Freestanding Emergency Departments: What Can We Learn

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Free-standing emergency departments (FSEDs) usually generate patient satisfaction scores above the 90th percentile, have a left-without-being-seen (LWBS) rate of virtually zero, and extremely low door-to-provider times. And these are EDs in every sense — they provide acute care; they have unscheduled, uncontrolled demand; and they have admission rates only slightly below the national average for hospital emergency departments in the United States. It is important to acknowledge that these *are* emergency departments *and* they achieve operational excellence. What can FSEDs teach us about operational management?

> "Both traditional EDs and freestanding EDs (whether hospital outpatient departments or independent) see similar types of patients, operate in an unscheduled/variable demand environment, and generate similar fees — but provide vastly different patient experiences and operational outcomes."

A FSED is defined as a facility that receives patients for emergency care and is structurally separate and distinct from the hospital. Freestanding EDs were initially established by hospitals in the 1970s in medically under-served, rural areas. However, FSEDs have proliferated over the past decade in suburban areas with more affluent patients. There are now approximately 500 FSEDs in 45 states. For simplicity, we can categorize FSEDs as either a hospital outpatient department (HOPD), owned or operated by a hospital but separate from the hospital's main campus; or as a completely independent FSED. Hospital-based FSEDs are subject to the same federal rules and regulations as hospitals, are bound by EMTALA, and account for 75% of all the FSEDs in the United States. Some states require that freestanding EDs be hospital-based, and that they obtain a certificate of need before being opened. An independent FSED does not require a certificate of need, is not recognized by Medicare and is not subject to CMS rules and regulations, and may choose not to serve Medicare or Medicaid patients. Independent FSEDs represent the remaining 25% of FSEDs. It is important to note that both types of freestanding EDs are allowed to charge *both* a facility fee *and* a professional fee.

There is a great debate as to whether FSEDs make financial sense for both the payer and the patient. From a billing standpoint, hospital outpatient department FSEDs are generally in-network and independent FSEDs are out-of-network with insurers. Regardless, the argument is that most of their patients would be better served by urgent care facilities, at lower cost. However, that's the same argument made against traditional EDs. Both traditional EDs and FSEDs, whether hospital-based outpatient or independent, generate facility fees that urgent care facilities do not. That is an important distinction between urgent care facilities and EDs of all kinds, and the primary reason for debate.

Both traditional EDs and freestanding EDs (whether hospital outpatient departments or independent) see similar types of patients, operate in an unscheduled/variable demand environment, and generate similar fees — but provide vastly different patient experiences and operational outcomes. A recent article in Common Sense, "Operational Margin: The Critical Final Pathway in Patient Flow," explored operational margin as the defining element in any successful ED and explained why FSEDs generally outperform traditional EDs.

What defines operational excellence? Every emergency department's goal is to see patients quickly (minimizing LWBS numbers) and complete the patient's care in a reasonable amount of time (minimizing length of stay). If these goals are achieved, other important outcomes such as quality, safety, and excellent patient satisfaction will follow. There is one operational concept that determines whether an ED of any kind achieves these goals. It is known as operational margin. It's analogous to a savings account or a personal line of credit, in that it's similar to money one has available to manage variance in personal spending, commonly known as liquidity (easily and quickly available cash). Without liquidity, there is a risk that one will spend too much and run out of cash — not a good thing. If one spent the same amount every day, every month, and every year, a savings account or line of credit would not be needed. Demand and supply would always be perfectly matched. The same principle applies to emergency departments. Liquidity for an ED is its surge capacity. It is essentially a line of credit or savings account on physician, nursing, and space availability that can be drawn on when needed. If the ED always saw the same number of patients per hour per day and per year, we wouldn't need to have extra capacity available. But in ED patient flow, as in your personal spending, there is unpredicted variation. This can only be managed by creating liquidity of critical resources — surge capacity — the essential definition of operational margin.

Now, let's look at how freestanding ED's create operational margin. Figure 1 below shows the relationship between utilization (patient intake) and response time (patient wait time), and shows that as one approaches

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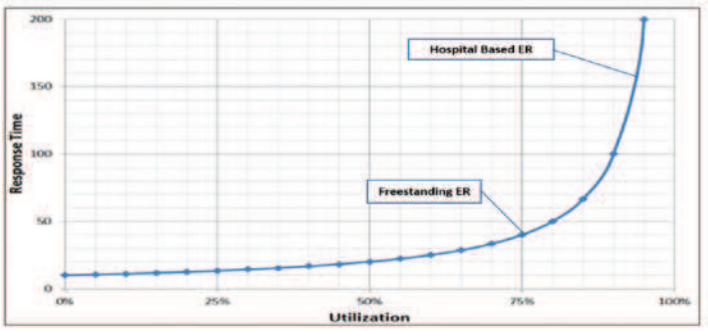

extreme utilization response time degrades exponentially because of depleted operational margin. It also shows where on the curve traditional EDs and FSEDs generally fall.

Figure 1 – Service Response vs Utilization

Provider productivity in independent FSEDs is approximately one patient per hour. The average provider productivity in traditional EDs is approximately two patients per hour. Freestanding EDs, as stated earlier, generally report fairly immediate door to provider times and essentially 0% left without being seen, yet this is accomplished with approximately half the average productivity (patients/provider per hour) of emergency departments nationally. Furthermore, there are hospital EDs with productivity of three patients/provider/ hour that achieve operational metrics similar to FSEDs, and EDs that average one patient/provider/hour that are operational disasters. The point is that operational excellence is unrelated to productivity — it depends on operational margin — the available capacity of provider, nursing, and space resources to meet demand with high probability. To be clear, the interplay of productivity and efficiency are important to throughput, as long as the utilization of resources is kept on the flat part of the curve in Figure 1. Operational excellence does not exist without operational margin — the ability to do the next thing *now*.

Whether productivity is at one patient/provider/hour or three, the ED must have the surge capacity to manage the inevitable variation in patient arrivals that exists in emergency medicine, just like any other service industry. Theoretically, this capacity can be created by supplying the necessary resources (physician, nursing, and space) in sufficient quantity to manage demand in all its variation, or by improving efficiency at any given level of productivity. That explains why some EDs succeed and some fail at identical levels of productivity — whether it's one patient/provider/hour or three.

Freestanding EDs provide excess capacity, implementing low-utilization staffing models and space plans, guaranteeing that sufficient resources are *always* available to manage demand — even with extreme variability. When demand begins to creep up, efficiency becomes increasingly important to maintaining the low utilization of resources. Freestanding EDs have essentially eliminated this requirement by creating resources for extreme levels of demand, guaranteeing that a room, a nurse, and a provider are always available.

How do they do it? Remember that every ED generates both a provider fee and a facility fee. The key difference between FSEDs and traditional EDs is how these fees are distributed. FSEDs keep both the provider fee and the facility fee in the FSED, whether the patient is discharged or transferred and admitted to a hospital. The result is fairly healthy financial margins. The hospitals that house traditional EDs sweep some of those fees into DRG-bundled payments for the admitted patient, and don't return those fees to the ED where they were generated. The result is a fairly unhealthy financial margin for the ED. From an accounting point of view, freestanding EDs look much better than hospital-based EDs — even though the care, costs, and fees for an identical patient would be essentially identical. Neither accounting system is inherently right or wrong. Subsidizing other hospital operations with ED income is the reality some hospitals face. The point is that FSEDs have the ability to invest more of their revenue in higher levels of resources — in themselves — and thus better manage variation in demand.

Whether you support or oppose the concept of freestanding EDs, you surely agree that quickly seeing, treating, and dispositioning every patient who presents with a potential emergency is a worthy goal. Generally, FSEDs are getting that done, and the emergency physicians who work in FSEDs are proud of what they do and have high levels of job satisfaction.

Traditional, hospital-based EDs that properly value the financial and non-financial contributions of their EDs, and adequately invest in them, can achieve the same operational excellence as freestanding EDs. Again, whether you agree with the concept of FSEDs or not, it is important to recognize that they have created an operational model that our specialty should learn from, and for many reasons, embrace.

Further Reading

1. Operational Margin: The Critical Final Pathway in Patient Flow. Joseph Guarisco, MD FAAEM FACEP *Common Sense Volume* 23, Issue 1 Jan/Feb 2016
2. Operational Margin: A Simplified Approach to Patient Glow. Joseph Guarisco, MD FAAEM FACEP 2015 Patient Flow Summit, Boston, MA, Sept 29, 2015.
3. Dissecting the Cost of a Freestanding Emergency Department Visit. Alan A. Ayers, MBA MAcc Board of Directors and Content Advisor, Urgent Care Association of America Associate Editor, *Journal of Urgent Care Medicine* Vice President, Concentra Urgent Care.
4. CMS S&C Memo 08-08, 2008 Requirements for Provider-based Off-campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services. January 11, 2008
5. https://www.acep.org/.../freestanding. American College of Emergency Physicians. A freestanding emergency department (FSED) is a facility that is structurally separate and distinct from a hospital.
6. www.modernhealthcare.com › Providers › Ambulatory Care. *Modern Healthcare*. Jul 4, 2015 - Free-standing ERs eye lobbying to win state approval for growth. ... Free-standing emergency room operators are exploring how to win state regulatory approval to expand their facilities nationwide despite opposition from hospitals.
7. How Freestanding Emergency Departments Help Patients. catalyst.nejm.org/how-the-freestanding-emergency-department-boom-can-help-patients/. Feb 18, 2016 - How the Freestanding Emergency Department Boom Can Help ... Nir Harish, MD MBA, Jennifer L. Wiler, MD MBA, & Richard Zane, MD.
8. Do Freestanding Emergency Departments Make Financial Sense? www.freemanwhite.com/do-freestanding-emergency-departments-make-financial-sense/. Do Freestanding Emergency Departments Make Financial Sense? FSED. January 28, 2015 | David White.
9. Free-Standing Emergency Rooms Causing Controversy - *Journal of Emergency Medical Services*. www.jems.com/articles/2013/07/free-standing-emergency-rooms-causing-co-0.html. Jul 31, 2013 - First Choice is a gleaming, stand-alone emergency room built like a drive-through dry cleaners, set in an affluent neighborhoods.
10. Overview of Existing Freestanding Emergency Departments (FEDs). https://dch.georgia.gov/.../Freestanding%20ER%20Overview%20-%20V2%2... Georgia Corporate. • Governmental Unit. • Partnership, etc. – Not all states allow a FED. Draffin & Tucker, LLP P.O. Box 71309 Albany, Georgia 31708-1309.