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SB 1152:
THE HOMELESS DISCHARGE BILL
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The Chapter and I have been fielding reports on how SB 1152 (Hernandez) has affected our emergency departments (EDs). As some parts of the law seem open to interpretation and are written in ways that create confusion, even among hospital attorneys, I hope to provide a few references and arguments that may help your discussions with your hospital administrators, social workers, case managers, and even Health Departments. Additionally, please let us know if you are having difficulty sorting out how to move forward with some of these interpretations.

While we do not expect to be able to make an immediate legislative change to this law, hearing what is happening in the field is critical to the Legislature understanding the consequences, intended and unintended, of their action. We want to hear from you and will collect and share experiences, both obstacles and success, so other emergency physicians and hospitals can learn from what you’ve gone through.

One physician reported that his hospital attorney’s interpretation of the law required keeping homeless patients in the ED until a shelter was able to accept the patient. The California Hospital Association published guidelines entitled “CHA Discharge Planning for Homeless Patients”, which included the following:

**FAQ:** I contacted the local shelter, and they told me they won’t have a bed for the patient until tomorrow. Are we required to keep the patient in the hospital until then?

No. The law explicitly states that it does not require a hospital to adopt a policy that would delay discharge or transfer of a patient [Health and Safety Code Section (k)(1)]. The hospital should inform the patient of the shelter’s availability for the next day, and work...
with the patient to identify a “residence” or “alternative destination” as defined below for the patient to go in the meantime.”

**FAQ:** What if there is no shelter that will accept a homeless patient who is ready for discharge/release?

This will frequently be the case. The author and sponsors of the homeless patient discharge planning legislation know that many communities don’t have adequate shelters or other social services. If this is the case, work with the patient to find out what location, if any, he/she considers his/her “residence” as defined above. If he/she does not identify a residence, then work with the patient to identify an alternative destination.

If your hospital administrators or attorneys are interpreting the law in a way that is inconsistent with the intent of the law and the availability of the resources we all know are terribly lacking in our communities, refer them to the California Hospital Associations’ “CHA Discharge Planning for Homeless Patients” Guidelines. Your hospital’s executive is likely to belong to CHA, the advocacy society for hospital execs, and hopefully CHA’s interpretation and guidelines will carry some weight.

Another concern we have heard about is that Local Health Jurisdictions (LHJ), such as County Health Services, are sending out memoranda in regards to their charge by the law to provide regional recommendations on vaccinations as follows:

“Section 2: Article (6) the homeless patient has been offered or referred to screening for infectious diseases common to the region, as determined by the local health department.”

In one county, a memorandum was sent out stating, “Providers should not discharge homeless patients suspected or confirmed to have either of those infections (Hepatitis A and Shigellosis) from medical care until a discharge plan has been developed with public health input and approval.” The law is written, “offered or referred to screening,” not keep in the hospital until confirmed or house all patients in the ED while the County Department and the hospitals come up with a discharge plan.

Another County’s memorandum states, “For…homeless patients being seen in the ED/Hospital setting, if the initial diagnostic work-up for presenting condition involves collection of blood, we recommend that protocol reflex orders be developed to perform, at minimum, an annual screen for HIV and Chronic Hepatitis C…and Syphilis.” This would be really nice to do for all of our communities, but we first have to build the infrastructure to refer these patients to counseling, treatment, and clinics to take care of them. Public health screenings do not benefit the patient unless they have real access to follow-up treatment.

Meanwhile, Section 2, article 7 of SB 1152 states, “The homeless patient has been offered vaccinations appropriate to the homeless patient’s presenting medical condition.” To me this may mean offering Pneumovax on a wheezing patient who presents with a COPD exacerbation. But nowhere in the law does it state I have to get public health input and approval in order to discharge a patient with chronic diarrhea because I may “suspect” an infectious etiology.

I understand how painful these unfunded mandates are. Even so, I try to stay the forever optimist—perhaps our government could not figure out how to resolve the homeless issue so they have placed the problem squarely in the hands of hospitals, physicians, and local jurisdictions to force us to find solutions. As we always do, we emergency physicians will innovate to make the lives of our patients better. We always find ways to collaborate with our hospitals and community members to take care of those that have nowhere else to go. When we focus on doing the right thing for our patients, we are able to take these mandates and turn them into innovation.

Please share with us your stories, experiences, concerns, and successes so we may not only commiserate, but share your achievements with others so that they may replicate your progress.

Thank you for continuing to stomp out disease while helping to remedy the difficult social issues of our society.

Yours,

Chi Perlroth, MD, FACEP

*You can reach the Chapter and Dr. Perlroth at info@californiaacep.org or 916.325.5455.*
As Jerry Brown, the youngest, oldest, and longest serving Governor of California, reaches the close of his final term, we pause to reflect on his tenure. Many reporters and political commentators have been writing about his legacy and his years of service.

Some of the more entertaining, have included “Brown-isms”. Governor Brown’s Jesuit training and love of Latin and Greek philosophers often drove people to Google in an attempt to figure out what he was saying or referencing.

Here are some examples of more notorious “Brown-isms”:

- “Age quod agis” or focus on the task at hand.
- He once referred to the California budget as “a pretzel palace of incredible complexity.”
- Rather than say that all politics are local, he once said “I ask you to consider the principle of ‘subsidiarity’.”
- “The new…comes out of the random.” He even went so far as to follow that up with “I’m not going to explain it. That’s a Jerry Brown-ism. Just take it home.”

Those of you who attended our 2014 Legislative Leadership Conference will remember a “Brown-ism” that did not appear in the paper. While he was gracious enough to come speak to our group, he couldn’t help but remind us that lobby days and the meetings we were about to embark on were insignificant. A stark contrast to our other speaker that year, Gavin Newsom who told us the importance of making our voices heard.

According to political consultant Ace Smith, the one way to convince Governor Brown in an argument was to quote 19th century English poetry or obscure historical minutiae.

“One time…I was trying to make a point about having the high ground on an issue, and was drawing a bunch of examples from when Cesar was fighting the Helvetii…(it) made all sorts of lights go in his head,” said Smith in an interview with CalMatters.

Along with the Brown-isms come the policy accomplishments. As his last two terms are reflected upon, his legacy is largely environmental, but also includes things like pension reform, criminal justice reform (Prop. 47), money bail reform, and passage of the water bond and gas tax. Despite California's historic expansion of Medi-Cal under the Affordable Care Act (ACA), one thing he is not credited with is being a healthcare governor.

As his term in office ends, those of us who call ourselves regulars in the Capitol begin to wonder what the next governor will bring. A recent headline in the Sacramento Bee said “Gavin Newsom’s first hires suggest the next California governor has big health care plans’. It’s not a surprise. Single payer was a significant discussion in the governor’s race, with Newsom widely supporting it. Since his election in November, he seems to have indicated that, while he still supports that in concept, it seems an unlikely possibility under the Trump administration, because federal waivers would be necessary. He seems instead to be focused on universal coverage. Nevertheless, the California Nurses Association, who sponsored the single payer bill SB 562 last year, has publicly stated they intend to pursue it again in 2019. It will be interesting to see how the Legislature and the Governor react this time.

More importantly, it will be interesting to see what a governor with a healthcare agenda and a large budget surplus, plans to do. In his inauguration address, Newsom committed to improving access to education, fair pay, and housing. On his first day in office, Newsom announced a plan to expand Medi-Cal to cover young undocumented immigrants and require consumers in California to carry health insurance. We are hopeful that this new attention to healthcare by the State’s top executive will mean improvements to our healthcare delivery system and to the role of emergency medicine in that system.

Because we write these articles a month in advance of publication, Governor Newsom’s State Budget has not been announced yet, but will have been released by the time you read this. His budget proposal will give us an indication of where he plans to go in his administration. However, it is by no means an outline or a blueprint of what will happen. Or even entirely what he hopes to accomplish. It is an opening salvo at the beginning of his first year of office.

Jerry Brown has been given high praise for taking us from the deepest recession and a deficit of $27 billion to a place of unparalleled budget surplus and rainy day fund of $14.5 billion. Gavin Newsom made clear in his inauguration address that he intends to safeguard the reserve, but be bold with additional revenues.

Only time will tell how the pent up pressures of interest groups who have been wanting to spend money, not only in healthcare, but on education, transportation, and all sectors, will be met by Newsom, who has both trumpeted that he will say yes to many policy proposals and, yet, be physically restrained. 2019 promises to be an interesting legislative year. We will be here to ensure that the voice of emergency medicine, its physicians and patients, is heard.
We want you to run for the California ACEP Board of Directors!

Nominations are open February 1st through March 15th at www.californiaacep.org
INTRODUCTION: An increasing number of behavioral health (BH) patients are presenting to the emergency department (ED) while BH resources continue to decline. This situation may lead to more external transfers to find care.

METHODS: This is a retrospective cohort study of consecutive patients presenting to a tertiary care academic ED from February 1, 2013, through January 31, 2014. Patients were identified through electronic health record documentation of psychiatric consultation during ED evaluation. We reviewed electronic health records for demographic characteristics, diagnoses, payer source, ED length of stay, ED disposition, arrival method, and distance traveled to an external facility for inpatient admission. Univariable and multivariable associations with transfer to an external facility in comparison with patients admitted internally were evaluated with logistic regression models and summarized with odds ratios (OR).

RESULTS: We identified 2,585 BH visits, of which 1,083 (41.9%) resulted in discharge. A total of 1,502 patient visits required inpatient psychiatric admission, and of these cases, 177 patients (11.8%; 95% CI = [10.2-13.5]) required transfer to an external facility. The median ED length of stay for transferred patients was 13.9 hours (interquartile range [IQR], 9.3-20.2 hours; range, 3.0-243.0 hours). The median distance for transport was 83 miles (IQR, 42-111 miles; range, 42-237 miles). In multivariable analysis, patients with suicidal or homicidal ideation had increased risk of transfer (odds ratio [OR] [95% CI], 1.93 [1.22-3.06]; P=0.005). Children younger than 18 years (OR [95% CI], 2.34 [1.60-3.40]; P<0.001) and adults older than 65 years (OR [95% CI], 3.46 [1.93-6.19]; P<0.001) were more likely to require transfer and travel farther to access care.

CONCLUSION: Patients requiring external transfer for inpatient psychiatric care were found to have prolonged ED lengths of stay. Patients with suicidal and homicidal ideation as well as children and adults older than 65 years are more likely to require transfer. [West J Emerg Med. 2016;17(6):783-90.]
**INTRODUCTION**

The population of patients in need of mental health care continues to grow despite increasing limitations in resources available for these patients.\(^1\) Behavioral health (BH) patients presenting to the emergency department (ED) who require transfer to other facilities, children and adults older than 65 years, and those with a history of violence or cognitive disorder are more likely to have prolonged ED length of stay (LOS).\(^3\) Long LOS strains ED resources and places the patient at increased risk of patient self-harm and other adverse events, including placing staff safety at risk.\(^9\)\(^11\)

The necessity for patient transfer to an external psychiatric facility results in prolonged ED LOS.\(^9\) Although prolonged lengths of stay for BH patients have been well documented,\(^3\)\(^6\)\(^8\) little is known about the subsequent effects on the patients themselves. Specifically, the distance that patients must be transported to be admitted has not been studied. The objectives of this study were to characterize the ED patients who require external transport to psychiatric facilities and to track the distances they must travel due to insufficient local psychiatric inpatient capacity.

**METHODS**

**Study Design and Setting**

This was a retrospective cohort study of consecutive patients who presented to the ED of the Mayo Clinic Hospital - Rochester, Saint Marys Campus from February 1, 2013, through January 31, 2014. The hospital has a tertiary care academic ED with 73,000 annual patient visits and includes a dedicated psychiatric hospital consisting of 73 psychiatric beds divided among a child and adolescent unit (18 beds), an acute adult unit (25 beds), an adult mood disorders unit (16 beds), and a medical psychiatry and geriatric psychiatry unit (14 beds). The city of Rochester, Minnesota, also has the Community Behavioral Health Hospital, which has 16 beds for adult patients.

The Mayo Clinic Institutional Review Board reviewed and accepted the study protocol before study initiation. The reporting of study results follows the reporting guidelines of Strengthening the Reporting of Observational Studies in Epidemiology (STROBE).\(^12\)

**Selection of Participants**

We identified all ED BH patients through documentation of a psychiatric consult during ED evaluation in their electronic health record. They were eligible for inclusion when they provided research authorization in accordance with Minnesota law.

**Data Collection and Outcome Measures**

The electronic health record was reviewed for data that were retrospectively collected, including patient demographic characteristics (e.g., age), diagnosis, payer source, ED LOS, ED disposition, arrival method, and distance traveled to an external facility for inpatient disposition. All patient data could be electronically extracted using the electronic health record in use (PulseCheck version 5.4; Optum) and did not require manual chart review. We characterized patients as transferred if they were discharged to a nonlocal external facility. Those who required admission and were hospitalized at the affiliated hospital were characterized as admitted. We subsequently calculated the distance to transfer sites on the basis of the number of miles reported on Google Maps.

**Statistical Analysis**

We summarized continuous features with median, interquartile range (IQR), and absolute range; categorical features were summarized with frequency count and percentage. Comparisons of patients who received a psychiatric consultation and were discharged from the ED with patients who received a psychiatric consultation and were admitted for psychiatric care were evaluated with Wilcoxon rank sum and \(\chi^2\) tests. We evaluated the differences in distance to the external facility between age groups with Wilcoxon rank sum tests. Univariable and multivariable associations with transfer to an external facility were evaluated with logistic regression models and summarized with odds ratios (ORs) and 95% confidence intervals (CIs). We conducted multivariable associations to determine if the significant associations observed on univariable analysis remained after multivariable adjustment. All variables of interest were used in both univariable and multivariable analyses. Univariable associations with transfer to an external facility were subsequently evaluated for the adult and pediatric cohorts separately. We performed statistical analyses with version 9.3 of the SAS software package (SAS Institute Inc). All tests were two-sided, and \(P\) values less than 0.05 were considered statistically significant.

**RESULTS**

During the study period, we identified 2,585 ED patient visits involving an ED consultation by psychiatry services. Multiple patients presented to the ED on more than one occasion. Of the 2,585 ED visits, there were 1,981 distinct patients seen in the ED. Of the ED visits, 1,083 (41.9%) were patients evaluated and discharged from the ED and 1,502 (58.1%) were patients evaluated and determined to require inpatient psychiatric care. In the second group, 1,325 patients (83.9%) were admitted to the affiliated hospital, 65 (4.3%) were transferred to the local community behavioral health hospital, and 177 patients (11.8%; 95% CI = [10.2-13.5]) required transfer to a nonlocal external facility (Table 1).

The characteristics of admitted patients were similar to the dismissed cohort (Table 1). The median age of BH patients was in the early third decade. More than one-half (54.0%) of the patients were female. Most patients arrived to the ED by personal transport. The cohorts differed in payer source, as well as diagnosis. Admitted patients also had a significantly longer LOS than the non-admitted patients.

The median distance required for transfer to outside facilities was 83 miles (IQR, 42-111; range, 41-280 miles) (Figure). Fifty patient transports (28.2%; 95% CI = [21.9-35.6]) were within 50 miles, 63 (35.6%; 95% CI = [28.9-43.2]) were transferred between 50 and 100 miles, and 46 (26.0%; 95% CI = [19.8-33.2]) were transferred between 100 and 200 miles. Children and patients older than 65 years also required longer transport distances. The median distance to the external facility for

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**REFERENCES**

\(^1\) Association of American Medical Colleges. (2017). \(\chi^2\) test.


\(^12\) American Psychological Association. (2022). \(\chi^2\) test.

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patients younger than 18 years (102 [IQR, 83-141; range, 72-262] miles) was significantly greater than for patients aged 18 to 65 years (60 [IQR, 42-85; range, 41-280] miles; P<0.001). The distance for patients older than 65 years (83 [IQR, 59.5-144.5; range, 42-226] miles) also was significantly greater than for patients aged 18 to 65 years (P=0.04).

The median ED LOS for patients transferred to an external psychiatric facility was 13.9 hours (IQR, 9.3-20.2; range, 3.0-243.0 hours). Patients who did not require transfer and were admitted to inpatient psychiatric services in house had significantly shorter stays (4.4 [IQR, 3.4-6.7; range, 0.3-76.0] hours; P<0.001).

The characteristics of patients who were admitted to our hospital vs those who required transfer to an external facility for admission are summarized in Table 2, with the results of the univariable and multivariable models to predict transfer to an external facility. The multivariable analysis indicated that patients with suicidal or homicidal ideation had increased risk of requiring transport to an external facility (OR [95% CI], 1.93 [1.22-3.06]; P=0.005). Patient age was also significantly associated with increased risk of patient transfer. Children younger than 18 years were more likely to require transfer than patients aged 18 to 65 years (OR [95% CI], 2.34 [1.60-3.40]; P<0.001). In addition, adults older than 65 years were more likely to require transfer to an external facility (OR [95% CI], 3.46 [1.93-6.19]; P<0.001). Lastly, patients with noncommercial medical insurance were more likely to be transferred to an external facility, independent of patient age (Medicare or Medicaid, OR [95% CI], 1.54 [1.04-2.27], P=0.03; self-pay/other, OR [95% CI], 2.08 [1.30-3.32], P=0.002).

We also analyzed associations with transfer to an external facility vs admission to our hospital in the subsets of adult and pediatric cohorts. In these univariable models, adults with a diagnosis of suicidal or homicidal ideation were still found to be more likely to be transferred to an external facility (OR [95% CI], 2.17 [1.23-3.81]; P=0.007); however, there was no longer a significant association in the pediatric population (OR [95% CI], 1.18 [0.56-2.51]; P=0.67) (Table 3).

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**Figure.** Locations for patients requiring transfer to an external facility for inpatient psychiatric care. Median transport distance was 83 miles; the longest distance was 280 miles.

**Table 1.** Summary of patient characteristics collected for behavioral health visits to the emergency department.

<table>
<thead>
<tr>
<th>Characteristica</th>
<th>All ED BH patient visits (n=2,585)</th>
<th>Patient visits resulting in discharge (n=1,083)</th>
<th>Patient visits resulting in psychiatric admission (n=1,502)</th>
<th>P value</th>
</tr>
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<tbody>
<tr>
<td>Age, y</td>
<td>31 (20-47; 4-93)</td>
<td>30 (20-46; 4-93)</td>
<td>32 (20-48; 5-90)</td>
<td>0.07</td>
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<td>Age, y</td>
<td></td>
<td>510 (20)</td>
<td>212 (20)</td>
<td>0.96</td>
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<tr>
<td>&lt;18</td>
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<td>1,941 (75)</td>
<td>816 (75)</td>
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<tr>
<td>18-65</td>
<td></td>
<td>134 (5)</td>
<td>55 (5)</td>
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</tr>
<tr>
<td>&gt;65</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1,392 (54)</td>
<td>585 (54)</td>
<td>807 (54)</td>
<td>0.88</td>
</tr>
<tr>
<td>Male</td>
<td>1,191 (46)</td>
<td>498 (46)</td>
<td>695 (46)</td>
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<tr>
<td>Mode of arrival</td>
<td>(n=2,579)b</td>
<td>(n=1,497)b</td>
<td>(n=1,497)b</td>
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<tr>
<td>Personal transport</td>
<td>1,761 (68)</td>
<td>728 (67)</td>
<td>1,033 (69)</td>
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<td>EMS</td>
<td>494 (19)</td>
<td>209 (19)</td>
<td>285 (19)</td>
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<td>Law enforcement</td>
<td>324 (13)</td>
<td>145 (13)</td>
<td>179 (12)</td>
<td></td>
</tr>
<tr>
<td>Payment type</td>
<td>Commerical</td>
<td>945 (37)</td>
<td>357 (33)</td>
<td>&lt;0.001</td>
</tr>
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<td>Medicare or Medicaid</td>
<td>1,132 (44)</td>
<td>461 (43)</td>
<td>671 (45)</td>
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<tr>
<td>Other/self-pay</td>
<td>508 (20)</td>
<td>265 (24)</td>
<td>243 (16)</td>
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<tr>
<td>Diagnosis</td>
<td>Mood disorder</td>
<td>629 (24)</td>
<td>246 (23)</td>
<td>&lt;0.001</td>
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<td>Suicidal or homicidal ideation</td>
<td>848 (33)</td>
<td>219 (20)</td>
<td>629 (42)</td>
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<tr>
<td>Altered thought processes</td>
<td>243 (9)</td>
<td>93 (9)</td>
<td>150 (10)</td>
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<tr>
<td>All others</td>
<td>865 (33)</td>
<td>525 (48)</td>
<td>340 (23)</td>
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<tr>
<td>Transfer to external facility</td>
<td>177 (7)</td>
<td>0</td>
<td>177 (12)</td>
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<tr>
<td>LOS, h</td>
<td>4.4</td>
<td>3.8</td>
<td>4.8</td>
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</tr>
<tr>
<td>LOS, range (IQR), h</td>
<td>0.2-243.0 (3.1-7.2)</td>
<td>0.2-74.6 (2.7-5.8)</td>
<td>0.3-243.0 (3.5-8.9)</td>
<td></td>
</tr>
</tbody>
</table>

BH, behavioral health; ED, emergency department; EMS, emergency medical services; IQR, interquartile range; LOS, length of stay.

- Values are presented as number (percentage) of patients unless specified otherwise.
- Sample size for characteristics with missing data.

**Table 1.** Summary of patient characteristics collected for behavioral health visits to the emergency department.
Nearly 12% of BH patients required transport to an external psychiatric facility. Other investigators evaluating ED LOS for psychiatric patients have reported significantly higher rates of external transfer (37%-46%) for patients presenting with a mental health concern. Similar to other studies, our analysis found that BH patients requiring transport to an external psychiatric facility have prolonged LOS compared with those discharged or admitted locally. In our study, this difference was approximately three times longer (4.4 vs 13.9 hours). Chang et al demonstrated a median LOS approximately 2.5 times longer (2.5 vs 6.3 hours). Although most of the protracted LOS instances were measured in hours, some were measured in days (longest period, >10 days).

Our study reinforces some of the data previously published on factors affecting ED LOS. Nevertheless, this is the first study, to our knowledge, to characterize the patient experience—including distances that ED patients are transported to access inpatient psychiatric care—when local care is unavailable.

We found that certain patients had a greater predisposition for external transfer for inpatient psychiatric hospitalization than other patients, and transportation distances were considerable for patients requiring this transfer. Adults older than 65 years, children, patients with suicidal or homicidal ideation, and patients with noncommercial medical insurance were more likely to require transport to an external facility. In addition, when external transport was required, the older adults and the children were transported farther distances to access inpatient psychiatric care. Although the median travel distance was 83 miles, 10% of transports spanned more than 200 miles. This may be due in part to the location of our facility, which has largely rural surrounding communities. The closest location from our facility for inpatient psychiatric care is 41 miles away. This problem, however, is not unique to our institution. Between 1990 and 2008, the number of hospital or residential mental health organizations decreased by 812, with a loss of 86,515 beds. As closures of psychiatric facilities throughout the country continue, many hospitals likely face similar, if not longer, distances to the next inpatient psychiatric facility. These distant hospitalizations can place substantial burdens on patients and their family members.

Patient age was strongly associated with increased risk of need for external transfer. Children were more likely to require transfer. This need may be due to the overall lack of pediatric inpatient psychiatric beds available in the region. Minnesota has approximately seven adult inpatient psychiatric beds for every pediatric bed.

| Table 2. Univariable and multivariable associations of behavioral-health patient characteristics with transfer to external facility. |

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No transfer (n=1,325)</th>
<th>Transfer (n=177)</th>
<th>Univariable OR (95% CI)</th>
<th>P value</th>
<th>Multivariable OR (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;18</td>
<td>244 (18)</td>
<td>54 (31)</td>
<td>2.20 (1.54-3.14)</td>
<td>&lt;0.001</td>
<td>2.34 (1.60-3.40)</td>
<td>&lt;0.001</td>
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<tr>
<td>18-65</td>
<td>1,022 (77)</td>
<td>103 (58)</td>
<td>1.0 (reference)</td>
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<td>1.0 (reference)</td>
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<tr>
<td>&gt;65</td>
<td>59 (5)</td>
<td>20 (11)</td>
<td>3.36 (1.95-5.81)</td>
<td>&lt;0.001</td>
<td>3.46 (1.93-6.19)</td>
<td>&lt;0.001</td>
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<tr>
<td>Female</td>
<td>709 (54)</td>
<td>98 (55)</td>
<td>1.0 (reference)</td>
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<td>1.0 (reference)</td>
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<tr>
<td>Male</td>
<td>616 (46)</td>
<td>79 (45)</td>
<td>0.93 (0.68-1.27)</td>
<td>0.64</td>
<td>0.97 (0.70-1.34)</td>
<td>0.84</td>
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<tr>
<td>Mode of arrival</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Personal transport</td>
<td>907 (69)</td>
<td>126 (71)</td>
<td>1.0 (reference)</td>
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<td>1.0 (reference)</td>
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<td>252 (19)</td>
<td>33 (19)</td>
<td>0.94 (0.63-1.42)</td>
<td>0.78</td>
<td>0.94 (0.61-1.44)</td>
<td>0.77</td>
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<tr>
<td>Law enforcement</td>
<td>161 (12)</td>
<td>18 (10)</td>
<td>0.81 (0.48-1.36)</td>
<td>0.41</td>
<td>0.78 (0.45-1.33)</td>
<td>0.35</td>
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<tr>
<td>Payment type</td>
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<tr>
<td>Commercial</td>
<td>534 (40)</td>
<td>54 (31)</td>
<td>1.0 (reference)</td>
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<td>1.0 (reference)</td>
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<tr>
<td>Medicare or Medicaid</td>
<td>584 (44)</td>
<td>87 (49)</td>
<td>1.47 (1.03-2.11)</td>
<td>0.04</td>
<td>1.54 (1.04-2.27)</td>
<td>0.03</td>
</tr>
<tr>
<td>Other/self-pay</td>
<td>207 (16)</td>
<td>36 (20)</td>
<td>1.72 (1.10-2.70)</td>
<td>0.02</td>
<td>2.08 (1.30-3.32)</td>
<td>0.002</td>
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<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Mood disorder</td>
<td>340 (26)</td>
<td>43 (24)</td>
<td>1.41 (0.86-2.32)</td>
<td>0.18</td>
<td>1.57 (0.93-2.63)</td>
<td>0.09</td>
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<tr>
<td>Suicidal/homicidal ideation</td>
<td>540 (41)</td>
<td>89 (50)</td>
<td>1.84 (1.18-2.87)</td>
<td>0.008</td>
<td>1.93 (1.22-3.06)</td>
<td>0.005</td>
</tr>
<tr>
<td>Altered thought processes</td>
<td>133 (10)</td>
<td>17 (10)</td>
<td>1.42 (0.75-2.69)</td>
<td>0.28</td>
<td>1.44 (0.75-2.77)</td>
<td>0.27</td>
</tr>
<tr>
<td>All others</td>
<td>312 (24)</td>
<td>28 (16)</td>
<td>1.0 (reference)</td>
<td></td>
<td>1.0 (reference)</td>
<td></td>
</tr>
</tbody>
</table>

EMS, emergency medical services; OR, odds ratio.
Values are presented as number (percentage) of patients unless specified otherwise.
indicate that adults and adolescents have a similar prevalence of mental illness, and in a recent report, adolescents had a higher rate of serious mental illness than adults (8.0% vs 5.8%). Children requiring psychiatric admission have the added stress of prolonged ambulance transport to an unknown facility and may have to travel without parental supervision. Parents are faced with the challenge of arranging their own transportation to visit their child and coordinating leave from their employer and care for other dependents. Although adult psychiatric care facilities have declined over the years, pediatric treatment centers have not experienced a similar trend and in fact have increased in number nationally—so, too, have the number of specialists certified in child and adolescent mental health care. While this is a positive trend, resources will need to continue to grow in order to meet the growing needs of the population.

Adults older than 65 years are also more likely to require transfer to an external facility than younger adults. In our institution, a limited number of geriatric psychiatric beds are available. In addition, a limited number of medical psychiatric beds are available to care for the higher rate of comorbid medical conditions in this population. Estimates report that more than 20% of geriatric patients have mental disorders, and as the U.S. population continues to age, this number is expected to double over the next 30 years. Cromwell and Maier demonstrated that these medical psychiatric units and geriatric psychiatric units require the most staff hours per patient per day compared with general adult units, psychiatric intensive care units, and dual psychiatric and substance-abuse units. The burgeoning geriatric population and the increased requisite psychiatric resources likely will pose challenges for inpatient placement and may continue to increase the transfer rate for these patients.

### Table 3. Univariable associations of characteristics with transfer to external facility for adult and pediatric patients.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Adult patients (n=1,204)</th>
<th>Pediatric patients (n=298)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No transfer (n=1,081)</td>
<td>Transfer (n=123)</td>
</tr>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-65</td>
<td>1,022 (95)</td>
<td>103 (84)</td>
</tr>
<tr>
<td>&gt;65</td>
<td>59 (5)</td>
<td>20 (16)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>564 (52)</td>
<td>67 (54)</td>
</tr>
<tr>
<td>Male</td>
<td>517 (48)</td>
<td>56 (46)</td>
</tr>
<tr>
<td>Mode of arrival</td>
<td></td>
<td></td>
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<tr>
<td>Personal transport</td>
<td>726 (67)</td>
<td>82 (67)</td>
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<tr>
<td>EMS</td>
<td>225 (21)</td>
<td>28 (23)</td>
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<tr>
<td>Law enforcement</td>
<td>126 (12)</td>
<td>13 (11)</td>
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<td>Payment type</td>
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<tr>
<td>Commercial</td>
<td>392 (36)</td>
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<td>Medicare or Medicaid</td>
<td>510 (47)</td>
<td>69 (56)</td>
</tr>
<tr>
<td>Other/self-pay</td>
<td>179 (17)</td>
<td>28 (23)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood disorder</td>
<td>283 (26)</td>
<td>32 (26)</td>
</tr>
<tr>
<td>Suicidal or homicidal ideation</td>
<td>407 (38)</td>
<td>57 (46)</td>
</tr>
<tr>
<td>Altered thought processesa</td>
<td>128 (12)</td>
<td>17 (14)</td>
</tr>
<tr>
<td>All others</td>
<td>263 (24)</td>
<td>17 (14)</td>
</tr>
<tr>
<td>Length of stay, median (IQR, range), h b</td>
<td>4.4 (3.4-6.4; 0.3-76.0)</td>
<td>12.8 (8.6-18.2; 3.3-140.1)</td>
</tr>
</tbody>
</table>

EMS, emergency medical services; IQR, interquartile range; NA, not applicable; OR, odds ratio.

a Values are presented as number (percentage) of patients unless specified otherwise.

b For adult patients, n=1,200; for pediatric patients, n=297.

c All other diagnoses were combined with this category for the analysis of pediatric patients.

d OR represents a 4-h increase in length of stay.
Inadequate local and regional psychiatric hospital capacity results in significantly prolonged ED LOS and puts many patients at risk for transfer outside their local community for care. Patients with suicidal ideation and homicidal ideation, patients older than 65 years, and children are at significantly increased risk for requiring transfer to an external facility for inpatient psychiatric care. Delays in transfers to distant facilities for inpatient psychiatric care strain the ED system, and the transfers place additional stress on patients and their families. A thorough evaluation of the BH system is needed to better address patient needs for inpatient psychiatric care.

**ACKNOWLEDGMENT**

The authors sincerely acknowledge and thank Mr. Thomas Roh for creating the Figure while with the Mayo Clinic Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery.

**CONCLUSION**

This study is limited by being isolated to a single tertiary care setting with a relatively large internal psychiatric inpatient capacity. Hospitals in a larger urban setting may experience different trends in the association between increased LOS and patient transfers. In addition, this study is limited in that data were extracted electronically rather than by manual individual chart review. Hence, the study is limited by what data could be extracted electronically from the health record.

**REFERENCES**

Mark Your Calendar: California ACEP's AdvancED 2019

September 20th
Hyatt Regency Orange County

Resident and Medical Student Conference
The California Emergency Medicine Advocacy Fund (CEMAF) has transformed California ACEP’s advocacy efforts from primarily legislative to robust efforts in the legislative, regulatory, legal, and through the Emergency Medical Political Action Committee, political arenas. Few, if any, organization of our size can boast of an advocacy program like California ACEP’s; a program that has helped block Medi-Cal provider rate cuts, lock in $500 million for the Maddy EMS Fund over the next 10 years, and fight for ED overcrowding solutions! The efforts could not be sustained without the generous support from the groups listed below, some of whom have donated as much as $0.25 per chart to ensure that California ACEP can fight on your behalf. Thank you to our 2017-18 contributors (in alphabetical order):

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- Antelope Valley Emergency Medical Associates
- Beach Emergency Medical Associates
- Chino Emergency Medical Associates
- Coastline Emergency Physicians Medical Group
- Culver Emergency Medical Group
- Hollywood Presbyterian Emergency Medical Associates
- Las Cruces Emergency Medical Associates
- Los Alamos Emergency Medical Associates
- Mills Peninsula Emergency Medical Group
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- Riverside Emergency Physicians
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- Sherman Oaks Emergency Medical Associates
- South Coast Emergency Medical Group, Inc.
- Tarzana Emergency Medical Associates
- TeamHealth
- Temecula Valley Emergency Physicians, Inc.
- US Acute Care Solutions
- Valley Emergency Medical Associates
- Valley Presbyterian Emergency Medical Associates
- Vikant Gulati, MD
- Vituity
- West Hills Emergency Medical Associates

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April 23, 2019 | Sacramento, California

AdvancED 2019
September 20, 2019 | Garden Grove, California

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For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

**FEBRUARY 2019**

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<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>1st</td>
<td>Board of Directors Nominations Open</td>
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<tr>
<td></td>
<td>Online</td>
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<tr>
<td>7th at 10 AM</td>
<td>Board of Directors Meeting</td>
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<tr>
<td></td>
<td>Sacramento, CA</td>
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<tr>
<td>18th</td>
<td>President's Day</td>
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**MARCH 2019**

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<td>7th at 11 AM</td>
<td>Government Affairs Subcommittee #1</td>
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<td>7th at 1 PM</td>
<td>Government Affairs Subcommittee #2</td>
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<tr>
<td>7th at 3 PM</td>
<td>Government Affairs Subcommittee #3</td>
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<td>14th at 2 PM</td>
<td>Government Affairs Committee (GAC)</td>
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<td>15th</td>
<td>Board of Directors Nominations Close</td>
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<td>15th</td>
<td>CMA Council on Legislation</td>
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**APRIL 2019**

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<td>12th-21st</td>
<td>State Legislature: Spring Recess</td>
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<td>22nd</td>
<td>State Legislature Reconvenes</td>
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<td>23rd at 9 AM</td>
<td>Legislative Leadership Conference (LLC)</td>
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<td>24th at 9 AM</td>
<td>Board of Directors Meeting</td>
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<td>Sacramento, CA</td>
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<tr>
<td>24th</td>
<td>CMA Legislative Advocacy Day</td>
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<tr>
<td></td>
<td>Sacramento, CA</td>
</tr>
</tbody>
</table>
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