

Vital Signs

MICRO-HOSPITALS: HOW FAST, HOW FAR?






CUSHMAN &
WAKEFIELD

Micro-hospitals represent another evolutionary step in consumer-direct healthcare delivery in the United States. With an estimated 60 micro-hospitals in the U.S., this is a relatively new type of asset that is distinct from both the small Critical Access Hospital (CAH) and Free-Standing Emergency Departments (FSED).

Cushman & Wakefield's analysis of the micro-hospital trend suggests that micro-hospitals will likely see significant growth, particularly in states like Texas that do not require a Certificate of Need. This type of asset may also represent a new delivery model for providing care in markets that cannot support a full-fledged short-term acute care hospital but require more substantial healthcare services than can be delivered in a Free-Standing Emergency Department including overnight patient stay.

How do these facilities stack up as real estate assets?

ASSET COMPARISON

			
NUMBER OF BEDS	No more than 25 beds	No overnight beds	Up to 50 beds; Average 8 to 12 beds
U.S. INVENTORY	1,346	566	60 (another 20+ planned or under construction)
LICENSURE	Fully licensed; facilities applying to become Critical Access Hospitals must be currently participating in the Medicare program and have a current license as an acute care hospital.	Varies by state; fully licensed as acute care hospitals in some states; licensed as community clinics or emergency centers in other states	Fully licensed; must be primarily engaged in inpatient care to qualify for Medicare payment accreditation
STAFFING REQUIREMENTS	Not required to have MD or DO on site 24/7.	Board Certified ER Physician must be onsite 24/7	Board Certified ER Physician must be onsite 24/7

THE TREND

Similar to many healthcare trends in the U.S., the roots of the micro-hospital movement are tied to treatment best practices and financial considerations. As large hospital systems started to put the brakes on traditional hospital development, the emergence of the free-standing EDs filled a gap in local service but without the ability to keep patients overnight in a traditional hospital setting. Micro-hospitals, also referred to as neighborhood hospitals, meet a need for patients requiring a short-term stay, generally no more than two days. Micro-hospitals are licensed hospitals but do not provide the full complement of services common in traditional short-term acute care settings such as operating rooms. Thus, providers can maintain the continuum of care without the investment of staff, money, or time required for a larger, full-service licensed hospital.

Micro-hospital construction costs typically fall in the \$10 to 25 million range – well below the costs associated with building even a 25-bed short-term acute care hospital. The smaller footprint as well as fewer specialized design needs (such as MRI for the imaging center and fully equipped dietary kitchens) allows for a faster construction timeline. Thus, for lower costs and less time, providers can add new access to quality care in their communities.

In contrast with Critical Access Hospitals, which by law must be located more than 35 miles from another hospital and generally serve a rural population, micro-hospitals populate urban and suburban markets. Often, micro-hospitals help to establish a suburban outpost for a local health system. Additionally, because of their remote locations, CAHs are not required to have an MD or DO physician on-site 24/7. However, micro-hospitals and FSEDs must have a board-certified ER physician on-site around the clock.

CURRENT LOCATIONS

Micro-hospitals are currently found in 19 states with a significant portion in Texas. Why Texas? According to the U.S. Census bureau's estimates, six of the top ten fastest growing counties in the United States are in Texas, with four in the Dallas Fort Worth (DFW) metro area. The dynamic growth of North Texas necessitated a greater number of healthcare facilities for the increase in covered lives. As a result, there has been significant interest within established systems (e.g., Baylor Scott & White Health) in this type of asset. And, importantly, Texas has no requirement for a Certificate of Need.

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A majority of micro-hospitals are new builds sited on strategically located parcels. Currently about one-half the micro-hospital inventory is health system-owned and operated, with the other half jointly owned with an operating partner. In a new twist, a Cleveland-based health system is repurposing existing urgent care and FSED locations into micro-hospitals, adding to their already robust outpatient offerings.

Micro-hospitals are viewed as traditional, acute-care hospitals and are required to meet the accreditation and regulatory requirements of such hospitals.

The health system or operator's market strategy also plays a role in the site selection process. According to Vic Schmerbeck, Executive Vice President of Business Development at Emerus, the nation's largest micro-hospital developer, an offensive strategy is designed to locate micro-hospitals in submarkets with strong or expected population growth but no short-term acute care hospital. Essentially, this strategy "plants a flag" in a given submarket and can help to anchor additional healthcare services to the community.

Conversely, there are defensive approaches to site selection, whereby the micro-hospitals are located near established short-term acute care hospitals or ambulatory care centers. In this case the micro-hospital is designed to reinforce barriers to entry in a given market, and protect and preserve existing market share for the provider.

Dignity Health recently demonstrated both approaches in Las Vegas. They have built micro-hospitals near their existing St. Rose Dominican hospitals in the southern region of the city, but also have sited a micro-hospital in a northern quadrant of the market, where they previously had no hospital presence.

LICENSURE

Micro-hospitals are viewed as traditional, acute-care hospitals and are required to meet the accreditation and regulatory requirements of such hospitals. CMS recently updated their Medicare reimbursement

guidelines, clarifying that a hospital must be "primarily engaged" in providing in-patient care in order to qualify for on-campus reimbursement levels, potentially leaving some micro-hospitals at risk. But unlike CAHs which are limited to no more than 25 beds, the bed count in a micro-hospital is not restricted.

Licensure requirements for FSEDs, on the other hand, vary from state to state. Some states require FSEDs to be fully licensed and tied to a fully licensed hospital. Some, not all, require ambulance reception. Other states, such as Colorado, define FSEDs as community emergency centers having a different set of licensure guidelines.

Of course, in any Certificate of Need state, all care delivery facilities must meet CON requirements before further licensures are granted.

CONCLUSION

Micro-hospitals are proving to be an opportunity for established healthcare systems to extend care delivery to either underserved or emerging growth markets within their service area at a cost that is competitive and operationally efficient. For this relatively new asset type, it is important to include a real estate service provider early. Location strategy, demographic analysis, land acquisition, and project management play critical roles in assuring both a successful micro-hospital strategy and alignment with the healthcare provider's other real estate assets and care delivery objectives.

Ultimately a decision to proceed with a micro-hospital project should support the overall mission and goals of the healthcare organization.



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