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AMERICAN ACADEMY OF PEDIATRICS
Committee on Pediatric Emergency Medicine

POLICY STATEMENT
Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Pediatric Care Recommendations for Freestanding Urgent Care Facilities

ABSTRACT

Treatment of children at freestanding urgent care facilities has become commonplace in pediatric healthcare. Well-managed freestanding urgent care facilities can improve the health of the children of their communities, integrate into the medical community, and provide a safe, effective adjunct, but not a replacement, to the medical home. We provide several recommendations for optimizing freestanding urgent care facilities' quality, communication, and collaboration in caring for children.

INTRODUCTION

Urgent care for children, as a segment of the current health-care industry, continues to grow in number, variety, and scope. The Urgent Care Association of America estimates that there are over 8,700 urgent care facilities providing over 150 million adult and pediatric visits annually in the United States.¹ The descriptors "urgent care" and "urgent care facility (or center)" have been used in a variety of ways, including after-hours or sick visits provided in a primary-care office or clinic, and hospital-based acute care provided in a non-emergency department setting. This

26 policy statement addresses acute care provided to sick or injured children in a freestanding
27 setting specifically designated for that purpose, and does not address hospital-based urgent care
28 facilities, hospital-based or freestanding emergency departments, or retail-based clinics.²

29

30 **BACKGROUND**

31 Urgent care typically focuses on providing acute visits for mildly or moderately sick or injured
32 patients, with an emphasis on rapid service and low cost. Freestanding urgent care facilities
33 typically provide unscheduled visits, but may also allow patients and families to make an
34 appointment. Business models include individual businesses, franchises, affiliates of a specific
35 health insurer, or subsidiaries of a hospital, among others. Facilities operating as part of a
36 hospital system will likely fall within that larger administrative structure, and include shared
37 computerized imaging, lab facilities, medical records, and other resources. The large majority of
38 urgent care facilities have at least one physician on staff.³ Plain radiography, suturing of
39 uncomplicated lacerations, and simple lab tests are typically offered. Some provide such non-
40 acute services as flu shots and pre-participation sports physical exams. One of the principal
41 challenges of urgent care is maintaining an appropriate and pre-determined scope of practice, as
42 it is common for patients with true emergencies to seek care at urgent care facilities; this
43 confusion is likely exacerbated by varying definitions of urgent care. Regulation of freestanding
44 urgent care centers varies greatly amongst the various states, ranging from little oversight to
45 actual prohibition of the term “urgent care” except by emergency centers.⁴ Patient screening and
46 other requirements of the Emergency Medical Treatment and Labor Act (EMTALA) may apply
47 to hospital-owned freestanding urgent care facilities if the center is licensed as an emergency
48 department, if it is advertised as providing care for emergency medical conditions on an urgent

49 basis, or if at least one-third of their outpatient visits are for treatment of emergency medical
50 conditions on an urgent basis without requiring a previously scheduled appointment;⁵ this would
51 require the Centers for Medicare & Medicaid Services to (retrospectively) rule that an urgent
52 care facility was a “dedicated emergency department” and remains controversial.^{5,6}

53

54 Despite the growth in pediatric urgent care, there is little existing literature beyond professional
55 policy statements and industry whitepapers on the subject. Research on the nature, scope,
56 quality, and outcomes is scanty^{3,7,8} and should be an important area of focus for future health
57 service researchers. As the role of freestanding urgent care facilities in pediatric care evolves, it
58 is important that they maintain the highest standards.

59

60 **RECOMMENDATIONS**

61 **Emergency Preparedness:**

62 Administrators at freestanding urgent care facilities serving children should ensure that their staff
63 is capable of providing timely assessment, early resuscitation and stabilization, and any
64 necessary transfer, of pediatric patients. This includes children with medical, traumatic, and
65 behavioral emergencies. Staff of freestanding urgent care facilities should have the training,
66 experience, and skills necessary to initiate pediatric life support during all hours of operation.
67 Simulation / mock codes, with scenarios that are complete from patient presentation to departure,
68 are often an important component of pediatric emergency preparedness. Triage, transfer, and
69 transport agreements should be prearranged with definitive care facilities that are capable of
70 providing the appropriate level of care based on the acuity of illness or injury of the child. Local
71 emergency medical services providers should be familiarized with the facility’s physical plant

72 and emergency plans. Programs to monitor and improve the quality of care for children with
73 emergencies should be in place. Although written for the primary care provider, the AAP policy
74 statement “Preparation for emergencies in the offices of pediatricians and pediatric primary care
75 providers” offers excellent guidance for preparation, recognition and response to children
76 requiring emergency care in the urgent care facility setting.⁹

77

78 **Scope of care:**

79 Freestanding urgent care facilities must give careful thought and planning to the scope of care
80 that they can and should provide to pediatric patients. This includes evidence-based, patient- and
81 family-centered, pre-determined approaches to common pediatric complaints, including fever,
82 asthma exacerbations, lacerations, gastrointestinal complaints, potential fractures and other
83 musculoskeletal injuries, as well as principles guiding the evaluation and management of other
84 complaints. Guidance regarding conditions that are / are not appropriate to the facility should be
85 readily available to parents and referring physicians. The timing and availability of child-
86 appropriate equipment, on-site and off-site lab testing, and imaging must be taken into
87 consideration. Planning should include pre-determined limits on care and pre-determined
88 systems for handovers of care, either when limits of available care are reached or the facility is
89 closing.

90

91 Facilities must have pre-determined plans for addressing requests for patient care, including
92 those involving children with emergency medical conditions, that occur before or after usual
93 hours of operation, including when staff members are physically present. Signage and directions

94 to nearby emergency facilities can be especially helpful to those seeking care when no facility
95 staff are present.

96

97 **The medical home:**

98 Urgent care facilities should complement and support the medical home model,¹⁰ providing
99 some services not routinely available in the medical home and providing an alternative for acute
100 care should the medical home be unavailable. They should not routinely provide continuity care
101 to children and should avoid appearing to replace the primary care provider. Urgent care
102 facilities should collaborate with primary care providers as referral centers for patients with acute
103 health concerns. Referring providers should provide to the freestanding urgent care facility
104 necessary clinical information and be available to provide consultation and context for their
105 patients' management. Whether a patient is referred or not, appropriate records should be kept.
106 Communication with the medical home regarding all aspects of the urgent care visit should be
107 prompt and seamless, to ensure appropriate continuity of care. Providers who refer children to a
108 freestanding urgent care facility should verify adherence to these recommendations with the
109 facility's leadership, and should expect high quality care for their patients.

110

111 **Staffing:**

112 Freestanding urgent care facilities serving children must be staffed by providers and staff with
113 the training and experience to manage children who are seeking urgent care, and to appropriately
114 initially manage and transfer children who may be seeking emergency care from the urgent care
115 setting. Educational opportunities directed at clinicians or administrators providing urgent care
116 for children are needed. Mid-level practitioners should have meaningful oversight by

117 appropriate physicians; even when not legally required, the opportunity for mid-level
118 practitioners to collaborate with a consulting physician is desirable. A clinician-manager
119 empowered to address off-hours questions regarding imaging, lab tests, prescriptions, etc.,
120 should be available at all times.

121

122 **Participation in systems of care:**

123 Freestanding urgent care facilities have become an important facet of pediatric care in many
124 communities. As such, they should participate in community systems of care. Area health
125 departments, medical societies, and other professional groups provide appropriate lines of
126 communication and avenues for this participation. Facility-specific disaster preparedness
127 preparations should be in place. In addition, urgent care facilities may be important participants
128 in local and regional disaster plans, through such avenues as providing syndromic surveillance to
129 assist in identification of disasters and epidemics, providing aspects of pediatric primary care
130 when disaster disrupts the medical home, and distribution of countermeasures and patient
131 education in the case of actual or potential outbreaks.

132

133 Urgent care facilities should have pre-arranged transfer arrangements with area hospitals capable
134 of providing pediatric or adult emergency care, as necessary. Providers should be able to
135 distinguish, ideally via pre-determined criteria, which patients require emergency ambulance
136 transfers, which require non-emergency ambulance-based transfers, and which may be
137 transferred by other means, such as private vehicle. Planned coordination with local Emergency
138 Medical Services is essential. Appropriate reimbursement should be available to both facilities

139 when a patient is transferred from a medical home to an urgent care center, or from an urgent
140 care center to an emergency department or other facility.

141

142 Medical professionals providing oversight to freestanding urgent care facilities serving children
143 should regularly review facility adherence to this policy statement.

144

145 **CONCLUSIONS**

146 The number of children being treated at freestanding urgent care facilities is large and growing.¹
147 Well-managed freestanding urgent care facilities can improve the health of the children of their
148 communities, be integrated into the medical community, and provide a safe, effective adjunct,
149 but not a replacement, to the medical home. Consistent oversight, planning, and quality are
150 crucial. There remains a great need for research on the role of urgent care in pediatrics.

151 Educational opportunities at the student, resident, fellow, or continuing education level involving
152 pediatric urgent care are minimal and should be developed, as more and more pediatricians and
153 other health care providers are employed by, provide oversight to, or work collaboratively with,
154 urgent care facilities.

155

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