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Community developments

Essentials of freestanding emergency centers

By Constance Nestor, FACHE

Essentials of freestanding emergency centers

Community-based patient needs have given rise to the newest health care facility type—the hospital-owned freestanding emergency center (FEC). Already, several dozen FECs have sprung up across the nation in an effort to provide convenient emergency health care services to isolated or growing communities and to decompress overcrowded hospital-based emergency departments.

What are they?

With a few exceptions, hospital-owned FECs approximate hospital-based emergency departments with respect to design and clinical programs.

FECs are equipped with advanced life support (ALS) technologies and equipment and are staffed 24/7 with board-certified emergency physicians, nurses and other skilled and technical staff. Patients who need to stay overnight may be moved into hospital beds within observation units where patients receive around-the-clock care in the company of their loved ones. FECs receive walk-in patients and patients transported by ambulance.

Because FECs are not directly connected to hospitals, trauma services, surgery, critical care and inpatient nursing care are not immediately available. Thus, trauma patients and those requiring acute care will be transported by paramedics to a full-service hospital. However, because patients suffering from heart or other serious problems may present for treatment, FECs are being planned to care for ALS patients. The more acute patients are stabilized and transferred to the closest hospital. Similarly, patients requiring surgery, catheterizations, critical care or other hospital-based services must be stabilized at the FEC and transferred to a hospital, requiring adequate ambulance staging and parking space, in addition to a helipad.

Emergency services are generally not big revenue generators and are usually subsidized by better-reimbursed services. Consequently, FECs will ideally be sited alongside revenue-generating services and located relatively close to physician offices to provide physician convenience and assist with physician relationship building.

Some FECs are being designed to accommodate independent outpatient testing to supplement revenues, especially during the initial years of business. Preadmission and presurgical testing, diagnostic imaging, infusion therapy, exams/physicals, sleep studies and other types of visits may be scheduled at an FEC to leverage usage in the initial period of operation.

Sponsor hospitals anticipate referral business from FEC patients who require follow-up care and inpatient admission. Ideally, patients requiring admission will be transferred to the sponsoring hospital. However, only 5 percent to 10 percent of an FEC population is expected to require transfer to an acute care facility.

Further, the current procedural terminology definition for emergency medical services—24-hour service, seven days a week—must be satisfied before Type A codes may be used. Co-payments for insured patients match hospital-based emergency service visits. FECs will have an obligation to treat all patients who present, including the uninsured and underinsured.

Patient flow

Whenever patient treatment rooms and caregivers are available, the triage process should consist of escorting or transporting the patient to an open exam/treatment room where staff may assess the patient's condition and begin treatment without delay. Only when the treatment area is full will it be necessary to direct patients to a triage room for assessment and initial treatment. The reduction of steps in the process will speed care, thereby improving outcomes and increasing patient and staff satisfaction.

Unless a family member is available to provide information, the registration process need not be completed until treatment is under way and the patient is stable. If an FEC bed is not available, patient vital signs and care may begin inside a triage room.

Registration will most often be completed at the patient bedside. The traditional registration area may not be required, but may function as the check-in/check-out area for other scheduled outpatient visits. It will be prudent to include a registrar work area within the core of the FEC patient treatment zone.

Once the patient has been placed in a treatment room, his or her care must be expedited and coordinated as effectively as possible. An average FEC patient visit should be completed in less than an hour from start to finish, though more serious cases may require much more time. Patients may be discharged at bedside. Automated discharge orders will further ensure that a patient is treated and released in a timely, competitive manner. And co-payments may be collected at the time of discharge at a formal check-out station, if desired.

The complete elimination of waiting rooms in emergency services settings is unrealistic because multiple family members often accompany patients or arrive afterward to await the health status of loved ones. As a matter of fact, stress-reducing elements such as aquariums and fireplaces are being introduced into FEC waiting rooms, resulting in a slight increase in the overall facility square footage. Customer satisfaction scores have improved where such amenities have been provided. However, the objective of eliminating patient wait times is important.

When patient volume is significant, an FEC's patient treatment rooms may be flexibly zoned for minor care and acute care areas. Most emergency facilities have implemented urgent or minor care programs to accommodate lower acuity emergency patients. The facility configuration, however, should permit staff to flow between major and minor care

areas with relative ease.

When constructing an FEC, it may also be beneficial to incorporate a critical decision unit (CDU) or observation unit. Based on demographic trends, the at-risk cohort for heart failure is expected to double over the next 30 years, according to a 2005 article by W. Frank Peacock, M.D., FACEP, on "Using the Emergency Department Clinical Decision Unit for Acute Decompensated Heart Failure," which appeared in Cardiac Clinics. Patients complaining of chest pain, congestive heart failure and asthma are candidates for observation. The FEC acute care area will be decompressed by removing these longer-term observation patients to a CDU area.

In certificate of need states, CDU space is considered nonreviewable and may provide additional flexibility in an FEC. Unfortunately, under the Outpatient Prospective Payment System (OPPS), there is no separate payment for the use of observation beds. The observation payment is bundled with the payment for any procedures or services covered under OPPS. Sleep study services may be a good fit for a CDU area during the startup months and provide an additional source of revenue.

Design basics

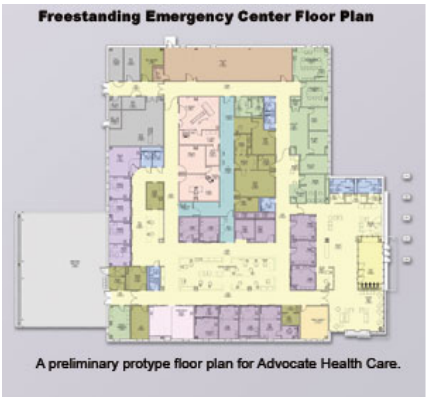
In general, an FEC is organized around four functional zones: patient intake (entrance, triage and waiting); treatment (exam, treatment and testing); clinical support (staff work, medications and storage); and administrative support (office, lounge and receiving).

Most communities are not familiar with FECs and are apt to confuse them with the services offered in immediate care centers; not expecting the level of services to be equivalent to hospital emergency rooms. Therefore, it is important to design and brand the facility with the image and signage of a hospital-based emergency department. The construction of a CDU for overnight stays in comfortable hospital beds provides an additional aspect of the traditional hospital setting that will reinforce the advanced acute care available in FECs.

FECs also require patient parking and a dedicated entrance for those who arrive by car or personal vehicle. A separate ambulance entrance should be configured near the trauma/resuscitation rooms.

In any emergency care setting, where patients may be critically ill, patient rooms are organized around unobstructed caregiver cores; offering unimpeded views of all patients from staff work areas. For the safety of the patients, clinicians and physicians must be able to observe and hear them at all times. In smaller services, treatment rooms are typically organized around a central work area, while decentralized room-side caregiver stations may be provided in larger facilities for easy patient access and observation.

Likewise, imaging capability is a must for any emergency medical service. According to a July 2006 National Hospital Ambulatory Medical Care Survey by the Centers for Disease Control and Prevention's National Center for Health Statistics, approximately 44 percent of the patients presenting at such FECs will require imaging, with nearly 17 percent requiring electrocardiograms. Additionally, complete laboratory blood counts will be needed for 33 percent of the patients, with 19 percent requiring urinalysis testing.



A preliminary protype floor plan for Advocate Health Care.

Startup FEC facilities typically offer computed tomography, general radiography and portable ultrasound. Depending on the services, it may make sense to accommodate magnetic resonance imaging testing. When affordable, unfinished space may be constructed for future imaging modalities.

Point-of-service lab testing is the norm, requiring a small code-compliant lab. Due to the intravenous mixture requirements, a pharmacy room that includes a fume exhaust hood is required, as is a room for instrument and equipment cleaning and sterilization.

Though trauma patients are generally not expected at an FEC, a resuscitation room outfitted similar to a hospital-based trauma room is recommended. In addition, provisions for gynecological exams, psychiatric patients, prisoners and other specialty needs must be accommodated. Ambulance routes to the FEC should be devoid of twists and turns that negatively impact vehicle maneuverability. Back-in ambulance bays and cross-mixing of vehicular and pedestrian flow should be avoided.

Treatment rooms must be large enough to accommodate monitors, computer technology, modular supply cabinets, portable technology and side chairs for family members and are typically being constructed at 150 to 170 square feet. Caregiver workstations and support spaces are best outfitted with flexible, modular work systems and equipment.

In keeping with the Disney concept, a “backstage” area should be included that provides privacy for staff to “break character” when off duty. It is important that this area be centrally located for quick response times to patients in need and it should maintain technological contact with the treatment rooms.

Pediatric care is most often integrated into the single adult/pediatric care-giving area. A free-standing pediatrics FEC function is not recommended unless the typical minimum standard of 16,000 to 20,000 dedicated annual visits is satisfied. Costs of a dedicated, separately staffed unit cannot be supported with smaller patient volumes. With the national declines in pediatric inpatient admissions at facilities other than referral children’s hospitals, it is also difficult to justify pediatric emergency/inpatient stay/outpatient care combination units.

A separate subarea in the waiting room should be furnished for children and may be partially isolated to minimize pediatric patient exposure to the adult population. Pediatric rooms should be decorated and furnished flexibly for many age groups. Isolation rooms and air pressure controls are necessary as is a disaster plan. Public waiting rooms should be subdivided or clustered into quiet and noise-friendly (i.e., TV) areas.

Paramedics and other emergency medical services (EMS) staff require areas to chart and to clean and store equipment. Each ambulance-provider organization needs secure

lockers. Supplies, linens and nondisposable supplies, such as backboards, should be stored in a single area near the EMS staff exit for ease of access. An equipment cleaning area that approximates a clean/soiled utility room is also required. Suction requirements in the decontamination room should also be considered with hazardous material shower capabilities.

Make or break

Emergency medical care facilities are among the most costly caregiving environments within the hospital business hierarchy. Efficient circulation and flows within the department are central to achieving appropriate lengths of stay.

The physical configuration of an FEC can make or break effective operations. A design that will optimize patient care, provide for future expansion and ease the way for potential reuse as new service lines emerge is ideal.

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Sidebar - Freestanding emergency regulations

Because freestanding emergency centers (FECs) are still relatively new, many states have not yet formulated legislation and rules for their governance.

Generally speaking, the medical director must be credentialed as an advanced life support-level emergency medical services (EMS) system physician with the facility complying with applicable emergency medical standards. Typically, the facility must be located within 20 miles of the resource hospital affiliated with the FEC and its EMS system.

Facilities are required to operate 24/7 and generally require on-site ambulance services staffed with paramedics as well as provisions for helicopter transport. Such facilities must comply with the federal Emergency Medical Treatment and Active Labor Act in addition to other state and local regulations, legislation and codes.—*C.N.*

Sidebar - For more information on FECs check out these resources

Though freestanding emergency centers (FECs) are on the cutting edge of health facilities development, they have already garnered much attention. The following is a sample of the information available on FEC topics in the health care and general interest medias:

"Clinical decision units in the emergency department: old concepts, new paradigms, and refined gatekeeping," *Emergency Medicine Journal,* 2003: http://emj.bmj.com/cgi/content/abstract/20/2/123

"Freestanding Emergency Centers: A Win-Win for Providers and Patients," *HFM Magazine,* May 2008: www.hfma.org/hfm/2008archives/month05/webextrafree.htm

"More emergency rooms open away from hospitals," *USA Today*, April 28, 2008: www.usatoday.com/news/health/2008-04-24-emergency-rooms-stand-alone_N.htm

"National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary," Centers for Disease Control and Prevention, National Center for Health Statistics, Advanced Data from Vital and Health Statistics, June 23, 2006: www.cdc.gov/nchs/data/ad/ad372.pdf

"OIG Focus on Observation Beds—Should You Be Concerned?" Connie A. Raffa, Arent Fox, Aug. 19, 2002: www.arentfox.com/publications/index.cfm?fa=legalUpdateDisp&content_id=961

"Quick! Turn an office building into a medical center: Fast-track emergency project demands a new way of designing," *Seattle Daily Journal* special section "Health Care Design and Construction," June 28, 2007: www.djc.com/news/co/11184024.html

"Using the Emergency Department Clinical Decision Unit for Acute Decompensated Heart Failure," *Cardiology Clinics,* 2005: www.emcreg.org/pdf/Peacock05.pdf

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