THE FREESTANDING EMERGENCY DEPARTMENT:
LESSONS LEARNED FROM THE FIELD

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Speakers

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Changing Care Patterns

- Growth likely to come through diversification away from acute care

Inpatient volume is largely stagnant and increasingly medical

Outpatient care is the fastest growing component of the U.S. healthcare system

Outmigration of care:
  - A threat
  - The greatest opportunity to grow profitable services
Access Continues to Decrease

The FED as the Solution

Freestanding ED as the Possible Solution

- Provide alternative for patients with non-life threatening conditions
- Becoming more prevalent
- Provide greater access to patient care

... freestanding EDs are not without their critics

- Growing criticism that freestanding EDs “skim off” patients that would otherwise go to primary care practices or urgent care centers

Sources: AHA, USA Today, SHSMD Annual Conference 2009
Urgent Care vs. FED

- **Urgent care centers are:**
  - A convenient, quick solution to a low-acuity health issue

- **FEDs are viewed as:**
  - alternatives to hospital EDs
  - providing a comprehensive solution
  - more accessible and convenient environment
Compared to FEDs, urgent care centers are:

- Low cost, minimally staffed and equipped
- Staffed by family practitioners and NPs (FEDs by board-certified ED physicians)
- Operationally more similar to a primary care practice than a hospital

Compared to FEDs, urgent care centers are:

- Low reimbursement, low profit margin
- Less likely to transfer patients for admission
- Not accredited the same as an on-campus ED
- Not open 24 hours
General Characteristics

- Located within 20 miles of flagship / “parent” hospital
- Serve as an anchor to an ambulatory facility
- Placed in areas with insufficient access to emergency care and/or primary and urgent care

General Characteristics

- Socio-economic factors:
  - More attractive to younger populations less focused on PCP relationships
- Target markets with desirable payer mix
- Key growth market or market share opportunity
- Payment methods and reimbursement rates the same as a hospital ER visit
General Characteristics

- FED needs to be licensed as a department of the hospital

Operations Overview

- More efficient operating environment than hospital
- More streamlined management structure
- Operations run 24 / 7
- Offloads volume from existing hospital
- Typically, 4-10% of patients are transferred to an acute-care setting
Operations Overview

- Include advanced imaging capabilities, clinical labs, and ED beds
  - Some include 24-hr. short stay or observation beds
- Additional services, such as PT, can be added as part of a greater “Healthplex”
- Can be located in “B” occupancy facilities, which significantly reduces capital costs

Critical Success Factors

- High-growth market opportunity
- Breakeven volumes from approximately 12,000 to 15,000 visits
- First-to-market as a key component of a successful strategy
- Strong coordination with local EMS providers
- No to minimal wait time
**Critical Success Factors**

- Fast turnaround times a primary driver to patient satisfaction
- Train staff to deliver exceptional service
- Develop a physician support network and physician alignment strategies

**Challenges**

- Risk of backlash due to perception that FED would “cherry pick” desirable patients
- Cannibalization of “parent/sister” hospitals
- Significant outreach efforts
- Right staffing and operating protocols
- May not be able to handle the most critically ill patients
- Capital and land requirements
Challenges

- Can be regulatory or CON restrictions (varies by state), usually related to total project cost or major medical equipment
  - Not allowed in some states (e.g., California)

Benefits

- Market penetration
- Secondary hub for outpatient services
- Downstream admissions
- Ancillary volumes
- Higher patient satisfaction
- Faster and more efficient throughput
- Profitability
- ROI
Benefits

- Lower capital cost than institutional occupancy standards
- Can utilize third-party financing

Is a FED Right for Me?

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Can the market support a FED?</td>
<td>✓</td>
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<td>What is needed to make a go / no-go decision?</td>
<td>✓</td>
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<tr>
<td>How is the market being served: provision of healthcare services, physician network and alignment, and competitive dynamics?</td>
<td>✓</td>
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<td>What impact will the expected healthcare environment have on a FED?</td>
<td>✓</td>
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<tr>
<td>Is your hospital system positioned to implement a FED?</td>
<td>✓</td>
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<tr>
<td>Can you generate critical mass volume to make it financially feasible?</td>
<td>✓</td>
</tr>
<tr>
<td>What would your FED look like in this market: scope of services, projected ED and ancillary volumes, facility size, capital budget, and profitability?</td>
<td>✓</td>
</tr>
<tr>
<td>If a FED is feasible, what are the next steps needed to move towards an implementation plan?</td>
<td>✓</td>
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A FED Business Plan

- Service area definition and demographics
- Location and drive time analysis
- ED visit volume, market share and use rates
- Physician supply and demand
- Inpatient market share by zip code
- Hospital competitor presence
- Urgent care and extended hours care
- Other competitors (if applicable)
- Facility ED visit volume by acuity level
- Projected cannibalization of existing volume
- Ancillary volumes, Sensitivity analysis
- Throughput and projected room/bed need
- SF requirements and space program
- Capital budget and pro forma
- Implementation requirements

ED use rates often go up when a FED is introduced to a market. Understanding market volume is important when projecting budget volumes.

Regulatory Issues
Some states have CON rules, although most CON states don’t have rules specific to FEDs. However, the size of the capital investment or the CT component can trigger a CON review.

Legal And Regulatory Freestanding Emergency Departments: Considerations

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Freestanding Emergency Departments

- Freestanding EDs Have Existed Since 1960s
- Estimated as of 2008, 222 Freestanding EDs Open in 16 States
- 191 of 228 are Hospital Affiliated
- 70% are Open 24/7

Freestanding Emergency Departments
Services Offered: More Than Urgent Care

- Defibrillation, Intubation
- Urgent and ER Care
- Laboratory Services – Lab Service, Rapid Tests
- Common Radiology Procedures – X-Ray, CT, Ultrasound
- Staffed by Emergency Medical Physicians and Nurses
Freestanding Emergency Departments
Services Offered (Cont.)

Also, Some Offer
- 9-1-1 Transports
- Observation Beds
- Helipad
- Physician Offices, Imaging Centers, Surgery Centers at Same Site

Freestanding EDs – Acuity Level

Center for Disease Control and Prevention Estimates (for 2008)
By Service Patients Need – All EDs

- Immediate 3.7% (needs to be seen immediately)
- Emergent 11.9% (needs to be seen in 14 minutes or less)
- Urgent 38.9% (needs to be seen in 15 to 60 minutes)
- Semi-Urgent 21.2% (should be seen in 61 to 120 minutes)
- Non-Urgent 8.0% (should be seen in 121 minutes to 24 hours)
- Unknown 16.3%

Fair to Assume Freestanding EDs Will Have Less than 15.6% Needing Immediate or Emergency Care (Few EMS – 9-1-1 Transports; FEDs Report 5% of Visits Result in Inpatient Admissions While Average Hospital ED Admission Rate is 12.14%)
FEDERAL REGULATIONS
42 CFR §489.24(b) Definition

- “Dedicated Emergency Department” Means
- “any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
  - (1) It is licensed by the state as an emergency room or emergency department;
  - (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
  - (3) During the prior calendar year, based on a representative sample, it provides at least one-third of all of the outpatient visits for the treatment of emergency medical conditions without requiring a previously scheduled appointment.”

Freestanding EDs

Organizational Structure

- Part of Hospital
  - Type A Dedicated
  - Type B Dedicated
- Not Hospital Affiliated – Operated as a Clinic
Better Reimbursement
- if a Type A Dedicated ED (hospital-based, same provider number as hospital, open 24/7, has EMTALA Obligations)
- If Type B (not open 24/7, still has EMTALA Obligations)

Type A reimbursement likely 25% to 100% more revenue per visit than Type B

42 CFR §413.65 Describes Conditions for Off-Campus Departments to be Provider-Based
- Licensure – same license
- Integrated Clinical Services
- Financial Integration
- Public Awareness as Part of the Hospital
- Meets Obligations of Hospital Outpatient Departments
- Within 35 Miles of Main Provider (Also an Alternative Test)
**FEDERAL REGULATIONS: EMTALA**

- Hospitals with an Emergency Department Must Comply with EMTALA (42 CFR §489.24)
  - Medical Screening Examination Within Capability of ED
  - Provide Stabilizing Treatment to Those With Emergency Medical Condition or in Active Labor or an “Appropriate Transfer”
  - Treatment Likely within Capability of the Facility, then Arrange for Transfer (Likely Not Sufficient to Call 9-1-1)

**FEDERAL REGULATIONS: 72-HOUR RULE**

- 72-Hour Rule Generally Requires Bundling of Hospital Outpatient Services with Inpatient Stay
- Diagnostic Services Performed Day of or Within 72 Hours of Inpatient Admission Must be Bundled into Inpatient Bill (for Medicare, the DRG)
- Non-Diagnostic Services Performed Within 72-Hours that Relate to the Admission Also Must be Bundled
- Has Been a Compliance Issue
FEDERAL REGULATIONS: CONDITIONS OF PARTICIPATION

- Emergency Services (42 CFR §482.55)
  - Services Organized Under Direction of Qualified Member of Medical Staff
  - Services Integrated with Other Hospital Departments
  - Policies and Procedures Established by and Ongoing Responsibility of Medical Staff
  - Supervised by Qualified Member of Medical Staff
  - Adequate Medical Staff and Nursing Personnel to Meet Written Emergency Procedures and Needs Anticipated by the Facility

- Accreditation
  - Same as Hospital
  - Joint Commission

STATE REGULATION

- Licensing and Regulation Predominantly a State Issue
- State by State Analysis Important
  - Some States Have Specific License and Regulations (Examples, Texas, Illinois, Delaware)
  - Some Specifically Have Analyzed and Regulate as Other Facilities (Outpatient) Under Same License (Florida)
  - Some Silent on FEDs (Wisconsin)
  - Have Effectively Excluded Them Through Definitions (California)
States With Specific Licensing Statutes

- Illinois Requirements
  - In a Municipality of 75,000 or Less Inhabitants
  - Within 20 Miles of Hospital that Owns or Controls the FED
  - Meet (Among Others)
    - Facility Design, Operation and Maintenance Standards
    - Equipment Standards
    - Number and Qualification of Emergency Medical Personnel (Including Having at Least One Board Certified Emergency Physician Present at All Times)

- Illinois (cont.)
  - Limit EMS System Participation to Receiving Runs According to Protocols
  - Provide Comprehensive Emergency Service
  - Ambulance Services On-Site
  - Report Patient Transfers
  - Submit Mortality Reports
  - Not Hold Itself Out as a Full-Service Hospital
STATE REGULATION (cont.)

Texas Example

- License Required
- By 8-31-13 Must be Open 24/7
- Regulation of Construction and Design
- Regulation of Staffing, Administration, Equipment, Medical Records
- Patient Transfer Policy
- Services Available
  - Laboratory and Pathology
  - Anesthesia
- Medical Staff Regulations

STATE REGULATION (cont.)

California Example –

- No Explicit Treatment of Free-Standing Emergency Departments
- But, Health & Safety Code Has Limits on Use of Term “Emergency” and “Emergency Medical Services”
- By Definition, a Facility Using the Term “Emergency” and Holding Itself Out as Providing “Emergency Medical Services” Must Offer Other Services (e.g., intensive care services with monitoring and equipment, surgical services, blood bank, etc.) that Essentially Mean a Full-Fledged Hospital
Also, “Emergency Department” Must be in a Hospital Licensed to Provide Emergency Medical Services

Limited Exception for Urgent/Emergent Care in Rural Areas Where Local EMS Agency Gives Approval
- Largely Urgent Care
- No Advertising as Emergency Centers
- Not Open 24/7
- Bill as Outpatient Visits

Some Potential Bills Introduced Over Past Several Years to Recognize Them

Certificate of Need on State by State Basis

Commonly Regulated Activities:
- Establishment of Facility
- Renovation of a Facility
- Purchase of Major Medical Equipment Over Dollar Limit
- Changes in Ownership
- At Times, By or on Behalf of a Hospital
OTHER ISSUES

- EMS Protocols – Proper Communication/Collaboration
- Transfer Policy
- Call Arrangements
- Services Offered
- Other Services at Same Location

Case Study:

Profitability & Lessons Learned
FED Case Study: Virginia

- **Virginia Health System**
  - The FED was part of a market expansion and penetration strategy
    - Opened in 2007 as the first FED by the health system (competitor has multiple FEDs in greater market)
    - Two years later, a competing FED from the market leader opened less than 1 mile away

- FED has thrived since opening despite being located in an area with close access to nearby hospitals, as two hospitals are within 10 miles
- The health system expanded services in 2010 with a new MOB across the street
Service Area & Demographics

Service Area Profile
- Total service area population: 130,000 (overall market region more than 1 million)
- Geographic area: approximately 13 miles width x 11 miles height
- 5-Yr Population Growth: 6%
- Suburban area with rural southwest
- ½ mile from major interstate highway, side road off of secondary major thruway

Market Positioning

Distance to Key Points
- Closest hospital in system: 6 miles
- Closest competitive FED: 1 mile
- Closest competitive hospital ED: 9 miles
- Area is accessed by one major interstate highway belt, one north-south state highway and a major retail road

Downstream Volume
- 5% transferred to hospital for admission
- 1 of 3 visits has an x-ray
- 1 of 8 visits has a CT
Market Positioning

- Hospital System Presence & Transfers
  - Inpatient market share in primary service area (PSA): 60%
  - Percent of hospital's ED visits from PSA: 50%
  - Percent of FED's visits from PSA: 70%

  Note: approximate recent numbers, FED has been open for eight years

Facility Overview

- Facility Information (all numbers approximate)
  - Facility size: 100,000+ SF (11,000 ED only), 2 floors
  - Number of beds: 17 (including 6 monitored beds, 3 fast track and 4 specialty rooms)
  - On new site developed with other attached buildings
  - In 2010, a new MOB opened across the street
Facility Overview

- Facility Information (all numbers approximate)
  - Cost $5 million (FED only)
  - Took nearly 1 year to get EMS traffic to building

Other Services in Building
- ASC
- Imaging Center
- Lab
- Women’s Center
- MOB
- PT & Sports Medicine
- GI and Endoscopy

Volume Growth

ED Market share range:
- 35-60% in PSA towns
- 10-20% in SSA towns
Acuity Comparison

- FY10 acuity mix for the average of all hospitals in the system and its one FED
- Uses Emergency Severity Index (ESI) Level Coding System for Triage
  - (Level 1 is highest acuity)
- Volume is all ED visits
  - Unassigned / LWBS patients are excluded

Acuity Comparison

- Both facilities have a similar proportion of ESI Level 3 patients
  - Hospital: 24% (ESI 1-2)
  - FED: 4%
- First year: 14% ESI 5 (lowest)
  - Over time acuity mix has gotten slightly higher
Profitability

- **Financial Overview**
  - Operating income near 10%
    - Not including downstream revenue from approximately 1,300 or 5% of ED visits that are transferred and admitted to the hospital

Lessons Learned

- **Lessons Learned**
  - Volume and revenue consistently came in over budget in first 2 years, often by more than 50% monthly
  - First to market strategy was key
    - When competitor FED opened next door, impact was less than expected
  - Cannibalization was less than expected (estimated less than 5%)
Lessons Learned

- Lessons Learned
  - Patient awareness, aggressive marketing, retail mindset and a seen-in-30-minute guarantee are important keys to success
  - High patient and physician satisfaction
    - No wait guarantee; straight to patient room on arrival (triage in room)
    - Positive word-of-mouth marketing

- Lessons Learned
  - Physician support from community-based ED physician network
  - Important growth strategy for system, especially since hospital volumes were stagnant
Case Study:

Prototyping

FED Case Study: Pacific Northwest

- Pacific Northwest Health System
  - Creating a network of FED-centered ACCs was at the core of a market expansion and penetration strategy
  - Speed-to-market was critical
Prototyping

- A rapid development cycle was important:
  - Due to the prospect of unfavorable changes in the State’s regulatory environment
  - Competitive threats were already forming
- Opening multiple FEDs as rapidly as possible would require development of a prototype
  - The prototype was based on a successful patient care model employed at the State’s first and only FED, which opened in 2005

Prototyping

- The first two facilities were:
  - Developed simultaneously
  - Completed in late 2010 and early 2011
  - Located in high-growth, medically underserved, outlying suburban communities
  - Located within 20 miles of the health system’s existing hospitals
  - Preemptively challenged (unsuccessfully) by competitors
Overview

- Patient Care Delivery Model
  - Bypass typical triage and registration / “direct bedding” of patients
  - “Stack” clerical and clinical encounters
  - Reduce average throughput to < 85 minutes
  - Minimize waiting areas
  - Build to hospital ER standards; staff with board-certified physicians, RNs and support personnel trained and experienced in ER care

Overview

- Facility Information (all numbers approximate)
  - Facility size: 85,000+ SF (11,000 ED only)
  - 3 floors
  - Number of beds: 18 (including 1 psych and 2 trauma / resuscitation)

Other Services in Building
- Diagnostic Imaging
- Lab
- MOB
- Physical Therapy
- Cardiac Diagnostics
- Sleep Center
- Future ASC
Features

- A cost-effective, high quality, branded facility with a simple rectangular footprint
  - Derived from the successful ED work flow and patient care model
- Core building services located at outside corners to maximize efficiency and flexibility
- Separate, clearly marked canopies and entrances for ED, MOB and ambulances

Features

- Tilt-up concrete panel design:
  - Cut construction schedule by 2 1/2 months
  - Eliminated most perimeter steel columns
  - Incorporated shear and seismic requirements, eliminating all interior bracing
Features

- Tilt-up concrete panel design:
  - Budgeted for brick veneer base and aesthetic detailing at upper levels

- Low Impact Development:
  - Site design included a “spine” of rain garden plantings

Benefits

- Completed core / shell in less than 8 months
  - Compared to 12 months for traditional construction methods (33% shorter schedule)

- Core / shell cost under $90 psf
  - Compared with $135 psf for similar benchmarked facilities (33% lower cost)
Benefits

- Design / documentation schedule for additional prototype facilities will be reduced to 2-3 months
  - To accommodate site requirements, incremental design improvements, and regulatory approvals
- Overall building efficiencies of 88% USF / GSF and 95% RSF / GSF were achieved

Benefits

- Improved effectiveness and speed of ED staff training in nearly identical facilities
- Clearly identifiable, branded facilities of consistently high quality
Questions?

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