SAMHSA Expert Panel on Best Practices in Statewide Real-time Crisis Bed Databases

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Disclaimer

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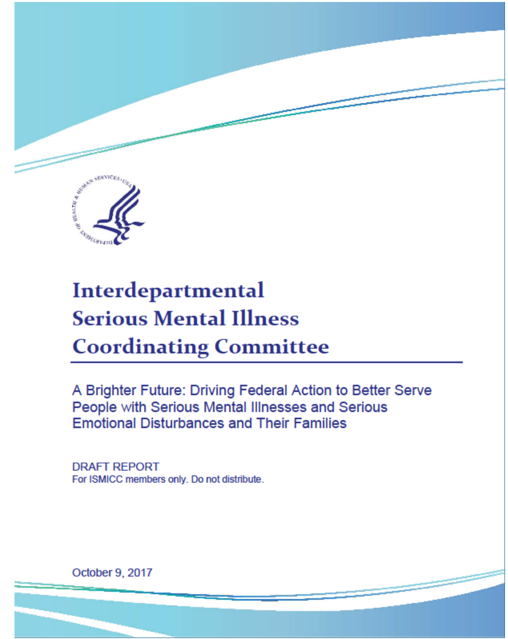
Section 9007 of the 21st Century CURES Act

Realtime database of beds at **inpatient** psychiatric facilities, **crisis stabilization units**, and **residential community** mental health and **residential substance use disorder treatment facilities….** for adults and children

Interdepartmental Serious Mental Illness Coordinating Committee Recommendations

2.2 Develop a continuum of care that includes adequate psychiatric bed capacity and community based alternatives to hospitalization.

3.1.g. Psychiatric crisis response using least-restrictive appropriate settings… eliminating "psychiatric boarding" in hospital emergency departments;



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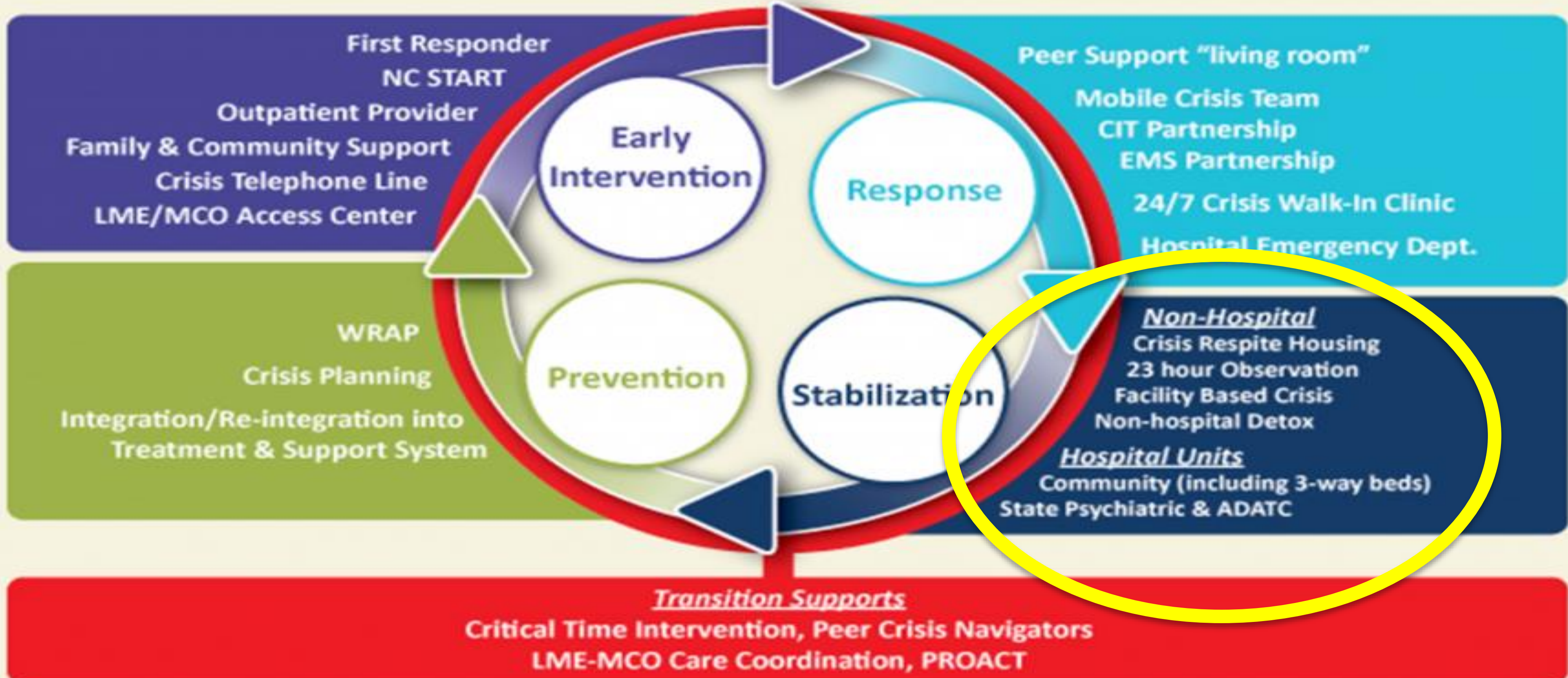
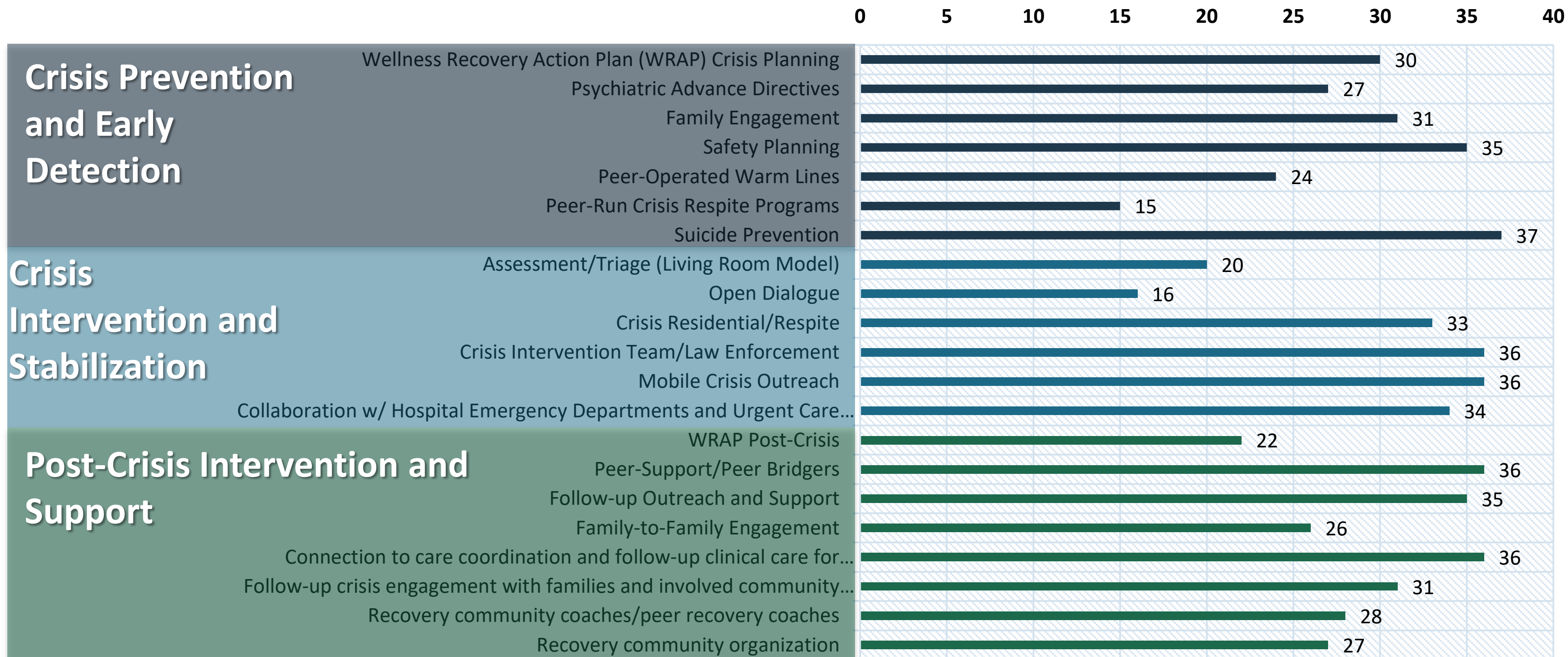


BUILDING A
Crisis Services Continuum
TO MATCH A CONTINUUM OF CRISIS INTERVENTION NEEDS
First Responder
NC START
Outpatient Provider
Family & Community Support
Crisis Telephone Line
LME/MCO Access Center
Early Intervention
Response
Peer Support "living room"
Mobile Crisis Team
CIT Partnership
EMS Partnership
24/7 Crisis Walk-In Clinic
Hospital Emergency Dept.
WRAP
Crisis Planning
Integration/Re-integration into Treatment & Support System
Prevention
Stabilization
Non-Hospital
Crisis Respite Housing
23 hour Observation
Facility Based Crisis
Non-hospital Detox
Hospital Units
Community (including 3-way beds)
State Psychiatric & ADATC
Transition Supports
Critical Time Intervention, Peer Crisis Navigators
LME-MCO Care Coordination, PROACT

2018 Block Grant Application



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2018 Block Grant Application

Crisis Prevention and Early Detection (N=40)

Service Categories	Count	Percent
Wellness Recovery Action Plan Crisis Planning	30	75%
Psychiatric Advance Directives	**27**	**68%**
Family Engagement	31	78%
Safety Planning	35	88%
Peer-Operated Warm Lines	**24**	**60%**
Peer-Run Crisis Respite Programs	**15**	**38%**
Suicide Prevention	37	93%

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Crisis Intervention and Stabilization (N=40)

Service Categories	Count	Percent
Assessment/Triage (Living Room Model)	**20**	**50%**
Open Dialogue	**16**	**40%**
Crisis Residential/Respite	33	83%
Crisis Intervention Team/Law Enforcement	36	90%
Mobile Crisis Outreach	36	90%
Collaboration with Hospital Emergency Departments and Urgent Care Systems	34	85%

2018 Block Grant Application

Post-Crisis Intervention and Support (N=40)

Service Categories	Count	Percent
WRAP Post-Crisis	**22**	**55%**
Peer Support/Peer Bridgers	36	90%
Follow-up Outreach and Support	35	88%
Family-to-Family Engagement	**26**	**65%**
Connection to Care Coordination and Follow-up Clinical Care for Individuals in Crisis	36	90%
Follow-up Crisis Engagement with Families and Involved Community Members	31	78%
Recovery Community Coaches/Peer Recovery Coaches	28	70%
Recovery Community Organization	**27**	**68%**

Expert Panel Objectives

1. To examine the experiences of states and MCOs that have implemented bed registries.
2. To identify the practical aspects of an effective registry.
3. To examine the policy challenges which must be resolved for a registry to be effective.

Expert Panelists

- Panelists represented a variety of stakeholders:
  - State mental health authorities
  - State health authorities
  - Managed care organizations
  - Hospital systems
  - Crisis service providers
  - Family members
  - Individuals with lived experience

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Seemingly Simple, but with Challenges to Overcome

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

- Use the SMHA’s role as a convener to conduct an analysis of the current system operation.
  - Question to stakeholders: How can a database improve the system operations for all users?

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Challenge 1: Stakeholders are invested in the existing process and distrustful of changes. (2)

- Stakeholders
  - SMHA
  - State Medicaid Office
  - State Health Authority
  - Attorney General
  - Families
  - People with lived experience
  - Police and EMS
- Emergency departments
- General hospital inpatient units
- Receiving hospitals
- Crisis services providers
- Managed care organizations
- NAMI/MHA
- State hospital association

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

- Value proposition for databases.
  - Increased accountability across the system and hierarchically
  - Better utilization of existing services.
  - Identification of mismatches between service needs and service capacities.

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Challenge 3: Relying on the database alone to make placements.

- Even though registries are automated, placements are always hands-on.
  - Complex cases will remain complex.
  - Receiving facilities may assert right to refuse individual cases

Challenge 4: Inadequate resolution of policy issues affects overall buy-in into the database.

- Navigating policy issues around EMTALA and the IMD exclusion
  - Requires partnerships among state agencies
    - State Medicaid Office and Attorney General are essential partners on addressing policy issues.
  - Transparency with stakeholders and organizations feeding data into the database

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How Should a State Proceed…

1. Inventory Existing Services and Systems

- State mental health commissioner can serve as a convener to the process.

- Inventory of state and local crisis systems
  - Call centers
  - Mobile and static crisis responses
  - Crisis stabilization
  - Community respite or residential
  - Inpatient
  - Specialized inpatient

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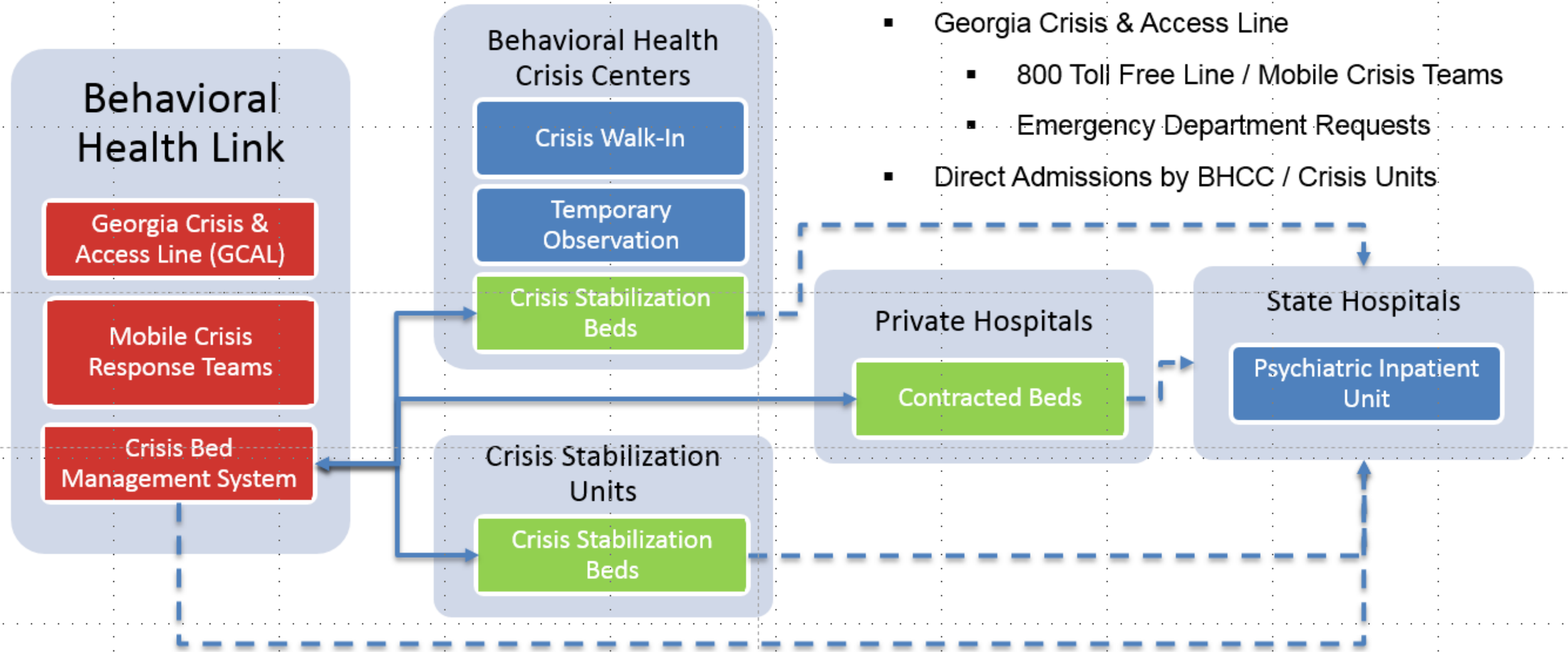
2. Develop a Description of the Existing System



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

Source: J. Quesenberry/W. Farmer (2018)

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3. Design a Database

- The database should be designed with two goals in mind:
  – To reflect the system that exists and
  – With an eye towards the system you want

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4. Engage Stakeholders

What are the benefits of a realtime electronic system for all stakeholders?

- Improving access to and use of most appropriate care
- Reducing wait times
- Reducing reliance on most expensive care
- Providing reliable data on utilization

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5. Incentivize Participation in the Registry

- Market to providers and hospitals that will feed data into the database.
  - Supply providers/hospitals with data which is meaningful to them.
- Use the database as a tool to improve the system as opposed to an enforcement mechanism.
- MCOs can more easily build incentives and disincentives in a database.

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6. "Real Time" Must be Useful to Users

- Few databases are real-time in that availability data are refreshed as <u>beds become available</u> or <u>beds are filled</u>.
- However, limited daily refreshes are a threat to long-term utility of the database.

- "Real time" must be operationalized for each registry.
  - Virginia: Revised statute requires the database be updated as the bed becomes available.
  - Georgia: Providers must update the database when a discharge date is set.

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7. Transparency and Quality Data-Sharing

- Transparency increases accountability across the system.
- Transparent to whom?
  - Hospitals
  - Service providers
  - Managed care organizations
  - Families and people in need of services?
    - Public-facing vs. Provider-facing levels of access

- Data-sharing of protected health information.
  - Improves value of the system for providers and hospitals who can make a determination as to whether the person in need of treatment matches the level of care they can provide.

8. High-Level Decision-Maker Oversees Registry

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

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9. Engage the State Medicaid Office in the Process

- The four key stakeholders at the state-level are the
  - SMHA
  - State Health Authority
  - State Medicaid Office
  - Attorney General
- The State Medicaid Office needs to have a seat at the table.
  - Many of the policy-level issues required SMO leadership.
    - EMTALA
    - IMD exclusion
    - Medicaid billing on more than one procedure per day

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Discussion

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Discussion

- Is there interest in your state to establish an electronic database of real time (no lag time in identified openings) crisis response bed registry?
- Does your state have a vision for a crisis system that minimizes the use of inpatient beds and maximizes the use of community resources?
- Does your state have a inventory of local and state crisis response systems?
- What are the incentives for hospitals and state systems to maintain the status quo?

Discussion (2)

- Are there existing stakeholder organizations that can be convened?
- Are there contract mechanisms to build alternative incentives for real time systems such as MCOs?
- What incentives exist in your state to implement a registry save money or use resources more efficiently?
- What opportunities do you see in your state to create a system?

Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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