Frequently Asked Questions: Innovative Care Models for Hospitals

Updated January 2023

Q: What are the innovative care models for hospitals announced by DOH in March 2022?

A: The innovative care models for hospitals announced by DOH include outpatient emergency departments, micro-hospitals, and tele-emergency departments.

Q: What is an Outpatient Emergency Department (OED)?

A: OED is an outpatient location of a hospital that offers emergency services and is not located on the grounds of the main licensed hospital. The term does not include independent, freestanding emergency departments that are not an outpatient locations under the license of a hospital. OEDs are not limited to rural areas but cannot be located within 35 miles of an existing emergency department unless the OED and the existing emergency department are under common legal ownership or if the OED is a critical access hospital or small rural hospital transitioning to an OED.

Q: What is a Micro-hospital?

A: A micro-hospital is an acute care hospital that offers emergency services and maintains facilities for at least ten (10) inpatient beds with a narrow scope of inpatient acute care services, such as no surgical services. A micro-hospital must maintain inpatient beds with appropriate physical resources and staff with appropriate personnel to meet the needs of patients, ensuring at least one physician and one registered nurse are on-site at all times. Additional medical staff, practitioners, and nursing staff are on-site as needed to meet the needs of admitted patients and patients on observation status.

Q: What is a Tele-emergency Department (Tele-ED)?

A: A tele-ED is an emergency department in an acute care or critical access hospital that is staffed by Advanced Practice Providers (APP) 24 hours per day/7 days per week (24/7) with a physician available at all times through telecommunications but not physically present in the emergency department.

Q: What are the differences between OED, Tele-ED and Micro-hospitals?

A: The models include different eligibility criteria, including emergency department volume, geographic location, minimum staffing, and minimum services. The guidance documents for each model more fully describe those differences.

Q: Is it safe to not have a physician present in a tele-ED?

A: Tele-EDs have been studied for over two decades and those studies have shown that tele-EDs improve clinical quality, expands the care team, increases resources during critical events,

shortens time to care, improves care coordination, promotes patient-centered care, improves the recruitment of family physicians, and stabilizes the rural hospital patient base.[1]

Tele-EDs have been operating in several states across the country have shown to be a cost-effective alternative for low-volume, rural hospitals that may otherwise be unable to maintain emergency care in the community due to staff recruitment and cost limitations. Tele-EDs will allow patients to have access to emergency care professionals while receiving care in their communities from qualified APPs.

Further, at this time, DOH is limiting eligibility for this model to hospitals in rural areas whose average daily emergency department visits are 46.0 patients or less to ensure the needs of patients can be met by the on-site staff with telemedicine physician support.

Q: How does the Census map work?

A: To use the U.S. Census Bureau's map to determine eligibility for the Tele-ED model, use the link in the guidance documents and follow these steps:

1. Open the menu using the icon in the upper left corner of the map.
2. Select the "Layers" tab (upper left corner of the menu).
3. Click the drop down menu under "Select Vintage" and choose "Census 2010."
4. Select the box to the left of "Urban Areas" and a check mark should appear.

The "Urban Area" layer will then be applied to the map. You can zoom in to the areas in Pennsylvania or you can enter an address in the search bar at the top of the map (a complete address is required).

Any area that is not an "urbanized area" (blue areas on the map) is an eligible location for operation of a tele-ED model. Locations that are within urbanized areas cannot be operated as a tele-ED, but may be eligible to operate as a micro-hospital or OED in accordance with the guidance.

Q: Why is 2010 Census data being used for eligibility for tele-EDs and not 2020 Census data?

A: As of the publication of these guidance documents, the U.S. Census Bureau's 2020 decennial census data and mapping for "urbanized areas" is not available. When the 2020 data becomes available for analysis, DOH will review and consider revision of the guidance documents to incorporate the 2020 data as appropriate.

Q: What hospitals are eligible to establish one of these models?

A: The eligibility criteria is different for each model. Generally, any hospital offering or intending to offer acute care services could operate a micro-hospital in accordance with the guidance, as long as they can maintain full or substantial compliance with applicable hospital

---

[1] Mueller KJ, et al. "Lessons from tele-emergency: Improving care quality and health outcomes by expanding support for rural care systems." *Health Affairs* (2014), vol. 33 , no. 2. http://doi.org/10.1377/hlthaff.2013.1016 .

regulations. Operation of a tele-ED and OED have geographic eligibility requirements and tele-EDs have ED volume criteria for eligibility, as well. Please refer to the innovative model matrix or guidance documents for each model for details.

Q: Who will be staffing the physical locations of these emergency departments?

A: In OEDs and micro-hospitals, the emergency departments will be staffed with traditional compliments of physicians, APPs, and nurses. For the tele-ED model, the emergency department will be staffed on-site with APPs and nurses. In all cases, the medical and hospital staff at an OED, tele-ED or micro-hospital must be able to meet the needs of patient. For the specific staffing requirements in the emergency department for each model, please refer to the guidance documents.

Q: Which hospitals can implement a tele-ED?

A: Hospitals located in a rural area with 46.0 or less average daily emergency department visits over a two-year period can use the structured exception process to implement a tele-ED.

Q: Is an exception(s) needed to operate a tele-ED, OED, or micro-hospital?
A: An exception is generally not necessary to operate an OED or micro-hospital, though there could be unique situations for each hospital where an exception may be necessary to address a particular challenge. Please contact the DAAC Central Office if you have questions about whether an exception is needed for a particular flexibility.

An exception request is required to operate a tele-ED as the model is not contemplated in existing regulations. Eligible rural hospitals will complete an exception request form. Please consult the Department's website or DAAC's Central Office for additional information on the exceptions process.

Q: How does a 'structured' exception request differ from other exception requests?

A: A structured exception request is an option made available to similarly situated hospitals. Rather than each hospital submitting an individualized exception request and separately identifying varying factors on how they will operate more efficiently under the exception while preserving patient safety, hospitals that can demonstrate that they meet the eligibility criteria and can maintain the conditions determined by the Department will receive a written approval for the exception. Hospitals can continue to use the individual exception request process if they choose.

Q: Why are tele-EDs limited to rural areas?
A: The primary purpose of these innovative models is to preserve and increase access to high quality care in areas that may be medically underserved. Hospitals in rural areas have a harder time with recruiting and maintaining staff and supporting inpatient services than hospitals in urbanized areas, due to location and patient population and volume. These innovative models allow rural hospitals to overcome some of those challenges and maintain emergency care in rural communities.

Q: Can a hospital operate an OED as a tele-ED?
A: No. The Department's pre-established criteria for the operation of an OED includes a requirement that at least one physician trained in emergency services is on-site at all times. The hospital-based emergency department of the main hospital could seek an exception to operate as a tele-ED if it otherwise met the criteria in the guidance, but the option would not extend to the OED.

Q: Could the availability of OEDs reduce access to inpatient care if existing hospital campuses with inpatient care transition to the model?

A: It is possible there could be a reduction of inpatient care beds if hospital campuses transition to an OED model. However, in many instances, hospitals have to choose to close a campus or hospital entirely because there are not meaningful or sustainable alternatives. The purpose of the OED model is to provide an alternative to closure to hospitals that are facing those operational challenges and are unable to sustain inpatient services. According to the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, only about 12% of emergency department visits result in a hospital admission. That means that, on average, over 85% of the population seeking emergency care at the OED will be able to get the care they need on-site and be discharged home. For the patients requiring inpatient care, OED staff would stabilize the patient for transfer in accordance with state and federal law and have them transported to a location that can meet their needs. There will always be an acute care hospital within 35 miles of the OED and transfer policies in place to make sure there are no unnecessary delays in care.

Q: Why are OEDs no longer limited to rural areas?

A: The Department engaged with stakeholders, including members of the General Assembly, to further discuss criteria established for location of OEDs. As a result of those discussions and upon further consideration, OEDs are no longer limited to rural areas but cannot be located within 35 miles of an existing emergency department unless the OED is a critical access hospital or small rural hospital transitioning to an OED.

Q: If there is an existing emergency department in a community, can an OED be opened?

A: Generally, no. Under the criteria to operate an OED, a hospital would be prohibited from opening a new OED within 35 drive miles of an existing emergency department (this would include main licensed hospitals, campuses, and other OEDs) unless the new OED and the existing emergency department are under common legal ownership.

Q: If a critical access hospital or small rural hospital plans to transition to an OED, is a 35-mile catchment area required?

A: No, if a critical access hospital or small rural hospital plans to transition to an OED, a catchment area is not required.