Goal: 100% of Consumers have access without delay to the most appropriate 24/7 emergency, crisis stabilization, inpatient or recovery bed:
Lessons Learned from States with On-Line Registries of Available Psychiatric Crisis and Inpatient Beds
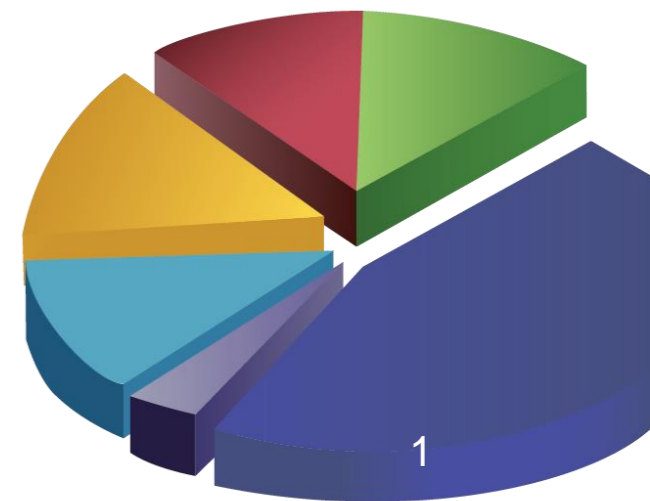
July 29, 2018
NASMHPD Commissioners Meeting
Ted Lutterman
Robert Shaw
National Association of State Mental Health
Program Directors **R**esearch **I**nstitute (NRI)

Shortages of psychiatric beds and behavioral health crisis services are frequently in the news and a focus of courts, advocates, providers, and states

"Md.'s psychiatric bed shortage detrimental to patients and community"

Baltimore Sun (MD), April 24, 2017

"Mental health problems strain ERs"

Rutland Herald (VT), July 15, 2017

"Amid shortage of psychiatric beds, mentally ill face long waits for treatment"

PBS News Hour, August 2, 2016

"Nation's psychiatric bed count falls to record low"

Washington Post, July 1, 2016

"Psychiatric beds disappear despite growing demand"

USA Today, May 12, 2014

"A dearth of psychiatric hospital beds for California patients in crisis"

NPR, April 14, 2016

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"Before I begin, one of the acronyms I'm going to use is completely made up. See if you can figure out which one."

Analytics Improving Behavioral Health℠

Elements of the Problem

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

- Without an on-line registry, searching for available placements is inefficient

- People in need of treatment are made to wait, unnecessarily.

In 2015, NRI asked SMHA if they were Experiencing Bed Shortages in State Psychiatric Hospitals
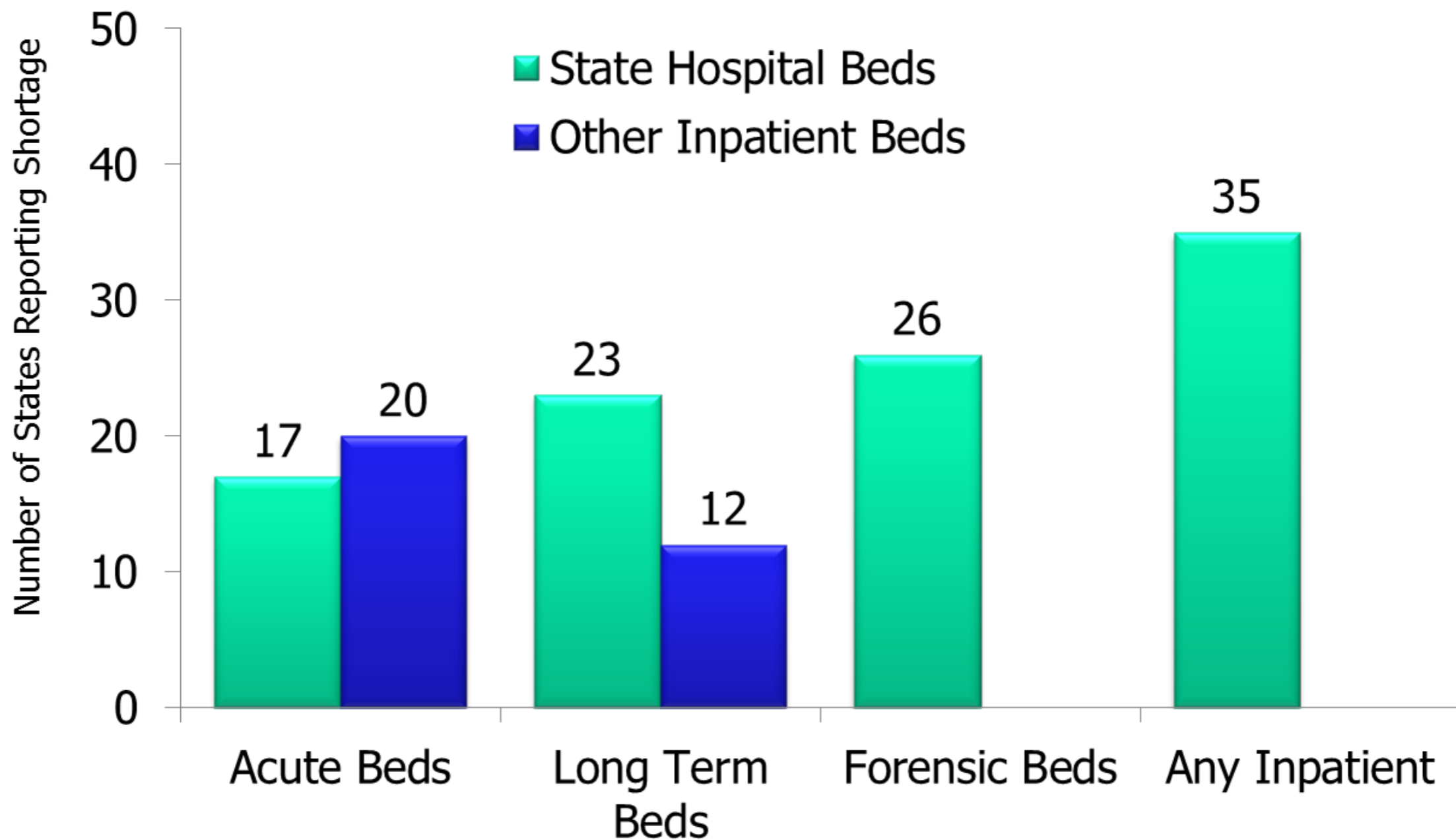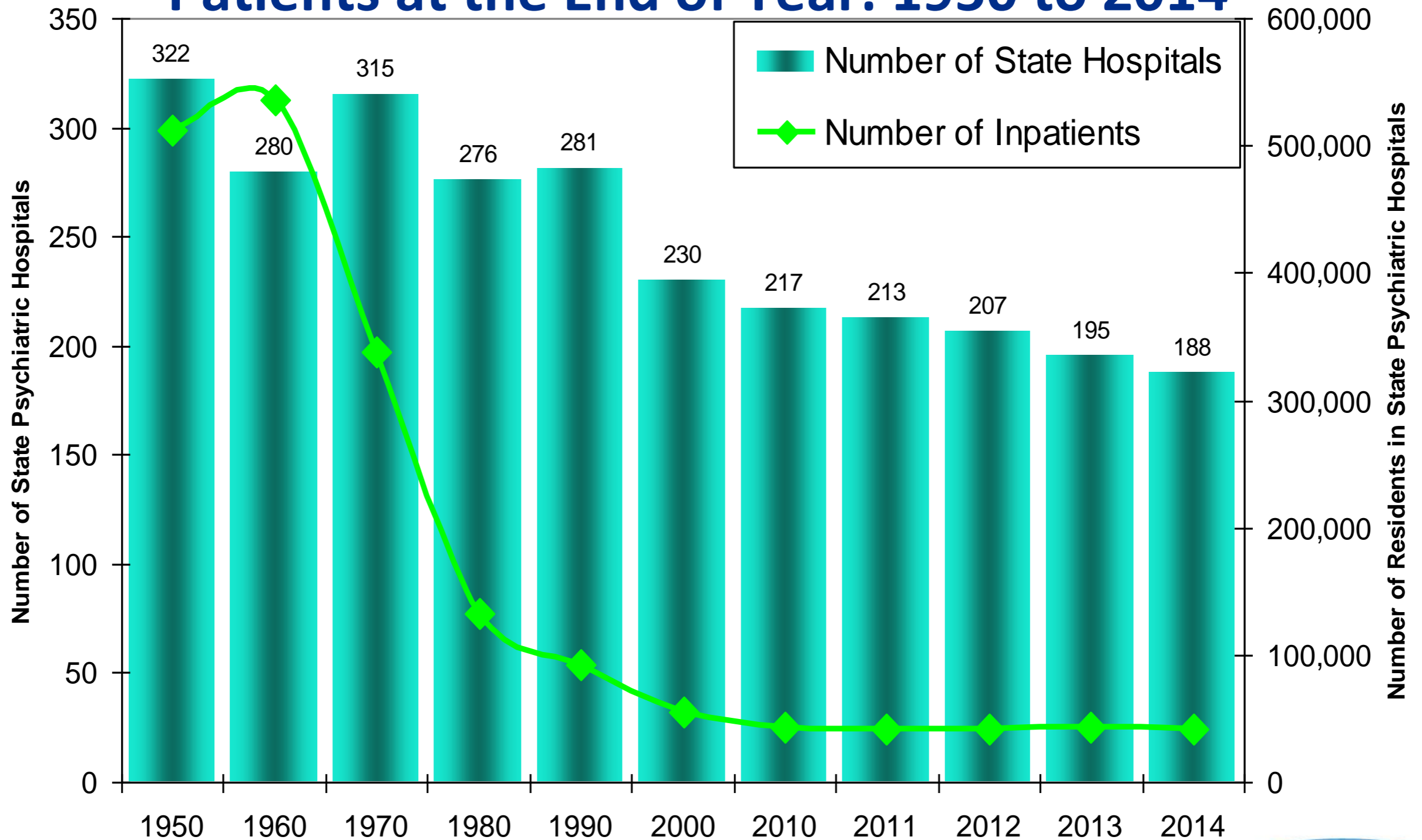

Source: NRI 2015 State MH Profiles

# In 2015 States Reported that Psychiatric Bed Shortages Have Led to
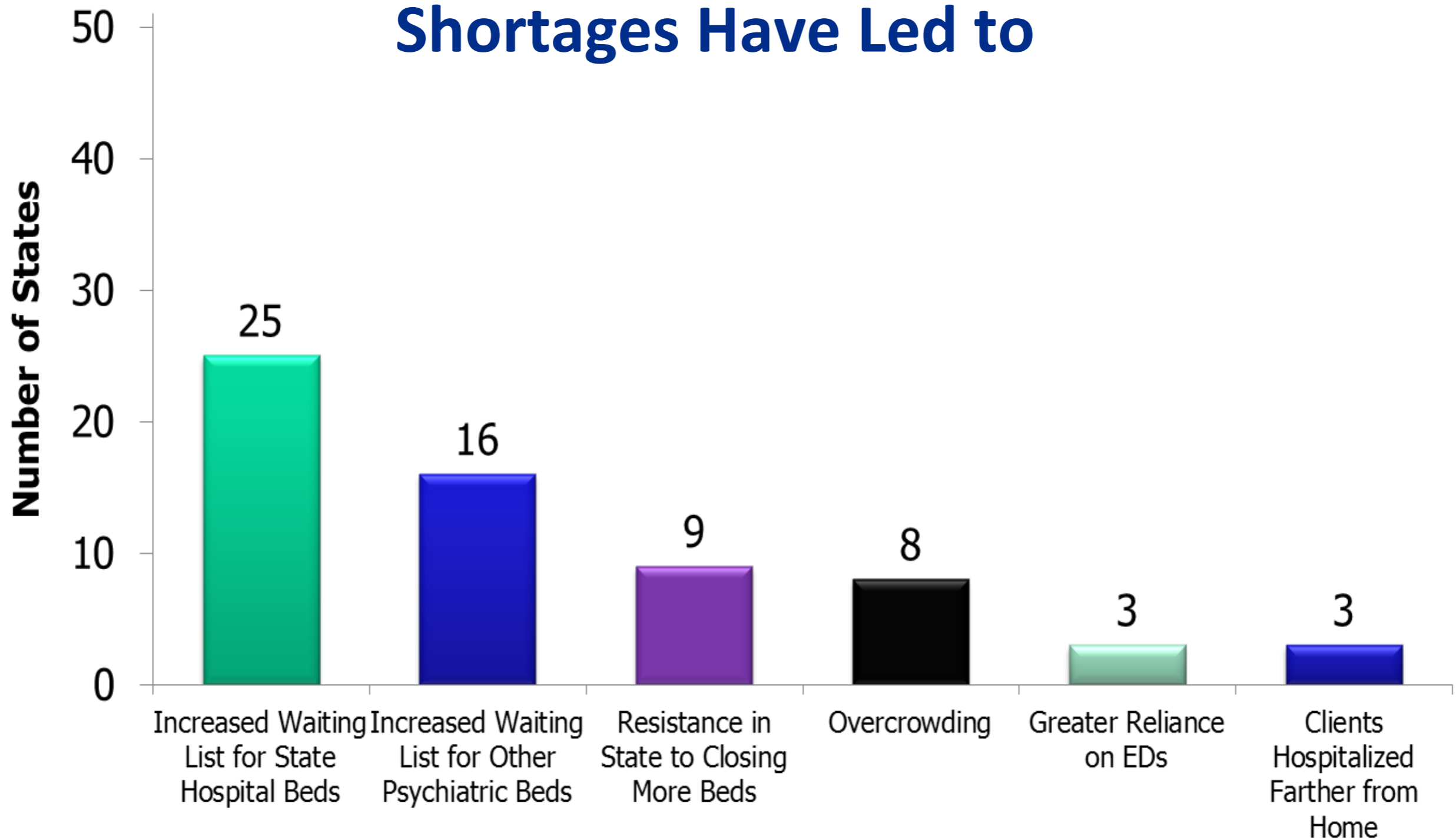
Source: NRI 2015 State MH Profiles

Number of State Psychiatric Hospitals & Resident Patients at the End of Year: 1950 to 2014

Legend:
- Number of State Hospitals
- Number of Inpatients

Number of State Psychiatric Hospitals (left axis): 322, 280, 315, 276, 281, 230, 217, 213, 207, 195, 188

Years: 1950, 1960, 1970, 1980, 1990, 2000, 2010, 2011, 2012, 2013, 2014

Left axis: Number of State Psychiatric Hospitals (0 to 350)
Right axis: Number of Residents in State Psychiatric Hospitals (0 to 600,000)

NRI — Analytics Improving Behavioral Health℠   Since 1987

7

Residents in State Psychiatric Hospitals, Jails, and Prisons, 1950 to 2016
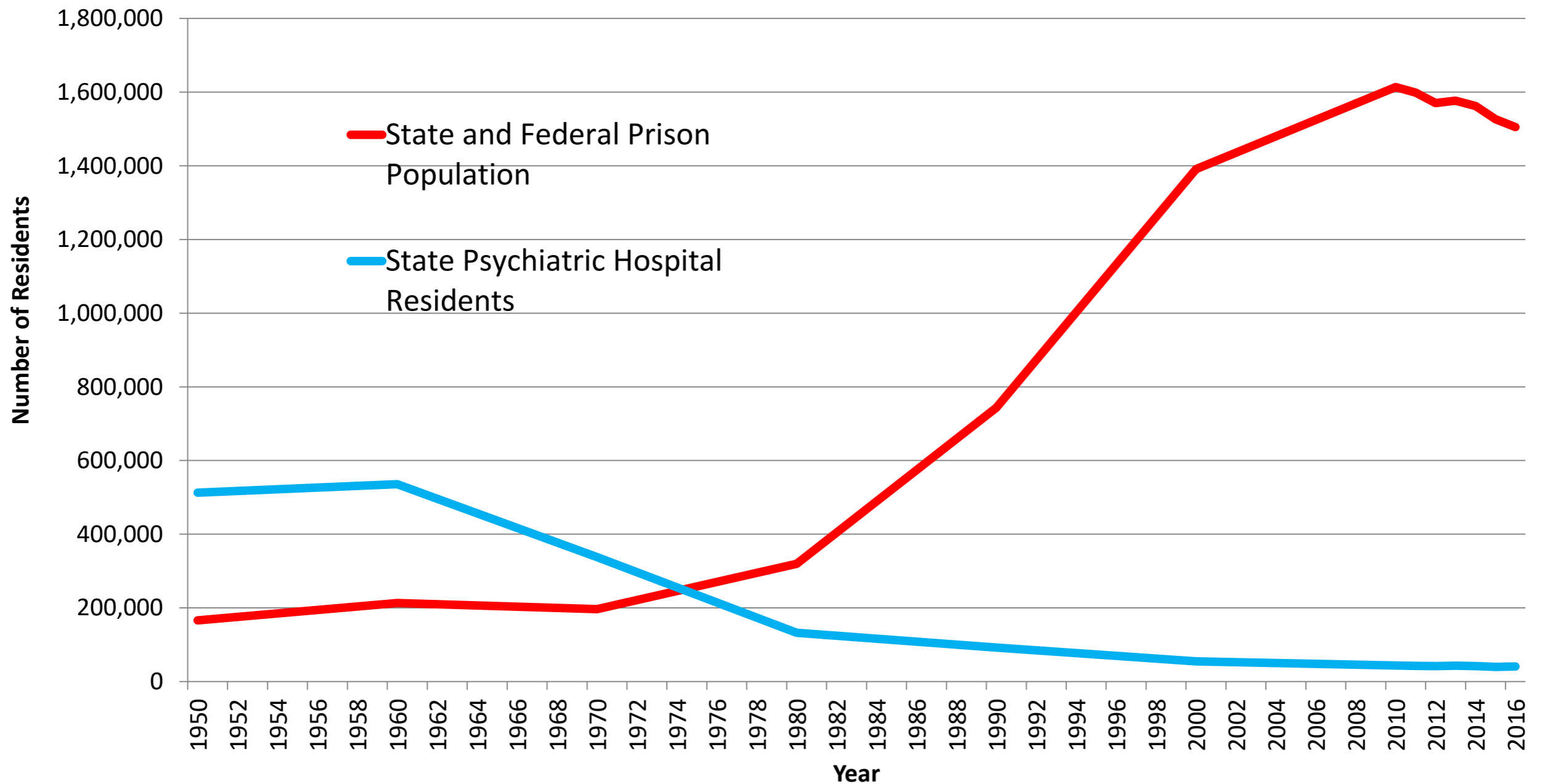
Sources: State Psychiatric Hospitals from: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2002, and SAMHSA Uniform Reporting System: 2004 to 2016

State and Federal Prison Population from: Bureau of Justice Statistics, *Prisoners Series*

State Psychiatric Hospitals Treat Different Caseloads than 40 Years Ago

In 1970

- 29.3% (99,087) Patients were age 65 and Over
- 24% (81,621) had an Organic Brain Syndrome
  - (45,811 of whom were Older Adults)
- 9% (31,884) had Mental Retardation.
- 7% (18,098) had an Alcohol or Drug Disorder (1973 data)

**In 2014**, only 8.8% of patients were age 65 and over
  In 2014 diagnosis was no longer collected by SAMHSA

In 2005

- only 3.8% of patients had a Mental Retardation and
- 3.6% had an Organic Brain disorder
- 5.1% had an Alcohol or Drug Disorder

Number of Public and Private Organizations Providing Inpatient and Other 24-hour Residential Treatment and Patients at the End of Year: 1970 to 2014
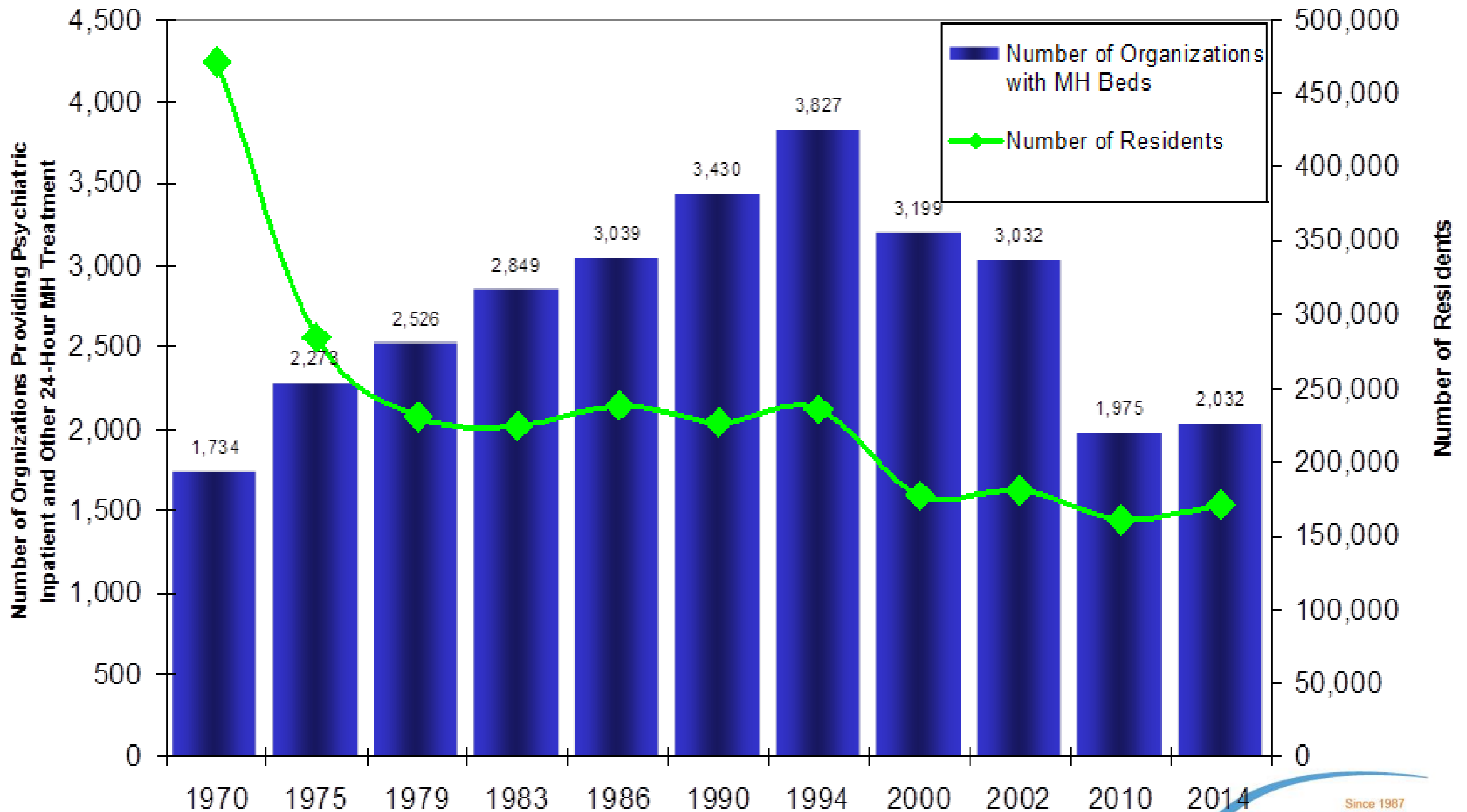
Sources: NIMH, SAMHSA IMHO, 2010 and 2014 NMHSS

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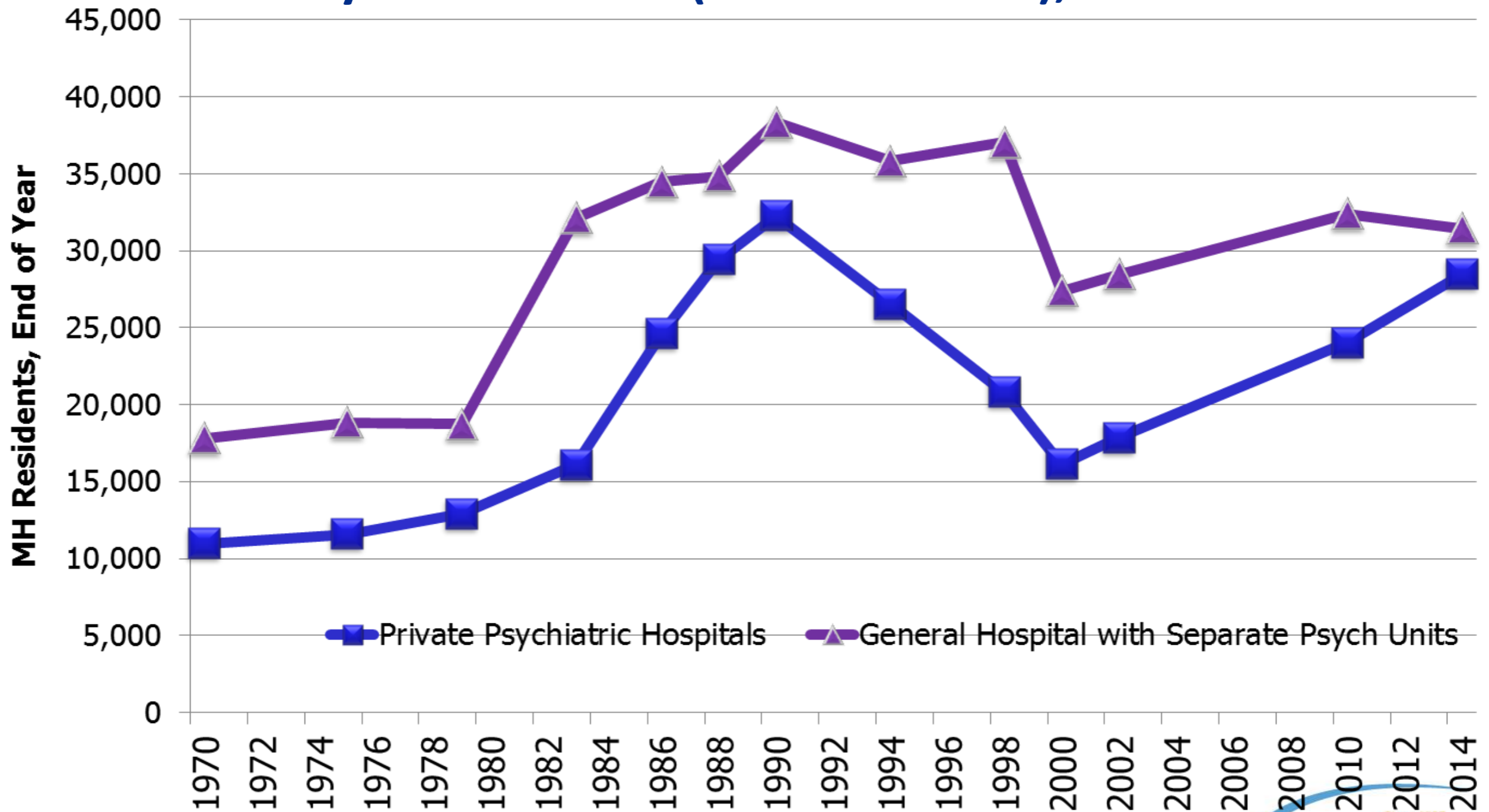
How Many Inpatient Beds Should There Be?

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

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

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

NRI 2017 Survey found 16 states with some form of a psychiatric bed registry

States Responding to Questionnaire on Psychiatric Bed Registries

Legend:
- Existing Registry
- Developing Registry
- Developing new system to replace old one
- States did not have a registry
- Uses registry to move patients out of inpatient beds and into community residential or crisis beds
- Did not respond

Note: Not All Territories are shown.
DC did not have an existing registry.

Existing State Psychiatric Bed Registries (2017 Results)

Existing state registries vary considerably in many areas

- Who operates the registry (state or other)

- What types of providers participate

- Voluntary or required participation

- Frequency of capacity updates

- Who can access and use the registry

NRI-NASMHPD 2018 TA Coalition Paper

To learn more about the experiences of states in operating psychiatric bed registries NRI conducted semi-structured interviews with 9 states

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

2018 TA Coalition Paper Process

- NRI worked with NASMHPD, SAMHSA, and SMHA leaders to develop semi-structured interview protocol

- Identified key staff in 9 states to interview about registry experiences

  - States were selected to reflect variability in several important areas (1) Required vs voluntary participation, (2) State run vs contracted, (3) Variation in types of beds, (4) Regional representation

Participating States:

GA, MD, MN, MO, NY, TN, VA, WI (and RI International in Arizona)

2018 TA Coalition Paper Process

- 1 hour phone interviews were held with staff in each state

  - States followed up with additional details

- NRI developed a summary of each interview that was reviewed by each state

- The draft summary report was reviewed by the interviewee's in each state

The Hospitals Receiving Patients Need to Participate

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

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

- States with "required" reporting to the registry still experienced delays in receiving timely information

  - Be aware that some providers may have financial or workforce incentive to cherry-pick their patients

"Real-Time" Bed Registries

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

- States indicated such a system is technologically feasible but would require provider approval

  - No state has had their providers currently willing to participate in such an automated system

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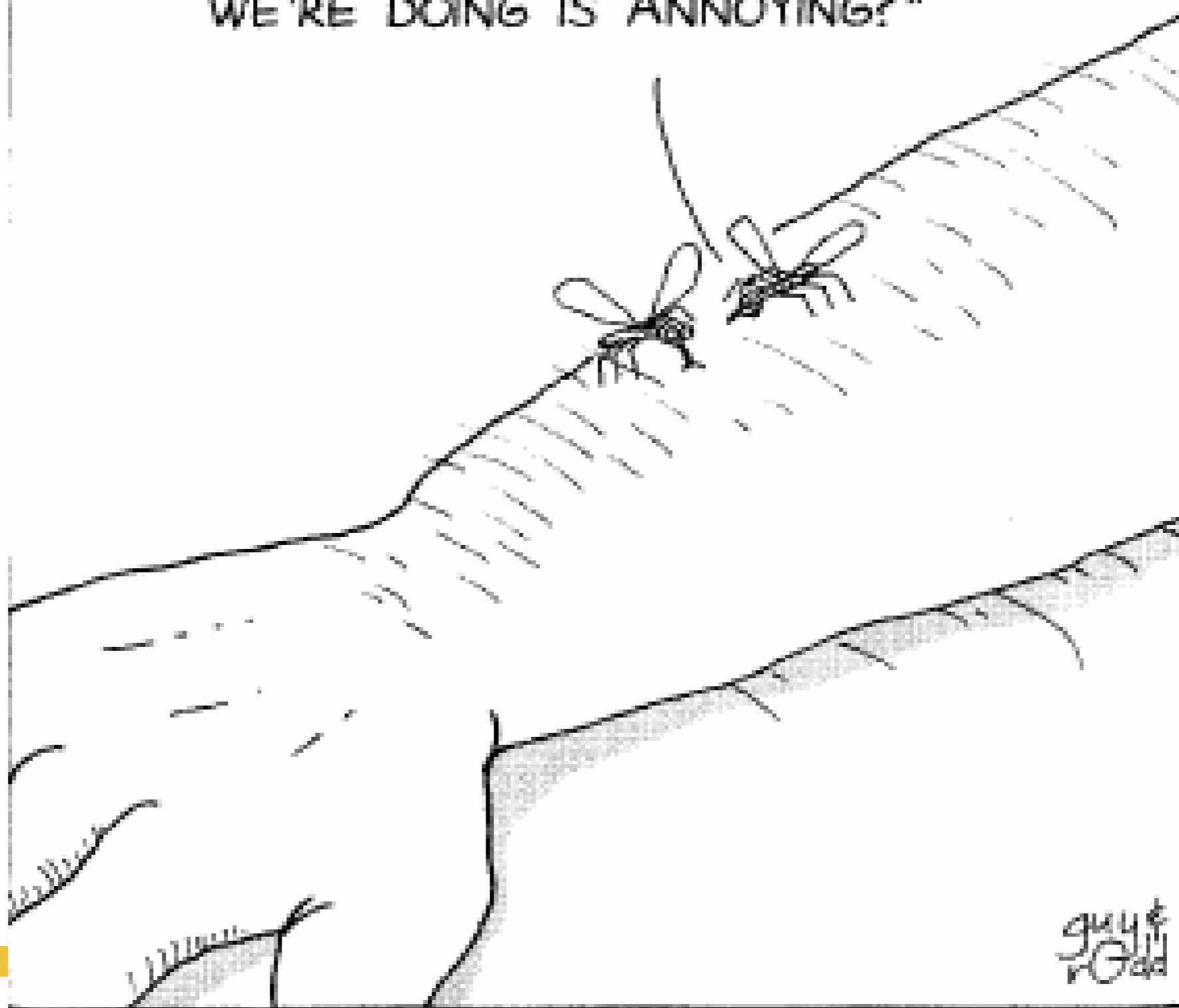
Technology is Not The Barrier: It Doesn't Cost Much To Build an On-Line Registry

- Useful, though basic, registries were built in as little as 16 hours and cost only $50,000.

- A State's cost to maintain a registry can be less than $60,000 annually.

- This buys a manually updated system that can track use and time between updates, allows possible available beds to be found easily.

  - It doesn't buy a reservation or a real-time system

A Registry as part of a Crisis Referral/Triage System: A Broader Conceptualization of Registries

- Several states have built their bed registry as part of a larger crisis response system
- An effective registry can allow the tracking of clients in need of mental health services giving system information that can allow them to:
  - Triage service needs from crisis response to inpatient care
  - Manage the flow of clients to the most intensive levels of care appropriate for client needs
  - Better serve clients in crisis by decreasing wait times

If You've Seen One State You've Seen One State

- There is great variation in how states organize and fund behavioral health services.

- The development of a registry in a state should involve all stakeholders and take into account that state's unique structures and needs.

- There's nothing wrong with just building an effective registry if it makes finding placements more efficient and reduces wait times for clients.

June 18th SAMHSA Expert Meeting on Crisis Bed Registries

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

- NRI presented preliminary results from the Bed Registries Study

- Several states presented on their experiences operating registries

- Identified themes and issues to consider in establishing registries

June SAMHSA Experts Meeting Suggestions (1 of 4)

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

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

- A "Real Time" Registry needs to be real time. A lag in available beds frustrates users and ends up reducing overall utility of the Registry

June SAMHSA Experts Meeting Suggestions (2 of 4)

- **Use the State Authority to get started**
  - Involve stakeholders including Families, MH Consumers, Emergency Departments, First Responders to drive participation

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

  - Sell the value of a Registry from the perspectives of each different stakeholder

June SAMHSA Experts Meeting Suggestions (3 of 4)

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

June SAMHSA Experts Meeting Suggestions (4 of 4)

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

- **A Registry can help document the number and type of specialty beds in a geographical area:**
  - Monitoring a Registry can identify shortages in crisis and inpatient beds in by specialty and area

For Additional Information…

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