Evolution of the Transformation Transfer Initiative Crisis Service Registries: 2019 through 2024

Faysal Shaikh
Research Associate

Robert Shaw
Senior Research Associate

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National Association of State Mental Health Program Directors Research Institute, Inc.
3141 Fairview Park Drive, Suite 370, Falls Church, VA 22042 // (703) 738-8160

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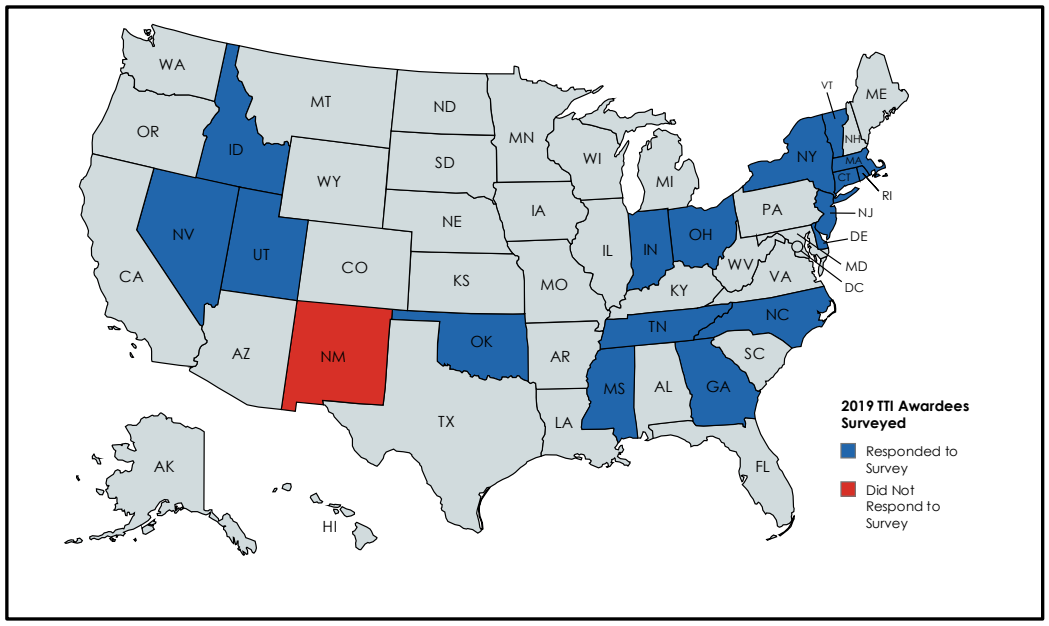
Evolution of the Transformation Transfer Initiative Crisis Service Registries: 2019 through 2024

In Fiscal Year 2019, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Transformation Transfer Initiative (TTI) awards to 22 states to implement or expand existing electronic behavioral health crisis service registries.[1] Since 2019, there have been significant changes to the behavioral health crisis services landscape nationwide, including the launch of 988, the three-digit behavioral health crisis hotline in 2022; expansion of federal and state investments to support behavioral health crisis services[2]; and the publication of SAMHSA's *National Guidelines for a Behavioral Health Coordinated System of Crisis Care*. The purpose of this report is to understand how these significant investments have impacted the use and functionality of the 2019 TTI-funded behavioral health crisis service registries during this five-year period.

In 2024, NRI surveyed the 18 TTI State Awardees who made significant progress expanding and/or implementing crisis service registries during their award period. TTI states surveyed include Connecticut, Delaware, Georgia, Idaho, Indiana, Massachusetts, Mississippi, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, Tennessee, Utah, and Vermont. Seventeen of the 18 states responded to NRI's request for information. See Figure 1. States were given the opportunity to review this report and make updates to their data in April 2025. A copy of the survey can be found in Appendix A.

Figure 1: 2019 TTI State Awardees Surveyed for 2024 Update



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[1] NASMHPD, NRI. (2021). *Improving access to behavioral health crisis services with electronic bed registries*. Substance Abuse and Mental Health Services Administration.

[2] In 2021, SAMHSA was directed by Congress through the Consolidated Appropriations Act, and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 to set aside five percent of the Mental Health Block Grant allocation for each state to support evidence-based crisis systems.

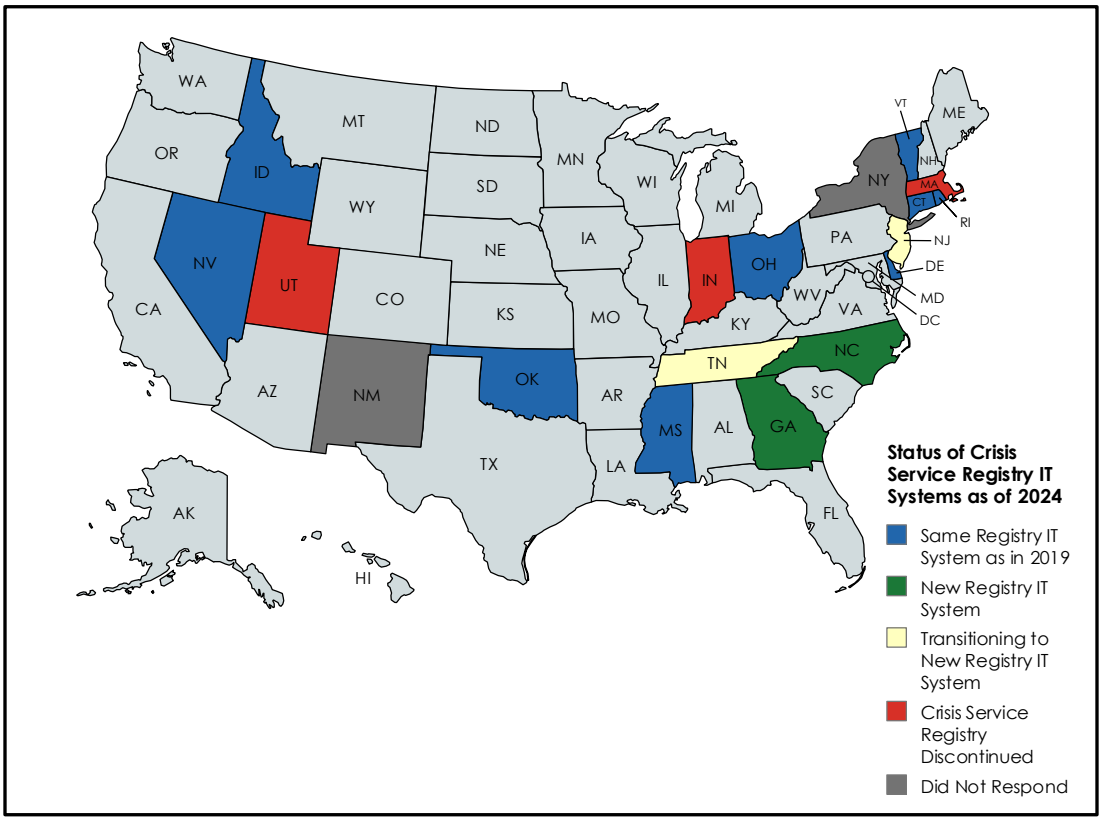
Summary of Findings

Changes in Crisis Service Registry Operations

The majority of the crisis service registries were still in operation at the time of the survey. Of the 17 states responding to the survey, crisis services registries for Utah, Massachusetts, and Indiana were no longer operational; however, Indiana is planning to eventually develop a new crisis service registry to facilitate the integration of 988, mobile crisis, and crisis stabilization services. The majority (9) of states are still using the same service registry IT system that was in place in 2019. Two states, Georgia and North Carolina, had adopted new IT systems. Georgia updated their IT system to enhance security features, and North Carolina updated their IT system to improve automation and integration with Electronic Health Records (EHRs) to increase data accuracy and expedite referrals between systems. Two other states, New Jersey and Tennessee, were still using their original IT systems; however, they were in the process of changing their platforms. New Jersey procured a new registry IT system (Bamboo Health's OpenBeds) that will be able to handle referrals for services as well as housing placements and inpatient beds. The new system will also include a crisis management module for 988 call center intakes and dispositions, as well as mobile crisis dispatch. Once New Jersey's new system is fully implemented, a public-facing portal and directory will also be available. Tennessee was in the process of transitioning from E-Telic to an internally developed IT system, which they expected to conclude in Spring 2025, and would enhance bed searches for psychiatric inpatient care. See Figure 2.

States were asked if they would recommend their system to others considering implementing a similar framework. Only two states responded to this question. Ohio indicated that they would recommend the OpenBeds platform, as it has been stable and reliable, and the contractor support team is very capable. The information transfer features, display capabilities, and data gathering are

Figure 2: Status of Crisis Service Registry IT Systems as of 2024



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useful and supportive of the work in Ohio. New Jersey noted that their new OpenBeds system had not yet come online, but that they would be willing to share their experiences with others considering a similar investment and would share more information once they have fully implemented all phases of the OpenBeds system.

Procuring, Developing, and Financing Registry IT Systems

States developed and procured their registry IT systems through a variety of mechanisms. Of the eleven responding to this question, three states, Georgia, Ohio, and New Jersey, released requests for proposals (RFPs) to identify the best vendor.

- In Georgia, the registry was one part of a larger RFP process. Behavioral Health Link is the State's subcontractor for call center services and manages the registry under a larger state contract with Carelon.
- Ohio developed and issued an RFP specifically for the behavioral health crisis services registry.
- New Jersey issued a mini IT bid to engage with an already State-approved software vendor to initiate a custom agreement with Bamboo Health.

Two states, Idaho and Mississippi, developed their registry systems "in house," using internal state resources and expertise.

The remaining states followed different processes:

- Delaware initially issued a waiver to contract with OpenBeds; when the waiver expired, Delaware leveraged a Cloud Services Agreement, allowing the State to bypass the RFP process.
- Nevada procured a contract with its registry IT vendor via a subaward.
- North Carolina's registry IT vendor contract was added through an existing contract during the COVID-19 Public Health Emergency.
- The contract for Rhode Island's registry is issued via single source to the State-designated entity for Health Information Exchange.
- Utah used a sole-source contract with vendor Juvare (EMResource©) that was also involved with the National Disaster Crisis Response System.
- Vermont's registry, since its launch, had been contracted through a long-standing, sole-source contract until the end of October, 2025. The State of Vermont now hosts its own registry.

Costs associated with establishing and maintaining the behavioral health crisis services registry vary significantly across states. Of the nine states responding to this question, initial development costs range from $40,000 in Connecticut, to nearly $924,000 in New Jersey. The variations in start-up costs may be due to the varying levels of infrastructure already established within the states at the time of registry development as well as the types of services included in the registry system.

Annual operating costs also vary widely across states and are not easily comparable to one another given the diversity in age, size, functionality, and scope across the states.

Table 1 provides an overview of the development and annual costs associated with each state's behavioral health services registry, as well as the source of funds used to maintain each state's registry, when available.

Table 1: Costs to Develop and Operate Behavioral Health Crisis Service Registries, from Responding States

State	Initial Development Cost	Annual Operating Costs	Funding Source	Notes
CT	$40,000	$12,000	State General Revenue Funds	
DE	$150,000	$400,000	Federal grants, not specified	
GA	Unknown	See Note	State General Revenue Funds, Mental Health Block Grant, Medicaid Administrative Match, and additional SAMHSA grant funding	Initial development costs are unavailable as the system was established more than a decade ago. Georgia is unable to separate costs of the registry from its overall crisis services system, which has an annual operating cost of $18, 947,541.
ID	$50,000	$43,000	TTI award funds for development; see notes.	Annual operating costs are relevant to the first two years; however, current operating costs are nil due to minimal use of a shared system.
MA	$250,000	$300,000	No Response	
MS	Unknown	$20,000	TTI award funds for development.	The annual operating costs are earmarked for staff salary to maintain the registry.
NV	Unknown	$67,500	Substance Use Prevention, Treatment and Recovery Services Block Grant	
NJ	$923,866	See Note	COVID Supplemental and ARPA Funds for development and ongoing costs through FY 2025.	New Jersey indicated an annual operating cost of $2,862,986, plus $3 million in annual recurring fees; however, this expense covers services within the crisis IT system, well beyond the registry.
NY	No Response	No Response	No Response	New York did not report this information.
NC	$500,000	$515,000	State General Revenue Funds	
OH	$150,000	$450,000	Mental Health Block Grant	Figures are approximate
OK	N/A	See Note	State General Revenue Funds	Annual operating costs are minimal given the registry is housed and operated within the larger ODMHSAS system.
RI	$132,125	$25,000	Mental Health Block Grant and the Substance Abuse Prevention, Treatment and Recovery Services Block Grant	$10,000 of the annual costs are paid for by the Mental Health Block Grant, and $15,000 by the Substance Abuse Prevention, Treatment and Recovery Services Block Grant.
TN	Unknown	Unknown	Tennessee Department of Health	TDH fully funds the registry, but is looking to TDMHSAS to contribute moving forward.
UT	$70,000	$48,000	TTI award funds for development, Mental Health Block Grant for continued operating costs	
VT	Unknown	$32,560	State General Revenue Funds	Initial development costs are unavailable as the system was established many years ago.

Effectiveness and Functionality of Crisis Service Registries

States were asked for overall impressions of how their behavioral health crisis registries were working. Of the responses, two states responded that their registries are working "very well," four responded that their registries are working "well," and one responded that their registry was "sufficient" to meet the state's needs. Six states provided detailed feedback and one state (New Jersey) felt it was too soon after implementing the new system to provide feedback.

Connecticut and Delaware indicated their crisis service registries were working "very well," with Delaware noting that there was very high adoption of the registry among providers, and that it is now "hardwired as a tool within their daily workflows."

Of the respondents indicating their registry is working "well," two caveated their responses. Georgia remarked that the "the registry works well, although it is taking time for the referring agencies, state-funded crisis units, and administrative staff to get accustomed to the new platform." Ohio noted that their registry is well established "in a large urban area with emergency departments (EDs) and inpatient psychiatric providers," and that the state is "looking to extend that network by adding a variety of [behavioral health] community providers."

Mississippi indicated its registry is sufficient to meet its daily needs, but itw ould be more effective if the registry were updated in real time and fully integrated with providers' EHRs.

Six states provided more nuanced descriptions about how well their registries were working, with most responses being positive, just a desire for more participation by providers and improved linkages with EHR systems.

- Idaho's Psychiatric Bed and Seat Registry (IPBSR) functions as a search engine that allows users to identify participating psychiatric hospitals, the number of beds and/or seats available at the facility, the population served by the provider, and any additional information the hospitals and crisis centers enter into the comments. The IPBSR is underutilized and not always kept up-to-date by end users.
- New York experienced COVID-19 pandemic-related challenges that affected the Office of Mental Health's (OMH) Bed Availability Survey (BAS) daily reporting rate, causing it to fall short of meeting the benchmark/target goal. However, introduction of the Health Electronic Response Data System (HERDS) for psychiatric beds in 2023 was largely successful, and OMH is currently focused on assuring data integrity and consistency.
- North Carolina indicated having high engagement among providers for daily updating compliance, noting that "while the registry will be enhanced once in-system referrals are available, [the registry] is utilized in its current state to identify where an open bed is available."
- Oklahoma noted that its service registry is helpful for small groups, but could be expanded to improve functionality.
- Tennessee indicated that "there are still several psychiatric inpatient facilities that do not participate [in the registry] as there is no mandate requiring their participation. This has caused a bifurcated referral process for psychiatric facilities. Ideally, all hospitals would participate so that there was one single referral process for all psychiatric inpatient facilities. However, overall, the state has received very positive feedback from those that do participate. State psychiatric inpatient facilities have reduced time spent processing referrals internally as a result of the streamlined process."
- Vermont stated that ther registry is liked and the state is always evaluating how to improve the registry. "Overall, it gives us the information that we all need."

Use of Data to Measure Effectiveness of Crisis Service Registries

Seven states collect data to document crisis service registries' value and utility (Delaware, Georgia, North Carolina, Ohio, Rhode Island, Tennessee, and Vermont). States were not asked about specific measures

collected; however, several did volunteer information on the types of data the state collects about their service registries. See Table 2.

Table 2: Crisis Service Registry Data Measures Collected by Responding States with Active Registries

State	Time to Placement	Wait Times	Registry Utilization Data	Referral Acceptance Percentage	Registry Data Timeliness	Referrals Made	Disposition	Provider Satisfaction	Not Specified
CT									✓
DE				Yes					
GA						Yes	Yes		
ID									✓
MS									✓
NV									✓
NJ									✓
NY									✓
NC								Yes	
OH			Yes	Yes					
OK									✓
RI		Yes							
TN	Yes								
VT					Yes				
Total:	1	1	1	2	1	1	1	1	7

Of the states that did not specify their data collection activities, Nevada indicated that the state is increasing its ability to collect data for the service registry; however, the state does not have a personnel position for data collection for the service registry, limiting the amount of data it can collect and analyze. New Jersey anticipates being able to collect data related to the crisis service registry once the new system is fully implemented.

Expansion of Services Included in the Registry

States were asked if they had changed or added the types of beds and services covered by the crisis services registries since 2019. Of the 14 service registries still in operation, five states (Connecticut, Delaware, New Jersey, North Carolina, and Vermont) have added services since 2019; no states indicated services were removed from their registries. Modifications include:

- Connecticut's registry now includes a static page that lists outpatient programs that have walk-in hours.
- Delaware added substance use disorder services, including sober living housing, primary care, dental, and OBGYN services for providers.
- New Jersey added short-term care facility beds.
- North Carolina added community inpatient psychiatric hospitals, facility-based crisis services, state-operated hospital beds, ASAM level 3.9 services, and drug and addiction treatment centers.
- Vermont added youth crisis beds and Department of Aging and Independent Living (DAIL) nursing facility beds.

Refresh Rate

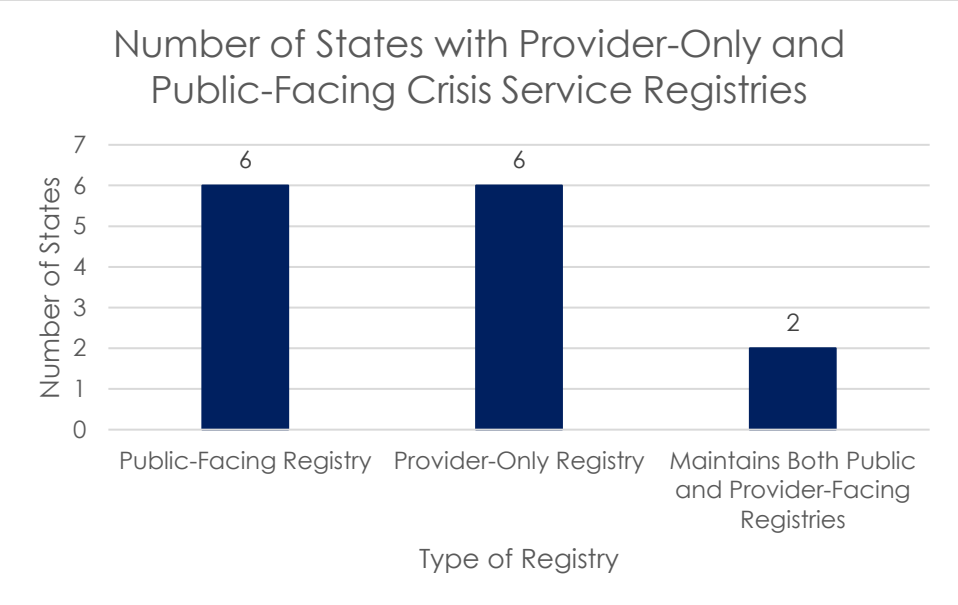
States were asked if they had changed how frequently information is updated in the registry. Of the 14 states with operational registries, only two have increased the frequency with which information is updated in the registry since the 2020 report.

- Mississippi's original objective was to have participating facilities update availability on a daily basis; however, since 2021, Mississippi has asked state hospitals to update the registry as records change periodically throughout the day.
- Initially, North Carolina's objective was to have facilities update their data twice daily, with the option of refreshing data more frequently. Since 2019, North Carolina has decreased the requirement to updating availability once per day. However, there is one large health system using the Automated Bed Availability system that refreshes their service data automatically once per hour.

Accessibility of Crisis Service Registries: Providers and the Public

Half of reporting states (6) report that their service registries are only available to their crisis service providers; however, eight states make their crisis service registry data available to both providers and the public, including Delaware and Ohio; each have two versions of the service registry, one that is public-facing, and another that is only available to providers. Delaware's public-facing registry contains less-detailed information than the provider-only registry, and Ohio's public-facing registry is only available in portions of the state where involvement in the registry is more robust. Other states with public-facing interfaces include Connecticut, Idaho, Nevada, Rhode Island, and Vermont. Several states with public-facing registries indicate that the data are public to improve transparency (Connecticut, Nevada), and to meet statutory requirements (Rhode Island). Idaho requires any user, whether they be a member of the public or a provider representative, to create a log-in to view the registry data. Figure 3. Vermont noted that it may take some education for the public to identify the most appropriate, available services listed in the registry.

Figure 3: Number of States with Provider-Only and Public-Facing Crisis Service Registries



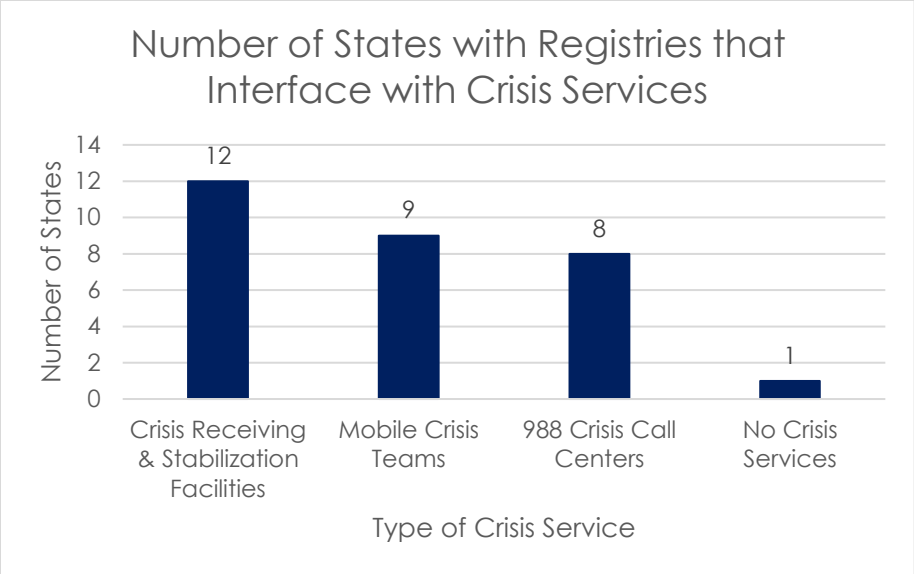
States with provider-only registry interfaces cite multiple reasons for keeping the registry data exclusive to state employees and participating providers, including concerns related to data privacy and protected health information (PHI), fears of overburdening an already-burdened service system, avoiding confusion around service availability and eligibility (e.g., an individual locating a state-funded service they are not financially eligible for), and ensuring that the crisis registry system is fully functional before making the data and interface available to the public. Two states, New Jersey and New York, have plans to make some registry data available to the public after their new systems are implemented and fully operational. States with provider-only registries indicate making the registry available to the following types of providers:

- Georgia: Providers who need to make referrals, including emergency departments, jails, and state-funded crisis facilities.

- Mississippi: Registered providers and chancery clerks to identify placements and report data in accordance to state laws
- New Jersey: State staff and state-funded programs
- New York: Hospital providers
- North Carolina: Allows providers to identify available beds throughout the state; eventually, the platform will allow for in-system digital referrals and EHR integration
- Ohio: Clinicians to make clinical referrals
- Oklahoma: Urgent recovery clinics
- Tennessee: Acute care facilities, psychiatric inpatient facilities, and ambulances

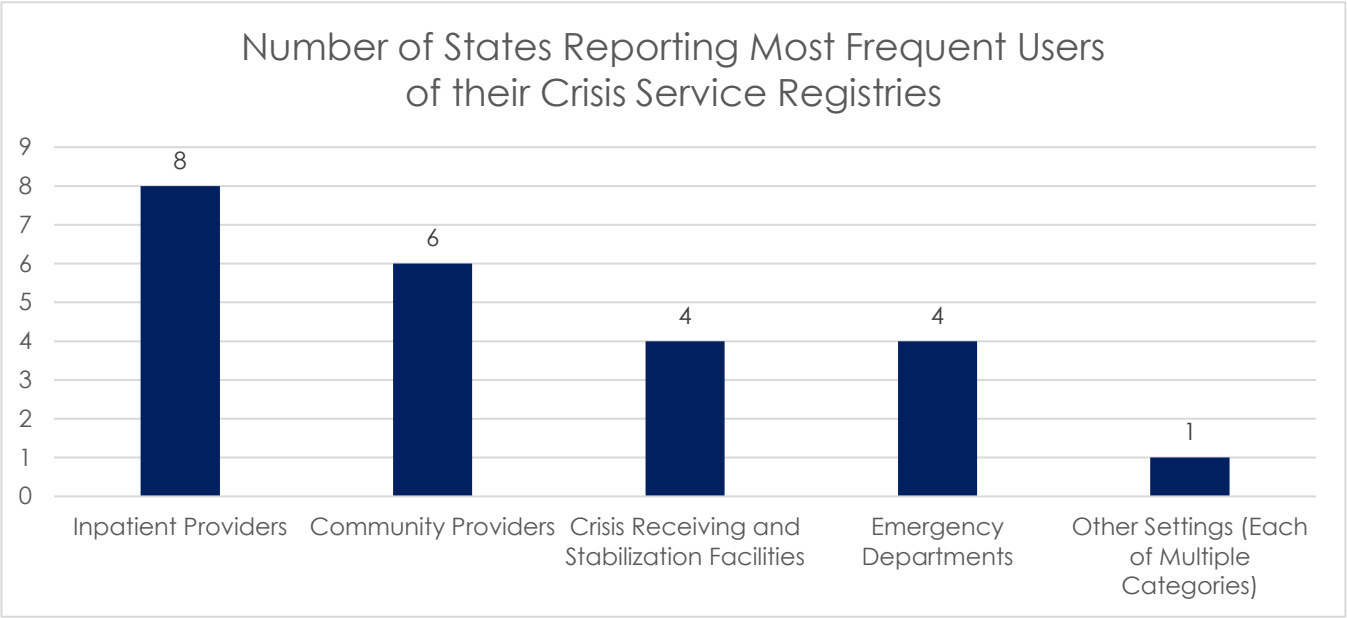
When asked about which components of the crisis continuum have access to the service registry, 13 states indicate that short-term crisis receiving and stabilization programs have, or will soon have (New Jersey), access to the registry, nine states make the registry available to mobile crisis teams, and eight states make the registry available to 988 crisis contact centers. New York's service registries do not currently interact with their states' behavioral health crisis continuums. Figure 4.

Figure 4: Number of States Whose Registries Interface with Specific Crisis Services



According to 14 responding states, the most frequent users of the registry include inpatient providers (reported by 8 states), followed by community providers (6), crisis stabilization and receiving facilities (4), emergency departments (4), and other settings (1 for each for 988 contact centers, mobile crisis teams, first responders, housing services, and state mental health authority). Figure 5.

Figure 5: Most Frequent Users of the Crisis Services Registry



Areas for Improvement

While many states are satisfied with the functionality and efficiency of their registries, 11 states identified areas for improvement, with the most common areas being related to expanding the types of partners and services included in the registry (six states), and improving the ability to capture data in real time (four states).

Of the states looking to expand the types of partners and services included in the registry, Idaho and Ohio indicated a need to expand to more, unspecified behavioral health provider programs. Oklahoma would like to include the entire behavioral health system, rather than just those providers that are state-operated or state-contracted. Oklahoma would also like for community partners to have better access to the registry. Rhode Island would like to add ouptatient appointment availability. Tennessee would add alcohol and drug abuse beds, as well as long-term skilled nursing beds. Vermont would improve their registry's ability to connect with community mental health agencies.

The four states indicating a desire to capture data in real time, Mississippi, New Jersey, North Carolina, and Tennessee, would improve their registries' interfaces with EHRs to automate the bed count process.

Georgia would improve its service registry to include more reporting options for state administrative staff to improve their ability to find information to better manage the system.

State Summaries

Connecticut

Connecticut's *Bed Availability* website was launched in 2020, which allowed individuals and their family members to find available addiction services across the state. The website initially included detox services, residential treatment services, recovery houses, and sober homes across the state. As of the 2021 report, Connecticut's Department of Mental Health and Addiction Services was planning to launch a similar site for mental health services.

Since the 2021 report was published (based on 2020 data),[3] Connecticut's *Bed Availability* website has expanded to include mental health services, including services for individuals with acquired brain injuries, forensic patients, and services for young adults. The registry now includes additional details about the available services, including outpatient programs with walk-in hours.

As in 2020, Connecticut's *Bed Availability* registry is available to both the public and providers; however, the provider base has expanded to include crisis services, including 988 contact centers, mobile crisis teams, and short-term crisis receiving and stabilization facilities. The most frequent users of the *Bed Availability* registry are members of the public seeking services for themselves or family members.

The *Bed Availability* registry had a start-up cost of $40,000, with an annual cost of $12,000 to maintain and update. These expenses are covered by State General Revenue Funds.

Project Contact: Julienne Giard (julienne.giard@ct.gov)

Delaware

Delaware has expanded their Treatment Connection crisis service registry, which included state and private psychiatric hospitals, psychiatric units in general hospitals, detoxification facilities, crisis stabilization units, crisis respite beds, and residential beds, to include services such as sober living housing, the state employment agency, primary care, dental care, and OB/GYN services for providers that serve the behavioral health population. Delaware has created a crisis system built on the same platform. The registry is now available to 988 contact centers, mobile crisis teams, and short-term crisis stabilization programs. There has been a slow rate of adoption among the 988 contact centers; Delaware has been working to integrate the system better to align the workflow with the 988 contact centers to increase utilization.

There is a public-facing and a non-public facing version of the registry; each draws from the same database. The public-facing registry provides more limited information compared to the non-public registry, which includes information about services, contacts, and availability. The registry's most frequent users are emergency departments, which use the registry to transition individuals to other facilities post ED care.

The registry was built and still operates on the OpenBeds© IT system. The state monitors declines and returns to services to ensure individuals are able to access treatment.

The initial cost to establish the registry was $150,000, with an annual operating cost of $400,000, paid for by federal grants. A waiver was used to establish the registry; however, when the waiver term ended, Delaware contracted with CARASOFT under a GSS Cloud Service Agreement.

Project Contact: Lisa Johnson (lisa@healtheinsights.com)

Georgia

The most substantive change to Georgia's service registry has been a change of platforms in September 2023. The platform change was necessary to enhance the system's security. This required that a new platform be built to manage the registry. Georgia have not changed the organization, Behavioral Health Link, which administers the service registry. The registry includes crisis stabilization units, contracted inpatient

[3] NASMHPD, NRI. (2021). *Improving access to behavioral health crisis services with electronic bed registries.* Substance Abuse and Mental Health Services Administration.

beds in private psychiatric hospitals and psychiatric units in general hospitals and large state hospitals, a crisis unit that addresses the needs of children with autism, state operated detoxification facilities and substance use residential settings.

Georgia's service registry was well established prior to the introduction of 988. The registry continues to be available to 988 contract centers and short term crisis receiving and stabilization centers but not to mobile crisis teams. Emergency departments and jails use the registry to refer patients while state funded crisis facilities use the registry to receive these referrals and communicate the acceptance of patients to the emergency departments and jails making referrals. The registry is not public because it contains protected health information and is intended to be used only for state-funded services under contract with the state mental health agency and those entities making referrals.

There are plans to add reporting options to be used by state administrators. Originally, the system was designed to be used only by the end users and not administrative staff. The system can be improved to allow better data sharing with administrative staff to address system and constituent challenges. Georgia can easily measure the number of referrals, the number of dispositions, and other measures; however, Georgia do not measure how the registry impacts waiting times for placements or other similar metrics

The registry has been built over more than a decade. Georgia do*es* not have information on the cost of building and upgrading the system. The registry was procured as part of a larger RFP for Georgia's Administrative Service Organization. Carelon was the successful bidder and subcontracts with Behavioral Health Link for call center services and for the management of the service registry. The registry is funded primarily with state dollars, the Mental Health Block Grant, and Medicaid's administrative match.

Project Contact: Dawn Peel *(*dawn.peel@dbhdd.ga.gov*)*

Idaho

The Idaho Psychiatric Bed and Seat Registry (IPBSR) launched in January 2020 to provide information about how many beds/seats are available for Idaho Behavioral Health Community Crisis Centers (BHCCCs), State Hospitals (SHs), and private psychiatric hospitals.

The implementation of 988 had no impact on IPBSR as it is a registry for mental health professionals, medical professionals, and first responders who are aiding Idahoans in locating psychiatric inpatient treatment or crisis stabilization. Currently, only adult and youth BHCCCs are required to use IPBSR. Privately owned and ran psychiatric hospitals are not required to use IPBSR. Those private psychiatric hospitals listed on IPBSR are voluntarily contributing to the registry.

The registry is an online platform that can be accessed by a computer or a mobile device 24/7, 365 days a year. IPBSR is hosted through Idaho Public Health's for emergency preparedness site, EMResource, which is developed and operated by Juvare.

IPBSR does not collect any data outside of what gender, age, medical conditions (ie COVID) the BHCCC, SH, or private psychiatric hospitals serve and have the number of beds/seats available at that time. The registry information is updated by each BHCCC, SH, or voluntarily participating private psychiatric hospital.

The initial cost to set up the registry was $50,000 and the estimated annual cost is $43,000 to operate the registry. The registry was funded by the TTI award and uses an IT system already used by Public Health to track resources for hospitals and the emergency room system.

Project Contact: Michaela Tourville (Michaela.tourville@dhw.idaho.gov)

Indiana

Indiana's service registry is no longer operational. The registry was discontinued as part of the state's strategy to connect 988 with mobile crisis response and crisis stabilization services.

Project Contact: Amanda Pardue (amanda.pardue@fssa.in.gov)

Massachusetts

Since 2019, Massachusetts had added services and modified the frequency with which information is updated in its service registry.

The registry initially reported on the availability of ten categories of crisis care, ranging from mobile crisis and crisis stabilization units to inpatient beds for mental health and substance use related crisis for adults and children. It also included preventive and aftercare services, including partial hospitalization programs and in-home behavioral health services. The following services had been added to the registry: behavioral health urgent care, open access outpatient care, and services provided by Community Behavioral Health Centers (CCBHCs), opioid treatment programs, including those that are office-based, and urgent care. Due to the variety of services and settings, the frequency of updates varied from three times per day to four times per year (for non-crisis related services), depending on the turnover rate and level of care. Auto reminders were electronically generated for two-hour lapses in updates for inpatient beds. Participation and 80% compliance with updating availability are quality indicators that insurance companies in Massachusetts considered when adjusting reimbursement rates. The newly added programs were required only to update availability once per quarter. Applied Behavioral Analysis updated availability monthly while Acute Treatment Services updated availability daily. The registry did not track information about wait times or delays to receive services.

The system had seen increased usage and was newly available to 988 contact centers, mobile crisis teams, and short-term crisis receiving and stabilization programs. The Behavioral Health Helpline was the biggest user of the registry. State agency staff, inpatient unit staff, and mobile crisis staff were also frequent users. The registry was public facing so anyone who needs to search for services could do so.

The registry used the same state-developed IT system and continued to perform well. Massachusetts tracked unique website hits and searches and uses the information to measure the registry's utility and value.

The initial cost to set up the registry was $250,000 and annual cost is $300,000. Massachusetts did not release an RFP or use a bidding process to develop the registry.

Massachusetts provided an update following our data collection that their crisis services registry had been discontinued.

Project Contact: Ret Major (ret.major@carelon.com)

Mississippi

There have been no substantial changes to Mississippi's service registry, although state hospitals have been asked to provide updates throughout the day as records change. Crisis stabilization beds are included in the registry but mobile crisis services and 988 are covered by different systems. While the registry is available to mobile crisis providers, it is not available to 988 contact centers. Community mental health centers and state psychiatric hospitals use it to report data and chancery clerks use it to find potential vacancies. Mississippi do not track how frequently the registry is used. The registry is not available to the public.

The registry uses the same IT system, which was developed in-house. Mississippi would like to make the registry real-time and integrate it into the Electronic Health Records of providers, which would make the registry more useful.

The annual cost to operate the registry is $20,000, which goes to staff salaries. The registry was funded by the TTI award.

Project Contact: Kim Wood (kim.wood@dmh.ms.gov)

Nevada

There have been no substantial changes to Nevada's service registry. The registry includes psychiatric units in general hospitals, public and private psychiatric hospitals, triage centers, social detoxification, and substance use residential treatment facilities, and outpatient and community support behavioral health services. Nevada have added a personnel position to work on the registry and have increased engagement with the registry vendor to include biweekly technical assistance. Nevada has released an RFP for oversight of the current 988 call center and to create a secondary call center that would cover the southern region of the state. It is available to the public, providers, 988 contact centers, mobile crisis teams, and short-term crisis receiving and stabilization centers. While the registry is available to the public, treatment providers, including those providing behavioral health and or substance abuse treatment services are the most frequent users of the registry. The public facing Treatment Connection can be accessed at https://www.treatmentconnection.com.

The registry uses the same IT system, OpenBeds©. and has not been expanded to cover additional services. Nevada would like to increase the ability to collect data from the registry, however, Nevada do not currently have a personnel position to collect and analyze the data.

The registry has an annual cost of $67,500 and is funded by the Substance Use Block Grant through a subaward rather than an RFP.

Project Contact: Rachel Isherwood (r.isherwood@health.nv.gov)

New Jersey

New Jersey expanded their service registry (BEDS) using a NASMHPD TTI award to include short-term care facility beds (their registry already included residential beds, state-funded beds in hospitals, recovery centers, and extended observation unites in psychiatric emergency centers). BEDS (the Bed Enrollment Data System was developed in 2015 as a search engine for mental health and substance use treatment providers to find available community supportive and recovery housing. The frequency of updates has not changed. A new registry has been procured and will replace the current registry. The most frequent users of BEDS are

state staff and state-funded provider agencies that provide community support services, residential housing, and short-term care facilities. There is no public access to BEDS.

The new registry, called Bamboo Health OpenBeds© will handle expand the services in the registry to include community-based services and will have a module for crisis management designed to be used by 988 call center intakes and disposition and mobile crisis dispatch. Bamboo will have a crisis management module for 988 call center intakes and disposition and will provide an inventory of available services and treatment opportunities. The new registry will have a public-facing portal, but it is not yet online. New Jersey anticipates that the new registry will increase access to placements to the providers and programs already covered by BEDS and to over twenty additional services or levels of care not currently part of BEDS. New Jersey expect that the most frequent users of the new registry will be community providers. Consumers and family members will have access to the treatment connections part of the new registry.

The initial cost to set up the registry was $923,866 and the annual cost is $2,862,986 and an annual recurring fee of approximately $3 million. New Jersey used COVID supplemental and ARPA funds to pay for the design and annual costs of BEDS. The New Jersey Department of the Treasury, Division of Purchase and Property holds a contract with Appriss/Bamboo, which is considered a software as a service product. The SMHA issued an IT mini-bid process to engage with a NJ approved software re-seller to initiate a custom agreement with Appriss/Bamboo.

Project Contact: Donna Migliorino (donna.migliorino@dhs.nj.gov)

New York

There have been no substantial changes to New York's service registry since 2019. It is available to hospital providers who operate inpatient psychiatric programs and by the SMHA for tracking and monitoring bed data. Data from the registry are available to the public, however data on psychiatric bed data are not included. There is a plan to grant greater access to the public.

New York reports that the challenges related to the COVID-19 pandemic affected daily reporting rates, however the introduction of the registry in 2023 was largely successful and the SMHA is focused on assuring data integrity and consistency.

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

Project Contact: Gina Bae (gina.bae@omh.ny.gov)

North Carolina

There have been changes to North Carolina's service registry. These changes include adding community inpatient psychiatric hospitals; facility-based crisis facilities; ASAM Level 3.9; state operated hospitals; and alcohol, drug and addiction treatment centers to the registry. Information in the registry is updated daily. North Carolina are not using the same IT system as originally to support the registry. North Carolina are now using the OpenBeds© platform through Bamboo Health. This system is called the Behavioral Health Statewide Centralized Access System (BH SCAN). North Carolina changed systems after identifying a need for additional automation and integration with EHRs. North Carolina hope that this automation would reduce staff burden, increase the accuracy of the data, and expedite referrals between systems. North Carolina

have one large health system using automated bed availability, which updates the beds automatically hourly. North Carolina have a high rate of compliance with updating the registry.

The current registry is not available to 988 contact centers or mobile crisis teams, but it is available to short-term crisis receiving and stabilization programs. The most frequent users are inpatient case managers and facility staff. It is not available to the public at this time because North Carolina did not want to burden facilities since facilities often have limited available bed capacity. It is felt that making the current system public would overwhelm the already strained system.

North Carolina's current crisis model is being redesigned to encompass all systems within one administrative umbrella. It is hoped that the redesign will create an integrated system that connects 988 as an entry point for mobile crisis services, be able to identify open beds, and allow individuals to access treatment and post-crisis follow-up services.

North Carolina would like more advanced technological registry offerings that would integrate with EHRs and automated bed availability to offer to all facilities. The current system has limitations that make North Carolina reluctant to enable in-system referrals.

North Carolina do not track the utility of the registry at this time, however, have used provider satisfaction surveys to indirectly assess registry effectiveness.

The initial system cost $500,000 to develop and has an annual operating cost of $515,000 per year. The registry was initially funded through an existing contract during the Public Health Emergency. The system receives a yearly budget allocation from the state's General Assembly.

Project Contact: Lisa DeCiantis (lisa.deciantis@dhhs.nc.gov)

Ohio

Ohio's registry includes psychiatric hospitals, inpatient units in general hospitals, and regional (public) psychiatric hospitals. Ohio are exploring extending the use of the registry to a broader range of behavioral health provider programs, such as community providers of behavioral health services.

The registry has a public facing portal and was launched in parts of the state where participation in the registry is most robust. The registry is available to short-term crisis receiving and stabilization programs but is not available to 988 contact centers, or mobile crisis teams. The most frequent users of the registry are emergency departments and inpatient psychiatric treatment providers.

The registry uses the same IT system, OpenBeds©, and Ohio would recommend this system to other states. The system has been reliable and stable and the contractor's support team has been very capable. Ohio are measuring the use of the registry by participating facility staff and are looking at the percentage of referrals accepted into a program, the timeliness of the referral process (such as referrals placed), and the decision provided to the referrer. Ohio would like to research the reduction in time spent in emergency departments due to the use of the registry.

The initial cost to set up the registry was $450,000 and the annual cost is $150,000 to operate the registry. Ohio released an RFP to develop and operate the registry.

Project Contacts: Justin Trevino, M.D. (justin.trevino@mha.ohio.gov) or Caitlin Beha (Caitlin.beha-worth@mha.ohio.gov)

Oklahoma

Oklahoma's registry includes state-run crisis centers and state-run psychiatric hospitals. The registry was developed in-house and links Electronic Health Information (EHR) data, AVATAR by Netsmart in this case, to the registry search engine.

The registry is not available to 988 contact centers but is available to mobile crisis teams and short-term crisis receiving and stabilization programs. The registry's most frequent users are urgent recovery clinics, crisis stabilization units, and inpatient facilities, all of which are represented in the registry. The registry is not public. The state has urgent recovery clinics that of a "no-wrong-door" model, which assess and connect individuals with the appropriate level of care.

The registry is state operated and is used to see which facilities have available beds, which facilities are full, and, for an urgent recovery clinic, to find a placement. The registry is working well but Oklahoma would like to expand access to law enforcement, emergency medical services, and fire departments. Oklahoma do not measure the registry's utility or value.

The annual cost of operating the registry is minimal and is funded by ODMHSAS. Oklahoma did not report how much the initial development of the registry had cost.

Project Contact: Tony Stelter (tony.stelter1@odmhsas.org)

Rhode Island

Rhode Island's registry includes inpatient behavioral health beds in general hospitals and private psychiatric hospitals, crisis stabilization units, community-based detoxification units, substance use disorder recovery houses, and substance use disorder residential treatment programs. The registry is available to providers, including 988 contact centers, mobile crisis teams, and short-term crisis receiving and stabilization programs. It is also available to the public, because of a statutory requirement. Rhode Island is not able to determine whether providers or the public are the most frequent users.

Rhode Island reports that registry is working well. Providers consistently update the bed availability. Rhode Island would like to add the outpatient appointments to the registry. Rhode Island are using OpenBeds© for their registry.

The state agency has access to all data submitted to the registry and has created dashboards and reports to inform leadership, and external partners, on trends in emergency department and psychiatric unit waiting times. To understand changes in waiting times for individuals, Rhode Island create multiple point-in-time comparisons because the data collected represents snapshots of distinct days.

The initial development of the registry cost $132,125. Rhode Island did not release an RFP or use a bidding process to create the registry rather the contract was issued via single source to the State Designated Entity for Health Information Exchange. The registry has an annual cost of $25,000, of which $15,000 comes from the Substance Abuse Block Grant and $10,000 from the Mental Health Block Grant.

Project Contact: Kelly Lewis (kelly.lewis@bhddh.ri.gov)

Tennessee

Tennessee is currently in the process of transitioning its technologic implementation of the service registry. The registry includes psychiatric units in general hospitals, psychiatric hospitals, and state hospitals that are licensed in the state. The most frequent users of the registry are providers involved with Mobile Crisis and Crisis "Walk-In" (Acute Care) Centers. State Psychiatric Inpatient Facilities also use the "Patient Bed Matching" application (embedded within the overall registry application) as a source of referrals from Mobile Crisis and Crisis Acute Care Centers.

As alluded to above, the registry is in the process of shifting from the E-telic (external vendor) platform to an internal Department of Health platform until the spring 2025. Tennessee are hoping that the transition results in enhancements and improvements to bed searches for psychiatric inpatient care. Additionally, Tennessee are investigating an "HLN interface" that would allow real-time updates, as the current process involves manual updates where some facilities only update bed counts once per day.

Tennessee reports positive experiences from those who use (and continue to use) the registry, although many State Psychiatric Inpatient Facilities are not using the registry since no regulatory mandate requires facilities to do so. State Psychiatric Inpatient Facilities who use the system have replaced old referral methodologies (e.g., calls, faxes, etc.) with more efficient and streamline processes, resulting in reduced time spent processing referrals internally.

Tennessee has finalized a data dashboard involving the data provided through this system and are now in the evaluation process. At this point, the data show a reduction in the overall amount of time taken to place patients at a State Inpatient Psychiatric Facility.

The registry's initial creation and modifications thus far have been funded fully by the Tennessee Department of Health (TDH), with no RFP or bidding process involved. TDH have additionally approached the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) for additional funding support. As of now, no users pay to use this application. The registry was developed in house but connects to Netsmart's electronic medical records.

Project Contact: Meisha Millwee (Meisha.Millwee@tn.gov)

Utah

Utah discontinued efforts to develop an inpatient bed registry, putting efforts into building an extensive crisis continuum.

Project Contact: Pam Bennett (pbennett1@utah.gov)

Vermont

Vermont's registry began with public and private psychiatric hospitals, psychiatric inpatient units in general hospitals, crisis stabilization units, community residential and intensive residential beds, and children's inpatient psychiatric units and crisis stabilization units. Vermont's registry includes nursing facility beds licensed and overseen by the Department of Aging and Independent Living. The registry is available to providers, including 988 contact centers, mobile crisis teams, and short-term crisis receiving and stabilization programs. CMHC crisis screeners are the highest users of the registry followed by emergency departments. The registry is public-facing. Anyone can log in to see the available beds, at any level. Vermont

feels that it is important to be transparent about bed availability. While the registry is available to the public, the public may not always understand that every open bed requires review by the admitting facility team to assess for the ability to meet the specific clinical needs of an individual referred.

Vermont measures how often the registry is updated with the goal of making the registry as real time as possible. Vermont monitors the weekly average number of closed, available, and occupied beds and this data is reported weekly to the governor.

The registry was developed many years ago by the Minnesota Hospital Association, with which DMH held a contract for maintenance of the website and database until the end of October, 2025. The website is now hosted by the State of Vermont as a collaboration between the Department of Mental Health, the Department of Aging and Independent Living, and the Agency of Digital Services.

Vermont does not have a specific number for the initial cost as it was developed many years ago and has continuously been improved through the years. The average operating cost in recent years has been $32,650 per year with the funding coming from state general funds. Although Bed board is a password protected website, the password and username are publicly available at https://mentalhealth.vermont.gov/providers/electronic-bed-board-system.

Project Contacts: Samantha Sweet (Samantha.sweet@vermont.gov), and Allie Nerenberg (Alexandra.Nerenberg@vermont.gov)

Appendix A: Behavioral Health Crisis Services Registry Update Survey

It has been several years since NRI worked with you to develop the NASMHPD reports on Crisis Bed Registry work supported by TTIs (see attached your state's TTI Registry project status report that is also available on the NASMHPD website: TTI 2019 Bed Registry Project Fact Sheets and Full Report | National Association of State Mental Health Program Directors (nasmhpd.org)).

States are looking to create a service registry or expand an existing service registry. Much may have changed since NRI and NASMHPD last looked at this issue, especially because of the implementation of 988 and the expansion of crisis service programs.

We would greatly appreciate it if you could take a few minutes to answer the questions below about the status of your state's crisis (bed) registry system. **Please respond to Faysal Shaikh** fshaikh@nri-inc.org **by Thursday April 4, 2024.**

1. Is your Registry still being operated? ☐ Yes ☐ No
    a. If the registry isn't operating any more, why not? What happened?
    Click or tap here to enter text.

2. Have you changed or added the types of beds/services covered by the registry?
    ☐ Yes ☐ No
    a. If yes, please describe what services have been added or deleted:
    Click or tap here to enter text.

3. Have you changed how frequently information is updated in the registry? ☐ Yes ☐ No
    a. If yes, please describe.
    Click or tap here to enter text.

4. Is your state using the same IT system to support your registry or have you changed platforms? ☐ Yes ☐ No

    a. If your state changed the IT system supporting your registry:
        i. Why did you shift IT systems?
        Click or tap here to enter text.
        ii. What system are you using now?
        Click or tap here to enter text.
        iii. Would you recommend this new system to other states? ☐ Yes ☐ No
            1. If yes, please describe why:
            Click or tap here to enter text.

5. How has the implementation of 988 and other crisis services (such as Mobile Crisis, Crisis Stabilization Services, etc.) impacted what services your registry covers and how they are used?
   Click or tap here to enter text.
   a. Is your registry now available to the following BH Crisis System providers:
      i. 988 Contact Centers ☐ Yes ☐ No
      ii. Mobile Crisis Teams ☐ Yes ☐ No
      iii. Short Term Crisis Receiving and Stabilization Programs ☐ Yes ☐ No

6. Who are the most frequent users of the registry now? Click or tap here to enter text.

7. Please describe who they are and how they use the registry:
   Click or tap here to enter text.
   a. Is the registry public or is it only available to providers/clinicians? ☐ Yes ☐ No
   b. Please describe why the registry is public or non-public:
   Click or tap here to enter text.

8. What, if anything, would you like to change/add/drop in your registry?
   Click or tap here to enter text.

9. How is the registry working (overall impressions)?
   Click or tap here to enter text.

10. What data are you using to measure the registry's value or utility? Are you able to document reduced time of individuals waiting in Emergency Departments or delays in receiving services? Please describe:

11. What is the annual cost of operating your system?
    $ Click or tap here to enter text.

    a. How is the system paid for?
       Click or tap here to enter text.

12. Approximately how much did the initial development of your bed registry cost?
    $ Click or tap here to enter text.

13. Did you have to release an RFP or utilize a bid process for either your original IT system or the one you are currently using? ☐ Yes ☐ No
    Please describe the bidding process: Click or tap here to enter text.

14. If another state would like to talk to someone in your state to learn more about your registry, who would be willing to talk with them:
    Name: Click or tap here to enter text.
    Email: Click or tap here to enter text.