Free Standing Emergency Departments

Executive Summary

Facilities that provide emergency department services but are not located on a hospital campus, or free standing emergency departments (FEDs), have been expanding rapidly nationwide over the last ten years and now number more than 400 in 45 states. In New York State there are several providers of emergency services currently operating outside of a traditional hospital setting.

Originally designed to fill voids in rural regions where emergency health care was scarce, FEDs have expanded to suburban and urban regions, especially in areas experiencing rapid population growth or with a significant transient population. CMS categorizes FEDs according to whether they are hospital affiliated or independent entities. FED service models vary as standards have not yet been developed by the American College of Emergency Physicians.

Although there is little academic study on the efficacy of FEDs, there is evidence that they may have potential for alleviating emergency department (ED) overcrowding and long wait times. They are typically staffed with board certified ED physicians and registered nurses, operate 24/7 and are equipped to handle most of the cases hospital based EDs treat. FEDs also have arrangements with their main hospital or other regional hospitals to transport patients that require more intensive or overnight care.

FED visits are expensive, costing two to three times as much as Urgent Care visits. In addition, there is some confusion about the distinctions between FEDs and Urgent Care Centers due to overlap in the types of patients they treat and similarities in their staffing patterns. Differences include that FEDs are equipped to treat higher acuity patients and are more likely to be open 24/7.

Among the key issues to consider for FEDs are whether to require that they be hospital affiliated or allow private non-hospital ownership, and how un-bedded FEDs are best utilized as a health care resource while controlling unfair competition and excessive costs. Questions have also arisen about whether the duplication of personnel and equipment between the acute care hospital and the free standing emergency room is good for a healthcare delivery system that is already facing financial pressures due to excessive costs.

I. Background

The American Hospital Association (AHA) defines a Free Standing Emergency Department (FED) as a facility that provides unscheduled outpatient services to patients whose conditions require immediate care in a setting that is geographically removed from a hospital. FEDs can be either independently licensed facilities or satellite hospital emergency departments (EDs) that are physically separate and distinct from the conventional hospital ED.

Free-Standing Emergency Departments (FEDs) were first developed in various parts of the country in the early 1970s to serve rural and other under-served regions where access to emergency care was scarce. In many states FEDs experienced rapid growth over the last decade particularly over the last five years. However, New York State's experience with FEDs has been very limited. Currently there are only four emergency departments in New York operating outside of a traditional hospital setting and the demand for new FED construction has been manageable.

Recent national FED expansion is due in part to the growing volume of hospital ED use and demand for ED services. A national 2011 study published by the Journal of the American Medical Association found a 27% decline in hospitals with EDs between 1990 and 2009, while ED visits increased by 30% between 1998 and 2008.

A 2008 nationwide survey of 222 FEDs found that 191 were hospital affiliated and 30 were physician owned. The survey also found 198 of the 222 FEDs were accredited by the Joint Commission. Most FEDs offer urgent and emergency care, lab services, common radiology including x-ray, CT and ultrasound and are staffed by emergency medicine physicians and nurses. The California Healthcare Foundation found that more than 91% of FEDs operate 24/7.

New York State's limited experience with the development of FEDs has been guided by Title 10 Section 45.19 that regulates emergency departments. This means that FEDs were required to operate 24/7 and adhere to the same staffing requirements as EDs located in traditional hospital settings. CON approval required that the FED be part of a hospital and include at least two inpatient beds. Recently New York has agreed to relax the inpatient bed requirements and is considering allowing part-time operation.

Based on CDC estimates that approximately 70% of ED visits nationwide are non-urgent, semi-urgent, or urgent, and could be adequately cared for at an ambulatory clinic rather than in a conventional hospital ED, it is thought that FEDs have the potential to help alleviate ED overcrowding, increase patient access to emergency services, and provide a needed public service.

Defining Characteristics of the FED

As a national emerging model of care, there is a need to clearly define the differences between services provided at an FED, and those provided in a hospital-based ED, urgent care clinic or other ambulatory care setting. Models vary across states and while there is some variation in services offered, most FEDs provide:

- Urgent and emergency care
- Lab services
- Common radiology services including x-ray, CT and ultrasound

FEDs may operate 24 hours per day or on a more limited schedule, and may or may not receive patients by ambulance. Although FEDs are staffed and equipped to handle some lifesaving emergency care, patients who require hospital admission and, in some instances, surgery or specialist care, must be transferred to a higher-acuity facility.

Urgent care providers offer many of the same services as FEDs. However, there are some important distinctions to be made between the two. Most importantly, FEDs can provide a higher level of care, including such procedures as defibrillation, intubation, and conscious sedation. FEDs are typically staffed with board-certified emergency medicine providers, while urgent care centers often are not. Most FEDs (more than 90%) are open 24 hours per day, and there is a push by state policymakers for all of them to have 24/7 operating hours to further distinguish them from urgent care providers. While FED models can vary, the table below reflects the Urgent Care Association of America's assessment of the distinctions between urgent care providers and FEDs:

Differences Between Urgent Care Providers and Freestanding Emergency Departments Nationwide

Reproduction from the Urgent Care Association

	Urgent Care	Freestanding Emergency Department
Net Revenue per Patient	$105 to $135	$350 to $500
Co-Pay Charged	Typically $35 to $50	Typically $75 to $100
Facility Fee Charged	Typically no facility fee is charged, except in certain instances in which the center is part of a hospital complex. Typically one invoice for all services on site.	A facility fee is charged in addition to a professional fee for the providers. Patient is often billed separately by the facility and physician group.
Cases Treated	Typically low- to-moderate acuity, with the bulk of patients presenting with minor infections, flu symptoms,	Typically non-emergent with greater emphasis on musculoskeletal injury and lacerations. Patients self-triage for acutely

	allergies, rash, lacerations, sprains/strains, and fractures.	rising conditions including high fever, automobile accidents, and asthma attack.
Operating Hours	Typically 10-12 hours a day, seven days a week.	Most are open 24-hours a day, 365 days a year although some privately held centers may operate 10-12 hours/day, seven days a week.
Square Footage	Typically 2,500 to 4,500 sq. ft.	5,000 to 20,000 sq. ft. depending on whether the center is independent or hospital-affiliated.
Trauma and Resuscitation	Providers typically certified in Basic Life Support although many have advanced life support certification. Center typically equipped with EKG, defibrillator and drug cart. Process is to stabilize patient, call 911, and then EMS transfers patient to hospital emergency room.	Providers certified in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). Capabilities to administer IV medications and perform cardiac enzyme and BNP labs. Process is to stabilize patient and admit to hospital (using contracted paramedic transport) under direct transfer agreement.
Provider Staffing	May be any combination of physicians, physician assistants, or nurse practitioners supported by medical assistants and technicians.	Emergency medicine physician on staff during all operating hours typically supported by an emergency medicine nurse. Ancillaries like lab and imaging supported by cross-trained technicians.
Provider Specialty	Typically family practice or emergency medicine with representation from internal medicine, pediatrics and other specialties. May or may not be certified by an ABMS-recognized board.	Typically board-certified in emergency medicine.
Laboratory	Varies by location. Typically CLIA-waived for point-of-care testing. Labs performed by medical assistants. Collection and send-out to reference laboratory for more advanced labs. Urine drug screening as a revenue center.	CLIA-certification for point-of-care testing plus automation for CBCs, D-Dimer, BNP, and cardiac enzyme testing. Laboratory technician on staff. Physician also utilizes microscope for diagnosis.
Imaging	Typically basic x-ray performed (depending on state law) by trained medical assistant or radiology technician. Consulting radiologist over-reads to validate diagnosis.	X-ray, low-resolution CT, and ultrasound performed by radiology technician, with consulting radiologist on-call to read images.

Urgent Care Association of America, 2012

CMS Requirements for FEDs

The Centers for Medicare & Medicaid Services (CMS) first recognized FEDs in 2004. CMS uses two classifications for EDs that are not part of the main hospital facility:

- ***Hospital Provider-Based EDs (also known as "Provider-Based Off-Campus EDs")*** - Most common model, occurs when a Medicare-participating hospital that offers

emergency services seeks to establish an ED located away from the main campus and to have that ED operate as a provider-based department of the hospital. This model does not require inpatient beds or 24/7 hours of operation.

• ***Hospitals Specializing in Emergency Services*** – Less common model, burden of proof is on the provider to demonstrate that it meets the statutory definition of a hospital, i.e. that it is primarily engaged in the provision of services to inpatient, has inpatient capacity, and 24/7 availability.

FEDs that comply with CMS and the Emergency Medical Treatment and Active Labor ACT (EMTALA) regulations can bill as a dedicated ED. In 2008, CMS divided the billing category for dedicated EDs into Type A and Type B:

• A ***Type A*** ED is one that provides services 24 hours a day, 7 days a week, and meets one or both of the requirements related to the EMTALA definition of a dedicated emergency department.

• A ***Type B*** ED is one that incurs EMTALA obligations but does not meet the Type A definition of providing service 24/7.

This rule established a significant difference in billing and reimbursement between FEDs and urgent care centers. In 2008, CMS reimbursed an average of $138 for an urgent care visit and $316 for an FED visit.

Current Status

National

According to the American Hospital Association and reports from State Health Departments there are now more than 400 FEDs operating nationwide. Recent expansion of FEDs includes suburban areas just outside cities and involves competitive strategies to garner larger market share. FED expansion is especially rapid around cities that have a large transient population and/or are experiencing rapid growth, where people are less likely to have a regular physician.

Several industry associations have accompanied the rapid growth of FEDs. However, some states such as Georgia have through CON and regulation denied requests to construct FEDs. Others such as Florida have declared moratoriums on further construction (after four were in operation) pending further study. The American College of Emergency Physicians (ACEP) is in the process of developing a section or subcategory of membership for Free Standing Emergency Room Physicians. ACEP has not yet developed standards for FEDs.

New York State

In New York State, there are currently several providers of emergency services that operate outside of a traditional hospital setting:

• Mercy Hospital Orchard Park Division, Orchard Park

- Adirondack Health, Lake Placid
- Tri-Town Regional Hospital, Sidney
- Montefiore Westchester Square, Bronx

All existing FEDs in New York State operate 24/7 as Provider-Based Off-Campus ED's. In addition, all have at least two inpatient beds with the exception of Montefiore.

Long Island Jewish Medical Center and Lenox Hill Hospital are constructing a two-bed FED in Manhattan to open in early 2014. In addition, Ellis Hospital has a CON application under review to convert their Urgent Care Center to an FED. Need criteria has considered FEDs with hospital beds a division of the hospital, and FEDs without beds an ambulatory care clinic. Legislation was introduced but not enacted to support a part-time FED in Lake Placid.

II. Assets and Liabilities of the FED Model

Pros:

- Increases the availability of high-quality emergency care in more convenient and readily accessible settings.
- Can relieve overcrowding of hospital-based emergency departments.
- Operate with faster throughput, resulting in reduced patient wait times and increased patient satisfaction.
- More economical and efficient than constructing new hospitals to fill health care voids in under-served regions
- Some private insurers have created reimbursement schedules for FEDs or have entered into contracts with FEDs to structure and reduce costs.
- Rapid growth and success experienced in other states.

Cons:

- More expensive than urgent care. FEDs treat many lower acuity patients who may have otherwise been seen by a primary care physician or urgent care at significantly lower cost. FEDs can also charge a facility fee, increasing costs to insurers or passed along to patients. Private insurers have sued FEDs to reduce costs.
- Overlap in scope of services with urgent care centers and hospital-based EDs can lead to consumer confusion about appropriate use.
- FEDs are not equipped to handle all trauma care, and some do not have on-call specialists. Patients who require hospital admission and, in some instances, surgery or specialist care, must be transferred to a higher-acuity facility and EMS transport protocols are needed to ensure prompt inter-facility transport.
- Concerns about access to care and availability of emergency services when FED operates less than 24/7.

- Patient over-reliance on FED may undermine relationship with primary care physician or patient medical home.
- FEDs are increasingly being built in locations to muscle in on a competing hospital's ED and siphon off its patients even if there are already adequate emergency services nearby.
- Concerns have been raised about whether the duplication of personnel and equipment between the acute care hospital and the free standing emergency room is a good thing for a healthcare delivery system already facing severe expense pressures.
- Minimal academic study confirming quality and effectiveness.