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Colorado Hospital Association

# Colorado's Freestanding Emergency Departments (FSED)

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OCTOBER 2016

# Key Concerns About FSEDs

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## Cost & Consumer Confusion

- Whether consumers can differentiate less-expensive urgent care from more-expensive emergency care
- Consumer out-of-pocket costs driven by high-deductible insurance plan designs

## Patient Safety & Care Quality

- Whether FSEDs can adequately respond – through on-site treatment or transfer to a higher level facility – to time-sensitive emergency conditions (such as trauma, stroke, heart attack)

## Independent FSED

### Number of Facilities: 0

- Staffed by physicians 24/7; in urban areas, likely board-certified emergency physician
- Licensed by state, but not by feds: EMTALA does not apply, facilities cannot take Medicare & Medicaid

## Hospital-Affiliated FSED

### Number of Facilities: <20

- Staffed by physicians 24/7; in urban areas, likely board-certified emergency physician and range of specialty care available
- Licensed by state, but applicability of federal rules depends on structure
- Charges may be the same in on-campus and off-campus EDs

## Hospital-Based ED & Hospital-Owned FSED

### Number of Facilities: 80-90

- Staffed by physicians 24/7; in urban areas, likely board-certified emergency physician and range of specialty care available
- Licensed by state
- Certified by feds: Comply with EMTALA; Take Medicare & Medicaid
- Charges are the same in on-campus and off-campus EDs

## REGULATORY REQUIREMENTS

LOW

HIGH

*Clinical capability for urgent care, clinics, and physician offices can vary greatly by location. There is no minimum standard under state law, other than what is required under a professional's license.*

## Urgent Care, Unlicensed Clinics, Physician Offices, Nurse Advice Lines

### Number of Facilities: 1000s

- Staffed by licensed practitioners
- Not licensed by state or feds: Clinical capability determined by professional scope of practice

## Licensed Community & Rural Health Clinics

### Number of Facilities\*: 50-60

- Staffed by licensed practitioners
- Licensed by the state: Clinical services determined by the clinic

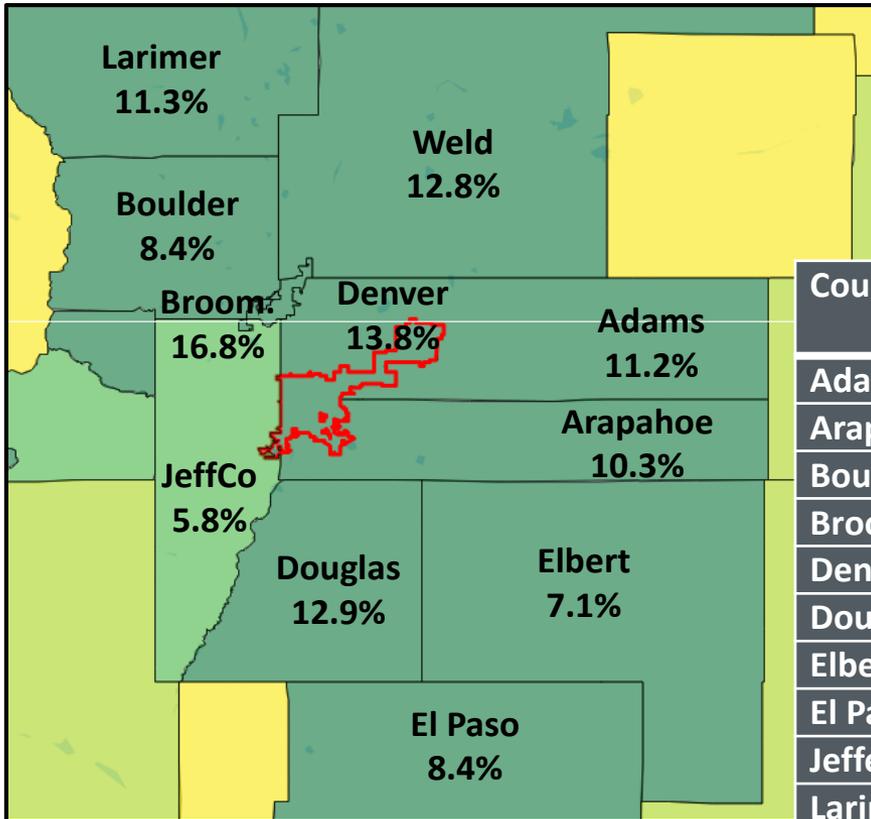
## Federally Qualified Health Centers

### Number of Facilities: 130-140

- Staffed by licensed practitioners
- Not licensed by the state
- Clinical and other standards determined by federal government

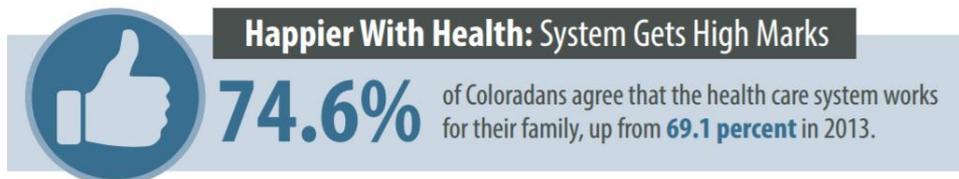
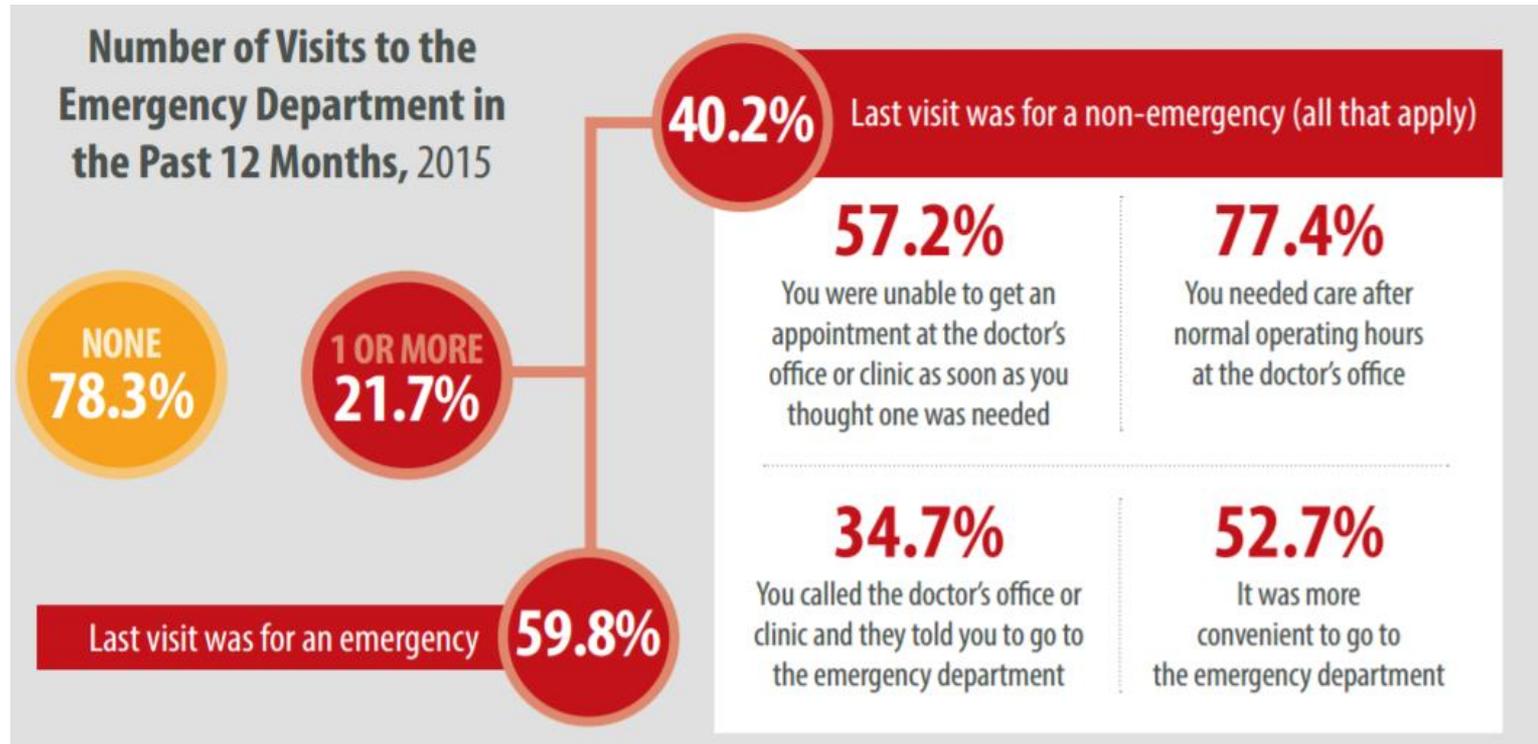
# As Metro Region Grows, So Do Options

Regional population growth, 2010-2015



County	Pop. (2015 est.)	Hospital ERs	FSEDs	ER per 100,000
Adams	491,337	5	7	0.41
Arapahoe	631,096	5	6	0.57
Boulder	319,372	4	1	0.63
Broomfield	65,065	1	4	0.13
Denver	682,545	5	2	0.95
Douglas	322,387	4	2	0.54
Elbert	24,735	0	0	0
El Paso	674,471	3	4	0.96
Jefferson	565,524	3	5	0.71
Larimer	333,577	5	1	0.55
Weld	285,174	1	4	0.57
<b>TOTAL</b>	<b>4,395,283</b>	<b>36</b>	<b>36</b>	<b>0.61</b>

# Recent ER Utilization Data



# Pros and Cons of FSEDs

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## Pros

Increased access to emergency care

Can relieve overcrowding of hospital EDs

Operate with faster throughput, reducing patient wait time and increasing patient satisfaction

More economical and efficient than constructing new hospitals

Some insurers have established payment relationships with FSEDs to structure and reduce costs

Rapid growth and success experienced in other states

## Cons

More expensive than urgent care, and FSEDs can charge a facility fee, increasing costs

FSEDs may treat lower acuity patients that could have been seen by primary or urgent care

Private insurers have sued FSEDs to reduce costs

Consumer confusion about the difference between urgent care and FSEDs

FSEDs may be located near competing hospitals/health systems in order to capture market share

Concerns regarding duplication of personnel and its impact on the broader healthcare delivery system

New York State Department of Health, 2013

# FSED Regulation in Other States

## State Policies for FSEDs (2015)

POLICIES	# OF STATES	COLORADO
<b>Licensing Requirements</b>		
State Issued License	13	<input checked="" type="checkbox"/>
Distance from Hospital or ED	9	
Population Requirements	1	
<b>Operating Requirements</b>		
Transfer Agreements with Hospital, EMS	23-25	<input checked="" type="checkbox"/>
Screening, Stabilization, Transfer	22-23	<input checked="" type="checkbox"/>
Open 24/7	22	<input checked="" type="checkbox"/>
<b>Service &amp; Staffing Requirements</b>		
Cardiac Defib., X-Ray, Lab, Peds	12-15	
Ventilation, OB, ultrasound, transfusion	4-9	
Physician (nurse) available all hours	15 (23)	<input checked="" type="checkbox"/>

# CHA FSED Policy Principles

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- Emergency Departments – in hospitals or FSEDs – are **not a substitute for primary care**
- Consumers should be able to **access health care services of their choice**, without barriers or restrictions, but they should be **notified of potential financial consequences**
- FSEDs should be **clearly identified** through prominent, lighted, external signage that includes the word **“emergency”**
- Hospitals and health systems should consider models of care that provide patients with the **appropriate level of care and bill accordingly** (“dual track” or “hybrid” model)
- Future growth of FSEDs should consider the **needs of underserved areas** as a strategy to address long-standing issues of access to acute and primary care.

# CHA Work in Progress & Next Steps

## Consumer Campaign

- PSAs
- Printed Materials
- Online and Social Media Presence
- Community Marketing

## Legislative Stakeholder Group

