HEALTH CAPITAL Topics
Volume 11
Issue 8
August 2018
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The New Kid on the Block: The Competitive Advantage of Micro-Hospitals

As discussed in the second installment of this *Health Capital Topics* five-part series on micro-hospitals, while market barriers to micro-hospital development (in some states) include certificate of need (CON) regulations and restrictive state architectural requirements, the relatively lower capital required to finance a micro-hospital makes it an attractive opportunity for existing health systems to expand patient access and establish new footholds for their brand in an innovative and cost effective manner.[1] Micro-hospitals, a/k/a "*neighborhood hospitals*,"[2] are typically developed in smaller, faster-growing communities with higher median incomes per resident, and more robust commercial payor coverage.[3] These areas are generally not large enough to support a typical full-service hospital, but are located within 20 miles of a tertiary care center for efficient referral of higher acuity patients.[4] As micro-hospitals fill a theoretical niche market position between that of an urgent care facility, or *freestanding emergency department* (FSED), and a full-service hospital, while still providing a variety of efficient, high quality services appropriately scaled to facility size, they can offer a very competitive service model at lower costs, putting them in position to be some of the "*winners*" in the shift to *value-based reimbursement*.[5] This fourth installment of the five-part series on micro-hospitals will review how this new provider type has carved out a relevant role in the current healthcare delivery system and the future implications of this strategy.

As mentioned above, micro-hospitals occupy a unique position along the healthcare continuum, by being able to provide: urgent/emergent services, like that provided by urgent care centers and FSEDs; ambulatory care, similar to *ambulatory surgery centers* (ASC); and, acute inpatient care, such as that provided by community hospitals.[6] In addition, while micro-hospitals serve patients with acuity levels similar to those seen at community hospitals,[7] they typically do not handle serious trauma or emergent specialty cases, e.g., stroke, allowing them to scale back space requirements to remain financially competitive, e.g., by avoiding construction of large triage areas, trauma bays, and interventional suites.[8] Additionally, by virtue of being able to selectively focus their service lines, these facilities can choose to provide higher-revenue services that make them more financially competitive, e.g., orthopedic surgery. For example, one independent micro-hospital in the Pittsburgh area has constructed four operating rooms in which it will provide a variety of high-revenue surgical procedures at a discounted price (by one-third to 50%) compared to other local competitors.[9] This selective focus allows micro-hospitals to be nimble as well, evolving their services to effectively care for an aging population with changing health needs.[10] For those micro-hospitals affiliated with a larger hospital or health system, they may be able to further reduce cost outlays and increase efficiencies by leveraging ancillary or support services of partner hospitals, e.g., supply contracts, sterile processing.[11] In this way, micro-hospitals that operate on a "*hub-and-spoke*" concept within a larger system may be able to produce better revenue margins than the typical community hospital.

Micro-hospitals have also been shown (in limited analyses) to provide higher quality and more efficient care in selected performance and outcome metrics when compared to the average hospital.[12] When *Emerus* (the premier developer of micro-hospitals, as discussed in the first installment of this series[13]) compared its micro-hospitals to national hospital averages, it found that its micro-hospitals performed better in multiple outpatient and emergency room metrics, including: average time from door to diagnostic evaluation (11 minutes for Emerus micro-hospitals versus 28 minutes for national hospitals); average time from emergency room arrival to departure (182 minutes versus 296 minutes); and, unscheduled 72-hour emergency readmission rate (1.2% versus 15.6%).[14] With the growing transparency of quality and performance metrics for hospitals and providers, micro-hospitals may have a significant advantage if they can demonstrate a notable and continued performance edge over traditional hospitals using standard metrics.

Currently, micro-hospitals have been shown to be most successful in smaller communities that are more affluent, but not large enough to support a traditional hospital.[15] In a healthcare environment with expected physician shortages in coming years, as well as continued issues associated with lack of access to care, the micro-hospital concept could be successfully adapted to rural or medically underserved areas.[16] The micro-hospital's adaptability, in terms of affordable building costs, as well as flexibility in the types of services offered, may be a boon for investors that wish to take the micro-hospital concept and apply it to different communities with a recognized healthcare gap.

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As mentioned in prior series installments, micro-hospitals have shown to be beneficial to investors thus far, as they can draw higher hospital reimbursement rates and can focus on high-demand and high-revenue procedures and service lines, all while decreasing capital and overhead costs. While the micro-hospital currently occupies a unique position along the healthcare continuum, some may argue that it remains a competitive concept only because of its "*newness*" in the market. It remains to be seen how long these facilities can "*fly under the radar*" o.f government regulators before they may face increasing barriers, such as increased CON restrictions or decreasing reimbursement, similar to the FSEDs they may be currently outperforming.

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