NASMHPD’s 2019 TTI Crisis Bed Registry Initiative:

April 25, 2019
State Webinar #1

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Chair, State Medical Directors of the National Association of State Mental Health Program Directors.
Proper care and support of individuals with serious mental illness requires policymakers to look "beyond beds" toward a full continuum of psychiatric care to meet treatment needs over time.
Agenda For Webinar

1. Information about the Crisis Registry Plans of the 23 States participating in the 2019 TTI Initiative

2. NRI report on Lessons Learned from States with On-Line Registries of Available Psychiatric Crisis and Inpatient Beds


4. Next Steps for TTI States:
   • Future Webinars, List serves, Technical Assistance
“Before I begin, one of the acronyms I’m going to use is completely made up. See if you can figure out which one.”
2019 TTI Crisis Bed Registry Project

State Characteristics and Project Plans
**Disability Responsibilities of 2019 TTI States**

| Most TTI States Are Responsible For Both Mental Health (MH) And Substance Abuse Services (SUD) | • CT, DE, FL, ID, IN, MD, NE, NV, NJ, NM, OH, OK, TN, UT, WV |
| Three TTI states are responsible for only MH | • MA, NY, VT |
| Five TTI states are responsible for MH, SUD, and Intellectual Disability Services | • AL, GA, MS, NC, RI |
TTI States Vary Widely In Population

Very Large Population States: over 10 Million Residents
- FL, GA, NY, NC, OH

5 to 10 Million Residents
- IN, MD, MA, NJ, TN

2 million to 5 million Residents
- AL, CT, ID, MS, NE, NV, NM, OK, RI, UT, WV

Less than 1 Million Residents
- DE, VT
TTI States Vary Widely In Number of Organizations with Psychiatric Inpatient Beds

<table>
<thead>
<tr>
<th>Category</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 100 Organizations with Psychiatric Inpatient Beds</td>
<td>FL, NY</td>
</tr>
<tr>
<td>Over 50 Organizations with Psychiatric Inpatient Beds</td>
<td>IN, MA, NC, OH</td>
</tr>
<tr>
<td>Over 25 Organizations with Psychiatric Inpatient Beds</td>
<td>AL, CT, GA, MD, MS, OK, TN</td>
</tr>
<tr>
<td>Less Than 25 Organizations with Psychiatric Inpatient Beds</td>
<td>DE (&lt;10), ID (&lt;10), NE, NV, NM, RI (&lt;10), UT, VT (&lt;10) WV,</td>
</tr>
</tbody>
</table>
Number of Mental Health Inpatient or 24-hour Residential Treatment Beds

- New York: 15,000
- Florida: 10,000
- New Jersey: 7,000
- Ohio: 6,000
- Massachusetts: 5,000
- North Carolina: 5,000
- Tennessee: 4,000
- Maryland: 4,000
- Georgia: 3,000
- Connecticut: 3,000
- Mississippi: 2,000
- Oklahoma: 2,000
- Utah: 1,000
- West Virginia: 1,000
- Nebraska: 1,000
- New Mexico: 1,000
- Idaho: 1,000
- Rhode Island: 1,000
- Nevada: 1,000
- Vermont: 1,000
- Delaware: 1,000

Legend:
- 24-Hour Residential Treatment Beds
- Psychiatric Inpatient Beds
Inpatient and Residential Treatment Beds
Per 100,000 Population, 2014

<table>
<thead>
<tr>
<th>State</th>
<th>Psychiatric Inpatient Beds</th>
<th>MH 24-hour Residential Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>Connecticut</td>
<td>31</td>
<td>43</td>
</tr>
<tr>
<td>Delaware</td>
<td>14</td>
<td>46</td>
</tr>
<tr>
<td>Florida</td>
<td>34</td>
<td>21</td>
</tr>
<tr>
<td>Georgia</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td>Idaho</td>
<td>36</td>
<td>23</td>
</tr>
<tr>
<td>Indiana</td>
<td>33</td>
<td>43</td>
</tr>
<tr>
<td>Maryland</td>
<td>39</td>
<td>29</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>36</td>
<td>37</td>
</tr>
<tr>
<td>Mississippi</td>
<td>55</td>
<td>38</td>
</tr>
<tr>
<td>Nebraska</td>
<td>43</td>
<td>24</td>
</tr>
<tr>
<td>Nevada</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>New Jersey</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>New Mexico</td>
<td>38</td>
<td>55</td>
</tr>
<tr>
<td>New York</td>
<td>43</td>
<td>27</td>
</tr>
<tr>
<td>North Carolina</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Ohio</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Oklahoma</td>
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<td>21</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>33</td>
<td>34</td>
</tr>
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<td>Tennessee</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>Utah</td>
<td>27</td>
<td>34</td>
</tr>
<tr>
<td>Vermont</td>
<td>50</td>
<td>91</td>
</tr>
<tr>
<td>West Virginia</td>
<td>32</td>
<td>53</td>
</tr>
</tbody>
</table>

Source: SAMHSA (2014 N-MHSS)
State TTI Crisis Bed Registry Plans
Plans for TTI Crisis Bed Registry Development

- **Developing New Bed Registry**
  - CT, ID, MD, NE, UT, VT

- **Expanding/Enhancing Existing Registry**
  - CT, DE, FL, GA, IN, MA, MD, MS, NV, NJ, NM, NY, NC, OH, RI, TN, VT

- **Developing Tools/Methods to Refine Bed Availability or Treatment Locator Databases**
  - DE, FL, GA, NJ, NY, NC, OK, RI, TN

- **Assessing State Capacity for Crisis System and Future Bed Registry**
  - AL, WV
Status Of TTI Bed Registry Initiatives

Legend

- Development of 1st Electronic Bed Registry
- Expansion of Current Bed Registry
- Expansion and Development of Tools/methods to Refine Bed Availability or Treatment Locating
- Enhancing Existing Bed Registry
- Other Registry Initiatives
# Who Will Build and Operate a Bed Registry

<table>
<thead>
<tr>
<th>State</th>
<th>• FL, GA, ID, MA, MD, MS, NC, NE, NJ, NV, NY, OK, TN, and UT</th>
</tr>
</thead>
<tbody>
<tr>
<td>OpenBeds®</td>
<td>• DE, IN, and NM</td>
</tr>
<tr>
<td>Other-Contracted Vendor</td>
<td>• CT, and RI</td>
</tr>
<tr>
<td>Unknown/To be Determined</td>
<td>• AL, OH, VT, and WV</td>
</tr>
</tbody>
</table>
### Reporting: Public Versus Privately Funded Facilities

<table>
<thead>
<tr>
<th>Category</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publicly Funded</td>
<td>CT, GA, ID, MA, MS, NJ, NM, and VT</td>
</tr>
<tr>
<td>Private</td>
<td>None</td>
</tr>
<tr>
<td>Both</td>
<td>DE, FL, IN, MD, NC, NE, NV, NY, OH, OK, TN, and UT</td>
</tr>
<tr>
<td>Unknown/To be Determined</td>
<td>AL, RI, and WV</td>
</tr>
</tbody>
</table>
### Reporting by Facilities: Mandatory or Voluntary

<table>
<thead>
<tr>
<th>Status</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>DE, MD, MA, NC, NM, NV, NY, OH, TN, UT, and VT</td>
</tr>
<tr>
<td>Mandatory</td>
<td>CT, FL, GA, ID, MS, NJ, OK, and RI</td>
</tr>
<tr>
<td>Both</td>
<td>IN</td>
</tr>
<tr>
<td>Unknown/To be Determined</td>
<td>AL, NE, and WV</td>
</tr>
</tbody>
</table>
## Reporting by Facilities: Frequency of Updates

<table>
<thead>
<tr>
<th>Frequency of Updates</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live/Real Time</td>
<td>GA, and NJ</td>
</tr>
<tr>
<td>Three Times per Day (Every 8 Hours)</td>
<td>MS</td>
</tr>
<tr>
<td>Once per Day</td>
<td>FL, ID, and NV</td>
</tr>
<tr>
<td>Twice Per day</td>
<td>DE, IN, MD, NC, NY, TN and UT</td>
</tr>
<tr>
<td>Varies based on Facility Type</td>
<td>VT</td>
</tr>
<tr>
<td>Unknown/To be Determined</td>
<td>AL, CT, MA, NE, NM, OH, OK, RI, and WV</td>
</tr>
</tbody>
</table>
Question for States:

1.A  Now or in the future, does your state plan to have a real-time registry?

1.b  How is your state defining real-time?
## Types of Beds Included in Registry

<table>
<thead>
<tr>
<th>Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychiatric Beds</strong></td>
<td>AL, DE, FL, GA, ID, IN, MA, MS, NC, NE, NJ, NM, NV, NY, OH, OK, RI, TN, UT, VT and WV</td>
</tr>
<tr>
<td><strong>Detox/Addictions Facility</strong></td>
<td>DE, FL, GA, IN, NC, NM, NV, RI, VT, and WV</td>
</tr>
<tr>
<td><strong>Residential</strong></td>
<td>CT, FL, MD, NJ, NM, NV, RI, VT, and WV</td>
</tr>
<tr>
<td><strong>Crisis/Respite/Stabilization</strong></td>
<td>AL, CT, GA, ID, MA, MD, MS, NC, NJ, NM, NV, OK, VT and WV</td>
</tr>
<tr>
<td><strong>Unoccupied or Soon to be Available</strong></td>
<td>GA, IN, MS, NE, NY, UT, and VT</td>
</tr>
<tr>
<td><strong>Other Beds of BH Services</strong></td>
<td>CT, DE, GA, IN, MA, NC, NV, and WV</td>
</tr>
</tbody>
</table>
Variation in the Types of Beds Included in Registries Among States

Number of Different Bed Types Included for in Bed Registries

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Bed Types Included in Bed Registries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>2</td>
</tr>
<tr>
<td>Connecticut</td>
<td>4</td>
</tr>
<tr>
<td>Delaware</td>
<td>5</td>
</tr>
<tr>
<td>Florida</td>
<td>6</td>
</tr>
<tr>
<td>Georgia</td>
<td>5</td>
</tr>
<tr>
<td>Idaho</td>
<td>5</td>
</tr>
<tr>
<td>Indiana</td>
<td>5</td>
</tr>
<tr>
<td>Maryland</td>
<td>5</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>3</td>
</tr>
<tr>
<td>Mississippi</td>
<td>2</td>
</tr>
<tr>
<td>Nebraska</td>
<td>2</td>
</tr>
<tr>
<td>Nevada</td>
<td>3</td>
</tr>
<tr>
<td>New Jersey</td>
<td>3</td>
</tr>
<tr>
<td>New Mexico</td>
<td>4</td>
</tr>
<tr>
<td>New York</td>
<td>4</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2</td>
</tr>
<tr>
<td>Ohio</td>
<td>3</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>2</td>
</tr>
<tr>
<td>Tennessee</td>
<td>1</td>
</tr>
<tr>
<td>Utah</td>
<td>2</td>
</tr>
<tr>
<td>Vermont</td>
<td>5</td>
</tr>
<tr>
<td>West Virginia</td>
<td>5</td>
</tr>
</tbody>
</table>
Organizations/Agencies Participating in Development/Modification

- Other: 19
- State Psychiatric Hospitals: 10
- County Behavioral Health Authority: 2
- Consumers and Advocates: 15
- Community Service Providers: 13
- NAMI: 8
- General Hospitals/EDs/Private Psych...: 10
- State Hospital Association: 12
- MCO(s): 5
- State Medicaid Agency: 8
- Department of Corrections: 4
- SMHA: 23

Number of States
Intended Users of the Registry

Intended Users of the Bed Registry

<table>
<thead>
<tr>
<th>Intended Users</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMHA</td>
<td>22</td>
</tr>
<tr>
<td>Crisis Service Providers</td>
<td>20</td>
</tr>
<tr>
<td>General Hospitals/Emergency</td>
<td>15</td>
</tr>
<tr>
<td>MH Providers</td>
<td>13</td>
</tr>
<tr>
<td>Community MH Providers</td>
<td>11</td>
</tr>
<tr>
<td>Private Psych Hospitals</td>
<td>4</td>
</tr>
<tr>
<td>MCOs</td>
<td>5</td>
</tr>
<tr>
<td>Dept of Corrections</td>
<td>3</td>
</tr>
<tr>
<td>General Public</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Unknown/Not Specified</td>
<td></td>
</tr>
</tbody>
</table>
Question #2 for States:

2. Now, or in the future, is your state considering allowing emergency responders (e.g. EMTs, firefighters) and criminal justice stakeholders (e.g. police, judges) to access the bed registry to link a person in crisis with treatment services?
NRI Work related to Crisis Bed Registries

- 2017 Report on trends in psychiatric bed capacity
- 2017 State survey of psychiatric bed registries
- 2018 Technical Assistance Collaborative report on experiences of states implementing bed registries
- 2019 Supporting NASMHPD TTI crisis bed registry initiative
Elements of the Problem

• Boarding of people with mental health crises in emergency rooms waiting placement or treatment beyond stabilization

• Individuals with mental illness in jails awaiting assessments and treatment are a critical issue in some states

• Searching for available placements is inefficient

• People in need of treatment are made to wait, unnecessarily.
Residents in State Psychiatric Hospitals, Jails, and Prisons, 1950 to 2016

Number of Residents

Thousands

State and Federal Prison Population

Sources: State Psychiatric Hospitals from: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2002, and SAMHSA Uniform Reporting System: 2004 to 2016

State and Federal Prison Population from: Bureau of Justice Statistics, Prisoners Series
Number of Public and Private Organizations Providing Inpatient and Other 24-hour Residential Treatment and Patients at the End of Year: 1970 to 2014

Sources: NIMH, SAMHSA IMHO, 2010 and 2014 NMHSS
Patients in Inpatient and Other 24 Hour Residential Units In Private Psychiatric Hospitals and General Hospitals with Psychiatric Units (at End of Year), 1970 to 2014
How Many Inpatient Beds Should There Be?

• The ideal number and type of inpatient capacity in a given area is useful to know but difficult to determine

• The number and types of inpatient capacity available at given time is unknowable without data (a registry can fill this need)

• Is there a better way to managed existing inpatient capacity?

• Crisis respite and other crisis response resources can greatly reduce the need for inpatient beds
NRI 2017 Survey found 16 states with some form of a psychiatric bed registry

States Responding to Questionnaire on Psychiatric Bed Registries

Note: Not All Territories are shown. DC did not have an existing registry.
Existing State Psychiatric Bed Registries (2017 Results)

Report found existing state registries vary considerably in many areas

• Who operates the registry (state or other)
• What types of providers participate
• Voluntary or required participation
• Frequency of capacity updates
• Who can access and use the registry
To learn more about the experiences of states in operating psychiatric bed registries NRI conducted semi-structured interviews with 9 states

• What led to the state’s development of the registry
• What types of providers report into the registry
  • Why are some providers not updating information?
• Who are the users of the registry?
• What did it cost to build and what does it cost to maintain?
• What is working and what isn’t?
• What are their lessons learned/suggestions for other states?
Who The State Worked with to Create the Registry

1. State Hospital Association
2. State By Itself
3. Crisis Service Vendor
4. Other
Who Built the Registry?

1. State
2. Hospital Association
3. Crisis Services Vendor
4. Managed Care Company
Types of Beds Included

1. Private Psychiatric and General Hospitals
2. State Hospitals
3. Crisis Mental Health
4. Crisis Substance Use Disorder
5. Residential Treatment Centers (children and adults)
6. Veterans Administration
7. County Psychiatric Hospitals
Intended Users

1. Emergency Departments
2. Community Behavioral Health Providers
3. Behavioral Health Crisis Teams
4. Other Behavioral Health Providers
5. Police/First Responders
Tracking/Reporting
(ties were reported on the same line)

1. Hospital Participation and Referrals/Rejections
2. Time to Respond and Available Placements
3. Bed Utilization and Number of Searches
4. Next Available Bed
Implications from NRI Report
Accurate and Timely Information about Available Beds is Critical

- Having **current timely** information about bed availability is a major challenge for registries.

- Lack of timely or accurate bed information frustrates users and reduces future reliance on the registry.

- The more hospitals and crisis residential programs cooperate with timely information about available beds, the more useful a registry will be for the purposes of finding placements.

- States with “required” reporting to the registry still experienced delays in receiving timely information.
EMTALA and Other Provider Concerns

• Provider concerns about receiving patients without insurance or “difficult” patients was cited by many states as a reason providers don’t provide timely bed availability
  • Proactive education and enforcement of the Emergency Medical Treatment And Labor Act (EMTALA) was recommended
  • Reducing financial impact of uninsured patients through managed care or state contracts for care increased provider responsiveness
“Real-Time” Bed Registries

• No state currently has a registry linked to Electronic Health Records (EHR) or Hospital admission/discharge data systems to automatically update bed availability

• States indicated such a system is technologically feasible but would require provider approval
  • No state has had their providers currently willing to participate in such an automated system

• Current registries rely on providers submitting bed availability. Typically updated every 8 to 24 hours
Technology is Not The Barrier: It Doesn’t Cost Much To Build an On-Line Registry

• Useful, though basic, registries were built in as little as 16 hours and cost only $50,000. One region in Arizona has a registry that is just a spreadsheet, updated daily.

• A State’s cost to maintain a registry can be less than $60,000 annually.
  • This buys a manually updated system that can track use and time between updates, allows possible available beds to be found easily.
  • It doesn’t buy a reservation or a real-time system
States Found Upfront Stakeholder Involvement is Important

Use the State Authority to get started

• Involve stakeholders including Families, MH Consumers, Emergency Departments, First Responders to drive participation

• Joint partnerships between MCOs and the State may leverage paying for care

• Sell the value of a Registry from the perspectives of each different stakeholder
Use Metrics to Monitor Reporting and Referrals can Improve Registry Performance

• Measure and report on the Registry Participation.
  • Track and report on timeliness of bed data from providers and referral acceptance rates
  • Let providers and users see which providers are not updating availability and which are rejecting referrals

• A Registry can help document the number and type of specialty beds in a geographical area:
  • Monitoring a Registry can identify shortages in crisis and inpatient beds in by specialty and area
A Registry as part of a Crisis Referral/Triage System: A Broader Conceptualization of Registries

• Several states have built their bed registry as part of a larger crisis response system (AZ, GA)

• An effective registry can allow the tracking of clients in need of mental health services giving system information that can allow them to:
  • Triage service needs from crisis response to inpatient care
  • Manage the flow of clients to the most intensive levels of care appropriate for client needs
  • Better serve clients in crisis by decreasing wait times
Question #3 for States:

3. In regards to linking an individual with the appropriate level of care, what are your state’s outcomes/goals?

• Open Ended question: States describe:
NRI Report Summary

• It can be DONE! Registries are working in several places.

• Don’t just use a Registry to place clients into inpatient beds, include crisis and alternatives in the Registry and reserve psychiatric beds for those who need them most.
  • Use a centralized point of entry and a standardized tool to measure the need for intensive levels of psychiatric care.

• A “Real Time” Registry needs to report openings and closings as they happen. A lag in available beds frustrates users and ends up reducing overall utility of the Registry.
If You’ve Seen One State You’ve Seen One State

• There is great variation in how states organize and fund behavioral health services.
  • Experiences and lessons learned by other states can help states starting out avoid common barriers/issues.
• The development of a registry in a state should involve all stakeholders and take into account that state’s unique structures and needs.
• There’s nothing wrong with just building an effective registry if it makes finding placements more efficient and reduces wait times for clients.
June 18th SAMHSA Expert Meeting on Crisis Bed Registries

• SAMHSA convened State mental health experts, along with public and private providers, managed care leaders, consumers, and family members to discuss registries

• NRI presented preliminary results from the Bed Registries Study

• Several states presented on their experiences operating registries

• Identified themes and issues to consider in establishing registries
Challenges and Best Practices in Setting up Crisis Bed Registries
Realtime database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities… for adults and children.
BUILDING A

Crisis Services Continuum

TO MATCH A CONTINUUM OF CRISIS INTERVENTION NEEDS

First Responder
NC START
Outpatient Provider
Family & Community Support
Crisis Telephone Line
LME/MCO Access Center

Early Intervention

Response

Prevention

Stabilization

Peer Support “living room”
Mobile Crisis Team
CIT Partnership
EMS Partnership
24/7 Crisis Walk-In Clinic
Hospital Emergency Dept.

Non-Hospital
Crisis Respite Housing
23 hour Observation
Facility Based Crisis
Non-hospital Detox

Hospital Units
Community (including 3-way beds)
State Psychiatric & ADATC

Transition Supports
Critical Time Intervention, Peer Crisis Navigators
LME-MCO Care Coordination, PROACT
Panelists represented registry stakeholders:

- State mental health authorities
- State health authorities
- Managed care organizations
- Hospital systems
- Crisis service providers
- Family members
- Individuals with lived experience
Challenges

1. Stakeholders are invested in the existing process and distrustful of changes.

2. Databases do not have a value in and of themselves.

3. Relying on the database alone to make placements.

4. Inadequate resolution of policy issues affects overall buy-in into the database.
Challenge 1: Stakeholders are invested in the existing process and distrustful of changes.

- Who are the stakeholders in your state?
- Why is building trust important?
- What systems, structures, and processes can you use to build trust and support for the registry during the process of building it?
Question #4 for States:

4. Who are the stakeholders you are engaging in the planning and implementation process?
   • Private psychiatric hospitals and general Hospitals?
   • State psychiatric hospitals
   • State Hospital Associations?
   • Family Groups and Consumers?
   • Emergency responders like police and EMTs?
   • Insurance companies?
   • Others: describe:
Challenge 2: Databases do not have a value in and of themselves.

- Potential value of the registry database? In addition to identifying openings, the database offers:
  - Transparency with stakeholders and organizations feeding data into the database
  - Increased accountability across the system
  - Potential to improve utilization of existing service across the continuum
  - Identification of mismatches between service needs and service capacities
Challenge 3: Relying on the database alone to make placements.

• Even though registries are automated, placements are always hands-on.

• Complex cases will remain complex.

• Receiving facilities may assert right to refuse individual cases
Challenge 4: Inadequate resolution of policy issues affects overall buy-in into the database.

- Navigating policy issues around EMTALA requires partnerships among state agencies.
- State Medicaid Office and Attorney General are essential partners on addressing policy issues.
Best Practices

1. Engage Stakeholders
2. Inventory Existing Services and Systems
3. Describe the Crisis Response Continuum
4. Design a “Real Time” Database Useful to Users
5. Incentivize Participation in the Registry
6. Establish a Transparent Data-Sharing System
7. High-Level Decision-Maker Oversees Registry
1. Engage Stakeholders Including State Medicaid

- State mental health commissioner can serve as a convener to the process.
- Identify existing problems and describing potential benefits of a realtime electronic system for all stakeholder
- Many of the policy-level issues require SMO leadership.
  - EMTALA
  - IMD exclusion waivers
  - Medicaid billing on more than one procedure per day
2. Inventory of state and local crisis systems

- Call centers
- Mobile and static crisis responses
- Crisis stabilization
- Community respite or residential
- Inpatient
- Specialized inpatient
3. Map the Existing System

Crisis Bed Referrals are made via:
- Georgia Crisis & Access Line
  - 800 Toll Free Line / Mobile Crisis Teams
  - Emergency Department Requests
- Direct Admissions by BHCC / Crisis Units

* Private Hospital beds are purchased by DBHDD for uninsured individuals when a crisis bed is not available.

4. Incentivize Participation in the Registry

- Market to providers and hospitals that will feed data into the database.

- Supply providers/hospitals with data which is meaningful to them.

- Use the database as a tool to improve the system as opposed to an enforcement mechanism.

- MCOs can more easily build incentives and disincentives in a database.
5. Design a Database Useful to Users

• Few databases are real-time in that availability data are refreshed as beds become available or beds are filled.

• Limited daily refreshes are a threat to long-term utility of the database.
6. Establish a Transparent Data Sharing System

Transparency increases accountability across the system.

- Hospitals
- Service providers
- Managed care organizations
- Families and people in need of service
7. High-Level Decision-Maker Oversees Registry

- Oversight/accountability
- Ensure long-term utility of the database
- Monitor for patterns of cherry-picking
- Examine utilization and bed capacity data to determine where need exists within the system for particular levels of care
Next Steps

NAMHPD and NRI will hold future webinars at 1 PM EDT on the 4\textsuperscript{th} Thursday of each month:
- May 23, June 27, July 25, August 22, September 26, October 24,

Potential Future Webinar Topics:
- Demos of existing crisis bed registries
- Addressing barriers to provider participation—EMTALA and financing
- Building metrics on use of registries
- Working with others to design and monitor registries
- Other state identified needs

Listserv for TTI States
- Is there interest in NRI establishing a listserv for TTI states?
- Listserv of all states or several topical listservs?
5. What topics for future Webinars will be most helpful?

- EMTALA and legal issues
- Demonstrations from states with existing registries
- Examples of reports from registries on timeliness of reporting and referrals
- Other: _________________________
For Additional Information...

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