Actionable Patient Safety Solution (APSS) #13:
ACCESS TO ACUTE PSYCHIATRIC BEDS

Executive Summary Checklist

- ▢ Survey and assess stakeholder support for those who are in need of a psychiatric bed registry.
- ▢ Increase and secure "buy in" with key players by continued education of need.
- ▢ Implement a real-time electronic bed tracking system.
- ▢ Communicate with key stakeholders who would be using the system.
- ▢ Ongoing monitoring to maintain system in order to adhere to current standards and protocols.
- ▢ Share data for times bed system is full and total bed need is not able to be met.

The Performance Gap

Between 1970 and 2000, the number of public psychiatric hospital beds dropped from 207 beds per 100,000 people to just 21, according to the federal Agency for Healthcare Research and Quality (AHRQ). A 2010 survey of 603 hospital emergency department administrators by the Schumacher Group, an emergency-room consultancy, found that 56 percent of emergency departments are “often unable” to transfer behavioral patients to inpatient facilities in a timely manner. More than 70 percent of administrators reported wait times of at least 24 hours, and 10 percent had boarded patients for a week or longer. In a 2008 survey of 328 US-based Emergency Department (ED) Medical Directors, 79.2% report routine psychiatric patient boarding with 35.1% boarding greater than 1 patient per day and 38.9% boarding for between 8-24 hours. The survey cited lack of an accepting transferring facility (19.9%), and the inability to transfer to an accepting facility due to bed availability (19.5%), as the most common reasons for extended ED length of stay. Wait time for psychiatric beds in the Emergency Departments are even longer for pediatric patients in comparison to adults. Wait time is even greater for children 12 and younger as even fewer psychiatric beds exist for these children.

Between 1995 and 2012, California saw inpatient psychiatric beds drop from 9,300 to 6,500. The fallout within communities by way of increased violence to self and others is undeniable. In 2014, the state of Virginia passed the “Acute Psychiatric Bed Registry" Code (37.2-308.1) as a result of a tragic death of the son of State Senator Creigh Deeds who killed himself after stabbing his father. The state of California has no mandatory psychiatric bed registry and locating psychiatric beds for those in crisis is a challenge. Therefore, a bed registry would allow facilities to locate vacant beds in a more efficient manner to improve quality of care and reduce otherwise avoidable death and suffering. By sharing information and utilizing real-time update systems, professionals are able to determine and locate appropriate facilities with bed availability and resources for the patient...

Currently, a great majority of the United States lack an organized system for locating and securing necessary inpatient hospital psychiatric services. The current system is inefficient, cumbersome and wasteful. This is compounded by the increased lack of inpatient psychiatric beds locally and nationally, causing an unreasonable and unnecessarily long wait time for critical patients in outpatient facilities, emergency departments, and other settings before they are able to be admitted to the safety of an inpatient setting. The results include:

- Delays in initiation of necessary treatment,
- Injury to staff by acutely ill and agitated patients being boarded in a setting not designed for psychiatric treatment (ie: emergency department),
- Reduced availability of ED beds for acutely ill medical patients,
- Unnecessary financial burden and loss for hospitals,
- Unnecessary and often times unmanageable stress for patients, which only leads to an exacerbation of further symptoms
- Misuse of hospital staff

Due to the vast majority of states lacking a psychiatric bed registry (**Figure 1**), the task of finding an open psychiatric bed is left up to various hospitals and practitioners. Currently, individuals must resort to repetitive and time consuming phone calls between facilities to locate a possible placement for a patient in crisis. Due to this practice, locating an appropriate bed is often ta result of "luck and timing." It is not uncommon to find multiple facilities placing calls at the same time in search for a bed. As a result, costs accumulate, the patient and family experience long wait times while they languish in emergency departments, on medical floors, and in psychiatric boarding rooms.A facility that is unable to locate an appropriate bed for the psychiatric patient is left to absorb the numerous financial costs, including but not limited to, extra staffing costs to supervise the patient, loss of revenue

for that occupied bed, possible departmental diversion costs, etc. All of these factors contribute to an overall increase in healthcare costs.

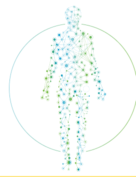
Currently, an electronic bed registry is in use in Virginia, Maryland and Minnesota. New York is currently undertaking legislation in this area, and Pennsylvania, Georgia, and Iowa health care advocates are requesting an inquiry into the possibility of such a system in their states. On December 13, 2016, President Obama signed the 21st Century Cures Act, which includes provisions that cover mental health. Part of the provisions under Helping Families in Mental Health Crisis Act of 2016 requires a database that:

- includes information on inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder facilities in the State involved, including contact information for the facility or unit;
- provides real-time information about the number of beds available at each facility or unit and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow for the proper identification of appropriate facilities for treatment of individuals in mental or substance use disorder crisis; and
- enables searches of the database to identify available beds that are appropriate for the treatment of individuals in mental or substance use disorder crisis.

In addition, $12.5 million has been appropriated to carry out this initiative between fiscal years 2018 through 2022.

Internationally, both the United Kingdom and Australia are already using this type of technology. For example, in the UK, Cygnet Health Care offers a searchable database to all of their hospitals and facilities within their system. Priory Group, also based in the UK, has a simple function on their website, which allows for24/7 access to their emergency bed availability for all of their facilities. In Australia, the private sector has a Private Bed Finder, which is service designed to help take the pressure off public hospital emergency departments by offering a simple, streamlined process for finding private doctors and hospital beds in Adelaide, South Australia.

While a critical lack of beds exists in this country, this system would help to better manage this scarce resource. In addition, such a system can identify the amount of time the system is on “diversion”, e.g. at capacity, no beds available. This information can be shared with key legislators and insurers to determine if bed capacity needs to be increased.



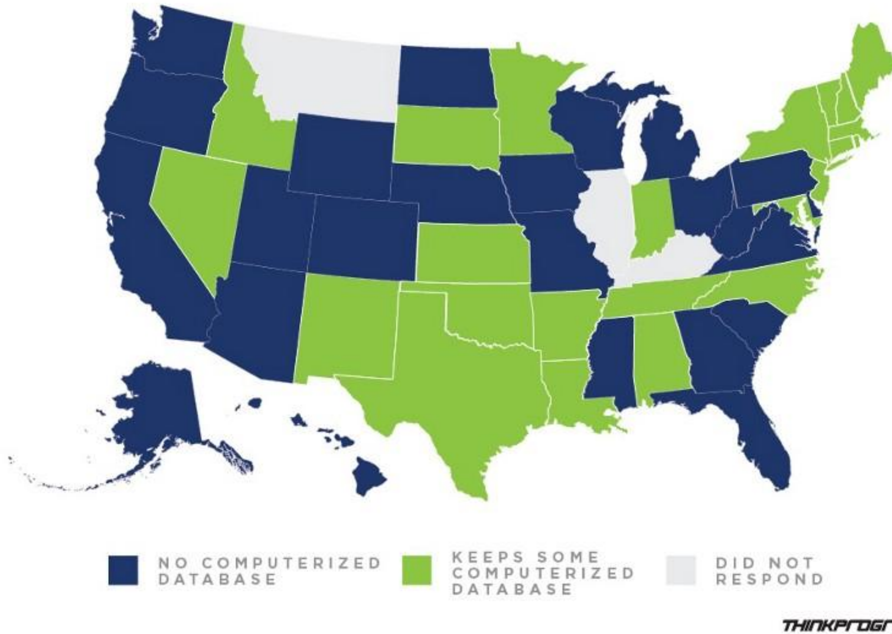


Figure 1: States that track the number of beds for psychiatric patients. (Credit: Adam Peck, thinkprogress.org)

Leadership Plan

- Identify key individuals in organizations that would benefit from use of a psychiatric bed registry such as:
    - Charge nurses
    - Intake coordinators
    - Emergency room supervisors
    - Behavioral health providers, who are often screening patients and making recommendations regarding placements, including: social workers, psychologists, psychiatrists, psychiatric nurse practitioners (NPs)
    - Public entities such as police and crisis team evaluators
- Present technology solutions, including the demonstration of use and integration
- Train key personnel
- Continue implementation support through transition period
- Continual improvement and monitoring/updating of systems
- Reporting and statistical tracking of positive system outcomes

Practice Plan

Create and maintain a web-based and mobile application psychiatric bed registry that serves as a platform for inpatient hospital bed openings, which must be maintained in real time. This system will streamline and expedite psychiatric patients transitioning into inpatient hospital beds by identifying open beds as they become available throughout the service area and prevention of an inpatient bed going unused because due to its availability remaining unknown..

The optimal system should:

1. Be maintained in real-time without undue administrative burden and
2. Identify search criteria such as what kinds of beds (e.g., male or female), on what kinds of units (e.g., child, adolescent, geriatrics), etc. are available so that patients are not routed to units that will not meet their needs.

The results:

1. A financial gain for hospitals.
2. Less stress and suffering for the patient and accompanied support system.
3. Hospital staffing and support is recovered and can be diverted to other operational duties as needed.

Technology Plan

Suggested practices and technologies are limited to those proven to show benefit or are the only known technologies with a particular capability. As other options may exist, please send information on any additional technologies, along with appropriate evidence, to info@patientsafetymovement.org.

- Web-based and mobile application Psychiatric Bed Registry
  - One known solution without clinical-based evidence is Patient Valet

Metrics

We discovered a lack of outcome metrics that can be captured to determine how many lives have been saved, or suicides averted, through increased access to psychiatric beds. The lack of measurement specifications within behavioral health highlights the need for organizations that generate standardized metrics, like the Agency for Healthcare Research & Quality (AHRQ), to place greater focus on developing tools that pertain to mental health. At this time we can recommend resources and process measures that might be further developed to address the issue at hand.

Additionally, we must develop a shared tracking system to collect data when system is on “diversion”, e.g. lack of available beds, and separate data by adults and pediatric patients (under 18 years of age).

Resources:

- Emergency Severity Index (ESI) Triage Tool for the ED[1]
    - This resource addresses mental health issues including suicidality among the broader range of problems that are observed in the ED. For example references to suicidal risk occur throughout the document.
- Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals presents step-by-step instructions for planning and implementing patient flow improvement strategies to alleviate crowded emergency departments.[2]
    - Overall improvements in patient flow are likely to benefit all patients including those suffering from mental health problems. Similarly, safety measurement and improvement initiatives that address mental health, but are broader-based and consider mental health in a larger context may not only be more feasible, but they may also serve patients better by providing insights that may not be evident in a more focused effort alone.
- VA National Center for Patient Safety’s Mental Health Environment of Care Checklist.[3]
    - The purpose of the checklist is to identify hazards within hospitals that may increase the chance of patient suicide or self-harm.

Process Measures:

- OP-20 Door to Doc Diagnostic Evaluation by a Qualified Medical Professional
    - This measure can be utilized to look at the median time from ED arrival to provider contact for ED patients. This measure could be adapted to compare patients with a primary Mental Health diagnosis vs. Medical diagnosis and reduce disparities in treatment efficiency and access.
- Decreased boarding time for psychiatric patients in emergency departments.
- Increased occupancy rate of beds in psychiatric facilities

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[1] Gilboy, N., Tanabe, T., Travers, D., & Rosenau, A. M. (2011). Emergency Severity Index (ESI): A triage tool for emergency department care, implementation handbook. Agency for Healthcare Research and Quality, Rockville, MD, 4th ed. AHRQ Publication, (12-0014).

[2] McHugh, M., VanDyke, K., McClelland, M., & Moss, D. (2012). Improving patient flow and reducing emergency department crowding: A guide for hospitals. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/ptflowguide.pdf

[3] U.S. Department of Veterans Affairs - VA National Center for Patient Safety. (n.d.). Retrieved from: http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp

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Revision History

Version	Primary Author(s)	Description of Version	Date Completed
Version 1	Steven Barker, Leila Entezam, Maggie Merritt, Michael Bruner, Elizabeth Bettinelli, Heather Huszti, Monica McAlduff, Robert Roca, Elaine Shamir, Jordan Gamart, Michael Ramsay, Ariana Longley, Jordan Gamart, Joe Kiani	Initial Release and Executive Review	January 2017