Returns to ED Overlooked in Data

Revisit *from page 1*

costs." For example, 80% of the return visits for asthma were to the ED and only 20% were inpatient admissions in this retrospective, observational study.

"So if you are only using hospital readmission data, you are missing 80% of the hospital utilization," said Dr. Steiner, an internist and research medical officer at the Agency for Healthcare Research and Quality. In contrast, 10% of heart failure readmissions were exclusive to the ED, "which tells me [these patients] in the ED are very likely to be admitted."

Emergency department costs are lower than those for inpatient care, so casting a wider net yielded little net increase in expenditures related to readmissions.

"We don't have a national ED database to set a benchmark" for ED admissions, but "we will soon," Dr. Steiner said.

Emergency department costs are lower than those for inpatient care, so casting a wider net yielded little net increase in expenditures related to readmissions. "Only about 6% of the [overall] cost is in ED since the average ED cost is $519 vs. $9,000 for average hospital costs."

Dr. Steiner and her associates assessed inpatient and ED data from the Healthcare Cost and Utilization Project's state inpatient databases and state emergency department databases. They analyzed aggregate data for four geographically diverse states: Arizona, Nebraska, New York, and Tennessee. The number of return visits to the hospital or ED during the 2 years following an index visit was the primary outcome measure.

The addition of the ED data increased the overall revisit rate by 17%, compared with hospital inpatient data alone.

The study included separate analyses of eight potentially preventable conditions that can lead to readmissions: pneumonia, pediatric gastroenteritis, and pediatric and adult cases of asthma, pediatric, adult and elderly diabetes, and heart failure.

The retrospective study showed that 83% of pediatric gastroenteritis patients were treated only one time. "We are not seeing a lot of ED revisits for bacterial pneumonia and pediatric gastroenteritis—these are acute conditions."

Dr. Steiner and her coworkers also assessed insurance status, specifically whether patients were "always insured" vs. "ever uninsured." They found 11% of the always insured group vs. 16% of the ever uninsured group had at least one return visit in one of the states, which has "implications for costs across the system."

A meeting attendee asked about potential limitations of the study. "What we don't have is the ambulatory care data or observation stay data. States generally don't collect that," Dr. Steiner said. ■

FDA Approves IV Ibuprofen For Hospital Use Exclusively

BY ELIZABETH MECHCATIE

An intravenous formulation of ibuprofen was approved by the Food and Drug Administration in June for treating mild to moderate pain, as an adjunct to opioid analgesics, and for the reduction of fever in adults.

This is the first injectable formulation of ibuprofen available and is for use only in the hospital, according to the FDA statement announcing the approval. The product, which will be marketed as Caldolor, is expected to become available later this year, according to the manufacturer, Cumberland Pharmaceuticals Inc.

In phase III studies, patients who received Caldolor reported a significant reduction in pain intensity after surgery and used significantly less morphine in the 24 hours following surgery, according to Cumberland.

An FDA statement announcing the approval cited a study of 319 women who had undergone an elective abdominal hysterectomy. Those who received Caldolor were less likely to request morphine than those who did not. "An injectable ibuprofen product can provide patients with relief from pain and fever when they cannot take oral products," Dr. Bob Rappaport, director of the FDA's division of anesthesia, analgesia, and rheumatology drug products, said in the statement. Until now, he noted, most NSAIDs have been available only in oral form.

For acute pain, the recommended dosage is 400-800 mg administered intravenously over 30 minutes, every 6 hours. For fever, the recommended dosage is 400 mg administered over 30 minutes, followed by 400 mg every 4-6 hours, or 100-200 mg every 4 hours, as needed, according to the FDA.

Nausea, flatulence, vomiting, and headache were the most common adverse reactions reported in clinical trials of Caldolor, which should be used with caution in patients with heart failure, renal impairment, or liver impairment; in those taking diuretics or ACE inhibitors; and in patients with a history of ulcers or gastrointestinal bleeding.

Caldolor is contraindicated in patients with asthma, urticaria, or allergic-type reactions to aspirin or other NSAIDs; during the perioperative period in patients undergoing coronary artery bypass surgery; and in patients with known hypersensitivity to ibuprofen or other NSAIDs, according to the manufacturer. Blood pressure should be monitored during treatment. ■

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INTERNATIONAL MEDICAL NEWS GROUP

Dr. Michelle Marks Joins Our Editorial Advisory Board

Hospitalist News is proud to welcome Michelle M. Marks, D.O., to the Editorial Advisory Board. Dr. Marks is a staff physician in the department of general pediatrics at the Cleveland Clinic, where she is director of pediatric hospitalist medicine and associate director of the pediatric residency. Also, she is the director of medical operations at Cleveland Clinic's Children's Hospital.

Dr. Marks earned a doctorate of osteopathic medicine at Ohio University in Athens and did a pediatric internship at Doctor's Hospital in Columbus, Ohio, before coming to Cleveland Clinic for her residency, where she served as chief pediatric resident. Dr. Marks is a member of the American Academy of Pediatrics, the Ambulatory Pediatric Association, the Society for Hospital Medicine, and the Association of Pediatric Program Directors. ■