A 38-year-old woman with a past medical history of anxiety, depression, and attention deficit disorder presented to a free-standing emergency department (FSED) with palpitations and globus sensation, following unsupervised cessation of vilazodone and phentermine for 3 days. Symptoms were similar to the patient’s previous panic attacks.

The patient started experiencing severe symptoms 2 h before FSED arrival. She was routed to the emergency department (ED) for acute anxiety treatment by her primary care physician (PCP). Her vital signs were normal but she seemed very anxious and hyperactive. She was moved to a hallway for comfort, given her severe claustrophobia.

With the calming measures instituted by the emergency physician (EP) and emergency staff, her behavior was quickly de-escalated, and she was amenable to trying lorazepam (Ativan) IM to control her anxiety symptoms. Within 45 min of arrival, the patient felt better and was ready for discharge, denying suicide attempts, hallucinations or suicidal/homicidal ideation. She was given referral to two local psychiatrists and directed to follow-up with her PCP to restart her medications under MD guidance.

**Introduction**

Over the last several decades, EDs have become increasingly overcrowded because of an increase in emergency department visits (EDVs) and a decrease in the total number of EDs. According to the Centers for Disease Control and Prevention, the number of EDVs has increased by 32% while the total number of EDs has shrunk 4.6% over the last decade. In a survey carried out by the American Hospital Association in 2007, 48% of hospitals in the US were functioning at or above the capacity.

Psychiatric emergencies and EDVs are also on the rise, for multiple reasons including psychosocial considerations (lack of insurance, social support, or limited resources for outpatient care for psychiatric patients) as well as the round-the-clock accessibility to EDs. From 2006 to 2011, there was a 20.5% increase in EDVs involving a diagnosis of Mental Health and/or Substance Abuse (MHSA) and a 53.3% increase in those involving MHSA comorbidities. Therefore, hospital systems are always looking for new and innovative ways to provide effective emergency care for individuals with mental illness.

With the emergence of FSEDs, one wonders if they are better equipped to deal with psychiatric emergencies than traditional hospital-based EDs, and how they fit into existing care paradigms. In this case report, we examine the pros and cons of managing psychiatric patients in an FSED using our experience as exemplified by the aforementioned case.

**Free-Standing Emergency Department – An Introduction**

An FSED may be defined as a facility providing emergency medical care but is structurally separate from an acute care hospital. In the 1970’s, the first FSEDs were meant to provide emergency medical services in rural areas where sustaining an entire hospital was not economically feasible. FSEDs have existed for the past 40 years but only grew markedly in popularity over the past decade.

More broadly, FSEDs are classified into two types based on ownership and hospital affiliation: namely, hospital outpatient departments (HOPDs, owned by hospitals) and independent FSEDs (IFSEDs, privately owned). They are usually open 24 hours a day (requirement may vary by state) and provide access to emergency physicians, nurses, and laboratory and radiological services including computed tomography scans.

With respect to payment for services, if the parent hospital of the HOPD is covered under Medicare and Medicaid, the same coverage will be provided at the HOPD. IFSEDs, on the other hand, are not currently recognized and covered by Medicare or Medicaid. Depending on licensing and state regulations, private insurers may cover all of the IFSED charges.

Even though most FSEDs are not covered by Medicare and Medicaid, patients are typically offered a medical screening examination (including for psychiatric complaints). The existence of an emergency medical condition, including suicidality, means the patient must be treated/stabilized at the FSED and transferred to a higher level of care if appropriate. Many states mandate IFSEDs to follow the provisions of the Emergency Medical Treatment and Labor Act as a requirement for licensing.

**Scope of Free-Standing Emergency Department Treatment**

FSEDs are well equipped to deal with emergency conditions such as myocardial infarction, stroke, or minor traumas including extremity lacerations and fractures, but cannot handle mass casualties and multi-trauma, for example,
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FSEDs lack on-call physician specialists, so consultations necessitate patient first be stabilized and transferred to the hospital, or outpatient specialist referral.[4]

FSEDs typically have a limited number of personnel, a front office registration clerk, nurse, radiology technician and a physician. Depending on the volume of the facility, additional personnel may be available including a paramedic and security personnel. FSEDs do not have the capacity to retain patients for a long time, but most (95%) FSED patients are walk-ins and rarely require overnight observation or hospitalization.[9] For patients requiring inpatient services, most FSEDs are located within 15–20 miles of a hospital.[4]

Nonetheless, FSEDs pride themselves in short throughput time when compared to traditional EDs. Some FSEDs report door-to-doctor time of <30 min, compared to 55.8 min for hospital-based EDs. Throughput time is significantly less (average of 90 min as compared to 180 for traditional EDs).[4]

**Management of Psychiatric Patients in a Free-standing Emergency Department**

Treatment of patients with primary psychiatric complaints typically presents challenges. Many patients presenting to the ED with psychiatric complaints require additional treatment and stabilization and must be evaluated to rule out organic causes for their pathology. This medical assessment generally requires multiple laboratory tests, which increases throughput time,[11] and may result in ED boarding, a phenomenon with far-reaching negative consequences for patients and negative financial consequences for the ED housing them.[12] The longer the patient’s length of stay, the greater the likelihood that their symptoms will worsen with ensuing decompensation.[13]

In this regard, FSEDs can be invaluable in the management of psychiatric patients. As the case illustrates, FSEDs are not as crowded as the traditional EDs; the environment is typically calm, stress-free which is ideal for stabilizing a psychiatric patient. In addition, the physicians get to spend more time with each patient, resulting in increased patient satisfaction.[4] Lower volumes of many FSEDs also means that there are no waiting lines, and the door-to-doctor time along with throughput time are significantly shortened, preventing escalation of patient’s symptoms. So what are the issues with FSEDs for psychiatric patients?

First, critics argue that FSEDs target insured patients and those from more affluent areas, thus avoiding populations with severe mental illness. In Houston, 66% of IFSEDs are located in neighborhoods where the average income is above $53,000/year, rather than in rural areas.[2,9,10] These facilities charge the same amount as hospital-based EDs, (both facility and professional fees).[9,14]

Critics also assert that FSED staffing may be inadequate to monitor suicidal or homicidal patients. Many FSEDs do not have independent security personnel, increasing the potential of violence toward staff. Furthermore, traditional EDs use on-call psychiatrists when available, whereas most FSEDs lack formal on-call specialists and often rely on informal arrangements with specialists. FSEDs can identify depression and refer for definitive care, with or without initiation of medication.[4] Psychotic or suicidal patients typically require admission, a complicated process leading to transfer to an inpatient psychiatric unit: this includes medical clearance, then administrative and peer-to-peer contact. Each psychiatric facility has its own list of exclusionary criteria which must be met before the patient can be transferred.[13] However, medical clearance requires lab work, and some tests might not be available at the FSED, in which case the tests will have to be sent out, which would increase emergency boarding. One example of a common send out lab is a urine drug screen.

**DISCUSSION**

Despite having some limitations, FSEDs are still a good alternative to the traditional EDs for managing psychiatric patients. Taking the above case as an example, the hospital-based EDs are overcrowded with long waiting lines and a tense environment, and this patient could have left without being seen. The crowded waiting room, excessive lighting, noise and other stimuli could have worsened the patient’s anxiety to a panic attack. If she did not choose to leave, her behavior could have escalated necessitating more potent emergency medications including haloperidol, lorazepam, and diphenhydramine, and possibly restraints and a psychiatric hold. This patient had indeed had negative experiences following panic attacks at local area hospital-based EDs, which is why she chose the FSED: In this case, the FSED offered timely care but was more importantly able to provide care in a calm environment that best suited her needs. This resulted in her anxiety being well-managed without any invasive methods. The patient left less than an hour after she arrived with her symptoms resolving and with follow-up.

The concept of FSEDs is still in its early phases of development and is far from being perfect. Patients with severe anxiety or depression are often suffering immensely by the time they come to the ED. Unfortunately, the limited resources of most EDs mean that if patients do not have suicidal ideation, homicidal ideation, or hallucinations they will be placed at the bottom of the triage pile. FSEDs can play a pivotal role in the community’s mental health-care system and help decompress the load on the hospital-based EDs by attending to more minor psychiatric emergencies such as our patient’s panic attack but can also stabilize and transfer those patients requiring hospitalization.
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Access this article online

Quick Response Code: 
Website: www.onlinejets.org
DOI: 10.4103/0974‑2700.216522

How to cite this article: Tucci V, Ahmed SM, Hoyer D, Moukaddam N. Management of psychiatric emergencies in free‑standing emergency departments: A paradigm for excellence?. J Emerg Trauma Shock 2017;10:171‑3.

Received: 26.10.16. Accepted: 27.10.16.