Individuals experiencing a psychiatric crisis can often experience long delays in accessing appropriate services. Delays can result in long waits at home, in emergency departments, or in jails for appropriate available services. Psychiatric bed registries are systems that efficiently allow users to find appropriate inpatient psychiatric treatment for patients in need of such care.[1] Through the Transformation Transfer Initiative grant awarded by SAMHSA, DMH has embarked on a project to assess the current Electronic Bed Board against current and future business needs to limit delays in placement and, once made, placements are made using the lowest level of care required, closest to home.

The Vermont Department of Mental Health currently supports a statewide electronic bed board with basic functionality. An evaluation of the bed board system will assist the Department to make critical decisions regarding future system modifications needed to ensure support of current and future business needs. As part of this project, DMH performed business analysis of the current system and compared the findings with business needs as determined through requirements gathered at various stakeholder meetings. Over the course of several months, DMH met with the emergency service screeners, inpatient facility directors, crisis bed managers, intensive residential directors, residential programs, designated hospitals and agencies, DMH Care Management, and hospital and provider associations.

Summary of Stakeholder Feedback:

GROUP	KEY NOTES
VAHHS	**Limitation**: Lack of real time data entry
	Note: Private hospitals have internal bed boards which hold authority
	Benefit: Powerful reporting tool
	Benefit: Facility search based on zip codes helps ensure placements as close to home as possible
	Requirement: Would be helpful to clarify what the bed board is used for – usefulness varies by bed type.
	Requirement: Evaluate training mechanisms for users
CRT Residential	**Limitation**: No consistency in when they update (once a month or as changes occur)
	Requirement: Explore interface/extract to EMR. EMR implementation varies by DA – some includes built in bed boards
	Benefit: Find utilization reports helpful
	Requirement: Housing – recommend tracking where people are discharged to (tracked in other systems)
CRT Directors	No input
DMH Care Managers	**Benefit**: Good tool to see the system as a whole
	Benefit: Includes facility information such as contact information and admission criteria
	Limitation: Lack of consistency in use across facilities
	Requirement: Determine how to get more buy-in for use. Tie to designation process? Features to add?
	Requirement: Explore including Community Care Homes (DAIL) as they are a discharge resource for inpatient facilities
Designated Hospitals	**Note**: This group didn't provide feedback directly but offered to take questions back to their admissions coordinators, social workers and discharge planners. For one hospital, nurses enter data during their shifts and the BedBoard is assessed during morning team

[1] Lutterman, T., & Shaw, R. (2018) SAMHSA Technical Assistance Coalition Working Paper: *Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements*.

	meetings while discussing discharge planning. No requirements recommended. For another facility, the Regional Transfer Teams update the EBedBoard. No barriers to use.
Emergency Service Directors	**Benefit**: BedBoard provides a good snapshot of the system.
	Benefit: Helpful in prioritizing calls
	Benefit: Includes facility information such as contact information and admission criteria – would be helpful if facilities could include more detail re: admission process
	Limitation: Needs real time data entry that includes more anecdotal information
	Notes: Screeners can't rely on internet access in ER.
	Notes: Challenging for callers when bed board shows inaccurate information
	Limitation: Not all facilities using the fields the same (anticipated admissions/discharges)
	Requirement: Explore potential for a referral-based system.
	Requirement: Explore possibility of adding wait list
Vermont Care Partners	**Requirement**: Explore EMR BedBoard capabilities (what do they track in terms of bed availability and occupancy rates
	Requirement: Differentiate between EBedBoard use for various levels of care (facility info vs bed availability)
	Requirement: Explore adding more facility types to aid in transitions of care (out of state beds/Cheshire, DAIL Community Care beds, Nursing homes, TCRs)
	Requirement: Explore DMH directive to continue calling all facilities even after availability is found
	Requirement: More discussion/research needed to determine what forms/procedures could be added to the Bed Board
Crisis Service Directors	**Limitation**: No consistency in when they update (once every 8 hours or as changes occur)
	Benefit: See the EBedBoard as a tool to get the data in for Keith's occupancy reports and find those reports helpful in ensuring they meet the 80% occupancy rate requirement
	Note: Credible EMR has BedBoard functionality and some users have added a link to the EBedBoard within their EMR.
	Note: The EBedBoard adds value in that it provides a view of the system of care and illustrates how each facility is part of that system, working together.
	Note: It is rare for an agency to take referrals from outside their own agency.
	Limitation: The EBedBoard feels under-utilized by referrers (CRT Case Managers, Crisis Workers, Social Workers) as many referrals are made without knowledge of the EBedBoard status.
	Requirement: Explore linking EMRs to EBedBoard to eliminate need for duplicate data entry.
Intensive Residential Recovery	**Note**: feed the bedboard information regarding bed availability. All update once per day at a minimum and some update once per 8-hour shift. They do not use the EBedBoard as a resource through might now that they know the CRT Residential/Group home beds are included
	Requirement: Some are moving to the Credible EMR and will look into adding the DMH BedBoard as a link. They would appreciate functionality that would link their EMRs to EBedBoard to eliminate need for duplicate data entry
	Benefit: The EBedBoard includes a place to add facility information regarding DMH prioritization and forms.
VPQHC	**Benefit**: VAHHS notes that the data that the EBedBoard generates is helpful in monitoring the system. While the Legislature may feel that we should be at 100% occupancy, policy feels that 85% is more realistic (due to acuity, staffing, etc). DMH uses 80% as a threshold for funding.

	Requirement: Work to create uniform use of EBedBoard across all facilities. Note that the emergency crisis area at SWVT will call DMH directly if they have placement issues. Indicates that different facilities use the EBedBoard differently.
	Requirement: Add fields to include more system "chatter" that occurs outside the EBedBoard. For example, number of ppl waiting in the ER, de-identified list of ppl waiting in the ER.
	Requirement: Explore adding more facility types, such as long-term care beds, geri-psych, out of state beds.
	Requirement: Explore regional partnerships with other bed boards.
	Requirement: Explore adding a wait list feature with minimal, de-identified information that shows who is waiting
DMH BedBoard Manager (Keith)	**Requirement:** When doing a bed search for inpatient beds, there should be a method to further filter between levels of care (level one, acute care, voluntary).
	Requirement: Use of a standard level of care tool would help match referrals to beds in the bedboard. Facilities could modify level of care on a specific bed rather than close it completely.

Business requirements (consolidated):

1. Explore ways to collaborate with existing EMR/BedBoard Systems.
2. Improve data entry time.
3. Improve data entry/quality by developing training and documentation to ensure uniform use across all facilities (clarification of how to use 'anticipated discharges/admissions').
4. Incorporate more information to effectively include information about the system of care caught through outside discussions and knowledge. For example, number of people waiting in the ER, de-identified list of clients/presentations in the ER, level of care data, boarding list with ability to upload EE paperwork.
5. Add more bed types (out of state beds, community care beds). Minimally add facilities for informational use only. Assess whether some of the existing types should be transitioned to "info only" facilities, such as IRRs.
6. Explore referral-based system where screeners enter a referral through the system and the facilities accept/deny.