTION COUNSELOR CERTIFICATION AND LICENSURE

"Why do Certified Addiction Counselor III's (CACIII) have to have at least a bachelor's degree?" [Section 21.330.53.B]

<u>Response</u>: Clinical treatment is to be provided by professional trained within their professional discipline regarding substance use disorders. This is current rule and was established in 2010.

"If it is important to have counselor certification and licensure in rule, why are rules for mental health professionals not included in rule?"

Response: Rules for mental health professionals are regulated and can be found under the Department of Regulatory Agencies (DORA), Division of Professions and Occupations rules. OBH oversees the qualifications and requirements for addiction counselors, however does not oversee the requirements for other mental health professionals.