Washington State Health Care Authority (HCA) Behavioral Health (BH) Bed Registry and Electronic Referral Tools Project Findings

Submitted by:

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***Please note:** These are recommendations from a third party and not indicative of steps HCA or Washington state will or plans on taking in full. It is not an exhaustive list of all considerations.

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Introduction

HCA engaged BerryDunn, an independent consulting firm, to help conduct a needs assessment for the successful implementation of a BH bed registry and electronic referral tools system. The vision for the Needs Assessment Report for HCA's project is "to prepare for the development and implementation of the BH Integrated Client Referral System [BHICRS] required in House Bill [HB] 1477: inform content of a BH bed registry, increase BH providers' awareness of the benefits of utilizing the BH bed registry and electronic referral tools, and engage persons with lived experience to inform access to needed resources."

Project goals include the following:

- Increasing providers' awareness and future use of a BH bed registry and electronic referral tools system, including identifying barriers and opportunities to providers' access and use of tools
- Identifying functionality needed for a BH bed registry in WA and how WA's Healthcare and Emergency and Logistics Tracking Hub (WA HEALTH) infrastructure could be extended to support these needs
- Identifying the type of behavioral health providers and information (e.g., crisis stabilization services, psychiatric inpatient care, substance use disorder [SUD] residential programs) to include in the BH bed registry in addition to those included in HB 1477
- Improving client access to the specific information available in a BH bed registry to help support access to services
- Identifying a communication methodology to share information available in the future BH bed registry with providers and care coordinators
- Supporting the identification of changes to behavioral health providers' workflow in implementing and integrating a BH bed registry and electronic referral tools
- Supporting the identification of future contracting requirements for managed care organizations (MCOs) and Behavioral Health – Administrative Service Organizations (BH-ASOs)

In alignment with these project goals, BerryDunn completed a literature review, conducted web surveys with HCA-identified interested parties, and facilitated a series of discovery sessions. The purpose of this needs assessment is to identify current needs and challenges in accessing BH bed availability and conducting referrals. It also aims to summarize recommendations and strategies shared by interested parties regarding state implementation of a BH bed registry and electronic referral tools system. BerryDunn compiled information gathered from the literature review, discovery sessions, and web surveys to develop this Needs Assessment Report—including recommendations for HCA to consider—to help support the implementation of a BH bed registry and electronic referral tools.

Assessment Findings

Summary of Findings

BerryDunn used information gathered from discovery sessions, web survey responses, and background documents to identify provider needs and challenges related to accessing bed availability and conducting referrals. BerryDunn analyzed and cross-referenced discovery session notes, web survey responses, and background documents to conduct a thematic analysis. The analysis identified data patterns to determine

themes. The themes are labeled with an alphanumerical identification (ID) tag. Although not exclusive, the following are common themes and key findings:

- **Technology and Tools**: Manual processes create multiple challenges. Providers across the state invest significant time and effort calling facilities to determine bed availability for individuals' placement using a MS Excel sheet—or other manual tools—to capture information. With frequent changes in bed availability, some staff spend a significant portion of their day calling multiple facilities for updates. This administrative burden hinders facilities' ability to efficiently care for individuals in crisis—a challenge compounded by staff shortages.
- **Admission Criteria:** Interested parties in multiple discovery sessions noted that if a facility has a bed available, it does not necessarily indicate that the individual will be accepted and receive the bed. Each facility operates with its own admission criteria and collects different data sets during admission. There is no standard set of admission criteria required for the same type of facilities. These differing admission criteria challenge the referral and admission process. As a result, providers face challenges in gathering the required information about the individual for admission.
- **Resources:** Some facilities in rural areas indicated barriers such as staffing, funding, and internet access to implement and use a BH bed registry and electronic referral tools system. In addition, individuals in rural areas often have difficulty accessing services that are farther away due to limited availability of public transportation or a lack of needed services in their area.
- **Processes:** Facilities across the state use multiple electronic health record (EHR) systems, and each system's functionality and processes depend on facility needs. In the absence of a statewide EHR, interested parties highlighted the need for a streamlined process and interoperability among different EHR systems to support provider implementation and utilization of the BH bed registry and electronic referral tools to help bridge the current gap.

Cost: Some facilities struggle with staff shortages, an issue interested parties highlighted as a potential barrier to successfully implementing a BH bed registry and electronic referral tools. In addition, if a new software system is required, some partners might have difficulty budgeting for associated costs due to administrative fee caps. These findings suggest the need for a streamlined, easy-to-use, and sustainable BH bed registry and electronic referral tools for providers to adopt and implement in their workflow. There is a need for interface and exchange of data among existing systems to reduce duplication of efforts and additional administrative burden on providers. BerryDunn details these findings below.

Needs and Challenges in the Current Environment

The table below outlines needs and challenges learned through web surveys, discovery sessions with interested parties, and review of background documents. Findings are categorized based on themes heard during data collection activities and are in no specific order. BerryDunn identified the category most relevant for each finding.

Needs and Challenges

ID	Categories	Description
F1	Processes	Interested parties use manual processes to track BH bed availability (i.e., MS Excel sheets, phone calls, emails, fax), which is time-consuming. This creates challenges in obtaining accurate bed availability counts due to potential for human error and/or the information is outdated by the time it is updated.
F2	Processes	Resources to search for providers have been developed; however, the tools that are publicly available consist of a long list of resources and do not have robust features to filter and locate a facility/provider that meets the individual's need. There is a need to tie all services into 988 and build a searchable database similar to the vaccine locator tool.
F3	Processes	Even with a screening/admission process in place to assess individuals, identify beds, and place an individual in a facility, there is no incentive for receiving providers to fill beds with high-need/high-risk individuals. This makes it difficult for referring providers to find a place for individuals with more extensive needs.
F4	Processes	Care coordination is not a billable service, and there is limited funding dedicated to increase care coordination staff. Without sufficient funding and resources, it will be a challenge to establish a full care coordination team to support efficient care delivery for individuals in crisis.
F5	Processes	Withdrawal beds are available on a first-come, first-served basis due to a reportedly high frequency of individuals missing the appointment. Interested parties noted that tracking bed availability is a fluid process. Most facilities overbook due to similar events, and/or the bed update might not be valid/reliable because the facility already has a patient waiting for a bed in the ER. Due to this, a bed might appear open when it is not.
F6	Processes	Interested parties do not have the ability to reserve beds. An individual can be given a bed allocation, but if they are unable to arrive at the facility within a few hours, the bed will be reallocated to another individual, even when the first individual is on their way to the facility.
F7	Processes	Interested parties have a medical clearance process that creates system delays by requiring information that only the hospital or BH facility has. This process also requires individuals in crisis to go to the ER for clearance, which may have long wait times or

		turn away individuals. This creates a challenge for obtaining timely information and placing an individual in the open bed.
F8	Processes	Individuals in crisis often depend upon various organizations and insurance companies to gather the list of BH providers. However, these organizations and insurance companies do not update the lists frequently, which leads to further delays and inefficiencies in accessing BH services.
F9	Processes	The varied accuracy of bed availability information from facility staff is often influenced by the unit's workload. For example, agencies might avoid calling facilities due to the strain it places on staff, opting to send people to facilities that handle voluntary admissions or dispatch a mobile crisis response team.
F10	Processes	In some locations, manually calling multiple facilities requires one full-time employee to call and maintain their bed tracking tools, such as MS Excel spreadsheets, to update bed availability. This compounds the challenges associated with existing staff shortages in the facilities.
F11	Bed Capacity	Interested parties are experiencing a supply and demand challenge for bed capacity. Facilities receive several referrals in a day for a single bed, resulting in long wait times to hear from providers on whether they can take patients.
F12	BH Bed Registry Content	There is a lack of tools to track open beds with criteria such as gender and age.
F13	BH Bed Registry Content	Some interested parties expressed concern over a BH bed registry not working due to manual components (phone call confirmations, emails, etc.) that staff must conduct to verify bed availability and an individual's suitability for admission.
F14	BH Bed Registry Access	There are mixed responses from interested parties on individuals in crisis having access to the BH bed registry. Interested parties highlighted individuals in crisis—or their friends/family—who are looking for bed availability might walk into a facility without an assessment that helps determine the appropriate treatment setting for that individual. This creates additional confusion and frustration among individuals in crisis, their family/friends, and facility staff.
F15	BH Bed Registry Functionality	Interested parties face challenges placing individuals in crisis into a facility that meets their needs in a timely manner. There is a desire to include exclusionary criteria in the BH bed registry by filtering through demographic and treatment options. This will

		allow BH staff to place individuals in crisis into an appropriate facility.
F16	Technology and Tools	Most interested parties use an EHR to track information on internal referrals. Currently, interested parties cannot track external referrals through their EHRs, which hinders their ability to electronically capture external referrals and the outcome of an individual once they leave the facility.
F17	Technology and Tools	Interested parties request an automatic update for BH bed availability data from their existing system to the BH bed registry to help ensure real-time reporting for availability. Without automation, staff would face another manual process.
F18	Technology and Tools	Interested parties built individual processes/tools to track bed availability and conduct referrals throughout the state. These processes and tools differ by organization, creating challenges to fully integrate individual systems with EHRs. There is a need for interface and interoperability among existing systems to reduce duplication of efforts for staff to maintain a BH bed registry and electronic referral tools.
F19	Technology and Tools	Interested parties do not currently share all available beds with BHAs due to the common practice of overbooking to help ensure consistent, full capacity, as individuals frequently miss their appointments. This creates a challenge for BH facilities to identify accurate bed availability because facilities might under-report their numbers.
F20	Technology and Tools	If an admission, discharge, and transfer (ADT) system is not used as a source of information for providers using EHRs to feed into the BH bed registry, there will be barriers such as administrative burden for providers to manually input information into the BH bed registry.
F21	Technology and Tools	Many interested parties use different EHR systems, and there is no way to access referral outcomes electronically if the individual is referred to a facility with a different EHR system. This creates a challenge to manage external referrals electronically. In addition, there is no automated process to receive information about referral outcomes.
F22	Technology and Tools	The current reporting systems that could be used to track available beds at the state level do not provide enough details for a BH bed registry, such as bed levels. If HCA decides to use WA HEALTH for the BH bed registry, there is a need for facilities to provide details on the level of bed/type.
F23	Technology and Tools	Customizing reports in the EHR is difficult for staff. This creates the challenge of using the EHR to run reports for items, such as

		bed availability and other essential tasks, due to a lack of flexibility.
F24	Technology and Tools	Interested parties mostly use fax or email to make referrals. This introduces the challenge of referrals getting lost and extends wait times to hear back from various facilities.
F25	Technology and Tools	Some interested parties do not track bed availability in a central location and must call facilities every time an individual needs an open bed or referral.
F26	Technology and Tools	Interested parties use software outside of the EHR to run reports (such as Power BI and PowerBuilder) and track bed availability (such as Redstream, XFERALL, and GE Tiles). This is a challenge due to the associated cost and training required for the separate software; moreover, interoperability between software is unknown.
F27	Technology and Tools	If interested parties use the EHR to track BH bed availability, it locks the bed when a referral is pending. This is a challenge because another individual cannot be placed in the bed if the individual does not arrive at the facility within the expected time frame, limiting facilities' capability to reach maximum capacity.
F28	Technology and Tools	Sometimes a bed can be available, but the facility cannot accept new patients due to the unit's level of acuity. There is a challenge with using an electronic system to update a BH bed registry automatically if the system lacks a mechanism to accommodate variabilities like unit acuity/staffing levels.
F29	Technology and Tools	Current BH bed tracking systems do not include all providers. This is a challenge because a location close to an individual may not show in a service directory when searching their current bed tracking system.
F30	Technology and Tools	The electronic bed registry might show beds as available, but facilities cannot admit any individuals due to different circumstances, such as an infectious disease outbreak or high acuity. This creates a challenge for individuals in crisis, as they may not be accepted to a facility even if it has open beds.
F31	Resources	Interested parties throughout the state have a BH staff shortage, creating barriers for timely updates and maintenance of the BH bed registry.
F32	Resources	There are no centralized locations for identifying BH services for persons with lived experience. Most of the time, accessing BH services depends on the relationships and connections that individuals with lived experience have.

F33	Resources	At times, persons with lived experience and care coordinators face challenges using web-based tools, as the tools can be difficult to navigate and/or internet connection issues can occur while trying to identify BH services.
F34	Resources	Transportation in rural areas is challenging (e.g., public and private transportation and ambulances), which creates difficulty in getting individuals to facilities with open beds. In addition, staff assist with providing transportation or working to arrange it, which impacts staff availability to provide consistent treatment. There is a dual burden of administrative tasks on the staff.
F35	Resources	Facilities have waitlists that individuals in crisis can join ahead of time for their treatment; however, individuals in crisis are not aware of the waitlist process. This creates a challenge for individuals in crisis seeking timely treatment.
F36	Resources	There are not enough specialized beds for older adults and individuals with developmental disabilities. Moreover, there is lack of withdrawal management, residential, and medical co-occurring beds, which creates a challenge for individuals in crisis to access services.
F37	Resources	Interested parties in rural areas struggle to find specific beds due to lack of facilities that provide different levels of care.
F38	Implementation	There is no standard process to track beds or conduct referrals, making bed tracking and referrals a time-consuming process.
F39	Implementation	Interested parties cannot currently receive external electronic referrals or their outcomes (e.g., referral resulted in an assessment, etc.). There is an administrative burden to manually receive outcomes about external referrals.
F40	Implementation	Creating a closed-loop electronic referral tool compliant with the Health Insurance Portability and Accountability Act (HIPAA) and 42-CFR is a challenge due to privacy issues.
F41	Care Coordination	Individuals and family members do not know how to navigate BH services to receive timely treatment. In addition, people with neurological disabilities might be unable to conduct their own research online using web-based tools if the tools are not accessible.
F42	Communication	There is a lack of awareness among individuals in crisis about existing tools, available services, providers, and resources that can be used during a crisis due to lack of frequent communications.

F43	Support	Interested parties are not aware if the EHR could be used for electronic referrals and/or the BH bed registry. This is a gap in knowledge and awareness of EHR functionalities.
F44	Requirements	Some facilities might not want their civil conversion beds posted in the BH bed registry. This will create challenges for facilities to identify the number of available long-term civil commitment beds and differentiate the type of beds that can accept individuals on 90- or 180-day holds for specific services.
F45	Requirements	If a requirement is established to update a BH bed registry more than twice per day, and the updates must be entered manually, there is a risk that providers will not adhere to the requirement. This is a challenge with making a real-time BH bed registry as required by HB 1477.
F46	Requirements	All providers and hospitals do not fall under the same authority within a service area. There is a difference between private and public hospitals and which hospitals fall under MCO authority. This makes it difficult for MCOs to implement requirements for all providers to update a BH bed registry.
F47	Cost	If a new system is required for an electronic reporting tools and BH bed registry, the cost may be a challenge for organizations. Specifically, this could be a challenge for nonprofits with limits on administrative and overhead costs, and budgeting for a new system could have long-term impacts.
F48	Cost	Previous efforts to track bed availability were unsustainable because of the time it took to update the tracker and connect with people who were not updating the tracker.
F49	Data	There is a lack of standardized data between hospitals and BH facilities, as they have differing minimum data standards, which hinders some facilities' ability to use an EHR. This delays the referral and placement process because facilities must rescreen the individual or wait for paperwork to be faxed to complete the referral.
F50	Regulations	Interested parties in multiple discovery sessions noted that if a facility has a bed available, it does not necessarily indicate that the individual will be accepted and receive the bed. Facilities have their own assessment criteria to admit individuals in crisis, and if individuals in crisis are to have access to the BH bed registry, it creates additional burden on them and the facilities.
F51	Regulations	Some BH facilities do not have state licenses, creating challenges for states to regulate and inspect these facilities and help ensure adequate treatment for underserved groups.

F52	Regulations	Previous efforts to implement a BH bed registry failed in part due to a lack of contractual requirements for organizations to follow.
F53	Regulations	Interested parties have long wait times because there is no requirement for facilities to make referral decisions within a certain amount of time.

Recommendations

Summary of Recommendations

BerryDunn identified nine recommendations for HCA's consideration based on findings from the literature reviews, web surveys, initial discovery sessions, follow-up discovery sessions, and background documentation. The recommendations are categorized into three focus areas: implementation, technology, and planning and are in sequential order of implementation for HCA's consideration.

These recommendations are for HCA's consideration. HCA's implementation of one or more recommendations could be impacted by multiple factors (e.g., resource availability, feasibility, future legislation changes, and changes related to system functionality of the BH bed registry and electronic referral tools.)

BerryDunn highlighted the future-state goal(s) addressed by each recommendation. Each recommendation is also categorized using the level of effort (LOE) as defined below:

- **High:** Requires substantial time, resources, and expertise, often involving complex tasks
- **Medium:** Requires a moderate amount of time and resources, typically involving tasks of moderate complexity
- **Low:** Requires minimal time and resources, usually involving simple or routine tasks

In addition, BerryDunn identified the estimated timeline of 0 – 6 months, 6 – 12 months, or 12+ months for HCA to complete the recommendations. Some recommendations depend on each other, and BerryDunn has noted these dependencies within recommendations. The table below summarizes recommendations.

Summary of Recommendations

ID	Recommendations	LOE	Estimated Timeline to Complete
R1	Conduct business process mapping and analysis of new workflow	High	0 – 6 months
R2	Plan for automation of a BH bed registry and electronic referral tools through broad interoperability with other data sources (e.g., various EHRs)	High	6 – 12 months
R3	Prioritize functionality and content of a BH bed registry and electronic referral tools	High	6 – 12 months
R4	Plan for a phase-based implementation approach	Medium	12+ months
R5	Implement BH bed registry update cadence based on level of care	High	12+ months
R6	Create a communication plan to support and continue coordination and partnership with interested parties for effective implementation	Low	0 – 6 months

R7	Develop specialized training plans to support providers' utilization of the BH bed registry and electronic referral tools	Medium	6 – 12 months
R8	Create incentives for providers to use and update the BH bed registry and electronic referral tools	High	12+ months
R9	Create a monitoring tool to track utilization of the BH bed registry and electronic referral tools	Medium	12+ months

Description of Recommendations

Recommendation 1

Recommendation Dashboard

Category: Implementation			
Recommendation 1: Conduct business process mapping and analysis of new workflow			
Findings Addressed: F3, F5, F6, F7, F8, F9, F33, F38, F53			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 6	High	0 – 6 months	Recommendation 2 and 3

Recommendation Description

HCA should continue working with interested parties to develop future business process maps and analyze a fully functional BH bed registry and electronic referral tools workflow. This could help provide HCA with a chance to further:

- Evaluate the content of the BH bed registry
- Identify systems with which to interface and maintain interoperability
- Identify processes that could be standardized
- Identify users of the BH bed registry and electronic referral tools
- Identify upcoming changes in provider workflows
- Identify additional functionalities of the BH bed registry and electronic referral tools
- Evaluate challenges and opportunities to improve the process in the following areas that interested parties expressed concern about:
    - **Timeliness of accessing the tools** – The amount of time it takes to access web-based tools and any connectivity challenges

- **Timeliness of locating services** – The amount of time it takes to locate available services
- **Timeliness of obtaining responses to a referral** – The amount of time it takes to receive a response from the initial referral
- **Timeliness of accessing services** – The amount of time it takes to receive services and the feasibility of meeting the next-day appointment criteria with a focus on individuals with more extensive needs

Recommendation 2

Category: Technology			
Recommendation 2: Plan for automation of a BH bed registry and electronic referral tools through broad interoperability with other data sources (e.g., various EHRs)			
Findings Addressed: F1, F7, F9, F10, F11, F16, F17, F18, F20, F21, F24, F25, F26, F38, F39, F40, F45, F48, F49			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1, 2, and 4	High	6 – 12 months	Recommendation 3

Recommendation Description

To help HCA limit staff burden and increase accuracy of the BH bed registry and electronic referral tools, information in the BH bed registry should be automatically uploaded from existing systems into one database. In addition, there is a need for electronic referrals to communicate across the EHRs and the diverse systems used across the facilities. HCA should consider developing an interoperability plan that will support interface functionality between diverse EHRs and reporting systems. To build an interoperability plan, HCA should consider taking the following steps:

- Develop a communication plan to promote the long-term benefits of interoperability across all EHRs and data systems.
- Establish a key interested parties' advisory group to engage vendors and providers and to help ensure consistency in the process to report on available beds across systems and interfaces.
- Compile an inventory of systems and data sets available across BH service providers.
- Develop and maintain an inventory of systems and identify what systems and data sets are needed to meet the needs of the BH bed registry and electronic referral tools.
- Standardize data collection processes across BH facilities to support information-sharing during electronic referral processes.
- Develop minimum standards for BH service providers to track data in their EHR or preferred electronic system.
- Determine HIPAA and 42-CFR rules around privacy to electronically exchange information regarding referrals.

- Facilitate information exchange conversations between service providers and vendors to understand anticipated changes in provider workflows.
- Develop a plan to support interfacing the BH bed registry and electronic referral tools with existing internal and external systems to reduce duplication of efforts for staff. This could include use of ADT as a source of information for providers using EHR to feed into the BH bed registry.

Recommendation 3

Category: Implementation			
Recommendation 3: Prioritize functionality and content of a BH bed registry and electronic referral tools			
Findings Addressed: F2, F3, F4, F5, F6, F8, F9, F11, F12, F13, F14, F15, F19, F22, F24, F25, F27, F28, F34, F38, F50			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 2, 3, and 4	High	6 – 12 months	Recommendation 1 and 4

Recommendation Description

To support successful implementation of a BH bed registry and electronic referral tools, HCA should determine the functionality and information that will be included in the BH bed registry. The functionalities and information/content should be largely informed by the needs of the future users of the BH bed registry and electronic referral tools. Below are the functionalities for HCA to consider when planning for the implementation of a BH bed registry and electronic referral tools. These functionalities are not listed in order of priority, and this recommendation is a pending decision for HCA (refer to Section 8 pending Decision 4).

- Easy access to the BH bed registry without multiple login criteria
- Ability to automate data entry and update bed availability as per HCA-determined cadence
- Searchable database that limits access to service providers or could include a public-facing version with ability to sort the beds as per individual's need
- Ability to hold a bed for the individual
- Ability to send an alert to provider(s) when a new bed is available
- Ability to complete referral forms embedded within the BH bed registry and electronic referral tools
- Ability to send electronic referrals
- Ability to send an alert to provider(s) on referral acceptance and patient admissions
- Ability to schedule and coordinate transportation when needed

In addition, HCA should consider the following content/information to be included in the BH bed registry and electronic referral tools:

- Information on provider name, program type/bed type, insurance accepted, and service location
- Exclusionary criteria (such as age, gender, and diagnosis), admission requirements, and information on acuity level of the facilities
- Total number of beds available based on age and gender
- Information about whether providers with available beds have the cultural competency to serve diverse groups
- Providers' licensing status (e.g., licensed, licensure pending)
- Information for care coordinators to use while supporting individuals in crisis
- Timestamp of last BH bed registry update (e.g., last updated August 25, 2024, at 11:32 a.m.)

Recommendation 4

Category: Implementation			
Recommendation 4: Plan for a phase-based implementation approach			
Findings Addressed: F29, F36, F44			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 4 and 6	Medium	12+ months	Recommendation 1 and 3

Recommendation Description

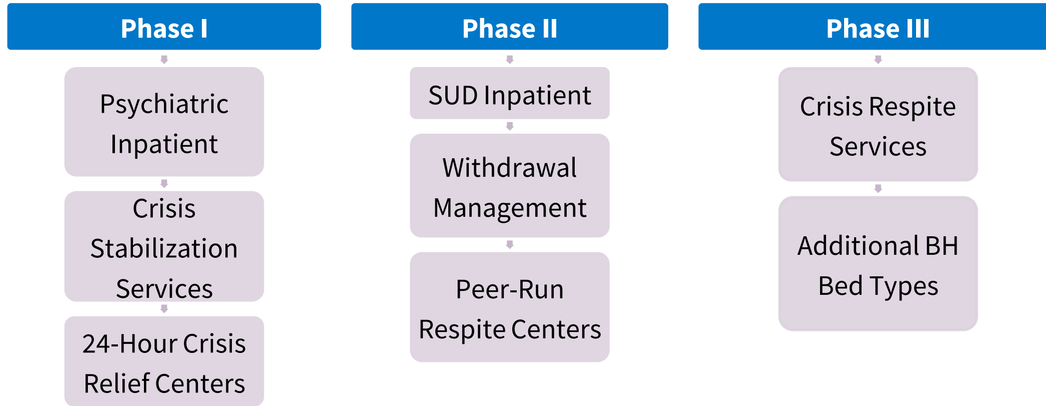
HCA should consider implementing the BH bed registry and electronic referral tools in phases to help ensure tool usage is well documented, processes are clearly defined, and procedures account for the differences across levels of care. A phase-based implementation approach could also help HCA ensure the systems are tested, user friendly, and efficiently manage a high volume of information and referrals. A phase-based implementation approach might include the following:

- **Phase I** – Identify vendor/vendors to build a system to host the BH bed registry and electronic referral tools. HCA can then start by selecting one region with established DCRs, robust use of EHRs, and collaboration models that exist across BH providers to roll out the implementation. This phase would include the rollout of BH bed types that were prioritized by the interested parties during discovery sessions.
- **Phase II** – Start incremental implementation for other BH bed types in Phase II when the BH bed registry and electronic referral tools have been tested for BH service types included in Phase I.
- **Phase III** – Focus on implementing crisis respite services and additional BH bed types in Phase III. As HCA continues to build on statewide data interfaces and interoperability across BH facilities, HCA should consider including additional BH service types (e.g., recovery housing, mental health residential

treatment beds, diversion beds, single vs. co-occurring beds, pediatric inpatient beds, long-term civil commitment beds).

Figure 3 below demonstrates a potential approach for the phase-based implementation of BH bed types—after identification of a system—for HCA's consideration.

Figure 3: Phase-Based Implementation



Recommendation 5

Category: Implementation			
Recommendation 5: Implement BH bed registry update cadence based on level of care			
Findings Addressed: F5, F9, F17, F45, F48			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 6 and 7	High	12+ months	None

Recommendation Description

Having access to real-time bed availability is essential for providing BH services. Due to variability of different bed types, a standard update cadence might not be feasible for all BH bed types. Based on feedback from interested parties during discovery sessions and in web surveys, Table 10 outlines a suggested BH bed registry cadence for updates. The bed types listed below is in no particular order.

BH Bed Registry Update Cadence Based on Level of Care

Bed Type	Update Cadence
Crisis Stabilization	Twice a day (during shift change)
Acute Care	Daily
Inpatient Services	Twice a day

Residential Treatment	At admission and discharge
Supportive Housing	At admission and discharge
Outpatient Services	At admission and discharge

To implement the update cadence, HCA should consider:

- Creating reporting requirements in the providers' contract related to the cadence for updating information in the BH bed registry based on level of care.
- Creating an automated email alert to the providers/facilities that are late in reporting the bed availability as per the update cadence.

Recommendation 6

Category: Planning			
Recommendation 6: Create a communication plan to support and continue coordination and partnership with interested parties for effective implementation			
Findings Addressed: F8, F9, F10, F30, F31, F32, F34, F35, F37, F41, F42, F47			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 5	Low	0 – 6 months	None

Recommendation Description

HCA should consider developing a robust communication plan that supports effective coordination and collaboration across service providers, individuals in crisis, vendors, and HCA. When developing the communication plan, HCA could consider the following strategies:

- **Engage change champions** – Establishing change champions from key interested parties can help with the implementation of the BH bed registry and electronic referral tools. Change champions are individuals selected based on their leadership and communication skills to help actively promote initiatives aimed at organizational and/or social change. They can support implementation activities by carrying forward messaging within their networks and advocating for the use of the new BH bed registry and electronic referral tools. Change champions can include hospital administrators, representatives of emergency departments, acute psychiatric inpatient units, mobile crisis responders, DCRs, and consumers.
- **Communicate clear and reliable timelines** – Communicating clear and reliable timelines for implementation activities can help provide clear expectations for:
    - How and when interested parties will be engaged during implementation activities

- Determination of the phase/activities where the interested parties' participation will be crucial to project success

- **Develop communication materials** – Developing communication materials relevant to the audience can help gain buy-in from interested parties. Communication materials can define how the BH bed registry and electronic referral tools will address the following areas of concern or other questions/concerns that interested parties might raise in the future. HCA can consider including communication materials related to:
  - **Funding** sources that will be available to support implementation early in the process. Communicating information about available funding can help alleviate concerns of financial burden on service providers (e.g., staffing shortage, transportation issues, lack of beds, new system costs, and ongoing oversight).
  - **Staff availability** and how the BH bed registry and electronic referral tools will work to decrease staff time required to locate available services and send or receive referrals.
  - **Automation** and streamlining of the business process that might limit administrative burden on staff.
  - **User flexibility** including information on manual options to update bed availability if unique acuity or staffing levels are not conducive for admitting new clients.
  - **Responsibility** and clearly defined roles for timely updates and ongoing maintenance of the systems.
  - **Accessibility** including information on if and how the BH bed registry and electronic referral tools will be accessible to people with lived experience through service providers and/or additional access as determined by HCA.
- **Identify effective communication channels** – Identifying methods to deliver the communication materials can help ensure there is a focus on HCA's intended audience. HCA could conduct webinars, regular meetings, and forums or share the communication materials via DTLL, newsletter, websites, or emails.

Recommendation 7

Category: Planning			
Recommendation 7: Develop specialized training plans to support providers' utilization of the BH bed registry and electronic referral tools			
Findings Addressed: F23, F26, F38, F43			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 6	Medium	6 – 12 months	Recommendation 3 and 5

Recommendation Description

When the BH bed registry and electronic referral tools are established, HCA should consider developing specialized training plans for the providers. To help prepare and account for the diverse use of existing EHRs and reporting systems across providers, HCA should develop the specialized training plans based on the EHR vendors that facilities are currently using. To develop the training plans, HCA should coordinate with the EHR vendors early in the process. Engaging EHR vendors early in the process can provide opportunities for these vendors to educate/train providers on how to use their EHR most effectively and efficiently in the providers' current environment to communicate with the BH bed registry and electronic referral tools. With EHR vendor input, training plans for EHR providers should support BH providers' understanding of the following items:

- Process for updating the BH bed registry and electronic referral tools based on information from the provider's EHR reports (e.g., a bed occupancy report that can be linked to the BH bed registry)
- Available reports in the EHR to inform the BH bed registry and electronic referral tools
- Submission and tracking of referrals (if available)
- Process to confirm accuracy of data being entered into the BH bed registry and electronic referral tools by the provider
- Process to report and track available beds and referrals in the provider's EHR
- Submission of available grants to support implementation of the BH bed registry and electronic referral tools
- Analysis of ongoing workflows and process redesign

Training plans for non-EHR providers will need to focus on understanding the following items:

- Process to track available BH bed workflows and submitting them into the BH bed registry
- Process to confirm accuracy of data being entered into the BH bed registry and electronic referral tools
- Process to report and track available beds and referrals
- Transition to an EHR in the long term

Recommendation 8

Category: Implementation			
Recommendation 8: Create incentives for providers to use and update the BH bed registry and electronic referral tools			
Findings Addressed: F5, F19, F52			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 6	High	12+ months	Recommendation 5

Recommendation Description

To encourage timely reporting and updates to the BH bed registry and the adoption of electronic referral tools, HCA should create a system of incentives that recognizes and rewards providers who consistently maintain accurate and current data. HCA should consider the following approaches and strategies when building and implementing incentives:

- **Recognition programs** – Publicly acknowledge/promote facilities that excel in timely reporting, which could help encourage other providers to report in a timelier manner. In addition, HCA should consider establishing an annual awards program highlighting top-performing providers, which could help enhance its reputation in the community.
- **Subsidies for technology adoption** – Provide subsidies or grants to facilities that implement the BH bed registry and electronic referral tools. This could help more providers integrate the new tools into their processes by lowering the amount of funding required to spend from the providers'/individual budgets.
- **Performance-based financial incentives** – Offer financial rewards to facilities that consistently update their bed availability and maintain accuracy in the BH bed registry. These incentives could be tied to identified metrics (e.g., the frequency of updates based on level of care).

Incorporating these strategies could lead to a more efficient, reliable BH bed registry update and use of electronic referral tools, which could help improve access to care for individuals in crisis.

Recommendation 9

Category: Implementation			
Recommendation 9: Create a monitoring tool to track utilization of the BH bed registry and electronic referral tools			
Findings Addressed: F46, F51			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 6	Medium	12+ months	Recommendation 5 and 6

Recommendation Description

HCA can consider creating a monitoring tool to track the utilization/implementation of the BH bed registry and electronic referral tools. An effective monitoring tool could include performance measures to help track adoption of the BH bed registry and the electronic referral tools. To limit staff and provider burden, performance measures should be informed by reports pulled from the system. It is important for HCA to standardize definitions and practices on which data to collect. HCA can develop key performance measures in coordination with interested parties. Table 15 below provides example performance measures.

ID	Performance Measures
1	Number of facilities using electronic referral tools to accept or decline referral within 24 hours once a referral is received
2	Within the first year of implementation, number of next-day appointments conducted for individuals accepted via an electronic referral
3	Of total facilities, X% updated the BH bed registry per the required BH bed registry and electronic referral tools update cadence
4	X% of facilities used the BH bed registry and electronic referral tools within the first year of implementation

In addition to including performance measures in the monitoring tool, HCA should consider determining the frequency of monitoring activities by creating a risk assessment to identify providers that might need additional support when implementing the BH bed registry and electronic referral tools. The risk assessment could include monitoring criteria for high-, medium-, and low-risk BH providers. Table 16 provides an example for criteria definitions of each risk level and possible cadence of monitoring activities based on these risk levels.

Risk Level	Monitoring Activities
Low – BH provider has an established EHR, or reporting system, that has tested and confirmed interoperability with the BH bed registry and electronic referral tools.	Quarterly
Medium – BH provider has an established EHR, or reporting system, and is still working to develop/enhance interoperability with the BH bed registry and electronic referral tools.	Monthly
High – BH provider does not have an EHR, or a well-established EHR, and will be responsible for manual updates to the BH bed registry. BH provider has no reporting issues within its systems and/or EHR. Note: An ideal BH bed registry and electronic referral tools will aim to limit the providers who fall into this category.	Biweekly

Additional Considerations

ID	Recommendations

AC1	Create a public-facing portal within the BH bed registry and electronic referral tools.
	• Interview the selected vendor to understand system functionality and capability.
	• Include the following information in the public-facing portal:
	  o Available services
	  o Service type by age
	  o Location
	  o Contact address
	  o Provider name
	  o Cultural competency of providers
	  o Accepted insurances
	  o Admission process/requirements to enroll in the programs
	  o Any lawsuits or complaints about the service providers
	  o Skill level of providers
	  o Additional resources such as information on wraparound services

AC2	Conduct analysis of care coordinator roles and responsibilities to determine the care coordinators' access and future use of the BH bed registry and electronic referral tools. • Conduct interviews and focus group discussions after implementation with existing care coordinators to understand their role in supporting individuals in crisis. Identify opportunities on how care coordinators could play a role in communicating information from the BH bed registry to individuals in crisis and connect them to needed services.
AC3	Identify appropriate requirements for providers to maintain the BH bed registry and electronic referral tools. • Coordinate with BH-ASOs and MCOs during implementation to help identify the appropriate requirements for providers. o Conduct in-depth interviews and working sessions with BH-ASOs and MCOs to identify the requirements that will help ensure providers' utilization and maintenance of the BH bed registry and electronic referral tools.

Key Pending Decisions

The table below provides a list of key pending decisions that HCA must make prior to selecting the future system and implementing recommendations.

Key Pending Decisions

ID	Title	Description
PD1	Utilization of Existing System(s)	HCA needs to determine whether to continue using its existing system or consider releasing a request for proposals (RFP) to solicit bids from other vendors to develop and implement a BH bed registry and electronic referral tools.
PD2	BH Bed Registry and Electronic Referral Tools Access	HCA needs to identify who would have access to the BH bed registry and what information would be available for each user.
PD3	Real-Time Data Availability	HCA needs to determine the cadence to update the BH bed registry (i.e., how often the providers should update the data).
PD4	BH Bed Registry and Electronic Referral Tool Functionality	HCA needs to identify the desired functionality of the BH bed registry (e.g., what information will be included in the BH bed registry, what filters and search options should be incorporated, and how the system will manage data quality and its overall security).

Next Steps

Next steps that HCA should consider in its implementation of the BH bed registry and electronic referral tools include:

- Prioritize recommendations based on feasibility and potential impact.
- Refine final Written Communication Materials in the HCA-preferred format and share them with designated interested parties.
- Review key pending decisions included in Section above and make informed decisions related to the implementation of the BH bed registry and electronic referral tools.