

November 21, 2014

Ms. Courtney R. Avery, Administrator  
Illinois Health Facilities and Services Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield IL 62761

**RECEIVED**

**NOV 24 2014**

**HEALTH FACILITIES &  
SERVICES REVIEW BOARD**

Re: Project 14-040  
Clarifying Information

Dear Ms. Avery:

We look forward to again being before the Review Board at its December 16<sup>th</sup> meeting. Our project has extraordinary community support and is needed to improve local access to emergency medical services and enhance emergency care by retaining ambulance and first responders within the community during emergency situations as has been thoroughly attested to by EMS providers and patients.

Attached is clarifying information which is intended to assist the Review Board in its determination. We believe there are some misperceptions regarding our proposed FSEC and its intent. Hence, the focus of the information is to clarify both Board perceptions and the SAR noncompliance determinations.

Please do not consider this clarifying information as "additional information" in that we must appear before the Board in December in that the underlying FSEC legislation sunsets and we require a final Review Board determination by December 31, 2014. Please disregard the attachment if it delays our December appearance before the Board.

Please let me know if you have any questions. I can be reached at 608-365-5686 or by e-mail at [tmckevett@beloitmemorialhospital.org](mailto:tmckevett@beloitmemorialhospital.org).

Sincerely,



Timothy McKeve  
President & CEO

Attachment: Clarifying Information

Cc: Mike Constantino  
Ed Parkhurst

**At-Home Healthcare**  
1904 E. Huebbe Parkway  
Beloit, WI • (608) 363-5885

**Beloit Clinic**  
1905 E. Huebbe Parkway  
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**Clinton Clinic**  
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**Darien Clinic**  
300 N. Walworth Street  
Darien, WI • (262) 882-1151

**Janesville Clinic**  
1321 Creston Park  
Janesville, WI • (608) 757-1217

**NorthPointe Health &  
Wellness Campus**  
5605 E. Rockton Road  
Roscoe, IL • (815) 525-4000

**NorthPointe Terrace**  
5601 E. Rockton Road  
Roscoe, IL • (815) 525-4800

**Occupational Health Sports  
& Family Medicine Center**  
1650 Lee Lane  
Beloit, WI • (608) 362-0211

**Riverside Terrace**  
3055 S. Riverside Dr.  
Beloit, WI • (608) 365-7222

**West Side Clinic**  
1735 Madison Road  
Beloit, WI • (608) 363-7510

# Clarifying Information

Project Number 14-040

NorthPointe Free Standing Emergency Center (FSEC)

Roscoe, Illinois

Beloit Health System

Beloit, Wisconsin

November, 2014

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### Introduction / Purpose

This submission intends to clarify certain information contained in the underlying Permit Application, Project 14-040, the resulting State Agency Report (SAR), and the perspectives voiced by the Review Board at its November 12, 2014 meeting where the proposed FSEC project received an intent-to-deny.

The document's purpose is to clarify select issues and not provide new information for the administrative record and Review Board consideration at its December 16, 2014 meeting.

### Review Board Meeting

Several questions and/or perceptions were voiced at the Review Board meeting. The following intends to clarify the applicant's perspectives.

#### 1. Safety Net

Beloit Health System will continue to operate a NorthPointe FSEC as a satellite of Beloit Memorial Hospital's Emergency Department. As such, all patients who present themselves will be treated as is required by EMTALA legislation / regulations. The current ICC, which is proposed to be converted into an FSEC, reimbursement was comprised of 24.2% Medicaid and 3.9 % uninsured in its most recent operational year. Beloit has a charity care policy in place which will also govern FSEC operations.

#### 2. Ambulance Transfers

As an FSEC, the facility will be able to accept ambulance transports which are a very small percent ( $\pm 5\%$ ) of anticipated visits. Assuming a nominal range of 12 to 16 percent ambulance transports / visits to a hospital-based emergency department, emergency personnel are trained to triage patients in the field and transport patients to the most suitable emergency facility. An FSEC will be, and is required by Illinois law, by-passed by ambulances in certain patient acuity circumstances, like trauma, where an FSEC is an inappropriate care location. Ambulance transports to an FSEC account for a small portion of potential arrivals.

If a patient arrives by ambulance at an FSEC, they will be stabilized, treated, and discharged or transported by ambulance to the patient's hospital of choice if an admission is required. Such transfers are based on patient preference, not the preference of the provider (NorthPointe).

3. Charges

Current NorthPointe ICC charges approximate Beloit Memorial Hospital's Emergency Department charges. If approved, the FSEC will not have to significantly, if at all, increase charges for applicable services.

The project is not being contemplated to increase reimbursement, but to respond to community need as has been testified to.

4. Licensing

It has been implied the Beloit Health System is required to have an Illinois hospital license in order to establish an FSEC.

Beloit Memorial Hospital has provided documentation to the IHFSRB, including a legal opinion, establishing that an FSEC does not have to be owned or controlled by an Illinois licensed hospital, but simply by an Associate Hospital or Resource Hospital. Beloit is recognized as an Associate Hospital (by contract) by two Rockford-based Illinois hospitals to provide EMS-type services. This fact has been formally recognized by Review Board staff. The FSEC, if approved, would be subject to regulatory oversight as an entity licensed under the Illinois EMS Act, unlike the current NorthPointe ICC.

5. Pre-Planning Costs (Attachment 7)

The original submission misallocated a consulting contract fee to pre-planning costs. Please see the included correction. The intent is to clarify submitted information and not in any way modify the underlying CON permit application. If this proposed correction is not viewed as a clarification, please disregard the information.

Review Board Criterion and SAR Non-compliance

1. Service Accessibility (1110.3230(b) and Service Duplication (1110.3230(c))

The proposed FSEC project received two non-compliance determinations (1110.3230(b) and 1110.3230(c) based on the State Board benchmark of 2,000 average visits per emergency department station.

Project related testimony provided updated information indicating this long-standing average 2,000 visit / utilization guideline was not contemporary given various changes in emergency department utilization. Research indicates emergency department utilization varies considerably based on:

- Month of year
- Day of week
- Hour of day, and
- Daily / hourly severity of illness presented by patients seeking care.

Other variables, including the type of emergency department classification, have an impact on optimum utilization. Basic emergency departments tend to have higher visit utilization per station in that the relative severity of illness or acuity is lower so the patient time in department is lower. The more advanced trauma centers have lower utilization per station based on, in part, increased patient severity and increased diagnosis and the treatment time in an emergency department.

Using data from the Government Accounting Office, the National Center for Health Statistics, National Ambulatory Care Survey, National Emergency Department Survey, Centers for Disease Control, American Hospital Association, American Academy of Emergency Medicine (Benchmark) and various published research papers, one can model the need for emergency stations in a given market to test the 2,000 visit / station benchmark.

Based on these various sources, the local market has been conservatively modeled for Review Board consideration in order to clarify how the average 2,000 visits per station “fits” local market utilization.

Modeling Assumptions for Exhibit A (6 of 10)

1. Annual operations ... 24/7/365
2. Average patient hours / ED visit ... 3.2 hours (National Ambulatory Care Survey)
3. Assumed hours / ED visit (conservative) 3.0 hours (Rockford Market)
4. Visits to an ED varies by hour of day (see Exhibit A for hourly distribution visits through the day based on various studies)
5. "Peak" daily ED visits / utilization ... Noon to 7:00 PM daily (8 hours)
6. "Peak" 8-hour utilization period represents 45.3% of daily total visits (calculated)
7. Assumed ED station utilization of 80% during peak periods (based on Review Board surgery utilization standard / station turnover requirements – admission / discharge)
8. Rockford Hospital 2013 ED visits (Rockford Memorial, Swedish American, and OSF) were 147,061.
9. Average daily visits approximate 403 with a peak of 484 ( $\pm 20\%$  increase) to account for seasonal and daily variation ... this is considered a conservative visit level given the wide variation in ED utilization over a given period.

Discussion

Exhibit A models the above conservative research-based assumptions for emergency department (ED) utilization. The findings and observations are:

1. Peak ED utilization occurs between noon and 7:00 PM on a daily basis.
2. Peak census approximates 87 patients occupying an ED station. (The Rockford hospital market has 95 stations.)
3. Assuming an 80% ED station utilization factor at peak census, the market need is for 109 ED stations or a deficit of 14 stations in the Rockford market.
4. Current average ED utilization for the Rockford hospitals is an 1,548 average visits / station annually.

5. Assuming 109 Emergency Department stations are required to accommodate a conservative average daily visit / census utilization peak, the average annual calculated utilization is 1,349 visits / station which is below the State Board 2,000 visit criteria.

### Conclusion

Based on this conservative modeling approach, the contemporary range of the ED station utilization, as testified, appears to be valid (between 1,300 and 1,700 visits per station annually). In addition, those first responders who have testified as having experience with the Rockford ED's are supported by this macro modeling analysis in their assertions that access to ED care is compromised and there are long wait times in the Rockford hospital emergency departments.

Although the 2,000 visit per ED station is the Review Board's benchmark, the model indicates a lower standard can be considered valid.

### 2. Pre-Planning Costs (1120.140(c) (Attachment 7))

The original permit application submission misallocated \$13,000 of clinical related consulting fees to the pre-planning category and not the consulting category. Attached are pages which correct this error. If this correction is considered a "permit modification", please disregard.

Exhibit A  
 NorthPointe FSEC

<u>Time of Day</u>	<u>Percent Visit Distribution</u>	<u>Average Hourly Visits (N = 485)</u>	<u>Cummulative Daily Visits</u>	<u>Discharges Based on 3.0 hour ALOS</u>	<u>Estimated Average Census</u>	<u>Required ED Stations @ 80 % Occupancy</u>
Midnight						
1:00 AM	1.8	9	9	--	--	--
2:00 AM	2.2	11	20	--	--	--
3:00 AM	2.7	13	33	--	--	--
4:00 AM	1.6	8	41	9	32	40
5:00 AM	1.6	8	49	20	29	37
6:00 AM	1.6	8	57	33	24	30
7:00 AM	1.6	8	65	41	24	30
8:00 AM	2.7	13	78	49	29	37
9:00 AM	3.2	16	94	57	37	47
10:00 AM	4.9	24	118	65	53	67
11:00 AM	5.4	26	144	78	66	83
Noon	6.5	32	176	94	82	103
1:00 PM	5.9	29	205	118	87	109
2:00 PM	5.4	26	231	144	87	109
3:00 PM	5.4	26	257	176	81	102
4:00 PM	5.4	26	283	205	78	98
5:00 PM	5.4	26	309	231	78	98
6:00 PM	5.9	29	338	257	81	102
7:00 PM	5.4	45.3%	364	283	81	102
8:00 PM	5.9	29	393	309	84	105
9:00 PM	5.4	26	419	338	81	102
10:00 PM	5.9	29	448	364	84	105
11:00 PM	4.9	24	472	393	79	99
Midnight	3.8	19	491 *	419	72	90
Total	100.5%	491 *	--	--	--	--

\* (1.4% over average daily peak census due to rounding)

This exhibit models the peak need for Emergency Department stations for the three Rockford hospitals utilizing 2013 AHQ ED visits (147,061) with an average daily peak visits approximating 484 (491 due to rounding). The distribution of visits throughout the day are based on published American Hospital Association (AHA) data and related studies. The average ALOS data is predicated on National Hospital Ambulatory Care survey data, 2011 Emergency Department survey tables.

**Project Costs and Sources of Funds**

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$18,000	\$7,000	\$25,000
Site Survey and Soil Investigation	2,500	2,500	5,000
Site Preparation	--	2,100	2,100
Off Site Work	--	72,191	72,191
New Construction Contracts (Bldg. Only)	--	--	0
Modernization Contracts	219,657	649,404	869,061
Contingencies	21,966	64,940	86,906
Architectural/Engineering Fees	23,920	70,720	94,640
Consulting and Other Fees	40,000	17,500	57,500
Movable or Other Equipment (not in construction contracts)	205,000	--	205,000
Bond Issuance Expense (project related)	--	--	--
Net Interest Expense During Construction (project related)	--	--	--
Fair Market Value of Leased Space or Equipment	--	--	--
Other Costs To Be Capitalized	12,500	12,500	25,000
Acquisition of Building or Other Property (excluding land)	--	--	--
<b>TOTAL USES OF FUNDS</b>	<b>\$543,543</b>	<b>\$898,855</b>	<b>\$1,442,398</b>
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$543,543	\$898,855	\$1,442,398
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$543,543</b>	<b>\$898,855</b>	<b>\$1,442,398</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Note: See Attachment 7, Project Costs and Services, Itemization / Allocation for detail.**

See also Attachment 7, Exhibits 1 and 2 for construction cost related information.

Attachment 7  
 Project Costs and Services  
 Itemization / Allocation

<u>Preplanning</u>	Clinical	Non Clinical	Total
Code / Facility Review	\$ 5,000	\$ 5,000	\$ 10,000
Utilization Analysis	<u>13,000</u>	<u>2,000</u>	<u>15,000</u>
Total	\$ 18,000	\$ 7,000	\$ 25,000
 <u>Site Survey / Soils</u>	 \$ 2,500	 \$ 2,500	 \$ 5,000
 <u>Off-Site Work</u>			
Helistop	--	\$ 68,314	\$ 68,314
Ambulance Pad	--	2,096	2,096
Sidewalks	--	<u>1,781</u>	<u>1,781</u>
Total	--	\$ 72,191	\$ 72,191
 <u>Moveable Equipment</u>			
Omni Cell	\$100,000	--	\$100,000
Glidescope	25,000	--	25,000
EMS Radio	25,000	--	25,000
Peds Crash Cart	7,500	--	7,500
Airway Cart	7,500	--	7,500
Instruments	20,000	--	20,000
Call Light	<u>20,000</u>	--	<u>20,000</u>
Total	\$205,000	--	\$205,000
 <u>Other Costs to be Capitalized</u>			
Permit Development	\$ 10,500	\$ 10,500	\$ 21,000
CON Processing Fee (estimated)	<u>2,000</u>	<u>2,000</u>	<u>4,000</u>
Total	\$ 12,500	\$ 12,500	\$ 25,000

**Project Costs and Sources of Funds**

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$5,000	\$5,000	\$10,000
Site Survey and Soil Investigation	2,500	2,500	5,000
Site Preparation	--	2,100	2,100
Off Site Work	--	72,191	72,191
New Construction Contracts (Bldg. Only)	--	--	0
Modernization Contracts	219,657	649,404	869,061
Contingencies	21,966	64,940	86,906
Architectural/Engineering Fees	23,920	70,720	94,640
Consulting and Other Fees	53,000	19,500	72,500
Movable or Other Equipment (not in construction contracts)	205,000	--	205,000
Bond Issuance Expense (project related)	--	--	--
Net Interest Expense During Construction (project related)	--	--	--
Fair Market Value of Leased Space or Equipment	--	--	--
Other Costs To Be Capitalized	12,500	12,500	25,000
Acquisition of Building or Other Property (excluding land)	--	--	--
<b>TOTAL USES OF FUNDS</b>	<b>\$543,543</b>	<b>\$898,855</b>	<b>\$1,442,398</b>
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Cash and Securities	\$543,543	\$898,855	\$1,442,398
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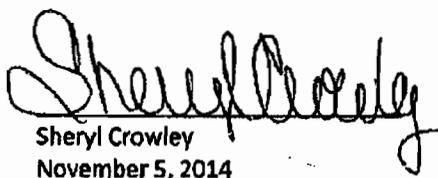
Attachment 7  
 Project Costs and Services  
 Itemization / Allocation

<u>Preplanning</u>	Clinical	Non Clinical	Total
Code / Facility Review *	\$ 5,000	\$ 5,000	\$ 10,000
Utilization Analysis **	<u>00</u>	<u>00</u>	<u>00</u>
Total	\$ 5,000	\$ 5,000	\$ 10,000
<u>Site Survey / Soils</u>	\$ 2,500	\$ 2,500	\$ 5,000
<u>Off-Site Work</u>			
Helistop	--	\$ 68,314	\$ 68,314
Ambulance Pad	--	2,096	2,096
Sidewalks	--	<u>1,781</u>	<u>1,781</u>
Total	--	\$ 72,191	\$ 72,191
<u>Moveable Equipment</u>			
Omni Cell	\$100,000	--	\$100,000
Glidescope	25,000	--	25,000
EMS Radio	25,000	--	25,000
Peds Crash Cart	7,500	--	7,500
Airway Cart	7,500	--	7,500
Instruments	20,000	--	20,000
Call Light	<u>20,000</u>	--	<u>20,000</u>
Total	\$205,000	--	\$205,000
<u>Other Costs to be Capitalized</u>			
Permit Development	\$ 10,500	\$ 10,500	\$ 21,000
CON Processing Fee (estimated)	<u>2,000</u>	<u>2,000</u>	<u>4,000</u>
Total	\$ 12,500	\$ 12,500	\$ 25,000

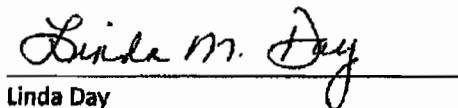
\* Preplanning costs associated with facility review / modification to meet Illinois FSEC licensing requirements.

\*\* Original costs re-categorized and reallocated to consulting and other fees. This cost was associated with consulting fees expended to analyze market demand for FSEC services during the CON preparation.

I am unable to attend this Hearing for NorthPointe for the free standing emergency treatment center. I am giving permission for the Village Clerk, Chris Marks, to read her statement regarding my recent medical emergency experience. I wish I could be here to personally share that experience with you.

  
Sheryl Crowley  
November 5, 2014

Notarized by:

  
Linda Day





www.atsambulance.com



November 11, 2014

To whom it may concern,

I would like to introduce myself. My name is Andy Schultz CEO/Founder of ATS Medical Services, Inc. We are a private ambulance provider located in Loves Park, IL. Our company also provides paramedic staffing for several Fire Protection Districts in the Northern Illinois area. I have been working in EMS as an EMT/Paramedic in the state of Illinois for 28 years. I started ATS in 2005 with the vision of improving the pre-hospital services for the community. I feel anyone associated with healthcare has an obligation to provide the service that is in the best interest of the community and patient. With that being said I want to show my support for the approval of NorthPointe immediate care to receive the CON as a Free Standing Emergency Center (FSEC).

I feel the most important need for this FSEC is to support the EMS providers in the surrounding communities. When Roscoe, Rockton and South Beloit have an ambulance transport they will typically transport these patients to one of the 3 Rockford hospitals or Beloit Memorial Hospital. Either of these facilities are equally 15 minutes further of driving, depending on the traffic. The ability to transport a patient in less than half the time will allow these EMS providers to return to service in their community much quicker.

I feel it's important to mention that frequently the 3 hospitals in Rockford have very busy emergency departments and when transporting an ambulance patient to them, you may have to wait in the hallway with this patient on your stretcher till a room becomes available. This may be 30 plus minutes sometimes. This only keeps that ambulance out of service even longer, leaving their community uncovered for medical response.

Sincerely,

Andrew T. Schultz, CCEMTP, NREMT-P

CEO/Owner ATS Medical Services, Inc.

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Ph 815.963.6885 Fax 815.639.9521

Dispatch  
215.963.5001

6050 Churchman Bypass, Indianapolis, IN 46203  
Ph 317.542.1111 Fax 815.639.9521

11/11/14

I believe that the State of Illinois should allow Northpoint to become a freestanding emergency care center.

It is my understanding that the State of Illinois uses a ratio of one ED bed for every 2000 annual ED patient visits to determine the number of ED beds needed in a particular area. At one point, that number may have been accurate. However, much has changed regarding the delivery of emergency medical care since that ratio was established.

Consider the following:

- Emergency visits across the country are increasing at twice the rate of the United States population (1).
- Two thirds of these ED visits occur during non-business hours (2).
- In the past decade, emergency department wait times have increased 30% (2).
- Most modern emergency departments now average 1350 to 1750 visits per ED bed, and the lower numbers are believed to be better for patient care. (3)

Therefore, the formula that is currently used underestimates the actual need for ED beds in the area, and should not be used as the sole determining factor for granting or denying this petition.

Roscoe/Rockton and the surrounding area will benefit by allowing Northpoint to function as a freestanding emergency center. It will allow the current EMS, Police, and Sheriff's organizations to better serve their communities by spending less time out of their local service area. It will offer some peace of mind to the citizens of the Roscoe/Rockton communities, and may lead to increased local population and economic growth, as having 24/7/365 access to high quality emergency care is a highly desirable attribute to any community.

Sincerely,



Shawn P. Wilson, MD

- References:
1. Institute of Medicine report, 2006  
<http://iom.edu/Reports/2006/Hospital-Based-Emergency-Care-At-the-Breaking-Point.aspx>
  2. National Hospital Ambulatory Medical Care Survey: 2010  
[http://www.cdc.gov/nchs/data/ahcd/nhamcs\\_emergency/2010\\_ed\\_web\\_tables.pdf](http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf)
  3. The Emergency Department Benchmarking Alliance.  
<http://www.EDBenchmarking.org>



**Ms. Courtney Avery, Administrator**  
**Illinois Health Facilities and Services Review Board-2nd Floor**  
**525 West Jefferson Street**  
**Springfield, Illinois 62761**

11/11/14

Ms Avery,

Unfortunately, due to prior academic commitments, I cannot attend the Rochelle IL meeting on November 12. I would like to submit this letter to convey my opinions supporting the establishment of a 24-hour freestanding emergency department at the BMH Northpointe facility.

As a bit of background ,I am residency trained ,board-certified emergency physician who has lived in northern Boone County Illinois ( approximately 6 miles from the Northpointe facility) for over 20 years. I have worked at 2 of the 3 emergency departments in Rockford Illinois as well as several area community hospitals. I have been medical director for both northern Illinois and southern Wisconsin EMS agencies. I am a clinical associate professor of emergency medicine at the University of Wisconsin as well as Chief flight physician for UW Health Med Flight.

As a result of the above I have a very good insight/understanding of the medical economics and politics of the Winnebago/Boone county region

Winnebago and Boone counties have a combined population of approximately 300,000. There are 3 large tertiary medical centers in the city of Rockford (all within a few miles of each other) with 24 hr emergency care services. There is also a 24 hr freestanding ED in Belvidere. If logically distributed, these 4 facilities would be able to provide adequate emergency care for region. Unfortunately all 4 are concentrated in a small area of the southern 1/3<sup>rd</sup> of the region. Anyone living in the northern 2/3<sup>rd</sup>s of Boone or Winnebago county has a significant drive to any 24 hour emergency care facility.

The "golden hour" of trauma is a medical urban legend which has never been supported by medical research. Some patients have 10 minutes, some patients have 6 hours –



there is nothing magic about an hour when it comes to trauma. Anyone who uses this sound byte is either trying to sell ambulances or market trauma services.

However, there are medical conditions which absolutely require emergent diagnosis and treatment. Sudden cardiac arrest, cardiac arrhythmias, acute MI, sepsis, stroke, airway obstruction/compromise – the delay of even 5 minutes to treatment can result in a significant increase in morbidity and/or mortality. Some areas of northern Boone/Winnebago county have a 35-40 minute ground transport time to emergency care. Also complicating the picture is the fact that all 3 Rockford hospitals are trauma centers and each receive their fair share of local and regional trauma. I do know from years of experience that patient flow through any emergency department often comes to a screaming halt when severely injured trauma patients arrive. This results in an increase in waiting time for the rest of the patients. Depending on the trauma volume and ED staffing, this wait can be hours.

Approximately 2 months ago I received a call from a neighbor and family friend because her 80-year-old husband had passed out in the bathroom. When I arrived to the house he was alert but had fever and chills. He had had a long history of urinary tract infections and felt that this was the case. Local EMS arrived within 10 minutes. They found him to have a temperature of 102 with a low blood pressure. He was transported to one of the Rockford area hospitals which is also a trauma center. The trip took almost 25 minutes. On arrival there he was taken to one of the ED rooms but not seen by a nurse for close to 10 minutes. She was apologetic stating that the staff was busy caring for several critical trauma patients. It was another 20 minutes before he was seen by a physician. Laboratory tests were ordered. It was almost 90 minutes before this elderly patient with obvious urosepsis received antibiotics and IV fluids. This is not even close to an acceptable treatment time for sepsis. He was subsequently admitted to the ICU but the significant delay definitive treatment no doubt had a negative impact on my neighbors recovery. If 24 hour care would have been available at Northpointe (10 minute transport time), he would have easily received treatment at least 90 minutes earlier. I realize this is a single example, but again from my 20+ year with the Rockford area emergency departments –it is a common scenario.

There is a large area of northern Boone and Winnebago counties which has a void when it comes to 24/7 emergency care. The population of this area is at an inherent disadvantage/risk because their lengthy transport time to the Rockford area EDs. There is also the issue of frequent prolonged wait times at these trauma centers/EDs. The establishment of a 24 hr, free standing emergency department in northern Winnebago



University of Wisconsin  
SCHOOL OF MEDICINE  
AND PUBLIC HEALTH

Department of Emergency Medicine

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county would, without a doubt, provide life saving, rapid access to emergency care for this underserved population.

If you any further questions for me regarding this very important health care access issue, feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "M Abernethy".

Michael Abernethy, MD FAAEM  
Clinical Professor of Emergency Medicine

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