NEBRASKA

ABOUT THE BED REGISTRY PROJECT

To assist states in transforming their mental health systems of care, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI). Twenty-three states received funding of up to $150,000 to establish or expand comprehensive psychiatric crisis bed registry systems through a program administered by National Association of State Mental Health Program Directors (NASMHPD). This report highlights the work of one state. For the complete report on all 23 state bed registry projects, visit **https://www.nasmhpd.org/content/tti-2019-bed-registry-project-report**.

"Bed registries" refer to regularly updated web-based electronic databases of available beds in behavioral health settings. Beds for adults and/or children can include public and private psychiatric hospitals, psychiatric units in general hospitals, crisis stabilization units (short and long term), crisis respite centers, residential settings, social detox centers, and recovery homes.

Many states are seeking to improve their coordination of crisis services by making web-based bed registries accessible to front line crisis counselors in local behavioral health agencies, mobile crisis teams, crisis call centers, and hospital emergency departments.

The types of settings included in bed registries extend beyond public and private psychiatric hospitals. This broad use of bed registries aligns with a 2015 SAMHSA study in which state mental health authorities (SMHAs) reported bed shortages in psychiatric hospitals in their states.[1] These shortages have resulted in waiting lists for inpatient treatment, overcrowding, consumers hospitalized further distances from their homes, and greater reliance on hospital emergency departments. To address shortages, states have expanded the use of crisis services to divert individuals away from inpatient beds, increased the availability to private hospital beds, reduced demand by increasing community-based care (such as Assertive Community Treatment) and improving the speed and effectiveness of transitions from hospitals back to community care to reduce the overall census and prevent re-hospitalizations.

Ideally, access to an up-to-date database of available crisis beds help providers quickly find and secure treatment for clients in appropriate settings, reducing delays or extended stays in emergency departments.

SAMHSA's National Guidelines for Mental Health Crisis Care: A Best Practices Toolkit[2] identifies the three core elements needed to transform crisis services (**https://crisisnow.com/**) and recommends the use of bed registry technology to support efficient connections to needed resources. Several states are working towards instituting a comprehensive crisis system and consider bed registries as essential tools to coordinate care across services.

> ***"We engaged stakeholders from the start and invited them to help us select the bed registry vendor."***
>
> **—Curt Vincentini, Project Director**

NEBRASKA'S BED REGISTRY

Current approach and need for change:

Law enforcement officers in rural/frontier areas often spend hours transporting individuals in behavioral health crises under emergency protective orders to emergency rooms and inpatient units. In 2016, Nebraska's Division of Behavioral Health (DBH) documented the pervasiveness of the problem through a survey of law enforcement departments across 87 counties. DBH assigned Emergency Service Coordinators to each of six regions, as shown in the figure, for police to call directly to ask for help to reduce delays and resolve problems arising from behavioral health crises. Coordinators are empowered to work with hospitals to identify protocols and processes that delayed evaluation and treatment. Impediments were overcome and delays eliminated in five of the six regions — one hospital at a time. The remaining Region 6 is the smallest geographic area and includes the greater Omaha metropolitan area. With multiple providers to deliver crisis services and a larger population to serve, DBH recognized that a more sophisticated bed registry system was needed to coordinate care. Working together, DBH and Region 6 providers chose a bed registry system that they believed could reduce delays and emergency department boarding and that they would participate in. The initial roll out of the Region 6 bed registry was launched October 8, 2020. With a successful pilot, the bed registry may be expanded to other regions of the state and include other types beds, treatment, and support services.

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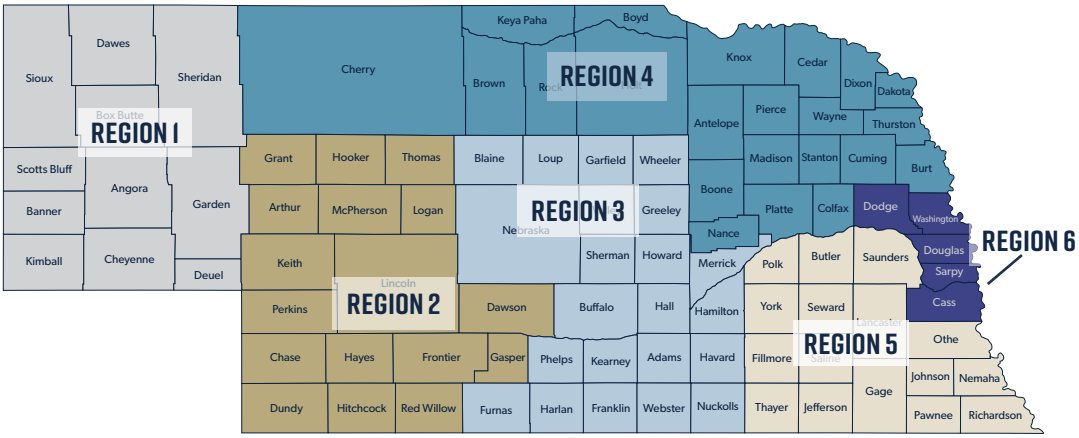

Map of Nebraska's Behavioral Health Regions

Type of bed registry: The Region 6 pilot project will be used as a referral system initially and expanded to a *referral network*[3].

Planning partners: Administrators of the hospitals in the region have established informal weekly meetings and daily updates on bed needs and availability in anticipation of an electronic registry. A workgroup including hospital administrators and representatives of emergency departments, acute psychiatric inpatient units, law enforcement, providers, county attorneys, and consumers continue to provide input into the implementation of the bed registry system.

Crisis system beds to be included in the registry: The registry will include a new psychiatric emergency services center (< 24 hour crisis stabilization unit), public and private psychiatric hospitals and psychiatric units in general hospitals in Region 6 and the adjoining vicinities of western Iowa that make up the greater Omaha metropolitan area. Later expansions will include crisis beds in other regions of the state, residential services, and outpatient treatment as well as housing, employment, and peer support.

Registry development vendor: The vendor is OpenBeds©.

Access to the registry: The registry will be accessible to behavioral health providers who are network members.

Refresh rate and entry process: A refresh rate has not been identified and data will be entered manually.

Meaningful metrics: The outcome measures below are collected by the state through contracts with hospitals to support inpatient treatment for Medicaid and indigent patients:

- Inpatient occupancy.
- Emergency department holding time.
- Incidents of denial to admission.
- Utilization and capacity for general and special care beds (examples of special care include beds designed to meet the needs of individuals with co-occurring disorders, histories of violence).

Impact of the COVID-19 pandemic on the bed registry: The time and attention of stakeholders were diverted during the pandemic period and unavailable for planning and training activities that were necessary to prepare for the project launch.

System oversight: The Administrator of System Transitions/ Disaster Behavioral Health Coordinator oversees the project and reports to the Director of the Division of Behavioral Health.

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[1] Substance Abuse and Mental Health Services Administration, Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015. HHS Pub. No. (SMA) SMA-17-5029. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

[2] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[3] Referral network websites provide regularly updated information on bed availability, support users to submit HIPAA compliant electronic referrals to secure a bed, and support referrals for behavioral health crisis and outpatient services to and from service providers who are members of the referral network.

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