COLORADO
Behavioral Health
Administration

Discovery Sprint Report

Inpatient / Residential Referrals

Published: Oct 20, 2023

Contributors:

Abbey Carlstrom, Abigail Fisher, Brandon Beltz, Chris Pimlott, Paul Craig, Victoria Kidd

Table of Contents

Executive Summary

[Brief summary of findings and recommendations]

A “Referral” in Colorado behavioral health can be defined as the transition of a client from one care setting to another based on a set of criteria identified about the client and the facility. Today, this process is facilitated ad hoc, operating without a State sanctioned order of operations or supportive technology system.

This research sprint is meant to deepen our knowledge base on how providers facilitate referrals today, how a State administered tech platform might improve efficiency, and how we as the BHA might hold the behavioral health community accountable to equitable practices through these improved processes. At this stage, our focus was on inpatient and residential placements as an initial use case for the platform, with the knowledge that other types of placements (ex. outpatient, social care services) would later be folded in.

From July through October of 2023, the Behavioral Health Administration’s Technology team conducted primary and secondary research on inter-provider referrals in partnership with Bloom Works, a digital services consulting company.

We engaged with 23 providers and service organizations in Colorado across a variety of geographies, behavioral health settings, services offerings, technical resourcing levels and population expertise in hour long interviews where we discussed their referral processes and their vision of opportunities for improvement. After concluding our interviews, we also followed up with providers in a survey to evaluate our hypotheses and fill remaining knowledge gaps. We also held in-depth conversations with 13 stakeholders within BHA and OIT, 5 group cross-agency interviews (including HCPF, OeHI, RAEs, CYF).

We also did secondary research using existing documentation, past improvement project plans, and the current BHA technology ecosystem.

Our Hypothesis: By more holistically capturing behavioral health providers of Colorado and their capacity and capabilities, we can add efficiency around the matching process to alleviate dependence on individuals relying solely on relationships. These insights led to our key recommendations detailed below.

Top Insights

The provider landscape lacks a centralized communication hub.
The referral landscape lacks important standardization, but also needs flexibility.
Providers have existing processes that work for them, but should be better supported.
Consent should be managed directly between providers and clients.
The average referral is fairly straightforward, but providers need support with hard-to-place clients.
Resource issues often create and exacerbate inequity.

Key Recommendations

Our overall vision for the Referral Platform is to provide infrastructure to meet legislative mandates around capacity tracking and start a foundation for improved coordination around referrals, but not to implement care coordination in its entirety. To this end, our overarching recommendations for the platform are:

- Begin with an MVP version of a referral platform – a very well-built, well-organized tool to search, assess, and communicate. This should include:
    - Standardized, anonymized “Preliminary Profiles” for clients
    - Ability to initiate referral requests
    - Standardized set of rejection rationales
    - Streamlined client escalation process
    - Key supportive features, such as preferred/favorited providers, referral request logs, consent reminders, and provider notifications and messaging
- Continue user testing to assess platform functionality and ability to meet provider needs.
- Conduct additional research to inform future platform features. In particular, the BHA should dedicate research resources to:
    - Understanding if, when, and how to implement “Care Chronology”
    - Identifying and implementing funding and program eligibility integrations
    - Determining the best way to implement waitlist functionality in the platform
    - Understanding the intersection between the platform and Care Coordination teams and processes across the State.

The Vision

Providers frequently need to transfer, or refer, a client to different providers for any number of reasons, including a need for different services or a change in acuity of care needed (i.e. “step-down” or “step-up” care). Currently, there is no standardized process in place for transferring client information during a referral (i.e. what information is transferred or how), leaving providers with the burden of both establishing and maintaining their own processes and navigating the processes of other providers. This burden is most extreme with clients for whom it is difficult to locate an appropriate placement. Furthermore, the absence of a comprehensive provider directory (with clinical information) leaves providers struggling to identify appropriate referral placements, resulting in increased administrative burden for providers who have to filter out inappropriate referrals and/or manage clients who are not well-suited for their services or care setting.

The overarching cost of this uncoordinated system and the resulting administrative burden is that clients often end up in a care setting that cannot provide the level of care and/or the services and treatments they need. How can the BHA better coordinate and streamline these processes to alleviate administrative burden and facilitate more appropriate care settings for the people of Colorado? As the centralized authority on behavioral health in the state, the BHA should provide a single tool that providers can use to identify and assess potential referral placements.

Consequences of Inaction

If the BHA does not act on the recommendations detailed in this report, there are direct impacts that will be felt by providers and people seeking behavioral health care in Colorado. These may include, but are not limited to:

- The BHA’s continued lack of visibility into data on client referrals.
- The traumatization of people placed in avoidably inappropriate behavioral health care settings.
- People remaining in inappropriate behavioral health care settings due to lack of support for providers struggling to identify more appropriate placements.
- People being refused care for discriminatory and inadmissible reasons without any record or documentation of the refusal.
- Providers spending disproportionate amounts of time on administrative tasks related to referrals (e.g. assessing incoming referrals, seeking out information on referred clients,

back-and-forth communication with external providers, etc.) rather than on providing clinical care.

- Disincentivizing new providers from entering the behavioral health workforce due to lack of coordinated support and unnecessarily high administrative burden.

Background

[Relevant foundational information on referrals; key definitions, historical projects, and funding streams]

General

What are Referrals? What is the Referral Process?

As previously stated, a “referral” in this context can be defined as the transition of a client from one care setting to another based on a set of criteria identified about the client and the facility. Today, this process is facilitated ad hoc, operating without a State sanctioned order of operations or supportive technology system.

The referral process typically begins with a determination that a client needs a different acuity of care or type of treatment, and cannot or should not continue being served in their current care setting. The clinical and administrative care teams at the *current provider* will then work together to determine what kind of care setting would more appropriately meet the client’s present needs and identify a specific provider they would like to refer the client to, after which they would reach out to the external provider to assess capacity and fit.

The *receiving provider* would either accept the referral, and the two providers would work together to coordinate client transfer and information release, or reject the referral at which point the *current referring provider* would try again to identify specific potential providers and start the process over again until they find a provider to accept the client.

Today, referrals are facilitated through an analog process of either calling around to potentially applicable facilities or fax-blasting client packets to see if anyone has availability for the appropriate level of care. This means that providers are sending and receiving packets that would never be the right fit just because they need to cast a wide net.

Why Does It Matter?

From the moment the determination has been made that a client is not in an appropriate care setting and needs to be referred elsewhere, that client is at risk of halting their therapeutic process, at best, and traumatization, at worst. Further, that client is in a bed that would be better suited for someone else who does need the level and type of care that care setting provides.

The longer a referral takes the more time individuals spend waiting for appropriate care, ultimately increasing the risk for negative outcomes.

Because the referral process is so bespoke to each facility and currently unmonitored, there is no way for the BHA to hold providers accountable to care for the populations they are licensed and appropriate settings for. As a result, we hear stories of, but have no data on, people being inappropriately denied care, providers cherry-picking clients, and clients ending up in obviously inappropriate care settings.

The lack of behavioral health beds is a well-documented and pervasive problem that cannot be solved by improved referrals processes alone. However, we cannot accurately assess the scope of the problem while inefficient, unsupported, and undocumented referral processes leave individuals in inappropriate care settings waiting for the care that they need.

Previous Activity

In 2019, the Colorado legislature passed HB19-1287, which mandated the creation of a "centralized, web-based behavioral health capacity tracking system" by January 1, 2021. In 2020, HB20-1391 amended the launch date to be "subject to available appropriations." In 2022, HB22-1278 created the BHA and brought the capacity tracking system within its purview.

HB19-1287 ("Treatment For Opioids And Substance Use Disorders'') legally mandates the creation of a "capacity tracking system" to alleviate the bed/residential treatment crisis in Colorado. The legislature recognizes an urgent need for intervention while threatening consequences for providers if they do not follow the mandate's reporting requirements.

In 2021, an RFP was released outlining criteria for a technology vendor to partner with the BHA in creating a platform to help to standardize and streamline the referrals process. Dimagi (CommCare) was awarded the contract, and has since started to build out what is known to date about the core components of a referral platform. This initial build was informed by a research sprint in Winter 2022-2023 focused on bed capacity, one component of a functional referrals platform.

📹For a more on the Bed Capacity Tracking research findings, read the final report here
▶ Bed Capacity Tracking Research Share Out

Although there were some initial findings on provider's referral processes and what features/functionalities of a platform might improve administrative churn, the bed capacity research sprint did not dive deeply into this topic.

In the Summer of 2023, the BHA technology team, in collaboration with Dimagi, began expanding the features and functionalities of the CommCare platform to include a "clinical-level" provider directory (including information only appropriate for providers/clinicians vs. the general public) inclusive of unit and capacity information.

This research sprint was meant to deepen our knowledge base on how providers facilitate referrals today, how a State administered tech platform might improve efficiency, and how the BHA might hold the behavioral health community accountable to equitable practices through these improved processes.

For this sprint, we are working with a focus on **inpatient and residential placements**, with the knowledge that in the future we could expand to additional kinds of behavioral health placements (ex. outpatient).

Key Definitions

Term	Definition
Referring Provider	The provider currently caring for a client, who determines that a different level or type of care would be more therapeutic for the client. This provider is looking to transfer the client out of their care into the care of another provider.
Reviewing Provider	A provider who has received a referral request to accept a specific client into their care. This provider must assess the information available on the client to determine if they can provide care for the specific client at the current moment in time.
Facility	A location with behavioral health services where an individual is receiving care.

Referral Platform (or “the platform”)	The platform that will be used to support and coordinate client referrals between behavioral health providers, or, the set of proposed features and functionalities to be added to the existing platform currently being developed by Dimagi and the BHA technology team.

Legislative Review

A major focus of this discovery research was talking to providers about their lived experiences, but we also needed specific knowledge about legal definitions and regulatory constraints to come up with permissible paths forward. To that end, we undertook a legislative review that informed our perspective on three major issues:

1. Data
2. Consent
3. Specific rules for priority populations.

Legislative Review | Data

BHA’s provider rules provided an excellent grounding for the “Preliminary Profiles” for clients (described later in this report) and a starting point for the legal “reasons for rejection” options for the platform.

- Chapter 2 (2.12.1-3) describes required information to be recorded during screenings and initial assessments, which became the foundation of our preliminary client profile recommendation for the platform MVP.
- Chapter 12 outlines the new rules for safety net providers, and details the permitted and non-permitted refusal reasons that we used to create our ‘rejection rationale’ list.

Legislative Review | Consent

Consent was a major topic of our research, particularly the idea of potentially storing personally-identifiable client data into a BHA-provided platform. We reviewed the HIPAA and 42 CFR Part 2 rules to better understand what counts as personal health information (PHI), about ‘de-identified’ data versus ‘limited data sets’, and about when disclosures of PHI are permitted.

In summary, HIPAA allows for personal data to be disclosed without consent between providers to facilitate transfers, but we are not recommending that approach at this point. Our concept of the preliminary client profile follow's HIPAA's minimum use principle: we think that de-identified data is enough to make the initial determination of the potential to provide care.

Source Texts

- Summary of the HIPAA Privacy Rule | HHS.gov
- HIPAA FAQs for Professionals | HHS.gov
- 42 CFR Part 2 — Confidentiality of substance use disorder patient records

Legislative Review | Priority Populations

Priority populations are important to the BHA and to its providers. For BHA, ensuring equity means tracking outcomes for priority populations, as well as ensuring that existing rules are being followed. Reviewing providers need to know about priority population information in the initial referrals request in order to plan appropriately. We have incorporated some of these 'priority flags' into our preliminary client profile, and also pulled out a few data points that would be useful to add to the searchable data model for facilities.

Partnership Review

Part of our research included a thorough partnership review to ensure our recommendations coordinate with, rather than duplicate, existing efforts. We met with representatives from various state agencies to discuss the scope of our work, how it may intersect with ongoing efforts at their agencies, and opportunities for collaboration.

Department of Health Care Policy & Financing (HCPF)

We met with HCPF representatives to discuss:

- Cross agency care coordination process planning between BHA and HCPF.
- Cross-agency data sharing as appropriate (ex. Medicaid validation)
- Future eligibility engines and workstreams

Office of eHealth Innovation (OeHI)

We met with OeHI representatives to discuss:

- Consent approvals and potential future integration with statewide eConsent initiative to implement more granular consent technology.
- Possibility of potential integration with future Social Health Information Exchange (SHIE)

Department of Corrections (DOC)

We met with DOC representatives to discuss:

- Population-specific needs and care coordination teams

Office of Children Youth and Families (OCYF)

We met with OCYF representatives to discuss:

- Population-specific needs, regulations, and care coordination teams

Other state agencies and organizations

We met with representatives from additional agencies, boards, and organizations to discuss:

- How to reach licensed providers and organizations outside of the BHA's purview who would be appropriate users of this platform
- Integration with crises services

As a result of this partnership review, it is clear to us that the work to develop a coordinated and unified behavioral health referrals platform is unique and needed.

To achieve this goal, the BHA will need dedicated funding that extends beyond ARPA funding and far into the future to tackle not only the current needs, but future iterations of this platform, including outpatient and social care services.

Research Overview

Research occurred between July and October 2023, and was conducted by a 6-person, cross-discipline team composed of BHA technology team members and Bloom Works staff, spanning roles from project management, technical strategy, to user research.

Research Objectives

The main objectives for primary research were:

1. Develop an understanding of the referrals process from behavioral health care providers' perspectives, to better address their needs, preferences, and pain points.
2. Clarify the barriers to effective referrals.
3. Describe the impact of referral processes on patient outcomes and satisfaction.
4. Deepen the understanding of how inequity shows up in this process today in order to create plans and processes for mitigation.
5. Develop a deeper understanding of technical considerations and possibilities for a referrals platform, particularly in relation to:
    a. Referrals data model/schema
    b. EHR/integrations
    c. Consent management

   d. Inter-provider/state care coordination team messaging/communications

6. Identify opportunities for improvement and provide recommendations on how the BHA might better support providers and people seeking care.

Research Participants

To address the research objectives we engaged with representatives from two major stakeholder groups.

State Agency Leadership and Staff

We talked with a range of perspectives including BHA teams and other state agencies:

- BHA Teams:
  - Care Coordination
  - Health Information Technology (HIT)
    - Legacy Systems
    - Data Interoperability
    - System Support / Help Desk
    - Technology Vendors
  - Legislation and Policy
  - Quality and Standards
  - Statewide Programs
- Other State Agencies:
  - Office Information Technology (OIT)
  - Department of Corrections (DOC)
  - Department of Health Care Policy & Finance (HCPF)
  - Office of eHealth Innovation (OeHI)
  - Office of Children Youth and Families (OCYF)

Behavioral Health Providers

We also interviewed representatives from behavioral health provider organizations in Colorado. Our goal was to get as diverse a sample as we could across the provider characteristics below.

Characteristic	Representation Elements	Recruitment Results
Interviewee job role(s)	Administration Care / Case Manager Clinical Social Worker Marriage and Family Therapist*	We were able to talk to at least one person in each desired job role, except those noted with an asterisk.

	• Mental Health Counselor • Psychiatrist* • Psychologist* • Referrals Staff • Finance Staff • Unit Staff	
Interviewee key tasks, responsibilities	• Create referrals • Evaluate referrals • Coordinate care	We spoke to several people for each of these referral related tasks.
Organization referral velocity	• Low # of incoming and outgoing referrals • High # of incoming and outgoing referrals	We spoke to several people from low and high velocity referral organizations. On the low end we heard a handful of referrals per year and the high end several referrals per day.
Organization referral tools, processes used	• Lower tech-resourcing: Paper and faxed based systems • Higher tech-resourcing: Mostly digital and cloud based tools	We heard about the processes from organizations with just paper based systems and organizations using several digital systems to track patient and referral data.
Organization Size	• Small: 1 - 50 employees • Medium: 50 - 1000 employees • Large: 1000+ employees	We heard from people representing small, medium, and large organizations.
Organization (Provider) Types	• Community Health Center • Crisis / Stabilization Unit • Hospital • Outpatient Treatment Center • Private Practice* • Residential Treatment Center • Safety Net Provider / Federally Qualified Health Center (FQHC)	We heard from organizations of all the indicated types, except those noted with an asterisk.

	- University or School-Based Clinic* - Walk - in Clinic	
Organization Populations Served	- Children, youth, and families - Civil / Criminal / Forensic - Disability Accommodation - Geriatric - LGBTQIA - Multilingual (e.g. Spanish) - Tribal* - Unhoused - Veterans*	We spoke to at least one person from organizations that work with the indicated populations, except those noted with an asterisk.
Organization Location / Region	- Rural - Urban / Metro	We heard from organizations working in rural, urban, and multi location settings.
Organization Insurance Types Accepted	- Private Insurance - Medicare - Medicaid - Self-pay (No insurance)	We heard from organizations who work with each and all of the desired insurance types.

Research Methods

Our primary research method was structured 1:1 interviews which we supplemented with a survey. See descriptions below.

Method	**Description**
State Stakeholder Interviews - 13 sessions with 23 participants - July 26 - August 3, 2023	Structured interviews with key state stakeholder groups. Topics: - State-wide vision - BHA roles and responsibilities - Health care systems - Health data and system interoperability - Related legislation

	- Background on behavioral health providers - Provider licensing - Care coordination - Equity in behavioral health
Behavioral Health Provider Interviews - 20 sessions with 23 participants - August 21 - September 15, 2023	Structured interviews with a representational segment of behavioral health and other social safety net providers. Topics: - Participant roles and responsibilities - Organization purpose and background - Referral processes and tools - Interactions with the state - Feedback on referrals platform concepts
Survey - 19 respondents - September 18 - 29, 2023	Survey sent to approximately 200 behavioral health providers from BHA email lists and other provider networks. Topics: - Referral processes - Usability feedback on the referrals platform

Research Procedure

Interviews typically lasted 60 minutes and included, from the research team, an interview lead and at least one observer/notetaker. All interviews were conducted virtually using Google Meet.

We asked participants for the following levels of consent, which we've maintained throughout these report artifacts:

- Permission to take written notes
- Permission to audio and video record the session

- Permission to use the person(s) names during any summaries, reports, or presentations of the research findings

During the sessions, the interview lead asked selected questions from an interview guide tailored to the interviewee's role/organization, based on a core interview guide (see appendix). Other research team members asked follow up questions as applicable. Immediately after each interview session, the research team held short 'debrief' meetings to review session notes and to record key takeaways for follow up via email with the research participants.

Every single interview participant received a recap of their interview and were provided a chance to refine or add to the research team's key takeaways.

The survey was sent to approximately 200 behavioral health providers and responses were collected from September 18 - 29, 2023. 19 people completed the survey. There was some overlap of topics between the interviews and the survey, as we wanted to provide a mechanism for more providers to give us feedback than what we could accomplish via interviews alone in our time frame.

Data Collection & Analysis

In terms of research artifacts, each interview session included, at a minimum, typed notes from one observer and the 'debrief' meeting notes from the research team. In sessions where participants provided their consent, we also recorded the session.

We processed the session recordings, observer notes, and debrief notes using Dovetail, a qualitative data analysis tool. We applied tags to the notes and transcripts to identify topical areas of interest and to look for commonalities and differences amongst participant responses. We used the tags to help structure and inform our understanding of the research objectives and to shape our findings outlined in this report.

Research Limitations

One limitation of this research is that it naturally cannot fully represent every provider perspective across Colorado. We did our best to recruit as diverse a range of providers as possible. Furthermore, in some interview sessions we were not able to cover all the topics we wanted, so some provider perspectives may be limited.

The survey was limited in that 10% of possible respondents completed it. We treated the survey as another channel for behavioral health providers to supplement what we learned in our interviews. We do not assume the survey is a comprehensive nor a representative channel for provider feedback.

Research Findings

Current Referrals Process

A primary goal of our research was to better understand the referrals process as it currently exists today – how providers handle these moments of transition, what their pain points are, and what opportunities exist for improvement. In addition to calling out key pain points in the process below and insights from our learnings, we have also documented our understanding of the process as it currently exists in a Journey Map (which can be viewed here Referral Discovery User Journey_Current State.png) and a Care Story (which can be viewed here Care Story _ Current state_Sharon.png), both of which are also included in the appendix of this report. For a description of our Care Stories, see Appendix A: Care Stories.

Currently there is no standardized process in place for establishing contact between providers or for transferring client information, creating inconsistencies and communication gaps in the behavioral health field. This uncoordinated landscape and administrative burden comes at a cost to clients, who often end up in a care setting that cannot provide the level of care they need. The primary pain points in the current referrals process are described below.

1. **Difficulty Finding Providers:** Providers experience difficulty in finding appropriate facilities for their client's needs. Providers need to know more than just a facility's capacity; they need more detailed information on the providers' capabilities, treatment types and admission requirements.
2. **Communication Gaps:** Providers are obstructed from performing timely and effective referrals due to irregular and disorganized communication practices. Collecting all relevant information to complete a referral currently requires extensive back and forth, and often results in long wait times and lack of response.
3. **Inappropriate Referrals:** Missing information and poor communication lead to increased rates of inappropriate referrals, meaning that facilities are receiving referral requests for clients they are not equipped to care for. This is a source of unnecessary administrative burden both for the provider who is sending the inappropriate referral, as well as the receiving facility who has to sort, review, and respond to requests that are not appropriate.

4. **No Clear Path To Support :** When a client's case is more complex, it can make finding appropriate inpatient/residential placement more difficult. Unfortunately, providers can find themselves in situations where they are unable to provide proper care for a client, but unable to find somewhere else for them to go. It is unclear in these instances what should happen next, what emergency options there are, or who to contact for support.

Key Insights

We've identified eight key insights that will be important in guiding the development of the referrals platform for MVP and beyond, which are discussed in detail below.

1) The referral process suffers from inter-provider communication gaps.

What we heard

Numerous communication gaps exist within the behavioral health space that cause coordination issues, particularly around referrals. Communication in this space is currently 1-to-1, where providers typically call or email each other directly. Significant back-and-forth conversations are required for providers to gather appropriate client data, which can have an impact on wait times. Providers cannot see when a client they've been processing or a client on their waitlist has been accepted elsewhere, and EHRs only track clients who are officially in treatment. Until then, clients may not "exist" anywhere in the system, or only exist in local, provider-specific spreadsheets.

> *"The referral process is a painful period. It does take a long time and we get a lot of non responses. So we will make calls and nobody will call us back or we'll send out packets and nobody responds. It takes a lot of time. Then we've got the phone tag where we're trying to connect and we're unable to do that."*
>
> *"A lot of time is spent tracking down nursing staff and clinicians. Sometimes, we accept a patient, and then 2 hours goes by and we haven't had that nurse to nurse (contact) and then they place them somewhere else."*

What it means

A centralized hub for providers to communicate with each other and with state intermediaries around the process of referrals could bridge these communication gaps. A centralized source could help facilitate provider searches and information exchanges more efficiently. The goal is not to replace all means of communication via a centralized hub, but rather fill existing gaps.

2) Standardize referral requests, but remain flexible.

What we heard

Currently the referral process requires admissions and intake teams to do additional digging and follow up with referring providers to gather all the information needed to determine eligibility and officially accept a client. Standardizing key referral information could streamline intake processes by making things more transparent and reducing the amount of back and forth needed to fill in missing information required to assess incoming referrals.

However, one thing we heard repeatedly from providers is that referrals are highly individualized and often come with nuances that cannot be fully standardized. Each facility and client is unique and requires a match between individual needs and provider capacity at a specific moment in time.

> *“Every patient is different. Every patient has something that has never come up before that we may need to talk through, every situation is unique and there is no way to make it completely standardized.”*
>
> *“I think if we could just streamline it so that each entity had the same requirements or same guidelines before they even referred someone, they (would know) each agency needs this information. Because I feel like a lot of our time is spent chasing information down and it just takes away from the care for the clients.”*

What it means

Offering a standardized referral form could expedite referrals and create consistency amongst providers. The form should include standard fields needed by the majority of providers. Additionally, open text fields should accompany form fields to allow for providers to customize or offer more details.

3) Support existing workflows, instead of replacing them.

What we heard

Providers have processes and systems currently in place that, though perhaps suboptimal, are currently working for them. Some are wary of the ability of a state-provided platform to meet their needs. To encourage adoption and trust in the platform and the state, a referral platform must work alongside provider’s current workflows and honor their existing processes, rather than forcing them to abandon what they know and rely on.

> *"Depending on how the form or system is built, even if it's built to support what I need to support my patients, if there's something a little extra or something a little different about this patient's presentation - especially if I had a relationship with the other provider - that's when I would pick up the phone.”*

What it means

Anticipate that providers will use the referral platform to supplement their existing processes. This could include users looking at supplemental data in EHR systems or local spreadsheets. The platform will certainly exist alongside communication channels like emails and phone calls. Rather than introducing a system meant to fully automate referrals, offer providers a robust search engine, directory, and communications hub through the platform to facilitate existing workflows. Providers should not be required to perform their referrals through the platform, there is also no legislative mandate for the BHA to enforce this. Instead, provider communications, workflow steps, and relevant data should be able to interplay with providers' tools/processes as seamlessly as possible.

4) Consent should be managed between providers and the client.

What we heard

There are two main aspects of consent as it relates to care generally:

1. A client gives consent for treatment to a provider in a moment of transition
2. A client will be asked to complete a Release of Information that allows Provider A to transfer the client's PHI and PII to Provider B.

These pieces of consent are currently, and should continue to be, managed entirely by providers. Provider consent forms are widely variable, and forcing a change to these processes would be an unnecessary deterrent to platform uptake.

> *"The state should not be responsible for gathering or storing consent, but there needs to be a system of record validating and recording the consent process."*

What it means

The referral platform would only need to gather platform-specific consent if it were to retain sensitive client information such as Personal Health Information (PHI) and Personal Identifiable Information (PII). If the referral platform uses anonymized client data for its functions (e.g. search, matching, communication, etc.), platform-specific consent is not needed. However, in the name of client-state agency content, the moment of a referral request is an opportunity for providers to speak with clients about their options, care preferences, and to get their permission to use the platform to find them placement.

5) The average referral is fairly straightforward, but providers need support with hard-to-place clients.

What we heard

From our conversations with providers, it seems as though the average referral is fairly straightforward and does not pose a major problem. However, when a client is more difficult to place (e.g. higher acuity, justice-involved individuals, or people with complex medical needs) the referral process becomes more unwieldy. Providers can become desperate as their clients may wait days or weeks for things to move forward. During interviews with BHA stakeholders, we heard stories of providers asking for support for difficult to place clients through a large number of channels. The support and resources presented in each instance depended entirely on the channel. A challenge is that a comprehensive and reliable process of escalation support is hard to find and sometimes providers don't even know where to start.

> *"Oh my God, [escalation support] would be wonderful. If the state is thinking about that, we're wholeheartedly behind that, we would definitely support it and use it."*
>
> *"I think that when you're in the mental health system or the systems that treat substance misuse, I think accessing the state system for support is far easier than it is for another organization."*
>
> *"I do wish that there was a way to (more easily receive support)."*

What it means

Providers want to resolve client referrals on their own when they can, but sometimes find themselves in a desperate place. This has a direct impact on the wellbeing of the client as well as a cascading impact on other clients in their environment. Standardizing the process of escalating hard to place clients can meaningfully improve a major pain point in the referrals landscape and potentially bring providers to the referral platform.

6) Inter-provider trust is key to successful referrals.

What we heard

Currently, providers have a strong sense of other facilities they do and do not trust to provide quality care and accurate referral information. They often refer primarily within the same set of providers they trust, even when additional options may be available outside these networks. Providers described receiving inaccurate referral information that led to inappropriate care settings and lowered their trust.

> *"We still need to know the services and how they work for people. I would still want to have that relationship to know the quality of the service, to know that they share the same visions and goals that I do."*
>
> *"People are looking for placement for these patients. And sometimes they're not so honest. So the level of care that they may require isn't the level of care that we can provide. And I think that sometimes causes a little distress between certain providers."*

> *"I really want to look at individual needs and I look at specialties. So we now have a provider that works with the LGBTQ+ community and so I might look towards them, right? I do a lot of, 'yes, I know these people will respond' or 'no, these guys have a really bad reputation.'"*

What it means

Not having all the necessary information upfront can break down trust between providers. Success hinges on giving "reviewing providers" the right information and calling attention to prioritized attributes which change the nature of the referral (e.g., if a client is on an involuntary hold or has justice-involvement). The referral platform can't solve the problem of "referring providers" *intentionally* hiding acuity information, but it can help reduce unintentional misunderstandings by providing standardized descriptions of providers and client profiles, allowing providers to send each other feedback through client rejections.

7) Resource issues often create & exacerbate inequity.

What we heard

When it comes to referrals, inequitable outcomes may be less about intentional discrimination and more about equity of offerings – in other words, it is not necessarily that individuals are being intentionally discriminated against, but that more complex cases require more specialized training and/or staffing leaving a dearth of options for more complex cases. For example, a youth facility that offers a certain level of support may not be trained or resourced to accept justice-involved youth or ones with certain comorbidities. It is not necessarily that individuals are being discriminated against, but potentially rather a state-wide lack of resources necessary to provide for their care. This platform can help to establish baseline data on these resourcing shortages.

> *"Those patients with that diagnosis are very difficult to manage. But that's still a psychiatric disorder, something we call a 1 to 1, meaning you're so dangerous either to yourself or others that you have to have a staff member within arm's reach."*
>
> *"Today, I got a referral for a nine year old who had an IDD and an autism diagnosis. That combination and he was already quite young for our program, and then on top of that, he's presenting much younger… It is for those reasons where we just don't have the staff because a lot of times those youth we've noticed require like one on one support. And we usually don't have that staff to provide."*

What it means

The BHA needs better data analysis to track where behavioral health resources and support are needed. Building the ability to track information on referrals, rejections, and priority populations in the referral platform is a step towards gaining that insight.

8) Adoption of the referral platform hinges on trust.

What we heard

Use of the referral platform relies on providers' belief that it is useful and usable, as well as their trust in the BHA in general. Some providers are skeptical about a referral platform's usefulness, specifically when capacity / availability data is extremely dynamic and can change multiple times throughout the day. How can a referral platform ensure that the data is up to date?

In addition, providers need to trust that use of the referral platform is meant to be helpful to them rather than a tool the BHA uses to monitor providers and punitively enforce state mandates.

> **"***One (boundary of adoption) is that I have to trust the system. I would have to use it several times and understand that it is giving me the same information that I get from this other source, or via phone call, or whatever. So just time, it would just take time."*
>
> *"I think that staff don't trust the system. I think staff go in and look at it and they're like, when was this last updated? Oh, it says that this was last updated four days ago or four weeks ago. So, like, I'm not even gonna use this as a tool. They may consider it a waste of their time. Once they look at it, they realize they have to call the facility anyway because it wasn't updated in four weeks."*

What it means

The referral platform should foremost be treated as a support system for providers. Continued efforts to add value to providers' workflows, and ensure accuracy of data in the platform, will support usage uptake.

Systemic Challenges

The following findings provide context on systemic challenges for the behavioral health landscape in Colorado. The challenges are beyond the scope of the referral platform; however it is important for us to understand and design for these implications.

1) There are not enough beds in Colorado.

No technology system can solve the primary issue behind access to inpatient/residential behavioral health care; there just simply are not enough beds (or said another way, staffing) to meet the needs of people seeking care.

> *“Somewhere around 40% of our patients don't actually meet the criteria to be here anymore, but they have no place to go. We want to serve more people who are acute and need this level of care, but because there's really no other providers to serve patients with comorbid diagnoses, by default they end up here.”*
>
> *“I think the frustrating part is just having to wait and like, the intake team will meet this kid and then three months will pass and then the kid moves in and it's like, wait, I need to refresh my memory on who this kid is. I don't know any way around that and beds have been, you know, there's not many beds in the state anymore.”*
>
> *“Foster care is usually a really difficult one. There are just not enough beds in the state.”*

2) Prevention efforts should increase.

Increasing awareness and access to lower levels of care may help to divert instances that would otherwise escalate to the level of needing higher acute care.

> *“Well, I don't think (improving capacity information) is impossible. I just don't think it'll be effective. So we need people at the lower level of care, the therapist, the psychiatrist, sometimes an acute treatment unit through the mental health center.”*
>
> *“The ideal solution is not necessarily more beds at a high level of care, but that lower levels of care are more available, known, and utilized to support people before they need residential treatment.”*

3) Medical acuity is a barrier to care.

Comorbidities and medical acuity are a primary barrier to successful behavioral health inpatient/residential placement. Very few facilities across the state have the ability to treat both behavioral health needs and medical needs, including a lack of SUD treatment programs that are able to meet the medical needs of individuals in withdrawal.

> *“Understanding those pieces across the community and being honest is probably one of the biggest struggles in terms of finding the best place for patients to receive care. Because they'll come all the way down from three hours away and just, we can't manage their medical acuity.”*

4) IDD diagnoses as a barrier to care.

Outside of a few specialty providers, finding behavioral health care for an individual that also has an intellectual or developmental disability (IDD) diagnosis is incredibly difficult. It is common for behavioral health providers to refuse service when there is a co-occurring IDD diagnosis. We heard from providers that refusals based on IDD diagnosis are often due to lack of education, societal misconceptions, and the erroneous conflation of behavioral health symptoms and IDD symptoms.

> *"(People with IDD) get told, I'm sorry, we don't do that. You need to go somewhere else. And it's a civil rights issue. It's a human rights issue and it's an access to health care discrimination based on disability."*

Additional Survey Insights

The most crucial survey questions with direct impact on the referral platform MVP focused on validating the data models for the Preliminary Profile and Rejection Rationale.

The **most frequent challenge that organizations face when referring patients** to other providers include difficulty finding open beds (*30% of responses*), long wait times (*26%*) and difficulty finding appropriate providers (*23%*). Additional reasons included patient history, (including justice-involvement and history of sexual offense), difficulty placing clients with IDD, and finding accommodation for medical needs.

The **most common factors that cause facilities to reject a referral** include client's acuity or treatment needs (*38% of responses*), bed availability or full waitlists (*23%*) and consideration for current milieu (*19%*). Additional factors included medical acuity and staffing.

Respondents indicated that **the most important features** of a centralized platform for facilitating inpatient/residential referrals include accurate data on available capacity, facility's admission requirements including insurances accepted and populations served, and generally more detailed and granular information about providers' capabilities and treatment types.

Recommendations & Roadmap

[Tactical recommendations and proposed plan for implementation.]

Overview

Scope & Philosophy

Referrals between behavioral health providers are a major moment of transition in an individual's care journey. Currently, there is substantial anecdotal evidence and informal knowledge that these moments of transition also generate undue administrative burden for providers and lead to negative outcomes for people seeking care. However, the BHA currently lacks any visibility into or oversight mechanisms around the process of referrals, and thus cannot meaningfully and measurably improve conditions around the transfer of care.

As the agency tasked with coordinating behavioral health care in the State of Colorado, the BHA has a responsibility to provide coordination and support for moments of transition within the behavioral health ecosystem. While a platform of this nature will be primarily used by behavioral health providers, we see the people of Colorado as the ultimate beneficiaries of improvements in this space, and their perspectives must be centered as we design and implement this platform.

The work around referrals should not end with this research sprint, or the January launch of the platform that is currently being developed by Dimagi, but must continue iteratively refining and expanding the platform based on additional research. We have built a foundation of macro insights and high level recommendations that will inform these smaller chunks of work to build toward a larger unified vision.

Our recommendations propose a minimum viable product (MVP) to develop for January's launch that we believe will solve quick-win provider pain points to bring them to the platform while also establishing a foundation for a more expansive platform. This approach will allow the BHA to begin rebuilding trust with providers while learning from a more narrowly-scoped product to hopefully ensure the platform is utilized and effective in the long-term.

The Big Picture

People seeking care frequently find themselves in care settings that are not optimal for their needs, either because their needs have changed or for any number of reasons to do with the complexities of securing good-fit placement. Any time spent in a non-optimal care setting is time at risk of delayed treatment, regression, or traumatization. Further, these mismatched placements make it difficult to assess the scale of bed and provider shortages.

While it is impossible to fully eliminate time spent in inappropriate care settings given the complexity of this landscape, it is crucial that the BHA work toward a future that minimizes the time any individual spends in a non-optimal care setting.

One way to do this is by supporting referrals once a provider has determined that a client is not in the optimal care setting. Currently, the BHA has no visibility into or oversight of this process, and providers are left to manage referrals independently without any streamlined state support. The BHA should provide a tool that facilitates the referral process and creates a coordinated path for state support.

The following recommendations consider:

- **Provider workflows and processes:** how new technology can fluidly integrate with and support existing workflows.
- **Longevity of data:** how much information needs to be shared with who and when, with the goal of providing people with the information they need at a given moment in time and no more than that.
- **BHA knowledge gaps:** what data the BHA should have around these interactions
- **MVP feasibility:** what is quickly feasible and beneficial for MVP, as opposed to what needs to be more deeply researched for future iterations.

This work is setting a foundation for a future where we can further explore those care coordination possibilities.

Minimum Viable Product

Our MVP recommendations are triangulated to solve a major provider pain point. One of our major shifts in thinking during this research was that, technically, we weren't proposing a 'referrals platform'. Instead, creating client profiles to find other providers is still part of the *search* process. Our MVP proposal facilitates *matches* by using the client profile as an enhanced search function.

Completing transfers of care is a coordination problem, with both actors needing to send and receive information at various points. Our MVP recommendations bundle the initial back-and-forth communication into a single action. Initially providers can search for facilities they think will match, and then send a targeted request that gives the reviewing provider relevant client information. The referring provider can see the reviewing facility's description, and then the reviewing provider can see information about who this request pertains to.

📃For a more visual description of MVP functionality, see Care Story _ MVP_Marissa.png , Care Story_MVP_Elliott.png , and Referral Discovery User Journey_Future State.png

Proposed Roadmap

Phase 0: Build out MVP

October – December 2023

Dimagi has already begun building the platform that will house both bed capacity tracking and referral support that will launch in January 2024. Our MVP features, described below, should be added to that platform ahead of the January launch.

Key features for MVP:

1. Preliminary client profile
2. Referral requests
3. Rejection rationale
4. Escalation trigger
5. Preferred/favorited providers
6. Consent reminder

Each feature is described in more detail below.

1) Preliminary client profile

Background
Referral requests typically go through two stages:

1. An initial outreach to known providers asking about availability and providing a sketch of the client, and
2. The subsequent transfer of a "referral packet" containing detailed personal health information (PHI) about a client.

Our proposal centers around formalizing the first stage by allowing providers to create a client profile *without personal information* and initiate requests to 'matching' providers. The client profile will contain, at minimum, information that is required in a screening and priority flags (e.g. client is pregnant, justice-involved, etc) with optional fields allowing referring providers to add additional information required in initial assessment.

Our proposed preliminary profile schema includes the following information (with an asterisk '*' denoting optional fields):

- Age (numeric entry)
- Gender (drop down)
- Referrer (auto-generated based on user)
- Reason for seeking care (text entry)
- ASAM level (drop down)*
- Symptoms (text entry)

- Provisional diagnosis (text entry)*
- Pre-existing medical conditions/needs (text entry)*
- Level of care needed (text entry)
- Waiting for a referral since (numeric entry)
- Current medications (text entry)*
- Insurance information (text entry)*
- Priority population (text entry)*
- Is involuntary (check box)*
- Is veteran (check box)*
- Is pregnant (check box)*
- Is justice-involved (check box)*
- Additional details (text entry)*

Our Recommendation

There are, broadly, two situations in which referrals are initiated:

1. When a provider has given care to a client and determines they have reached a point where they need a different level or type of care (usually ‘step-down’ care).
2. When a provider receives a walk-in, has not given care and is looking to gain the client admission at another facility.

In both cases, providers will have the information required by the screening, and likely information required by the initial assessment.

We recommend that the platform include the ability to create an anonymized profile with the minimum information needed to determine potential fit, including standardized fields, priority flags, and (optional) text areas to capture additional details as needed. While providers don’t like having to enter the same information into multiple systems, it is likely worth the effort of clarifying the client’s condition if it increases their chances of successful placements. The task we’re asking them to do isn’t ‘report this data’, it’s ‘find placement’, so it is reasonable that providers will take that extra effort.

Further Questions

There is a persistent tension between providers receiving referrals who generally want to see a lot of detail, and asking too much of referring providers who need to create the profile. (For example, Colorado’s Placement Support Request: very detailed, but extremely specialized and impractical as standard). Using many specific fields (e.g. age, gender, symptoms, etc.) makes the profile easier to understand and compare but may make the data entry appear longer when compared with a few more general text areas to capture many data points in one field.

The loosest formal structure would be a big text area where providers can enter information in a 'prose' format (For example, this diagnostic profile we were sent). This could conceivably be easiest for providers entering information if they are able to copy+paste this in from notes they have elsewhere. However, related goals of the project are to (a) reduce back-and-forth, and (b) capture data about what kinds of people are being denied. Submitting unstructured text blocks leads to data which is inconsistent and harder to programmatically interpret, so our compromise here is to come up with standard fields that every referral needs, while offering various "details/notes" text areas to capture additional details.

- What if "details" notes include personal information, is there some kind of prevention necessary?
- Are there specialized fields that come up based on checkboxes you click?
    - E.g. if you click a checkbox that says "justice-involved", should you also be prompted to answer about violent crimes / gang affiliation?

2) Referral requests

Background

We heard often from providers about communication-related challenges around the referrals process: lots of administrative back and forth to seek additional information, hard to get in touch with the right person, and generally wanting to hear back quickly about availability, acceptances, or denials. Providers prefer to hear "yes", but if the answer is "no", it's better to receive that quickly and explicitly rather than waiting for days or weeks without an answer — which is also a "no", but slower.

Further, reviewing providers who are processing a referral are unaware if that person has been accepted elsewhere in the meanwhile. So it is not just the referring provider who wants the answer, but other providers this referral has been sent to would also benefit from this information.

The opportunity here is not to solve all communication within the platform, but to solve for common pain points around coordinating referrals by providing standardized information and standardized responses. Referral requests can help in two ways here:

1. Streamlining getting answers during initial outreach (ie, "we may be able to accept, please phone" or "no, not a fit for our clinic"), and

2. Facilitating global awareness about particular cases (eg, everyone can see whether or not a referral is still “open”).

Our Recommendation

We recommend focusing on the initial referral *request* being managed in-platform, and assume follow-up conversations happen off-platform using familiar channels (e.g. emails and phone calls). Messages around referral requests are either provider-to-provider (e.g. phone call to clarify something) or system-to-provider (e.g. automated notification triggered by a request).

For the MVP:

- A referral request should trigger notification emails, which (hopefully) spur other providers to review and respond with a yes or no response.
- Follow-up messages happen off-platform, with the platform itself serving as a phone-book: listing other providers and methods for getting in touch.

Concretely, a provider with a client to refer would create a preliminary client profile (mentioned above), search for ‘matching’ providers (eg, based on age/gender requirements and level of care offered), and then send referral requests which include their client profile. Sending a referral request triggers an automated email to reviewing providers. The referring provider is able to view a list of sent requests per client profile.

Once the notification email is sent, the reviewing provider will receive an email saying that there is a profile for them to review. They click the link in the email and are taken to the referral request.

The reviewing provider can see the referring provider, the client profile, and contact information for the individual who sent the request. The reviewer can ‘provisionally accept’ or ‘decline’ the request, or follow up for more information. At this point, this request is ‘seen’, which can be indicated to the referring provider.

The reviewing provider can take one of five actions:

1. **Ignore the request:** take no follow-up actions (this is not desirable, but cannot be prevented at this time).
2. **Reject the request:** select ‘decline’, and then select from a list of refusal reasons, including some detail.

3. **Provisionally accept the request:** select ‘provisionally accept’: they think they can take this person, but need to confirm over the phone and/or they need to see the full packet.
4. **Waitlist the request:** Select ‘waitlist’: means that this client is suitable for the waitlist but they can’t be accepted currently. This is still an open request that other providers can see.
5. **Request more information on the request:** Request more information from the referring provider.

Options 2-5 should trigger a notification to the referring provider. In the case of (1) for long-running referrals (the referral is created and sent out, some providers deny formally but others just never respond one way or another), the referral itself should not just sit there open indefinitely. For referring providers, there should be some reminder to either ‘deny’ (They never responded, so that’s in essence a denial — this means referring provider denials should incorporate this) or ‘waitlist’ them, where technically the request is still open but there is no timeline on when they can be accepted.

Further Questions

- What happens if requests are never closed (e.g. ignored, or “provisional approval” but never formally approved)?
- How can/should the platform ensure follow-up information is accurate and useful?
    - For example, it would be frustrating for a provider to provisionally accept a request, and then try to phone and get a help desk that doesn’t know about the referral.
- What, if any, should be the role of in-platform messaging?
    - We have recommended keeping the majority of direct communication between providers as email and phone, but is there a desire for in-platform direct messages?

3) Rejection rationale

Background

Providers told us repeatedly that getting any answer to a referral request, even if it is a no, is more useful than not hearing back. They also would like to understand the reason for rejection, in order to help them decide what steps to take next. For example, reviewing providers may reject a referral on grounds that the referring provider is able to reassure them about and change their minds. Similarly, the BHA would like to understand who is getting refused, why those refusals are happening, and how long referred clients are waiting.

Our Recommendation

A standardized set of rejection rationale would allow providers to give feedback to other providers in a way that is easy, compliant, and useful for both the referring provider and the BHA in the future. BHA's upcoming provider rules define a list of circumstances under which safety net providers are allowed to refuse. We used these rules as a basis for our recommended list of rejection rationale, although they will only legally apply to safety net behavioral health providers. We recommend implementing this standardized set of rejection rationale using a checklist of predetermined reasons, with an additional text area for details where providers are prompted to give a sentence or two to describe the details of their rejection. The text area should include a sentence of hint text to give providers an indication of what this explanation should include.

Our proposed rejection rationale are:

- Individual's diagnosis is *outside the scope of practice*
- Individual *does not fall within the population(s) served*
- Individual presents a need for a *level of care the facility does not provide*
- The facility *cannot provide services within an appropriate time frame* per the individual's needs
- The facility does *not have the proper staffing* to meet the needs of the request
- The individual presents a need for a level of care that would cause a *disruption to existing milieu*
- Individual presents with *medical needs that exceed the capability of the facility*.
- Criminal History, *Behavioral Concerns*

For example, a provider submitting a rejection may select "does not fall within the population(s) served", and then follow up with "we are qualified to treat pregnant women, but not youth (below 18)."

Further Questions

As mentioned, safety net providers' ability to refuse is constrained to predetermined reasons, and we also know there are staff-to-patient ratio restrictions that apply to specific categories of providers.

- Should refusal reasons take into account the type of provider (e.g. Comprehensive providers see fewer options) or should everyone get the same reasons?
- Should there be an "Other" option allowed where providers are able to refuse for another reason but required to enter explanatory text?

We also know that safety net providers will have constraints on when they are permitted to deny an incoming client. It would be a good idea to restrict the on-screen refusal reasons based on whether the provider is a safety net provider or not, to prevent them from making non-compliant entries.

4) Escalation trigger

Background

Many providers described difficulty or confusion with complex cases, leading to situations where they have run out of good options and aren't sure what to do next. Currently, providers use a variety of methods to work through this: fax blasting, calling in a favor, looking for lower-rated services that may be more available, escalating, retaining clients for longer then they original intended (often while they are on a waitlist for another facility), or even downplaying the acuity of the client in their outreach to other providers. These all lead to undesirable outcomes, both for the client, the individual provider, and the provider landscape at large. Particularly savvy or well-connected providers may know who or where to reach out to at the state level for additional support, but many do not.

Escalating for support for complex cases gives providers access to coordinating bodies (the BHA, RAEs, ASOs, MSOs, other state agencies, etc.) with access to more resources (they can provide training, enhanced payment, reassurance, additional pressure, material supports) which can help identify uncontacted providers and/or encourage providers who previously refused to reconsider.

From the perspective of the people who receive these escalations, we heard that they benefit from contextual awareness for any escalated cases: Who is this person, how long have they been waiting, what have you tried so far?

Our Recommendation

Providing a simple escalation mechanism — e.g. a screen or button that allows providers to send an email to a monitored inbox — will help give providers with complex clients a clear path forward, and (if support is forthcoming) serve as an incentive to use the platform.

We also recommend that the provider be required to answer three questions as part of their escalation request that will be included in the email:

1. What have you already tried?
2. What are the main placement barriers?
3. Who have you already reached out to?

We believe this email should go to the BHA's Care Coordination program team, but this will depend on the team's capacity to manage incoming escalations. Since the platform keeps track of a history of referral requests, the referring provider will be able to pass along this information to the person receiving the escalation, helping them understand who has been reached out to and why they have been denied.

Further Questions

One thing to be mindful of is the potential for providers to spam the escalation path. We do not believe this to be likely and that providers instead would only like to involve the state when they truly feel at a dead end, but in the event that it becomes a problem for the response team, the option to escalate may need to be situational or available more sparingly. Possibilities for situational moments to offer escalation include:

- Referring provider does a search which returns 0 results
- Client has been waiting more than 48 hours (note that admission time may be different from the creation of the client profile)
- Client profile indicates a priority population
- Client has been rejected X number of times
- Client is on an involuntary hold with 24 hours remaining

Adding restrictions may lessen the efficacy of this avenue or, in the worst case, fail to provide this option to someone who genuinely needs it, but there is likely an acceptable middle ground between 'everyone can request an escalation anytime' and an overly burdensome set of conditions.

5) Preferred/favorited providers

Background

Providers currently have (mostly in-county) networks of other providers with whom they have trusted relationships. When initiating referrals, they reach out to those familiar providers first, broadening their search if none are able to accept a client. The provider landscape is confusing for everyone, including providers, and these informal networks of 'trusted contacts' help facilitate trust and smooth over rough patches. For providers, it is valuable to know which facilities they've worked with before, and who is equipped to work with your type of clients. Further, we often heard that a single individual at a facility may hold the institutional knowledge of which providers they prefer working with, rather than that knowledge being documented somewhere for longevity. This is the intent behind allowing providers to create lists of 'favorites'.

Our Recommendation

A way to “Favorite” other provider listings aligns with providers’ current workflows, allowing them to indicate preferred providers and see them later.

This feature should be very simple. In brief, a UI element to ‘star’ providers should be available on provider overview pages and in search results. ‘Starring’ a provider doesn’t affect search ranking, it only affects the UI by adding a visible marker. An additional suggestion here would be to add a search filter: “only show me my favorite providers”. Thus, ‘favorited’ providers who show up in search results indicate to other staff the facilities they should try first.

Further Questions

If providers like the ‘favorite’ feature, the provider search could trial boosting the rankings of starred providers, or giving them preference in other parts of the platform. For an initial implementation, we recommend building something simple and seeing if/how users adopt it.

6) Consent reminder

Background

According to HIPAA, “there are no restrictions on the use or disclosure of de-identified health information”. We have proposed a client profile that avoids the inclusion of identifiable data (no name, phone number, SSN, etc). In essence, this is not a true ‘referrals’ platform, instead it is an enhanced provider search: allowing providers to find appropriate providers to connect with and *then* complete a formal referral off-platform. Following HIPAA’s ‘Minimum Necessary’ principle, we believe that sharing an initial de-identified client profile is enough for providers to make a “call me/don’t proceed” decision. Sharing a de-identified client profile would not require an explicit consent step, because it does not qualify as a release of identifiable information.

However, it is a principle of the BHA that clients should be informed about their care decisions, and our understanding is that for the majority of referrals, clients consent to the referral before the referral is initiated. Thus, in practice, there is still a ‘consent’ step here: acknowledging that the client is informed and desires, or understands the need for, the referral.

Our Recommendation

In the spirit of client’s involvement in their health care decisions, we recommend including a checkbox at the moment of creating the preliminary profile that reiterates for providers a message like ‘I have discussed the possibility of referral and the use of this platform with the client and obtained the client’s consent to initiate this referral.’ The exception to this would be if the client profile explicitly includes “involuntary hold,” meaning that the client is deemed at-risk enough to be held without consent.

In all other cases, we believe that a ‘consent’ step when the profile is created would be a reminder to providers to include the client care decisions wherever possible, thereby using the platform as a way to advocate for client agency.

Further Questions

While formal, in-platform consent does not seem necessary at the MVP stage of the platform, what should consent look like if/when information in the platform does become identifiable? Do we ever build out a full system?

Phase 1: Launch MVP, ongoing research

January – June 2024

Once the platform has launched in January 2024, the product/design team should pivot from development to research. During this time, targeted research should be conducted with early users of the platform to collect information on usability and user experience, and broader research should begin untangling remaining questions from this Discovery Sprint in order to inform Phase 2 features. User testing should aim to identify what is and is not working from a UX perspective, and evaluate base functionalities (i.e. preliminary profile, referral request, escalation email, and rejection rationale), as well as explore with users the potential usefulness of expanded features (i.e. in-platform messaging, waitlist functionality.)

The following are topics requiring further user research during Phase 1:

- Preliminary Profile
- Rejection Rationale
- Mass Escalation Email
- Favorites/Preferred Provider List
- In-Platform Messaging
- Provider Metrics
- Waitlist Functionality
- File Transfer

📃See Future Research: Phase 1 Section for more details.

Phase 2: Improve existing functionality, add new features

July – TBD 2024

While platform evaluation and iteration should be constant, at the end of the six month period post MVP launch, the product team should pivot from deep learning to refining and developing features based on these learnings. Our vision for this phase of work is loose since much will depend on findings during Phase 1, however we do have theories and ideas of what may be useful to build out during this second phase of development.

Before going into the detail of Phase 2 recommendations, it is worth emphasizing an important line in the sand around privacy and consent.

Our MVP notion of a preliminary client profile relies on creating profiles that are not personally identifiable, which means that we don't have to scope in features around client consent as we would if it were someone's personal record being uploaded and/or stored in the platform.

Many of the features proposed in the MVP roadmap section prior to this one can be built iteratively, without introducing the complexity of individually-identifiable information, as specified by HIPAA or 42 CFR Part 2. However, the moment that individually-identifiable information does touch the platform represents a clear line in the sand regarding the need for platform-specific consent.

Many of our Phase 2 recommendations do cross that line, transforming the *client profile* from a general health care profile where only the referring provider knows which specific person it is associated with, into an *individual record:* an identifiable record that is persistent between interactions. All to say, it is imperative that the platform team not implement features that create individual records without first solving for client consent.

Platform features and functionality we imagine may be important for a second phase of platform development are detailed below. These ideas should be further explored and discussed within the product team during Phase 1.

1) Add care team

Will trigger a need for more complex consent.

Background

Clients will sometimes have care workers/case workers, either from a state entity or from a private/non-profit program, assigned to help them navigate the care landscape. Case workers typically aren't medical professionals, but are helping to seek out resources/appointments and make introductions on the client’s behalf, providing support where necessary. Case team members are only ‘loosely coupled’ to the client, however. Clients will sometimes leave their treatment facilities or not show up to scheduled appointments, at which point their case worker loses track of them. Then, weeks or months later, the client may end up in a hospital or another treatment center, and those doing the intake have no idea that the client has an assigned case worker (with a lot of context and history), while the case workers themselves have no way of learning about their client’s admission unless they happen to be phoning regularly (as part of what they call a ‘diligent search’).

Additionally, we heard that sometimes providers are more likely to accept a referral if they see that there is a care team/case worker attached, because to them this indicates that this client has extra support.

The opportunity here is to include a mechanism to associate a care worker with an individual, so that future treatment providers don’t lose that continuity. One of the care coordinators we talked to spelled this out explicitly, concluding the interview by emphasizing it: “Please have a flag that we’re involved.”

Questions For Research

The larger precondition here is moving from ‘preliminary client profiles’ to individualized profiles that persist through time and are visible to providers. This need not necessarily be a full individual record of care (i.e. including full care history), but more like a record of admissions and discharges, where each provider would be able to note their episode of care and see some information about past admissions. Information about an assigned case-worker would then follow this individual profile around. In this version, when a provider admits a client, they would either be creating a brand-new profile for them (including personally-identifiable information), or finding a match that already exists. In the latter case, they would be able to see information about their care history and reach out to that person’s case worker.

Our research points to a widespread desire to have easier ways to understand a client’s history and find individuals who can speak to their history with that client — including past clinicians and past/active case workers. However, we heard plenty of concerns voiced that this type of information could lead to biased decision-making (for example, a provider could look at how many re-admissions a client has had and decide they are likely to be troublesome). Any visibility into past history would need to balance a providers’ legitimate need for context to make informed care decisions versus the risk of disqualifying prospective clients based on negative impressions of their care history.

2) Targeted escalation paths

May trigger a need for more complex consent.

Background

Providers told us that “complex” clients (those with overlapping diagnoses or particular priority populations) are almost always difficult to place. In many of these cases, the referring provider will regularly receive denials from reviewing providers, and eventually, feeling themselves out of options, begin to escalate the case (or otherwise act in desperation by, for example, holding the client longer, withholding information about the client in order to get them placed, etc). We heard of many different routes for escalations: to HCPF/RAEs, to the BHA/ASOs/MSOs, to out of state agencies, sometimes through elected officials’ offices. It is our impression that the “correct” escalation pathway is always somewhat dependent on the unique circumstances of the client which can leave providers without a clear path forward, resorting to email blasting lists of people who may be able to help. The previous section (Phase 0) describes the need for a simple escalation pathway in the platform — an email to a monitored inbox — but this may not be the optimal long-term solution (e.g. it risks overwhelming a particular group or at minimum requiring additional effort to triage incoming requests). The opportunity here is to create formalized escalation paths, so that a given provider’s escalation request for a particular client would be sent to the appropriate entity to handle that case, rather than a generic inbox requiring triage.

Questions for Research

Our understanding is that, at the time of writing this report, ‘correct’ escalation paths are still being formulated and documented across state agencies, with different administrative organizations coming online at various points, so it will not yet be as simple as defining a static ‘escalation tree’ diagram for individual providers (or for types of clients). Eventually, we do believe that an escalation diagram would be beneficial to share across the behavioral health landscape. In particular, the type of client (e.g. youth) affects who should be assigned to support the escalation of a particular case. We also know that particular kinds of clients result in more refusals, so it would be unlikely that the burden of escalation support would be equally shared. There is also an open question around managing how often escalations can be triggered and whether there would need to be some kind of ‘proof of effort’ or lapsed amount of time required before escalations would be available.

3) Waitlist functionality

Will trigger a need for more complex consent.

Background

We heard a lot about waitlists, but we also heard there was a lot of variability here. Many inpatient programs maintain waitlists which never go to zero: there are always people waiting for admission. Other programs are never 'full,' and are able to staff up when more capacity is required. An interesting feature of 'being waitlisted' is that it is neither an approval nor a rejection, it's a 'probably but not not right now'— a client is in-principle accepted but as the referring provider, the client is still your ongoing responsibility. Referring providers will say yes to placement on waitlists, but continue to look for more immediate placements. This means that waitlists can quickly become out of date, since the referring provider may find an alternative placement, and the waitlist maintainer has no way of knowing this until they phone back to start the pre-admission process.

We also heard that waitlists are generally ad-hoc systems (spreadsheets and lists). Once clients are formally admitted they are entered into EHR systems, but prior to admission, they aren't actually clients and can only be tracked in informal systems. We heard multiple people express resignation that their waitlist tools were not ideal but they were what was available.

One caution here: we also heard that, in order to manage expectations, some facilities don't want their waitlists to be externally visible. Not all waitlists are first-come-first-served — i.e. just because someone is "next" on the list doesn't mean they are going to be the right person to fill the next available bed or space. For this reason, they want to keep their waitlists internal to manage expectations and better control who is coming in, which may include prioritizing new cases over others who have been waiting longer.

It also must be noted that waitlists necessitate the inclusion of PII, since waitlists always identify individual clients, so this would cross the threshold of storing and maintaining personally identifiable health care data.

The opportunity here is twofold:

1. To provide supportive technology around facility- or unit- or program-level (i.e. not system-wide) waitlists for those maintaining waitlists and
2. Subsequently, to see how waitlist information available to the platform can be leveraged to help referring providers (eg, you could show "Waitlist: ~5", or estimate the wait time).

Questions for Research

We heard waitlists mentioned regularly, but we were focused on referrals, so we don't have a concrete idea of what waitlists currently look like, or the proportion of units who maintain them (waitlists are typically program/unit specific). We heard various pain points (e.g. ad-hoc solutions, awkward to maintain, out of date, no outside visibility), but we don't have a clear idea of what waitlists look like, how much time people spend maintaining them, or what the ecosystem benefits if waitlists were brought into the platform. We heard various theories of how an in-platform waitlist functionality could help give information to referring providers:

- seeing that there is a waitlist at all
- seeing numbers of people awaiting admission
- being able to ‘automatically’ add clients if they met certain criteria
- being able to de-register clients from waitlists if they found alternative placement

These all sound like reasonable ideas but we don’t have a lot of confidence in them (particularly ‘automated matching’). The most fruitful avenue here would likely be to solve the implementation for providers who maintain waitlists, migrating them away from their ad-hoc Excel lists and *then* looking to add ecosystem benefits, once waitlist info is reliable and accurate enough to share more broadly.

4) Provider-specific platform usage metrics & indicators

Unlikely to trigger a need for more complex consent.

Background

The referral requests workflow we are proposing for MVP relies on an actively engaged provider network, or at least reaching a critical mass. We also think there is likely to be an ‘urgency asymmetry’ in the referrals workflow, where the referring provider wants an answer as soon as possible (high urgency) and the reviewing provider may take longer to respond (medium/low urgency). While a high-engagement platform would encourage providers to onboard and continue using the system, one in which referring providers habitually don’t receive answers will do the opposite: discourage use over time. One way to mitigate this is by giving providers using the platform visibility into the provider-level use of the platform, so that they can temper their expectations at the provider level rather than losing faith in the platform as a whole. We hypothesized about various metrics that could work to give referring providers information ahead of time and potentially serve as light encouragement for reviewing providers to respond. These could include:

- **Response rates:** percentage of requests responded to
- **Average response times:** typical amount of time to receive a response
- **Read receipts:** whether a message has been read, or has it never been opened
- **“In review” flags:** someone is reviewing the request but no decision has been made
- **Quality rating:** some complaint/grievance logging process or rating system for providers to share information across the network

Questions for Research

Generally the idea is to give the referring provider information about what is happening or what is likely to happen so that they can target requests more effectively and also see indicators of progress while they are in a high-urgency situation of waiting for answers to come back. However, before the platform exists, we have no real idea what usage patterns will look like, so it feels premature to start planning for these kinds of interventions before there is a broader understanding of how people actually use the platform. Additionally, these metrics are dependent on what communications happen on-platform vs off-platform (see next section on in-platform messaging and on messaging section below). For example, if providers follow-up about requests by email, we wouldn't be able to capture average response times, but we *would* still be able to see average times to action for a request (i.e. denial or provisional acceptance).

5) In-platform messaging

May trigger a need for more complex consent.

Background

In lieu of centralized systems or formal guidance, providers have created 'desire paths' in how they manage their workflows around referrals. In terms of messaging, they rely heavily on emails and faxes to send actual referral packets, and on phone calls and emails to do the initial outreach and coordination around prospective referrals. We heard plenty of complaints about this — contact info can become outdated, staff turnover is high, information is not easily shared between providers, etc. — but on the whole, providers are comfortable with emails and phone calls to coordinate referrals, and we believe that for the MVP, it is best to leave that intact. However, in the future, in-platform messaging could be introduced to replace email, giving the BHA more comprehensible usage data, and alleviating problems of lost continuity/institutional memory due to staff turnover. It may also streamline communication by not cluttering up general inboxes but instead provide a dedicated channel for each referral request, and features like in-chat read receipts and typing notifications might help give providers more insight into how active the recipient is.

Questions for Research

Similar to the previous recommendation, we simply don't yet have enough information on system usage patterns, or whether there is a widespread desire to move away from email as a messaging platform. The risk would be that in-platform messages could be more easily ignored, while the email inbox continues to be monitored. Additionally, it is far more likely that PHI and PII would wind up in unstructured conversations via in-platform messaging, so we recommend waiting to implement this feature until a strategy around in-platform consent is identified. Creating in-platform messaging is a very large feature and at this point there is simply too little known about providers' preferences to confidently pursue this, but it may prove to be beneficial or desirable in the future.

6) File transfers

May trigger a need for more complex consent.

Background

Currently, providers are sending each other referral packets over encrypted email and over fax. We heard there was a preference for email over fax, but didn't have a strong impression that encrypted emails were beloved (or even always used instead of non-encrypted emails), rather, they were simply better than fax. There is a promising opportunity here to provide a secure file-transfer feature to facilitate secure uploads and downloads of sensitive files between providers. Unlike creating individual records, this wouldn't necessarily include metadata about whose packet it is or an understanding of what data is contained within, rather it would be a simple service where providers upload a file securely, create a link for another provider to download it, and then the file would be deleted after a set amount of time. Various services like this exist, such as WeTransfer or SwissTransfer, so it is an established product category. The simplest possible implementation is likely all that would be needed to provide value over the current status quo.

Questions for Research

Facilitating secure file transfer doesn't obviously meet any BHA data-reporting goals around more situational awareness or a clearer understanding of who is being placed, but it would introduce broader ecosystem efficiencies: removing a pain point for providers, reducing ambiguity around what's allowed and not allowed in terms of data transfer, and, if successful, act as an incentive to use the platform. The strategy of the MVP-to-future-state roadmap is to gradually take responsibility for pieces of the referral journey until all or most of it can be brought into a centralized platform. The MVP features proposed in this report would improve the coordination around referral requests, but referrals themselves happen off-platform. Providing a secure file-transfer capability moves more of the referrals workflow into a BHA-maintained platform, particularly a portion of the workflow related to a pain point we have confidence that providers are looking for solutions to and has meaningful implications for consent.

7) Prepopulate Preliminary Profile

May trigger a need for more complex consent.

Background

BHA has also done research into providers' "administrative burden," or, administrative overhead providers encounter as a by-product of providing clinical care (e.g. in creating periodic reports for different systems, often copying information between different systems that don't talk to each other). Our proposal to build out a preliminary client profile is designed with this in mind, asking providers for an intentionally small amount of information to create a profile. However, there is a question here around whether the platform can further reduce administrative burden by allowing providers to upload a file — a document/PDF or an export from an EHR system — and pre-fill a client profile, minimizing manual duplication. This idea is more speculative than the others in this section since we don't yet understand the formats of existing client documents, and should probably only be investigated or embarked upon after the previous recommendation around file transfers.

Questions for Research

From a technical perspective, this could end up being pretty daunting, as we would expect providers to use all manner of formats for their client records and so it wouldn't be as straightforward as parsing structured data from an API. On some job application sites, you can upload a resume and see a best-guess approach at filling in your name, address, and past work experience — something similar could work here if there is a generally-followed presentation of information for client records. The main goal here is alleviating the tension between providing more information about the client (which helps receiving providers and the BHA) and the burden of asking the referring provider to duplicate that information in this platform. It may be that the matching system works well enough that referring providers find it is worth the upfront work to create more complete client profiles in order to get the best matches. Clearly, this is an area where there remains much ambiguity; we believe it is better to solve for secure file transfers before embarking on pre-populating forms.

8) More advanced consent

Background

While the MVP version of the platform that we are proposing does not require comprehensive, platform-specific consent (as introduced in the Consent Reminder section above and explored in detail in the Consent and Privacy section to come), there are a number of potential or proposed platform additions that would necessitate a more sophisticated approach to consent. Generally, HIPAA allows for disclosures between providers to facilitate care (which referrals qualify as) without requiring consent, but 42 CFR Part 2 requires written consent for non-emergency disclosures that include substance abuse information.

- With individually-identifiable health information, the system containing that data must meet HIPAA data standards.
    - If the data *does not contain* information related to substance use disorders, then it falls under HIPAA, which allows for disclosures between providers for the purposes of referrals. Client consent is not required.
        - Client consent is required to disclose to other actors or for reasons other than treatment.
    - If the data *does contain* information related to substance use disorders, then it falls under 42 CFR Part 2, which requires written consent to disclose information *if* the client being referred is not having a medical emergency.

We have also heard that OeHI is currently working on a statewide eConsent initiative to develop and/or procure a platform that can manage more granular user consent across the full state health ecosystem.

From the perspective of referrals, the best approach to more advanced consent would be some kind of information sharing system similar to Apple's app notifications where the user (in this case the client) is able to see what information is contained about them and when, where, and with whom it is being shared. The risk here is that this could unintentionally cause a bottleneck, for example, waiting on a permission to come through and missing a slot for an appointment. Honestly, this is a difficult problem. We envision that clients will be able to give consent to share their data, see who has access to their data, and revoke consent at any point throughout the process. However, this represents a pretty massive undertaking to build even if we could map out all those points of consent, which can't be fully known ahead of time. Data can *become* personally identifiable if there is enough context and it is sent to the right provider, so it is hard to plan out ahead of time when that threshold is crossed.

Questions for Research

Foremost would be a better understanding of when in the current process this is happening. We understand that clients are signing blanket consent forms and then everything that happens after that is out of their control. Visibility into their data and where it is going seems like the first step here.

There also should be internal conversations at the BHA about state-ownership and retention of identifiable client information, consent practices the state wants to encourage or discourage, and the legal distinction between storing identifiable information for clinical purposes versus coordination purposes.

9) Funding, payment, and program eligibility flags

May trigger a need for more complex consent.

Background

There are numerous state-coordinated or state-administered programs, funding sources, and payment options available to specific populations of clients. For example, we heard reference to additional funding that is available for pregnant substance users seeking behavioral health treatment. However, our understanding is that these additional resources are currently inaccessible because they require providers to be aware of and understand the eligibility criteria for all such programs or, at the very least, the ones that may be relevant to the populations they serve. This is a big ask for already over-burdened providers.

We also know that understanding a client's payment source(s) is one of the first things that providers look to do upon admission and during screening. Most providers we talked to had a large number of Medicaid patients, and would typically start a Medicaid pre-authorization process before starting treatment.

More research should be done to further understand and document the pre-authorization process and how it impacts referrals, but what we do know is that providers need to check with HCPF if a particular client's treatment will be covered by Medicaid.

Over the course of our research, synthesis, and ideating, we came to the loosely-defined idea that the platform should flag or indicate to a provider when a profile they've created or are reviewing may be eligible for state-administered programmatic support or funding. Additionally, if the platform were to collect data on an individual, it could potentially be sent to a state-maintained Medicaid validation app that would be able to verify Medicaid eligibility and identify potential additional funding sources for a client.

If/when the platform supports persistent individual records, it could be useful to be able to see where a client was last and get in touch with that provider to ask them about their insurance/payment situation. Perhaps the insurance status could be added to the individual record for future providers to see.

Questions for Research

We know very little about the spaces of Medicaid, state-administered programs, and funding streams, but to our knowledge this topic reaches far beyond the BHA, spanning the entire state. The ideas outlined above should be more thoroughly explored in cross-department/agency teams to better understand what might be feasible and useful in this domain.

10) EHR integration

Will trigger a need for more complex consent.

Background

We understand EHRs to be sporadically used with wide variations in type/structure, and thus quite difficult to integrate. While there is a requirement for primary care providers to use EHR systems, there isn't the same requirement in the BH space, so uptake of EHRs is not consistent in this ecosystem. Larger providers will typically have EHRs and smaller providers won't. In terms of integrations, we heard pretty much every time that it isn't easy for EHRs to talk to each other, and that building integrations for EHRs is very taxing. All told, it doesn't add up to a very promising avenue for short-term improvements. While we understand the provider burden exists and is real, we didn't hear of many successful examples of integration in our discussions with providers.

We have heard that more systematic research into behavioral health EHR usage across the state and how integrations might be supported across technologies is on the horizon or currently underway, and we recommend waiting to explore EHR integrations with the referral platform until more is known from this statewide research.

Questions for Research

Platform usage patterns need to be better understood before future research can identify the likely avenues for improvement in the space of EHRs. It is possible that EHRs could export data into the CommCare system, or that there is some way to pull bed availability data out of them, or some other unknown functionality, but before we really know how the referrals platform is being used, it's not possible to say what particular functionality should be pursued.

Additional Recommendations

In addition to the specific features recommended above for the platform MVP, we have a number of broader recommendations or guiding principles that should be considered as platform development and evolution unfolds.

Consent & Privacy

As part of our research, we did a deep dive into HIPAA and 42 CFR Part 2 to specifically understand the regulations around client privacy: what data needs to be protected, when consent would be needed, and what consent should look like.

Our intention around Preliminary Client Profiles is for providers to create descriptive profiles that *can* be used by other providers to make an initial determination on "fit" but *can't* be used to identify individual clients (following the HIPAA principle of minimum necessary disclosures). Both HIPAA and CFR Part 2 agree that de-identified information does not have restrictions on use. In our proposal, sharing Preliminary Profiles need not trigger any kind of consent activity because Preliminary Profile information doesn't specifically identify an individual client.

The threshold between non-identifiable profiles and ones that are identifiable comes down to personal identifiers, or an aggregate of data that allow a recipient to narrow determine the specific individual being referenced.

- Personal identifiers include: names, contact information (address, phone, email, etc), ID numbers, etc.
- As stated in 42 CFR: "information by which the identity of a patient [...] can be determined with reasonable accuracy either directly or by reference to other information"

It is our opinion that the Preliminary Client Profile does not cross this threshold — but given there are opportunities for providers to enter free-text data, (at minimum) a warning should be included to caution users against entering identifying information in the platform. Further, additional legal review should validate our opinion and approach, which Abigail Fisher and Alex Mayo have already begun coordinating at the time of this report.

Additionally, once the personally-identifiable threshold is reached, the product team must determine whether the information being shared relates to substance use in any way. 42 CFR Part 2, which addresses privacy for substance use disorder (SUD) client information, is notably more restrictive than HIPAA in terms of requiring consent. HIPAA permits disclosures without consent between health care providers facilitating treatment (including referrals) and care coordination. 42 CFR Part 2 does not: a written disclosure is required every time, unless the situation is a medical emergency.

If the information being shared can be used to identify an individual *and* contains health information related to SUD care, then providers are obligated to have their clients sign an authorization form before that information can be disclosed to any other provider or state actor.

Implications for Care Coordination

The Referrals Platform, as proposed, is closely related to but distinctly separate from the broader BHA Care Coordination programming. The platform is meant to coordinate and streamline specifically the transfer of care, not the entirety of care. In this way, it may be a useful tool to support Care Coordination programming, but cannot fulfill the infrastructure requirements legislatively mandated for the Care Coordination program in CRS 27-60-204.

There are, however, a number of important implications of the Referrals Platform for the broader Care Coordination effort that the program team should be aware of and prepared for.

Escalation triage

For the MVP version of the platform, the Care Coordination team will act as a first line of escalation when providers are unable to identify an appropriate placement for a client. As described above in the Escalation Trigger section, the platform will allow providers to indicate that they need placement support, which will trigger an email to the general Care Coordination email address. This team will then be responsible for supporting escalated cases and delegating to appropriate external state agencies as needed.

Care Chronology

Providers and BHA staff both expressed a desire to be able to view a client's (non-clinical) care history in order to facilitate referrals and better coordinate care. Providing insight into a client's chronological care history would improve care continuity and coordination, and decrease the rate of inappropriate referrals. Essentially, this would be an audit log of an individual's interactions within the behavioral health care system: other providers they have received care from, if they are on waitlists, how many providers rejected them and for what reason, how much time elapses between interactions, etc. Whereas a medical record describes symptoms, treatments, and responses to treatments, the 'chronological log' describes a client's *journey* through the health care landscape.

Providers who have admitted a client want this information so they can build a fuller picture of a client's history and follow up with past providers. Reviewing providers want this so they can see who has declined the client before and why (although whether they should be able to see this information is a different story). State coordinators and case workers want this information so that they see why their clients are getting denied and if there is any way to change one of those denials into an acceptance.

Development of this type of record would be a major undertaking, with a number of important equity considerations around the concept of a care chronology. Namely, what information to include, who can view this information and when, and how long this information stays on a client's record.

> *"It's a pretty big waste of time when we know that there's providers who may have had contact with the client and they just don't know to reach out to us."*

> *"It would be valuable to have a discharge summary and see what the client has engaged with; are they on a path?"*
>
> *"I think the benefit would be that people could see the number of places that we have referred to and the places that have not accepted [the client]. Because we refer and we refer and we refer, and you would be able to see that. I don't think the referral system would change the fact that a lot of these places just aren't willing to take our (justice-involved clients,) I don't think it'll change the acceptance rate of our folks, but I think there would be data."*

While this information would undoubtedly impact and support referrals, at this time we do not believe it belongs within the referral platform, and instead falls under the broader umbrella of care coordination, and should be further explored by that program team, including if and how to implement, equity considerations, consent mechanisms, and data security, retention, and access.

A key distinction we want to make is that providers at no point expressed a desire for a state-wide or state-administered EHR. They only wished they could more easily access specific, relevant contextual information about a client (e.g. what settings have/haven't worked for them in the past) to support and inform their ability to identify an appropriate placement.

Additional Implications

In the coming months, the Care Coordination team should be involved in key pieces of research that relate to the future state of the referral platform, including:

- If, when, and how to implement Care Chronology and how it should interact with the Referrals Platform if at all.
- Development of an escalation flowchart which could, at a future date, be built into the infrastructure of the Referrals Platform to encourage more targeted escalation.
- Outlining program and funding eligibility, and how to integrate that knowledge in the Referrals Platform.
- Identifying platform Key Performance Indicators (KPIs) from a Care Coordination perspective.

Additional Referrals Platform potential future features that may interact with the Care Coordination program team include:

- The addition of outpatient services and, potentially, wraparound (social care) services

- Assigning a Care Navigator or support team to a client case

Rollout & Engagement

Providers are wary of the BHA's ability to provide a technology tool that adequately meets their needs and addresses their pain points. With this in mind, the rollout of the program and engagement with providers around the referral platform will be crucial for provider buy-in and take-up, and thus overall platform success.

We recommend that the rollout and marketing of the platform highlight and clearly communicate:

1. *S*pecific value adds that the platform can provide and how these relate to specific pain points identified during research. (*To draw providers to the program)*
2. *W*hat the platform can and cannot be used to accomplish (i.e. where the platform functionality begins and ends). (*To manage expectations around the platform)*

Value-adds for providers, or what the MVP platform *can do* (i.e. points to include in BHA marketing, a platform fact sheet, etc.) include:

- Streamlined support with difficult to place cases
- Facilitated inter-provider communication (especially around referral status)
- Referral request log to track open/pending referrals
- More robust provider directory and search functionality
- Reduced administrative burden through reduction in inappropriate referrals, time to assess incoming referrals, and time to gather information about incoming referrals
- Greater BHA insight into resource gaps and resourcing issues
- Value-adds associated with the bed capacity tracking functionality

The MVP version of the platform ***will not*** be able to transfer full referral packets, retain client PHI or PII, provide real-time bed availability, or fully automate the referral or transfer process (e.g. automatic acceptances). To avoid disappointment that drives providers away from the platform, it is crucial that the BHA temper expectations about what can and cannot be accomplished within the platform.

Additionally, we asked survey respondents where the platform should be promoted to encourage take-up and use, and received numerous valuable ideas, including behavioral health roundtables, RAE newsletters, the BHA website, CDHS newsletter, through other state agencies like DOC and DORA, LADDERS and OwnPath, and various individual organizations and groups.

Any and all promotions of the new platform should point to a singular, consolidated place or person providers can go to as they learn about the platform to gain more information and understand how they can begin using the platform.

Data Model Updates

Our proposed MVP requires three new concepts that enable providers to better facilitate referrals:

1. Preliminary Client Profile
2. Referral Request
3. Rejection Rationale

In short, our research proposes a new workflow around referrals using these three new concepts:

1. Referring providers can create a **client profile** (without PHI)
2. Referring providers can send **referral requests** to reviewing providers which include the client profile
3. Reviewing providers can accept or deny a referral request
4. Reviewing providers who deny a referral request will complete a **rejection rationale**
5. Referring providers can see and manage their own open/denied/waitlisted requests

This workflow reflects a streamlined, technology-supported version of the process that providers already employ for referrals that we believe will be more efficient and effective.

Proposed additions to the referral platform data model		
Data model	**Description**	**Purpose**
Preliminary client profile	Client profiles allow referring providers to describe a client they want to refer to another provider without including personal information. A client profile can be	The client profile allows providers to capture representative information which will allow reviewing providers to quickly make a determination on "fit": is this client appropriate for my facility, given my licensing, staff, and current milieu? The client profile speeds up the initial yes/no decision without compromising client privacy.

	associated with zero or many referral requests.	
Referral request	A referral request is an object sent by one provider to another. A referral request includes a client profile, contact information, and has a status (open, accepted, expired, etc).	Referral requests will formalize the initial outreach when providers start searching for other providers to accept a client. Referral requests will allow referring providers to see how many requests they have sent, the status of sent requests, and how many have been answered or viewed. Unneeded referral requests can also expire, allowing reviewing providers visibility into when a client has found alternative placement.
Rejection rationale	A rejection rationale is a lightweight object containing a list of predetermined rejection reasons, and a sentence or two of explanation. A rejection rationale is required for referral requests which have been denied.	Currently, information on when and why referrals are denied is not tracked systematically. Referral requests and rejection rationale will help referring providers understand why their client is not eligible for placement, they will help care coordinators see what has been tried already for a given client, and it will give the BHA insight into common rejection reasons across the state.

Comparing the BHA's draft data dictionary to the Open Referral data model

We compared the BHA's draft data dictionary against other open-source/popular standards around health care data structures — primarily Open Referral. We looked at how the BHA's **provider data** compares to Open Referral, as well as how the **preliminary client profile** differs from other popular 'referrals' standards.

Ultimately we do not have strong recommendations about the structure of the data itself for the purposes of referrals, but we do believe **it is important that priority flags are accounted for in provider-level data**. Aside from this, we remain mostly neutral on closely following the Open Referral standard.

Regarding the *client profile* data, we found that many other 'referral' data standards are not using the same concept of a referral as we are, which is why we have avoided modeling our client profile after them.

On Messaging

In lieu of centralized systems or formal guidance, providers have created ‘desire paths’ in how they manage intra-provider communications. In terms of messaging, they rely heavily on emails and faxes to send actual referral packets, and on phone calls and emails to do the initial outreach and coordination around prospective referrals. We don’t think that in-application messaging functionality is necessary for MVP, but it is worth exploring messaging as it relates to the referral request process.

Typically inter-provider communications are 1-1: most of the time providers email and phone each other. The exception to this would be email blasts, which are 1-to-many, but follow-ups from email blasts again become 1-1 messages. For referral requests, the advantage of this platform is creating a ‘hub’ where the current status of a referral can be updated in one place and communicated to many providers.

For notifications and messaging, we are focusing on the *request* being managed in-platform, and assuming follow-up conversations happen off-platform using established channels. Messages are either provider-to-provider (e.g. phone call to clarify something), or system-to-provider (automated notification triggered by a request). For the MVP, we recommend:

- Provider-to-provider messages occur off-platform, with the platform itself serving as a phonebook (i.e. listing other providers and methods for getting in touch).
- System-to provider messages are event-driven emails based on some kind of user action. In-platform actions by a provider will trigger notification emails, which would (hopefully) spur other providers to review and respond.

We have outlined anticipated message and notification types in more detail (which occur inside vs. outside the platform, what each contains, etc.) in Appendix C: Inter-provider referral messages and notifications.

Messaging Channels

Providers talked a lot about calling and emailing each other, although the formal referral packet can also be faxed. For this platform, we should default to sending emails, using an email address for the facility as a default, but allowing the recipient(s) to be user-configurable. Providers will often have alternate contacts for different units/programs, so we should allow for that level of customization.

We also heard that providers want to get answers quickly, so it would be good to optionally allow SMS alerts on an opt-in basis. If the notification types were very granular, that would likely help with improving response times and reducing administrative burden. For example, providers might not want a text alert of someone denying their referral request, but likely they would want to know right away when they have a potential match so that they can follow up. For a potential SMS feature, assume a user-input number that is likely their personal number rather than prefilling with the general phone number of the facility.

Account Types

Broadly, there are four ‘user types’ who may be implicated in a referral.

1. Clients
2. Clinicians/Providers
3. Care Coordinators
4. State users

In the best case, only the client and the clinicians are involved. Generally, the more people that are involved, the less straightforward the referral. Additionally, the more PII and PHI that is available, the greater the need for clear delineation between account types and corresponding permissions.

We will briefly elaborate on these user types; however, it is worth stating upfront that we do not anticipate any major changes to current users’ roles and permissions, or the creation of new user types beyond those already configured in the existing CommCare system.

Clients

At the outset of this research, we assumed that a (persistent) individual record would be created, and that therefore a consent step would be necessary. However, we now believe the Preliminary Profile allows providers to make an initial determination without implicating a specific individual. Preliminary Profiles, therefore, are temporary generic profiles, which are no longer relevant once a referral concludes. The preliminary profile is its own *database entity*, but it is not an account type.

Clinicians/Providers

Clinicians (aka providers) are behavioral health care workers who create client profiles, send referral requests and respond to them. They are the same as the current ‘mobile workers’ assigned to a facility. We are proposing building out a referrals workflow that doesn't currently exist, but we aren't proposing creating new permissions or a new account role for this.

Care Coordinators

Care coordinators may be case workers or administration and coordination staff, such as those at RAEs. They may be involved with clients from the outset or they may be called in when a case is escalated for support, but they are not involved in the majority of cases. We have proposed creating an "escalate this case" feature, but our recommendation is to send an email to begin a conversation off-platform. It may be useful for care coordinators to know about the rejections (and rationales) for individual clients, but this can be communicated to them by agency staff. Overall, we don't believe that care coordinators need their own accounts in the system to facilitate referrals — it's enough that clinicians know how to find them.

State Users

State users may sometimes be fulfilling a role as care coordinators, but they will also be interested in aggregate platform data. In addition to data about provider facilities, the referrals workflow will result in anonymized client profiles and a general visibility around referrals: when they are sent, who receives them, how long they sit before a response, how many are denied vs accepted and why. Thus the current state web user account is sufficient here, with additional reporting functionality to enable greater insight about referrals in the state of Colorado.

Success Metrics

There are two main categories of metrics we recommend the MVP platform be set up to collect so that the BHA can assess the impact and efficacy of the platform:

1. Standard usage patterns
    a. Best practice usage/activity metrics (e.g. time in platform, page visits, etc.)
    b. Metrics-comparisons between and around new user adoption (logins) versus recurring users and active users
2. Platform-specific actions/tasks
    a. Referral activity: Users completing searches (number and characteristics of searches), reaching out to people, creating & sharing preliminary profiles, responding to preliminary profiles
    b. Escalation activity: number of emails sent to the BHA, frequency & proportion of escalations over time

c. Metrics around what happens after a referral or escalation, to be tracked outside of the platform (e.g. length of time it takes the BHA Care Coordination team to respond to and resolve a case)

These lists are simply starting points, and should be reviewed and supplemented by the development and product teams.

Past OpenBed Research

A previous discovery project was targeted more specifically at bed capacity tracking: to find out what worked and what didn't).

Throughout that discovery, the research team (which included Paul Craig, Abigail Fisher, Victoria Kidd, and Chris Pimlott, all members of the current referrals research team) met with other states who have built systems specifically for tracking bed capacity to ask them how they designed and managed their systems (we also reviewed relevant literature).

What we found was a mixed bag: systems were typically bespoke, results varied, and required responsive staff. The only widely-used fully-featured product that we found in this space was OpenBeds, by Bamboo Health. While there are certainly upsides to OpenBeds' "we do everything" model, our conclusion was that this would not be the ideal solution for Colorado.

The dynamic we observed regarding successful bed trackers is that they are generally deliberately simple, that successful rollouts usually involve some back-and-forth between the state and health care providers, and that even after launching, they are able to change in response to provider feedback. A state's relationship with providers is crucial to establishing this kind of feedback loop.

To sum up, successful bed trackers we saw:

- Are (deliberately) simple
- Collect similar sets of data but not the same, with the unique set of data informed by provider input before launch
- Are responsive to provider feedback after launch
- Require the state to have an open and direct relationship with providers

Whereas the OpenBeds system is:

- Fully-featured (complex)
- Creates a uniform reporting structure, not one that is custom to the state

- Intentionally wants to own the relationship with providers: the state would talk to OpenBeds and providers would talk to OpenBeds, but there would be less interaction directly between the state and health care providers.

In some states, for example states with smaller behavioral health teams, weaker provider relationships, or without a responsive team to respond to questions and feedback, OpenBeds could be a good option, but in Colorado, this is not the case. Colorado has a large BHA team, a desire to work closely with health care providers, and the capacity to design a custom system, so this should be preferred to a generic (and likely incomplete) solution such as OpenBeds.

Future Research

[Major watchouts, out-of-scope / cross-division considerations and recommended future research.]

There are two main buckets of research we believe should begin during Phase 1 (January-June 2024) once the MVP has launched:

1. Research to assess the MVP
2. Research to inform Phase 2 of the platform

Specific research topics for each bucket are discussed below.

To Assess MVP

Research should be conducted with early users of the platform during Phase 1 (post launch of MVP) to collect information on usability and user experience, information architecture, and content design to inform improvements to the existing platform. The following are topics requiring further user research during Phase 1.

Preliminary Profile

The goal of the Preliminary Profile is to standardize and anonymize the information being shared when seeking matching facilities during a referral, in order to reduce administrative burden and expedite communication. Interviews with users during Phase 1 should seek to assess whether the Preliminary Profile form is successful in reducing administrative burden or whether users see it as duplicative labor. Research should aim to identify whether the Preliminary Profile form is sufficient in capturing the data that is needed during initial matching and identify what other fields or features may be needed if any, as well as general impressions and viability of the Preliminary Profile concept.

Rejection Rationale

The introduction of Rejection Rationale is meant to more formally track why providers are rejecting specific referral requests, and aims to increase transparency between providers in order to reduce inappropriate referral requests and expedite the referral process. User testing during Phase 1 should aim to gather general impressions and viability of the Rejection Rationale concept, as well as assess whether the platform has properly captured a sufficient list of reasons for rejection and whether anything is missing from the options presented. Other research questions include whether the Rejection Rationale should be customized for the type of provider reviewing the request (e.g. comprehensive providers should perhaps see fewer options for refusal than Safety Net Providers based on legislative requirements) or whether all users should be offered the same list of reasons for refusal.

Escalation Trigger

The MVP proposes an option for users to escalate difficult cases to the BHA to receive support. For MVP, the platform will offer an option for users to escalate a case, which will trigger an automated email to a BHA monitored email inbox, likely within the Care Coordination program team. Research during Phase 1 should assess the frequency of these escalations, the nature of the requests, and any patterns or insights about the types of cases that require support. User testing should aim to refine which moments in the referral process and which locations in the platform are best to offer a call-to-action for escalation, including whether there are ever instances when an escalation to the BHA should be automatic (e.g. after a referral has been unresolved for a certain amount of time or after a certain number of rejections). In addition, the BHA can use Phase 1 to begin identifying which state agencies are responsible for managing different types of cases in order to establish more streamlined escalation paths.

Favorited/Preferred Providers List

User research should seek to assess the usefulness and usability of a “Preferred Providers” list, including whether this feature is seen as valuable, how and where users would like to see their “favorites” displayed, and any other insights or impressions around the concept of preferred providers.

In-Platform Messaging

While MVP will not include in-platform messaging, research should be conducted with the early users to assess whether and how there may be value in providing in-app messaging, and whether the features of in-app messaging may integrate well with workflows and improve communication transparency (e.g. “read receipts”). Research with users should aim to inform details around preferences for notifications (i.e. what types of events spur notifications, as well as method of notification).

Provider Metrics

User research with providers using the platform should include questioning around which kinds of provider-level metrics would be valuable for users to see as part of provider/facility profiles and search results (i.e. last active, read receipts, complaints and grievances, ratings/reviews).

To Inform Phase 2

There are a number of platform features we believe would be useful, but need to explore more with early users to determine if and how to implement them. These topics are described below.

Waitlist Functionality

Interviews with MVP users might identify whether they feel that migrating their ad-hoc waitlists to the platform would be valuable and what use-cases there may be for doing so. Further research should be conducted to determine who at the state (if anyone) has visibility into facility waitlists, and whether the BHA may manage their own independent waitlist.

Prepopulate Standardized Form via Chart Upload

The Discovery phase showed that flexible standardization of information and processes are necessary, but that each facility uses different forms, and there are already grievances over instances of duplicating efforts when having to reenter/recreate client data. One hypothesis is that including functionality to pre-populate the Preliminary Client Profile by uploading existing documents may alleviate admin burden. Research with users during Phase 1 should include questioning around whether this functionality would be useful, and what file formats providers are using for their charts/assessments/intake forms.

File Transfer (e.g. packets, assessments, etc.)

While MVP will not include functionality to transfer referral packets or assessments, research with providers (both users of the platform and non-users) should include inquiry around whether there is desire to be able to transfer these documents inline, and whether the inclusion of file transfer would be an incentive for wider use of the platform. A survey could inform what file formats are being used across providers for referral packets and assessments. Extensive research would need to be conducted in order to inform the implications for gathering and storing consent if introducing an exchange of PHI + PII in-platform.

Higher-Level Topics to Explore

The following are recommended research topics to be conducted during or after initial launch of the platform, but do not involve testing with users of MVP. Rather, they are more broad research sprints meant to inform improvements to the platform and the behavioral health landscape as a whole.

Care Coordination

A research sprint around care coordination should focus on exploring outpatient and social service integration. More research should be done around BHA support and care teams, including identifying which state agencies are responsible as first line of response in instances of case escalation and exploring which types of non-BHA organizations may be added to care teams. Attention should be paid to the implications of long-lasting profile data and the effects this may have on in-platform consent.

Care Chronology / Client History

Discovery showed that there is great potential for value-add in offering a way for care navigators to view a client's journey through the behavioral health landscape, including which providers have denied their referral requests and for what reason, how long they've been waiting or length of time between different touch points with the system, and what therapeutic or medicinal approaches to care have been successful for them or should be avoided. The introduction of a feature like this has significant implications for consent, high risks associated with data retention, as well as potential equity impacts based on the visibility of rejection reasons and client interactions with the state. Future research should aim to dig deeper into these issues, as well as identify who should and should not have access to this information. Research should further aim to address which touch points with the state and behavioral health care system are most informative for care coordinators, as well as where this information should live and who exactly will be tasked with such care coordination.

Consent

Introduction of any PII and PHI to the platform opens up potential for many more research epics. Integration of an advanced consent mechanism is dependent on OeHI's ongoing development of a statewide eConsent platform or mechanism. A better understanding is needed around when consent is happening in the current behavioral health care experience, what levels of consent granularity are required and how and when to allow for consent revocation. More legal review is needed to determine with certainty the point at which information crosses from 'anonymous' to 'identifiable.'

Funding and Program Eligibility Engine

BHA time and effort should be dedicated to performing a full BHA program audit and analysis in coordination with the BHA program teams and the BHA finance team to identify and document funding and program opportunities and their eligibility criteria. This audit should ideally produce a comprehensive, but user-friendly graphic or documentation of the findings that can be made available to providers and care teams across the state. There is opportunity to partner with HCPF around integrating their medicaid eligibility engine and other API integration with PEAK.

EHR Integration

EHR integration presents complications, particularly due to the lack of standardization in the EHR landscape as well as inconsistent use of EHRs across providers. Some providers have indicated that EHR integration could potentially add value to the referral platform, for example the ability to automatically create an EHR profile for a client who has been accepted via the referral platform. More research is needed in these areas before considering EHR integration.

Acknowledgements

[Key quotes from providers and other research participants.]

We want to acknowledge our deep thanks for the providers and other stakeholders that participated in this research. We know that every hour spent with us is an hour away from supporting clients. We take this responsibility seriously, and were dedicated to upholding the BHA’s value of co-creation by expressing the truth as we heard it and making it clear that those closest to the problem directly drove the creation of these proposed solutions.

The following quotes allow providers to speak to the recommendations included in this report in their own words. All quotes are anonymous.

On Lack of Resources

“Somewhere around 40% of our patients don't actually meet the criteria to be here anymore, but they have no place to go. We want to serve more people who are acute and need this level of care, but because there's really no other providers to serve patients with comorbid diagnoses, by default they end up here.”

"I hate turning them away or saying we don't know where to point them. I would say that one of our biggest pain points is when we have to say, we can't help you right now. We try to refer them to different places, but that's the hardest part."

On Client Impact

"They lose hope. They don't have a lot of hope as it is, but they begin to lose hope. They deteriorate, mentally, they continue their [substance] use. So I think it has devastating impacts when individuals can't get the assistance they need."

"We've found that if they're a youth who is doing well, they can reach a point where they actually start to deteriorate in our program if they're with us for too long."

"I think in some ways with our referral system, we just set people up to fail. And then of course, it looks like the client didn't want to, when in reality, we didn't set them up to be successful by doing the referral the way that we did."

On Provider Impact

"I think the most important thing when I think about referrals is that it is a simple process, but as soon as it becomes complicated then people are less prone to do it and definitely less prone to do it well."

"I had an individual call me and she was in tears. She says 'I just cannot get this person the care that they need. And I'm tired, I'm frustrated and I don't know what to do.' This particular individual had [Adult Protective Services] involved, had family involved, had primary care involved. So all of these systems are involved, but it seems like there is no path forward and this person was being evicted from their home. And the staff person is saying, 'I just can't get the system to be able to work together.' They're trying to do right by individuals and can't."

On Care Coordination

"When a patient is referred to our facility, we are asking on the front end what their discharge plan is. We want to make sure that whoever is trying to get their patient in here is also willing to take the responsibility of ensuring that the patient has outpatient care when they leave here. If a patient is sick enough to [be here], they're going to be someone that we want to ensure has outpatient care to follow."

On Trust

"People are looking for placement for these patients. And sometimes they're not so honest. So the level of care that they may require isn't the level of care that we can provide. And I think that sometimes causes a little distress between certain providers."

On Equity / Priority Populations

“[*People with IDD*] *get told, I'm sorry, we don't do that. You need to go somewhere else. And it’s a civil rights issue. It's a human rights issue and it's an access to health care discrimination based on disability.”*

“I think in our communities there is a big misconception that people on parole aren’t members of the community. It’s not our job to use the incarceration system to treat mentally ill people. We are trying to connect them to resources in the community. I think there is a misconception among mental health providers that they are not just like other members of the community, but we think they are.”

“Sometimes providers are transparent and honest about rejecting a referral because the client is justice-involved, but there is no guarantee that they will be.”

On Relationships

“We still need to know the services and how they work for people. I would still want to have that relationship to know the quality of the service, to know that they share the same visions and goals that I do.”

On Communication

“A lot of our time is spent clarifying, like, what are you looking for? What's going on?”

“(There are large providers who) I’ve been trying to build a relationship with for a long time. They look good on paper but they just don’t communicate.”

“A lot of time is spent tracking down nursing staff and clinicians. We accept a patient, and then 2 hours go by and we haven't had that nurse to nurse (contact) and then they place them somewhere else.”

Appendices

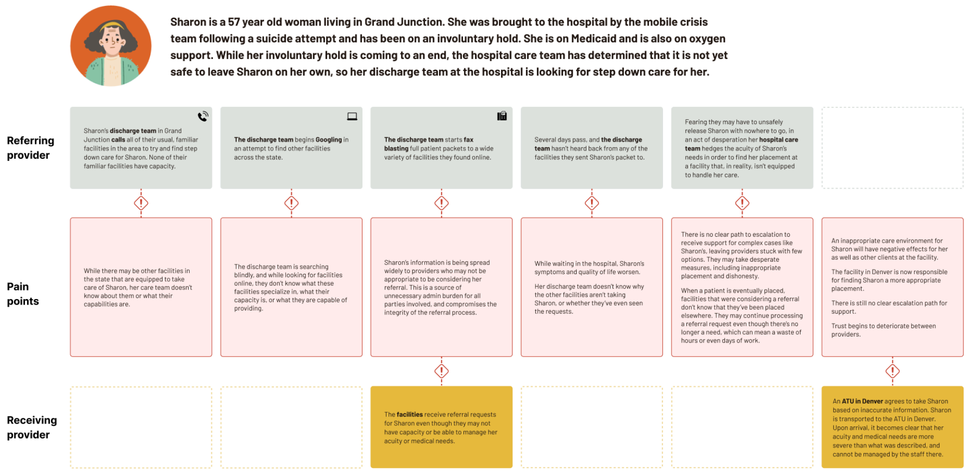
[Artifacts and deep dives.]

Appendix A: Care Stories

We have composed six Care Stories that outline individual client care journeys and the providers involved, specifically around possible edge cases or scenarios in which referrals become complex. Our research demonstrated that average referrals are not overly complex or difficult, but the edge cases are when the process would benefit from additional structure, standardization, and support. To document this, we felt it was important to illustrate these moments of impasse. Our six stories represent different types of clients and circumstances and describe the current referral process (1 story), how we envision the process will operate once the MVP is launched (2 stories) and visions of a potential future platform that has expanded in scope and capabilities (3 stories).

📃To see a Care Story depicting the current state of referrals, see Care Story _ Current state_Sharon.png .

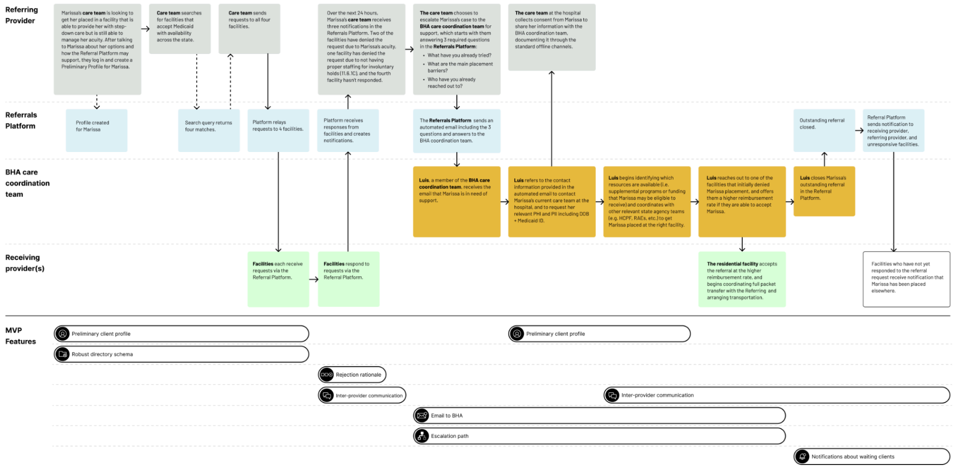
📃To see Care Stories depicting the proposed MVP state of referrals, see Care Story _ MVP_Marissa.png and Care Story_MVP_Elliott.png .



Sharon is a 57 year old woman living in Grand Junction. She was brought to the hospital by the mobile crisis team following a suicide attempt and has been on an involuntary hold. She is on Medicaid and is also on oxygen support. While her involuntary hold is coming to an end, the hospital care team has determined that it is not yet safe to leave Sharon on her own, so her discharge team at the hospital is looking for step down care for her.

Referring provider	Sharon's **discharge team** in Grand Junction **calls** all of their usual, familiar facilities in the area to try and find step down care for Sharon. None of their familiar facilities have capacity.	**The discharge team** begins **Googling** in an attempt to find other facilities across the state.	**The discharge team** starts **fax blasting** full patient packets to a wide variety of facilities they found online.	Several days pass, and **the discharge team** hasn't heard back from any of the facilities they sent Sharon's packet to.	Fearing they may have to unsafely release Sharon with nowhere to go, in an act of desperation her **hospital care team** hedges the acuity of Sharon's needs in order to find her placement at a facility that, in reality, isn't equipped to handle her care.	
Pain points	While there may be other facilities in the state that are equipped to take care of Sharon, her care team doesn't know about them or what their capabilities are.	The discharge team is searching blindly, and while looking for facilities online, they don't know what these facilities specialize in, what their capacity is, or what they are capable of providing.	Sharon's information is being spread widely to providers who may not be appropriate to be considering her referral. This is a source of unnecessary admin burden for all parties involved, and compromises the integrity of the referral process.	While waiting in the hospital, Sharon's symptoms and quality of life worsen. Her discharge team doesn't know why the other facilities aren't taking Sharon, or whether they've even seen the requests.	There is no clear path to escalation to receive support for complex cases like Sharon's, leaving providers stuck with few options. They may take desperate measures, including inappropriate placement and dishonesty. When a patient is eventually placed, facilities that were considering a referral don't know that they've been placed elsewhere. They may continue processing a referral request even though there's no longer a need, which can mean a waste of hours or even days of work.	An inappropriate care environment for Sharon will have negative effects for her as well as other clients at the facility. The facility in Denver is now responsible for finding Sharon a more appropriate placement. There is still no clear escalation path for support. Trust begins to deteriorate between providers.
Receiving provider			The **facilities** receive referral requests for Sharon even though they may not have capacity or be able to manage her acuity or medical needs.			An **ATU in Denver** agrees to take Sharon based on inaccurate information. Sharon is transported to the ATU in Denver. Upon arrival, it becomes clear that her acuity and medical needs are more severe than what was described, and cannot be managed by the staff there.

Marissa is an 18 year old on day 5 of an involuntary MH hold in the hospital due to ongoing SI and multiple attempts. She is on Medicaid and has no additional medical needs. Marissa is ready to step down her care, but the discharge coordinator has been having a hard time finding availability at other facilities, which means Marissa has been kept on Involuntary Hold because it's not safe to release her.



Referring Provider

Marissa's **care team** is looking to get her placed in a facility that is able to provide her with step-down care but is still able to manage her acuity. After talking to Marissa about her options and how the Referral Platform may support, they log in and create a Preliminary Profile for Marissa.

Care team searches for facilities that accept Medicaid with availability across the state.

Care team sends requests to all four facilities.

Over the next 24 hours, Marissa's **care team** receives three notifications in the Referrals Platform. Two of the facilities have denied the request due to Marissa's acuity, one facility has denied the request due to not having proper staffing for involuntary holds (11.6.1C), and the fourth facility hasn't responded.

The care team chooses to escalate Marissa's case to the **BHA care coordination team** for support, which starts with them answering 3 required questions in the **Referrals Platform**:

- What have you already tried?
- What are the main placement barriers?
- Who have you already reached out to?

The care team at the hospital collects consent from Marissa to share her information with the BHA coordination team, documenting it through the standard offline channels.

Referrals Platform

Profile created for Marissa

Search query returns four matches.

Platform relays requests to 4 facilities.

Platform receives responses from facilities and creates notifications.

The **Referrals Platform** sends an automated email including the 3 questions and answers to the BHA coordination team.

Outstanding referral closed.

Referral Platform sends notification to receiving provider, referring provider, and unresponsive facilities.

BHA care coordination team

Luis, a member of the **BHA care coordination team**, receives the email that Marissa is in need of support.

Luis refers to the contact information provided in the automated email to contact Marissa's current care team at the hospital, and to request her relevant PHI and PII including DOB + Medicaid ID.

Luis begins identifying which resources are available (i.e. supplemental programs or funding that Marissa may be eligible to receive) and coordinates with other relevant state agency teams (e.g. HCPF, RAEs, etc.) to get Marissa placed at the right facility.

Luis reaches out to one of the facilities that initially denied Marissa placement, and offers them a higher reimbursement rate if they are able to accept Marissa.

Luis closes Marissa's outstanding referral in the Referral Platform.

Receiving provider(s)

Facilities each receive requests via the Referral Platform.

Facilities respond to requests via the Referral Platform.

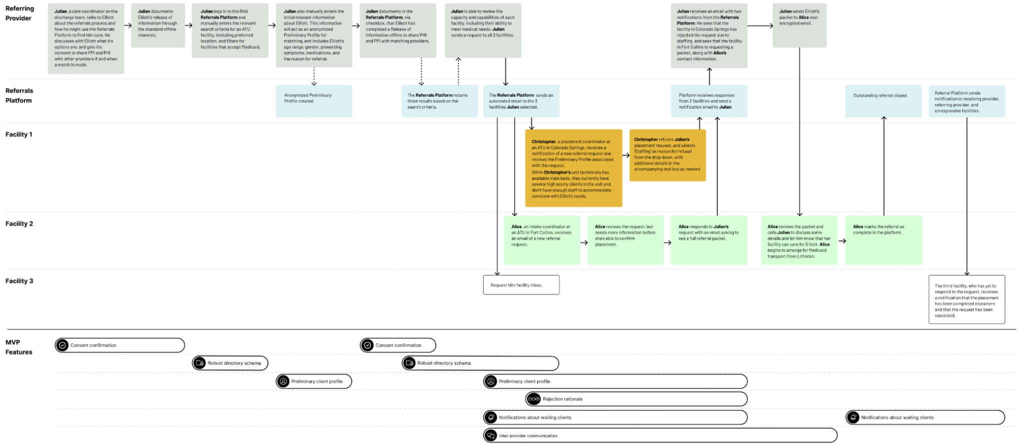
The residential facility accepts the referral at the higher reimbursement rate, and begins coordinating full packet transfer with the Referring and arranging transportation.

Facilities who have not yet responded to the referral request receive notification that Marissa has been placed elsewhere.

MVP Features

Preliminary client profile
Robust directory schema
Rejection rationale
Inter-provider communication
Preliminary client profile
Inter-provider communication
Email to BHA
Escalation path
Notifications about waiting clients

Elliott is a 43 year old man living in Littleton. He has spent the past six weeks in a state hospital psych unit, and is ready for step-down care. He is on Medicaid and has no additional medical needs. Elliott's discharge team is looking for placement for him in an ATU.



Referring Provider

Julian, a care coordinator on the discharge team, talks to Elliott about the referrals process and how he might use the Referrals Platform to find him care. He discusses with Elliott what his options are, and gets his consent to share PPI and PHI with other providers if and when a match is made.

Julian documents Elliott's release of information through the standard offline channels.

Julian logs in to the BHA **Referrals Platform** and manually enters the relevant search criteria for an ATU facility, including preferred location, and filters for facilities that accept Medicaid.

Julian also manually enters the initial relevant information about Elliott. This information will act as an anonymized Preliminary Profile for matching, and includes Elliott's age range, gender, presenting symptoms, medications, and the reason for referral.

Julian documents in the **Referrals Platform**, via checkbox, that Elliott has completed a Release of Information offline to share PHI and PPI with matching providers.

Julian is able to review the capacity and capabilities of each facility, including their ability to meet medical needs. **Julian** sends a request to all 3 facilities.

Julian receives an email with two notifications from the **Referrals Platform**: He sees that the facility in Colorado Springs has rejected his request due to staffing, and sees that the facility in Fort Collins is requesting a packet, along with **Alice's** contact information.

Julian sends Elliott's packet to **Alice** over encrypted email.

Referrals Platform

Anonymized Preliminary Profile created

The **Referrals Platform** returns three results based on the search criteria.

The **Referrals Platform** sends an automated email to the 3 facilities **Julian** selected.

Platform receives responses from 2 facilities and send a notification email to **Julian**.

Outstanding referral closed.

Referral Platform sends notification to receiving provider, referring provider, and unresponsive facilities.

Facility 1

Christopher, a placement coordinator at an ATU in Colorado Springs, receives a notification of a new referral request and reviews the Preliminary Profile associated with the request.
While **Christopher's** unit technically has available male beds, they currently have several high acuity clients in the unit and don't have enough staff to accommodate someone with Elliot's needs.

Christopher refuses **Julian's** placement request, and selects 'Staffing' as reason for refusal from the drop down, with additional details in the accompanying text box as needed.

Facility 2

Alice, an intake coordinator at an ATU in Fort Collins, receives an email of a new referral request.

Alice reviews the request, but needs more information before she's able to confirm placement.

Alice responds to **Julian's** request with an email asking to see a full referral packet.

Alice reviews the packet and calls **Julian** to discuss some details and let him know that her facility can care for Elliott. **Alice** begins to arrange for Medicaid transport from Littleton.

Alice marks the referral as complete in the platform.

Facility 3

Request hits facility inbox.

The third facility, who has yet to respond to the request, receives a notification that the placement has been completed elsewhere and that the request has been rescinded.

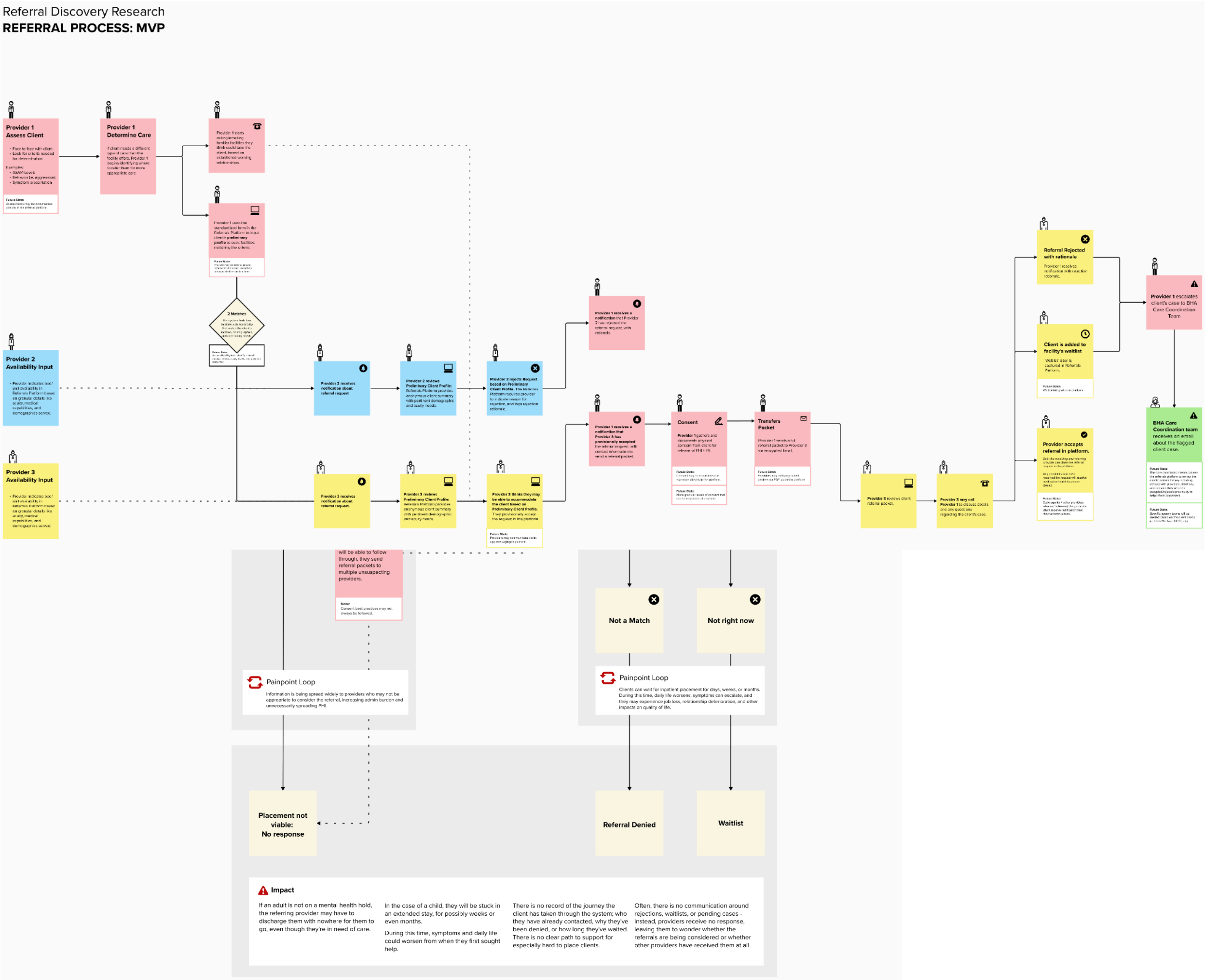
MVP Features

Consent confirmation
Robust directory schema
Preliminary client profile
Consent confirmation
Robust directory schema
Preliminary client profile
Rejection rationale
Notifications about waiting clients
Notifications about waiting clients
Inter-provider communication

Appendix B: Journey Maps

Referral Discovery User Journey_Current State.png

Referral Discovery User Journey_Future State.png



will be able to follow through, they send referral packets to multiple unsuspecting providers.

Note: Consent best practices may not always be followed.

Painpoint Loop

Information is being spread widely to providers who may not be appropriate to consider the referral, increasing admin burden and unnecessarily spreading PHI.

Painpoint Loop

Clients can wait for inpatient placement for days, weeks, or months. During this time, daily life worsens, symptoms can escalate, and they may experience job loss, relationship deterioration, and other impacts on quality of life.

Impact

If an adult is not on a mental health hold, the referring provider may have to discharge them with nowhere for them to go, even though they're in need of care.

In the case of a child, they will be stuck in an extended stay, for possibly weeks or even months.

During this time, symptoms and daily life could worsen from when they first sought help.

There is no record of the journey the client has taken through the system; who they have already contacted, why they've been denied, or how long they've waited. There is no clear path to support for especially hard to place clients.

Often, there is no communication around rejections, waitlists, or pending cases - instead, providers receive no response, leaving them to wonder whether the referrals are being considered or whether other providers have received them at all.

Appendix C: Inter-Provider Referral Messages and Notifications

Purpose of Message	Between Who	Medium	Details
Call a provider for information	Provider to provider (outside of system)	Use email/phone number from provider	Hi, I see your request here, I wanted to ask

		listing	about X
Request a bed for a client	Provider to provider (through system)	In-app notification, Triggers email, optional SMS	I have a client profile for you to review and give me a yes/no
Responding to a request for a bed	Provider to system	Accept/reject flow	I am using a UI in the platform to review the profile and accept/maybe/reject
Referral is rejected	System to provider	Triggers in-app notification, email, optional SMS	Unfortunately, your referral for provider X has been denied
Referral is rejected: follow-up	N/A	N/A	The referring provider gets the “no” answer and moves on
Referral maybe, more details requested	System to provider	Triggers in-app notification, email, optional SMS	Provider X may have space, please follow up with them.
Referral maybe: follow-up	Provider to provider (either one may initiate this)	Use email/phone number from provider listing	Hi, I am calling for more details about the client. We may have a bed available but need to know…
Referral accepted	System to provider	Triggers in-app notification, email, optional SMS	Provider X accepts your client, please follow up with them.
Referral accepted: follow-up	Provider to provider (either one may initiate this)	Use email/phone number from provider listing	Hi, we would like to accept this client, here’s what we need…
Referral accepted: remove expired referral requests	System to provider	Triggers in-app notification, email, optional SMS	This client has been accepted by another provider, this request is no longer needed.
Send referral packet	Provider to provider	Use email/phone /fax number from provider listing	Here are client’s medical details

Appendix D: Report Summary

- **Report summary:** *Two-page summary of the high level findings and platform recommendations and roadmap.*