Psychiatric Bed Registries

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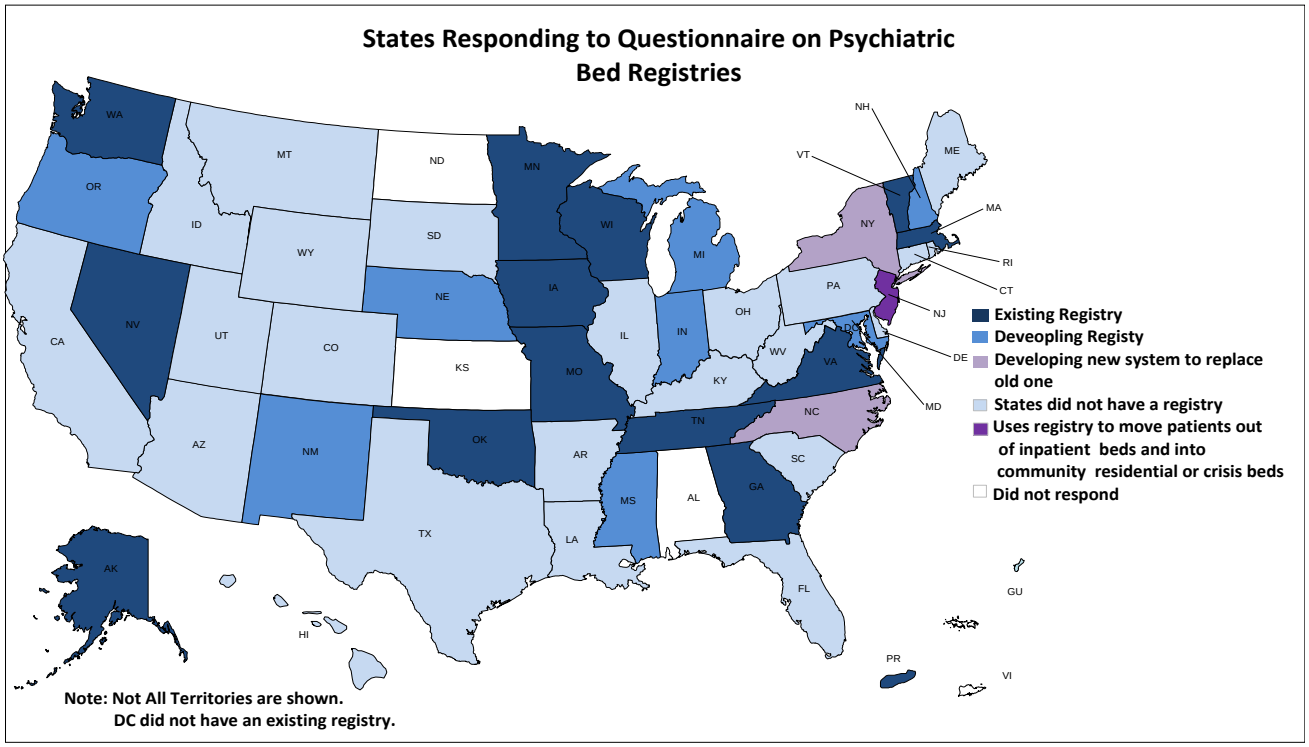
For individuals who require a high-level of intensive psychiatric services (often on an emergency basis to protect their own safety), beds exist in a variety of settings such as private psychiatric hospitals, general hospitals, state hospitals, and community-based crisis care facilities. However, clinicians often face challenges when attempting to locate a bed available to an individual in need. Clinicians must consider the diagnosis and acuity of the patient, age, gender, and needed level of security when researching facility availability – which may translate into countless hours of phone calls to identify an appropriate placement. This is especially problematic for emergency departments (EDs) because these departments tend to be the gateway for accessing inpatient care.[1,2] The 21st Century Cures Act passed in 2016 authorizes to grants to states to develop, maintain, or enhance bed registries to mitigate the challenges accessing treatment.

For purposes of this study, a **bed registry** was defined as a centralized system that uses real-time tracking to monitor the availability of psychiatric beds.

Psychiatric bed registries have been gaining attention as one method to help connect patients with the appropriate services in a timely manner. NRI conducted a study to examine how many State Behavioral Health Agencies have implemented (or were in the process of developing) bed



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registries along with how these agencies are (or plan on) operationalizing their registries. In this study, a bed registry was defined as a centralized system that uses real-time tracking to monitor the availability of psychiatric beds. The survey was sent to all 50 State Behavioral Health Authorities, plus the District of Columbia and six territories. Responses indicated that 14 states currently have an operational bed registry and 8 states are planning on developing, or are in the process of developing, a bed registry. Two states have an existing registry but are developing a new system (For the purposes of this paper, the responses for these states were included with the other states that already have an existing system).

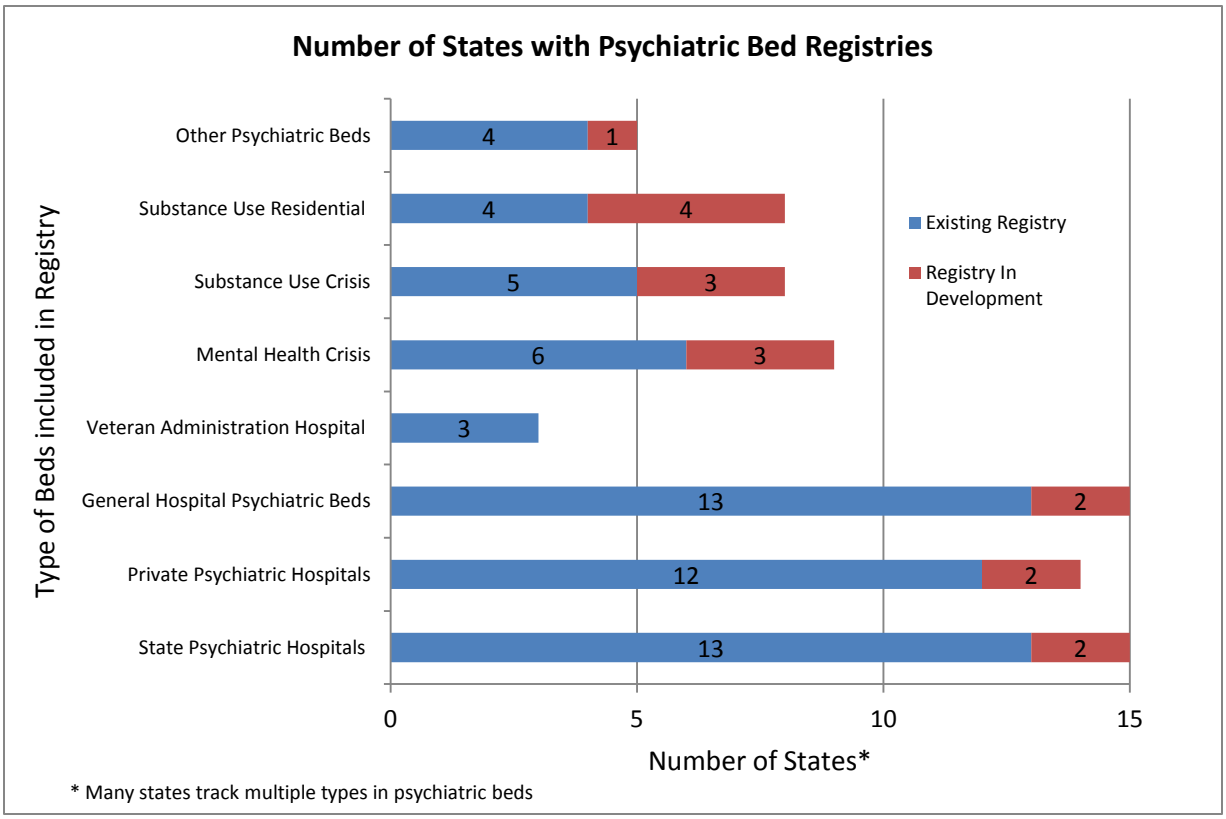
Psychiatric Bed Registries

Out of the 16 states that had operational bed registries more than half (9 states) of the states reported that participation in the bed registries was voluntary. It should be noted that in one of these nine states participation in the registry was mandatory only for facilities that were working with or overseen by the Department of Mental Health. In this state, other facilities that provide other types of services (e.g. substance use services) and that were not overseen by the Department of Mental Health were not necessarily required to submit data to the registry. While only one state that had an existing registry reported this distinction, registries in other states are likely to have similar inclusion/exclusion nuances that affect the degree to which the registry is a comprehensive representation of all psychiatric beds available within a state. Many of the states (11 states) also reported that they updated the registry periodically (e.g. every morning, when new information is available, several times a day, etc.) as opposed to using real-time tracking. A majority of the states (15 out of 16 states) tracked the availability of beds within multiple types of facilities. The types of beds that were most commonly tracked were state psychiatric hospital beds (13 states), general hospital psychiatric beds (13 states), and private psychiatric beds (12states).

Eight states indicated that they are developing a bed registry; of those, three states specified their plans for their bed registries. One state indicated that it planned on making participation mandatory, while the other state indicated that participation would be voluntary. The third state specified that participation would only be mandatory for facilities that were licensed by the state's Division of Mental Health and Addiction services; for all other facilities participation was voluntary. Two of the responding states (2 states) indicated that they planned on having the registry updated continuously (real-time 24/7 updates), while the third indicated that they planned on having the registry updated periodically. Like the states that currently have operational bed registries, several (4 states) that reported what types of beds they planned on tracking indicated that their bed registries would include multiple types of facilities. The types of beds that these states planned on tracking were residential beds for substance use disorders (4 states), crisis beds for individuals with mental health disorders (3 states), crisis beds for individuals with substance use disorders (3 states) general hospital psychiatric beds (2 states), state psychiatric hospitals (2 states), and private psychiatric hospital beds (2 states).

Development of Community Bed Registries

While many of the states that have existing bed registries or are in the process of planning the development of a bed registry system are using these systems to track the availability of inpatient and community psychiatric beds, one state is using its bed registry for another purpose. New Jersey has a web-based tracking system that provides state psychiatric hospitals and all other Division funded facilities with information on bed availability for mental health crisis beds along with its Division funded supportive housing, residential group homes, and supervised apartments. Participation in New Jersey's web-based bed registry is mandatory. The system is continuously (24/7) updated with real-time information about bed availability.



Conclusion

Very few states reported having bed registries that were updated 24/7 with real-time information. This may be because, as one state indicated, real-time bed registries are complex and can impact the success of the system if not implemented properly. Even if they are not updated 24/7, bed registries can be used to reference which facilities may have inpatient beds available, increasing the rate at which a patient is connected with inpatient services. This is important since patients may remain in facilities that are not equipped to handle their needs for a long period of time.[3,4]

Community beds such as crisis beds are important to include in registries because they may be able to address the needs of individuals at a lower intensity level of service than placements to

inpatient care in general hospitals or private or public psychiatric hospitals. For patients that require more intensive psychiatric inpatient services registries that include all available psychiatric inpatient beds can be used by community facilities, crisis facilities, and emergency departments to determine which facilities (e.g. state psychiatric hospitals, general hospitals, and/or private psychiatric hospitals) have available inpatient beds for these patients. By more efficiently identifying and utilizing existing inpatient capacity, waits for beds can be reduced and pressures to open new state psychiatric hospital beds can be minimized. Registries that can match patient need with the types of available beds have the potential to lead to more efficient use of psychiatric inpatient capacity in states. States that have state statues/policies requiring them to focus on utilizing their state psychiatric hospital beds for patients who have more complex psychiatric disorders and/or who require a more secure setting (e.g. forensic patients) can use registries to help triage patients to the most appropriate type of bed.
Nonetheless, bed registries can be used to facilitate quicker bed location, which can assist facilities in reducing the chances that a patient's symptoms will be exacerbated while he/she waits for a bed to become available and, specifically for emergency departments, help these facilities save money.[5, 6]

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[6] (American College of Emergency Physicians, 2008, Nolan, Fee, Cooper, Rankin, & Blegen, 2015).

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