COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

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November 6, 2020

The Honorable Louise Lucas, Chair
Senate Education and Health Committee
The Honorable Mark Sickles, Chair
House Health, Welfare, and Institutions Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Lucas and Delegate Sickles:

Chapter 235 of the 2020 Acts of Assembly (SB 739/HB 1453) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with other state agencies and stakeholders, to evaluate the role of the acute psychiatric bed registry. Specifically, the language states:

That the Department of Behavioral Health and Developmental Services (the Department) shall establish a work group to include representatives of such stakeholders as the Department may deem appropriate (i) to evaluate the role of the acute psychiatric bed registry (the registry) in collecting and disseminating information about the availability of acute psychiatric beds in the Commonwealth and collecting data and information to ensure adequate oversight of the process by which individuals are referred for acute psychiatric services, the structure of the registry, and the types of data required to be reported to the registry and (ii) to make recommendations for statutory, budgetary, or other actions necessary to redefine the purpose of the registry and improve its structure and effectiveness. The work group shall report its findings, conclusions, and recommendations to the Governor and the Chairmen of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century by November 1, 2020.

In accordance with this item, please find enclosed the report for SB739 and HB1453 of the 2020 General Assembly Session. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Daniel Carey, MD
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

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November 6, 2020

The Honorable R. Creigh Deeds, Chair
Joint Subcommittee to Study Mental Health Services in the Twenty-First Century
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Deeds:

Chapter 235 of the 2020 Acts of Assembly (SB 739/HB 1453) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with other state agencies and stakeholders, to evaluate the role of the acute psychiatric bed registry. Specifically, the language states:

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November 6, 2020

The Honorable Ralph S. Northam
Governor of Virginia
1111 East Broad Street
Richmond, VA 23219

Dear Governor Northam:

Chapter 235 of the 2020 Acts of Assembly (SB 739/HB 1453) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with other state agencies and stakeholders, to evaluate the role of the acute psychiatric bed registry. Specifically, the language states:

That the Department of Behavioral Health and Developmental Services (the Department) shall establish a work group to include representatives of such stakeholders as the Department may deem appropriate (i) to evaluate the role of the acute psychiatric bed registry (the registry) in collecting and disseminating information about the availability of acute psychiatric beds in the Commonwealth and collecting data and information to ensure adequate oversight of the process by which individuals are referred for acute psychiatric services, the structure of the registry, and the types of data required to be reported to the registry and (ii) to make recommendations for statutory, budgetary, or other actions necessary to redefine the purpose of the registry and improve its structure and effectiveness. The work group shall report its findings, conclusions, and recommendations to the Governor and the Chairmen of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century by November 1, 2020.

In accordance with this item, please find enclosed the report for SB739 and HB1453 of the 2020 General Assembly Session. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Daniel Carey, MD
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Acute Psychiatric Bed Registry Workgroup Report

Chapter 235 of the 2020 Acts of Assembly (SB 739/HB 1453)

November 6, 2020

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Preface

Chapter 235 of the 2020 Acts of Assembly (SB 739/HB 1453) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with other state agencies and stakeholders, to evaluate the role of the acute psychiatric bed registry. Specifically, the language states:

> *That the Department of Behavioral Health and Developmental Services (the Department) shall establish a work group to include representatives of such stakeholders as the Department may deem appropriate (i) to evaluate the role of the acute psychiatric bed registry (the registry) in collecting and disseminating information about the availability of acute psychiatric beds in the Commonwealth and collecting data and information to ensure adequate oversight of the process by which individuals are referred for acute psychiatric services, the structure of the registry, and the types of data required to be reported to the registry and (ii) to make recommendations for statutory, budgetary, or other actions necessary to redefine the purpose of the registry and improve its structure and effectiveness. The work group shall report its findings, conclusions, and recommendations to the Governor and the Chairmen of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century by November 1, 2020.*

Executive Summary

The purpose of this report is to provide a summary and recommendations from the Acute Psychiatric Bed Registry Workgroup (Chapter 235 of the 2020 Acts of Assembly, SB 739/HB 1453, to the Governor and the Chairmen of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century, based on the collective views of the behavioral health and developmental disability system stakeholders in addressing the Acute Psychiatric Bed Registry (the registry). The registry was initially created to assist Emergency Services Pre-screeners in finding an open bed for individuals who meet the criteria for civil commitment. It was intended to collect real-time data regarding availability of public and private inpatient psychiatric beds and Crisis Stabilization Unit (CSU) beds. Since changing vendors for the registry in 2018, some stakeholders have expressed concern that the registry is not user-friendly, which creates barriers to the level of participation necessary to get an accurate picture of bed availability across the Commonwealth. In addition, the current bed registry does not operate in real-time. Therefore, information on bed availability in the registry is not up-to-date and does not accurately portray available beds at any given time, preventing it from serving its primary purpose of identifying available beds.

The Department of Behavioral Health and Developmental Services (DBHDS) currently has the opportunity to restructure the registry as a part of the larger goal to develop the crisis continuum of care. DBHDS plans to issue a request for proposal (RFP) for a new registry vendor to meet the needs of the Department and stakeholder community. The workgroup was able to determine key features of the registry that are essential to informing the RFP process and to meeting the key goals of the registry.

The workgroup determined that the top barriers to utilization of the bed registry was the lack of a user-friendly platform and lack of accurate, up-to-date information. To address these issues, the workgroup determined the following recommended features and data points to be implemented by the registry.

- Interoperability with multiple electronic health records (EHR) or bed management systems – leveraging the best practice, HL7 messaging standard – with real-time or near real-time synchronization
- Fields that can be filtered by users such as clinical inclusion and exclusion criteria and other key bed characteristics including location, beds that are offline versus online, and occupied beds
- Ability to securely upload and store documents on patient profiles, including the emergency services pre-screening form, and send this information to an individual facility or group of facilities based on the filters outlined above
- High-quality user-experience design that allows users to quickly navigate the registry with minimal clicks and minimal manual updates
- Flexible user roles and permissions so that CSB pre-screeners, facility staff, and DBHDS staff are only able to access the functionalities they need
- Customized, aggregated, and identified reporting available in machine-readable format

- Analytics dashboard to real-time utilization and referral patterns at organization, regional, and state levels with appropriate user authorizations enabled
- Standardized digital screening, intake, and registration functionality to allow for CSB pre-screeners or case managers to minimize duplication if submitting requests to multiple programs
- Digital authentication to ensure only authorized users access the platform
- Secure digital referral capability to social support services and community treatment providers that include email and text capabilities
- Clinical decision support tool for providers and non-clinicians to support crisis call center staff in making the determination of the appropriate level of care

The workgroup also recommended specific data points that the bed registry should collect to allow for better information-sharing among emergency services pre-screeners and facility staff as well as system-wide analysis. Additionally, the workgroup recommended that specific protocols be developed for the use of the registry, including specific user roles and permissions and protocols for bed search process and the use of geographic filters. Finally, the workgroup recommended continuing to engage stakeholders in the RFP process and review as well as ongoing investment to maintain the bed registry.

Overview of the Current Bed Registry

DBHDS began work to establish an online psychiatric bed registry in FY2009. Due to funding constraints at the time, there were delays in its implementation. The registry went live in March of 2014 under a contract with the Virginia Health Information (VHI). As a result of the "Bed of Last Resort" legislation in 2014, the registry became mandatory for public and private hospitals to update with real-time information.[1] At the end of the contract renewal period with VHI, DBHDS published an issue for bid for a provider platform for the registry. The contract was awarded to eTelic and went live under the new system in February of 2018. This is the same platform that the registry currently utilizes.

The current mandates for the registry are outlined in § 37.2-308 of the Code of Virginia. Under this current law, the bed registry is required to:

- Include contact information for every public and private inpatient psychiatric facility and crisis stabilization unit in the Commonwealth
- Provide real-time information regarding the number of available beds at each facility and the type of patient that may be admitted
- Allow healthcare providers to search the registry for available beds for individuals who meet criteria for civil commitment

Overview of Psychiatric Bed Registries in Other States

Other states – including Georgia, Rhode Island, North Carolina, and New Mexico – utilize psychiatric bed registries in order to facilitate communication regarding various types of psychiatric services in their states. While none of these bed registries contains all the elements

[1] §37.2-809

that are recommended for Virginia's bed registry, there are elements of each one that would be useful in Virginia.

Georgia
Georgia maintains a statewide bed registry of all of their state-funded crisis stabilization units. While this is only a piece of what Virginia's registry is required to include, Georgia's registry does include referrals being initiated through the system (and facilities responding to the referrals through the bed registry). In addition, Georgia's bed registry tracks information on patient acceptance and denial by facility.

Rhode Island
Rhode Island's bed registry has seen multiple iterations. Their most recent registry includes information regarding "blocked" beds, or beds that are not occupied but are not available for a variety of reasons (staffing, acuity, COVID-19, etc.). This level of detail is critical to meeting the goal of portraying the true availability of beds which can be subject to fluctuations in admissions, workforce, infection, and more.

North Carolina
North Carolina is continually working to expand and enhance its bed registry, which includes information for both psychiatric and substance use facilities. Additionally, North Carolina's registry includes secure, system-wide messaging to facilitate internal communication between users.

New Mexico
New Mexico's bed registry is similar to Georgia's in that it allows users to initiate and accept referrals through the registry itself. New Mexico has ensured that its bed registry is accessible on mobile devices, making it user friendly for highly mobile evaluators and providers. It also includes the use of clinical assessment tools such as the American Society of Addiction Medicine (ASAM) levels of care. In addition, New Mexico's bed registry allows users to search for available treatment based on an individual's specific clinical presentation, not just demographics. Through New Mexico's bed registry, referrers are able to see the status of their referral at any time during the process.[2]

Current Crisis System and Goals for Future

An ongoing priority for the DBHDS has been addressing the state hospital census and diverting children and adults from state-operated facilities when appropriate. Since FY2013, Virginia has experienced a nearly four-fold increase in temporary detention order (TDO) admissions to state psychiatric hospitals. Key to preventing TDOs and diverting state hospital admissions is a robust crisis system, which DBHDS envisions for all Virginians regardless of age, disability, or support need. The purpose of a crisis continuum of services is to ensure the availability of care to meet

[2] Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements. National Association of State Mental Health Program Directors. (August 2018).

Establishing and Building Statewide Crisis Service/Bed Registries: Three Different Models for Success. SAMHSA. (2019).

people where they are (literally and figuratively) when they are experiencing a crisis because of an acute mental health or behavioral emergency.

According to the National Association of State Mental Health Program Directors, a comprehensive cross-disability life span crisis service system contains three major components based on national best practice. These crisis services include:

1. A crisis hotline that is available 24/7, 365 days/year to dispatch a mobile crisis response, link to community services or connect to urgent response (police, ambulance);
2. Mobile crisis services that respond to people in the community wherever they are and provide crisis intervention and stabilization supports in the community; and
3. Residential crisis stabilization for those who need more targeted support to allow the person to receive services in an alternative community location to a hospital.

Currently, Virginia has crisis services managed by DBHDS in each of the three major NASMHPD areas. However, in order to adopt a comprehensive crisis system based on best practices, DBHDS would need to build on existing services in each of the three major areas. The current system and vision for the future system are demonstrated below:

	Current Crisis System		Future System
Crisis Hotline	Virginia's crisis hotline system is bifurcated, confusing to consumers and not universally available 24/7. There is the traditional emergency services system operated by local CSBs. There is also a developmental disability-specific crisis hotline encompassed in the Regional Education Assessment and Crisis Habilitation (REACH) program. This developmental disability-specific crisis hotline is housed in five regions, meaning citizens in Virginia only need to call one of five crisis lines. To access emergency services, citizens in Virginia would need to call roughly 40 different phone numbers, one covering each CSB catchment area.	→	Regional or statewide crisis hotline for all citizens to access.
Mobile Crisis	There are major gaps in Virginia's mobile crisis services. For DD population they are offered through regional REACH programs. Some regions have children's behavioral health mobile crisis services in region 4 (CREST) and region 2 (CR2) and six other CSBs have a limited behavioral health mobile crisis capability. There is not sufficient adult behavioral health mobile crisis available in Virginia.	→	Statewide 24/7 mobile response and supports in the community regardless of disability type or age.
Residential Crisis/Crisis Stabilization Services	For adults, there 5 crisis therapeutic homes for individuals with DD. For individuals with BH needs, there are 14 residential crisis stabilization programs (CSUs) across the state, some of which provide medically managed withdrawal services (detox). Additionally, there are over 40 Crisis Intervention Assessment Centers (CITAC) and 20 CSBs provide 23-hour crisis stabilization services. For children, there are CSUs in Region 3 (6 beds), Region 4 (8 beds) and Region 5 (6 beds). DD services will also be opening 2 CTHCs for children. However, there is not a statewide network of universally available and consistent CSU and detox services for all individuals across the lifespan.	→	Statewide availability of 23-hour crisis stab; statewide capacity and availability of CSU child and adult; and statewide availability of detox beds as part of the CSU structure.

DBHDS works to develop planning and programming to build out services in each of these areas and plans to gather comprehensive data on the crisis system to help DBHDS and its partners to assess the effectiveness of supports and services within Virginia's crisis system. With regard to the crisis hotline, DBHDS plans to gather data on incoming calls, the outcomes of the calls, the ability to dispatch mobile crisis services and the outcomes of mobile crisis services, and linkages to other services. The crisis hotline is also planned to link to the acute psychiatric bed registry, to allow for staff to identify available beds in real-time. Thus, an acute psychiatric bed registry that has the ability to portray real-time bed availability along with inclusion and exclusion criteria as well as facilitate secure communication between crisis hotline staff, facilities, community services boards, and more is essential to the development of Virginia's comprehensive crisis system.

Bed Registry Workgroup

The Bed Registry Workgroup convened twice in order to achieve the following goals.

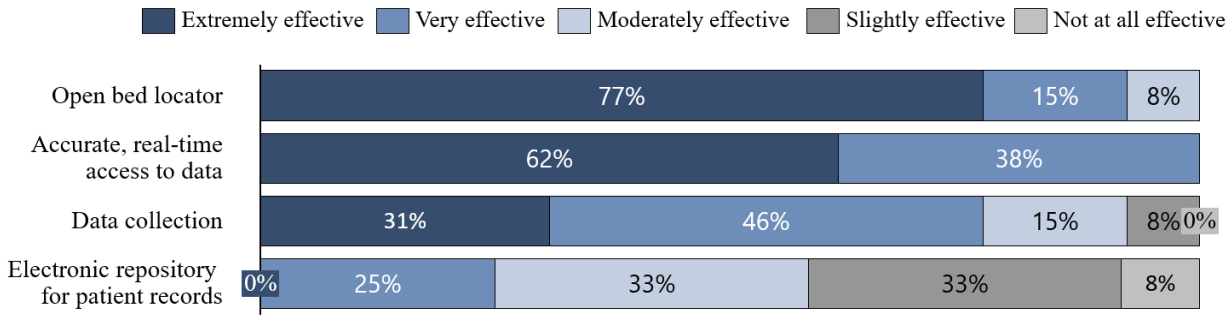
1. Determine the recommended function for the bed registry
1. Determine necessary information for providers and admitting facilities
2. Determine necessary functions and capabilities of registry to improve participation
3. Inform RFP process for a Bed Registry vendor

During its two meetings, the workgroup discussed what the principle goals of the bed registry should be, the barriers to achieving those goals, and specific recommendations for improving the registry's functionality. Additionally, the workgroup reviewed Virginia's current platform, the role of the registry in a comprehensive crisis system, and bed registry models from other states. Finally, in order to better understand the barriers to utilization of the workgroup and the areas of improvement, the workgroup completed a brief survey (Appendix A) prior to its first meeting. Thirteen workgroup participants completed the survey out of a total of nineteen workgroup members (68%).

Recommended Function for the Bed Registry

The workgroup was asked to rate different key functions for the bed registry, including its use as an open bed locator; the ability to deliver accurate, real-time access to data; use in collecting data for system-wide analysis; and serving as an electronic repository for patient records. The most highly rated functions were its use as an open bed locator and the ability to deliver accurate, real-time access to data (Figure 1).

Figure 1: Functions of the Bed Registry, Rated



In order for the bed registry to serve as an open bed locator, accurate, real-time access to date is critical. This enables an emergency services pre-screener to quickly, easily, and securely upload patient data including a prescreening form; send that information to nearby facilities with open beds that meet the patient's individual needs; receive prompt, electronic responses or requests for additional information. Inpatient psychiatric facilities could reflect their real-time bed availability (which can vary greatly by time of day, diagnosis, and staffing schedules) without any manual input, and the emergency services pre-screeners could access this data and share patient information without having call each facility individually and share information separately.

Necessary Information for Providers and Admitting Facilities

The workgroup also discussed the particular data points that the bed registry should require in order to improve its functioning. Table 1, below, lists patient data points that should be collected, when applicable; Table 2 lists data points regarding providers and admitting facilities; and Table 3 lists system-level data points useful for research and analysis.

Table 1: Patient Data Points	
Demographics	
	Male/Female/Genderqueer or Non-Binary
	Age
	Location of residence
	Military Status
Diagnosis	
Support Needs	
	Suicidality
	Level of Acuity
	Specialized Support Needs (ASAM level of Care Need; DD, Medical)
Insurance	
	Status
	Payer

Table 2: Provider and Facility Data Points	
Name of Program/Business	
Location of program	
Beds available	
	Type of Bed (CSU/Hopsital, etc.)
	Male/female
	Child/Adolescent/Adult/Geriatric
	Level of Acuity
	Specialized Support Needs (ASAM level of Care Need; DD, Medical)
Length of stay	
Admit date	
Discharge Date	
Reason for declination	

Table 3: System-level Data Points	
Referral Source	
Date/Time of Referral	
Date/Time of connectivity to support	
Screening Tool	
	Assess level of risk
Waitlist for beds (number of days waiting; where waiting)	

Necessary Functions and Capabilities of the Registry

Much of the workgroup's discussion centered on the necessary functions and capabilities of the bed registry in order for the registry to serve as an effective open bed locator. In order for the registry to meet this goal, minimizing the barriers to participation on behalf of both emergency services pre-screeners and admitting facilities is critical. Prior to the first workgroup meeting, stakeholders ranked the following capabilities in order of priority to encouraging participation in the bed registry (Table 4).

Table 4: Capabilities of a Bed Registry Ranked in Order of Priority, (1 = Top priority, 10 = Lowest priority)

Option	Average rank
User-friendly	2.18
Provides real-time information	3.09
Displays accurate information	3.82
Describes criteria for patient acceptance accurately and in detail	3.82
Documents number of unoccupied beds	5.00
Documents total number of beds online vs offline	6.45
Documents number of occupied beds	7.00
Dedicated staff to keep information up-to-date	7.09
Can produce real time, daily, weekly, monthly, quarterly and annual reports	8.27
Electronic Health Record compatibility	9.00

Through discussion, the workgroup synthesized what the registry needed in order to serve as an effective bed locator as well as other value-adding functionality such as reporting and analytics capabilities. The key areas identified fell into four main areas, summarized below, including accuracy and timeliness of the information reflected in the registry; ease of use; data analytics and reporting capabilities; and other, general recommendations to improve the effectiveness of and participation in the registry.

Accuracy and Timeliness of Information

The workgroup agreed that the data housed within the bed registry must be accurate and always up-to-date. Without holding the bed registry data to this standard, it fails to serve its purpose as a real-time open bed locator. Currently, emergency services pre-screeners must, when conducting a bed search, work through a list of facilities, calling each one and faxing patient information until a facility agrees to accept a particular patient. An effective bed registry would significantly reduce this workload. If the data on the bed registry around open beds and the patient's information is accurate and up-to-date, much of this process can be automated, allowing pre-screeners to quickly filter available beds by patient inclusion or exclusion criteria, geography, age group, and more, and allowing facilities to quickly and securely access patient data to understand his or her particular service needs.

In order to achieve this, the bed registry should have the following capabilities:

- Interoperability with multiple electronic health records (EHR) or bed management systems – leveraging the best practice, HL7 messaging standard – with real-time or near real-time synchronization
- Fields that can be filtered by users such as clinical inclusion and exclusion criteria and other key bed characteristics including location, beds that are offline versus online, and occupied beds
- Ability to securely upload and store documents on patient profiles, including the emergency services pre-screening form, and send to this information an individual facility or group of facilities based on the filters outlined above

Ease of Use

Key to the effective use of the bed registry is its user-friendliness, which, when not considered, serves as a major barrier to participation in the registry and prevents the registry from serving as a bed locator. The user-friendliness of the bed registry depends on the functionalities described above related to accuracy and timeliness, because reducing the manual workload required to use the registry and allowing for storage of key data and simple filtering is fundamental to increasing participation. Additionally, the bed registry should be designed with a simple user experience design that minimizes any training necessary to use the registry and provides a simple, ideally mobile-friendly experience.

In order to achieve these goals, the bed registry should have the following capabilities:

- High-quality user-experience design that allows users to quickly navigate the registry with minimal clicks and minimal manual updates
- Flexible user roles and permissions so that CSB pre-screeners, facility staff, and DBHDS staff are only able to access the functionalities they need

Data Analysis and Reporting Capabilities

The workgroup also discussed ideal reporting capabilities for the bed registry. Allowing emergency services staff to run reports on the patients they have placed, facility staff to run reports on individuals they have admitted or denied, and DBHDS staff to run reports on system-wide bed utilization could help identify and understand system needs over time.

Ideally, Virginia's bed registry would allow for the following reporting capabilities:

- Customized, aggregated, and identified reporting available in machine-readable format
- Analytics dashboard to real-time utilization and referral patterns at organization, regional, and state levels with appropriate user authorizations enabled

Other Recommendations to Improve Participation

Other capabilities that the workgroup agreed would enhance the effectiveness of the bed registry in Virginia include:

- Digital, mobile-friendly entry of the emergency services pre-screening form, intake, and registration
- Digital authentication to ensure only authorized users access the platform

- Secure digital referral capability to social support services and community treatment providers that include email and text capabilities
- Clinical decision support tool for providers and non-clinicians

Summary of Necessary Functions and Capabilities of the Bed Registry

- Interoperability with real-time or near real-time synchronization
- Fields that can be filtered by users such as clinical inclusion and exclusion criteria
- Ability to securely upload and store documents
- High-quality user-experience design
- Flexible user roles and permissions
- Customized, aggregated, and identified reporting
- Analytics dashboard to real-time utilization and referral patterns
- Digital, mobile-friendly entry of the emergency services pre-screening form, intake, and registration
- Digital authentication
- Secure digital referral capability
- Clinical decision support tool to assess level of care needed

Participation in Registry

Currently, despite participation mandates, bed registry data is often unreliable, highlighting the need for changes to make the registry more user-friendly and valuable to all parties.[3] In order to ensure the success of a future iteration of the registry, DBHDS will continue to engage the stakeholders represented in this workgroup throughout the RFP process as well as the development of protocols for the use of the bed registry. This may include the specific roles and permissions of user types as well as user flows. One important example would be requiring that a bed search begin within a particular geographic region, closest to the patient, and extend out to a larger geographic radius in order to prioritize bed placements nearest to the patient which minimizes law enforcement transport time and eases the discharge process. The workgroup also recommended ongoing investment to maintain the bed registry, including investment in 1 FTE to manage the bed registry and make necessary changes to data fields and user permissions on an ongoing basis, provide and supporting training on the use of the bed registry, field concerns, encourage and monitoring participation, and run system-wide data analytics.

[3] §37.2-308.1 in the Code of Virginia

Conclusion

The acute psychiatric bed registry could be a valuable tool to help cut down on the time consumed through the bed search process for emergency services pre-screeners and inpatient facilities alike by cutting down on unnecessary manual workload. However, in order for the technology to be successful, it must contain accurate and up-to-date information and be user-friendly and simple to use. DBHDS plans to use the results of this workgroup to inform the RFP process for a new, enhanced bed registry platform.

Appendices

Appendix A: Bed Registry Workgroup Survey

HB1453/SB739 requires DBHDS to establish a workgroup to evaluate and make recommendations regarding the role of the acute psychiatric bed registry. Under current law (§ 37.2-308.1), the bed registry is required to:

1. Include contact information for every public and private inpatient psychiatric facility and crisis stabilization unit in the Commonwealth.
2. Provide real-time information regarding the number of available beds at each facility and the type of patient that may be admitted.
3. Allow healthcare providers to search the registry for available beds for individuals who meet TDO criteria.

This workgroup is expected to evaluate the role of the bed registry in collecting and disseminating information about available psychiatric beds.

Before our first workgroup meeting, please complete this brief survey to help us craft the meeting agendas and ensure we consider all relevant information on this issue.

Name [Free Response]

Organization [Free Response]

Please rate the importance of the following bed registry functions (Scale: Extremely important, very important, moderately important, slightly important, not at all important):

- Open bed locator
- Accurate, real-time access to data
- Electronic repository for patient records
- Data collection
- Other (please specify)

What information should healthcare providers seeking a bed for a patient be able to glean from the bed registry? (Check all that apply):

- ☐ Number of operating beds
- ☐ Total number of available beds
- ☐ Beds by gender
- ☐ Beds by age
- ☐ Beds available for patients' with specific diagnoses and complexities
- ☐ Other (please specify)

What information should inpatient providers admitting or determining whether to accept a patient be able to glean from the bed registry? (Check all that apply)

- ☐ Patient demographics
- ☐ Patient psychiatric diagnoses
- ☐ Patient medical needs
- ☐ Presenting problem/behaviors requiring hospitalization
- ☐ Full patient medical records
- ☐ Other (please specify)

Please rank the most important characteristics of the bed registry that would encourage active participation in updating information on bed availability. (Click and drag to change the order)

- User-friendly
- Provides real-time information
- Displays accurate information
- Describes criteria for patient acceptance accurately and in detail
- Documents total number of beds online vs. offline
- Documents number of occupied beds
- Documents number of unoccupied beds
- Can produce real time, daily, weekly, monthly, quarterly and annual reports
- Electronic Health Record compatibility
- Dedicated staff to keep information up-to-date
- Other (please specify)

Please rank the most important characteristics of the bed registry that would encourage active participation in using the registry to find open beds. (Click and drag to change order)

- User-friendly
- Provides real-time information
- Displays accurate information
- Describes criteria for patient acceptance accurately and in detail
- Documents total number of beds online vs. offline
- Documents number of occupied beds
- Documents number of unoccupied beds
- Can produce real time, daily, weekly, monthly, quarterly and annual reports
- Electronic Health Record compatibility
- Dedicated staff to keep information up-to-date
- Other (please specify)

Are there resources around this issue you would like to share such as possible speakers, articles, or other relevant information? [Free text]

Is there anything else you hope the workgroup will discuss? [Free text]

Appendix B: Workgroup Participants

Participant Name	Organization
James Newton	Bon Secors
Bill Wasserman	Carilion Clinic
Oketa Winn Stephanie Pollay	Department of Medical Assistance Services
Kelsey Wilkinson	Medical Society of Virginia
Bruce Cruser	Mental Health America of Virginia
Beth Tolley Sarah Wilson Carolyn Wood	National Alliance on Mental Illness-Virginia
Adam Kaul, M.D. Mark Hickman	Psychiatric Society of Virginia
Brandie Williams	Rappahannock Area CSB

Participant Name	Organization
Curt Gleeson	Region Ten CSB
Jennifer Faison	Virginia Association of Community Services Boards
Aimee Perron Seibert	Virginia College of Emergency Room Physicians
Jennifer Wicker	Virginia Hospital and Healthcare Association
Deidre Johnson Elizabeth Bouldin-Clopton	VOCAL
Ashley Airington	VOICES for Virginia's Children
Brandon Rodgers	Western Tidewater CSB

Department of Behavioral Health and Developmental Services (DBHDS) Representatives
Commissioner: Alison G. Land, FACHE

Workgroup Chairs:

Angela Harvell
Deputy Commissioner for Facility Services

Heather Norton
Assistant Commissioner for Developmental Disability Services

DBHDS Staff:

Emily Lowrie	Senior Policy Advisor
Alex Harris	Policy and Legislative Affairs Director
Cari Hennessy	Statistical Methodologist
Suzanne Mayo	Director of Community Integration
Heidi Dix	Deputy Commissioner, Compliance, Regulatory, & Legislative Affairs