

Selected Topics: Psychiatric Emergencies



PSYCHIATRIC PATIENT LENGTH OF STAY IN THE EMERGENCY DEPARTMENT FOLLOWING CLOSURE OF A PUBLIC PSYCHIATRIC HOSPITAL

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Abstract—Background: Psychiatric patient boarding in the emergency department (ED) is a ubiquitous problem associated with increased morbidity and mortality. **Objective:** We evaluate the effect of closing a public psychiatric facility in a major metropolitan area on the ED length of stay (LOS) of psychiatric patients. **Methods:** This was a retrospective chart review at two metropolitan EDs of all patients assessed to require inpatient psychiatric hospitalization. The time of arrival, time of disposition, time of transfer, insurance status, and accepting facility type were collected prior to and following the closure of a local inpatient psychiatric facility. **Results:** We analyzed a total of 1107 patients requiring inpatient psychiatric hospitalization, with 671 patients who presented prior to the closure of the closest public psychiatric facility and 436 patients that presented following the facility closure. Following hospital closure, patients with private insurance (620 min before, 771 min after) and Medicare/Medicaid (642 min before, 718 min after) had statistically significantly longer ED LOS, as well as patients transferred to a private psychiatric hospital (664 min prior, 745 min after). However, overall ED length of stay following hospital closure for transfer of all psychiatric patients requiring inpatient hospitalization was not found to be statistically significant (1017 min prior, 967 min after). **Conclusion:** There was a statistically significant increase in ED LOS for patients with private insurance, Medicare/Medicaid, and for those patients transferred to a private psychiatric facility following closure of a public mental health hospital; however, overall, ED LOS was not increased for patients transferred to an inpatient psychiatric facility. This study highlights the significant impact that the closure of a single inpatient psychiatric facility can have on nearby EDs. We

hope to bring attention to the need for increased psychiatric services during a time when there is a nationwide trend toward the reduction of available inpatient psychiatric beds. © 2017 Elsevier Inc. All rights reserved.

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Emergency departments (EDs) are faced with a growing number of patients presenting with mental health complaints, comprising 6–9% of all ED presentations (1,2). There are few onsite mental health resources available in the ED, and psychiatric patients often wait hours to days for an inpatient psychiatric bed.

The Emergency Medical Treatment and Labor Act mandates that the emergency provider stabilize and treat all individuals who enter the ED regardless of their ability to pay. When the patient is deemed to have an emergency psychiatric condition, treatment often involves admission to an inpatient psychiatric bed. Since the 1960s, the “deinstitutionalization” of psychiatric patients has led to a drastic reduction in the number of public and private inpatient psychiatric beds available for these patients (3). Private facilities often refuse patients without insurance. Furthermore, financial reimbursement for treating psychiatric patients is minimal, due, in part, to the Medicaid Institutions for Mental Disease exclusion that bars federal government reimbursement for the cost of medically necessary inpatient care in certain Medicaid recipients (3).

Holding of psychiatric patients in the ED is a ubiquitous problem associated with increased morbidity and mortality, fatigue among ED staff, and may decrease the quality of care among both psychiatric and medical patients seeking care in the ED (4,5,6). It has been suggested as both a cause and effect of ED overcrowding (3). In 2008, 80% of ED medical directors surveyed reported boarding of psychiatric patients, and 90% indicated they boarded psychiatric patients every week, with 55% reporting daily boarding (3,7). Multiple studies have attempted to quantify the length of psychiatric patient holds, with average times ranging from 6.8 to 34 h (8).

Recently, holding of psychiatric patients has received attention in medical literature and the lay press. The Washington State Supreme Court recently filed an opinion that the boarding of psychiatric patients under the state's Involuntary Treatment Act violated the constitutional rights of the patients (9).

Despite an increasing number of ED presentations with mental health complaints and limited outpatient mental health treatment options, the state of Illinois closed three mental hospitals with 497 beds. We sought to identify changes in boarding times of psychiatric patients following the closure of a publicly funded mental health hospital near our EDs. This closed facility accepted 27% (181 of 671) of psychiatric patients transferred from our EDs prior to closure, with the remaining 73% (491 of 671) being placed in 35 various mental health institutions. In addition, the closed facility we studied was within 11 miles of both of our EDs, with the other two closures taking place 111 miles and 220 miles from our EDs. The state planned to close six of the 12 state-run mental health centers and shift resources toward purchasing mental health services from local community hospitals, citing recommendations from the New Freedom Commission Report on Mental Health (10). The Affordable Care Act of 2010 aimed to increase medical coverage to uninsured patients, including psychiatric patients, during the study period.

METHODS

Study Design

The authors conducted a retrospective chart review of adult patients presenting from July 1, 2010 through May 10, 2013, assessed to require inpatient psychiatric hospitalization. Institutional Review Board approval was granted by the host hospital system and the host educational institution. The primary outcome was the comparison of time the patient was in the ED in minutes before and after closure of the public psychiatric facility. All patients were evaluated in the ED and deemed to

require inpatient psychiatric treatment by the attending emergency physician. Patients were determined to require acute inpatient psychiatric services in accordance with the Petition for Involuntary/Judicial Admission form provided by the State of Illinois (11). This includes patients who present a danger to themselves or others, who are unable to provide themselves basic physical needs, or who are refusing or not adhering to treatment and expected to suffer mental or emotional deterioration. Placement at psychiatric facilities was determined by a regional psychiatric coordination service that assists with patient placement to appropriate facilities based on factors such as bed availability and patient insurance, which included transfer to approximately 36 outside regional psychiatric facilities, as neither study hospital had an in-house psychiatric unit at the time of the study.

Study Setting and Population

The study took place at two metropolitan teaching hospital EDs. Inclusion criteria were all patients presenting to either ED with a psychiatric complaint and deemed by the attending emergency physician to warrant acute inpatient psychiatric treatment. Exclusion criteria were patients under 18 years of age, patients over 65 years of age, patients who required admission for stabilization of a medical condition prior to transfer, patients who were pregnant, and patients who were discharged from the ED prior to transfer to a psychiatric facility. The state-funded mental health facility that closed accepted patients with commercial medical insurance, Medicare, and self-pay patients.

Study Protocol

The hospital medical records department created a list of patients meeting inclusion criteria. Using predefined variables, a standardized Web-based data collection tool that populated a Microsoft Excel spreadsheet was created (12). Medical student abstractors, who were blinded to the study hypothesis, each received 30 min of training using practice charts and the standardized Web-based data collection tool. Data were taken exactly as reported in the medical charts; no interpretation was needed (12). In addition, the Web-based data collection tool minimized these errors by using restricted ranges. Charts were checked for accuracy and outliers by the main investigator (RM) weekly. The date, time, and day of the week of presentation to the ED, and the date and time of patient transfer to a psychiatric facility were extracted. Additionally, the patient's chief complaint, age, gender, insurance status, qualitative toxicology screen, alcohol level, day of the week, use of diagnostic imaging, restraint use, and place of transfer were recorded. These data were then

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