



IMPROVING ACCESS TO BEHAVIORAL HEALTH CRISIS SERVICES WITH **ELECTRONIC BED REGISTRIES**

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SAMHSA's "National Guidelines for Behavioral Health Crisis Care — A Best Practice Toolkit," provides a framework to develop a "continuum of crisis care" designed to provide treatment to anyone, anytime, anywhere it is needed. This continuum of crisis care includes call centers, mobile crisis response teams, and community-based treatment settings. Having a bed registry of available options for treatment and supports in a variety of contexts — child, adult, suicide, crisis residential, detox — is a critical component of this continuum of crisis care. People having a mental health crisis should not be languishing in hospital emergency rooms for days or weeks, or end up being sent home without resolving the crisis because an available treatment setting couldn't be found. Rather than having care providers call around trying to find available services, an internet-based, bed registry, updated in real time, would allow for prompt, appropriate placement in a variety of settings. Bed registries take on an even greater urgency as we embark on the implementation of the universal mental health/suicide crisis line number 988, modelled after the 911 system. By July 2022, the 988 system will be in place to redirect callers experiencing a mental health or suicide crisis to the [National Suicide Prevention Lifeline](#). Real-time available bed registries can serve as the link between 988 and resources to help people in crisis. This year, SAMHSA's state mental health block grants directs 5% of funding to support the continuum of crisis care.

In FY 2019, SAMHSA, working with NASMHPD, awarded Transformation Transfer Initiative (TTI) projects to twenty-three (23) states 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 TTI is a SAMHSA program that assists states and territories through utilization of flexible, "tipping point" resources to behavioral health communities. The TTI initiatives have shown clear evidence of success through the years, as well as sustainable, positive impact on state behavioral health systems. The TTI supports efforts that work with the present reality of limited resources to show what can be accomplished to achieve important goals in more effective ways. Each of the initiatives embodies a spirit of expertise, resourcefulness, and innovation to address significant behavioral health needs that demand creative responses, unique to each state.

We are excited to help showcase the important work done by the twenty-three projects included in this Bed Registry Guide and proud to have partnered in their successful work. We encourage more state and local systems to use these blueprints to better the coordination of their crisis service systems.

Sincerely,

Anita Everett, MD, DFAPA
Director
Center for Mental Health Services
U.S. HHS SAMHSA

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INTRODUCTION

INTRODUCTION

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 (ED). Bed registries offer a promising technology to facilitate communication and care coordination of treatment and recovery support services for individuals experiencing a behavioral health crisis.

“Bed registries” are regularly updated, web-based electronic databases of available beds in behavioral health settings. Beds for adults and 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.

The types of settings included in bed registries extend beyond public and private psychiatric hospitals. As noted above, bed registries include alternate settings like crisis stabilization units to divert hospitalizations, as well as residential settings to support transitions from state hospitals. This broad use of bed registries aligns with a 2015 Substance Abuse and Mental Health Services Administration (SAMHSA) study in which state mental health authorities (SMHAs) reported bed shortages in psychiatric hospitals.¹ These shortages have resulted in wait lists for inpatient treatment, overcrowding, consumers hospitalizing consumers outside of their communities, and increasing 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 of private hospital beds, and 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.

Despite the growth of crisis call centers, mobile crisis teams, and crisis stabilization units to address behavioral health crises in states across the country, hospital

emergency department use continues to rise.² Commonly, when a person experiences a behavioral health crisis, they are transported to the nearest hospital emergency department for evaluation and treatment. If inpatient treatment is indicated and available, they are admitted. If a bed is not available, the emergency department must search, typically inquiring by phone, for an inpatient bed at a different hospital. This time and labor-consuming process has led to excessive “bed boarding,” where patients wait for hours and sometimes days in the emergency department (ED) to be admitted or transferred to the appropriate care setting. According to the Joint Commission, boarding increases “psychological stress on patients who may already be in depressed or psychotic states; delays mental health treatment that could mitigate the need for a mental health inpatient stay; consumes scarce ED resources; worsens ED crowding; delays treatment for other ED patients — some of whom may have life-threatening conditions; and has a significant financial impact on ED reimbursement.”³

Ideally, access to an up-to-date database of available beds helps providers quickly find and secure treatment for clients in appropriate settings, reducing delays or extended stays in EDs. Some bed registries have additional functionality that supports the electronic submission and receipt of referrals reducing communication difficulties or transmission impediments brought on by faxing.

*SAMHSA’s National Guidelines for Mental Health Crisis Care: A Best Practices Toolkit*⁴ identifies the three core elements needed to transform services, including regional crisis call centers, crisis mobile team response, and crisis

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 Nordstrom, K., Berlin, J. S., Nash, S. S., Shah, S. B., Schmelzer, N. A., & Worley, L. (2019). Boarding of Mentally Ill Patients in EDs: American Psychiatric Association Resource Document. *The Western Journal of Emergency Medicine*, 20(5), 690–695.

³ https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.pdf

⁴ Center for Mental Health Services, SAMHSA. 2020. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

FIGURE 1: Three Core Elements Needed to Transform Crisis Services



Regional Crisis
Call Centers



Crisis Mobile
Team Response



Crisis Receiving and
Stabilization Facilities

receiving and stabilization facilities. The Guidelines also recommend the use of bed registry technology to support efficient connections to needed resources (Figure 1 above; more details available at <https://crisisnow.com/>). Several states are working toward instituting a comprehensive crisis system and consider bed registries as essential tools to coordinate care across services.

A 2019 analysis by Mark, Howard, Misra, and Fuller⁵, conducted under contract to the Assistant Secretary for Planning and Evaluation (ASPE) found that 17 states had electronic bed monitoring and referral systems in 2019. Stakeholders interviewed from a sampling of states reported that these systems had a generally positive impact. The analysis outlines the limitations and challenges to establishing a bed registry that include monitoring bed availability updates to ensure timeliness and reliability; balancing patient referral information with urgency to determine if the setting will meet a particular patient's needs; training and supporting hospital staff unfamiliar with using the system; generating awareness of the bed registry; and recruiting hospitals to participate.

In a report on state efforts to develop bed registries⁶, National Association of State Mental Health Program Directors (NASMHPD) documented several reasons that hospitals were reluctant to participate in a bed registry. Survey respondents from seven states with bed registries cited hospital concerns, including the fear that they would lose control over which patients are admitted; that the bed registry could be used to monitor their compliance with the 1986 Emergency Medical Treatment and Labor Act⁷;

that the bed registry information would be inaccurate and therefore counterproductive; that data entry would take staff time away from clinical care; and that bed registries would create an unnecessary step to the admission process. Addressing these concerns is key. The report concluded, "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."

These challenges suggest that stakeholder support is crucial to the success of the bed registry and underscore the value of early engagement to build trusting partnerships. Referral sources depend on bed providers to update the registry with timely and correct information, bed providers expect referral sources to provide accurate patient information for placements, and both depend on state government to create a transparent and user-friendly system interface, monitor its use, and hold participants accountable.

The 21st Century Cures Act of 2016 authorizes SAMHSA to support states to develop a real-time database of



"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."

⁵ Bed Tracking Systems: Do They Help Address Challenges in Finding Available Inpatient Beds? Tami L. Mark, Ph.D., Jennifer N. Howard, Ph.D., Shilpi Misra, B.S., Laurel Fuller, M.P.H. Published Online: 19 Jun 2019. <https://doi.org/10.1176/appi.ps.201900079>

⁶ Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements. <https://www.nasmhpd.org/sites/default/files/TAC-Paper-2-NRI-RegistryPaper-508C.pdf>

⁷ In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>

beds, including inpatient beds, crisis stabilization, and residential community beds. Working with NASMHPD and NRI, SAMHSA Center for Mental Health Services (CMHS) convened a panel of experts in 2018 to learn from states that had developed bed registries. The panel represented key stakeholders of bed registries including state health departments, SMHAs, managed care organizations, hospital systems, crisis service providers, and individuals with lived experience and family members.

States that were successful in establishing bed registries shared several characteristics; chief among them were the early and frequent involvement of stakeholders in the planning process. Stakeholders were consulted on bed registry data to be collected, such as compliance rates and transparency. The most important characteristic was whether the bed registry system was useful to users. Systems with inaccurate and unreliable bed updates were not useful and, therefore, not used.

To assist states in transforming their mental health systems of care, SAMHSA's CMHS created the Transformation Transfer Initiative (TTI). The TTI provides, on a competitive basis, flexible funding awards to states, the District of Columbia, and the Territories to strengthen innovative programs. In the fall of 2018, 23 states applied and were approved by SAMHSA for funding to establish or expand comprehensive psychiatric crisis bed registry systems. Funding was distributed by the NASMHPD through contracts with each of the states for up to \$150,000.

NRI and NASMHPD have supported TTI state projects throughout their implementation and expansion efforts. As soon as SAMHSA approved the 23 state projects, NRI staff worked with those states to prepare a summary report regarding the goals and plans of each of the funded projects. NRI also worked with the 23 state projects to identify technical assistance needs. NRI used the information in this report to help plan a series of monthly technical assistance webinars for TTI state

projects and other interested states. The topics of the 2019 webinars were:

- **April:** NASMHPD's 2019 TTI Crisis Bed Registry Initiative
- **May:** Demonstration of A Crisis Bed Registry: Georgia
- **June:** Building Successful Partnerships to Establish and Expand Bed Registries
- **July:** Measuring the Operations and Outcomes of Crisis Bed Registries
- **August:** Crisis Now: Analyzing Outcomes & Business Case for Bypassing the Hospital ED
- **September:** The Emergency Medical Treatment and Labor Act (EMTALA) and Psychiatric Hospitals
- **October:** Demonstration of Bed Registries in Massachusetts and North Carolina
- **November:** State Experiences Getting and Using Information About Behavioral Health Clients in Emergency Departments
- **December:** ASPE Report on Crisis Bed Registries and Measuring Impact of Registries

NRI and NASMHPD staff were in regular contact with TTI state project directors to support their work including in-person and telephone discussions about their progress. These discussions provided the framework, along with questions about the impact of COVID-19 pandemic on the projects, for structured interviews that NRI conducted in June and July 2020 with project directors. The interviews were condensed into the state bed registry profiles in this report and reviewed by project directors for accuracy. The profiles are preceded by a summary, organized to help readers compare the purposes, organization, stakeholder participation, critical measures, and technical approaches that projects undertook to establish or expand state bed registries. Because states use different terms to refer to similar services, a glossary of bed types follows the project descriptions.

SUMMARY OF TTI STATE BED REGISTRY PROJECTS

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SAMHSA made available TTI grants of up to \$150,000 in October 2018 to states or territories for projects to establish and expand comprehensive, crisis psychiatric bed registry programs. State grantees could use the funds to track and monitor the availability of psychiatric beds and include other crisis service supports such as crisis assessment centers, crisis residential programs, respites, mobile crisis teams, and centralized crisis call centers. These flexible TTI funds could be used to identify, adopt, and strengthen transformative initiatives and activities implemented in the state, through either a new initiative or expansion of one already underway. The project had to focus on services for persons with serious mental illness and/or serious emotional disorders. Twenty-three states were awarded funds through a competitive process.

WHY ARE THE TTI STATE PROJECTS DEVELOPING BED REGISTRIES?

While the bed registries reflect a wide diversity in design, participation, and resources, they share the common purpose to advance behavioral health care. State projects consistently viewed bed registries as tools to expedite engagement of people in crisis into appropriate treatment for people in crisis and ultimately improve outcomes. Initiatives to build bed registries also grew from state policy imperatives, mandates from the executive or legislative branches of their states, or U.S. Department of Justice civil actions. Some states developed psychiatric bed registries to expand successful substance use disorder bed registries. Project directors regard registries as critical supports for crisis responders such as call centers and mobile crisis teams. Apart from their ability to support a comprehensive crisis system, state administrators view bed registries as a data repository on the day-to-day demand for and supply of behavioral resources. Bed registries provide stakeholders with a transparent view of the crisis system's flow: bed capacity, referrals, commitments, bottlenecks, placements, and denials of treatment.

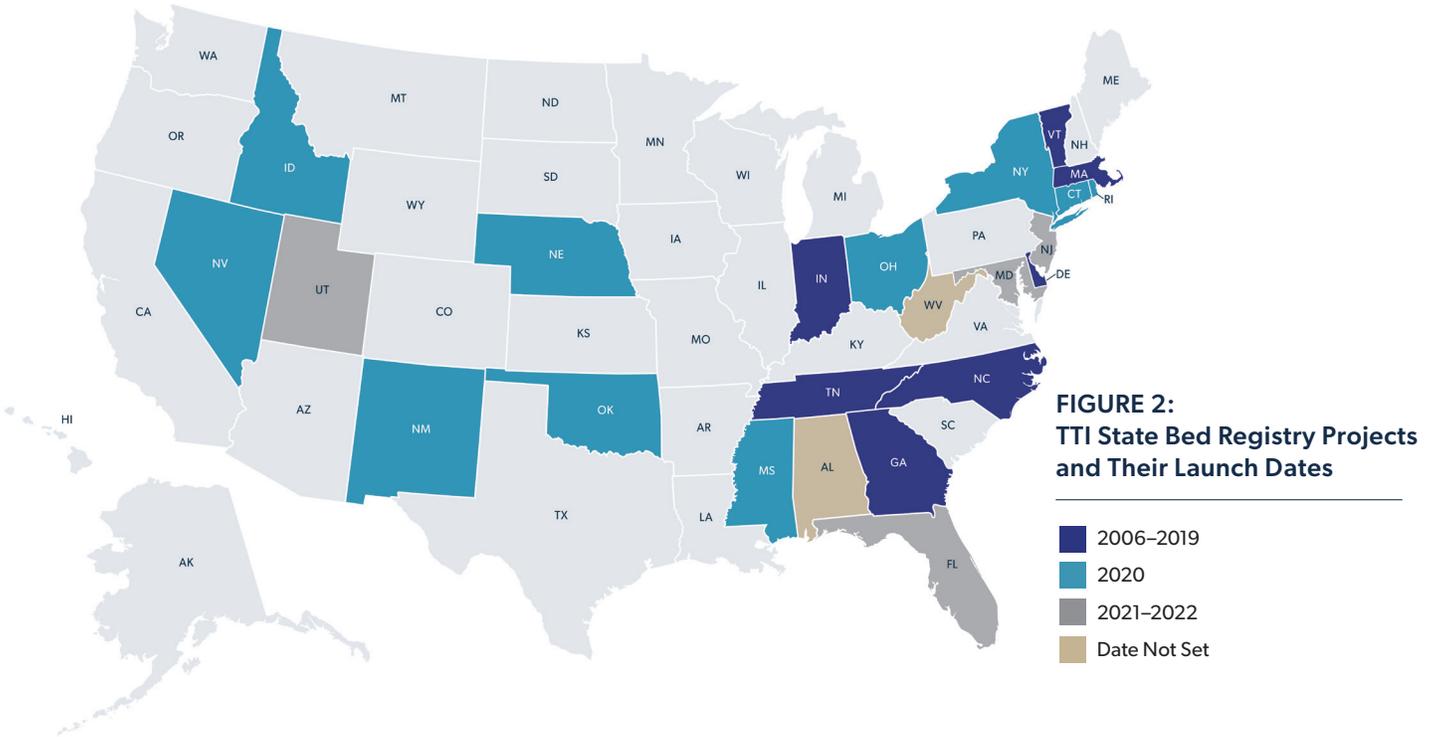
As depicted in Figure 2 on the following page, a few early adopters among the TTI states have had bed registries for many years and used TTI funding to improve their functionality and/or broaden participation. Most of the state projects were in the process of starting or planning to start a bed registry program when TTI funding was awarded. Four states with psychiatric bed registries already in place used funding to make improvements

in data collection, user interface, and/or expanding the listing of providers and services. Four states (DE, CT, IN, and NY) had already launched similar registry for substance use disorder treatment beds, and two states (AL and NJ) had registries of residential services. As noted later in this summary, many states have delayed the launch of their bed registries due to the COVID-19 pandemic.

HOW ARE TTI STATES ENGAGING STAKEHOLDERS IN PLANNING BED REGISTRIES?

As described in the introduction, engaging stakeholders, particularly hospitals, is vital to the success of the bed registry, and most state projects encourage stakeholder participation in its design and implementation. A few of the TTI projects (OH, NE, and MD) are piloting bed registries in regions of the states with strong stakeholder support.

As depicted in Figure 3, some states are engaging existing state advisory committees, such as Behavioral Health Planning Councils; establishing ad hoc advisory boards; or are engaging existing state provider associations. Other states seek broader input through focus groups or presentations at statewide conferences. Hospitals and their associations are the most common stakeholders engaged in planning, followed by local behavioral health authorities (that may also manage crisis stabilization units (CSUs) and mobile crisis teams), and consumer and family advocacy organizations. Some states sought input from mobile crisis teams and first responders for their "street-level view" of how the registry should



work. One state concluded that they would be unable to implement a bed registry system without involving their state’s managed care organization and integrating its network of pre-approved referrals. In some states, stakeholder input led projects to pause implementation of the registry to first align and organize crisis system resources. Even after bed registries are launched, projects continue to seek input from data entry staff, registry users, and hospital and agency administrators to discuss data accuracy, patient flow, and system fixes. States with long-standing bed registries have continued to maintain a positive relationship and seek input from stakeholders whenever a modification or change is considered.

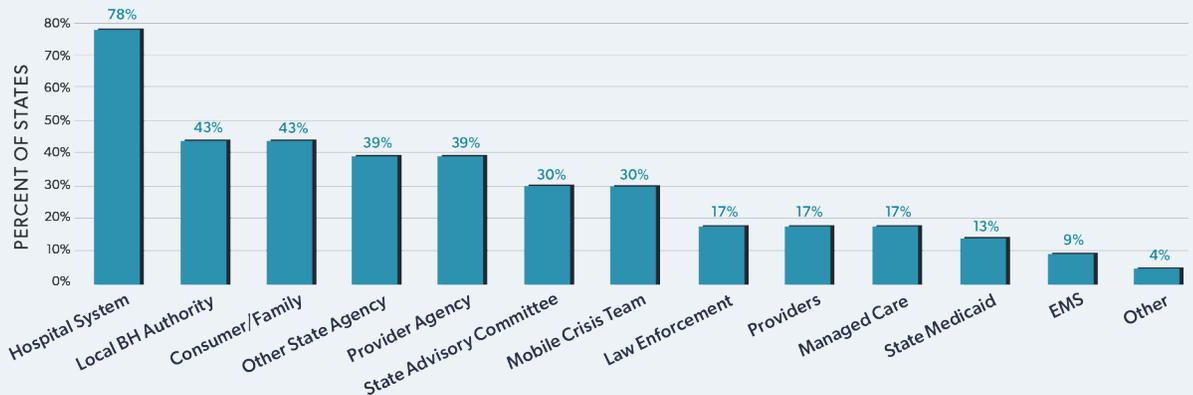
HOW ARE BED REGISTRIES ORGANIZED?

State projects either procure web-based platforms and software from independent vendors (14) or modify existing state-operated data platforms (8). One state project that is exploring bed registries has not determined the type of registry it will develop, nor has it selected a vendor.

Registries fall into one of three categories described below. In each category, inpatient and other crisis bed facilities update on bed availability one or more times per day to a website. Updates are typically time stamped and monitored by state authorities to ensure reliability.

FIGURE 3: Stakeholders Engaged in Planning Bed Registries

Percentage of TTI States Engaging Stakeholders (N=23)



Search Engines

Fourteen of the states (AL, CT, FL, ID, MD, MA, MS, NJ, NY, OK, RI, UT, VT, and WV) are implementing or expanding web-based search engines.

Users visit the website to view information on crisis bed facilities, their locations, services, availability, and contact information. Users call the facility or an intermediary, such as a call center, to request a bed.



Referral Systems

Three states (GA, NC, and TN) are implementing or expanding referral systems.

In addition to providing regularly updated information on bed availability, the websites support authorized users to submit HIPAA-compliant electronic referrals to secure a bed using preset forms and protocols. Once received, facilities respond electronically to referrals. The referral process and its disposition can be timed, documented, and monitored.



Referral Networks

Six states (DE, IN, NE, NV, NM, and OH) are implementing referral networks. The bed registry websites provide regularly updated information on bed availability, supports users to submit HIPAA-compliant electronic referrals



to secure a bed, *and* supports referrals for behavioral health crisis and outpatient services to and from service providers who are members of the referral network. As with referral systems, the process and disposition of referrals can be tracked.

WHO BUILDS AND MANAGES THE WEBSITE?

All six of the referral networks are using the same vendor to build and manage the bed registry websites. Two of the referral systems use different vendors, and one relies on in-house expertise to build and manage their websites. Seven of the search engines are built and managed by different vendors, and five are insourced. One of the search engines that updates bed availability automatically is a collaboration between insourced data systems and outsourced electronic health record systems.



“We built a system that balances the greatest degree of information with the fewest clicks and distractions.”

—Keith Goslant, Mental Health Analyst, Vermont DMH

FIGURE 4:
Types of Beds Listed By the Bed Registries

Types of beds listed by number of TTI states (N=23)

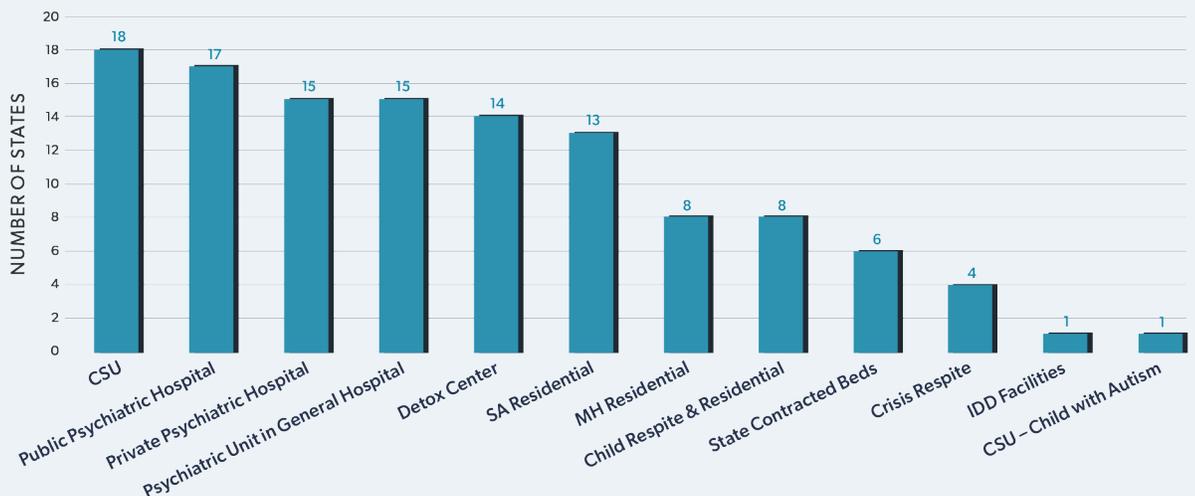
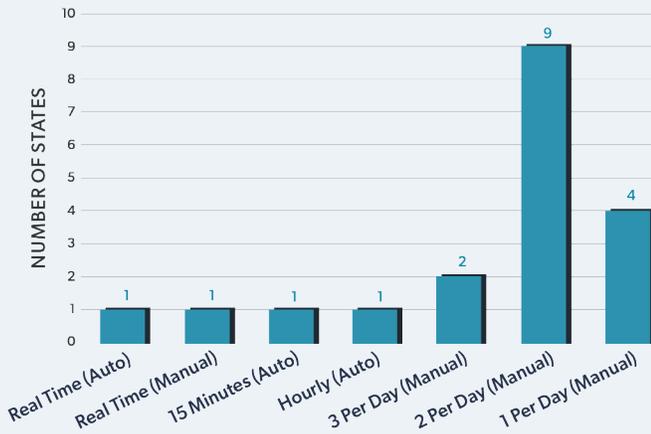


FIGURE 5: Frequency and Method of Bed Registry Data Updates

Refresh rate by number of TTI states (N=20)



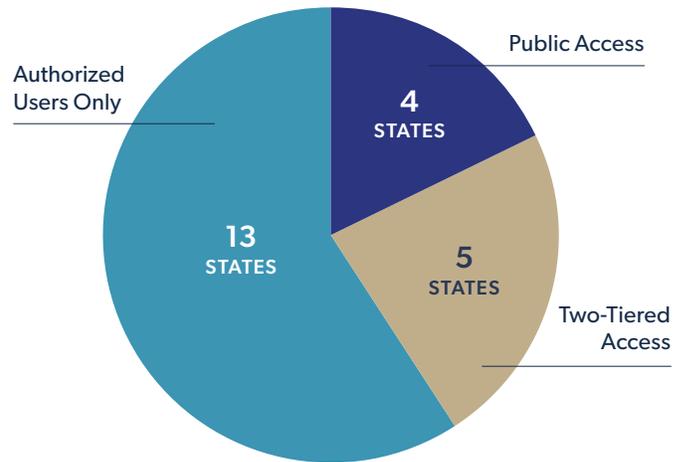
WHAT TYPES OF BEDS ARE INCLUDED IN BED REGISTRIES?

The types of beds that the state projects are including or planning to include in registries vary significantly. With 18 of 23 states, the most common types of bed listed in registries are CSUs (Figure 4). Public psychiatric hospital beds were slightly less likely to be included in the registries because access to them was limited or required multiple approvals in some states. As noted in the introduction, engaging private hospital systems in the registry has been challenging. Several states use Medicaid and other service contracts with hospital systems to leverage their participation in the registries. Some state systems have limited registry listings to resources that they control either directly or indirectly through contracts, including hospital beds. More than half of the states include substance use disorder (SUD) settings in a unified bed registry. States that have separate SUD bed registries are not included in this count. Eight state registries include beds for children and youth. About one-third of states use the registry to track community residential beds to support transitions from hospitals to the community, freeing up hospital beds for those who need them. Four states include crisis respite settings, and one state includes facilities for specialized populations.

HOW OFTEN ARE BED AVAILABILITY DATA REFRESHED?

Establishing the frequency of updates, particularly when data must be entered manually by facility staff, is a careful

FIGURE 6: Access to TTI State Bed Registries



balancing act for states (Figure 5). The data must be relevant enough for the registry to be used, but not updated so often that facility staff would be unable to meet the expectation. Most states find that balance by requesting data to be refreshed twice per day when staff changes shifts. Shift changes provide facilities adequate time to assess their capacity to anticipate openings, adjust for staffing shortages, or in the case of the COVID-19 pandemic, implement risk-reduction practices. Three states are implementing hybrid automated systems that bridge electronic health records (EHRs) of some providers with the bed registry platform. Bed providers whose EHRs are not compatible, enter data manually.

All state projects have monitoring systems in place to automatically notify the state and the bed provider when there is a lag or lapse in updating bed availability. Project directors typically take a problem-solving approach to address non-compliance and find this works well. One state project credited hiring a bed registry coordinator to problem solve and work directly with facility staff for improving overall compliance by 24%. Three state projects that have not implemented a bed registry had not determined a refresh rate.

WHO CAN ACCESS THE BED REGISTRY WEBSITES?

In four states, the public can access the bed registry. Public inquiries may be referred to an intermediary



Because registries collect bed-use data regularly, they can document the day-to-day impact of policy and resource allocation... When triangulated with other data sources, hospital boarding for example, state policy makers can begin to see when and where people are helped to stabilize their conditions or conversely, how treatment is delayed or denied.

service such as a call center, mobile crisis team, emergency department, or walk-in center to discuss the crisis and the best options for resolving it. The majority of state projects limit access to crisis service providers to help them find available beds. Five states have a two-tiered system with one portal for the public to view bed availability and a second portal accessible to authorized users to make and receive referrals. One state had not yet determined who will be able to access the bed registry (Figure 6).

Authorized use (Figure 7) is most often designated to crisis service providers including participating hospital systems, mobile crisis teams, emergency departments, and local behavioral health authorities. Some registries have

also established special relationships with entities that encounter individuals in crisis, including crisis call centers, jails, community emergency medical services (EMS), law enforcement, and specialized courts.

HOW WILL STATES KNOW THAT BED REGISTRIES MAKE A DIFFERENCE?

During the implementation phase, states are appropriately concerned with ensuring that bed registries provide regularly updated and accurate counts. States with active registries are monitoring compliance with bed count updates and taking steps to ensure the accuracy and reliability of the data (Figure 8).

Because registries collect bed-use data regularly, they can document the day-to-day impact of policy and resource allocation. Search engines collect daily metrics on capacity and utilization of various bed types (e.g., CSU and inpatient), and by geographic region. Referral systems and networks have the added benefit of collecting referrals (indicator of demand), as well as time and distance to obtain treatment. When triangulated with other data sources, hospital boarding for example, state policy makers can begin to see when and where people are helped to stabilize their conditions or, conversely, how treatment is delayed or denied.

Eight state bed registries measure the time it takes to arrange and get individuals into treatment. The most common measure is time from referral to placement.

FIGURE 7: Authorized Users of Restricted Bed Registries

Authorized users of restricted bed registries by number of states (N=18)

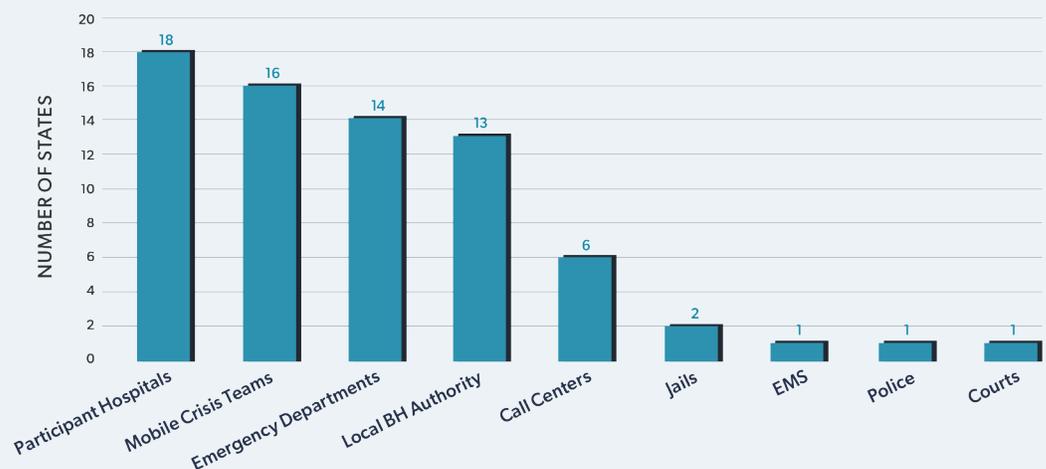
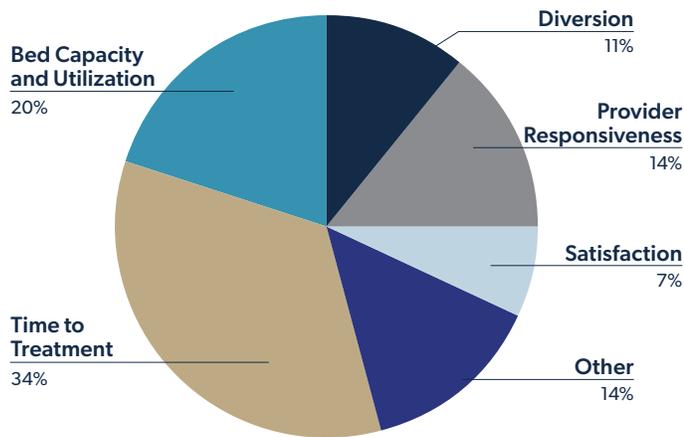


FIGURE 8: TTI States' Bed Registry Metrics



Nine of the state projects use bed registry data to measure bed capacity and utilization to monitor resources, promote their appropriate use, and inform budget and policy decisions.

Five states use bed registry data to measure the effectiveness of diversion policies and strategies to treat crises in the least-restrictive environment. Diversion from inpatient settings to CSUs was the most common measure used by three states, followed by diversion from state hospitals to local hospitals and CSUs used by two states.

Six state projects with referral and network systems measure how responsive providers are by capturing the number of referrals made, accepted, and declined, as well as the number of referred individuals that arrive for treatment.

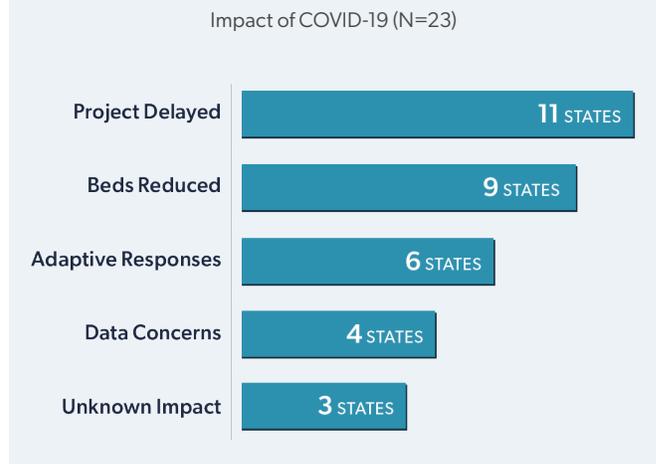
Three state projects plan to measure user satisfaction with the bed registry system through surveys or public comment.

Six state projects identified other measures of the effectiveness of bed registries, such as their impact on call center volume and whether they can help reduce the distance that patients travel to receive treatment. Four states that have not launched bed registries have not defined their impact metrics.

WHO OVERSEES THE BED REGISTRY?

Bed registry projects are overseen by state departments of behavioral health and managed by senior or mid-level

FIGURE 9: Impact of COVID-19 Pandemic on TTI Bed Registry Projects



department managers. Department leadership receive regular reports about the bed registry and/or data collected from it on a regular basis. Six of the project directors report directly to the SMHA director or deputy directors, and two SMHA Medical Directors oversee the projects.

WHAT IMPACT HAS THE COVID-19 PANDEMIC HAD ON BED REGISTRIES?

The COVID-19 pandemic has had, and may continue to have, a significant impact on bed registry projects (Figure 9). Implementation or expansion was delayed in many TTI states, and five projects that had not launched by March 2020 were delayed by six months or more. Delays are mainly due to the reassignment of project staff to assist states and providers deal with the pandemic. Inpatient and other bed providers have also been diverted from the project by the exigencies of the pandemic. In nine states, bed capacity was significantly decreased as CSUs and hospitals reduced double occupancy rooms to single occupancy rooms to promote physical distancing. In some cases, whole units were quarantined for weeks when a current patient tested positive for COVID-19. At the same time, demand often did not exceed availability as consumers and their loved ones avoided EDs and inpatient settings to reduce their exposure.

Four state projects reported concerns about the reliability of data as bed capacity frequently shifted to reduce risk

and/or isolate infections in settings. One state health department imposed an alternate emergency response reporting system on all hospital beds. To avoid the confusion and burden of entering data into two systems, the bed registry reporting requirements were suspended.

Six state projects reported adaptive changes resulting from the pandemic. Agencies and hospitals participating

in the registry communicated more frequently to address problems arising from the pandemic, and two state projects were able to use the bed registry system to rapidly announce capacity or procedural changes. One state project reported that bed providers became more vigilant about refreshing bed data as they recognized the value of the bed registry system in a time of crisis. Three state projects did not identify a COVID-19 pandemic impact on projects.

TTI STATE BED REGISTRY PROFILES

ALABAMA

Current Approach and Need for Change

Like many states, Alabama closed state hospitals and downsized the census from 4,000 in 2009 to 1,600 in 2017. Supporting the transition of state hospital patients to the community, the Alabama Department of Mental Health (ADMH) increased community residential and supportive housing services and established limited-stay crisis residential programs⁸ throughout the state. With a precipitous drop in the availability of state hospital beds, ADMH has also expanded services and systems to divert individuals in crisis from the state hospital to local services such as mobile crisis teams and local hospitals. A subcommittee of the Statewide Health Coordinating Council is currently developing a methodology to determine, by region and bed type, the number of inpatient beds needed. Key to that methodology is the identification and tracking of inpatient bed use. ADMH has woven these efforts, along with current plans to establish three new crisis centers and five rural mobile crisis teams, into developing an overall strategy to establish a statewide, coordinated crisis system. The system redesign, including recommendations for a bed registry, is expected to be completed in 2021.

Type of Bed Registry

ADMH is likely to create a *search engine* for hospital beds that resembles the Mental Illness Community Residential System (MICRS) already in use. MICRS is an electronic database that was launched in 2002 to track ADMH residential program beds that include community residential, supportive housing, and crisis residential programs statewide in real time (manually entered by residential staff at the time of admission and discharge) (Figure 10).

Planning Partners

In addition to the Statewide Health Coordinating Council, planning partners include the State Medicaid Agency, Department of Public Health, Alabama Hospital Association, Wings Across Alabama (statewide consumer organization), NAMI Alabama, the Administrative Office of the Courts, and two provider associations. ADMHA has also convened eight regional stakeholder focus groups for input and recommendations on a redesigned crisis system.

Crisis System Beds to Be Included in the Registry

Psychiatric hospitals and psychiatric units in general hospitals and crisis residential programs.

Registry Development Vendor

To be determined if the registry will be developed in-house or by a vendor.



“We are shifting our crisis system from reactive to coordinated.”

—Kim Hammack, Project Director (AL)

Access to the Registry

The website is likely to be restricted to mobile crisis teams, crisis centers, community mental health centers, crisis residential programs, crisis stabilization units, and participating psychiatric hospitals and psychiatric units in general hospitals.

Refresh Rate and Entry Process

A data refresh rate has not been determined.

Meaningful Metrics

Metrics have not been determined.

Impact of the COVID-19 Pandemic on the Bed Registry

Although no in-person meetings were held, development of the crisis system strategy continued.

System Oversight

Director of Mental Illness Community Programs for Mental Illness and Substance Abuse Services

Project Contact

Kim Hammack, Director, MI Community Programs, ADMH, at Kim.Hammack@mh.alabama.gov or 334-242-3209.

⁸ Crisis Residential Units provide time-limited (maximum stay of 180 days) crisis services within a residential setting that has no more than 16 beds. Services include crisis assessment, intervention services, and crisis stabilization, including referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community. These are Designated Mental Health Facilities (DMHF) that primarily serve individuals who are involved with the probate court and are typically connected to a civil commitment petition or ADMH probate commitment. This program often serves an ADMH civilly committed individual.

FIGURE 10: A Daily Summary of Alabama’s Crisis Residential Units By Region

Alabama Department of Mental Health - CMHC Stabilization Beds								
* Total of Reserved and Unreserved Vacancies								
Service	CMHC	Program Type	Program Name	Cap	Vac	Vol	Invol	
Region 1	Highland Health Systems	Crisis Residential	Crisis Stabilization Unit	16	2	2	12	
Region 1	Northwest Alabama CMHC	Crisis Residential	Crisis Residential Program	16	5	0	11	
Region 1	Wellstone	Crisis Residential	Crisis Stabilization Unit (Wellstar)	16	2	0	14	
Region 1	Wellstone	Crisis Residential	Reid House (Cullman)	16	1	0	15	
Region 1	Wellstone	Crisis Residential	Respite Crisis Center (CRC)	10	3	1	6	
Region 2	Indian Rivers CMHC	Crisis Residential	Crisis Unit	10	5	5	0	
Region 2	J.B.S. MH/MR Authority	Crisis Residential	Hillcrest Competency Restoration	16	2	0	14	
Region 3	East Alabama CMHC	Crisis Residential	Brief Intensive Treatment	11	1	10	0	
Region 3	East Central MH/MR Board	Crisis Residential	Spring Manor Crisis Residential	15	6	0	9	
Region 3	Montgomery Area Mental Health	Crisis Residential	Assessment Center	8	3	2	3	
Region 3	Montgomery Area Mental Health	Crisis Residential	Beth Manor Crisis Residential	16	2	4	10	
Region 3	Montgomery Area Mental Health	Crisis Residential	Crisis Residential Unit	16	8	3	5	
Region 4	AltaPointe	Crisis Residential	Adult Intermediate Care Program -	16	1	0	15	
Region 4	AltaPointe	Crisis Residential	Zeigler Adult Intermediate Care	16	6	4	6	
Region 4	South Central Alabama CMHC	Crisis Residential	Seravasa CRU	16	2	5	9	
Region 4	Spectracare	Crisis Residential	Middleton CRU	16	3	4	9	

CONNECTICUT

Current Approach and Need for Change

In response to frequent pleas from people with addictions and their families for help to find available treatment beds, the Department of Mental Health and Addiction Services (DMHAS), launched a search engine in November of 2017. The *Bed Availability* website was made accessible to the public to make transparent the openings in detox, residential treatment, recovery houses, and sober homes across the state (Figure 11). The website is well used and receives positive feedback from clients, families, providers, treatment advocates, and legislative leaders. Seeking to replicate this success, DMHAS, will launch a similar search engine for mental health settings. DMHAS sees this site as a way to increase communication across stakeholders, introduce more transparency in the utilization process, and educate stakeholders about the continuum of care available. It is expected that the site and its use will evolve over time.

Type of Bed Registry

The *search engine* launched in August 2020.

Planning Partners

A steering committee of approximately 20 representatives from Local Mental Health Authorities, a consumer organization, and state service coordinators advise the development of the site. The committee has expanded to include the DMHAS Forensics Division and an additional

Local Mental Health Authority, the CT Mental Health Center. The discussion and relationship building that occur in the steering committee have been pivotal to translating the informal protocols for use in a transparent bed registry tool. A soft launch for planning partners was held in early August with a final launch later in the month.

Crisis System Beds to Be Included in the Registry

The new mental health *Bed Availability* website lists 1,766 DMHAS-operated and funded mental health beds for adults across six types: inpatient, intensive residential, group homes, supervised apartment, transitional residential, and respite.

Registry Development Vendor

A private firm, ICAL Systems, designed and hosts the *Bed Availability* website platform for addiction treatment beds and will do the same for mental health beds.

Access to the Registry

The registry is accessible to the public at www.ctmentalhealthservices.com.



“We built the registry in response to people and their families asking us in desperation, ‘Where are the treatment beds?’”

—Julienne Giard, Project Director (CT)

Refresh Rate and Entry Process

Refresh rates will vary from daily to every seven days, depending upon the frequency of bed turnover as listed programs cover a wide array of temporary and long-term settings.

Meaningful Metrics

The University of Connecticut is developing an evaluation of the registry. DMHAS anticipates the evaluation to cover:

- Increased satisfaction of individuals seeking these services.
- Mental health system stakeholder satisfaction with the site.
- Increased utilization rates of all mental health beds.

Impact of the COVID-19 Pandemic on the Bed Registry

Although the bed registry has not launched, DMHAS has observed that flow from one setting to another has substantially slowed to reduce the risk of introducing opportunities for contagion.

System Oversight

The project director will continue to oversee the project and report results to the Deputy Commissioner of DMHAS.

Project Contact

Julienne Giard, LCSW, Director, Community Services Division, DMHAS, at Julienne.Giard@ct.gov or 860-418-6946.

DELAWARE

Current Approach and Need for Change

With the START (Substance Use Treatment and Recovery Transformation) Initiative, Delaware's Department of Health and Social Services (DHSS), Division of Substance Abuse and Mental Health (DSAMH) sought to increase access to care and treatment for individuals living with behavioral health disorders by fostering system-wide improvement based on a framework that measures client outcomes. One of the tools they use is the digital referral system called the Delaware Treatment and Referral Network (DTRN) to expedite treatment for patients in both outpatient and inpatient settings. Initially established in September 2018 to assist in referrals to addiction treatment, the program expanded in 2019 to include mental health care. With strong support from the leadership of the Division, the DTRN network of behavioral health services has grown to include 52 participating organizations that can make and receive electronic referrals for care. Referrals include non-behavioral health support services including health,

FIGURE 11: Screenshot of Connecticut's Bed Availability Website

Select Language Powered by Google Translate

dmhas Connecticut Department of Mental Health and Addiction Services
Addiction Services Bed Availability

[home](#) [about](#) [faq](#) [links](#)

Disclaimer: This website is for information only. Admission is not guaranteed even if availability is reported on this site. Call a program and complete their initial screening process for admission. Note: If a program shows no open beds, please call for waitlist options.

[Detox Programs](#) [Residential Treatment](#) [Recovery Houses](#) [Sober Houses](#)

Detox Programs	City	Phone	Open	As of
Medically managed detox				
CT Valley Hospital (CVH) - Blue Hills Hospital, Detox	Hartford	860-293-6400	1	7:28 am
CT Valley Hospital (CVH) - Merritt Hall, Detox	Middletown	800-828-3396 x5	1	7:09 am
Medically monitored detox				
Cornell Scott Hill Health Center - South Central Rehabilitation Center (SCRC), Detox	New Haven	203-503-3639	1	7:31 am
InterCommunity - Residential Detox	Hartford	860-569-5900 x515	0	7/24
MCCA - Residential Detox	Danbury	203-792-4515	0	7:46 am
Recovery Network of Programs (RNP) - First Step Detox	Bridgeport	203-416-1915	2	6:23 am
Rushford - Residential Detox	Middletown	877-577-3233	2	7:59 am
Southeastern Council on Alcoholism and Drug Dependence (SCADD) - Residential Detox	New London	860-447-1717	2	7/24

For questions or comments please contact DMHAS at 860-418-6946

<< **FIGURE 12: The Delaware Treatment and Recovery Network**

housing, and transportation. Delaware used federal resources to support the training of staff across provider agencies to fully utilize the system and employ best practices in making and accepting referrals.

Type of Bed Registry

DTRN is a password-protected *referral network*⁹. A second publicly accessible website *Treatment Connection* informs the public of available services.

Planning Partners

Planning partners include the executives of 52 provider agencies and DSAMH who meet regularly to oversee the START Initiative. Providers' staff, who make and accept referrals, have met regularly with DSAMH to discuss best practices and identify improvements with the DTRN system.

Crisis System Beds to Be Included in the Registry

The system supports referral to state and private psychiatric hospitals, psychiatric units in general hospitals detoxification facilities, crisis stabilization units (both 23-hour and multi-day programs), crisis respite beds, and residential beds. In addition to crisis beds, the system supports referrals to outpatient and support services.

Registry Development Vendor

OpenBeds[®] has a HIPAA-compliant, cloud-based platform that allows secure messaging and referrals.

Access to the Registry

DTRN is accessible to behavioral health providers and participating support agencies throughout the state, including select providers in surrounding states. The



“DTRN [the registry] has allowed us to do an inventory of the behavioral health services available across the state and the flow of care through the system.”

—Kris Fraser, Project Director (DE)

publicly accessible *Treatment Connection* can be accessed at <https://www.treatmentconnection.com>.

Refresh Rate and Entry Process

Provider agencies are encouraged to refresh at shift change (two times per day, if operating 24-hour facilities).

Meaningful Metrics

- “Close the Loop” — the percentage of organizations that report whether the client showed/no showed to an appointment.
- The number of clients who make it to their appointments.
- Whether the referring agency received a response within 30 minutes of receipt.
- For referrals that are declined, a reason must be provided over 90%.

Impact of the COVID-19 Pandemic on the Bed Registry

- Because DTRN has been in place for well over a year, COVID-19 and prevention efforts had little effect of refreshing data or on referral and acceptance processes.
- Hospital Emergency Departments met with Behavioral Health Inpatient facilities to find ways to reduce the number of patients awaiting placement in the emergency area to ensure that health system emergent beds stayed free for COVID patients. They agreed on workflow protocols that would accelerate the referral process even further.

System Oversight

The Secretary of Health and Social Services, the Division Director, and internal DSAMH leadership receive weekly reports on metrics. Provider specific reports are sent to participating Behavioral Health providers monthly.

Project Contacts

- Kris Fraser, MPH, Manager, Research, Evaluation and Population health, DHSS/SAMH, at Kris.Fraser@delaware.gov or 302-255-9478.
- Sean Miller, Deputy Chief of Health Informatics, DHSS/SAMH, at Sean.Miller@delaware.gov or 302-255-9407.
- Lisa Johnson, Principal, HEALTHe Insights, at Lisa@healtheinsightsconsulting.com or 302-893-8954.

⁹Referral 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.

FLORIDA

Current Approach and Need for Change

The delivery of behavioral health care in Florida is coordinated through seven regional managing entities (RMEs) under contracts with the state. Services are tailored to the specific needs in the various regions and those seeking help are directed to the RMEs for assistance. The state legislature enacted F.S.394.082 directing the Florida Department of Children and Families (DCF) to establish a database of daily use of state behavioral health services and resources and particularly crisis and hospital beds. Although local behavioral health providers send daily utilization reports to the RMEs, the state receives the daily numbers at the end of the month. Figure 13 shows the aggregated use of beds contracted by the state. As DCF works to improve the accuracy and reliability of the bed reports that it receives, it is simultaneously moving towards reducing the reporting time from one month to one day with the eventual aim of creating a bed registry search engine that providers will update directly.

Type of Bed Registry

The type of bed registry envisioned is a *search engine* to be launched in 2022.

Planning Partners

The critical partners in the development of a daily reporting system are the providers and RMEs who collect and report data.

Crisis System Beds to Be Included in the Registry

The bed registry would include the wide array of beds that RMEs currently report addressing both mental health and substance abuse needs: crisis stabilization; detoxification centers, and addiction-receiving facilities (ARFs), inpatient state-contract beds, state psychiatric hospital beds, residential treatment beds, and short-term residential settings.

Registry Development Vendor

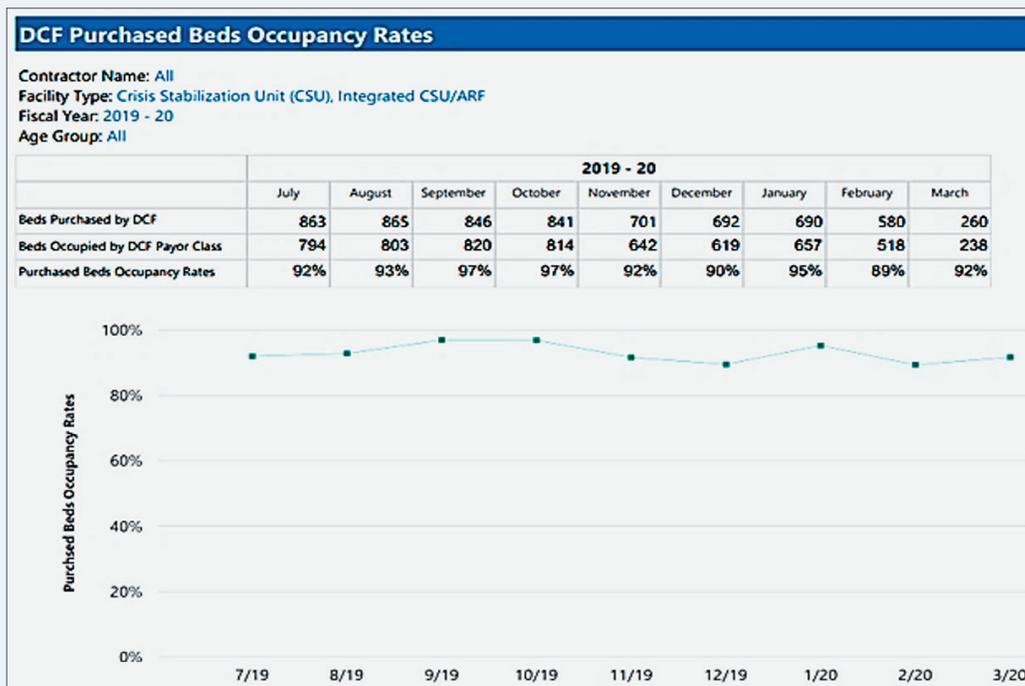
FEI is the DCF’s electronic health records vendor and has participated in meetings with providers, RMEs and FSC



“We know that we will need all of the stakeholders to commit to the creation of the bed registry and how it will be utilized.”

—Greg Nix, Project Director (FL)

FIGURE 13: Utilization of CSUs Across Florida



to coordinate efforts. The bed registry is expected to be added by the state to its current report dashboard (<https://myflfamilies.com/service-programs/samh/dashboard/>).

Access to the Registry

The publicly accessible website, <https://myflfamilies.com/service-programs/samh/dashboard/> (pending), will allow users to search for a service in a geographic area.

Refresh Rate and Entry Process

As envisioned, facilities would update bed registry data at shift change, 2–3 times per day.

Meaningful Metrics

Use of state-funded services.

Impact of the COVID-19 Pandemic on the Bed Registry

Provider's awareness of their interdependence was heightened in response to the pandemic and underscored the need for mechanisms to locate treatment resources more efficiently.

System Oversight

Florida Department of Children and Families' Office of Substance Abuse and Mental Health, Quality Assurance is providing oversight.

Project Contact

Greg Nix, MSW, LEAD, Substance Abuse and Mental Health Quality Assurance Business Analyst, Florida Department of Children and Families, at Gregory.Nix@myflfamilies.com or 850-717-4138.

GEORGIA

Current Approach and Need for Change

Georgia first established a central crisis call line in 2006 and a bed registry in 2012 to better respond to behavioral health crises and manage its resources. The Georgia Crisis and Access Line (GCAL) is a central statewide number for consumers, families, and first responders to call for help in a behavioral health crisis. GCAL-certified staff logged 250,000 calls in 2019 and resolved the callers' crises over the phone, scheduling 24/7 urgent outpatient care in a

clinic close to the caller, dispatching mobile crisis teams to conduct a face-to-face assessment and determine treatment needs (15,000 dispatches), or facilitating placement in 1 of 580 treatment beds (nearly 3,500 placements were facilitated). A real-time, web-based registry "referral board" is currently in place to assign state-controlled resources. TTI funds have been used to improve the current interface for more streamlined use and data collection, make enhancements that will electronically screen medical clearance guidelines, and develop systems for better partnerships with local emergency departments. With many years of developing an integrated system, Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) has combined the core components of SAMHSA's National Guidelines for Behavioral Health Crisis Care regional crisis call center, crisis mobile team response, and crisis receiving and stabilization facilities into its behavioral health system.

Type of Bed Registry

The *referral system*¹⁰ is integrated with the GCAL referral system. Authorized referral sources complete a pre-admission referral form (PARF) that includes all the information required for admission and posted to the board (Figure 14). Receiving facilities are automatically notified of the referral. GCAL staff track the referral process to ensure the swiftest possible admission.

Planning Partners

Partners include mobile crisis teams, the registry development vendor, the state hospital association, community service boards, the Georgia Sheriff's Association, and the Administrative Services Organization (ASO) that manages authorizations and utilization management for the crisis continuum of services.

Crisis System Beds to Be Included in the Registry

This referral system is fully integrated into the GCAL network of services. The system lists DBHDD-operated or -funded crisis beds for adults and children who are medically indigent or Medicaid eligible. The Bed Board reports on availability in 26 crisis stabilization units, 17 contracted inpatient beds in private psychiatric hospitals and psychiatric units in general hospitals, and in 4 large state hospitals. One 10-bed crisis unit addresses the special needs of children with autism. State-operated

¹⁰ Referral system websites track bed availability and support authorized users to submit HIPAA-compliant electronic referrals to secure a bed using preset forms and protocols. Once received, facilities respond electronically to referrals.

FIGURE 14: Referrals Posted in Georgia with Names Removed

BHL Behavioral Health Link
HOSPITAL PORTAL

PENDING STATUS Return To Menu

Menu

- Pending (91)
- Completed (1543)
- Rejected (9)
- New PARF

Refine Search

Start Date: 5/23/2020

End Date: 6/22/2020

Region: Region 1, Region 2

Show 10 entries

Individual Name	Created Date/Time	Referring Facility Name	Action
	6/4/2020 6:16:19 AM	Hutcherson Medical Center	[Edit] [Delete] [Check] [Print]
	6/22/2020 1:36:54 PM	Memorial Health University Medical	[Edit] [Delete] [Check] [Print]
	6/22/2020 12:59:23 PM	Carleville Medical Center	[Edit] [Delete] [Check] [Print]
	6/22/2020 12:43:25 AM	Spalding Regional Medical Center	[Edit] [Delete] [Check] [Print]
	6/22/2020 9:21:47 AM	Henry Medical Center	[Edit] [Delete] [Check] [Print]
	6/22/2020 7:28:29 AM	Northside Hospital Fulton	[Edit] [Delete] [Check] [Print]
	6/22/2020 1:10:00 AM	North Fulton Regional Hospital	[Edit] [Delete] [Check] [Print]
	6/21/2020 7:15:31 AM	Coffee Regional Medical Center	[Edit] [Delete] [Check] [Print]
	6/21/2020 2:19:10 AM	Memorial Health University Medical	[Edit] [Delete] [Check] [Print]
	6/20/2020 10:20:39 PM	East Georgia Regional Medical	[Edit] [Delete] [Check] [Print]

Showing 1 to 10 of 91 entries

Previous 1 2 3 4 5 ... 10 Next

detoxification facilities and substance use residential settings have recently been added. Private facilities in which bed stays are reimbursed through private insurance or direct pay are overseen by a different department in the state.

Registry Development Vendor

Behavioral Health Link developed and hosts the platform and provides system data used by the Georgia Collaborative ASO (Beacon Health Options) to establish performance metrics.

Access to the Registry

Access to bed registry is limited to GCAL call-center clinicians, walk-in crisis centers, emergency department staff, jail staff, and mobile crisis team staff refer individuals whose crises require a bed in a receiving facility.

Refresh Rate and Entry Process

Facilities with state-controlled or -operated beds manually enter bed availability data in real time as admissions and discharges occur. The ASO and DBHDD monitor bed occupancy, length of stay, and other performance metrics to ensure compliance with this requirement.

Meaningful Metrics

With many years of data, DBHDD has established benchmarks (in parentheses below) to monitor performance using the following metrics:

- Occupancy rate of crisis stabilization units (90% required).

- Denial rate (no more than 10%).
- Length of stay (average of seven calendar days or less).
- Diversion rate (percent of individuals who present to walk-in centers or temporary observation units and are treated in fewer than 24 hours and no longer require inpatient admission to a crisis unit or hospital).

Impact of the COVID-19 Pandemic on the Bed Registry

- During March and April, demand was reduced by more than half as consumers and their families avoided hospital emergency departments and leaving home. As hospitals began resuming non-emergency activities in May, demand began to climb. In June, demand has exceeded pre-pandemic levels.
- Although mobile crisis dispatches did not grow during the pandemic, telehealth contacts with providers did.
- Crisis capacity in DBHDD-operated or -funded crisis beds was decreased by as much as one third (580 to 400) as settings took measures such as reducing



“Transparency is a big plus of the program. We can see the crisis system statewide, and this helps us know where we need to make changes.”

—Debbie Atkins, Project Director (GA)

FIGURE 15: A Training Example of a User’s View in Idaho

Psychiatric Hospital	Avail Adult Psych Bed	Female Adult Psych	Male Adult Psych	Adolescent Psych	Child/Ado Inpatient Psych	Male Geri Psych	Female Geri Psych	Comment
Bingham Memorial: Gero-Psych Unit								
Intermountain Hospital								
Lifeways Hospital Boise								
Summary								
Crisis Centers	Crisis Seats	Female Adult Psych	Male Adult Psych	Comment				
BH Crisis Center of East ID								
Rural Crisis Center Ntwrk R2- Clearwater								
Rural Crisis Center Ntwrk R2- Latah								
Rural Crisis Center Ntwrk R2- Nez Perce								
South East Idaho BH Crisis Center								
Western Idaho Community Crisis Center								
Summary								

occupancy to reduce the risk of infection. In some cases, entire facilities either closed temporarily to disinfect or refused new admissions when a patient tested positive for COVID-19.

- The bed board made it convenient for crisis system stakeholders to receive critical and time-sensitive announcements about admission policies and changes to the availability of beds so that delays in finding beds could be avoided.

System Oversight

Oversight is conducted by the DBHDD Director of Crisis Coordination in tandem with the Director of ASO Coordination.

Project Contacts

- Jill Mays, MS, LPC, Director, Office of Behavioral Health Prevention and Federal Grants, Georgia DBHDD, at Jill.Mays@dbhdd.ga.gov or 404-657-5681.
- Debbie Atkins, LPC, Director of Crisis Coordination, Georgia DBHDD, at Debbie.Atkins@dbhdd.ga.gov or 706-728-5573.

IDAHO

Current Approach and Need for Change

State-funded mental health treatment has been provided by seven community-based regional behavioral health centers serving all 44 counties in the state. In 2018, nearly three quarters (74%) of adults served by regional behavioral health centers received crisis services. As a result of Medicaid



“Data from the bed registry will inform our statewide strategic crisis response plan.”

—Seth Schreiber, Project Director (ID)

coverage expansion, which began on January 1, 2020, the Division of Behavioral Health (DBH) expects that there will be far fewer medically indigent consumers dependent upon state-provided outpatient services and will be able to shift resources to improving a fragmented crisis response system. Following an environmental scan of crisis services across the state, DBH launched the Idaho Psychiatric Bed and Seat Registry (IPBSR) in January 2020 to support the coordination of crisis call centers, mobile crisis teams, crisis stabilization centers (expanded from 2 to 7 in the 2019), crisis respite, and inpatient beds across the state. Staff are continuing to reach out to stakeholders across the state to seek their input on how a redesigned crisis system can best support community needs and how the registry can make that easier.

Type of Bed Registry

IPBSR is a *search engine*. An example of the interface is included in Figure 15.

Planning Partners

Before launching the IPBSR, DBH sought input from hospitals through state public health district liaisons,

spoke at meetings of emergency medical services, police, hospital administrators, tribal health administrators, and psychiatric unit charge nurses. The bed registry is a regular agenda item of the statewide Crisis Cross-Functional Team (meeting regularly to implement improvements to the crisis system).

Crisis System Beds to Be Included in the Registry

The registry includes beds in psychiatric units in general hospitals, psychiatric hospitals, and seats (< 24-hour stay) in crisis stabilization units (CSUs). Some private hospitals and slightly less than half of crisis centers participated in initial IPBSR launch.

Registry Development Vendor

IPBSR is hosted by Idaho's existing emergency preparedness "surge" website *EMResource*, developed and operated by Juvare.

Access to the Registry

Access is limited to emergency room staff, participating inpatient units, police and EMS, and mobile crisis teams have access.

Refresh Rate and Entry Process

Crisis centers and hospitals with regular turnover rates update the registry twice per day at shift change. All sites are expected to refresh bed availability at least once per day.

Meaningful Metrics

DBH is monitoring IPBSR to identify meaningful data that can be gleaned.

Impact of the COVID-19 Pandemic on the Bed Registry

The pandemic arrived soon after IPBSR was launched. Initiating risk reduction procedures and meeting needs in new ways diverted mental health providers and hospitals from joining in or fully participating in IPBSR. The lack of full participation at launch may have a long-lasting impact.

System Oversight

The registry is of key interest to Idaho Department of Health and Welfare, DBH, who will receive reports on both process and outcome data. Information from the registry will be considered in the ongoing process of designing and implementing the strategic crisis response plan.

Project Contacts

- Nicole Coleman, at IPBSR@dhw.idaho.gov or 208-334-0461.
- Seth Schreiber, Project Director, at IPBSR@dhw.idaho.gov or 208-334-5727.

INDIANA

Current Approach and Need for Change

In response to the opioid crisis and increasing demand for treatment, the Indiana Family and Social Service Administration (FSSA) launched a bed registry for inpatient and residential substance use disorder (SUD) treatment services and accelerate the referral and admission process. The *Treatment Connection* website developed as a partnership between the state, Indiana 211, and providers in the state. With the initial success of the network, FSSA added mental health services provided by community mental health centers and non-profit hospital organizations that accept Medicaid in the fall of 2019. To grow their continuum of behavioral health crisis services, Indiana is creating two crisis stabilization units (< 23-hour settings) and has obtained an 1115 waiver from the Medicaid IMD exclusion¹¹.



"Building a bed registry network requires knowing the connections between facilities and government agencies as well as seeding the ground with a lot of stakeholder engagement."

—Kelsi Linville, Project Director (IN)

Type of Bed Registry

A password-protected *referral network* supports referrals to inpatient and outpatient services.

Planning Partners

In addition to the *Treatment Connection* partnership, this project fosters collaboration with the Indiana Hospital Association and the Indiana chapter of the National Alliance on Mental Illness (NAMI). About half of 20 hospitals anticipated in the initial roll out have enrolled.

¹¹ Under the waiver, the Centers for Medicare & Medicaid Services (CMS) gives Indiana has the authority to pay for short-term residential treatment services in an institution for mental disease (IMD) using Medicaid funds.

FIGURE 16: Public View of the Indiana Bed Registry

Treatment CONNECTION Search

About | Blog | Resources [Login/Join Provider Network](#) [User Login / Sign-up](#)

Search Substance Use or Mental Health Treatment Facilities

Use filters to narrow down your search results and find treatment facilities.

Clear Filters

Zip Code: 46077

Distance From Zip Code: 50 Miles

Substances

Gender and Age

Treatment Type

Payment Type

7 matches found based on your selection.

These Facilities have been vetted by the State government

[List View](#) [Map View](#)

Fairbanks - Acute Inpatient / Dual Diagnosis
Substance Use Disorder, Anxiety, Depression and Trauma. Over 13 for Adolescent programs. Medicaid 21 and under and 65+ standard package A only Detox and IOP.
More Information

8102 Clearvista Parkway, Indianapolis, IN 46256 | (317) 572-9396 | View Website | 13.67 miles from your zip code

• Taking Patients Currently
Last updated on 07-16-2020 [Contact About Treatment](#)

Options Behavioral Health Systems - Acute Inpatient / Dual Diagnosis
Traditional Medicaid only accepted as primary insurance for people under 22 or over 65, or for Detox ONLY. Self-pay requires a \$3000-4000 deposit at time of admission.
More Information

5602 Caito Dr, Indianapolis, IN 46226 | (317) 541-8760 | View Website | 15.17 miles from your zip code

Crisis System Beds to Be Included in the Registry

Network member private psychiatric hospitals and psychiatric units in general hospitals are included. The two crisis stabilization units under development will be added to the registry when they open. State Psychiatric Hospitals (SPH) are not included in the registry¹².

Registry Development Vendor

OpenBeds[®] is the web-based software platform that provides listings of available beds as well as the capacity to make and track referrals across all network members. Services are fully compliant with HIPAA requirements.

Access to the Registry

The referral network is limited to network members to view available beds, submit electronic referrals, and track placements. A second website, <https://treatmentconnection.com>, provides information on services to the public.

Refresh Rate and Entry Process

Bed availability is manually entered twice per day.

Meaningful Metrics

Compliance with refreshing data as well as the interval from referral through acceptance and transfer to inpatient units

will be monitored. FSSA is contemplating other metrics available through Open Beds[®].

Impact of the COVID-19 Pandemic on the Bed Registry

- Inpatient units have been half capacity following Indiana's Department of Health guidelines to isolate new patients to single room occupancy. All available beds have been occupied during the pandemic.
- One wing of the state hospital was taken over by the Department of Health for COVID-19 positive psychiatric patients.

System Oversight

The project is managed by the FSSA's Adults with Mental Illness and Co-occurring Disorders Bureau and overseen by the Director of the Division of Mental Health and Addiction.

Project Contact

Kelsi Linville, Chief of Adults with Mental Illness and Co-occurring Disorders Bureau, Division of Mental Health and Addiction, Indiana FSSA, at Kelsi.Linville@fssa.in.gov or 317-234-6795.

¹² Admission to an SPH requires screening by a community mental health center (CMHC) and review by a designated Medical Review Board. Forensic admissions are made through civil commitment obtained by a CMHC, the Department of Corrections at the end of a prisoner's sentence, or directly from a criminal court order in the instance that an individual is found Not Guilty by Reason of Insanity or Incompetent to Stand Trial.

MARYLAND

Current Approach and Need for Change

When an individual is assessed and determined to need a bed in a crisis stabilization unit or hospital, crisis workers must call individual facilities to identify openings. The process of identifying an open bed that is appropriate to the needs of the individual may take hours, especially when the list of facilities is outdated and/or erroneous. The Maryland Department of Health, Behavioral Health Administration (BHA) is planning to build on the Substance Use Disorder Bed-Finder System used in one county and expand it across the state. The Maryland Bed Availability Registry (MD-BAR) will display bed availability and driving directions to the facility using web-based ArcGIS (Global Information System) software. A performance dashboard designed for administrators and policy makers provides a high-level summary of available beds and tracks the location of available beds in relation to the reported crisis to inform resource allocations.

Type of Bed Registry

The password-protected *search engine* will display availability and location of available beds.

Planning Partners

A statute to establish a bed registry has been in development for several years and has gained the attention



“We want to enable professionals to get people in crisis to the care they need quickly — without having to call every hospital nursing station in the area looking for an opening.”

—Susan Bradley, Project Director (MD)

of providers, advocacy organizations, government officials, and legislators to the project. Frequent turnover of department leadership has resulted in several starts and stops as new administrations align the project with the evolving legislation and policy shifts. When a contract to build out the platform is executed, a broad representation of stakeholders will be invited to participate in focus groups. Participants will include local behavioral health authorities, treatment providers, hospitals, consumer advocates, the state Mental Health Association, state Medicaid, and mobile crisis team members.

Crisis System Beds to Be Included in the Registry

BHA will roll out the project in three phases, beginning in January 2021. Information from state licensing on listed facilities will be used as the foundation to populate the database on bed capacity.

- Phase I: Substance abuse and mental health crisis stabilization units, psychiatric hospitals and psychiatric units in general hospitals, and substance abuse social detoxification centers.
- Phase II: Substance use residential treatment facilities will be added.
- Phase III: Residential rehabilitation programs, mental health group homes, and substance use recovery houses will be added.

Registry Development Vendor

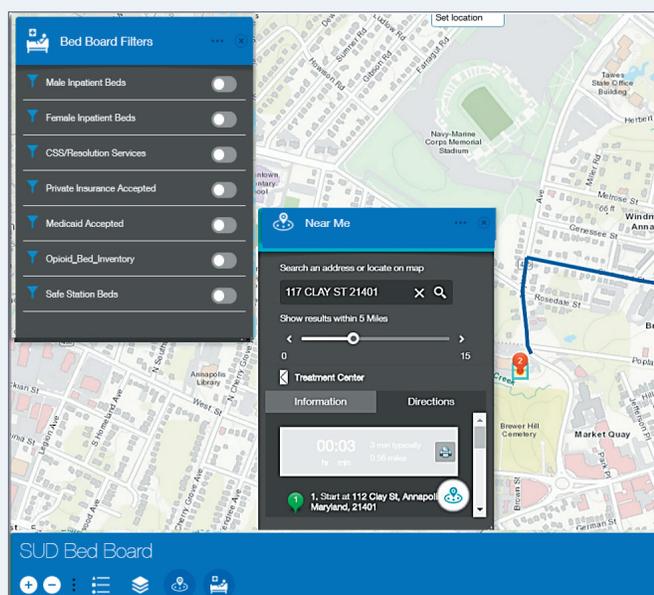
A contract to develop the software and host a bed registry platform is in process and expected to be awarded in Spring 2021.

Access to the Registry

Access will expand in phases:

- Phase I: Crisis counselors, mobile crisis teams, safe stations/walk-in centers, community-based behavioral health crisis beds, emergency department

FIGURE 17: User View of Closest Available Bed in Maryland



staff, inpatient treatment staff in private psychiatric hospitals and psychiatric units in general hospitals.

- Phase II: Substance use residential treatment facilities staff will be added.
- Phase III: Staff of residential rehabilitation programs, mental health group homes, and substance use recovery houses will be added.

Refresh Rate and Entry Process

Bed availability will be entered manually at least twice daily and ideally in real-time.

Meaningful Metrics

To be determined.

Impact of the COVID-19 Pandemic on the Bed Registry

The project has been significantly delayed so that staff time could be redeployed to other efforts related to pandemic prevention efforts.

System Oversight

The program is overseen by the Maryland Department of Health Behavioral Health Administration.

Project Contacts

- Susan Bradley, Director, Office of IT and Data, BHA, at Susan.Bradley@maryland.gov or 410-402-8323.
- Trena Bumbray, IT Supervisor, Office of IT and Data Unit, BHA, at trena.bumbray@maryland.gov or 410-402-8328.

MASSACHUSETTS

Current Approach and Need for Change

The Massachusetts Behavioral Health Access (MABHA) website was first launched in 2009 as a tool for emergency services (mobile crisis teams) to place an individual in crisis. In 2015, the availability of most behavioral health services, except inpatient and crisis beds, were made publicly accessible. The system allows users to search providers in nine categories of mental health, 12 of substance abuse and 14 of child and family treatment and support services across the Commonwealth. Mobile crisis teams have access to a second tier of the website that identifies the availability of inpatient and crisis stabilization beds by locality across the state. During the pandemic, MABHA made all services, including inpatient care, publicly accessible for an indefinite period. Figure 18 displays an example of the list of inpatient beds accessed from the publicly available <https://mabhaccess.com> website. MABHA also collects performance data behind the scenes not only to monitor services, but to notify leadership of problems that are developing in real time. For example, MABHA collects data on emergency department boarding that exceed 24 hours and notifies the Department of Mental Health, allowing it to directly intervene. MAHBA’s most recent expansion now identifies programs with walk-in services and providers of medically assisted substance use treatment. Like all other expansions, these changes were preceded by consultation with the providers and system users to identify and overcome potential complications such as differences in terminology.

FIGURE 18: User View of Available Beds Near Springfield, Massachusetts

Facility	City	Available Capacity (Openings)	Referral Phone	Comments	Gender	Distance (Miles)	Last Updated
BAYSTATE MEDICAL CENTER INC (Adult 18+)	SPRINGFIELD	0	413-794-3870	Effective 6/20/2020 Total Capacity is 25	All	1.41	54 minutes ago
HOLYOKE MEDICAL CENTER INC (Adult 18+ LIM Class 6)	HOLYOKE	0	413-534-2593		All	7.38	16 hours ago
HOLYOKE MEDICAL CENTER INC (Adult 18+)	HOLYOKE	1	413-534-2593	Please call 413-534-2627 Option 1 to make a referral between 7:00 AM- 11:00 PM. After hours please call 413-534-2593.	All	7.38	16 hours ago
Providence Behavioral Health Hospital - licensed under Mercy Medical (Adult 18+ LIM Class 6)	Holyoke	0	413-539-2971		All	7.38	2 hours ago
Providence Behavioral Health Hospital - licensed under Mercy Medical (Adult 18+)	Holyoke	0	413-539-2971		All	7.38	2 hours ago
NOBLE HOSPITAL FOWLER WING (Adult 16+ LIM Class 6)	WESTFIELD	0	413-568-2811 ext 5545		Male, Female	10.41	2 hours ago
NOBLE HOSPITAL FOWLER WING (Adult 18+)	WESTFIELD	0	413-568-2811 ext 5545		Male, Female	10.41	2 hours ago
Baystate Wing Hospital (Adult 18+)	Palmer	1	413-370-5269	2 blocked	Male	14.80	2 hours ago
COOLEY DICKINSON HOSPITAL INC	NORTHAMPTON	2	413-582-2974		All	16.44	43 minutes ago

Type of Bed Registry

MABHA is a *search engine*.

Planning Partners

MABHA was launched in 2009 as a joint effort between the Massachusetts Medicaid Office of Behavioral Health MassHealth (MassHealth), Department of Mental Health (DMH), and the Massachusetts Behavioral Health Partnership (MBHP). Additional partners include trade associations, providers, consumer organizations, the DMH Consumer Advisory Committee, and the other state agencies.

Crisis System Beds to Be Included in the Registry

The system reports availability for 10 categories of crisis care, ranging from mobile crisis teams and crisis stabilization units, to inpatient beds for both mental health and substance use-related crises for adults and children. The system also lists preventive and aftercare services, including in-home behavioral health services and partial hospitalization programs.

Registry Development Vendor

MBHP developed and manages the website.



“Seek input from all the stakeholders before you design or modify the bed registry, otherwise, what you’ve created may not be useful to users and will be incompatible with how providers operate.”

—Kathy Sanders, MD, Project Director (MA)

Access to the Registry

Prior to the pandemic, the website operated as a two-tiered search engine. The public access website, <https://mabhaccess.com>, allowed anyone to search for all behavioral health services available in the commonwealth except inpatient hospital, crisis stabilization, and specific programs for substance use treatment that were accessible to mobile crisis teams and emergency departments. During the pandemic, that exception was removed. MBHP is weighing whether it will re-impose two-tiered access.

Refresh Rate and Entry Process

Due to the variety of services and settings, the frequency of updates varies from three times per day to four times per year (for non-crisis related services), depending on the turnover rate and level of care. Auto reminders are electronically generated for two-hour lapses in updates for

inpatient beds. Participation and 80% compliance with updating availability are quality indicators that insurance companies in Massachusetts consider when adjusting reimbursement rates.

Meaningful Metrics

- Compliance with updating.
- Number and regional location of available beds.
- Emergency department boarding.
- Administratively necessary days (days in hospital awaiting essential community-based aftercare) that inform capacity and efficiency of the crisis response system.

Impact of the COVID-19 Pandemic on the Bed Registry

Demand initially fell, then fluctuated, and gradually plateaued to its previous level. More emergency department boarding occurred as some crisis stabilization units and hospital units closed or reduced capacity.

System Oversight

MBHP oversees project function and distributes reports to the state mobile crisis team director and the DMH director. The project is directed by the DMH Deputy Commissioner and MassHealth.

Project Contact

Kathy Sanders, MD, DMH Deputy Commissioner, at Kathy.Sanders@massmental.state.ma.us or 617-626-8059.

MISSISSIPPI

Current Approach and Need for Change

The Mississippi Department of Mental Health’s (DMH) crisis system has been undergoing major changes with the establishment of mobile crisis teams operated by community mental health centers (CMHCs) within their catchment areas. DMH has also funded an additional 48 crisis stabilization unit (CSU) beds, for a total of 176 statewide that are operated by CMHCs to meet the identified need. The CSUs give crisis teams the option of referring individuals in crisis to treatment in a setting that is as close to their homes as possible. The bed registry was launched April 1, 2020, and lists the daily updated availability of these the crisis bed options in the state. It also provides DMH with a daily portal to view patient flow and

FIGURE 19: Electronic Form to Update Bed Availability in Mississippi

MS Department Of Mental Health Bed Registry

Crisis Stabilization Unit - Occupied Beds

Select a single provider or your assigned Provider is loaded by default. Enter the number of licensed beds and active beds available for each unit/service type and each gender.

Provider: Location:

Occupied Beds Last updated on :

Unit/Service	Male	Female	Pend Adm	Pend Dis	Number of Denials	Acuity
	<input type="text"/>					

Date:

Service	Total Certified Beds	Occupied Beds					
		Male	Female	Pend Adm	Pend Dis	Number of Denials	Acuity
	<input type="text"/>	<input type="checkbox"/>					

intervene to reduce wait times for treatment. For example, the bed registry identifies the number of people waiting for an opening in a state hospital and the agency that referred them. DMH may have the agency refer individuals to a CSU instead depending on vacancies. If accepted, the individual is diverted from the waitlist for immediate admission to treatment. The overall goal is to maximize availability and accessibility of crisis stabilization and acute psychiatric inpatient beds for Mississippians.

Type of Bed Registry

The MS Department of Mental Health Bed Registry is a *search engine*. The graphic above displays the form used for updating the system.

Planning Partners

Planning partners include the users of the database: state hospitals, intellectual and developmental disabilities (IDD) facilities, CSUs, and CMHCs.

Crisis System Beds to Be Included in the Registry

CMHC-operated and state-funded CSUs, state hospital beds, community living facilities (long-term residential), IDD crisis units, and child/adolescent facilities.

Registry Development Vendor

The state developed the platform using its statewide data management system.¹³

Access to the Registry

A password-protected website is available to state hospitals, IDD facilities, and CMHCs that include their mobile crisis teams and crisis stabilization units.

Refresh Rate and Entry Process

Updates are entered manually once per day.

Meaningful Metrics

- Reduce the average wait time for acute psychiatric admissions to state hospitals.
- Divert from more restrictive environments such as jail and hospitalizations to crisis stabilization units.

Impact of the COVID-19 Pandemic on the Bed Registry

Admission procedures have been revised and bed capacity has been adjusted at the state hospitals and at CSUs to accommodate new admissions more safely. A corresponding reduction in demand for beds was also observed during the period.

System Oversight

Oversight is provided by the Mississippi Department of Mental Health Deputy Executive Director.

Project Contact

Denise Jones, Chief Information Officer, Mississippi Department of Mental Health, at Denise.Jones@dmh.ms.gov or 601-359-5182.



“We want people to have access to crisis services as close to their home community as possible.”

—Steven Allen, Deputy Executive Director, Mississippi Department of Mental Health

¹³ The Bed Registry is a web-based application using an SQL database and developed using Apache Tomcat. The security for the application is managed by an external active directory. The application will reside at the State Datacenter and will be external facing so all authorized users can log into the system from their locations.

NEBRASKA

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 Figure 20, 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.

Type of Bed Registry

The Region 6 pilot project will be used as a referral system initially and expanded to a *referral network*.



“We engaged stakeholders from the start and invited them to help us select the bed registry vendor.”

—Curt Vincentini, Project Director (NE)

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.

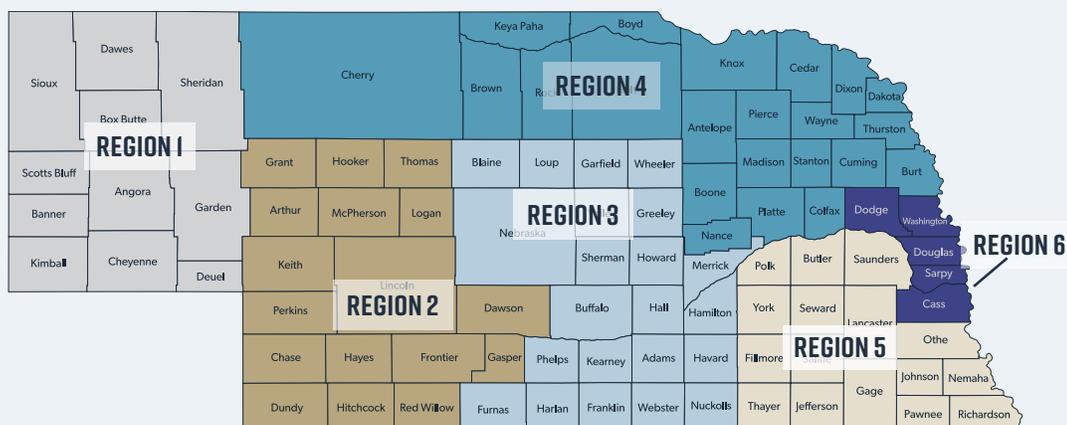
Registry Development Vendor

The vendor is OpenBeds®.

Access to the Registry

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

FIGURE 20: Map of Nebraska’s Behavioral Health Regions



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.

Project Contact

Curt Vincentini, Manager of Emergency Services, Region 6 Behavioral Healthcare, at cvincentini@regionsix.com, 402-444-7719, or cell 402-658-1298.

NEVADA

Current Approach and Need for Change

In much of the country, people most often take themselves or their loved ones to a hospital emergency department to treat a behavioral health crisis. If stabilization in an inpatient setting is indicated, many of them will wait hours and even days in the emergency department before treatment can begin. In Nevada, one of only a few states that collect data on wait times, an average of 94 emergency room patients with a psychiatric condition are held for two to three days while emergency room staff call inpatient psychiatric

units to find a bed. Paradoxically, many crises that lead to boarding can be treated and resolved outside the hospital emergency departments from a continuum of services that include crisis call centers, mobile crisis teams, peer-run respite settings, and crisis stabilization units. Nevada's Department of Health and Human Services, Division of Public and Behavioral Health, (DPBH) has been steadily building a continuum of crisis care (Figure 21) that improves resilience, reduces treatment costs, relieves emergency room crowding, and makes judicious use of inpatient beds patterned on the Crisis Now model¹⁴. DPBH launched Nevada Health Connection in August 2020 as a tool to identify and connect resources and services to people in crisis.

Type of Bed Registry

Nevada has launched a password-protected *referral network*. A second publicly accessible website Treatment Connection informs the public of available services.

Planning Partners

DPBH engaged stakeholders to build support and consensus for the adoption of the Crisis Now model by presenting at Regional Behavioral Health Board Meetings, Substance Abuse Prevention and Treatment Agency (SAPTA) board meetings, the Behavioral Health Planning and Advisory Council meetings, and convening two statewide Crisis Now Summits. Hospital associations and managed care organizations were key planning partners. DPBH has also had significant input from the University of Nevada and RI International to design and build the continuum of services and the bed registry.

Crisis System Beds to Be Included in the Registry

The first phase includes psychiatric units in general hospitals, public and private psychiatric hospitals, triage centers, social detoxification, and substance abuse residential treatment facilities that receive state funding for treatment of Medicaid and/or uninsured patients. The

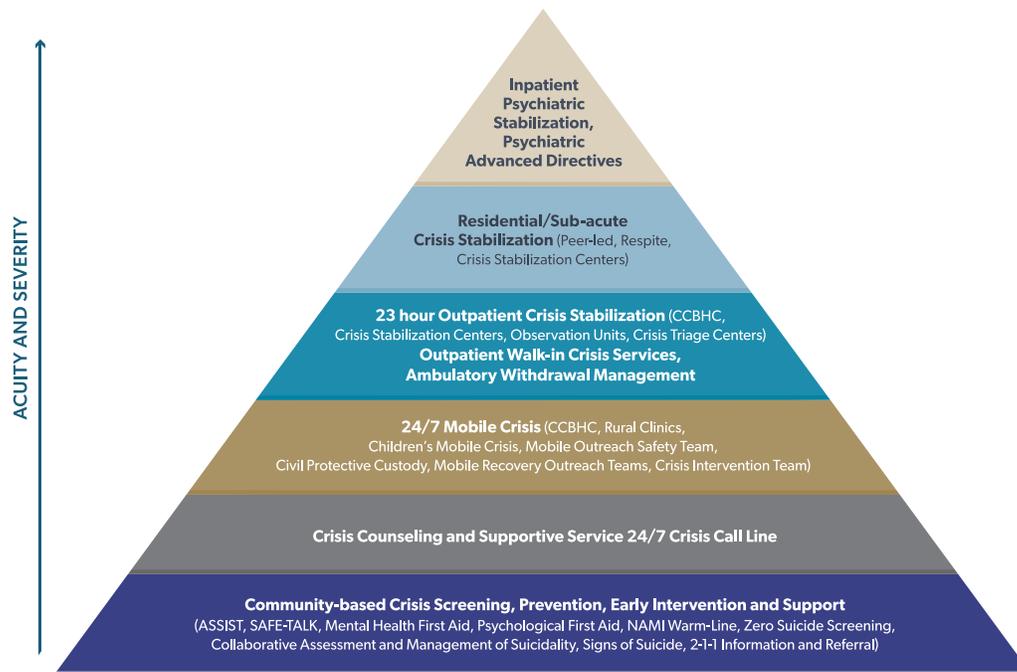


“For the registry to be successful, we set and met a critical threshold of participation and have enrolled 75% of providers in the state.”

—Elyse Monroy, Project Manager, University of Nevada

¹⁴To view the Crisis Now model, please see NASMHPD's web page <https://www.nasmhpd.org/content/crisis-now-dedicated-transforming-mental-health-crisis-systems>

FIGURE 21: Nevada's Continuum of Crisis Care



system also includes outpatient and community support behavioral health services.

Registry Development Vendor

Nevada selected OpenBeds® to build the platform, operate the registry, and produce reports.

Access to the Registry

Call centers, emergency room staff, participating inpatient units, triage centers, and mobile crisis teams will be able to identify available beds and submit a referral electronically to a provider through the password-protected referral network. Specialty judicial court administrators and jails will have access to make referrals when the network is expanded. The publicly accessible *Treatment Connection* can be accessed at <https://www.treatmentconnection.com>.

Refresh Rate and Entry Process

Nevada plans to have participating facilities update bed availability at shift change, once per day

Meaningful Metrics

- Time from referral to placement.
- American Society of Addiction Medicine (ASAM) Levels of Care.
- Emergency room boarding.
- Declined referrals and the reason for the decline.

- Call center's volume of calls.
- Case resolution and diversion by mobile crisis teams.

Impact of the COVID-19 Pandemic on the Bed Registry

Project staff convened virtual meetings with stakeholders. Although the lack of face-to-face meetings hindered relationship building, the project met its goal of recruiting 75% of providers in March 2020, despite the pandemic.

System Oversight

The project leads within DPBH will continue to provide oversight of the registry as a critical element of continuum of crisis care.

Project Contact

Dawn Yohey, DPBH, at dyohey@health.nv.gov or 775-461-6533.

NEW JERSEY

Current Approach and Need for Change

The New Jersey Division of Mental Health and Addiction Services (DMHAS) established the Bed Enrollment Data System (BEDS) in 2015 to provide an electronic search engine for mental health and substance use treatment providers to find available community, supportive, and

FIGURE 22: Beds Listing of Available Residential Programs in One County of New Jersey

Bed Search		Referrals Made		Admitted Clients		Admin		Reports		Help			
County:	-- All --	Agency:	OAKS INTEGRATED COMMUNITY SERVICES	Target Population:	-- All --	Bed Type:	-- All --	Level of Care:	-- All --	Gender:	-- All --		
<input type="button" value="Search"/>  													
Please make selection(s) from drop-down list(s) above to narrow down the search results.													
TOTAL VACANT BEDS ARE 46													
Provider	SiteId	Address	City	Zip	County	Bed Id	Bed Type	Level Of Care	Gender Target	Target Population	ADA Accessible	Program Element	CEPP Risk
OAKS INTEGRATED COMMUNITY SERVICES	5483	3 East Holly, APT. C	Haddon Heights	08107	Camden	3418	Supportive Housing (Traditional)	Supportive Housing	Male	Supportive Housing (Traditional)	No	Supportive Housing	Other
OAKS INTEGRATED COMMUNITY SERVICES	1976	2155 Harbour Drive	Palmyra	8065	Burlington	3431	Supportive Housing (Traditional)	Supportive Housing	Female	Supportive Housing (Traditional)	No	Supportive Housing	Other

recovery housing for people transitioning from inpatient settings. DMHAS recently added housing support vouchers for individuals in recovery from opioid use disorders. With support from the TTI grant, DMHAS is expanding BEDS to include psychiatric beds in community hospitals (STCF for short-term care facility), and peer-run respite facilities. Although system modifications were completed, the COVID-19 pandemic risk-reduction efforts delayed the pilot testing for the system and the subsequent statewide launch to the Spring of 2021. Ongoing plans include further modifications to make data publicly accessible in compliance with recent state legislation.



“Understanding how people move through the crisis system was essential to advancing the bed registry.”

—Harry Reyes, Assistant Division Director, DMHAS Office of Treatment and Recovery Supports (NJ)

Type of Bed Registry

BEDS is a *search engine*. The figure on the next page displays a search for open residential beds in Essex County.

Planning Partners

Planning partners include Collaborative Support Programs — New Jersey, the National Alliance for the Mentally Ill, the Mental Health Association of New Jersey, the NJ Association of Mental Health and Addiction Agencies (NJMHAA), the Coalition of Mental Health Consumer Organizations (COMCO), hospital associations, and local mental health authorities.

Crisis System Beds to Be Included in the Registry

In addition to the current residential beds, DMHAS is adding 420 state-funded beds in 24 hospitals (short-term care facilities, STCFs), two recovery centers, psychiatric emergency centers’ extended observation units (<24 hour CSUs), and four peer-run respite facilities to the BEDS system.

Registry Development Vendor

DMHAS’s Information Technology staff built and maintain BEDS. They will expand the system, troubleshoot problems with users, and update the system as needed.

Access to the Registry

State hospital discharge staff, provider agencies, wellness centers, psychiatric screening services, affiliated emergency services, have role-specific access to sub-categories of beds. Discharge staff for example can access residential programs and STCF staff have access to their own, as well as other STCF beds. DMHAS Central Office monitors overall flow and encourages full utilization of available beds and services.

Refresh Rate and Entry Process

Bed availability at STFCs, CSUs, and respite centers are entered manually, twice per day. Bed availability in residential settings is manually updated on the day that change occurs.

Meaningful Metrics

- Matching residential vacancies with patient need.
- Reduced emergency room boarding.
- Diversion from hospitalization to crisis respite beds.
- Diversion from state/county psychiatric beds to STFCs.

FIGURE 23: Screenshot of a Referral Request in New Mexico

Referral Request	
Contact Information	
Treatment Organization:	Albuquerque Health Services
Service:	Medication-Assisted Treatment: OTP
Address:	172 Montano Road NW, Albuquerque, NM 87107
Phone #:	(505) 344-4427
Email:	nwclinic@abqhealthservices.com
Your preferred method to contact as per your profile is	
E-Mail <input type="text"/>	
Submit Request	
Urgency of need*	
<input type="text" value="Symptoms do not represent an immediate risk and/or highly anticipated risk"/>	
Gender and Age*	Substance(s) and Non-Substance(s) Treated*
<input type="text" value="Adult (18 and older) - Female"/>	<input type="text" value="Alcohol"/>
Difficult to Place Medical and Psychiatric Conditions	Special Populations
<input type="text"/>	<input type="text"/>
Payment*	
<input type="text" value="Sliding fee scale"/>	



“Make sure you have an accurate inventory of beds and reconcile differences before you start your system.”

—Donna Migliorino, Deputy Assistant Division Director, DMHAS Office of Olmstead, Planning, Research, Evaluation, and Prevention (NJ)

Impact of the COVID-19 Pandemic on the Bed Registry

Obtaining an accurate count of vacancies has been challenging because programs have had to make changes each day to social distance residents and reduce risk of infection. The bed registry launch was delayed six months.

System Oversight

The DMHAS Assistant Division Director, DMHAS Office of Treatment and Recovery Supports oversees the program.

Project Contact

Steve Fishbein, Deputy Assistant Division Director, Office of Treatment and Recovery Supports, DMHAS, at Steve.Fishbein@dhs.nj.gov.

NEW MEXICO

Current Approach and Need for Change

Individuals, their families, and first responders currently call hospitals or arrive in emergency rooms to access mental health and substance abuse crisis care. It is a haphazard process that often results in significant delays while

placements are sought. In tandem with the Department of Health, Behavioral Health Services Division (BHSD) of the Department of Human Services has implemented a behavioral health referral process that will empower people in crisis and their families to access treatment and enable providers to quickly assess needs and deliver appropriate services. The services are not limited to crises alone and address the full continuum of behavioral health care including outpatient and support services. The new registry, launched June 2020, is accessible to the public for information and to make self-referrals to care (Figure 23). Those interested in making self-referrals are directed to call the New Mexico Crisis and Access Line to advise them on the most appropriate level of care and guide them through a self-referral process or connect them directly. To expand crisis care resources, New Mexico is establishing two new crisis triage centers (crisis stabilization units) that offer 23-hour outpatient, detox management, and short term residential.

Type of Bed Registry

The bed registry is a password-protected *referral network* that supports electronic referrals such as the one displayed in the figure. A second website, Treatment Connection, provides information on services to the public.

Planning Partners

Stakeholder meetings have been convened as needed to obtain input and build support. Partners include state licensing agencies, providers, managed care organizations, and the state’s Behavioral Health Planning Council. The state hospital association was a crucial partner, serving as a bridge to engage hospitals across the state.

Crisis System Beds to Be Included in the Registry

The network includes public and private psychiatric hospitals, psychiatric units in general hospitals, and crisis triage centers. Outpatient, substance abuse residential care, children's residential care, and other behavioral health services are also included in the registry.

Registry Development Vendor

OpenBeds® provides the platform, analytics, training, and follows up with network members that do not regularly update availability.

Access to the Registry

The New Mexico Behavioral Health Referral Network (NM BHRN) was launched June 9, 2020, for providers, state agencies, crisis line staff, and the courts to 101 services from 58 receiving facilities (that may also refer out). *Treatment Connection* <https://www.treatmentconnection.com> launched June 17, 2020, and is accessible to the general public for information and assisted self-referrals.

Refresh Rate and Entry Process

Bed availability is manually entered once per day for crisis beds.



“People in crises may die without immediate help, and we must be ready to act in that moment.”

—Tiffany Wynn, Deputy Director,
Treatment & Programs Bureau, BHSD (NM)

Meaningful Metrics

BHSD is interested in demonstrating improved access to care, particularly in reducing wait times and increasing the volume of people engaged in treatment. BHSD will compare, among other indicators, emergency department lengths of stay before and after the network launch as well as metrics related to referral activity as well as impact on individuals accessing treatment.

Impact of the COVID-19 Pandemic on the Bed Registry

The system is too new to assess any impact of the pandemic on the operation of the registry; however, access to the bed registry and other resources may be impeded by shelter at

home orders because some homes in this rural/frontier state have limited or no access to the internet.

System Oversight

The BHSD Staff Manager provides oversight and reports to the Deputy Director.

Project Contact

Hazel Mella, PhD, BHSD, at Hazel.Mella@state.nm.us or 505-709-5670.

NEW YORK

Current Approach and Need for Change

Mobile crisis teams and behavioral health staff have access to the crisis stabilization units that their community service boards (local mental health authorities) manage. When hospitalization is needed however, behavioral health staff must call hospitals to find an open bed. The Office of Mental Health launched the Bed Availability System (BAS) website March 1, 2019, so that mobile crisis teams could quickly identify available beds across the state. The BAS is patterned on the state's *Provider and Program Search* website, a registry of substance abuse services. Searches can be filtered by age, gender, and proximity, and result in a listing of “next available” dates for each facility (Figure 24). While hospitals in the state are willing to participate, many of them have had difficulty entering updates every day. TTI funding has been used to hire a coordinator who works with hospital staff to address and overcome technical and administrative challenges. Since having begun outreach and engaging hospital staff in March 2020, the effort has improved on-time updates by 24% statewide.

Type of Bed Registry

BAS is a password-protected *search engine*.

Planning Partners

The Hospital Association of New York State and the Greater New York Hospital Association.

Crisis System Beds to Be Included in the Registry

BAS accounts for 5,832 beds across 107 facilities that include state hospitals, psychiatric units in general hospitals, and private psychiatric hospitals.

FIGURE 24: Screenshot of a User's Search Filters in New York

Registry Development Vendor

The registry was developed and is hosted by the state as part of the state's Health Electronic Response Data System (HERDS).

Access to the Registry

Access is limited to those with Health Commerce System¹⁵ accounts and includes the staff of hospitals, emergency departments, community service boards including their mobile crisis teams.

Refresh Rate and Entry Process

Providers are asked to update the system twice per day and a minimum of once per day.

Meaningful Metrics

Percentage of daily updates completed and the comparison of reported beds to licensed beds. The benchmark is 80% of hospitals reporting every day.



“Having the resources to actively reach out and help hospitals resolve problems when they aren't updating bed availability on time has dramatically improved compliance and made the registry more accurate and dependable for crisis teams.”

—Susan Strangia, Project Director (NY)

Impact of the COVID-19 Pandemic on the Bed Registry

- The operation of the bed registry was disrupted as the state implemented emergency monitoring to ensure adequate bed capacity. Hospitals were required to report bed availability into a separate system. To lessen their reporting burden, OMH suspended its daily reporting requirement into the BAS from March 30, 2020, to June 15, 2020.
- Both demand as well as availability of beds appeared to have been reduced during the pandemic period.

System Oversight

The system is overseen by the Assistant Director, Bureau of Inspection and Certification.

Project Contact

Susan Strangia, Director, Bureau of Inspection and Certification, at Susan.Strangia@omh.ny.gov or 518-474-5570.

||| NORTH CAROLINA

Current Approach and Need for Change

Professionals in North Carolina serving individuals experiencing behavioral health crises must call numerous treatment facilities and hospitals to find an available and appropriate bed for someone in crisis, use various

¹⁵The Health Commerce System is a secure online communications system operated by the NYS Department of Health. It supports the exchange of routine and emergency statewide health information by local health departments and health facilities, providers, and practitioners.

means of records transmission, often followed by follow-up communications, consuming critical resources and delaying treatment. As mandated by state statute, North Carolina established the Behavioral Health Crisis Referral System, (BH-CRSys) as a secure web-based behavioral health referral system in 2018 to aid professionals in the identification of potential placements. Authorized users at eligible facilities have access to the system. Users can review facility profiles for important admissions information. Searches can be narrowed using filters that include accepting status (whether and when the facility is/will be accepting referrals), admission criteria, specialized services, and proximity to the person in crisis. Once accepting facilities are identified, users can submit referrals to multiple facilities simultaneously. Designated hospital and facility staff are notified of the referral and are expected to respond within a four-hour window. Funding from the TTI grant supported modifications to the system to make it easier to use, fields to capture additional information including involuntary hospitalizations, and the development of a pilot module to facilitate patient transportation to care.

Type of Bed Registry

The BH-CRSys is a *referral system*, which is a secure HIPAA-compliant web application that supports electronic referrals (Figure 25).

Planning Partners

With almost 200 facilities in 100 counties committed to or using the system, BH-CRSys has engaged approximately 80% of all eligible public and privately funded referral and receiving facilities in the state. The project understood that there were many challenges in building a bed registry and that strong relationships with the potential user facilities and those that carry out the placement work every day would be key to developing a useful and successful program. Staff began by attending professional meetings and visiting facilities to speak with, and learn from, referral and admissions staff. The Division also established an advisory committee to engage hospitals, mobile crisis teams, professional organizations, state facilities, and other entities to identify processes, needs, and gaps in the placement process and design the system. As the system took shape and integrated their recommendations, stakeholders grew more confident and willing to participate. Their partnership continues to help structure protocols and identify critical information necessary to speed the referral and



“Relationships are key to a successful system. Through relationships with the professionals who know the placement processes, a system can be developed that is useful to stakeholders.”

—Krista Ragan, Project Director (NC)

admission process. In addition to designated staff to enter data, each facility has a designated oversight manager, a supervisory level staff member who serves as the primary contact and BH-CRSys coordinator at the facility.

Crisis System Beds to Be Included in the Registry

General hospitals with psychiatric inpatient units, private psychiatric hospitals, state psychiatric hospitals, state alcohol and drug abuse treatment centers, facility-based crisis centers, and non-hospital medical detoxification facilities are included in this registry. The system includes all age groups, including child, youth, adult, and geriatric.

Registry Development Vendor

ESO (who acquired the original vendor, EMSpic) is the registry development vendor.

Access to the Registry

The facilities participating in BH-CRSys as well as hospital emergency departments, mobile crisis providers, and 24/7 behavioral health urgent care centers are eligible for access to the registry.

Refresh Rate and Entry Process

The accepting status goal for each facility, as determined by the Advisory Committee, is twice daily. However, most facilities update once daily. Facilities can update as frequently as needed and can include additional admissions information with the status. Updating status is monitored daily. If not refreshed in 24 hours, the system generates an automated message. If not updated in 72 hours, state staff are notified and follow up with the facility directly. An automated report of accepting information (including accepting status and the time of the last update) is provided to BH-CRSys participating facilities twice daily.

Meaningful Metrics

- Number of facilities using BH-CRSys.
- Frequency of updating accepting status.
- Points in time: The time of arrival at a crisis facility, the time that a referral is made, the time that the facility accepts the patient for placement and the time that the patient is admitted to participating facilities.
- Average distance travelled from point of referral to admission among participating facilities.
- Number of involuntary commitments among participating facilities.

Impact of the COVID-19 Pandemic on the Bed Registry

- As in many states, NC DHHS has deployed staff time from ongoing projects to other activities that support pandemic prevention efforts. However, BH-CRSys has maintained its support, and attempted to ensure additional relevant information and assistance related to COVID-19 needs are provided to BH-CRSys partners.
- There have been increased compliance by facilities with daily updates to bed availability during the pandemic.
- Facilities have been encouraged to use BH-CRSys to report any COVID-19 restrictions.

System Oversight

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services as charged by state statute to establish and maintain the bed registry (BH-CRSys).

Project Contact

Krista Ragan, MA, BH-CRSys Program Manager, Quality Management, North Carolina Department of Health and Human Services, at Krista.Ragan@dhhs.nc.gov or 984-236-5206.

OHIO

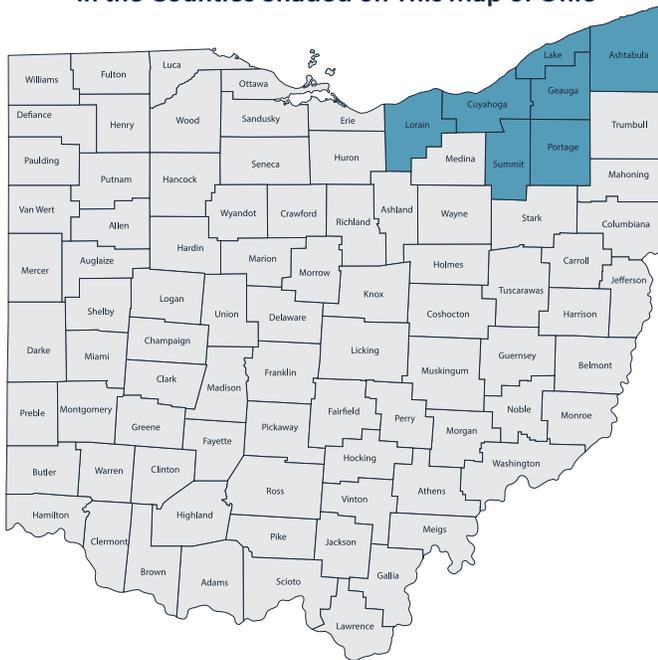
Current Approach and Need for Change

In 2008, collaboration among inpatient psychiatric units in Franklin County and the Central Ohio Hospital Council led to the creation of an electronic “bed board” that has been in operation since that time. Having observed the success of that partnership, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) explored the possibility of partnering with local behavioral health service boards to pilot a regional bed registry. Community mental health and addiction treatment services in Ohio are coordinated through local county (single and multiple) authorities or Boards. The Boards vary greatly in the array of crisis services available in their counties in terms of mobile crisis teams, crisis stabilization units, and inpatient hospital beds. In 2019, Boards in the greater Cleveland-area/Northeast (NE) Ohio region started investigating the possibility of establishing a bed registry of their own. Identifying an opportunity for collaboration, OhioMHAS reached out to these Boards to offer support for the project. OhioMHAS launched a regional bed registry pilot

FIGURE 25: Screenshot Displaying Results of a Bed Search in North Carolina

<p>BH Test Facility Raleigh Accepting Status: Accepting Referrals Accepting Status Last Updated: June 25, 2020 8:57 AM Accepting Status Description:</p>	
<p>General Information Physical Address: 306 North Wilmington Street Raleigh, NC 27601 Wake County</p> <p>Mailing Address: 306 North Wilmington Street Raleigh, NC 27601 Wake County</p> <p>Primary Phone: 919-733-0696 Secondary Phone: 919-733-0696 Fax: 919-000-0000 Website: https://www.ncdhhs.gov/bh-crsys</p>	

FIGURE 26: The Bed Registry Will Initially Be Piloted in the Counties Shaded on This Map of Ohio



network (Network) in September 2020 in the NE Ohio region, with the goal of expanding its use to other regions of the state.

Type of Bed Registry

The pilot is a *referral network* initially limited to psychiatric inpatient settings and their referral sources.

Planning Partners

Planning partners include the Alcohol Drug Addiction and Mental Health Services Boards of Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Portage, and Summit counties, major Cleveland-area hospital systems providing inpatient psychiatric services, and NE Ohio private psychiatric hospitals. Ohio Hospital Association (OHA), the Ohio Association of County Behavioral Health Authorities (OACBHA), the Ohio Council of Community Behavioral Health and Family Service Providers (Ohio Council), and the National Alliance on Mental Illness-Ohio chapter (NAMI-Ohio) were enlisted to provide support and feedback as the Network was started and throughout its continued development as it expands to other areas of the state. OhioMHAS credits its successful partnership with the Boards and hospitals in the northeast Ohio region to shifting from policy orientation to relationship-building and a hands-on approach in close coordination with the project vendor.

Crisis System Beds to Be Included in the Registry

Hospital sites within the seven-county region are voluntarily participating in the pilot. They include psychiatric hospitals, inpatient units in general hospitals and the regional (public) psychiatric hospital. As the Network grows, it will include behavioral health treatment providers and crisis call centers, 2-1-1, and organizations that provide transportation, food, shelter, rehabilitation, and entitlement assistance.

Registry Development Vendor

OpenBeds® is the registry vendor.

Access to the Registry

Member organizations including OhioMHAS, service boards, psychiatric hospitals and hospital organizations recognized as network treatment sites, and community referral sites have access.

Refresh Rate and Entry Process

Facilities will update the bed registry once per day.



“The purpose of the bed registry is to get people to the right provider the first time.”

—Caitlin Beha Worth, Project Director (OH)

Meaningful Metrics

- Number of digital referrals attempted and completed.
- Frequency of bed count updates by network providers.
- Number of minutes of unplanned system downtime during the month.
- Number of complaints received from providers, by type and disposition.
- Access to any training or user guides furnished to the Network sites.

Impact of the COVID-19 Pandemic on the Bed Registry

Efforts to establish the bed registry were put on hold during the pandemic period (mid-March 2020 to mid-May 2020). Work was resumed in May 2020 and the registry launched September 2020.

FIGURE 27: A Screenshot of Bed Availability at Two Facilities in Oklahoma

100 GRIFFIN MEMORIAL HOSPITAL 900 E. Main Norman, OK 73071 Phone: 405-573-6623 (Last updated time: 6/14/2020 10:28:30 AM)		
Female	Available Beds	0
	Pending/Possible DC	0
Male	Available Beds	0
	Pending/Possible DC	0
Crisis Care	Available Beds	12
	Pending/Possible DC	0

ONE MALE BED DOWN FOR MAINTENANCE, TOTAL CENSUS CURRENTLY 119 (45 FEMALES/74 MALES). REPAIRS EXPECTED TO BE COMPLETED BY 8/19/2019.

System Oversight

The project is overseen by the OhioMHAS Medical Director and Chief Information Officer.

Project Contact

Caitlin Beha Worth, Director of Clinical Services — Hospital Services, OhioMHAS, at Caitlin.BehaWorth@mha.ohio.gov or 614-466-8404.

OKLAHOMA

Current Approach and Need for Change

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has been developing a more comprehensive crisis system in recent years. It now has a 24/7 statewide call center linked to providers as well as crisis centers, mobile crisis response (MCR) teams in much of the state, and urgent recovery centers (crisis stabilization units with varying lengths of stay), which provide an alternative to emergency rooms. Though MCR teams and providers have been able to search for psychiatric beds in an online “Bed Board” system, data has not been updated consistently, leaving doubts about the accuracy of bed availability. To ensure consistent and reliable bed availability data, ODMHSAS is adding new functionality to the electronic health records (EHR) system used by many providers in the state to automatically link admissions and discharges with the Bed Board. The Bed Board has the added benefit of documenting bed occupancy as unit staff conduct required bed checks every 15 minutes. As displayed in

Figure 27, providers can also post comments about the reason for changes in bed availability. A pilot launched in the fall of 2020.

Type of Bed Registry

The Bed Board will be a *search engine*.

Planning Partners

A number of consumer and family organizations have been consulted, as well as the State Advisory Team (SAT for children’s services) and the Planning and Advisory Council (PAC for adult services). Regional focus groups were held to gather needed specifications of agencies and hospitals participating in the pilot. For the past three years, ODMHSAS has partnered with the Oklahoma Health Care Authority (OHCA) to create a monthly Inpatient/Residential Roundtable meeting comprised of state agency staff and acute psychiatric inpatient and residential providers.

Crisis System Beds to Be Included in the Registry

A group of state-run crisis centers (with crisis stabilization units) and state-run psychiatric hospitals voluntarily



“Establishing a bed registry requires a top-down and bottom-up approach. You need buy-in from stakeholder leaders as well as the system users.”

—Jackie Shipp, Project Director (OK)

implement and pilot the system. Once the pilot phase is completed, the registry will be expanded to include all state-run psychiatric hospitals and crisis stabilization units and voluntary private psychiatric hospitals and units in general hospitals treating adults and children. Inspired by this effort, ODMHSAS implemented a bed board to search for substance use treatment residential and recovery settings in 2019.

Registry Development Vendor

The state is developing its own platform to link EHR data with a real-time bed registry search engine. The EHR system is AVATAR by Netsmart.

Access to the Registry

Participating agencies and crisis bed providers, call-center staff, and mobile crisis teams have access to the registry.

Refresh Rate and Entry Process

During the first year of the project, participating inpatient units will update changes to the bed board manually when bed checks are completed every 15 minutes — essentially real time. Several modifications to systems are being completed during a one-year pilot period that will allow EHRs to update the bed board automatically.

Meaningful Metrics

The accuracy of electronically generated data is being checked every 15 minutes during the pilot phase of the project. Following the pilot, the state intends to define and measure meaningful use by providers as well volume of use by providers. ODMHSAS's Decision Report Services are assisting in developing measures.

Impact of the COVID-19 Pandemic on the Bed Registry

The project has been significantly delayed as the efforts of all state staff were redirected towards confronting challenges to the delivery of care during the pandemic. Information technology (IT) staff, upon whom this project is dependent, were called on to rapidly extend telecommuting and telehealth capabilities and services. Lastly, hospitals are only just beginning to be able to focus on non-COVID-19 projects such as a bed registry.

System Oversight

The project is directed by the Senior Director of Treatment who reports to the interim commissioner of ODMHSAS.

Project Contact

Jackie Shipp, Senior Director of Treatment, at JShipp@odmhsas.org or 405-248-9391.

RI RHODE ISLAND

Current Approach and Need for Change

Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, and the Division of Behavioral Health (BHDDH) creating a public-facing, real-time website to help people find help when they or a loved one is in crisis. An act of the state legislature requiring the state to "develop a strategy to assess, create, implement, and maintain a database of real-time availability of clinically appropriate inpatient and outpatient services" (23-17.26-3) for substance use disorder served as the catalyst for change. A common health information exchange among hospitals will allow bed availability to be automatically updated every hour, slated to begin in August. Agencies that do not participate in the health information exchange update information manually at specified intervals described below. The website was launched May 26, 2020, and is continuing to roll out additional service through August. With a semi-automated bed registry, mobile crisis teams, central statewide call center, and crisis stabilization unit for triage, Rhode Island has developed a crisis care continuum of services.



"To overcome providers' reluctance to participate, we committed to ensuring information listed on the website was accurate and reliable."

—Olivia King, Project Director (RI)

Type of Bed Registry

The RI BH Open Beds¹⁶ website is a *search engine* directing inquiries to a statewide call center, BH Link.

Planning Partners

Under state statute, hospitals are also required to make available real-time information about the availability of

¹⁶ RI BH Open Beds is not affiliated with OpenBeds®, an Apriss owned company.

FIGURE 28: Screenshot of Treatment Bed Listings in Rhode Island

This page allows for filtering of columns by clicking the drop-down arrow inside the box above each column. You can also sort ascending/descending, by click the double arrows to the right of each column name.

The appearance of "-" in a listing indicates that a numerical entry is not applicable for this bed type, or information isn't collected.

For a description of each bed type and service, see the [About page](#). For more information about a particular provider organization, click the name of the organization in the "Provider" column.

PROVIDER	BED TYPE	STATUS	SERVICE	SETTING	AVAILABLE	FILLED	WAITING	UPDATED
AdCare	Monitored Detox (ASAM 3.7)	FILLED	Substance Use	Community	0	5	--	6/12/2020 1:01 PM
Bradley Hospital	Unit (BH - Adolescent)	OPEN	Mental Health	Hospital	5	29	--	6/12/2020 10:20 AM
Bradley Hospital	Unit (BH - Children)	FILLED	Mental Health	Hospital	0	17	--	6/12/2020 10:20 AM
Bradley Hospital	Unit (CADD)	FILLED	DD Mental Health	Hospital	0	19	--	6/12/2020 10:20 AM

clinically appropriate inpatient and outpatient services and have been partners in the planning process.

Crisis System Beds to Be Included in the Registry

Inpatient behavioral health beds in general hospitals and private psychiatric hospitals, crisis stabilization units, community-based detoxification units, substance use disorder recovery houses, and substance use disorder residential treatment. State-managed mental health psychiatric rehabilitative residences will be included in 2021.

Registry Development Vendor

RIQI developed, installed, and now maintains the health information exchange for participating agencies. RIQI will extend the system to include community-based beds wherever integration is possible and populate the website with availability and wait times specific to behavioral health facilities.

Access to the Registry

The website is publicly accessible at <https://www.rihOpenBeds.org/>. Although facilities and availabilities are listed, phone numbers are not unless supplied by the behavioral health facility. Inquiries are directed to BH Link <https://www.bhlink.org/> to access care. BH Link offers a 24/7 statewide hotline and triage center (<23-hour crisis stabilization unit). Kids' Link is also available as a 24/7 statewide hotline for behavioral health crises for those under 18.

Refresh Rate and Entry Process

Refresh rates vary by capability and turnover. Data from settings that participate in the RIQI information health exchange are refreshed automatically every hour. Programs that experience frequent turnover but are not part of the health information exchange are manually updated once per day. Programs with infrequent turnover, such as residential programs are updated weekly. Updates are timestamped and posted on the website.

Meaningful Metrics

- Number and days waiting for a bed by type of facility.
- Hospital emergency department length of stay awaiting placement.

Impact of the COVID-19 Pandemic on the Bed Registry

None reported.

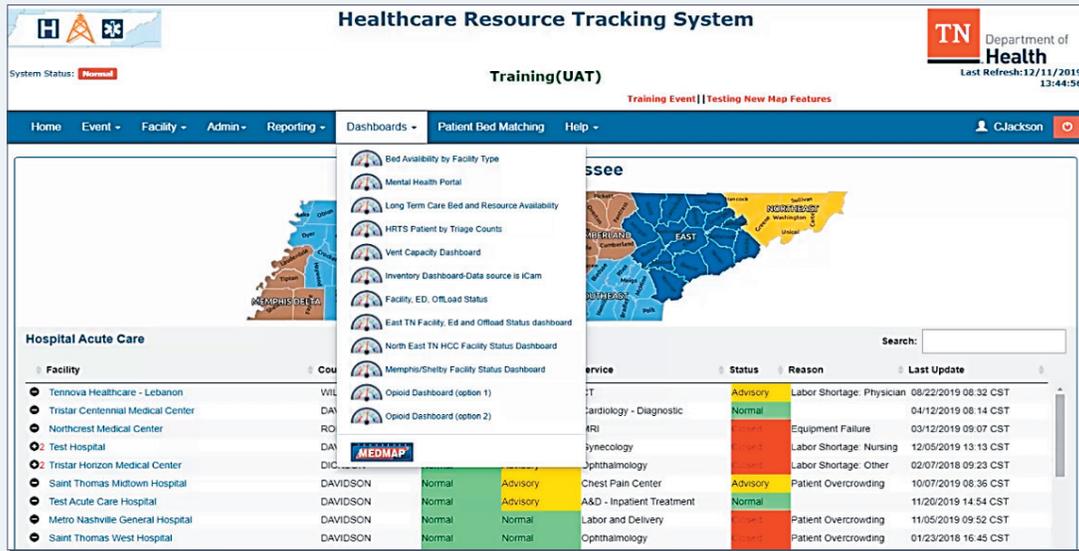
System Oversight

The project is overseen by the BHDDH Administrator of Contracts.

Project Contact

Olivia King, Behavioral Health IT Coordinator, BHDDH, at olivia.king@bhddh.ri.gov or 401-327-4128.

FIGURE 29: Training Screen of Tennessee’s HRTS Dashboard



TENNESSEE

Current Approach and Need for Change

The Health Department’s Office of Emergency Preparedness oversees the Hospital Resource Tracking System (HRTS) that lists bed availability in 49 inpatient health facilities including mental health. HRTS was first launched in 2006 and has recently undergone changes to improve its utility including those that accommodate mental health treatment. The mental health portal in HRTS is accessed 40 times per day by providers seeking placements, but the data on bed availability is not consistently updated. To improve the reliability of data, the TN Department of Mental Health and Substance Abuse Services (TDMHSAS) in partnership with the Department of Health, have been meeting with hospital systems to encourage their participation. TDMHSAS has also been developing an electronic communication bridge that allows recently installed electronic health records systems to automatically update bed availability in real time at state hospitals. A second innovation, the Patient Bed Matching System (PBMS), will allow referral sources to submit HIPAA-compliant information to inpatient facilities. PBMS was mostly completed, but work paused during the pandemic. The project is expected to be launched in 2022 as the state recovers from the pandemic and staff return to normal duties.



“Hospital systems that used the bed registry saw a reduction in their emergency department boarding.”

—Laura Young, Chief Nursing Officer, TDMHSAS (TN)

Type of Bed Registry

HRTS is a search engine designed primarily to coordinate health and behavioral health care during emergencies (Figure 29). The PBMS *referral system*, currently in development, will augment the HRTS to support electronic referrals for behavioral health beds. The HRTS dashboard below displays the status of health care facilities across the state during a simulated emergency. A drop-down menu allows sorting by bed type.

Planning Partners

The statewide HRTS system planning partners are representatives of mobile crisis teams, hospital associations, and emergency rooms.

Crisis System Beds to Be Included in the Registry

Psychiatric units in general hospitals, psychiatric hospitals, and state hospitals serving adults and/or children that are licensed in the state are listed in HRTS. Participation is not mandatory.

Registry Development Vendor

Tennessee developed and operates HRTS to manage healthcare facility bed, service, and asset availability. NetSmart is the electronic medical record vendor for the state hospital system.

Access to the Registry

Access is limited to mobile crisis teams, crisis stabilization units, hospital emergency departments, psychiatric units in general hospitals, psychiatric hospitals, state hospitals, and relevant state health department and mental health department staff have access to HRTS.

Refresh Rate and Entry Process

Manually entered at least daily in HRTS. The interface supporting automatic updates between the registry and the state hospital's electronic health records system is expected to be completed in 2022.

Meaningful Metrics

- 75% or more of facilities with mental health inpatient beds will report availability daily.
- Hospital boarding as reported by mobile crisis teams.

Impact of the COVID-19 Pandemic on the Bed Registry

TDMHSAS was in the process of rolling out the PBMS referral system and integrating the EHR system to provide real time updates to HRTS, but work paused during the pandemic.

System Oversight

The TN Department of Health's Office of Emergency Preparedness oversees the HRTS bed registry, and through collaboration both TDOH and TDMHSAS manage the patient bed matching project.

Project Contact

Melissa Sparks, MSN, RN, Deputy Assistant Commissioner, Division of Hospital Services, at melissa.sparks@tn.gov or 615-253-4641.



Current Approach and Need for Change

Reports from consumers, emergency room staff, and treatment advocates point to significant delays in finding inpatient beds for individuals in mental and/or substance

use crises. In October 2019, the Governor's office issued a strategic plan to improve mental health care in the state. The plan recommended an *"enhanced call center that would serve as a 911 for behavioral health. It will include a triage process to get people to the right care at the right time, by being connected to a comprehensive system of care."* As one tool to implement the Governor's vision, Utah's Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH) began work on a bed registry as an important tool for mobile crisis teams and emergency departments to identify and secure *"to the right care at the right time."* A lengthy procurement process and disruption by the pandemic has delayed the Utah Behavioral Health Availability Platform until later this year. A kickoff to announce the bed registry and begin user training scheduled for late 2020 was postponed so that project staff could address urgent pandemic issues.



"Hospitals are interested in a bed registry as a time saving tool."

—Shanel Long, Project Director (UT)

Type of Bed Registry

The Utah Behavioral Health Availability Platform is a *search engine* (Figure 30).

Planning Partners

DSAMH convened focus groups across the Wasatch Front (the metropolitan region in the north-central part of the state where 75% of the population resides). DSAMH has convened the state's Hospital Association and representatives of Crisis Intervention Teams, National Alliance for Mental Illness, peers, and emergency medical services as well as the local mental health authorities and regional Medicaid managing entities for input on the type of system stakeholders wanted. They also met with front-line staff of inpatient and crisis stabilization units to address obstacles to their participation.

Crisis System Beds to Be Included in the Registry

Beginning with mental health inpatient beds, the program will expand to include substance use disorder residential programs and social detoxification centers along the Wasatch front.

Registry Development Vendor

Juware is providing the EMSResource® platform and will capture and report data. The vendor also provides a smart phone app that enables users to enter and access data through mobile devices.

Access to the Registry

Emergency room staff, participating inpatient units, call centers (including the University of Utah), and mobile crisis teams will be able to access the search engine.

Refresh Rate and Entry Process

Utah plans to have participating inpatient units update bed availability twice per day at shift changes likely to occur mid-morning and early evening.

Meaningful Metrics

- Time in emergency departments awaiting placement.
- Inpatient bed turnover.

Impact of the COVID-19 Pandemic on the Bed Registry

Staff involved with the bed registry were reassigned to address urgent pandemic related matters. Meeting with planning partners was suspended during the pandemic.

System Oversight

The current project directors will continue to manage the system and review data. Monthly reports outlining significant trends will be submitted to the state director of DSAMH.

Project Contacts

- Pam Bennett, Adult Mental Health Program Administrator, at pbennett1@utah.gov or 801-819-9450.
- Shanel Long, Adult Substance Abuse Treatment Administrator, DSAMH, at shlong@utah.gov or 801-995-2176.

VERMONT

Current Approach and Need for Change

Launched August 13, 2011, Vermont’s “E-Bed Board” is among the longest operating electronic bed registries in the U.S. The E-Bed Board is a part of a greater care management system at Vermont’s Department of Mental Health (DMH) and provides bed availability for crisis stabilization, inpatient, residential (step-down), and intensive residential beds, as well children’s inpatient and crisis beds throughout the state. The graphic below displays the list of local facilities. More detailed information is provided on each facility when “view” is selected and includes referral forms to be completed. E-Bed Board also provides information on programs that are designed to serve individuals with higher levels of acuity. A recent evaluation of the program concluded that the system is working well to meet the needs of the Department, providers, and users. Additional pages are being added to provide tutorials and training so that users can take full advantage of its functionality.

Type of Bed Registry

The E-Bed Board is a *search engine* accessible to anyone.

FIGURE 30: Projected Display of Utah’s Bed Registry

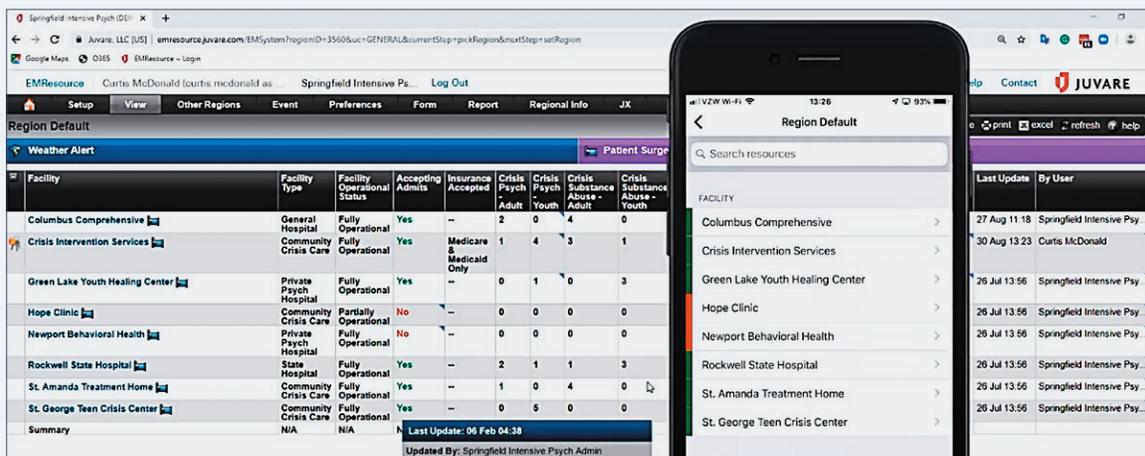
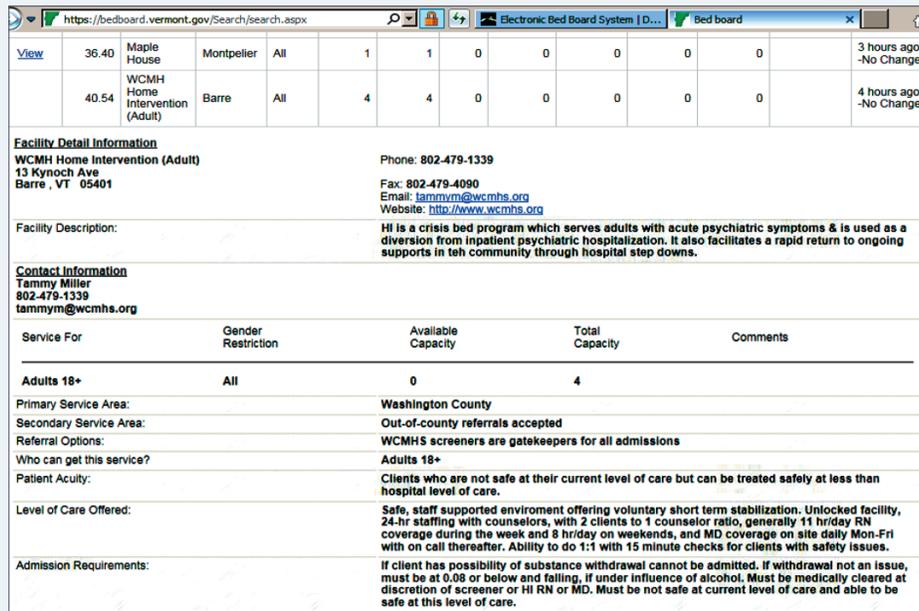


FIGURE 31: A User View of Vermont's E-Bed Board



The screenshot shows a web browser window with the URL <https://bedboard.vermont.gov/Search/search.aspx>. The page displays search results for facilities. Two results are visible:

View	Facility ID	Facility Name	Location	Gender	Available Capacity	Total Capacity	Other Metrics	Update Time
View	36.40	Maple House	Montpelier	All	1	1	0 0 0 0 0 0	3 hours ago -No Change
	40.54	WCMH Home Intervention (Adult)	Barre	All	4	4	0 0 0 0 0 0	4 hours ago -No Change

Below the search results, the facility details for WCMH Home Intervention (Adult) are displayed:

Facility Detail Information
WCMH Home Intervention (Adult)
13 Kynoch Ave
Barre, VT 05401
Phone: 802-479-1339
Fax: 802-479-4090
Email: tammym@wcmhs.org
Website: <http://www.wcmhs.org>

Facility Description: HI is a crisis bed program which serves adults with acute psychiatric symptoms & is used as a diversion from inpatient psychiatric hospitalization. It also facilitates a rapid return to ongoing supports in the community through hospital step downs.

Contact Information
Tammy Miller
802-479-1339
tammym@wcmhs.org

Service For	Gender Restriction	Available Capacity	Total Capacity	Comments
Adults 18+	All	0	4	

Primary Service Area: Washington County
Secondary Service Area: Out-of-county referrals accepted
Referral Options: WCMH's screeners are gatekeepers for all admissions
Who can get this service? Adults 18+
Patient Acuity: Clients who are not safe at their current level of care but can be treated safely at less than hospital level of care.
Level of Care Offered: Safe, staff supported environment offering voluntary short term stabilization. Unlocked facility, 24-hr staffing with counselors, with 2 clients to 1 counselor ratio, generally 11 hr/day RN coverage during the week and 8 hr/day on weekends, and MD coverage on site daily Mon-Fri with on call thereafter. Ability to do 1:1 with 15 minute checks for clients with safety issues.
Admission Requirements: If client has possibility of substance withdrawal cannot be admitted. If withdrawal not an issue, must be at 0.08 or below and falling, if under influence of alcohol. Must be medically cleared at discretion of screener or HI RN or MD. Must be not safe at current level of care and able to be safe at this level of care.

Planning Partners

Emergency service screeners, inpatient facilities, crisis bed managers, intensive residential directors, residential programs, designated hospitals and agencies, DMH Care Management, and hospital and provider associations had significant input at the program's inception and meet occasionally as the need arises.

Crisis System Beds to Be Included in the Registry

Public and private psychiatric hospitals, psychiatric inpatient units in general hospitals, crisis stabilization units, community residential and intensive residential beds, and children's acute and crisis beds.

Registry Development Vendor

The Minnesota Hospital Association built and maintains the website and database.

Access to the Registry

Although <https://bedboard.vermont.gov> is a password-protected website, the password and username are publicly available at <https://mentalhealth.vermont.gov/providers/electronic-bed-board-system>.

Refresh Rate and Entry Process

The system runs an automatic query on bed availability daily at 8 a.m., 4 p.m., and 12 a.m. If updates have not



“Don't start building the system you think you need until you've asked the stakeholders what they want it to do.”

—Amy Guidice, Project Manager, Vermont DMH

been entered into the system within pre-determined standards as agreed upon by DMH and provider partners, E-Bed Board notifies the provider to prompt an update. Inpatient and crisis settings are updated once per 8-hour shift or as changes occur; intensive residential settings are updated once per day or as changes occur; and residential settings are updated once per month or as changes occur.

Meaningful Metrics

- Occupancy rates, particularly Level 1 (high) acuity.
- Anticipated bed availability in comparison to emergency room boarding.
- First arrival to the hospital emergency department until admission to a treatment bed for every voluntary commitment of consumers with medical care paid or subsidized by state and federal funding and all involuntary commitments in the state.

FIGURE 32: West Virginia's Help4WV Search Engine

Impact of the COVID-19 Pandemic on the Bed Registry

- At the start of pandemic prevention efforts, facilities delayed updating the E-Bed Board as they were shifting beds to prevent contagion in units such as reducing double rooms to single rooms. Timeliness improved once spaces prevention efforts were in place.
- At its lowest, there was a significant 37% reduction in bed capacity in hospital settings as accommodations were made, infected units were closed, and staffing levels fell due to illness.
- As capacity fell so did demand. Based on emergency department wait times, demand is increasing as restrictions lift.
- Providers entered comments on their status related to the pandemic such as reduced capacity and special admission procedures.

System Oversight

Department staff manages day-to-day operations of the E-Bed Board. The state Care Management Director incorporates metrics listed above into a monthly report to the Department Director

Project Contact

Samantha Sweet, Care Management Director/
Operations Director, at Samantha.Sweet@Vermont.gov
or 802-560-0605

WEST VIRGINIA

Current Approach and Need for Change

Since a 2014 U.S. Department of Justice civil action critical of West Virginia's behavioral health services to children, the West Virginia Bureau for Behavioral Health (BBH) has worked steadily to improve in-home and community-based services, make critical mental health services more readily available, and reduce extensive wait times at West Virginia's Comprehensive Centers. Consulting with Connecticut, New Jersey, and Oklahoma on their systems of care, WVBBH is designing and putting into place a continuum of care that integrates call centers, mobile crisis teams, and wraparound services for children and their families. The development of a bed registry is expected to follow the establishment of these critical system components:

- **Statewide call center:** The Help4WV call center with 24/7 call, chat, and text lines provides immediate help to individuals with an addiction and mental health crisis. Help4WV (<https://www.help4wv.com>) can directly connect callers with providers during calls.
- **Mobile crisis teams:** Children's Mobile Crisis Response and Stabilization (MCRSS) service teams are available in five of the state's six regions, with the final region coming online in 2021, when the services will be available in all 55 West Virginia counties. Crisis response services by phone are already available statewide through the Children's Crisis and Referral Line launched in October 2020 as part of Help4WV with

First Choice Services, which is also the state’s National Suicide Prevention Lifeline call center.

- **Community alternatives to hospitalization:** Establishing respite care as alternative settings to inpatient psychiatric placements for children.
- **Preventing crises from occurring:** Children’s Wraparound services¹⁷, available to families in all 55 counties statewide.

Type of Bed Registry

The current website (<https://www.help4wv.com/resources>) displays key information about crisis and treatment services for behavioral health disorders. Regularly updated information on bed availability will be added to the website as it continues to evolve. The bed registry is a *search engine* (Figure 32).



“The bed registry will complement the state’s efforts to build a comprehensive crisis system for children and their families and improve access through a statewide call center.”

—Nikki Tennis, Director of Children’s Behavioral Health Services, BBH (WV)

Planning Partners

BBH has collaborated with the Office of Medical Facilities, Hospital Association, Primary Care Association, Bureau of Children’s and Families, and the Behavioral Health Planning Council. The University of Maryland and West Virginia University are completing surveys of stakeholders, with an emphasis on gathering feedback from families to inform the design of the crisis system and the bed registry.

Crisis System Beds to Be Included in the Registry

The bed registry will initially focus on substance use treatment facilities and residences. A later expansion will include public and private psychiatric hospitals, psychiatric units in general hospitals, and crisis triage centers. In addition, it will include outpatient, substance abuse residential care, children’s respite, and residential care.

Registry Development Vendor

BBH is in the process of selecting a bed registry vendor.

Access to the Registry

The state has not determined the type of registry (*search engine* or *referral*) or whether access to the registry website will be public or limited.

Refresh Rate and Entry Process

The refresh rate and entry process have not been established.

Meaningful Metrics

Metrics have not been determined.

Impact of the COVID-19 Pandemic on the Bed Registry

None reported.

System Oversight

The Director of Children’s Behavioral Health Services, WVBBH, oversees the project and reports to the Deputy Commissioner.

Project Contact

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¹⁷Wraparound is a team-based care planning approach that builds upon strengths to identify appropriate formal and informal supports. Wraparound partners with the youth and their family to convene a team of cross-sector service providers, community members, friends, and other supports to develop a comprehensive, individualized, and creative plan of care. (SAMHSA, Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders: State and Community Profiles. SAMHSA Publication No. PEP19-04-01-001. Rockville, MD, 2019)

GLOSSARY

24-Hour Crisis Lines or Call Centers provide assessment, screening, triage, preliminary counseling, information, and referrals to services and are often the first point of contact for a person in crisis or their loved ones.

Click for More Information

Clinically Managed High-Intensity Residential American Society of Addiction Medicine (ASAM) Level 3.5

includes 24-hour care with trained counselors to stabilize patients in multidimensional imminent danger and prepare them for outpatient treatment. This level of care is for patients able to tolerate and use a full, active milieu or therapeutic community. *Click for More Information*

Clinically Managed Low-Intensity Residential ASAM Level 3.1

includes 24-hour structure with available trained personnel; at least five hours of clinical service per week. *Click for More Information*

Clinically Managed Medium-Intensity Residential ASAM Level 3.3

includes 24-hour care with trained counselors to stabilize multidimensional imminent danger. This level includes less intense milieu and group treatment for those with cognitive or other impairments who are unable to use a full, active milieu or therapeutic community. *Click for More Information*

Crisis Stabilization Units (CSUs) are small inpatient facilities with less than 16 beds for people experiencing a mental health crisis whose needs cannot be met safely in residential service settings. CSUs may be designed to admit on a voluntary or involuntary basis when the person needs a safe, secure environment that is less restrictive than a hospital. CSUs try to stabilize the person and get them back into the community quickly. *Click for More Information*

Crisis Observation Units (also known as Extended Observation Units (EOUs) or <24-hour Crisis Stabilization Units)

are settings with a maximum stay of less than 24 hours that can provide stand-alone services or be embedded within a CSU. Admission to an EOU is appropriate when the crisis can be resolved in less than 24 hours. EOUs are designed for persons who may need short, intensive treatment in a safe environment that is less restrictive than a hospital. *Click for More Information*

Inpatient psychiatric hospitals provide the most-intensive level of psychiatric care that is delivered in a

licensed hospital setting. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour, secure and protected, medically staffed, and psychiatrically supervised treatment environment. They offer 24-hour skilled nursing care, daily medical care, and a structured treatment milieu. The goal of acute inpatient care is to stabilize patients who display acute psychiatric conditions associated with a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the patient poses a significant danger to self or others or displays severe psychosocial dysfunction. Behavioral health providers may also have physical, chemical, and mechanical restraint, seclusion, and a locked unit available as additional resources.

Click for More Information

Medically Managed Intensive Inpatient ASAM Level 4

includes 24-hour nursing care and daily physician care for severe, unstable problems. This includes counseling to engage individuals in treatment.

Click for More Information

Medically Monitored Intensive Inpatient ASAM Level 3.7

includes 24-hour nursing care and 16-hours-per-day counselor availability, with the added availability of physicians for significant problems. *Click for More Information*

Mobile Crisis Teams intervene wherever the crisis is occurring, often working closely with the police, crisis hotlines, and hospital emergency personnel. Mobile teams may provide pre-screening assessments or act as gatekeepers for inpatient hospitalization and can also connect an individual with community-based programs and other services. *Click for More Information*

Peer Crisis Residential Services are operated by individuals with experience living with a mental illness (i.e., peers). Peer crisis programs are designed as calming environments with supports for individuals in crisis. They are delivered in community settings with medical support. Services are intended to last less than 24 hours but may extend up to several days if needed. Peer crisis services are generally shorter term than crisis residential services.

Click for More Information

Psychiatric Residential Treatment Facilities (PRTFs)

are stand-alone entities providing a range of comprehensive services to treat the psychiatric condition

of residents under the age of 21 on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the individual's condition or prevent further regression so that the services will no longer be needed. *Click for More Information*

Respite Care provides parents and other caregivers with short-term childcare services that offer temporary relief, improve family stability, and reduce the risk of abuse

or neglect. Respite can be planned or offered during emergencies or times of crisis. *Click for More Information*

Walk-in crisis services, such as clinics or psychiatric urgent care centers, offer immediate attention. They focus on resolving the crisis in a less-intensive setting than a hospital, though hospitalization may be recommended when appropriate. Walk-in clinics may serve as drop-off centers for law enforcement to reduce unnecessary arrests. *Click for More Information*

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