National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #2

Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements

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Second in a Series of Ten Briefs Addressing: Bold Approaches for Better Mental Health Outcomes across the Continuum of Care

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Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements

Technical Writer: Robert Gould Shaw, M.A.

National Association of State Mental Health Program Directors

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314
703-739-9333 FAX: 703-548-9517

www.nasmhpd.org

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Executive Summary

Individuals experiencing a psychiatric crisis can often experience long delays in accessing appropriate services. These delays can result in long waits at home, in emergency departments, or in jails for appropriate available services to be identified. NASMHPD has established a goal that 100 percent of clients experiencing a psychiatric crisis receive appropriate care without delay. The use of a psychiatric bed registry that tracks all available crisis and inpatient psychiatric beds is one tool that many states are implementing to help address this issue.

Psychiatric bed registries are systems that efficiently allow users to find appropriate inpatient psychiatric care for patients in need of such care. Effectively implemented they can help a system ensure that there is 100 percent no delay in accessing the most appropriate 24/7 emergency, crisis stabilization, inpatient, or recovery services.

However, bed registries on their own can only attempt to solve the problem of finding available beds. They can only be more efficient than cold calling a list of hospitals if a) the information in the registry is accurate, b) the information in the registry is timely, and c) the hospitals in the registry are willing to accept patients for their empty beds. But they can also be an important part of a crisis services management system that allows a mental health service system to manage the flow of patients in crisis to appropriate levels of care, of which psychiatric hospital care is only a small part of a continuum, and provide information that can allow a system to determine the appropriate service capacity for all levels of care.

Goal: 100% of Consumers have access without delay to the most appropriate 24/7 emergency, crisis stabilization, inpatient or recovery bed

Introduction

The December 2017 Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) Report to Congress identified the goal of assuring that individuals with serious mental illnesses receive critical intensive care in the least-restrictive safe settings available that meets their needs:

*Access to Treatment and Recovery Focus 2.2: Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization. Through partnerships at the federal, state, and local levels, build the capacity of the mental health system to provide a continuum of services that includes inpatient psychiatric care, when needed, with community-based resources also available. Ensure that people with [serious mental illness (SMI)] and [serious emotional distress (SED)] receive care in the least-restrictive safe setting available that meets their mental health service needs.*
A major barrier to the efficient use of psychiatric crisis and inpatient bed capacity can be the lack of a reliable and accessible way to identify available beds or safe alternatives with the appropriate level of care. The difficulty of finding available beds, or access to other less intensive treatments, can contribute to waits, or “boarding”, in emergency departments.

The 21st Century Cures Act of 2017 includes authorization for SAMHSA to support the development, maintenance, and or enhancement of databases of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health (MH) and substance use disorder (SUD) treatment facilities.¹

Psychiatric bed registries are one tool being developed in many states to try to streamline the process of finding an available psychiatric crisis stabilization service or inpatient bed appropriate for a particular client. The better a registry accomplishes the task of quickly assisting mental health clients in need of receiving appropriate care, the more useful the registry is. A registry can also help a state monitor the number, type, and location of inpatient beds and the demand for these beds by collecting and analyzing information on requests for referrals through the registry. In addition, a registry can help a state better manage its existing inpatient service capacity by controlling the flow of patients.

In 2017, the NASMHPD Research Institute (NRI) conducted a study to determine the extent to which psychiatric bed registries were being implemented in the US. For the purposes of the NRI survey, a bed registry was defined as a “centralized system that uses real-time tracking to monitor the availability of psychiatric beds.” The study found that sixteen states had bed registries and that an additional eight states were in the process of planning or developing a bed registry. In just over half the states with bed registries (nine states), participation in the registry was voluntary.

Despite the definition of registry requiring the inclusion of real-time information, eleven of the states with registries had registries that were updated not in real-time, but periodically, ranging from several times a day to daily. NRI concluded that “very few states reported having registries that were updated 24/7 with real-time information.” The types of beds covered by the registries generally included beds in state and private psychiatric hospitals, and general hospital psychiatric beds. Only a few registry systems included crisis beds, either for mental illness or substance use disorders, or Veterans Administration beds.²
Experiences and Lessons Learned in States with On-Line Databases, August 2018

To understand the experiences and lessons learned in states with experiencing psychiatric bed registries, NRI staff conducted semi-structured interviews with nine states selected based on information from the 2017 report. States were selected to be interviewed based on the following criteria:

- Did they have a currently operating psychiatric bed registry?
- Did they once have a bed registry that was no longer operational?
- Were they available for an interview?

Eight states and a vendor, Behavioral Health Link (BHL), were interviewed. BHL operates Georgia’s bed registry as part of running its crisis service hotline. The approach used by BHL led us to expand our conception of the bed registry issue from a registry focused on identifying available psychiatric beds to a holistic system that allows for the management of all crisis services, of which psychiatric beds are the most intensive and expensive part. A description of the bed registries, present and past, of eight states are provided in this white paper, as well as a description the approach used by Georgia and several other states and cities.

### Common Concepts Related to Psychiatric Bed Registries

#### Boarding

People with mental health issues showing up in emergency rooms is common and not a new phenomenon. Boarding is the term used for the keeping of psychiatric patients in
hospital emergency rooms and in other locations in hospitals while they await transfer to a treatment unit at the same hospital or at some other treatment facility. The problem of clients in need remaining boarded in an emergency department is caused by a variety of factors, including the lack of screening tools or qualified staff to perform psychiatric screening, the lack of availability of placements in crisis, inpatient, and out-patient care, and the need for authorization by insurance companies prior to placement.iii

According to a 2008 survey by the American College of Emergency Physicians, 99 percent of emergency room physicians admit psychiatric patients daily.iv Not all boarding is caused by factors external to the emergency rooms. Maryland reported that hospitals could alleviate some of the boarding occurring in their emergency rooms if, for example, screening and other clinical staff were available 24 hours a day, seven days a week. In some instances, a patient arriving on a Friday evening may have to wait until Monday morning to be screened. A wait in an emergency room for a prolonged length of time, even for several days, can have an adverse impact on a patient’s health by increasing their levels of stress and delaying treatment.v

Delay

“Delay” refers to the time between a patient’s arrival and their transfer to appropriate treatment, which can include inpatient and outpatient care beyond what is considered to be reasonable. This is a value judgment. No delay is ideal, but a reasonable definition could be that a wait becomes a delay when the wait begins to adversely affect the health of the patient. The Washington State Supreme Court, in the case of In re the Detention of D.W. et al. ruled that it was illegal to board psychiatric patients in emergency rooms and acute care centers based on a lack of space at certified psychiatric treatment facilities.vi

Bed Capacity

“Bed capacity” refers to the number of psychiatric beds available in a defined area, such as a city, county or state. As some of the states that were interviewed noted, bed capacity is more complex than just the gross number of beds available for use. The nuances include the appropriateness of a bed for patients of a particular gender or age, whether or not a bed is in a locked or unlocked unit, and even the service capacity of a facility at a particular time, as limited by available workforce. Transferring a patient to an open bed that is theoretically appropriate for that patient’s needs when the facility is unable, at the time the patient is transferred, to treat the patient becomes boarding in a new location.

Another bed capacity issue that is determining is the appropriate number of psychiatric beds a given area should have. This is a contentious subject, with the Treatment Advocacy Center advocating for 40 to 60 psychiatric beds per 100,000 people.vii For Wisconsin, the development of their bed registry was an outgrowth of their desire to determine the number of psychiatric beds they should have. Other states, like Georgia, have taken an approach different from focusing on bed capacity to look at crisis services as a whole and a continuum of services from outpatient to various levels of inpatient care. The latter approach focuses on providing timely services to individuals in crisis at levels appropriate to their need, which may not be in an inpatient setting. In the Olmstead decision of 1999, the U.S. Supreme Court ruled that persons should be treated in the least restrictive environment possible.viii
Cherry Picking

Cherry picking is the act by facilities of selecting referred patients in a way that is in the financial or service interest of the facility at the expense of the needs of patients. Among the reasons cherry picking occurs is the desire to serve patients with the highest reimbursement rates or the lowest service needs, or patients who are the least troublesome. Individuals with a serious mental illness with previous criminal justice involvement, especially with a history of violence, may be seen as difficult patients to be avoided by some facilities.

Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 ensures access to emergency services regardless of a patient’s ability to pay. Section 1867 of EMTALA requires hospitals with emergency services that participate in Medicare to provide medical screening when a request for examination or treatment for an emergency medical condition is made, and then to provide stabilizing treatment. If the emergency room is unable to stabilize the patient, or if the patient requests a transfer, the patient should be transferred to a facility that can provide appropriate care. Hospitals participating in Medicare that provide specialty services cannot refuse an appropriate transfer from an emergency department if they have the capacity to treat the patient. While the patient is in an emergency room, the patient is their patient until they are transferred.

Psychiatric Bed Registry

A psychiatric bed registry is an electronic system, most often web-based, that allows persons looking to place a patient in inpatient psychiatric care to find an available bed. In the absence of a bed registry, persons looking to find available beds would need to have a list of all the relevant inpatient and crisis facilities, a description of the services provided by the facilities, and contact information for the facilities to call each facility to determine where beds are available so that the patient is not transferred blindly to a facility that may not have an available or appropriate bed. An ideal registry system would eliminate the need for any calls and would include a reservation system. A user would be able to search the registry, find an open and appropriate bed that best matches the needs of the individual with mental illness, reserve the bed for their patient, and be able to transfer the patient to the facility. The receiving facility would have all relevant information on the patient being transferred to them and would have an estimated time of arrival for the transferring patient.

None of the nine states interviewed had this ideal system that covers all potential psychiatric beds. The states interviewed with currently operating registries are able to use their registries to narrow down the number of facilities they need to contact to arrange the transfer of a patient, but none of the states currently have real-time bed availability and reservation capacity across all types of psychiatric beds.

For an ideal registry system to work, the data in the registry would need to be updated in real time and include not only currently available beds, but also beds soon to be available. The users of the information have to be able to rely on the timeliness, accuracy, and comprehensiveness of the data provided. Registries that cannot ensure timeliness,
accuracy, or comprehensiveness will not be useful and may fall out of use or frustrate potential users. In general, the data in existing registries is updated manually every 8 hours, or even every 24 hours.

A Virginia Inspector General’s Report on the implementation of Virginia’s first bed registry reported that 54.7 percent of its users found it was taking longer to place patients than before the registry was implemented in part because facilities were not uniformly updating the registry when a bed became available. Virginia implemented a greatly revised registry based on state and user experiences with their initial registry.\textsuperscript{xi}

Georgia and Arizona are instead implementing a crisis service model that has re-conceptualized the registry. These states have moved away from simply providing information on available beds to instead use a mental health crisis system to quickly triage clients to the most appropriate level of care. These systems are designed to limit the use and need for the most intensive inpatient services.

Background

History of Boarding

In 2008, 79 percent of facilities that responded to a survey conducted by the American College of Emergency Physicians were boarding psychiatric patients in their emergency departments, with one-third of boarded patients staying in the emergency department for at least eight hours. A 2010 report by the Agency for Healthcare Research and Quality found that, in 2000, 5.4 percent of emergency room department visits were due to behavioral problems, with that percentage increasing to 12.5 percent in 2007.\textsuperscript{xii} As a new, far less institutional and more community-based mental health system was created over the last decades; a mismatch was created between the needs of patients and the infrastructure for determining and serving their needs. As the economist Thorstein Veblen wrote, “Whatever is, is wrong.”

That doesn’t mean that things cannot be improved. An article in the journal Health Affairs entitled “A Plan To Reduce Emergency Room ‘Boarding’ of Psychiatric Patients” suggests that the following steps could be taken to address boarding:

- Quantify the problem;
- Improve care in emergency rooms;
- More efficiently use existing resources, including bed capacity and community services;
- Collaborate between emergency departments and community-based providers;
- Provide comprehensive community crisis services;
- Train law enforcement to manage mental health crises; and
- Provide continuity of care.\textsuperscript{xiii}

More efficiently use existing resources, including bed capacity and community services can be addressed by a real-time registry of psychiatric crisis services and beds.
The vast majority of the state psychiatric hospital bed closings occurred decades prior to the rise of boarding issues. Many of the beds that existed at the peak of state psychiatric hospital capacity were filled with patients who would not currently be served in an inpatient psychiatric hospital setting, such as patients with dementia.xiv

**History of On-Line Registries**

The need for an on-line registry collecting current bed availability by facility is a natural outgrowth of the need for emergency departments, clinicians, and first responders to find appropriate placements for patients. There are 16 states with active bed registries.xv Despite having a registry, states have found that finding a placement can still be time consuming, involving multiple calls. The need to find placements is not solely a problem for behavioral health. In Missouri and Tennessee, two of the states interviewed, their bed registry was an outgrowth of an existing registry for general acute care. At least two of the states—Missouri and New York—had registries that dated back to at least 2002.

**21st Century Cures Act**

In response to difficulties experienced by individuals and families experiencing mental health crisis in finding appropriate care, Congress included in the 21st Century Cures Act of December 2016, § 520f “Strengthening Community Crisis Response Systems,” grants to states, local government and Indian tribes “to enhance community-based crisis response systems” and for states “to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for adults with a serious mental illness, children with a serious emotional disturbance, or individuals with a substance use disorder.”xvii

**Registry Mechanics**

This section describes only the entities interviewed as research for this paper and not to all states or localities with psychiatric bed registries.

**Developing Registries**

State governments, county governments, and—in the cases of Wisconsin and Missouri state hospital associations initiated the development of bed registries in eight states. In Missouri, the registry originally focused solely on acute, non-mental health care. In five of the states, the state’s hospital association had a major role in the development of the registries, including developing and hosting the registries. In Virginia, the registry was initiated by legislation that was a response to a tragic incident involving a state legislator and his son. In Missouri and Tennessee, registries were extensions of existing registry systems focused on acute care.

**Cost to Build and Maintain**

Only four of the states were able to report on the costs to build and maintain their system. Their systems are not technically complicated and required manual updates by facilities.
The estimated costs ranged from 16 hours of work to $50,000. The annual costs to operate the registries ranged from $30,000 to $60,000. The registries were built by contractors and in-house staff. In two states, the state’s hospital association was paid to build and maintain the registry.

**Intended Users**

Most commonly, the emergency departments are the intended users of the registries (seven states), followed by behavioral health crisis response teams. In Georgia, the system is oriented around managing crisis services, of which identifying available inpatient beds is only one part. Community behavioral health providers are the intended users in five states. No states reported that police and other first responders or family members were the primary intended users, although, in Tennessee, the bed registry is publically available—the only state where the registry is publicly available.

In Georgia, police and first responders can access the registry second-hand by contacting the crisis service system. In Minnesota, the police have requested access to the system, but has been denied access by the hospital association out of concern that patients would be dropped off and the police would leave before the emergency department could assess the patient.

**Updating Bed Availability in a Registry**

In three of the states, facilities are required to update their records on the registry, although in Tennessee, it is only mandatory for state hospitals and not for private facilities. In Virginia, participation is mandatory but there has been little enforcement. In four other states, including in Maryland which no longer has an operating system, participation has been voluntary. In three states, updates are expected daily and in three other states they are expected to be made every eight hours. Only Georgia has real-time updating of their registry. For the rest, updating is done manually through a data entry screen.

A lack of participation has created problems with the timeliness and completeness of information in the registry, limiting the usefulness of the registry in four states, including Maryland. In Minnesota, which has a system that covers acute care as well as mental health, the acute care bed information is more up-to-date than the psychiatric bed information. Other states do not report problems with the accuracy of their registry.

**Information About Available Beds**

Most of the registries (seven) in entities responding to the survey record the age-appropriateness of available beds, and their gender-appropriateness (five). Legal status, forensic involvement, or commitment status is captured in less than half of the registries (four) in entities responding. Whether or not beds are in locked or unlocked units is captured in only three registries, although in some states all psychiatric beds are locked. Co-occurring mental health and substance use disorder suitability is captured in only three of the registries in responding entities and the types of insurance accepted by the facility is captured in only two registries. In some of the registries, facilities are able to add comments or notes allowing them to further describe the characteristics of their available beds.
The entities interviewed were also asked about children’s beds but none of them were doing anything specific to those beds that was different from what they were doing for adult beds.

**Facilities Participating**

Private psychiatric hospitals are covered by the registries in eight of the nine entities interviewed. State hospitals and general hospitals are covered in seven of the entities. Where the state hospital does not participate, operating at capacity and not needing to advertise for new patients was the reason given for nonparticipation. In Wisconsin County and private hospitals participate even though the state hospitals do not. Crisis beds are covered in only four states and the Veterans Administration and residential treatment centers only participate in two states. Crisis beds for substance use disorder are only covered in one state although, in Minnesota, the substance use disorder system has its own, separate bed registry. In Georgia, the registry is designed for identifying crisis beds and psychiatric inpatient beds the state has contracted for. Psychiatric beds not contracted by the state are not included in Georgia’s registry.

**Barriers to Successful Implementation**

Potential cherry picking by hospitals was the most cited issue that affected the usefulness of registries. In Indiana, the hospitals try to pick patients based on reimbursement rates. In Maryland, Sheppard Pratt’s inpatient facilities, around Baltimore, are seen as the default facilities since they will take all referrals and receive patients originating from remote parts of the state. Limited participation by facilities was the second-most cited barrier. Minnesota reported that the more participation oversight there was, the higher the level of participation. Missouri reported that only four to five of their 40 facilities update the registry regularly.

Respondents to the survey suggested the Maryland and Virginia registries were not user-friendly. Virginia scrapped its original design and created a new design, taking into account the concerns of its users. Georgia reported that their facilities regularly have occupancy rates of 85 to 90 percent and therefore have little financial disincentive not to accept a referral. If users have trouble using a registry or the registry does not make the search for a placement more efficient than blind-calling facilities because the information is either not reliable or incomplete, it will not be successful.

**Reports Generated from Bed Registries**

Many of the states interviewed used reports generated from their registry systems to track the most recent updates by inpatient facilities and or how often the facilities updated their records in the registry. Some states were able to report how long it takes for an individual to find an appropriate bed. Reports could also be used to track unsuccessful referrals.

Some states suggested that publishing and sharing reports on how frequently providers were updating their bed availability and the number of referrals they accepted could promote increased timeliness of reporting.
Experiences with Bed Registries

Georgia

The current system used by Georgia’s Department of Behavioral Health and Developmental Disabilities (DBHDD) isn’t exactly a bed registry in the traditional sense. Most registries are self-reported, point-in-time mechanisms where facilities report whether or not they have beds available for referrals. What DBHDD has instead created, in multiple iterations since 2012, is a live census of occupied and available beds used by their state-funded, state-wide crisis stabilization units. Their crisis telephone line, a system managed by BHL, uses the system to manage the referral process. Referrals are initiated through the system and facilities respond to the referrals and place accepted patients into virtual beds. The system tracks all occupied and available state-funded beds and also tracks information on patient acceptance and denial by facility.

Georgia’s system is only for managing their crisis beds. They have contracted with some psychiatric hospitals to care for individuals without Medicaid coverage. The state hospitals use the referral system, but not in the same way as the private facilities. There are about 25 to 26 crisis stabilization programs in Georgia.

When their crisis call line is called and it is determined that the patient should receive crisis stabilization services, the patient is placed in the referral system. The system knows the number of beds available at each location in each region. Various agencies review each patient’s case to determine whether or not they should be referred to a crisis stabilization bed. A local provider is notified that a referral has been requested. The provider looks at the information on the patient and, if appropriate, places that individual in a virtual bed on the system until that individual arrives at the facility. It is also possible to get into a crisis stabilization bed by means other than the referral system, such as by showing up as a direct admission.

DBHDD has a strong relationship with the police. The police also have access to the referral system and can link a patient to a bed or they can take the patient directly to an emergency room.

The referral system was rolled out in stages beginning in 2012 and expanded, region by region, through 2015 until all of the state’s crisis units were using the system to receive and manage referrals, and track the live census. The system was developed in conjunction with BHL, their crisis line vendor, during a time when the call volume was rising and the state needed a way to manage referrals without having to make calls to multiple facilities. At the time, they were also closing some of their state psychiatric hospitals and needed a way to manage their crisis stabilization system and to ensure that patients were referred to crisis stabilization units. Making the crisis stabilization system a first line of referral, they could lessen the need to use costly private psychiatric facilities to handle patient overflow.

The referral system is a live census of crisis stabilization beds, including crisis beds, for treating substance use disorders. It is not used for their state psychiatric hospital beds and only for private psychiatric beds that are contracted by the state as overflow beds. The referral system also does not cover general hospital psychiatric beds, except where the
state has a contract with the hospital, Veterans Administration beds, or residential treatment center beds for children.

Participation in the system is mandatory for the crisis stabilization units through their contracts with the state for units serving adults or children. Although the system covers crisis stabilization units for children, children are not served in either state psychiatric hospitals or private psychiatric hospitals, except for crisis services in private facilities. Typically, children have insurance so that the state of Georgia does not put them in either the state hospital or in the private contracted beds. The state has only five crisis stabilization units for children.

DBHDD does have a live census of individuals in private psychiatric beds whose care is funded by the state, but not a census of overall private psychiatric bed capacity. The system is live, in that it is updated automatically through the admissions and discharges to and from the actual beds through a manual process. The system is live in the sense that when a person is placed, the bed closes and when a person is discharged, the bed becomes available. Though it is live, it is not connected to any electronic health record system. When someone is placed in a bed, authorization for that service is sent to Georgia’s third party administrative services company.

The system captures beds by age group, gender, legal status, forensic involvement, and commitment status, locked or unlocked units, and co-occurring mental health and substance use disorder status. Individuals with legal involvement can be sent to a crisis stabilization unit to be evaluated. The system does not track insurance acceptances or in-network status for beds, although the overall crisis line system does keep this information and will refer patients accordingly.

The intended users of the referrals system request access by calling the state’s 1-800 crisis line. Police, emergency departments, and community providers all have to go through the crisis line. As noted previously, the crisis line does not just provide access to the crisis stabilization units but also to their behavioral health crisis centers, which have three components: walk-in observation, temporary observation, and the crisis stabilization beds. The average length of stay in the crisis stabilization beds is five to ten days. After ten days, the patient’s chart must go through an additional clinical review.

BHDD determines user access for the referral system. Some DBHDD staff can see activity for entire regions or the entire state. Crisis call line staff can see all facilities, down to the individual bed level. Providers have access to the information about their own facility and can manage their census and referrals.

Georgia tracks information on the people served by the beds, including diagnosis at discharge. Providers are given four hours to determine whether or not they will accept or reject a referral and they are required to say why they have made the decision. The system tracks how many people are waiting for a referral and how many beds are available. It can also see the responses of facilities with open beds to referrals and track their acceptance and denial rate and the time it takes a person to go from referral to acceptance. The occupancy rate for crisis stabilization beds in Georgia is 85 to 90 percent.
The cost to set up and operate the referral system was not available at the time of the interview, but it is included in the state’s ongoing contract with BHL. The software underlying the system is capable of being used by other states, with some customization.

**Maryland**

There are four free-standing, private institutions for mental disease (IMDs) in Maryland, including the Sheppard Pratt Health System, which has two inpatient facilities, both near Baltimore, with specialized units. The state’s public psychiatric hospital system mostly serves criminal court-ordered (“forensic”) patients. There are very few civil admissions to the state psychiatric hospitals.

For a variety of reasons, including patients presenting with conditions requiring specialized psychiatric services remaining in emergency departments for extended periods of time while they waited for an appropriate bed, Maryland was an early adopter of an electronic solution to the problem of matching patients with psychiatric inpatient beds. Maryland lacked appropriate community resources to either facilitate prompt discharges for individuals with special needs from inpatient settings or to manage individuals in crisis without emergency room intervention.

Maryland has worked hard to ensure EMTALA rules are enforced, whereby hospitals must admit patients based on capability and capacity and not insurance status. Maryland general hospitals are part of an all-payer waiver system, which has incentivized hospital-based care over community-based care for publicly funded (Medicaid and Medicare) care. The all-payer system has worked over all, but has hindered the development of crisis services that are not emergency room-based.

In November 2012, the Maryland Mental Hygiene Administration launched a psychiatric bed registry in cooperation with the Maryland Hospital Association and the Maryland Chapter of the American College of Emergency Physicians. The registry was for patients entering the emergency departments of the state’s private hospitals for voluntary or involuntary treatment and was designed to reduce the delays experienced in inpatient placement. The placement delays were, in part, due to the lack of ready visibility of the availability of inpatient beds in psychiatric hospitals.

The registry had two parts that were located on a secure internet tool that supported the Facility Resources Emergency Database (FRED) and the County Hospital Alert and Tracking System (CHATS). The two parts of the registry were the Psychiatric Bed Registry (PBR) and the Emergency Department Psychiatric Patient Information Matrix (EDPPIM). The PBR was designed to contain the numbers and types of available psychiatric inpatient beds by facility, with direct contact numbers to ease the identification of potential beds by emergency department staff. It was hoped that this would dramatically reduce the workload of emergency department and crisis service staff by obviating the need to blindly call around to psychiatric hospitals in search of available beds. The EDPPIM was a list of current patients in need of some form of inpatient psychiatric care and some of their particular service needs. The EDPPIM would allow psychiatric hospitals to see the current demand for their beds.

The state of Maryland was passionate about having a registry. It wanted to create greater transparency and simplify the process of matching patients to beds. The project was well-
intentioned, yet doomed from the outset because, while the impetus came from the state of Maryland, implementation was assigned to a work group at the Maryland Hospital Association. The work group members did not embrace the project from the beginning because they believed the system would create an EMTALA “gotcha” situation for them, where patients might appear to be assigned or reassigned based on diagnosis. The work group wanted very basic information that would categorize patients by gender and age and fought passionately against including diagnoses. Because some hospitals would not accept some patients, and so did not always want to be transparent about their capacity, the information captured by the registry was kept very general and vague. The IMD’s were more open to a registry, seeing it as a means to reach out to offer up their bed capacity, since they did not have an emergency room that patients could flow through. When the system was operating, people trying to make placements would consult the registry but, with the exception of Sheppard Pratt, the hospitals with inpatient units were not participating.

An additional complication was that the software platform underlying the registry was not particularly user-friendly. It was an adaptation of an existing trauma registry and was not specifically funded in the state budget. The last update of the registry, two to three years ago, was performed by Sheppard Pratt. For Sheppard Pratt, updating the registry required a full-time employee position.

Sheppard Pratt is seen as the default for inpatient placements in Maryland, admitting anyone referred to them. Emergency rooms will by-pass all other hospitals between them and Sheppard Pratt’s two locations. On average, there are 35 to 45 admissions and discharges a day at Sheppard Pratt. The situation is always fluid, and data can quickly become out of date.

Registries are sometimes seen as a quick fix to the problem of boarding and delays but, based on Maryland’s experience; they may not solve the problem. Even if there is physical capacity in the general hospitals, programmatic capacity may be lacking where a facility like Sheppard Pratt is relied on for tertiary psychiatric care for special populations. Another problem is that a hospital’s psychiatric departments may feel that the use of a registry causes it to lose control over its department and how its resources are used.

In addition, some of the wait times in hospitals are the result of decisions the hospital may make on patient flow. Trying to solve patient flow and to optimize the use of existing capacity is in part a behavioral problem and not solely a capacity problem. If a social worker at the hospital charged with assessments does not begin work till 10:30 a.m., patients may wait to be served until the social worker arrives, thus impeding patient flow. If a hospital accepts all cases, but waits to call for a referral or transport at one time for all patients, that impediment to patient flow is caused by the hospital. Hospitals may complain about boarding and delays in their emergency rooms, but some of the problem is within their control to alleviate.

**Minnesota**

Minnesota’s bed registry was developed in 2007 by the state hospital association, with crisis and residential beds added to the registry in 2011. Its development was triggered
neither by an incident nor an event, but rather as a part of their move to a more community-based system that includes community-based hospitals. In Minnesota, it is the county’s responsibility to provide access to crisis services. The registry allows users to limit the number of hospitals they need to call to make placements, but does not eliminate the need to make placement calls.

The Minnesota registry includes state psychiatric hospitals, including the children’s psychiatric hospital, and general hospital psychiatric beds, but not the state’s forensic hospital. The majority of the state’s psychiatric beds are in general hospitals. Crisis beds for mental illness are tracked in the registry but not crisis beds for substance use disorders, which are in a different registry system, called “Fast Tracker.” Residential treatment centers for adults are in the system, but because there is not a psychiatric hospital specifically for children, the availability of beds or services for children is not tracked.

The registry was not established by legislation. The state contracted with the state hospital association to build and manage a registry that would track bed availability. The registry cost $50,000 to build and costs $60,000 per year to maintain, all paid for by the state. In 2011, crisis and residential beds were added to the registry. Initial training on the system was conducted jointly by the state’s mental health agency and the hospital association. Other than the initial training and the training provided when the crisis and residential beds were added, there has not been an ongoing training program for new users.

Because participation in the registry is not mandatory, some providers are not updating their records frequently enough. However, there has been an increase in buy-in as the state’s hospital association, which manages the system, encourages its members to participate.

The intended users of the registry are hospitals, case managers, crisis social workers, and behavioral health providers. Hospitals and the other intended users have the same access to the registry, except that the hospitals can update their own bed availability. Law enforcement has asked to have access to the registry, but the hospitals have not agreed to allow them access, concerned that patients will be dropped off at emergency departments by law enforcement first responders who will then leave before the hospital triages the patient. Families and consumers also do not have access to the registry.

Age-group appropriateness and location are mandatory elements of records. Including gender, legal status, whether or not access to a bed or unit is locked, co-occurring mental health and substance use disorder status and insurance is not required, but some facilities may include that information voluntarily. Records are supposed to be updated every eight hours, but the state hopes they are at least updated daily. The state, can track when records have been updated, and updates actually range from within 18 minutes to within 74 hours, although the state has not calculated an average for length of time between updates. It hopes that users will notify facilities and contact the hospital association if a facility has not been updating its records or the information’s accuracy is in doubt.

Minnesota believes it is not realizing the full potential of the system and would like to make reporting required. They have found that usage increased when they were able to enforce participation. They receive weekly reports that show participation is 90 percent,
but do not feel they can rely on the accuracy of that data. There have not been complaints that the system is difficult to use.

The registry is not tied to EMTALA enforcement. The state’s commerce department and department of health have oversight for EMTALA. If the mental health agency receives an EMTALA complaint, the complaint is referred to those other agencies.

Minnesota is piloting a single phone system for mobile crises that tracks the location of the caller by using cell tower technology, but this is hampered by the fact that there are parts of the state that do not have cell phone coverage.

**Missouri**

Missouri’s development of a bed registry began in 2002. The state had received a Department of Homeland Security grant from the Assistant Secretary for Preparedness and Response (ASPR) to look at their surge capacity for emergency rooms in the event of a disaster. When the system was being developed, the hospital association surveyed hospitals to determine how many beds existed at each facility. In 2007, it was decided to expand the project from just emergency departments and general hospital beds to a registry of psychiatric beds, including government-funded beds in state and private hospitals. The registry has been a cooperative effort among the hospitals themselves through the state’s hospital association, which maintains the registry using software by IAN Resource that is used by other states to monitor emergency department surge capacity. Participation is voluntary, not mandatory.

The mental health portion of the registry covers beds in state psychiatric hospitals, private psychiatric hospitals, general hospitals with psychiatric beds, and Veterans Administration psychiatric beds. It does not cover residential treatment center beds for children, crisis beds for mental illness or substance use disorder, or residential beds for substance use disorder.

Emergency departments are the primary users of the registry. Psychiatric hospitals are also users. Community mental health providers have accounts in the system, but their level of usage is minimal. First responders, families and consumers, and behavioral health crisis teams are not participants. There are no restrictions on access to the registry.

The registry lists available beds by age- and gender-appropriateness and legal status. Co-occurring mental health and substance use disorder status is not specified, although that information can be included in the comments section. Insurance accepted is not recorded, nor is whether or not access to the unit or bed is locked or unlocked, because all inpatient psychiatric facilities in Missouri are locked.

Availability and other information are entered into the registry manually through a web-based application. Hospitals that have not updated their information in a timely manner receive an automatic request for an update. One of the conditions of the grant that funds the registry is that the information in the registry must be updated at least quarterly.

The registry updates are supposed to occur every shift, or every eight hours. Initially, there was an expectation that the registry would be updated as beds became available. However, participation has fallen off, in part because of the legal barrier posed by EMTALA. Approximately 80 percent of EMTALA complaints made to the Centers for
Medicare and Medicaid Services are related to transfers to psychiatric beds. If a bed is known to be available at a receiving hospital, the receiving hospital can make a dumping claim against the sending hospital.

In Missouri, there are about 40 hospitals with psychiatric beds but only four or five of them update their bed availability in the registry. As a result, emergency rooms have to call hospitals throughout the state to find available beds, which defeats the purpose of the registry. If a hospital, cherry-picking its patients, is restrictive in its admission process, it can take additional hours before a patient is cleared for transfer to that hospital.

The amount of boarding has increased as the registry has fallen into disuse, but the state is limited in how it can penalize non-participating hospitals. A separate state agency licenses hospitals. The state does not track information about individual placements, although it does get quarterly reports about overall hospital participation.

The opioid crisis is taking precedence in Missouri to making improvements to the psychiatric bed registry. The wait for substance use disorder treatment beds can take two to three months.

**New York**

New York has two bed registry systems, a legacy system (ABRS), that is being phased out, and a new system (HERDS), that soon will be implemented.

**ABRS**

The New York State Office of Mental Health (OMH) has operated a bed availability system, the ABRS, since before 2002. This internal system is currently in the process of being replaced by a new system which was to be operational by summer 2018. These tools, historic and new, will help locate beds and reduce the pressures that result from boarding.

ABRS is available to mental health providers, although it is not advertised to the public. ABRS contains information on the hospital, the populations served, current and projected bed availability, and when the information was last updated. The new system will use a different platform and will incorporate information already reported by hospitals to the state department of health, with expanded data collection.

Most counties have their own crisis response set-up which, informally, tracks local crisis beds. Substance use disorder beds are handled by the Office of Alcoholism and Substance Abuse Services, which maintains its own registry, and there is no current discussion of merging the two systems. As with other states, the availability of forensic beds in general hospitals is limited (New York’s forensic mental health system is largely state-operated, in State Psychiatric Centers). There is no formal system that tracks the placement of forensic patients in general hospitals.

**Health Emergency Response Data System (HERDS)**

This system developed and operated by Department of Health (DOH) does not require mandatory participation by other state agencies. However, DOH is considering regulations or legislative changes to require participation. DOH is building the ability to
run reports on facilities which have not updated their records and to notify these facilities of their oversight. New York State hospitals are under an obligation to evaluate all patients, regardless of bed availability.

This new system will add more specific information, such as how many unoccupied functional beds are available today, available appointments, and the gender-appropriateness of beds. It will also provide trending to assess changing need at a state, regional, and county level. Users will be able to search available beds by zip code. As with the legacy system, the new system will only cover hospital beds, including those in state psychiatric hospitals, private psychiatric hospitals, and general hospitals. It will not include crisis beds, substance use disorder beds, or forensic beds in general hospitals.

The intended users of HERDS are people in healthcare who are looking to place patients, including community behavioral health providers and emergency departments. It is not a publicly available system and is currently unavailable to police and other first responders. All users have the same access. Legal status is not included in the registry. They would like to make the system publicly available, theoretically, but believe that identifying publicly that a bed is available is not the best way to get appropriate services to an individual.

OMH does not view the registry as a way to capture EMTALA violations. They already do outreach with their hospitals, and are in regular communication with their state’s two major hospital associations.

**Tennessee**

Tennessee established its bed registry in July 2016 as an expansion of a registry for acute care beds that was established in 2007. The State Department of Mental Health and Substance Abuse Services worked with the Tennessee Department of Health (TDH) and the Tennessee Hospital Association (THA) to create a tool that providers could use when their emergency rooms were full or their crisis mitigation teams needed to find an inpatient bed. The registry was built and is maintained by the Department of Health.

The mental health part of the registry includes state, private and general hospital psychiatric beds, Veterans Administration psychiatric beds, crisis beds, and residential treatment center beds for children. It is estimated that it took about 16 hours of programming time to set up the registry. It costs about $60,000 each year to maintain the system, but that is a fixed cost for the entire system whether the mental health bed information is included or not. The software is open source and available to anyone. The small amount of funding needed for the registry comes from the TDH ASPR Hospital Preparedness Program cooperative agreement.

Community behavioral health providers, behavioral health crisis response teams, and emergency departments are the intended users of the registry although the registry is publicly available at:

The registry collects bed information by age-appropriateness, and co-occurring mental health and substance use disorder status. Bed information is not collected by gender-appropriateness, legal status, insurance coverage, or whether or not beds are in locked or
unlocked units. In Nashville, the crisis response teams have a whiteboard that has all the local facilities listed by the insurance they accept. The hospital insurance information would be helpful in the registry, but the state wishes not to promote insurance providers.

Participation in the registry is mandatory only for state hospitals. There are no penalties for not participating. A couple of psychiatric facilities have declined to participate because of concerns about the accuracy of the information in the registry related to facilities only advertising the availability of beds with more favorable reimbursement rates. Updates are requested to be made daily and must be made manually using a process that takes about 30 seconds. State-operated facilities are empowered to update every shift. Updates are expected to be made daily by 10:00 a.m. and the system is able to report updating compliance rates for selected periods.

The registry tracks the number of website hits per day for bed inquiries. The use of the registry peaks during the week and drops off on the weekends when the crisis centers are not operating. Information related to rates of successful placements is not available; however, the state says it would be open to innovative ways of capturing the rate of successful placement. The continued use of the application leads to an inference of positive outcomes.

THA sponsors regular meetings with the chief executive officers of the psychiatric facilities and believes that there is support for the registry, but the updating compliance rate for mental health beds in 2017 was 29 percent.

Based on Tennessee’s experience, States looking to create their own registry should involve stakeholders early in the planning process, as identifying incentives for participants that can be integrated throughout the system is key for participation. In Tennessee, the major incentives are moving patients out of the emergency rooms, providing a mechanism for law enforcement first responders to place patients, and helping facilities maintain high occupancy. All of the stakeholder groups in Tennessee are working collectively to make the system work.

**Virginia**

Virginia established its psychiatric bed registry (PBR) by legislative enactment in 2014 (see Appendix), although it had decided to create a registry a few years previously. The tragic events surrounding the November 2013 assault on State Senator Creigh Deeds by his adult son, who had been unable to get a bed in an inpatient psychiatric hospital and subsequently committed suicide, was the impetus for the establishment of the PBR. The PBR covers state and private hospital psychiatric beds and crisis stabilization beds for people experiencing a mental health crisis. Participation is mandatory.

The PBR’s intended users are Community Services Boards/Behavioral Health Authorities (CSBS), public and private inpatient psychiatric facilities, and public and private crisis stabilization units (CSUs). Users are divided into the categories of updaters and searchers. The updaters can update the number of vacant beds and search for available beds at other facilities. The searchers can only search for available beds, but cannot update the number of available beds at any facility. Central Office Administrators at the state Department of Behavioral Health and Developmental Services (DBHDS) have
access that allows them to monitor compliance with the updating timeframe requirements, enter data, and review use by end users.

The PBR contains information on beds by age group, gender, legal status (although not forensic involvement), and whether or not the beds are on a locked or open unit. Co-occurring mental health and substance use disorder is not officially in the system, but hospitals can indicate if they have detoxification beds. Accepted insurance plans are reported by some hospitals. Hospitals/CSUs can also indicate criteria for acceptance or exclusion with regards to intellectual and developmental disability, medical co-morbidities, and aggression.

By law, the PBR is to be updated in real time or if no change in bed availability has occurred at least daily. The program includes a prompt that searchers can use to indicate whether the bed availability information was accurate or not and, if an applicant for admission was denied, the reason given for denial.

A 2014 addition to the law requires that state mental health hospitals be the option of last resort. If a private hospital bed or CSU cannot be located for a person within eight hours of an Emergency Commitment Order (maximum timeframe for evaluation by a CSB), the person must go to a state mental health hospital. Since this legislative change was enacted, Temporary Detention Order admissions have decreased in private hospitals and increased in state mental health hospitals.

However, private hospital compliance in updating their available beds has also decreased. In order to address this concern, two features have been added to the PBR—automatically generated email reminding hospitals and CSUs of their obligation to update the PBR in real time or at least daily, and a compliance rating for each hospital/CSU that is available for all users to review.

DBHDS was made responsible under the law for developing, monitoring, and maintaining the PBR. Over time, they have contracted with two different companies to design and revise the PBR. The current contractor built the current program with an initial cost of $15,000. Subsequent revisions/additions have come at an additional cost. Some of those revisions/additions have been mentioned previously. Additional ones include:

- Permitting an individual bed search to be left open for another staff person to finish;
- Permitting a review of closed searches to be performed by clicking a search history button; and
- Permitting the saving of a completed search in which a person is placed at a hospital in Word, which can then either be printed for faxing or sent via encrypted email to any necessary party.

When staff from any agency opens the program it goes to their agency dashboard revealing the number of searches completed, the number of people placed, the number of calls made, and the facility’s current compliance rating (if a hospital or CSU).
Wisconsin

Wisconsin’s bed registry was created by the state’s legislature and came online in July 2016.

The idea for the registry began with the Healthcare Partnership, formed a dozen years ago by the local health system, the Federally Qualified Health Centers (FQHCs), a county-based psychiatric hospital, the state’s Department of Health Services. The group meets regularly, often with the Wisconsin Hospital Association, and one of their regular topics of discussion had been bed placement, with much of the discussion centered on trying to determine how many beds are needed and appropriate for Milwaukee County. The Partnership had no way to track, in real time, the ebbs and flows of their daily census and what bed availability existed.

The Partnership was interested in something more real-time than Minnesota’s voluntary, web-based system used by emergency rooms to track psychiatric inpatient beds in order to identify where to make calls for placements, and they also wanted to define an open bed. Defining an open bed proved difficult, and no agreement was reached because there are so many types and variables related to psychiatric beds.

When it was decided that a registry would be developed, the decision was made to implement it statewide rather than just in Milwaukee County, in part because the hospital association thought that it would be inexpensive to develop. The registry was developed for $50,000 and has cost $30,000 per year to operate. The system, which was modelled on the Minnesota model, has limitations but is real-time, although hospitals have to manually enter their data. The software that was developed can be used by other states; its low cost is one of the benefits of the system.

The hospital association was able to get buy-in by its hospital members, in part because it was seen as a private sector solution to the problem rather than a government solution. Participation is not mandatory for inpatient facilities. Private general hospitals have a higher participation rate than county psychiatric hospitals. The hospitals that are not participating have given lack of available staff time or having too few psychiatric beds as their reasons for not doing so. Having open beds to fill is an incentive for the hospitals to participate. If a hospital is full and does not feel the need to advertise beds to fill, they do not participate.

Updates to the registry are supposed to occur every eight hours, manually through an online data screen. If, after 24 hours, a hospital has not updated its records, an automated reminder is sent.

State officials note that the system is not intended to be a reservation system, in part because it is difficult to convey in a registry all the variables related to a psychiatric bed. They say that if that level of information was available, even though users would like it, it would be difficult to ensure that the information was fully accurate. For example, a hospital might have three open beds. Technically, the beds are available but the hospital is serving other patients who are very acutely ill and at that moment they don’t have the staffing capacity to take on additional patients. In that case, the beds are open but not practically available. An electronic registry cannot replace conversations between admitting physicians and emergency room doctors.
The registry includes private psychiatric hospitals, general hospitals with psychiatric beds, and county psychiatric hospitals. It does not include the state psychiatric hospital, Veterans Administration psychiatric beds, residential treatment center beds for children because they are not inpatient, or crisis beds not designated for either mental illness nor substance use disorder. Some, but not all, of the county psychiatric hospitals participate in the registry, although many county hospitals will only take residents of their own county. The Winnebago Mental Health Institute takes civil commitments that have not found another placement, but they have been over capacity for years and so do not participate in the registry.

Under the statute that established the registry (see Appendix),xix the intended users are those with admitting privileges, primarily to emergency departments. The emergency departments screen for medical issues that the psychiatric unit is not equipped handle. The legislature wanted patients to go to the emergency room first and did not want law enforcement first responders or crisis response teams to transport people to hospitals. Patients do not have to go to an emergency room to be admitted to a psychiatric inpatient bed, but they do need to be medically cleared. A crisis assessment has to happen in order for an emergency detention to be approved.

County crisis response teams do crisis assessments and help decide the level of care that a patient requires. Patients who go through an emergency room are often admitted to a bed even though they might better be served in another setting. Wisconsin feels the process it has established has prevented the boarding issues that other states have experienced, even though there are still long waits in emergency rooms before a placement is found.

The registry includes designations of age- and gender- appropriateness, whether insurance is accepted, whether units are locked or unlock, and the number of discharges pending. Legal status is not a registry field, but can be included in the comments section.

Here are links to the registry:


The Wisconsin Hospital Association says EMTALA does not really have implications for the Wisconsin registry since EMTALA focuses on emergency rooms and their registry focuses on inpatient beds. Nevertheless, the main users of the registry are the emergency rooms, which must perform an evaluation and, if the individual cannot be stabilized must transfer the individual to an appropriate facility, a transfer facilitated by the registry.

Based upon its experience, the Wisconsin Hospital Association suggests that registries be voluntary. It says that with mandatory systems, the focus can stray to nitpicking on compliance details, losing sight of the goals. The Association says making a registry mandatory does not make it more accurate, but it can create worries. It suggests that states start small and then grow, and make sure that stakeholders are involved to test the product on a small group before it is implemented statewide.
Behavioral Health Link

As noted previously, BHL is a private company that has operated Georgia’s crisis and access line for more than a decade and has been a model upon which crisis services in New Mexico, Colorado, and New York City have been based. The model uses an air traffic control model to manage a range of crisis services, including inpatient beds.

The system used by Georgia, for example, allows for the electronic scheduling of outpatient intake, mobile crisis teams that can be dispatched statewide, intensive service referral tracking, a real-time bed inventory, and a reporting system that allows for transparency and accountability. The tracking of average minutes to disposition allowed Georgia to reduce waits from 592 minutes to 166 minutes.

The idea behind the system is that people in crisis have access to a full array of services where the patient is. Patients seen by the crisis service system are assessed to determine their service needs, ranging from outpatient to inpatient care. If a patient presents at an emergency room, a crisis service team can screen the patient at the emergency room. This approach allows the state’s behavioral health system to manage the use of its inpatient capacity, including determining gaps and redundancies by analyzing historical data collected by the system. Ideally, this approach will allow a state to predict the volume of services needed and match those needs with services appropriate to the needs of patients. A crisis capacity calculator was developed by RI International, a company associated with BHL, which works with Maricopa County, Arizona’s crisis service system.

Conclusion

A bed registry, in its simplest form is just a tool for people searching for a placement for a patient that allows them to make placement in a more efficient manner than having to call every single facility in the area. Many of the states built their systems for under $100,000 and are able to maintain their system for under $100,000 year. If a system performs well, many hours of work can be saved annually and boarding and other treatment delays can be reduced. One cost that is important to note is the cost to facilities of keeping their records in the registry updated. Facilities are willing to support that cost if they feel that participating in the registry is to their benefit.

If a bed registry is part of a holistic approach to service needs, the system can provide a behavioral health system with a feedback mechanism that can inform decisions on staffing, crisis service needs, and bed needs. The fact that an inpatient facilities is at capacity does not necessarily mean that there are too few beds. It could mean that bed utilization is not being properly managed or that the overall behavioral health system is doing an inadequate job in providing crisis and community mental health services that can help to avoid inpatient stays. It could also mean that people who need a bed unnecessarily remain in that bed after they are ready for discharge. It can also mean that there are too few beds. The holistic, crisis service approach used by Georgia can collect enough information to provide a better answer to the question of adequate capacity.

A bed registry that doesn’t have buy-in from the providers of inpatient services is going to have difficulty in succeeding, even if participation is mandatory. However, if hospital administrators see the registry as a way to fill their beds in a way that is to their benefit, they are likely to work hard at making sure that the information they provide to the
registry is timely and accurate, and orient the services they provide to the types of patients they are interested in attracting. Several states built their registries in collaboration with their state’s hospital association.

EMTALA compliance may impact providers’ buy-in to a bed registry. In some states interviewed for this white paper, it was a big enough problem to hamper the system by making hospitals with psychiatric bed capacity reluctant to fully participate in keeping the registry updated. In other states, it was not a concern. Each state is different and state developing a registry should at least speak with its hospitals to determine whether or not EMTALA is a concern and, if so, how the system can be designed to alleviate that concern.

A bed registry has to make the process of finding placements easier than no system at all. Buy-in by users will be directly related to the system’s usefulness. An affordable, basic system may be all that is needed. A basic registry that reduces boarding and delays by making the search for bed placements easier should be counted as a success.

Greater ambitions come at greater cost but not necessarily at an unreasonable cost, especially if compared to the overall cost of a state’s mental health system. Connecting a registry to the electronic health record system of a hospital to provide real-time updates to the registry is not technically complicated, although obviously more complicated and expensive than building a manually updated on-line registry.

What can be difficult is determining what information to collect from hospitals, deciding on common definitions, and creating a mechanism to make improvements to systems based on feedback from users, providers, and patients. That requires hospitals with available psychiatric bed capacity accepting complete transparency in order to ensure full participation in a registry that is of value to both users and providers.
Appendix

Virginia Psychiatric Bed Registry Statute

Virginia Code § 37.2-308.1. Acute psychiatric bed registry.

A. The Department shall develop and administer a web-based acute psychiatric bed registry to collect, aggregate, and display information about available acute beds in public and private inpatient psychiatric facilities and public and private residential crisis stabilization units to facilitate the identification and designation of facilities for the temporary detention and treatment of individuals who meet the criteria for temporary detention pursuant to § 37.2-809.

B. The acute psychiatric bed registry created pursuant to subsection A shall:

1. Include descriptive information for every public and private inpatient psychiatric facility and every public and private residential crisis stabilization unit in the Commonwealth, including contact information for the facility or unit;

2. Provide real-time information about the number of beds available at each facility or unit and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow employees or designees of community services boards and employees of inpatient psychiatric facilities or public and private residential crisis stabilization units to identify appropriate facilities for detention and treatment of individuals who meet the criteria for temporary detention; and

3. Allow employees and designees of community services boards, employees of inpatient psychiatric facilities or public and private residential crisis stabilization units, and health care providers as defined in § 8.01-581.1 working in an emergency room of a hospital or clinic or other facility rendering emergency medical care to perform searches of the registry to identify available beds that are appropriate for the detention and treatment of individuals who meet the criteria for temporary detention.

C. Every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department shall participate in the acute psychiatric bed registry established pursuant to subsection A and shall designate such employees as may be necessary to submit information for inclusion in the acute psychiatric bed registry and serve as a point of contact for addressing requests for information related to data reported to the acute psychiatric bed registry.

D. Every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department shall update information included in the acute psychiatric bed registry whenever there is a change in bed availability for the facility, board, authority, or provider or, if no change in bed availability has occurred, at least daily.

E. The Commissioner may enter into a contract with a private entity for the development and administration of the acute psychiatric bed registry established pursuant to subsection A.
2015 WISCONSIN ACT 153

An Act to create 20.435 (2) (cm), 20.435 (4) (bk), 49.45 (29r), 49.45 (29u) and 51.045 of the statutes; relating to: behavioral health care coordination pilot projects, psychiatric consultation reimbursement pilot project, access to information on availability of inpatient psychiatric beds, and making appropriations.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

Section 1. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated: - See PDF for table

Section 2. 20.435 (2) (cm) of the statutes is created to read:

20.435 (2) (cm) Grant program; inpatient psychiatric beds. The amounts in the schedule to award a grant under s. 51.045.

Section 3. 20.435 (4) (bk) of the statutes is created to read:

20.435 (4) (bk) Mental health pilot projects. As a continuing appropriation, the amounts in the schedule to pay the state share of behavioral health care coordination pilot projects under s. 49.45 (29r) and the state share of a psychiatric consultation reimbursement pilot project under s. 49.45 (29u).

Section 4. 49.45 (29r) of the statutes is created to read:

49.45 (29r) Behavioral health care coordination pilot projects. (a) In this subsection, "health care provider" does not include a health maintenance organization.

(b) Subject to par. (c), the department shall develop and award at least 2 pilot projects lasting no more than 3 years each to test alternative, coordinated care delivery and Medical Assistance payment models designed to reduce costs of recipients of Medical Assistance under this subchapter who have significant or chronic mental illness. A health care provider that is awarded a pilot project shall target a Medical Assistance population of high volume or high intensity users of non-behavioral health medical services, such as individuals with more than 5 emergency department visits in a year or individuals who have frequent or longer than average inpatient hospital stays, who also have significant or chronic mental illness. The department may not limit eligibility for the pilot project or awards under this subsection on the basis that the health care provider that is awarded the pilot project serves a target population that includes individuals enrolled in a Medical Assistance health maintenance organization. Each pilot project under this subsection shall include either a Medical Assistance payment on a per member per month basis for a specified pilot project population that is in addition to existing payment for services provided under the Medical Assistance program, including services reimbursed on a fee-for-service basis and services provided under managed care, or shall include an alternative Medical Assistance payment for a specified pilot project. The department shall require health care providers that are awarded a pilot project to submit to the department interim and final reports analyzing differences in utilization of services and Medical Assistance expenditures between individuals in the pilot project population and individuals in a control group that is agreed upon by the health care provider awarded the pilot project and the department. A health care provider that is awarded a pilot project

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shall submit the interim report by January 1, 2017, and shall submit a final report by January 1, 2019, and at the conclusion of the pilot project if the project concludes later than January 1, 2019. The department shall provide to a health care provider that is awarded a pilot project the Medical Assistance utilization and expenditure data necessary for the health care provider to create the reports. The department shall award the pilot projects and allocate funding only to health care providers that meet all of the following criteria:

1. The health care provider provides all of the following services directly or through an affiliated entity:
   a. Emergency department services.
   b. Outpatient psychiatric services.
   c. Outpatient primary care services.
   d. Inpatient psychiatric services.
   e. General inpatient hospital services.
   f. Services of a care coordinator or navigator for each individual in the pilot project.

2. The health care provider provides, directly or through an affiliated entity or contracted entity, the coordination of social services fostering the individual's recovery following an inpatient psychiatric discharge.

(c) Subject to approval by the federal department of health and human services of any required waiver of federal Medicaid law or any required amendment to the state Medical Assistance plan, the department shall implement the pilot projects under par. (b) beginning no earlier than January 1, 2016.

(d) Subject to par. (c), the department shall allocate a total state share amount of $600,000 plus any federal matching moneys as funding for all 3-year pilot projects under this subsection. The department shall seek federal Medicaid moneys to match the state share allocated for the pilot projects under this subsection.

Section 5. 49.45 (29u) of the statutes is created to read:

49.45 (29u) Psychiatric consultation reimbursement pilot project. (a) In this subsection, "health care provider" does not include a health maintenance organization.

(b) Subject to par. (e), the department shall develop and award a pilot project lasting up to 3 years to test a new Medical Assistance payment model for adult recipients of Medical Assistance that is designed to encourage the provision of psychiatric consultations by psychiatrists to health care providers treating primary care issues and to selected specialty health care providers to help those providers manage and treat adults with mild to moderate mental illness and physical health needs. An applicant for the pilot project under this subsection shall submit a strategy to use the pilot project funding to improve mental health access in the applicant's service area and to reduce overall Medical Assistance costs. The department shall require the health care provider that is awarded the pilot project to submit to the department interim and final reports analyzing the differences in utilization of services and Medical Assistance expenditures between individuals in the pilot project population and individuals in a control group that is agreed
upon by the health care provider awarded the pilot project and the department. A health care provider that is awarded a pilot project shall submit the interim report by January 1, 2017, and shall submit a final report by January 1, 2019, and at the conclusion of the pilot project if the project concludes later than January 1, 2019. The department shall provide to a health care provider that is awarded a pilot project the Medical Assistance utilization and expenditure data necessary for the health care provider to create the reports.

(c) The department shall award a pilot project only to a health care provider that is an organization that provides outpatient psychiatric services and primary and specialty care outpatient services for physical health conditions. The department shall allocate funding to the health care provider that is awarded a pilot project or to individual psychiatrists providing care within the organization of the health care provider that is awarded a pilot project. The department shall allocate a total state share amount of $200,000 plus any federal matching moneys as funding for the 3-year pilot project under this subsection. The department shall seek federal Medicaid moneys to match the state share allocated for the pilot project under this subsection.

(d) The department may limit a pilot project awarded to a health care provider described under par. (c) to specific providers or clinics within the multispecialty outpatient clinic organization.

(e) Subject to approval by the federal department of health and human services of any required waiver of federal Medicaid law or any required amendment to the state Medical Assistance plan, the department shall implement the pilot project under par. (b) beginning no earlier than January 1, 2016.

Section 6. 51.045 of the statutes is created to read:

51.045 Availability of inpatient psychiatric beds. From the appropriation under s. 20.435 (2) (cm), the department shall award a grant in the amount of $80,000 in fiscal year 2015-16 and $30,000 in each fiscal year thereafter to the entity under contract under s. 153.05 (2m) (a) to develop and operate an Internet site and system to show the availability of inpatient psychiatric beds statewide. To receive the grant, the entity shall use a password protected Internet site to allow an inpatient psychiatric unit or hospital to enter all of the following information and to enable any hospital emergency department in the state to view all of the following information reported to the system:

(1) The number of available child, adolescent, adult, and geriatric inpatient psychiatric beds, as applicable, currently available at the hospital at the time of reporting by the hospital or unit.

(2) Any special information that the hospital or unit reports regarding the available beds under sub. (1).

(3) The date the hospital or unit reports the information under subs. (1) and (2).

(4) The location of the hospital or unit that is reporting.

(5) The contact information for admission coordination for the hospital or unit.

1 21st Century Cures Act: SEC. 520F. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.
(a) **IN GENERAL.**—The Secretary shall award competitive grants to—

“(1) State and local governments and Indian tribes and tribal organizations, to enhance community-based crisis response systems; or

“(2) States to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for adults with a serious mental illness, children with a serious emotional disturbance, or individuals with a substance use disorder.


[xvii] Ibid., §520F.

[xviii] Virginia Code § 37.2-308.1.