Regulation of Freestanding EDs Varies Widely by State

BY JEFF BAUER

There is great variation in state regulations concerning freestanding EDs, with no standard requirements for location, staffing patterns, or clinical capabilities, according to a recent study published in *Health Affairs*.

Researchers used information from state departments of health and other state agencies to compile a list of freestanding EDs in the United States. They identified state policies and regulations regarding freestanding EDs by contacting state departments of health, by searching the departments' Web sites for regulations, and by searching an online legal research database.

Overall, the study identified 400 freestanding EDs in 32 states; Texas and Ohio had the highest number of such facilities. Twenty-three states had hospitals that operated affiliated freestanding EDs. Twenty-one states had policies concerning freestanding EDs. These policies were either incorporated into hospital regulations or listed independently. Among states with such regulations, there was great variation in the requirements for freestanding EDs to provide specific medical services, products, and technology. For example, 12 states with freestanding EDs required pediatric equipment to be on site, 13 required a cardiac defibrillator, and 9 required blood products for transfusion. Only two of the 32 states (6%) had policies that were in concordance with all seven of the American College of Emergency Physicians (ACEP) recommendations for freestanding EDs.

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Twenty-nine states had no regulations. New York and Washington regulate freestanding EDs on a case-by-case basis, and California indirectly bars them in its hospital regulations.

The study's authors concluded that variations in state regulations may lead to more freestanding EDs opening in states with fewer regulations, and fewer facilities in states with stricter regulations. They added that consistent regulation of freestanding EDs is needed so patients can better understand these facilities' capabilities and costs.

1. Gutierrez C, Lindor RA, Baker O, Cutler D, Schuur JD. State regulation of freestanding emergency departments varies widely, affecting location, growth, and services provided. *Health Aff (Millwood).* 2016;35(10):1857-1866.

Psychiatric Patients Face Inordinately Long Wait Times in EDs

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FRONTLINE MEDICAL NEWS

Individuals with psychiatric conditions are facing increasingly longer wait times in EDs across the country, including children, according to a pair of studies presented at the American College of Emergency Physicians (ACEP) 2016 annual meeting.

Suzanne Catherine Lippert, MD, of Stanford University and the lead author of both studies, said that seeing psychiatric patients sit in the ED for days prompted her to finally look into this issue.

Both studies were conducted retrospectively, looking at data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) collected between 2001 and 2011, and focusing on patients who had been brought to mental health EDs with *International Classification of Diseases, Ninth Revision* codes indicating substance abuse or a primary psychiatric diagnosis. The first study, which looked at ED length of stay for psychiatric patients, defined length of stay as the time from the patient's arrival at the ED to the time of disposition, divided into categories of >6 hours, >12 hours, and >24 hours. Overall, 65 million ED visits were included in the study.

Patients with bipolar disorder had the highest likelihood of waiting more than 24 hours in the ED, with an odds ratio of 3.7 (95% confidence interval, 1.5-9.4). This was followed by patients with a diagnosis of psychosis, a dual diagnosis of psychiatric disorders, multiple psychiatric diagnoses, or depression. The most common diagnoses were substance abuse, anxiety, and depression, which constituted 41%, 26%, and 23% of the diagnoses, respectively. Patients with psychosis were admitted 34% of the time and transferred 24% of the time; those who self-harmed were admitted 33% of the time and transferred 29% of the time; and patients with bipolar disorder were admitted 29% of the time and transferred 40% of the time. Patients who had either two or three diagnoses were admitted 9% and 10% of the time, respectively.

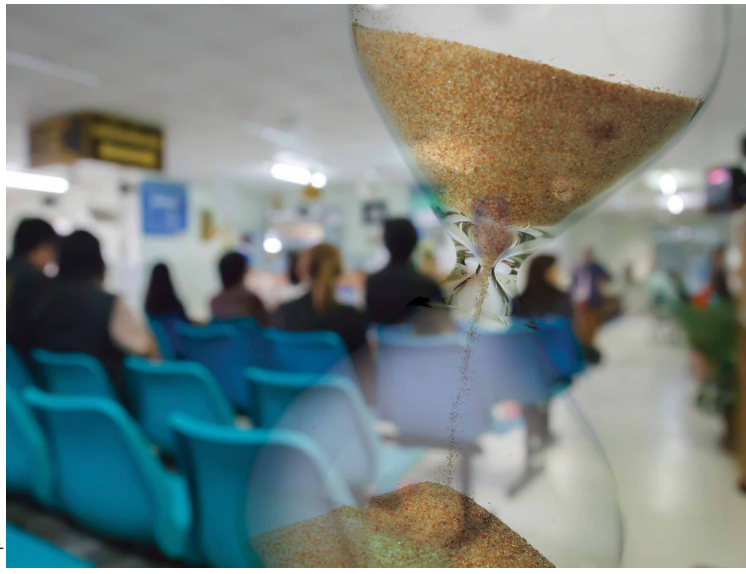
"Further investigation of the systems affecting these patients, including placement of involuntary holds, availability of ED psychiatric consultants, or outpatient resources would delineate potential intervention points for the care of these vulnerable patients," Dr Lippert and her coauthors wrote.

The second study looked at the differences in waiting for care at EDs between psychiatric patients and medical patients. Length of stay was defined the same way it was in the previous study, with disposition meaning either "discharge, admission to medical or psychiatric bed, [or] transfer to any acute facility." Length of stay was divided into the same three categories as the previous study.

Psychiatric patients were more likely than medical patients to wait more than 6 hours for disposition, regardless of what the disposition ended up being, by a rate of 23% vs 10%. Similarly, 7% of psychiatric patients vs just 2.3% of medical patients had to wait longer than 12 hours in the ED, while 1.3% of psychiatric patients had to wait longer than 24 hours, compared with only 0.5% of medical patients. The average length of stay was significantly longer for psychiatric patients: 194 minutes vs 138 minutes for medical patients ($P < .01$).

Additionally, psychiatric patients were more likely to be uninsured, with 22% not having insurance, compared with 15% of medical patients being uninsured. Furthermore, 4.6% of the psychiatric patients' previous visit to the ED had been within the prior 72 hours, compared with 3.6% of medical patients. A total of 21% of psychiatric patients required admission, compared with 13% of medical patients, while 11% of psychiatric patients were transferred, compared with just 1.4% of medical patients.

"These results compel us to further investigate the potential causes of prolonged length of stay in psychiatric patients and to further characterize the population of psychiatric patients most at risk of prolonged stays," Dr Lippert and her coinvestigators concluded.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American College of Emergency Physicians President Rebecca B. Parker, MD, explained that a survey of more than 1,700 emergency physicians revealed some "troubling" findings about the state of EDs over the last year.

The nation's dwindling mental health resources are having a direct impact on patients having psychiatric emergencies, including children, Dr Parker said. "These patients are waiting longer for care, especially those patients who require hospitalization."

Findings of the survey indicate that 48% of ED physicians witness psychiatric patients being "boarded" in their EDs at least once a day while they wait for a bed. Additionally, <17% of respondents said their ED has a psychiatrist on call to respond to psychiatric emergencies, with 11.7% responding that they have no psychiatrist on call to deal with such emergencies. And 52% of respondents said the mental health system in their community has become noticeably worse in just the last year.

Dr Parker voiced outrage about the situation. "Psychiatric patients wait in the emergency department for hours and even days for a bed, which delays the psychiatric care they so desperately need," she said. "It also leads to delays in care and diminished resources for other emergency patients. The emergency department

has become the dumping ground for these vulnerable patients who have been abandoned by every other part of the health care system."

For more on the extended boarding of psychiatric patients in the ED, see "A Wintry Mix of Patients, Redux" by Editor in Chief Neal Flomenbaum, MD (*Emerg Med*. 2015;47[3]:101).

High Resting Heart Rate May Signal Exacerbation Risk in COPD Patients

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FRONTLINE MEDICAL NEWS

Higher resting heart rate (HR) may predict future risk of exacerbation in patients with recent chronic obstructive pulmonary disease (COPD) exacerbation, results from a multicenter study suggest.

"Resting heart [rate] is often...readily available clinical data," lead study author Ahmad Ismail, MD, said in an interview in advance of the annual meeting of the American College of Chest Physicians. "Its significance is often overlooked in daily clinical practice until tachycardia or bradycardia happens. In COPD patients, it has been shown that the resting HR can predict mortality. However, there is a lack of data showing its association with the rates of exacerbations, the major player in determining overall outcome in patients with COPD."

In an effort to identify the association between resting HR and risk of exacerbations, Dr Ismail of Universiti Teknologi MARA, Malaysia, and his associates at nine other centers evaluated 147 COPD patients who were recruited during acute exacerbation of COPD that required hospitalization between April 2012 and September 2015. The researchers recorded each patient's sociodemographic data, anthropometric indices, and medication history during their acute exacerbation at the hospital. Next, they followed up with the patients in clinic at 3 months after the recruitment (month 0), and collected resting HR, spirometry, and COPD Assessment Test (CAT) scores. Subsequently, patients were followed up in clinic at 6 and 12 months, and followed up in between via telephone interviews to collect data on exacerbation history.

The mean age of the study population was 67 years, and 77% had higher resting HR, defined as exceeding 80 beats/min (bpm). The mean resting HR in the higher resting HR group was 92 bpm, compared with a mean of 70 bpm in the lower resting HR group. Dr Ismail reported that at month 3, patients with higher resting HR had a significantly higher proportion of exacerbations, compared with those who had a lower resting HR (54% vs 27%; $P = .013$). The trend was followed through until month 9. There was also a statistically significant moderate strength linear correlation between resting HR and exacerbation frequency at 3, 6, and 9 months ($r = 0.400$, $P < .001$; $r = 0.440$, $P < .001$; and $r = 0.416$, $P = .004$, respectively). The mean exacerbation frequency was also significantly higher in the higher resting HR group at month 3 and month 6 (2.00 vs 0.48, $P < .001$; and 3.42 vs 1.14, $P = .004$).

"Higher resting heart rate may predict future risk of exacerbation in patients with recent COPD exacerbation," Dr Ismail concluded. "Further study however is required to determine the effect of lowering resting heart rate on the future risk of exacerbation." He acknowledged certain limitations of the study, including the fact that it excluded patients who were on beta-blockers or any rate-modifying drugs, and those with history of cardiac failure and ischemic heart disease, and that there was no baseline echocardiogram performed to ensure the absence of ischemic heart disease and other possible causes of the higher resting HR. "We also had slightly higher than expected dropouts giving a nonsignificant result at 12 months follow-up, though the trend follows the overall results of the study," he said.