



# OeHI

Office of eHealth Innovation

**Meeting Name: Consent Management Working Group**

**Call In:**

Zoom Link: <https://us02web.zoom.us/j/84144212711>

(Panelists, please use your individual links sent to your email)

**Meeting Materials:**

- [Friends and Family Form](#)
- [Friends and Family FAQ](#)
- [House Bill 24-1217](#)

**Meeting Date:** 1/17/25

**Meeting Time:** 10:00-11:00 am

Agenda Topic	Time
<p><b>Welcoming Remarks &amp; Introductions</b></p> <p><i>Allie McGee &amp; Tiffany Sailer</i></p>	5 mins
<p><b>Overview of Family and Friends Form</b></p> <p><i>Andrea Jones, Deputy Policy Director, Colorado Behavioral Health Administration</i></p> <p><b>Allie McGee:</b> Today we have a special guest, Andrea Jones. She's going to be presenting the (Behavioral Health Administration) BHA's Friends and Family form that they are working on in partnership with the consent repository that we are going to start working on.</p> <p><b>Andrea Jones:</b> This all came about from House Bill 24-1217 last session. There are two parts to it- the consent repository and the feasibility of that that you all are working on. There is also the BHA side of it, which was the development of this form. The point behind it is giving loved ones, friends, and family members of a behavioral health patient a way to provide useful information to the providers legally, without necessarily a release of information having been executed on the front end or psychiatric advance directives, etc. As you can imagine, a lot of the discussion has been around the use of the form, which is what we are going to be discussing in our upcoming working groups, which are detailed a little bit more in the frequently asked questions.</p> <p>I tried to break this down into two chunks of development and decided to start with the development of the form itself, so that's what we were working on. All through the fall. We had three hybrid, in person, and virtual working group sessions in Alamosa, Montrose, and Boulder to talk with various community members, advocates, providers about the development of this form. What was really interesting to me was how long, people in Colorado have been doing a version of this. They have packets of information, medication dosages, and other things that would be very helpful in the provision of</p>	15 mins



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safety net services. However, typically, it has been met with legal concerns by the provider accepting the information for any number of legitimate reasons. So, part of the point of this form is to standardize what it looks like so that providers know what they're looking at, can legally accept it, and be reasonably assured that it is within parameters of what the BHA allows for their facility.

This is the 3rd draft of the form which is based on what we heard in all those working group sessions. The main theme of what we heard on the development of the form was that we want it on a standardized template so that, like I said, providers know what they're looking at and are more comfortable accepting the form, even if they're not legally required to. Another common theme was to get all the health and safety information upfront- the most critical things that a provider would need to know, and teasing that out a little bit more. People were really concerned about medication interactions, missed dosages, recreational drug use, and things like that that would, in an attempt to stabilize a patient, be really relevant. So we put those up front.

A lot of the additional input considerations are around multi system involvement and previous involvement with the system letting a provider know that they've got someone who's cycling through ineffective treatment if they've presented 3 times. You may not know that if you're not talking to this other provider. So sort of from that care coordination lens, it's helpful there in the administration. So we gave a lot more prompts and suggestions on how this should be done.

All of this to say in the [frequently asked question document](#), there is a link to a Google form where you can just fling input at me about anything you see on this draft form that works, doesn't work, anything you thought of, etc. We're consolidating all the feedback, and I imagine this form will probably be on draft 5 by the time it goes live. Technically, it's supposed to go live January 1 of '26. Our goal is to get it on our website with the launch of our new intermediaries, our BHASOs (behavioral health administrative service organizations). We've got 4 regions and they launched July 1. We're hoping this will be available for them with guidance for their providers that will hopefully start seeing this form soon. That is a little bit ambitious. We recognize that we're moving at the speed of government, but I think we can get it done. All of that to say, any comments on the form, please send them right at me using the feedback form or my email directly.

What we did not have in the first draft was who the person submitting the form was and there was a lot of discussion around that along with privacy concerns around that, and what the providers will do with the information. So part of our task at Bha has been differentiating that out for service providers and saying "Hey, there's no obligation or liability to your actual practitioners in using the information in this form or not to. They are the experts. They are licensed and regulated by Colorado Department of Regulatory Agencies (DORA). They work within the scope of their practice to know what information they're looking at, if it is applicable and helpful to their client and their care or not". Trying to make that differentiation for facilities versus individual practitioners has been kind of hard. So that's where we're trying to get with the language around the form. I know we've got multiple privacy officers here, including our own, Lynn. So any language suggestions around that specifically, and making clear what is and is not a legal obligation here, we are well open to as I know you all encounter it a lot.

Moving on to the FAQ, we know we will be going back to Boulder because there was a



great turnout and a lot of engagement there with some advocacy groups. We are also very open to other suggestions in the State where you've got a lot of engagement, or have traditionally seen a lot of interest on this, so please feel free to fling those suggestions at me as well.

We took our best shot at detailing in the FAQ that providers don't *have* to accept this form, but our goal here is to make it so that they are comfortable doing so, and we're getting pretty close there. The farthest, I think, we'd probably go as an agency and a regulator of behavioral health services is to require our safety net providers to have a policy in place that says what they do when they receive one of these forms. That is a way for us to ensure that they know what it is and are as comfortable as they reasonably can be saying "We're going to set a policy that says it's within our professionals discretion. We take all these forms, and we put them here".

What we have heard around the use of the form and, what I think is very relevant to this group, is that it is very expected that it be available electronically for obvious reasons. Now, the interoperability of that on an Electronic Health Record (EHR) or an actual consent repository, we don't know the viability of that right now. We're testing fillable PDFs. Obviously, we would love much more sophisticated interoperability on that, but we just don't know where we are in the state versus what we'll be able to do. I think that's why the upcoming conversations are a lot more relevant to this group than the development of the form itself and why we're pretty poised to talk about what y'all have come to, if you're just getting started kind of procedurally, or where you see the intersection points with what we might be able to do here.

So that's kind of my pitch. All of the information is in the materials for how to get a hold of me and put feedback into the Google form, etc. I would love to hear from you all on where you're at on it, and how you see this all going. Thanks.

## Open Discussion

*Tiffany Sailer & Allie McGee*

### Allie McGee:

I know providers probably feel reluctant to just jump in with this. How are you guys going to get some of that buy-in if they don't have to technically use the form?

### Andrea Jones:

We're trying to make it very clear to providers that their professionals that work within their facilities that are regulated by the BHA can use this information at their professional discretion.

### Allie McGee:

Has there been any conversation about where providers would store this information and has the repository come up in any capacity? Also, if we did find that this is a feasible solution, do you foresee support in that?

### Andrea Jones:

I think the reason that these agencies (BHA and OeHI) are kind of smashed together in this bill is because it was debated that a consent repository would be a natural place for

20 mins



something like this to live. It has always been discussed in our group that the other half of the bill is part and parcel of its use, and where it would be stored in the interim is expected, and I think, under the terms of the bill, that we will house it on BHA's website. I am in development with Joy right now on building that web page for us at BHA. All the language that's going to go on it will differentiate different things. One of the things that we've heard in the Consent group is: "How is this different from an ROI?", "How is this different from a psychiatric advanced directive?". Our idea is to pull all of that information onto one web page so that we're hitting the parameters of the bill. For example, "Here's the friends and family input form, but you may have stumbled on this looking for something else that is more appropriate".

**Allie McGee:**

I know Tiffany [Sailer] mentioned that, at Denver Health, they already do something sort of like this, so you thought it might be a bit of a ask to have them want to get behind something like a repository. So, I guess I'm wondering how we get like physicians who might not necessarily be involved in mental health, to have to be bought into wanting to source consents in a repository.

**Andrea Jones:**

Over the next working group sessions. We're developing all those technical assistance materials for providers, for intermediaries that our bosses can also help push out to the providers that they contract with, which is a lot of the IPN as well, is essential providers, and say, here's all your training materials to know exactly what you're looking at.

**Tiffany Sailer:**

At Denver Health, consents are not done with providers. They're done with registration staff. The registration staff has like two minutes or so to register a patient. All the registration staff says about consent forms (HIPAA, consent to treat) is ensuring that clients know that they're consenting to treatment. Any conversations beyond that would be a hard conversation for a registration clerk to have with a client because that is a different conversation.

**Andrea Jones:**

The parameters in the bill right are that we need to state that this form might become part of the patient's medical record, and I feel like that's where that sort of blanket consent and sharing of information lies. It's effectuated in different ways at different providers to your point to say "Hey, this could very well end up in a record that is subject to all of these patient privacy releases etc.", but it's not going to arrive in that record via the same channel as patient initiated. And so what we're working with at BHA is the parameters in the bill saying providers can accept this form. BHA can make rules around its use, which is where this would really like in our regulated facilities. Like, I was saying, if we say "you have to have a policy that supports the use of this form in some way", that's kind of the intersection there. I love the idea of combining as many notices, and consents into one easy transaction and vehicle as possible. But again, I don't know what the reality is here, which I think is what this group is largely testing.

**Erin Crites:**

I think that's kind of where my brain was going in this conversation, too, and where you just landed. Where do these forms end up? And then who has access to them once they're given to the provider? I don't know how much everybody knows about the



foundation behind the bill, but one of the big challenges is when a family member knows that their family members in a facility, and they call the facility says “I can't confirm or deny that that person is there” , and they're saying “but I have information that may be helpful” and kind of trying to find a way to be able to share that information without the provider having to disclose that the person is there if they don't already have a release of information and informed consent for that. The other piece that I wanted to throw out there is how this might work if somebody is in a criminal justice setting, and what would that look like if somebody is in a jail, the Department of Corrections, or some other correction facility or custodial placement that is not traditionally considered a healthcare environment?

**Andrea Jones:**

That is exactly what we're moving into. I will volunteer Joy Hart, my criminal justice and involuntary policy advisor, to work through those questions specifically with you.

**Mary Beth Haugens:**

When I look at that from a medication standpoint, those things change frequently, so I'd make sure that the document is dated, but then, how are we going to manage that?

If you're talking about it becoming part of that patient's medical record, that patient will have access to that information and some of that information that family members are sharing, they might not want that patient to have view or access to it. If it becomes part of their record, the provider is responsible for knowing that that document is there. So, from an organizational standpoint, if they don't incorporate it as part of their medical record, it will be lumped into outside information. That, in my opinion, is kind of a nightmare for providers to go through because it could have hundreds of pages.

**Andrea Jones:**

Whether or not it becomes incorporated into the patient's medical record, we haven't really explored that trigger. I think those are the discussions we need to have.

**Allie McGee:**

I'm wondering if maybe the repository could almost act as a big computer that people are allowed to connect to really quickly to see if that form is there or just a form that we make for the use of the repository that just lets a provider see that the information is there.

**Tiffany Sallier:**

There are the two regional health information exchanges, but I think we need to move away from working at the regional level which is embracing the Trusted Exchange Framework and Common Agreement (TEFCA).

**Jane Wilson:**

You mentioned you were doing some field hearing in different communities. Was Pueblo one of those sites given their community might be impacted.

**Andrea Jones:**

I think it's a really good callout and we should do that, so I will push for that, absolutely.

**Public Comment**

5 mins



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<p><i>Tiffany Sailer &amp; Allie McGee</i></p> <p>No public comment.</p>	
<p><b>Closing</b></p> <p><i>Tiffany Sailer &amp; Allie McGee</i></p>	<p>5 mins</p>