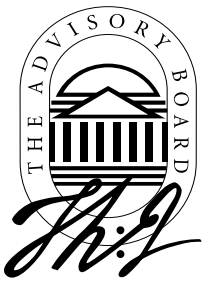



Advisory.com

# Current Trends in Freestanding EDs

*Original Inquiry Brief* • *December 3, 2008*

**ASSOCIATE**
Rachel Shaffer

**MANAGER**
Kate Lessard

**RESEARCH IN BRIEF**

In recent years, the number of freestanding emergency departments (EDs) in the United States has grown dramatically. As a response to increased overcrowding in hospital-based EDs—and the growth of affluent, suburban communities seeking convenient, efficient care—clinicians in freestanding EDs in at least 16 states now offer the same emergent care services available in hospital-based EDs and often collocate outpatient services such as physician offices, imaging centers, and rehabilitation (rehab) facilities. Administrators—who are accountable to the same regulatory standards as traditional EDs—cite an array of benefits to the freestanding model, such as increased market share, favorable payer mix, and a faster throughput than in hospital-based EDs as lower-acuity patients tend to obtain care at satellite facilities. This review of literature provides an overview of current trends in freestanding EDs including prevalence, services, staffing, regulation and reimbursement, as well as the benefits and attributes of successful freestanding EDs.

**MAJOR SECTIONS**



THE ADVISORY BOARD COMPANY
WASHINGTON, D.C.

## I. INTRODUCTION TO FREESTANDING EDS

According to leaders at the Atlanta, Georgia-based Centers for Disease Control (CDC), annual emergency department (ED) visits grew from 90 million in 1996 to 119 million in 2006. Simultaneously, the number of EDs decreased from 4,109 to 3,833.[1] As such, ED staff nationwide increasingly struggle to provide efficient care in overcrowded facilities. In addition, the growth of affluent suburban communities—typically inhabited by informed consumers who seek a high quality of service—has elevated the demand for accessible, timely emergency services.[2] In response, leaders at hospitals across the country are establishing freestanding EDs—facilities not physically connected to the hospital, but which offer comparable emergency care.[3]

Typically, staff operate freestanding EDs 24 hours per day, 7 days per week and offer the same services as staff in hospital-based EDs—treating conditions from minor abrasions to acute abdominal pain, chest pain, and upper respiratory distress—and accept ambulance traffic. Leaders most commonly locate freestanding EDs—also known as satellite EDs—within 15 miles of the flagship hospital but occasionally construct them to provide emergency services for isolated geographic regions.[4] While the most basic satellite EDs offer emergency care and imaging, some collocate additional services such as physician offices and rehabilitation (rehab) on-site. Although Baltimore, Maryland-based Centers for Medicare and Medicaid Services (CMS) guidelines mandate that freestanding EDs are subject to the same regulatory and accreditation standards as hospital-based EDs, no two are exactly alike in terms of service offerings, staffing, and bed size.[5] The following chart provides an overview of common freestanding ED models:

**Staffing and services vary greatly among freestanding ED models**

*Basic freestanding ED models, 2006*

| Freestanding ED model | Bed size | Hours of operation | Staffing, per shift | Imaging | Additional services |
|---|---|---|---|---|---|
| "Bare bones" model | 6 – 7 | 16 – 20 hours/day | • 1 physician<br>• 1 – 2 registered nurses (RNs) | • Basic X-ray<br>• Ultrasound<br>• 4-slice CT | • Physician offices |
| Standard model | 8 – 12 | 24 hours hours/day | • 1 physician<br>• 2 – 3 RNs | • Basic X-ray<br>• Ultrasound<br>• 16-slice CT | • Physician offices<br>• Rehab clinic |
| Healthplex model | 14 – 16 | 24 hours hours/day | • 2 physicians during peak shift<br>• 3 – 5 RNs | • Basic X-ray<br>• Ultrasound<br>• 64-slice CT<br>• Mobile MRI | • Ambulatory surgery center (ASC)<br>• Fitness center<br>• Physician offices<br>• Rehab clinic |

Source: Health Care Advisory Board (HCAB), *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*, Washington, D.C.: The Advisory Board Company, (2006).

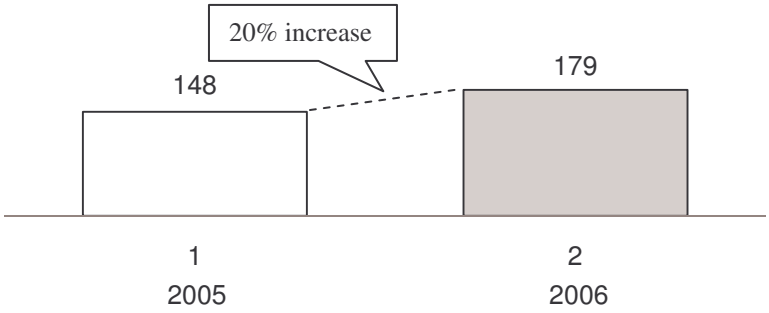
[1] Boodman, S. "ER Care, Stat!" *Washington Post*. (September 16, 2008). www.washingtonpost.com/wp-dyn/content/ (Accessed October 15, 2008).
[2] Rogers, J. "Freestanding Emergency Departments: Brief Overview and Considerations." The Karlsberger Research Group. (June 2006). www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008).
[3] Financial Leadership Council (FLC). "Freestanding EDs Easing Patients' Access to Care, Improving Hospitals' Market Positions." *Finance Watch.* Washington D.C.: The Advisory Board Company. (June 6, 2008).
[4] Rogers, J. "Freestanding Emergency Departments: Brief Overview and Considerations." The Karlsberger Research Group. (June 2006). www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008).
[5] Lott, J. "Hybrid and Freestanding Emergency Departments: Rx For Our Ailing Emergency Medical Services System." Hospital Association of Southern California (HASC) Briefs Focus. (March 4, 2004). www.hasc.org /download.cfm?ID=7120 (Accessed October 18, 2008).

## II. CURRENT TRENDS IN LOCATION AND OPERATIONS

Given that no single definition of a freestanding ED exists, health care industry experts agree it is challenging to estimate the number of freestanding EDs in the United States today.[6, 7] However, a survey released in 2007 by leaders at the Chicago, Illinois-based American Hospital Association (AHA) indicates that 179 freestanding EDs existed nationwide in 2006—a 20 percent increase from 2005 levels, as depicted in the chart below.

**AHA survey documents 179 freestanding EDs nationwide**

*Number, freestanding EDs, AHA survey, 2005 to 2006*




Source: Andrews, M, "Need the Emergency Room? Skip the Wait," *U.S. News and World Report*, (September 17, 2008), http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

While experts continue to debate the exact number freestanding EDs, they typically concur that clinicians operate freestanding EDs in at least 16 states—and agree that the prevalence of freestanding EDs is on the rise.[8, 9, 10] While freestanding EDs tend to proliferate in high-growth states such as California and Texas, providers in all regions of the country are adopting the satellite model of emergency care. However, hospital and health system executives maintain full ownership of most freestanding EDs nationwide.[11] While independent physician groups operate a small number of such facilities—primarily in Texas—currently, literature indicates that no hospital-physician group joint venture (JV) freestanding EDs exist.[12] According to leaders at both the AHA and CMS, given the recent increase in freestanding EDs—and the continued congestion in hospital-based EDs—clinicians nationwide will likely continue to duplicate the model.[13, 14]

---

[6] Greene, J. "ED, Set Free." *Hospital and Health Networks.*80(3). (March 2006).

[7] *Trustee Magazine.* "The Other ED." (September 2006). www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/PubsNewsArticleGen/data/2006September/0609TRU_Update_ED&domain=TRUSTEEMAG (Accessed October 16, 2008).

[8] FLC. "Freestanding EDs Easing Patients' Access to Care, Improving Hospitals' Market Positions." *Finance Watch.* Washington D.C.: The Advisory Board Company. (June 6, 2008).

[9] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report.* (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

[10] CMS. "Requirements for Provider-Based Off-Campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services." (January 11, 2008). www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCletter08-08.pdf (Accessed October 15, 2008).

[11] *ibid.*

[12] "Examples of Freestanding ED Joint Ventures." (April 2006).

[13] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report.* (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

### Staff at freestanding EDs treat virtually all emergent conditions…

With few exceptions, staff at freestanding EDs offer the same emergent care services and diagnostic capabilities as medical personnel at hospital-based EDs, including advanced life support technology.[15] Clinicians at satellite EDs treat a full range of emergency conditions, including—but not limited to—the following:[16]

- Abdominal pain
- Allergic reactions
- Cardiac arrest
- Chest pain
- Concussions
- Ear infections
- Fractures
- Gastrointestinal (GI) wounds
- Gunshot wounds
- Influenza (flu)
- Motor vehicle injuries
- Myocardial infarction (MI)
- Occupational injuries
- Severe cuts and burns
- Skin punctures
- Sports injuries
- Transient ischemic attacks (TIA)

Further, although freestanding EDs do not admit inpatients, clinicians supervise patients requiring overnight care in "observation beds." The number of observation beds varies by facility size, ranging from five to six at the smallest freestanding EDs to over 25 at the largest. Additionally, in order to provide comparable trauma care to hospital-based EDs, staff also maintain support services such as imaging and laboratory (lab) departments. As staff in these departments—which often contribute to throughput delays in hospitals—exclusively process freestanding ED patient information, there is relatively less wait time for these services than in a hospital-based ED.[17]

### …and administrators often collocate numerous additional outpatient services on-site

In addition to emergency care, administrators often situate supplemental services along with the freestanding ED. Most commonly, these comprise a medical office building (MOB) with physician offices, a rehab facility, or occupational health. However, leaders of larger "healthplex" EDs collocate a breadth of outpatient services, including the following:[18,19]

- Ambulatory surgery center (ASC)
- Endoscopy
- Imaging center
- Infusion
- Occupational therapy (OT)
- Pharmacy
- Physical therapy (PT)
- Physician specialty clinics
- Residential assisted living community
- Skilled nursing facility (SNF)
- Sleep disorders lab

---

[14] CMS. "Requirements for Provider-Based Off-Campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services." (January 11, 2008). www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCletter08-08.pdf (Accessed October 15, 2008).

[15] Nestor, C. "Community Developments: Essentials of Freestanding Emergency Centers." *Healthcare Facilities Management Magazine (HFM).* (July 2008). www.hfmmagazine.com/hfmmagazine_app/jsp/articledisplay.jsp?dcrpath=HFMMAGAZINE/Article/data/07JUL2008/0807 HFM_FEA_Planning&domain=HFMMAGAZINE. (Accessed October 15, 2008).

[16] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report.* (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

[17] Clinical Advisory Board (CAB). "Freestanding EDs: Stand-Alone Facilities Gain Traction But Face Ongoing Hurdles." *Clinical Strategy Watch.* (June 20, 2008).

[18] Rogers, J. "Freestanding Emergency Departments: Brief Overview and Considerations." The Karlsberger Research Group. (June 2006). www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008).

[19] "Freestanding ED Center Operations." June 2008.

By offering such services, hospital leaders increase accessibility to services in areas where a full-service hospital may not be feasible or warranted. In turn, administrators draw additional outpatient volumes—and often arrange imaging contracts—at these facilities and as a result, generate additional revenue. Moreover, constructing MOBs in close proximity to the freestanding ED provides convenient access and thus, fosters relationships with physicians and on-call specialists.[20]

While no two freestanding EDs in the United States are identical, the following chart compares attributes of several "healthplex" model facilities:

**Staff at "healthplex" model freestanding EDs typically treat over 20,000 patients annually**

*Select attributes, "healthplex" model freestanding EDs, 2007*

| Parent institution | Year established | Distance from parent hospital | Total beds | Annual volumes | Square footage | Collocated services |
|---|---|---|---|---|---|---|
| **Shady Grove Adventist Hospital,** *Shady Grove, Maryland* | 2005 | 8 miles | 21 | 22,000 | 27,000 sq. ft. | • ASC<br>• Medical office building (MOB)<br>• Occupational therapy (OT)<br>• Pharmacy<br>• Rehab center<br>• Residential assisted living community<br>• Speech therapy |
| **Swedish Medical Center,** *Seattle, Washington* | 2004 | 15 miles | 14 | 20,000+ | 55,000 sq. ft. | • ASC<br>• Full diagnostic imaging capability, including MRI<br>• MOB<br>• Quiet rooms for families<br>• Sleep disorders center |
| **WakeMed Health** *Raleigh, North Carolina* | 2005 | 12 miles | 10 | 28,000 | 104,000 sq. ft. | • Endoscopy suites<br>• Full diagnostic imaging capability, including MRI<br>• MOB<br>• ASC<br>• Rehab center<br>• Women's imaging center |

Source: Rogers, J, "Freestanding Emergency Departments: Brief Overview and Considerations," The Karlsberger Research Group, (June 2006), www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008); Appleby, J, "More Emergency Rooms Open Away From Hospitals," *USA Today*, (April 24, 2008), www.usatoday.com/money/industries/health/2008-04-24-emergency-rooms-stand-alone_N.htm, (Accessed October 21, 2008); Lott, J, "Hybrid and Freestanding Emergency Departments: Rx For Our Ailing Emergency Medical Services System," Hospital Association of Southern California (HASC) Briefs Focus, (March 4, 2004), www.hasc.org /download.cfm?ID=7120, (Accessed October 18, 2008).

[20] Nestor, C. "Community Developments: Essentials of Freestanding Emergency Centers." *HFM.* (July 2008). www.hfmmagazine.com/hfmmagazine_app/jsp/articledisplay.jsp?dcrpath=HFMMAGAZINE/Article/data/07JUL2008/0807HFM_FEA_Planning&domain=HFMMAGAZINE. (Accessed October 15, 2004).

### Staffing levels at freestanding EDs comparable to hospital-based facilities

According to CMS guidelines, staff at freestanding EDs must comply with state regulations regarding traditional EDs, including hours of operations; thus, clinicians typically provide care at freestanding EDs 24 hours per day, 7 days per week. Additionally, freestanding ED personnel must be part of a single medical staff along with providers at the flagship hospital.[21] Given that administrators are accountable for staffing freestanding EDs in compliance with state requirements pertaining to hospital-based EDs—and that freestanding ED experts nationwide similarly recommend that staffing capability be, at minimum, equivalent—staffing ratios at virtually all freestanding EDs mirror those of their hospital-based counterparts. Freestanding ED staff typically include those listed below:[22, 23]

- Emergency medicine physicians
- Lab technicians (techs)
- Medical technologists (med techs)
- Radiology technicians (rad techs)
- Registered nurses (RNs)
- Ultrasound techs

However, as freestanding EDs are commonly smaller than hospital-based EDs, administrators typically schedule fewer clinicians, and vary staffing levels in accordance with peak patient volumes.[24] One board-certified emergency medicine physician, along with one to two nurses, is typically capable of providing sufficient care at most hours of the day; only leaders at the largest freestanding EDs schedule multiple physicians simultaneously around the clock.[25] In addition, administrators maintain a panel of on-call specialists to address complex cases; in some states, such as Florida, state regulations stipulate that freestanding EDs employ a specialty on-call schedule identical to traditional ED on-call schedules.[26]

Although aggregate staff levels vary by institution size, the case study on the following page provides an example of staffing levels at one freestanding ED.

---

[21] CMS. "Requirements for Provider-Based Off-Campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services." (January 11, 2008). www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCletter08-08.pdf (Accessed October 15, 2008).

[22] Rogers, J. "Freestanding Emergency Departments: Brief Overview and Considerations." The Karlsberger Research Group. (June 2006). www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008).

[23] Florida College of Emergency Physicians. "Freestanding Emergency Department Position Paper." (August 2, 2004). www.fdhc.state.fl.us/freestanding/contents.shtml (Accessed October 15, 2008).

[24] Rogers, J. "Freestanding Emergency Departments: Brief Overview and Considerations." The Karlsberger Research Group. (June 2006). www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008).

[25] HCAB. *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*. Washington, D.C.: The Advisory Board Company. (2006).

[26] CAB. "Freestanding EDs: Stand-alone Facilities Gain Traction But Face Ongoing Hurdles." *Clinical Strategy Watch.* (June 20, 2008).

***Case study: Freestanding ED staffing model maximizes resources, maintains continuity***

Administrators at the Miami, Florida-based Mount Sinai Medical Center's freestanding ED—a Level II ED located 12 miles from the flagship facility—staff one emergency medical physician 24 hours per day, 7 days per week. In addition, they maintain an on-call panel of 14 specialists who are part of the same emergency medical group that serves the main campus. During peak ED hours, administrators schedule three RNs, and at non-peak hours, staff two RNs as well as the following personnel:

- Laboratory technician (lab tech)
- Radiologist
- Respiratory therapist
- Ultrasound tech

The ultrasound tech is on-site during normal business hours and remains on-call at night. Finally, a unit secretary also serves as an emergency tech. Each freestanding ED staff member reports to corresponding department leaders at the main medical campus, thus maintaining continuity of care and fostering accountability across the facilities.

Source: Clinical Advisory Board (CAB), "Freestanding EDs: Stand-Alone Facilities Gain Traction But Face Ongoing Hurdles," *Clinical Strategy Watch,* (June 20, 2008).

## Staff at freestanding EDs admit fewer patients than their hospital-based counterparts

Despite the fact that freestanding EDs are highly similar to hospital-based EDs in terms of staff and services, some providers nonetheless express concern that clinicians in those facilities may compromise care for the most acute patients as they do not maintain advanced resources available at a hospital-based ED, including the following:[27]

- Catheterization (cath) lab
- On-site specialty consultation
- Operating room (OR)

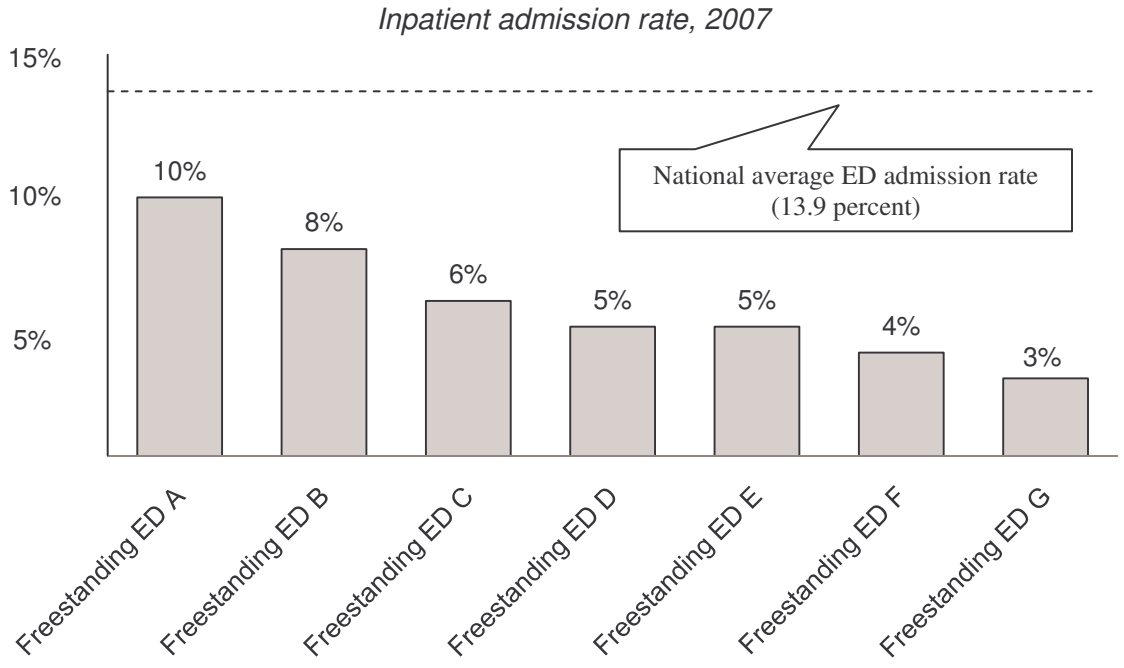
As such, emergency medical services (EMS) staff transporting patients requiring immediate surgical intervention sometimes bypass freestanding EDs in favor of the nearest full-service hospital.[28] Consequently, patients in the freestanding ED are, on average, of lower acuity than those in hospital-based EDs and, thus, clinicians admit a relatively smaller percentage to inpatient beds. While the national average admission rate at hospital-based EDs hovers around 14 percent, the staff at their satellite counterparts typically admit between five and six percent of patients.[29] The chart on the following page depicts the inpatient admission rate at seven freestanding EDs.

[27] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report.* (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

[28] Appleby, J. "More Emergency Rooms Open Away From Hospitals." *USA Today*. (April 24, 2008). www.usatoday.com/news/health/2008-04-24-emergency-rooms-stand-alone_N.htm (Accessed October 14, 2008).

[29] Cain, B. "Alone Again." *Health Leaders Media.* (2008). www.healthleadersmedia.com/content/81603/topic/WS_HLM2MAG/Alone-Again.html (Accessed October 14, 2008).

**Staff in freestanding EDs admit as few as one-fifth the national average of patients**




Source: HCAB, *Emergency Department Investment Blueprint,* Washington, D.C.: Advisory Board Company, (2007); "Freestanding ED Center Operations," (July 2008).

## Collaboration with EMS providers key to ensuring patient safety, sufficient volumes

Although freestanding ED staff rarely transfer patients for more advanced treatment or admission, it is nonetheless crucial that they establish transport protocols with EMS to ensure patient safety and compliance with Emergency Medical Treatment and Active Labor Act (EMTALA) guidelines.[30] Moreover, by developing criteria for delivering patients to the freestanding ED based on acuity and condition in collaboration with EMS staff, administrators assure EMS staff of the quality of care at the freestanding ED. In turn, EMS staff transport patients to the satellite facility when appropriate, thus ensuring sufficient volumes to support the facility.[31] The chart on the following page depicts transfer policies at three freestanding EDs.

[30] "EMTALA Q & A." *ED Management*. (October 1, 2007). http://ahcpub.com/archive/?efrlk=306 (Accessed October 14, 2008).

[31] "Preplanning Critical for Freestanding ED." *ED Management*. (October 1, 2007). http://ahcpub.com/archive/?efrlk=306 (Accessed October 14, 2008).

## Administrators design transfer policies in partnership with EMS staff

*Select freestanding ED transfer policies, 2005 to 2008*

| Facility | Transfer policy | Details |
|---|---|---|
| *Freestanding ED H* | • EMS staff transfer high acuity patients to hospital via ambulance<br>• EMS automatically transport patients with the conditions listed below to hospital-based ED:<br>◦ Acute MI<br>◦ Labor<br>◦ Open fractures<br>◦ Severe dehydration<br>◦ Severe trauma | Freestanding ED administrators developed these criteria in conjunction with EMS staff; they contend that maintaining open dialogue with paramedics is key to transporting patients quickly to proper care and thus, ensuring success of the freestanding ED |
| *Freestanding ED I* | • "EMS Truck" transports non-emergent patients to hospital for admission<br>• "Hot transport" rapid-response vehicles transfer high-acuity patients to hospital | Freestanding ED administrators developed an arrangement with EMS to provide both urgent and non-urgent transportation from the Freestanding ED to the flagship hospital |
| *Freestanding ED J* | • EMS staff transport high-acuity patients or those requiring surgery to the hospital via helicopter or ambulance<br>• EMS staff divert certain complex cases, such as late-term pregnancies, to the hospital-based ED | Freestanding ED administrators worked with EMS staff to establish transport arrangements that minimize travel time and transfers for critical patients; by developing trust with EMS staff, the freestanding ED is the preferred EMS destination for almost all patients |

Source: "Freestanding ED Center Operations," (July 2008); "Exploring the Operations and Impact of a Freestanding ED," (November 2005).

## III. REGULATION AND REIMBURSEMENT

In January 2008, CMS leaders released a memorandum containing guidance on the regulatory standards that govern satellite EDs and "emergency services hospitals"—hospitals where staff specialize in emergency services but are not affiliated with a flagship hospital. In order to qualify for reimbursement under these regulations, staff at freestanding EDs must comply with the same standards that govern hospital-based EDs in their state, including:

- Ancillary services
- Building compliance
- EMTALA compliance
- Hours of operation
- Licensure
- Nurse and physician staffing
- EMS transportation

Moreover, staff at satellite EDs must demonstrate compliance with the hospital conditions of participation (CoPs) and document compliance with the service requirements in 42 CFR 413.65(d)(2), documented below.

***Provider-based regulations: 42 CFR 413.65(d)(2)***

- Medical records are integrated into a unified retrieval system.
- Hospital medical staff committees are responsible for medical activities in the off-campus ED.
- Off-campus ED professional staff have clinical privileges at the main campus of the hospital.
- The hospital maintains the same monitoring and oversight of the off-campus ED as it does for any of its other departments.
- The medical director of the off-campus ED maintains a reporting relationship to the hospital's chief medical officer (or similar position) that is similar to that of a department director.
- Off-campus ED services are integrated into those of the hospital's main campus, and off-campus ED patients who require further care have access to all services of the main campus.

Source: Center for Medicare and Medicaid Services (CMS), "Requirements for Provider-Based Off-Campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services," (January 11, 2008), www.cms.hhs.gov/ surveycertification geninfo/downloads /SCletter08-08.pdf, (Accessed October 15, 2008).

Providers who seek certification to operate a hospital specializing in emergency services maintain the burden of proof to demonstrate they meet the statutory definition of a hospital for Medicare and Medicaid purposes. This entails a detailed local needs analysis and application, which both regional and national CMS office staff scrutinize on a case-by-case basis. Although Medicare and Medicaid guidelines do not recognize "emergency services hospitals" as a separate category—and stipulate that staff at hospitals dedicate, at minimum, 51 percent of beds to inpatient services—CMS leaders will, at the request of applicants seeking to develop a hospital specializing in emergency services, examine other factors in addition to bed ratio. However, they consider the burden of proof to "increase substantially" as the ratio of inpatient to other beds decreases.[32]

[32] CMS. "Requirements for Provider-Based Off-Campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services." (January 11, 2008). www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCletter08-08.pdf (Accessed October 15, 2008).

### State government officials remain skeptical of care quality

Although CMS permits freestanding EDs, lawmakers in several states express concern that staff at freestanding EDs may provide insufficient care for high-acuity patients. In fact, leaders placed a moratorium on freestanding ED construction in Florida while a commission investigated the level of care at such facilities.[33] Although the moratorium expired in 2004—and lawmakers found no indication of quality of care concerns—some regulatory officials continue to doubt the capacity of satellite EDs to provide sufficient care. Additionally, officials express concern that providers at freestanding EDs may siphon insured patients from competitors, thus impairing their ability to provide services to the wider community. As such, administrators in many states, including California, Florida, North Carolina, and Maryland, must complete a state "certificate of need (CON)," demonstrating a dearth of emergency services in the region, prior to establishing a satellite ED.[34]

### Reimbursement at ED rate contingent on hours of operation

As CMS leaders hold administrators of freestanding EDs accountable to the same standards as hospital-based EDs, they similarly consider individuals seeking care at freestanding EDs to be "outpatients" and reimburse for their care according to standard ED rates. However, providers at freestanding EDs which do not remain open 24 hours per day, 7 days per week—and thus, do not typically meet state government criteria—must bill insurers at urgent care center (UCC) rates, which are considerably lower. For instance, for one emergency care procedure, CMS reimburses providers $316 at the ED rate, but just $138 at the UCC rate.

### Freestanding EDs staff treat fewer Medicare/Medicaid patients than hospital EDs

Although providers at freestanding EDs must remain compliant with CMS guidelines—and thus, state regulatory guidelines—a small percentage of patients in freestanding EDs possess Medicare or Medicaid coverage relative to hospital-based EDs. Given that staff in hospital-based EDs commonly provide care to a high percentage of underinsured patients—and are often subsidized by more well-reimbursed services—the department is not traditionally a major source of revenue. Consequently, hospital leaders typically locate freestanding EDs in affluent communities with highly insured patient populations to ensure profitability. Thus, by virtue of location, payer mixes in freestanding EDs tend to comprise primarily commercially insured patients.[35] The graphic on the following page depicts the payer mixes at a hospital-based ED and a freestanding ED in a wealthy, growing suburban community located 15 miles from the flagship facility.

---

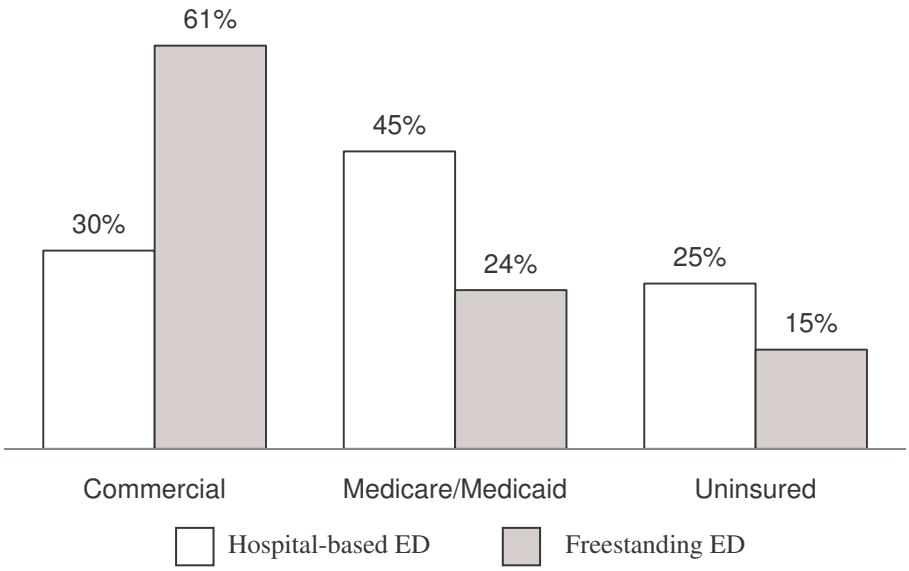
[33] Agency for Health Care Administration (AHCA). "Report on Freestanding Emergency Departments." (December 2004). www.fdhc.state.fl.us/freestanding/contents.shtml (Accessed October 15, 2008).

[34] Wagner, R. "Wellmont Outlines Need For a New Emergency Department." *Times News.* (March 2, 2008). www.timesnews.net/article.php?id=9005369 (Accessed October 17, 2008).

[35] Green, J. "ED, Set Free." *HHN.* March 1, 2006. www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006March/0603HHN_InBox_Facilities&domain=HHNMAG (Accessed October 16, 2008).

**Freestanding ED staff treat twice as many insured patients as hospital-based ED**

*Payer mix for freestanding ED patients, 2006*




Source: HCAB, *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*, Washington, D.C.: The Advisory Board Company, (2006).

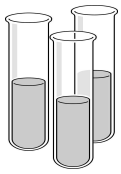
## IV. EXPECTATIONS, BENEFITS, AND KEY ATTRIBUTES

From a patient perspective, freestanding EDs offer numerous advantages, rendering medical care efficient and readily accessible. While scant research is available regarding patient expectations at freestanding EDs, studies indicate that patients who seek care in freestanding EDs hold expectations for short wait times across the continuum of care, as depicted in the graphic below.

**Patients in freestanding EDs expect rapid medical service**

*Patient expectations for wait times in freestanding EDs, 2008*

**Waiting room:**
13.8 minutes



**Laboratory testing:**
23.4 minutes

**Imaging studies:**
31.3 minutes

**Total:**
64.0 minutes

Source: Meyer-Reed, EJ, et al, "Patient Expectation in a Freestanding Emergency Department," *Annals of Emergency Medicine,* (October 2008).

Beyond a short length of stay (LOS), 93.3 percent of patients in a recent study indicate that they prefer to receive care from a staff physician, as opposed to a medical student, resident, or nurse practitioner (NP) at the freestanding ED. Further, patients indicate the following as "extremely important" components of their freestanding ED experience:[36]

- ***Clarity***—Obtain a clear explanation of condition and treatment
- ***Participation***—Seek "to have a say in the care"
- ***Sanitation***—Observe facility cleanliness

### Freestanding EDs deliver patient benefit in terms of efficient care, calm environment

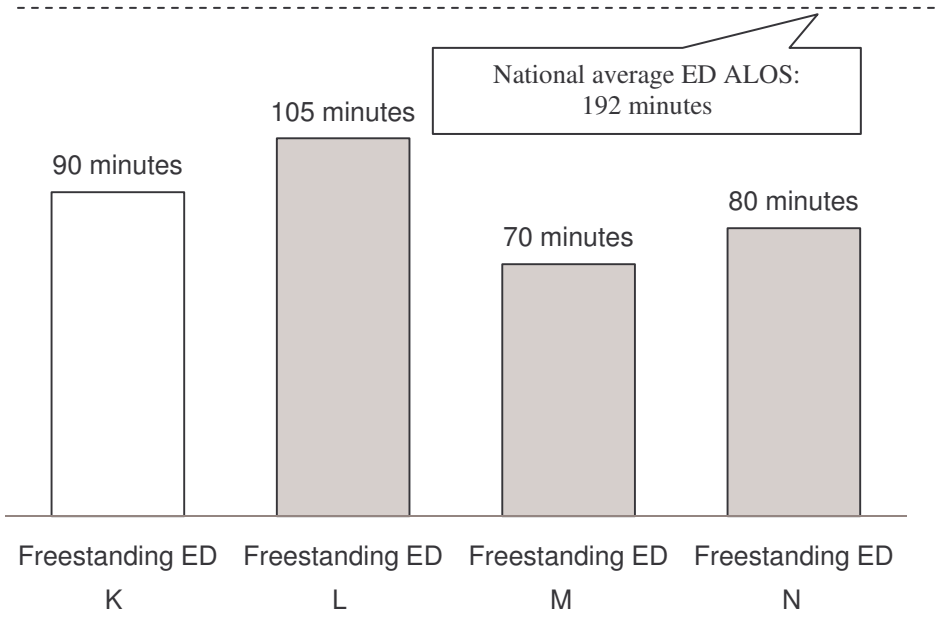
Given that the wait time in a hospital-based ED is 192 minutes on average—and may exceed 48 hours—patients typically obtain faster care in freestanding EDs. The presence of on-site lab and imaging—and a lower admission rate—enable staff to provide more efficient service than at a hospital-based ED.[37] The chart on the following page depicts average length of stay (ALOS) in four freestanding EDs.

[36] Meyer-Reed, E., et al. "Patient Expectation in a Freestanding Emergency Department." *Annals of Emergency Medicine.* (October 2008).

[37] Boodman, S. "ER Care, Stat!" *Washington Post*. (September 16, 2008). www.washingtonpost.com/wp-dyn/content/article/2008/09/12/AR2008091203002.html (Accessed October 15, 2008).

**ALOS in freestanding EDs significantly shorter than in hospital-based EDs**

*Select freestanding ED ALOS, 2006*




Source: HCAB, *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*, Washington, D.C.: The Advisory Board Company, (2006).

Due in large part to these low ALOSs—and as a result, minimal overcrowding—patients frequently perceive the atmosphere of freestanding EDs to be more pleasant and customer-service oriented than their hospital-based counterparts.[38] Moreover, freestanding EDs are a boon for patients formerly facing inadequate access to emergency care, such as those in rural areas, high-traffic urban environments, and newly-established bedroom communities.[39] As such, administrators observe that freestanding EDs are typically well-received by communities and enjoy positive reputations—further evidenced by the fact that patient satisfaction scores in freestanding EDs are consistently higher than those at hospital-based EDs.[40]

[38] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report.* (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

[39] "Number of Freestanding EDs Up, Helping Ease Overcrowding, Serving Rural Areas." *ED Management.* (September 1, 2005). http://ahcpub.com/archive/?efrlk=306 (Accessed October 15, 2008).

[40] Fisher, M. "Free-Standing ED: Alternative Medicine for DC's Hospital Headache." *Washington Post.* (April 11, 2006). www.washingtonpost.com/wp-dyn/content/article/2006/04/10/AR2006041001717.html (Accessed October 20, 2008).

### Administrators leverage freestanding EDs to gain market share, favorable payer mix

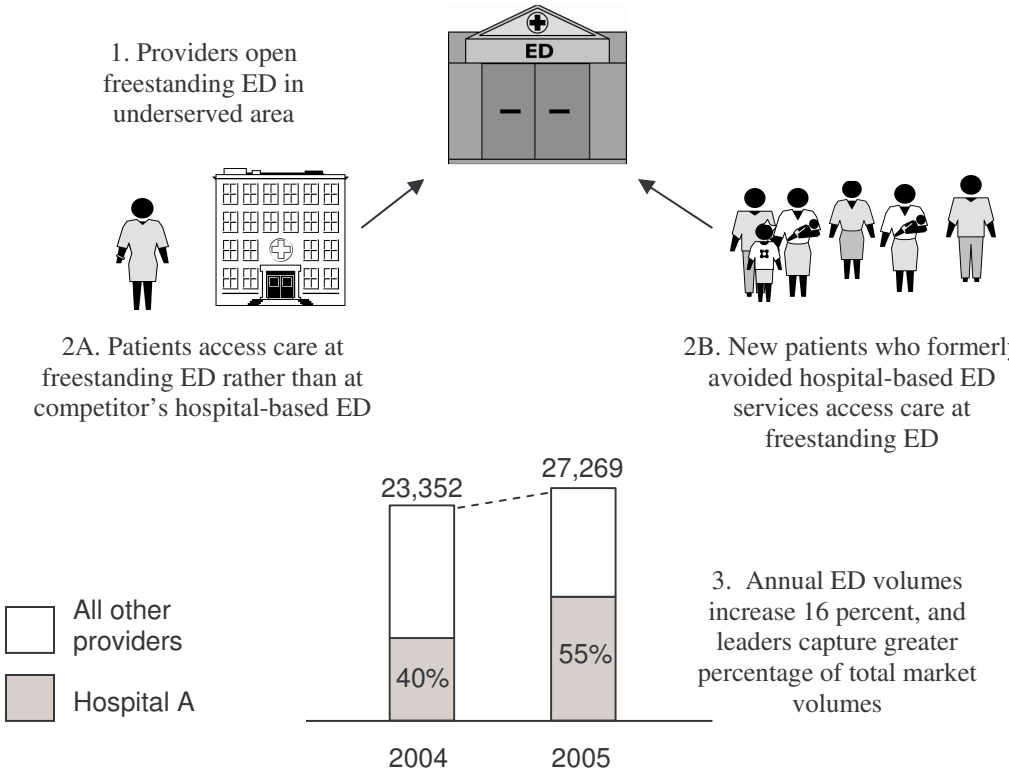
Beyond offering myriad benefits for patients in terms of convenience and service efficiency, the freestanding ED model offers an array of advantages to hospital leaders, described below.

- ***Faster throughput at flagship facilities***—Clinicians observe that freestanding EDs siphon patients who would otherwise access care at the flagship ED and, as such, alleviate overcrowding and improve service efficiency at the parent hospital.[41]
- ***Favorable payer mix***—Leaders typically construct freestanding EDs in affluent communities with a high proportion of commercially insured residents, consequentially garnering greater profits than in a traditional ED and securing downstream revenue through ancillary services and inpatient admissions.[42,43]
- ***Growth opportunity***—Administrators often establish freestanding EDs to cultivate a presence in an emerging market; leaders use freestanding EDs to study the prospects for profitability of a full-service hospital in the future.[44]
- ***Market share expansion***—Providers at freestanding EDs capture patients competitors previously treated—as well as low-acuity patients who would otherwise have avoided a congested hospital ED—due to the lower ALOS and customer-service reputation. As a result, they grow overall ED volumes, as depicted in the graphic on the following page.[45]

[41] Appleby, J. "More Emergency Rooms Open Away From Hospitals." *USA Today*. (April 24, 2008). www.usatoday.com /news/health/2008-04-24-emergency-rooms-stand-alone_N.htm (Accessed October 14, 2008).
[42] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report.* (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html. (Accessed October 14, 2008).
[43] CAB. "Freestanding EDs: Stand-Alone Facilities Gain Traction But Face Ongoing Hurdles." *Clinical Strategy Watch.* (June 20, 2008).
[44] Cain, B. "Alone Again." *Health Leaders Media.* (2008). www.healthleadersmedia.com/content/81603/topic/WS_HLM2 _MAG/Alone-Again.html (Accessed October 14, 2008).
[45] "Number of Freestanding EDs Up, Helping Ease Overcrowding, Serving Rural Areas." *ED Management.* (September 1, 2005). http://ahcpub.com/archive/?efrlk=306 (Accessed October 15, 2008).

**Market share expands 16 percent as new patients, former patients of competitor, seek care at freestanding ED**

*Market share capture, freestanding ED of Hospital P, 2005*




Source: HCAB, *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*, Washington, D.C.: The Advisory Board Company, (2006).

## Attributes of a successful ED include affluent location, EMS support

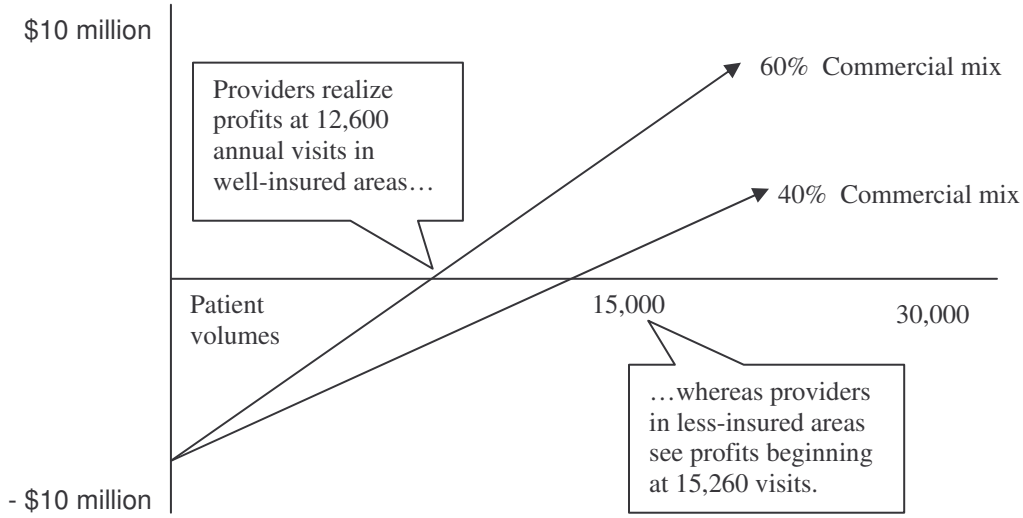
Aside from contention surrounding the level of care staff at freestanding EDs provide high-acuity patients, there are virtually no documented drawbacks of the facilities for hospital leaders. However, several key attributes typically underpin the success of satellite EDs, including the following:

- ***Affluent location***—Leaders locate successful freestanding EDs in affluent, fast-growing regions to ensure a well-insured patient population, an expanding market share, and rapid profitability, as depicted in the chart on the following page.[46]

[46] Andrews, M. "Need the Emergency Room? Skip the Wait." *U.S. News and World Report*. (September 17, 2008). http://health.usnews.com/articles/health/2008/09/17/need-the-emergency-room-skip-the-wait.html (Accessed October 14, 2008).

**Administrators realize profits rapidly in predominantly commercially insured areas**

*Break-even analysis, freestanding ED, 2006*




Source: HCAB, *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*, Washington, D.C.: The Advisory Board Company, (2006).

- ***Convenience to flagship hospital***—Administrators construct successful freestanding EDs anywhere between 2 to 30 miles from the flagship facility. However, in order to improve physician access and promote staff sharing between the flagship hospital and freestanding ED—as well as expedite high-acuity patient transport—leaders typically site EDs approximately 15 miles from the flagship hospital.[47]
- ***Experienced medical staff***—Clinicians in freestanding EDs typically practice with small staffs relative to hospital-based EDs; as such, administrators seek to hire experienced practitioners who are comfortable working without back-up support.[48]
- ***Outpatient service offerings***—Providers substantially increase total revenues of the freestanding ED complex by collocating additional services not otherwise available to patients and physicians in the area.[49]

[47] Rogers, J. "Freestanding Emergency Departments: Brief Overview and Considerations." The Karlsberger Research Group. (June 2006). www.karlsberger.com/downloads/FreestandingED-06.pdf (Accessed October 14, 2008).
[48] "Freestanding ED. New Models of Urgent and Emergent Care Beyond the Hospital." (2006).
[49] *ibid.*

- ***Specialist and physician buy-in***—Leaders secure physician and specialist buy-in—thus, securing availability of on-call providers for high-acuity cases—by engaging them early in the planning process to lay the groundwork and select appropriate technology, ensuring they are prepared to practice in a facility they perceive advantageous. Additionally, establishing strategies to minimize specialists' need to provide care on-site—such as purchasing technology to transmit diagnostic imaging and other patient information to on-call physicians to facilitate telephone consults—further promotes physician specialist satisfaction. Finally, locating freestanding EDs with convenient access to MOBs and services such as ASCs, also secures provider buy-in.[50, 51]
- ***Support of EMS staff***—EMS staff play a key role in transporting patients to and from the freestanding ED. As such, leaders of successful EDs earn the trust and support of EMS staff by including them in planning patient delivery criteria and transfer protocol from day one and, in turn, secure safe—and substantial—patient volumes.[52]

[50] Nestor, C. "Community Developments: Essentials of Freestanding Emergency Centers." *Healthcare Facilities Management Magazine (HFM).* (July 2008). www.hfmmagazine.com/hfmmagazine_app/jsp/articledisplay.jsp? dcrpath=HFMMAG AZINE / Article/data/07JUL2008/0807HFM_FEA_Planning&domain=HFMMAGAZINE (Accessed October 15, 2004).

[51] "Staff Buy-in Is Key With Freestanding ED." *ED Management.* (October 1, 2007). http://ahcpub.com/archive/?efrlk=306 (Accessed October 14, 2008).

[52] Wagner, R. "Wellmont Outlines Need For a New Emergency Department." *Times News.* (March 2, 2008). www.timesnews.net/article.php?id=9005369 (Accessed October 17, 2008).

## Research Methodology

During the course of research, Original Inquiry staff searched the following resources to identify current trends in freestanding emergency departments (EDs):

- Advisory Board's internal and online (www.advisory.com) research libraries
- American Hospital Association (AHA) Quickdisc. 2007.
- EBSCO® Health Business FullTEXT™
- Factiva™, a Dow Jones company
- Lexis-Nexis™
- Internet, via search engines and multiple websites, including the following:
  - ✓ American College of Emergency Physicians (ACEP) at www.acep.org
  - ✓ *Annals of Emergency Medicine*
  - ✓ *ED Management* at www.ahcpub.com
  - ✓ *Emergency Medical Services Magazine* at www.emsresponder.com
  - ✓ *Health Affairs Journal at* www.healthaffairs.com
  - ✓ *Health Leaders Media* at www.healthleadersmedia.com
  - ✓ *Healthcare Facilities Management (HFM)* at www.hfmmagazine.com
  - ✓ Florida College of Emergency Physicians at www.fdhc.state.fl.us
  - ✓ *Journal of Emergency Medicine* at www.sciencedirect.com
  - ✓ *Journal of the American Medical Association (JAMA)* at www.jama.ama-assn.org
  - ✓ Karlsberger Research Group at www.karlsberger.com
  - ✓ *Modern Healthcare* at www.modernhealthcare.com
  - ✓ *New York Times* at www.nytimes.com
  - ✓ Various hospital and health system website
  - ✓ *Washington Post* at www.washingtonpost.com

## Professional Services Note