POLICY STATEMENT

Pediatric Care Recommendations for Freestanding Urgent Care Facilities

abstract

FREE

Treatment of children at freestanding urgent care facilities has become common in pediatric health care. Well-managed freestanding urgent care facilities can improve the health of the children in their communities, integrate into the medical community, and provide a safe, effective adjunct to, but not a replacement for, the medical home or emergency department. Recommendations are provided for optimizing freestanding urgent care facilities' quality, communication, and collaboration in caring for children. *Pediatrics* 2014;133:950–953

COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE

KEY WORDS

pediatrics, urgent care, medical home, emergency care, health services

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

www.pediatrics.org/cgi/doi/10.1542/peds.2014-0569

doi:10.1542/peds.2014-0569

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2014 by the American Academy of Pediatrics

INTRODUCTION

Urgent care for children, as a segment of the current health care industry, continues to grow in number of facilities, variety, and scope. The Urgent Care Association of America estimates that there are 4500 urgent care facilities (private communication, Urgent Care Association of America, 2013) at which more than 150 million adult and pediatric visits occur annually in the United States.[1] The descriptors "urgent care" and "urgent care facility (or center)" have been used in a variety of ways, from describing after-hours or sick visits provided in a primary care office or clinic to the provision of hospital-based acute care in a non–emergency department setting. This policy statement addresses acute care provided to sick or injured children in a freestanding setting specifically designated for that purpose and does not address hospital-based urgent care facilities, hospital-based or freestanding emergency departments, or retail-based clinics.[2]

BACKGROUND

Urgent care typically focuses on providing acute assessment and management of mildly or moderately sick or injured patients, with an emphasis on rapid service and low cost. Freestanding urgent care facilities typically provide unscheduled visits but may also allow patients and families to make an appointment. Business models include individual businesses, franchises, affiliates of a specific health insurer, or subsidiaries of a hospital, among others. Facilities operating as part of a hospital system will probably fall within that larger administrative structure and include shared computerized imaging, laboratory facilities, medical records, and other resources. Most urgent care facilities have at least 1 physician on staff.[3] Plain

Downloaded from www.aappublications.org/news by guest on February 18, 2019

radiography, suturing of uncomplicated lacerations, splinting of uncomplicated musculoskeletal injuries, and simple laboratory tests are typically offered. Some provide such nonacute services as immunizations and preparticipation sports physical examinations. One of the principal challenges of urgent care is maintaining an appropriate and predetermined scope of practice, because patients with true emergencies may seek care at urgent care facilities; this confusion is probably exacerbated by varying definitions of urgent care. Regulation of freestanding urgent care centers varies greatly between the states, ranging from little oversight to actual prohibition of the use of the term "urgent care" except by emergency centers.[4] Screening of all patients for emergency medical conditions and other requirements of the Emergency Medical Treatment and Labor Act apply to hospital-owned freestanding urgent care facilities if either the center is licensed as an emergency department, it is advertised as providing care for emergency medical conditions on an urgent basis, or at least one-third of its outpatient visits are for treatment of emergency medical conditions, as judged by the Centers for Medicare and Medicaid Services, on an urgent basis without a previously scheduled appointment.[5,6]

RECOMMENDATIONS

As the role of freestanding urgent care facilities in pediatric care evolves, it is important that they maintain the highest standards of care. Despite the growth in pediatric urgent care, there is little existing literature beyond professional policy statements and industry white papers on the subject. Research on the nature, scope, quality, and outcomes of pediatric urgent care is scant.[3,7,8] With these limitations, the recommendations here represent expert consensus by leaders in pediatric emergency medicine and related fields. Given its growing importance, a better understanding of pediatric urgent care should be an important focus for health service researchers.

Emergency Preparedness

Freestanding urgent care facilities serving children should be capable of providing timely assessment, initial resuscitation, and stabilization and be able to initiate transfer of pediatric patients who need a higher level of care. This includes children with medical, traumatic, and behavioral or mental health emergencies. Staff members at freestanding urgent care facilities should have the training, experience, and skills necessary to initiate pediatric life support during all hours of operation. Simulation or mock codes, with scenarios that are complete from patient presentation to departure, are often an important component of pediatric emergency preparedness. Triage, transfer, and transport agreements should be prearranged with definitive care facilities that are capable of providing the appropriate level of care based on the acuity of illness or injury of the child. Local emergency medical services providers should be familiar with the facility's physical plant and should familiarize urgent care facility staff with their pediatric capabilities. Programs to monitor and improve the quality of care for children with emergencies should be in place. Although written for the primary care provider, the American Academy of Pediatrics policy statement "Preparation for Emergencies in the Offices of Pediatricians and Pediatric Primary Care Providers" offers excellent guidance for preparation, recognition, and response to children needing emergency care in the urgent care facility setting.[9]

Scope of Care

Freestanding urgent care facility operators must give careful thought and planning to the scope of care that they can and should provide to pediatric patients. This includes evidence-based, patient- and family-centered, predetermined approaches to common pediatric complaints, including fever, asthma exacerbations, lacerations, gastrointestinal tract complaints, potential fractures, and other musculoskeletal injuries. Principles guiding the extent of evaluation and management of other complaints should be established. Urgent care facilities should be capable of managing children with special needs. Recognition and management of child abuse or neglect and other aspects of interpersonal violence should be addressed. Guidance regarding conditions that are or are not appropriate to the facility should be readily available to the public, including parents, referring physicians, and other referral sources, such as triage nurse telephone services. This should include guidance on when even a common pediatric complaint is too severe to be appropriate for urgent care, such as injuries or illnesses that may warrant hospitalization, advanced imaging, or invasive procedures. The timing and availability of child-appropriate equipment, on-site and off-site laboratory testing, and imaging must be taken into consideration. Planning should include setting limits on the intensity and scope of care and predetermined systems for handovers of care when those limits are reached or the facility is closing.

Facilities must have predetermined plans for addressing requests for patient care, including those involving children with emergency medical conditions, occurring before or after usual hours of operation, including when staff members are physically

Downloaded from www.aappublications.org/news by guest on February 18, 2019

present. Signage and directions to nearby emergency facilities can be especially helpful to those seeking care when no facility staff are present.

The Medical Home

Urgent care facilities should complement and support the medical home model,[10] providing some services not routinely available in the medical home and providing an alternative for acute care should the medical home be unavailable. They should not routinely provide continuity care to children and should avoid appearing as a replacement for the primary care provider. Urgent care facilities should collaborate with primary care providers as referral centers for patients with acute health concerns. Referring providers should provide necessary clinical information to the freestanding urgent care facility and be available to provide consultation and context for their patients' management. Whether a patient is referred or not, appropriate records should be kept. Communication with the medical home should be prompt and seamless. Medical homes must provide easily accessed channels for this communication. Providers who refer children to a freestanding urgent care facility should verify adherence to these recommendations with the facility's leadership and should expect high-quality care for their patients.

Staffing

Freestanding urgent care facilities serving children must be staffed by providers and staff with the training and experience to manage children who are seeking urgent care and to initially assess and manage, resuscitate if needed, and transfer children who are seeking emergency care from the urgent care setting. Educational opportunities directed at clinicians or administrators providing urgent care for children are needed. Nonphysician providers should have meaningful oversight by appropriate physicians; even when not legally required, collaboration with a qualified physician is desirable. A clinician–manager empowered to address off-hours questions about imaging, laboratory tests, prescriptions, and the like should be designated.

Participation in Systems of Care

Freestanding urgent care facilities provide service that can enhance pediatric care in many communities. Therefore, they should be an integral part of community systems of care. Area health departments, medical societies, and other professional groups should provide appropriate lines of communication and avenues for this participation. Facility-specific disaster preparedness preparations should be in place. In addition, urgent care facilities may be important participants in local and regional disaster plans by providing syndromic surveillance to assist in identification of disasters and epidemics, pediatric primary care services when disaster disrupts the medical home, and countermeasures and patient education in the case of actual or potential outbreaks.

Urgent care facilities should have transfer arrangements with area hospitals capable of providing pediatric or adult emergency care as necessary. Providers should be able to distinguish, ideally via predetermined criteria and in conjunction with families, which patients need emergency ambulance transfers, which need nonemergency ambulance-based transfers, and which may be transferred by other means, such as private vehicle. Planned coordination with local emergency medical services is essential. Appropriate payment should be made to both facilities when a patient is transferred from a medical home to an urgent care facility or from an urgent care facility to an emergency department or other facility.

Medical professionals providing oversight to freestanding urgent care facilities serving children should regularly review facility adherence to this policy statement. Accreditation by external reviewers of urgent care facilities serving children should include meaningful assessment of quality measures and performance of appropriate pediatric care.

CONCLUSIONS

Well-managed freestanding urgent care facilities can enhance the provision of urgent services to the children of their communities, be integrated into the medical community, and provide a safe, effective adjunct to, but not a replacement for, the medical home. Urgent care facilities serving children should be able to rapidly assess, begin stabilization, and initiate transfer of children with emergencies. Consistent oversight, planning, and quality monitoring and improvement are crucial. The scope of care offered to children should be well defined and well communicated. Providers and staff must have the training and experience to manage children. There remains a great need for research on the role of urgent care in pediatrics. Educational opportunities at the student, resident, fellow, or continuing medical education level involving pediatric urgent care are minimal and should be developed as more and more pediatricians and other health care providers are employed by, provide oversight to, or work collaboratively with urgent care facilities. Accreditation of urgent care facilities serving children should include meaningful assessment of quality measures and performance of appropriate pediatric care.

Downloaded from www.aappublications.org/news by guest on February 18, 2019

LEAD AUTHOR
Gregory P. Conners, MD, MPH, MBA, FAAP

COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE, 2012–2013
Joan E. Shook, MD, MBA, FAAP, Chairperson
Alice D. Ackerman, MD, MBA, FAAP
Thomas H. Chun, MD, MPH, FAAP
Gregory P. Conners, MD, MPH, MBA, FAAP
Nanette C. Dudley, MD, FAAP
Susan M. Fuchs, MD, FAAP
Marc H. Gorelick, MD, MSCE, FAAP
Natalie E. Lane, MD, FAAP
Brian R. Moore, MD, FAAP
Joseph L. Wright, MD, MPH, FAAP

LIAISONS
Isabel A. Barata, MD – *American College of Emergency Physicians*
Kim Bullock, MD – *American Academy of Family Physicians*
Jennifer Daru, MD, FAAP – *AAP Section on Hospital Medicine*
Toni K. Gross, MD, MPH, FAAP – *National Association of EMS Physicians*
Elizabeth Edgerton, MD, MPH, FAAP – *Maternal and Child Health Bureau*
Tamar Magarik Haro – *AAP Department of Federal Affairs*
Jaclynn S. Haymon, MPA, RN – *EMSC National Resource Center*
Lou E. Romig, MD, FAAP – *National Association of Emergency Medical Technicians*
Sally K. Snow, RN, BSN – *Emergency Nurses Association*
David W. Tuggle, MD, FAAP – *American College of Surgeons*
Cynthia Wright, MSN, RNC – *National Association of State EMS Officials*

STAFF
Sue Tellez

REFERENCES

1. Urgent Care Association of America. About urgent care. Available at: www.ucaoa.org/home_abouturgentcare.php. Accessed March 19, 2013
2. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Policy statement: AAP principles concerning retail-based clinics. *Pediatrics*. 2014;133(3):e794–e797
3. Weinick RM, Bristol SJ, DesRoches CM. Urgent care centers in the U.S.: findings from a national survey. *BMC Health Serv Res*. 2009;9:79
4. Williams M, Pfeffer M. Freestanding emergency departments: do they have a role in California? Oakland, CA: California Healthcare Foundation; 2009. Available at: www.chcf.org/publications/2009/07/freestanding-emergency-departments-do-they-have-a-role-in-california. Accessed March 19, 2013
5. Moy MM. *The EMTALA Answer Book, 2012 Edition*. New York, NY: Wolters Kluwer Law & Business; 2012
6. Centers for Medicare and Medicaid Services. HHS. §489.24. Available at: www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol4/pdf/CFR-2007-title42-vol4-sec489-24.pdf. Accessed March 19, 2013
7. Yard EE, Comstock RD. An epidemiologic comparison of injuries presenting to a pediatric emergency department and local urgent care facilities. *J Safety Res*. 2009;40(1):63–69
8. Conners GP, Hartman T, Fowler MA, Schroeder LL, Tryon TW. Was the pediatric emergency department or pediatric urgent care center setting more affected by the fall 2009 H1N1 influenza outbreak? *Clin Pediatr (Phila)*. 2011;50(8):764–766
9. Frush K; American Academy of Pediatrics Committee on Pediatric Emergency Medicine. Preparation for emergencies in the offices of pediatricians and pediatric primary care providers. *Pediatrics*. 2007;120(1):200–212
10. American Academy of Family Physicians; American Academy of Pediatrics. American College of Physicians; American Osteopathic Association. Joint principles of the patient-centered medical home. 2007. Available at: www.pcpcc.net/joint-principles. Accessed March 19, 2013

Downloaded from www.aappublications.org/news by guest on February 18, 2019

Pediatric Care Recommendations for Freestanding Urgent Care Facilities
COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE
Pediatrics 2014;133;950
DOI: 10.1542/peds.2014-0569 originally published online April 28, 2014;

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/133/5/950
References	This article cites 5 articles, 2 of which you can access for free at: http://pediatrics.aappublications.org/content/133/5/950#BIBL
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): **Emergency Medicine** http://www.aappublications.org/cgi/collection/emergency_medicine_sub **Trauma** http://www.aappublications.org/cgi/collection/trauma_sub **Administration/Practice Management** http://www.aappublications.org/cgi/collection/administration:practice_management_sub **Quality Improvement** http://www.aappublications.org/cgi/collection/quality_improvement_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.aappublications.org/site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: http://www.aappublications.org/site/misc/reprints.xhtml

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Downloaded from www.aappublications.org/news by guest on February 18, 2019

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Pediatric Care Recommendations for Freestanding Urgent Care Facilities

COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE

Pediatrics 2014;133;950
DOI: 10.1542/peds.2014-0569 originally published online April 28, 2014;

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/133/5/950

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2014 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Downloaded from www.aappublications.org/news by guest on February 18, 2019