IMPROVING ACCESS TO BEHAVIORAL HEALTH CRISIS SERVICES WITH ELECTRONIC BED REGISTRIES

2021 TTI CRISIS BED REGISTRY PROJECTS
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SUMMARY

Through its Transformation Transfer Initiative (TTI) program administered by NASMHPD, SAMHSA funded six states to explore, establish, or expand behavioral health crisis services registries in 2021. These projects were in addition to 23 state bed registry projects funded in 2019. During the project period, NRI consulted with project directors and in some cases, stakeholders on building consensus on registry functionality and value, decision points in system design, and similarities and differences of existing registry systems in other states. NRI also met with stakeholders in several other states interested in exploring registries to outline key issues in registry design and development.

Circumstances for the 2021 projects were dramatically different than they were for the 2019 cohort. The 2021 cohort faced a number of disruptions as they began to implement plans. Chief among them was the disruption of the COVID-19 pandemic. State mental health authorities redirected their staff including those involved in registry projects, to ensure the delivery of behavioral health services amidst staffing shortages, program shutdowns, and risk reduction efforts. State mental health authorities grappled with addressing the impact of the pandemic on behavioral health with existing resources bolstered by American Rescue Act funds. In addition to addressing urgent behavioral health needs brought on by the pandemic, state mental health authorities had to prepare for the anticipated launch of the national 988 Suicide & Crisis Lifeline and the availability of SAMHSA Mental Health Block Grant Application for the new Crisis Services 5% set-aside. These major initiatives prompted a reexamination of the responsiveness, integration, and impact of crisis services leading to detours and delays to deploy registries for most of the six projects. Having explored registry options, two states (DC and SD) postponed development of a registry until their crisis system has been re-designed. Encouraged by the state's 988 Implementation Coalition, another state (PA) restructured its approach to the registry project's leadership and stakeholder engagement. The registry is one component of a complex and coordinated strategy in one state (WA), to redesign crisis services and is currently in procurement. One state (HI) will launch a registry in early 2023 and one state (MN) expanded its existing registry.
WASHINGTON, DC began exploring the integration of electronic health record systems into a unified structure that can track consumers as they are admitted and discharged across services including outpatient, crisis stabilization, and hospital in-patient. The registry was postponed until the crisis system redesign has been completed and electronic health record systems have been integrated.

HAWAII is establishing a data dashboard that will allow providers of long-term, transitional and crisis beds with whom the mental health authority contracts, to update availability daily. The dashboard is integrated in the mental new electronic medical record (EMR) system, also in development, that includes residents of housing programs. In the short term, the platform will support a web-based application that will. The bed registry is anticipated to launch a web-based system referral system in early 2023.

MINNESOTA used TTI funds to improve the functionality of its existing search engine of behavioral health services, invite participation by more providers and in more areas of the state, and make consumers and family members aware of the resource.

In PENNSYLVANIA, providers' initial support for a crisis bed registry gave way to concerns that a statewide system could result in local resources becoming overwhelmed by referrals from outside regions. However, a different group of stakeholders, represented in the 988 Coalition overseeing implementation of the national lifeline in Pennsylvania, encouraged development of a registry of crisis bed resources in the state. The mental health authority is now developing a contract to employ a third party to build stakeholder support and design a registry.

SOUTH DAKOTA's mental health authority conducted an analysis of needs in the state through stakeholder engagement and researched registries in other states to determine if it a registry would be feasible and worthwhile. In a state with few resources stretched across thousands of miles of rural landscape, it concluded that launching a bed registry would be premature before establishing a more comprehensive crisis care system.

WASHINGTON enacted legislation to establish a Crisis Response Improvement Strategy Committee (CRISC) to plan for implementation of the 988-crisis hotline and crisis response system enhancements; imposed a tax on radio access lines, voice-over internet protocol service lines, and switched access lines to fund activities; and required its state health agencies to collaborate to establish crisis call center hubs and an enhanced response system. Washington is now in the procurement stage of developing registry that tracks real-time bed availability and supports electronic referral.

OVERALL STATUS OF REGISTRIES

Of 29 TTI registry projects, 19 have implemented or expanded a web-based database (CT, DE, GA, IN, MA, NE, NV, NJ, NM, NY, ID, MN, MS, NC, OH, OK, RI, TN, and VT); six are planning for a launch date in the future (FL, HI, MD, PA, UT, and WA), and four did not have plans to launch a registry in the future (AL, DC, SD, and WV).
FIGURE 1: TYPE OF CRISIS BED REGISTRY

TYPES OF BED REGISTRIES

A map of states receiving TTI awards to establish or expand registries in 2019 and 2021 is presented in Figure 1 color coded for type of registry. Of the 25 states that have launched or plan to launch registries, the most common (14) type is a search engine (FL, CT, MD, MA, NJ, NY, ID, MN, MS, OK, PA, RI, UT, and VT). Five states have or are planning to have referral systems (GA, HI, NC, TN, and WA), and six states (DE, NE, IN, NV, NM, and OH) have referral networks.

During the project period, NRI consulted with project directors and at their request, system stakeholders, on building consensus on registry functionality and value, decision points in system design, and the similarities and differences of existing registry systems in other states. NRI also met with stakeholders in several states interested in exploring bed registries to outline key issues in registry design and development. Brief descriptions of the 2021 TTI projects follow this summary.
CURRENT APPROACH AND NEED FOR CHANGE:

Washington D.C.’s Department of Behavioral Health (DBH) saw the services registry as a means to integrate care and reduce the impact of untreated illness particularly during behavioral health crises. As behavioral health facilities instituted restrictions to reduce COVID-19 infections and faced staffing shortages brought on by the pandemic, the identification of available beds became even more critical. DBH and its crisis services staff improvised a “bed board” that lists on a daily basis, the availability of beds in the seven hospitals and Institutes for Mental Disease (IMDs) in DC. The registry project would convert the bed board into an electronic database of hospital and residential behavioral health disorder beds available through the web, eventually expanding its functionality to include the ability to make electronic referrals. Over the ensuing 18 months, a number of local and national initiatives precluded the development of a registry. At the national level, federal funding from the American Rescue Act and SAMHSA’s block grant set aside and the implementation of a nationwide 988 crisis call number prompted the review and redesign of crisis response services in DC. At the local level, DBH began exploring the integration of electronic health record programs into a unified system that can track consumers as they are admitted and discharged from all services including outpatient, crisis stabilization units, and hospital in-patient beds. The bed registry was postponed until the crisis system redesign had been completed and electronic health record systems had been integrated. Currently, local hospitals and IMDs email daily availability of inpatient beds to DBH.

PLANNING PARTNERS:

District hospitals, the 988 Implementation Committee, the DC Hospital Association, the McClendon Center, Total Family Care Coalition, Access HelpLine, and mobile crisis teams and DC’s crisis stabilization unit participated in stakeholder meetings.

TYPE OF BED REGISTRY:

DBH sought a referral system capable of making electronic referrals for inpatient care and tracking responses.

CRISIS SYSTEM BEDS TO BE INCLUDED IN THE REGISTRY:

Beds in the seven hospitals and Institutes for Mental Disease (IMDs) in DC were to be considered for the initial launch.

“We want to strengthen behavioral health upstream and connect people after a crisis so that crises become rare and non-recurring.”

—Dr. Richard Bebout, Senior Deputy Director, DBH

1 A facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and chemical dependency disorders.
REGISTRY DEVELOPMENT VENDOR:
The project’s last stakeholder meeting featured a demonstration by Xferral, a vendor that provides an electronic referral system. As DBH decided to postpone the project, a final selection was not made.

ACCESS TO THE REGISTRY:
Access to the system was to be made available to DBH staff and contracted service providers including hospitals.

REFRESH RATE AND ENTRY PROCESS:
A data refresh rate has not been determined.

MEANINGFUL METRICS:
Metrics have not been identified.

IMPACT OF THE COVID-19 PANDEMIC ON THE BED REGISTRY:
The reduced capacity of many inpatient settings driven by the COVID-19 pandemic created shortages of beds for people going through behavioral health crises and impelled DBH to seek more efficient ways to find available beds. As the pandemic receded, pressure to establish a web-based registry subsided.

SYSTEM OVERSIGHT:
DBH Director of Crisis Services

For more information about this project, contact Richard Bebout richard.bebout1@dc.gov

HAWAII

CURRENT APPROACH AND NEED FOR CHANGE:
Hawaii’s Adult Mental Health Division (AMHD) manages 1000 long term, transitional, and crisis care beds and supported living arrangements provided by more than 30 agencies across the islands. Because all referrals for housing and services move through and are approved by AMHD, an accurate daily census is critical to ensuring that consumer live in the least restrictive environments conducive to their care. AMHD has had to rely upon daily updates emailed and faxed from providers to monitor utilization and approve placements. This outmoded process plays out every morning requiring hours of staff time to gather, assemble, and organize the updates to track usage and availability.

“Creating a single site for everyone to see available long term and crisis beds would be a big help in managing resources.”
— Yara Sutton, Project Director

AMHD used TTI funds to procure a contract to explore pathways to implement a web accessible database of beds and recommend a feasible approach. As recommendations were completed, the CDC Foundation, assigned to support AMHD during the COVID-19 pandemic, began to assist AMHD in designing a web-based registry dashboard that can
automatically organize data and provide daily reports on bed utilization. In the short term, the platform will support a web-based application that will permit housing providers to manually update bed availability, generate reports and support electronic referrals. The dashboard is integrated in AMHD’s new Electronic Medical Record (EMR) system, also in development that will include consumers who reside in AMHD-managed housing programs. In the long term, it is expected that the EMR platform will be able to generate a separate daily report on bed availability based on clients’ admissions and discharges from housing programs. The system will differentiate beds and facilities by location, eligibility (age, insurance, gender), and acuity level (type of housing). Figure 2. Illustrates a transitional housing program funded by AMHD.

The bed registry is anticipated to launch in early 2023.

PLANNING PARTNERS:
Partners have included AMHD program staff, information technology staff, utilization management staff, mobile crisis teams, stabilization units, and case managers, the CDC Foundation, and provider agencies.

TYPE OF BED REGISTRY:
The bed registry is a search engine. Referrals are made separately through a sharepoint site.

CRISIS SYSTEM BEDS TO BE INCLUDED IN THE REGISTRY:
The registry will include crisis stabilization units (>24 hours) and five level of community housing settings:

1. Acute beds are in secure facilities for up to 90 days.
2. Therapeutic living provides a step down from the acute level with staff on duty 24/7.
3. Semi-supervised settings have staff on duty 8-16 hours per week.
4. Semi-independent settings have staff checking in up to 8 hours per week.
5. Supported housing residents live on their own and receive support as needed.

REGISTRY DEVELOPMENT VENDOR:
Netsmart is the platform for the new EMR and will support the bed registry.

ACCESS TO THE REGISTRY:
The system will be accessible only to AMHD staff and housing providers.

REFRESH RATE AND ENTRY PROCESS:
Housing providers will manually update residential settings once per day at 8 a.m. Crisis
stabilization settings will update mornings and evenings. In the long term, integration with electronic health records will support real-time automatic updates on bed availability.

**MEANINGFUL METRICS:**
AMHD intends to develop metrics to collect and analyze data on:
- Vacancy rates,
- patient transfer time into and between facilities, and
- patient health outcomes/disposition

**IMPACT OF THE COVID-19 PANDEMIC ON THE BED REGISTRY:**
The pandemic caused housing providers to initiate quarantining procedures for new residents and or to quarantine entire group residences because of exposure. In addition, AMHD rented some 300 hotel rooms to create space to quarantine individuals between moves. Other departments of Hawaii’s state government also used these hotel rooms to quarantine individuals. The CDC Foundation became involved during the pandemic to assist AMHD to design and develop a data dashboard to manage housing programs and hotel use for quarantine.

**SYSTEM OVERSIGHT:**
The AMHD Services Coordinator oversees the Dashboard.

For more information on this project, contact Yara Sutton at yara.sutton@doh.hawaii.gov.

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**MINNESOTA**

**CURRENT APPROACH AND NEED FOR CHANGE:**
Recent events including stress of racial unrest and the losses, isolation, and distress due to COVID-19 have exacerbated demand for behavioral health services. Families, County leaders, ombudsman, hospitals, and advocacy groups have expressed their frustration to the Minnesota Department of Human Services, Behavioral Health Division (BHD) with their difficulty locating residential placements for youth in crisis as availability has declined. Facing similar resource shortages, inpatient psychiatric bed usage rates have exceeded 130%² of capacity. While continuing to expand crisis response resources including Collaborative Intensive Bridging Services, BHD wants to move to a recovery model and reduce the need for crisis by making it easier for people

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to seek and find services such as Wraparound. BHD used TTI funds to support FastTracker in expanding and publicizing its existing online database of services. FastTracker was launched in 2012 to provide mental health professionals as well as the general public with information about available mental health and substance use treatment services in the state. Now in its 4th iteration, FastTracker will capture a broader array of services and expand wait-time categories, replacing “available within 1 week” as displayed in Figure 3, with “immediate” for crisis services. Users can narrow their search for services by zip code, service type, and insurance coverage to generate a list of providers (with the date of their last update). All licensed behavioral health providers are invited to participate.

**PLANNING PARTNERS:**
To better understand the needs of system users, the project conducted a number of focus groups with stakeholders around the state including hospitals and their association, people with mental illness and substance use disorders and their families; providers; county sheriffs and municipal police departments; warm line call takers; providers including community mental health agencies and clinics; mobile crisis teams; psychiatric residential treatment facilities; and foundations.

**TYPE OF BED REGISTRY:**
FastTracker is a search engine that allows anyone to conduct a personalized search for behavioral health treatment services in the state by zip code.

**CRISIS SYSTEM BEDS TO BE INCLUDED IN THE REGISTRY:**
FastTracker reports the availability of substance use residential services, psychiatric residential treatment facilities (for children), and mobile crisis teams. Crisis stabilization unit beds will be added later in 2022. FastTracker also reports the availability of all known behavioral health outpatient and support services. A separate Bed Board search engine that is operated by the Minnesota Hospital Association lists inpatient hospital beds and is accessible only to authorized hospital staff.

**REGISTRY DEVELOPMENT VENDOR:**
Minnesota Mental Health Community Foundation developed and manages FastTracker and will provide monthly reports on system usage and other metrics.

**ACCESS TO THE REGISTRY:**
Access to FastTracker is available to the general public: [https://fasttrackermn.org/](https://fasttrackermn.org/)

**REFRESH RATE AND ENTRY PROCESS:**
Refresh rates vary by service category. Crisis services are updated daily while other services such as outpatient services are updated less frequently.

**FIGURE 3: SCREENSHOT OF SEARCH RESULTS FOR CRISIS SERVICES.**
MEANINGFUL METRICS:
- Updates are date and time stamped and monitored by the vendor. About 50% of the crisis services are updated daily and 75% are updated within 5 business days. Most providers update outpatient services within 5 business days.
- The number of site visitors and amount of site traffic
- The percentage of known licensed programs that are participating
- User pathway analytics including how users arrived at FastTracker, how long they remain on the site, what services they are seeking, and where/when they need those services are metrics under development are.

IMPACT OF THE COVID-19 PANDEMIC ON THE BED REGISTRY:
The COVID-19 pandemic has led to increased demand for mental health services due to the anxiety, grief, and prolonged isolation of individuals and families. At the same time, reductions in facilities and staffing resulting from COVID-19 have contributed to resource shortages. BHD and behavioral health practitioners have expanded the use of web-enabled tools to respond including the use of telehealth by mobile crisis teams to respond to calls.

SYSTEM OVERSIGHT:
Children’s Mental Health Consultant at State of Minnesota Department of Human Services.

For more information, contact Diane Marshall at diane.marshall@state.mn.us.

PENNSYLVANIA

CURRENT APPROACH AND NEED FOR CHANGE:
Pennsylvania’s Office of Mental Health and Substance Abuse Services (OMHSAS) originally planned to use TTI funds to establish a psychiatric bed registry for forensic patients in the southeast region of the state. Interest in establishing a bed registry had developed from a statewide policy scan of resources, gaps, and opportunities to divert individuals with serious mental illness from justice involvement. One of the opportunities identified was the development of a statewide database that could allow for continuity of care as a person moves between systems and across counties in that region of the state. Although there was initial support to pilot a bed registry, providers became concerned that the capacity of inpatient psychiatric units could be overwhelmed by referrals from outside the region and lead to shortages of psychiatric beds for in-region residents. Support for the project waned and OMHSAS began consulting other entities that expressed interest in bed registries. Among them, the American College of Emergency

“We are growing our resources so that everyone in the state will have access to crisis services.”

—Dr. Dale Adair, OMHSAS Medical Director
Room Physicians, and the Peer Support Coalition expressed strong interest in seeing a bed registry develop in the state. The 988 Coalition overseeing implementation of the national lifeline in Pennsylvania encouraged development of a registry of crisis bed resources in the state. Based on their input, the project shifted to developing a web-based registry of residential crisis settings (these crisis stabilization units are identified in Figure 4) across the state. Currently, OMHSAS is seeking to procure a contract with a non-profit agency to lead the implementation of a crisis services registry. The contractor will convene stakeholders and elicit input; layout the development of a bed registry, recommend the platform to host the registry, and identify incentives for residential crisis settings to participate and submit availability data regularly.

PLANNING PARTNERS:
Because of its close affiliation to crisis services, the 988 Coalition and its diverse membership have guided the development of a bed registry towards crisis residential settings. Two enduring allies in this process have been the American College of Emergency Room Physicians, and the Peer Support Coalition, both representing groups of people who have observed and been impacted by lengthy delays in acquiring crisis care. Additional stakeholders such as managed care organizations, community mental health agencies, and crisis residential providers will be engaged as planning recommences.

TYPE OF BED REGISTRY:
The bed registry is anticipated to be a search engine that will identify bed vacancies, and qualifiers (age, gender, and other characteristics).

CRISIS SYSTEM BEDS TO BE INCLUDED IN THE REGISTRY:
OMHSAS and its partners intend to focus on crisis residential settings in the state. As the program becomes established, other crisis services including inpatient beds may be added.

REGISTRY DEVELOPMENT VENDOR:
OMHSAS is exploring the Department of Health’s database systems for possible modification to this purpose.
ACCESS TO THE REGISTRY:
Initial plans are to limit access to the bed registry to 988 and other crisis call centers, mobile crisis teams, hospital emergency departments, and community mental health agencies. Law enforcement and other first responders may be authorized access to the registry as the program becomes established.

REFRESH RATE AND ENTRY PROCESS:
A data refresh rate has not been determined.

MEANINGFUL METRICS:
Pennsylvania will measure the following outcomes:
1. Identify number of crisis residential beds located in SE Region eligible for individuals with mental illness.
2. Identify number of crisis residential beds located in SE Region that have a waiting list.
3. Identify community providers who will provide information to registry.
4. Identify community providers and stakeholders who will access the registry.
5. Identify essential factors provided in the registry for efficient use.
6. Develop strategic plan in creating and implementing the registry.

IMPACT OF THE COVID-19 PANDEMIC ON THE BED REGISTRY:
None reported.

SYSTEM OVERSIGHT:
The OMHSAS Medical Director will oversee the system.

For more information about this project contact Dr. Dale Adair at c-daadair@pa.gov.

SOUTH DAKOTA

CURRENT APPROACH AND NEED FOR CHANGE:
Designing a comprehensive crisis system for a state that is large (75 thousand square miles), sparsely populated (900,000 population), mostly rural (65 of its 66 counties are either frontier or rural), and short on mental health professionals (See Figure 5, Map of South Dakota Mental Healthcare Shortage Areas) pose a number of significant challenges. In rural and tribal areas, law enforcement are often the first responders to behavioral health crisis, crisis stabilization centers are mainly in more densely populated areas and inpatient hospital units are few and far between. In designing a comprehensive crisis care system, "We are empowering local communities to come together to see how they can make the Crisis Now model work where health professionals are in short supply and internet coverage is lacking – ideas like embedding behavioral health professionals in EMT teams.”

—Tiffany Wolfgang, DBH Director
South Dakota Division of Behavioral Health (DBH) wanted to explore if and how a registry of crisis services might help. DBH envisioned a registry that might include real time availability of residential crisis services, inpatient beds, mobile crisis services, outpatient mental health and substance use disorder treatment, mental health and substance use residential settings, and supported and recovery housing. Using TTI funds, DBH engaged a Health Management Associates (HMA) to analyze the state’s registry needs, find options to meet those needs, and support DBH in identifying the best solution to meet its goals. The analysis included a review of the current landscape of electronic BH registries including those used in several other states; interviews with registry platform vendors and their users; and interviews with South Dakota stakeholders about what they want from a registry. The current landscape of crisis behavioral health resources included:

- Four main providers of inpatient behavioral services mainly in more populated areas of the state;
- 11 Community Mental Health Centers (CMHCs)
- 33 SUD Treatment Providers
- 21 Prevention Treatment Providers
- The certified Lifeline call center in the state also operates the 211-information line and will assume responsibilities for 988.
- Expanded behavioral health services, including inpatient bed capacity, in all areas of the State.
- DBH is in the process of awarding Appropriate Regional Facilities (crisis stabilization units) to support serving adults who have been placed on a five-day hold under the emergency commitment process.

In rural areas of the state, there are few beds available for crisis care and those that are open may be hours away by car. With few options, a single phone call to the nearest facility is all that is necessary to determine availability in most of the state. Although a standardized, centralized
registry for monitoring inpatient behavioral health bed capacity in South Dakota would be useful, there have not been widespread issues with connecting residents with open beds. While appealing to both stakeholders and DBH, they concluded that it would be premature to launch a web-based registry before establishing a more comprehensive crisis care system with multiple options for response. DBH supports its CMHCs to engage with communities to innovate solutions that can deliver crisis care when and where people need it most. The remainder of this report describes the type of registry stakeholders would like to someday employ based on the report by Health Management Associates.

PLANNING PARTNERS:
HMA conducted 15 stakeholder interviews to gather feedback on and requirements for an electronic BH bed registry. Stakeholders included crisis centers, county or regional mobile crisis service providers/oversight entities, providers of crisis respite/stabilization services, peer support service providers, emergency room providers, inpatient substance use disorder (SUD) providers, tribal leaders, and providers of publicly funded outpatient BH services. The report was also vetted by the state’s 988 oversight committee. The process was designed to obtain information from those organizations with capacity and those seeking capacity to gauge their interest in a system, their understand of the value it would provide, and what capabilities they would like it to have.

TYPE OF BED REGISTRY:
Stakeholders expressed a strong interest in building a web-based system to update and share information on system capacity.

CRISIS SYSTEM BEDS TO BE INCLUDED IN THE REGISTRY:
In addition to information on psychiatric inpatient services, many stakeholders expressed a strong interest in a system that would support capacity information for crisis beds, substance use disorder services, and Appropriate Regional Facilities. DBH is interested in establishing a registry that would include all behavioral health services that are needed to support people in the community to resolve and recover from behavioral health crises.

REGISTRY DEVELOPMENT VENDOR:
DBH intends to build a modest registry at some future date using in-house state platforms.

ACCESS TO THE REGISTRY:
Stakeholders envision the registry with access limited to authorized users rather than the general public.

REFRESH RATE AND ENTRY PROCESS:
A refresh rate and entry process were not determined.

MEANINGFUL METRICS:
Metrics have not been determined.

IMPACT OF THE COVID-19 PANDEMIC ON THE BED REGISTRY:
Efforts to expand the capacity of crisis services across the state were limited because staff availability was reduced during the pandemic.

SYSTEM OVERSIGHT:
Division Director, Division of Behavioral Health Services, Department of Social Services.

For more information on this project contact Nicholas Oyen at nick@sageprojectconsultants.com.
CURRENT APPROACH AND NEED FOR CHANGE:

In 2020, Congress passed the National Suicide Hotline Designation Act requiring states to launch a national hotline number, 988, by July 16, 2022. In 2021, the Washington state legislature passed House Bill 1477 (HB 1477) to take advantage of the 988 designation to improve the state’s behavioral health crisis system. HB1477 establishes a Crisis Response Improvement Strategy Committee (CRISC) to plan for implementation of the 988 crisis hotline and crisis response system enhancements, required the Department of Health (DOH) and Health Care Authority (HCA) to collaborate to establish state crisis call center hubs and an enhanced crisis response system, and imposed a tax on radio access lines, voice-over internet protocol service lines, and switched access lines to fund activities. Figure 5 depicts the broad scope of HB1477 and the complexity of coordinating the many components of a comprehensive and interoperable crisis response system.³

Among the requirements of HB1477, DOH and HCA must establish a system that tracks real-time bed availability for behavioral health crisis services including crisis stabilization, triage facilities, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds.

Having conducted stakeholder meetings and interviews with other states and vendors about crisis bed registry programs, HCA and DOH are making plans for the next step in procuring a registry platform and anticipate launching the system within the next two years (by July 2024).

PLANNING PARTNERS:

Final plans for the crisis bed registry fall to the Steering Committee of CRISC, represented by diverse stakeholders. The Technology Subcommittee of CRISC is tasked with exploring and recommending options for information systems and is comprised of technology and communication experts representing law enforcement and medical first responders, managed care and administrative care organizations, hospitals, behavioral health and crisis service providers, and 988 and 911 call systems. To design a system with value for its users, stakeholders, including persons with lived experience and tribal representatives, were engaged in a series of meetings in 2021. DOH and HCA plan to continue involving stakeholders in the implementation of the registry at every step to build ownership and showcase the value of the tool.


“It’s only as good as it gets used, so we are building value through stakeholder involvement.”

—Allison Wedin, Crisis System Supervisor
**TYPE OF BED REGISTRY:**
HCA is exploring platforms that allow users to search for available crisis and behavioral health beds, capture information about the types of services provided, and to make and close electronic referrals.

**CRISIS SYSTEM BEDS TO BE INCLUDED IN THE REGISTRY:**
- Ambulatory detoxification centers
- Crisis stabilization (<24-hour)
- Substance use disorder inpatient
- Crisis stabilization (>24-hours)
- Substance use disorder residential
- Crisis respite including peer-run
- Voluntary and involuntary inpatient treatment
- Community residential beds

**REGISTRY DEVELOPMENT VENDOR:**
A vendor has not been selected.

**ACCESS TO THE REGISTRY:**
Access has not been determined at this time.

**REFRESH RATE AND ENTRY PROCESS:**
Policy decisions on the frequency with which bed availability information will be required to be updated have not been made.

**MEANINGFUL METRICS:**
Metrics have not been identified.

**IMPACT OF THE COVID-19 PANDEMIC ON THE BED REGISTRY:**
None reported.

**SYSTEM OVERSIGHT:**
The system will be overseen by HCA as defined in the technical and operational plan and recommendations from the CRIS committee.

For more information contact Allison Wedin at allison.wedin@hca.wa.gov.