

Freestanding Emergency Departments and Urgent Care Centers

An Information Paper

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The purpose of this information paper is to compare and contrast freestanding emergency departments (FSEDs) with urgent care centers (UCCs). In some areas of the country, the distinction between FSEDs and UCCs is straightforward, as FSEDs are open 24/7 and follow EMTALA, while the UCCs are open for limited hours and do not have an EMTALA obligation. But in many areas of the country, those distinctions are not present. This paper provides information about the similarities and differences between these two entities, recognizing that there is a large area of overlap.

Definition of Freestanding Emergency Departments

An FSED, also referred to as a freestanding emergency center, is a facility that provides emergency care but is structurally separate and distinct from a hospital. There are two types of FSEDs: a hospital outpatient department (HOPD), also referred to as an off-site hospital-based or satellite emergency department (ED), and an independently-owned freestanding emergency centers (IFEC). The number of FSEDs is increasing rapidly with an ever-changing regulatory and health care environment.¹

Additional specifics (comments in parentheses refer to licensed FSEDs in Texas and Colorado):

- May or may not be affiliated with or owned by a larger entity or healthcare institution
- Usually (always) open 24 hours per day, 365 days per year
- Usually (always) staffed 24/7 with an emergency-trained physician but can also be co-staffed with an advanced practice registered nurse (APRN) or physician assistant (PA)
- Also employs registration, ancillary support, and nursing staff
- Often (always) has x-ray, ultrasound, and computed tomography (CT) scanning available on-site
- Usually (always) will have laboratory capabilities for routine hematology and chemistry studies, pregnancy testing, and cardiac enzymes.
- Intravenous (IV) medications, including resuscitative medications, and IV fluids available
- Most (all) have narcotics available
- Usually (always) capable of treating all age ranges
- Should (must) follow the intent of the EMTALA statute in that all patients should be provided an appropriate medical screening examination (MSE) to determine whether or not the patient needs emergency care

Definition of Urgent Care Centers

Urgent care centers (UCCs) are freestanding walk-in ambulatory clinics generally open 7 days per week with extended (variable) hours, usually extended from normal business hours. UCCs are often located in high-traffic retail locations. They provide urgent medical treatment and unscheduled, episodic care to patients who require timely care but whose condition is non-life threatening. Payment is often expected at the time of service. Commercial insurance is accepted by many UCCs. Patients needing a higher level of service will be referred to a specialist or an ED. Acutely ill patients may be referred by ambulance through activation of the 911 system because most UCCs are not equipped or staffed to handle life-threatening emergencies. UCCs generally operate without a regulatory governing body.

A National Academy for State Health Policy article from a 2009 survey, “Analysis of State Regulations and Policies Governing the Operation and Licensure of Retail Clinics,”² states that according to the retail

clinic representatives, the most powerful state regulatory tools affecting their operations are the scope of practice regulations that govern nurse practitioners and other non-physician medical personnel. For a majority of the states surveyed, the care provided in the retail clinic setting is not subject to oversight by health departments but by the applicable practitioner licensing authority. According to the American Association of Nurse Practitioners, 22 states allow nurse practitioners to practice independently without physician oversight. The remaining states allow reduced or restricted practices. Some states regulate the frequency and proximity of supervision, requiring the physician to be on site for a certain number of hours or within a certain radius of a nurse practitioner-staffed clinic.

According to an Urgent Care Association of America (UCAOA) 2014 survey, "...approximately 80% of UCCs employ a combination of physicians, physician assistants, and nurse practitioners to provide care, while the remaining 20% use physicians only."³

Additional Specifics:

- May or may not be affiliated with or owned by a larger entity or healthcare institution
- Usually open 8-16 hours per day (12 hours is most common)
- Often open 365 days per year
- May be staffed with an APRN or PA
- May be staffed with a physician
- Usually have registration/greeter, nursing, and ancillary support (x-ray) staff
- Limited laboratory capability
- May have plain x-ray capability
- May have electrocardiography capability
- May have IV fluids
- Medications such as antibiotics are usually stocked
- Some centers have narcotics while others do not
- Some will not treat infants
- Generally would not have to follow EMTALA principles

Compare/Contrast an FSED with an UCC

One question that often comes up is exactly how an FSED differs from an UCC. In most instances, the differentiation is clear. An FSED offers the same scope of services that a traditional ED does but is not attached to a hospital. An FSED is often open 24 hours, 7 days a week and holidays. In contrast, an UCC typically offers fewer and less emergent services, is open fewer hours, and may not be open 7 days a week or on holidays.

The American College of Emergency Physicians (ACEP) policy, [Definition of Emergency Medicine](#) states that emergency medicine "may be practiced in a hospital-based or freestanding emergency department (ED), in an urgent care clinic, in an emergency medical response vehicle or at a disaster site." This definition is not meant to imply that UCCs are the same as FSEDs.

A number of organizations provide guidance on when to go to an ED rather than an UCC. ACEP provides guidance to the public in a brochure titled, "Emergency Care, Urgent Care - What's the Difference?"⁴

Other organizations provide lists of illnesses and injuries indicating the appropriate setting for evaluation and treatment. Examples include:

When you need to go to the Emergency Department:

- Chest pain
- Shortness of breath or difficulty breathing
- Severe bleeding or head trauma

- Change in mental status such as confusion or loss of consciousness
- Sudden dizziness, weakness, or change in vision
- Severe or persistent vomiting or diarrhea
- Suicidal or homicidal feelings
- Abdominal pain
- Severe headaches
- Dehydration

When a UCC may better meet your needs:

- Minor burns
- Minor cuts requiring stitches
- Sprains and strains
- Coughs, colds, and sore throats
- Ear aches
- Fever or flu-like symptoms
- Rash or other skin irritations
- Mild asthma
- Animal and insect bites
- Minor broken bones
- Flu shots and physicals for sports or school.

The chart below was compiled from a variety of sources to compare and contrast FSEDs and UCCs.

	FSED	UCC
Chest pain/heart attack	Yes	No
Cardiac resuscitation, defibrillation and intubation	Yes	No
Moderate to severe respiratory distress	Yes	No
DVT evaluation/treatment	Yes	Sometimes
Pulmonary embolism	Yes	No
High-risk abdominal pain	Yes	No
Simple lacerations, bruises, sprains	Yes	Yes
CT scan onsite – 24/7	Yes	No
X-ray/radiology onsite - 24/7	Yes	Sometimes
Ultrasound onsite – 24/7	Yes	Sometimes
Complex laceration	Yes	No
Fracture reduction	Yes	Simple only, sometimes
Abscess drainage	Yes	Simple only
Standard lab onsite	Yes – moderate complexity at	Limited tests only

	least	
Electrocardiography/ cardiac enzymes	Yes	Sometimes
Open 24/7/365	Yes	Almost never
Direct admission/transfer agreements in place	Yes	Dials 911 for transfer
Staffed by board certified/board eligible emergency physicians	Often/considered an ideal	Rarely; typically staffed by family/internal medicine/APRN/NP
Moderate/severe trauma	Yes	No – simple trauma only
Owned/operated by physicians	Sometimes	Sometimes
Emergency nursing experience	Yes	Rarely
State-licensed facility	Yes	Yes
Equivalent physical plant to a hospital-based ED	Yes	No
Billing – emergency facility charge	Yes	No
Billing – professional fee	Yes	Yes
Insurance accepted	Accepts most	Accepts most
Medicare/Medicaid accepted	CMS does not recognize if independent freestanding emergency center	Usually
Cash payment	Yes	Yes

Fiscal Impact

There is a concern, articulated in a perspective piece in *Annals of Emergency Medicine* in 2011⁵ that FSEDs will skim high-reimbursing patients and will leave hospital-based EDs with Medicaid and uninsured patients. Strong evidence is lacking to date. One article correlated the closure of hospital-based EDs with market competition and the presence of a competing ED within 15 miles.⁶ It did not differentiate between FSEDs and hospital-based EDs, though, and competition was not the only factor involved.

Anecdotally, this is a concern because IFECs cannot accept Medicaid or Medicare (CMS does not recognize or reimburse IFECs). These centers should see all patients who enter the premises, but patients may elect to leave and go to another facility after a medical screening exam, or may be requested to leave if no emergency medical condition is present and the patient cannot or will not pay for services. This, however, could occur at EDs of all types. IFECs are typically located in urban areas where they will be seen and frequented by a commercially insured patient mix, but this is the case for many hospital outpatient departments and hospital EDs as well. FSEDs typically advertise short wait times, convenient locations with free parking, and other amenities to attract customers, but this occurs with EDs of all types

as well. The actual fiscal impact is likely variable depending on the patient/payer mix in the hospital's catchment area, the actual geographic distances between the two, and the number or market share percentage of high-reimbursement patient visits that the FSEDs are able to attract. In addition, hospitals earn the majority of their revenues from admissions rather than ED visits. Since FSEDs do not have the capacity to admit patients, they transfer their patients who require admission to hospitals and cannot benefit from inpatient revenue. Other anecdotal experience shows that the improved access at FSEDs captures revenue from inpatient care, and can prevent expensive complications from the overcrowded hospital ED experience. Delays at overcrowded EDs are well documented to increase morbidity and mortality. Patients who avoid EDs altogether suffer complications as well, but cannot be documented.

UCCs often accept Medicare/Medicaid, but, like FSEDs, will usually require upfront payment from the uninsured. They also compete with hospital-based EDs for level 1- to level 3 visits by the insured patient population. Like FSEDs, UCCs offer shorter wait times and more convenient locations that attract patients. Revenue for commercially-insured patients is exponentially higher for level 4 and level 5 visits, whereas the increase is not as dramatic for Medicare and Medicaid patients,⁷ so the loss of the lower-acuity visits by the commercially insured to UCCs is likely to be less significant financially to hospital-based EDs than the loss of level 4 and 5 visits that FSEDs may attract.

Workforce

Concerns regarding shortages in the emergency medicine workforce have been discussed for more than 20 years. Even prior to the emergence of UCCs and FSEDs, there were projections and concerns about shortages within the emergency medicine workforce. ACEP states in the policy, [Emergency Medicine Workforce](#), "...that there is currently a significant shortage of physicians appropriately trained and certified in emergency medicine." The ACEP Board of Directors approved this statement in 1987 and reaffirmed it in 2012.

Holliman, et al published a study in *Academic Emergency Medicine* in 1997 looking at workforce projections. Their results stated that "Under most of the scenarios tested, there will be a large deficit of EM board-certified emergency physicians (EPs) well into the next century. Even in scenarios involving a decreasing 'demand' for EPs (eg, in the setting of hospital closures or the training of physician extenders), a significant deficit will remain for at least several decades."⁸

While it is reasonable to conclude that the explosion of UCCs and FSEDs will likely magnify the shortage of board-certified emergency physicians by creating additional employment options for them, it is important to remember that it is the demand for emergency services by patients that ultimately creates the need for the additional care delivery venues and therefore the job openings for the emergency physician.

UCCs may have less impact on the workforce deficit as they are typically less regulated and may be staffed by APRNs, NPs or family practice physicians. Emergency physicians who work in UCCs may be moonlighting for extra income or transitioning out of full time practice as they near retirement. Some believe FSEDs may have a greater impact on the workforce deficit for hospital-based EDs, as they are usually required to be staffed by physicians, and emergency physicians may choose to work in FSEDs over hospital-based EDs. On the other hand FSEDs are providing needed emergency care to the community, often improving access.

Though it seems reasonable to conclude that increasing numbers of both UCCs and FSEDs will contribute to increasing the emergency medicine workforce deficit, the true answer lies in a much more complex analysis that must include additional factors such as increased ED demand due to population growth and the increased numbers of insured patients due to the ACA in the absence of sufficient primary care access, and the increased usage of advanced practice clinicians.

State Legislation and Regulation

State legislation and regulation for FSEDs are frequently changing and varied, ranging from states with no legislation or provisions for FSEDs (New Jersey) to states with significant legislation (Texas). Most states with legislation or regulation require services be provided 24 hours per day (but not all states require this, such as Rhode Island). The ACEP information paper titled "[Freestanding Emergency Departments](#)" includes links to state regulations.

Many states do not have any regulations specific to UCCs. In those states, the rules that apply to opening a medical office, such as medical licenses, business licenses, and registration of lab and x-ray equipment, would be applicable.

Some states have developed regulations specific to UCCs that require licensure, registration, or accreditation and may define "urgent care" in regulation. Other states have limited the scope of UCCs.

Illinois restricts the use of the term "emergency" to EDs. [Illinois Health Facilities and Regulation \(210 ILCS 70/\) Emergency Medical Treatment Act](#) states in part:

"...No person, facility, or entity shall hold itself out to the public as an 'emerge-' or 'emergent' care center or use any similar term, as defined by rule, that would give the impression that emergency medical treatment is provided by the person or entity or at the facility unless the facility is the emergency room of a facility licensed as a hospital under the Hospital Licensing Act or a facility licensed as a freestanding emergency center under the Emergency Medical Services (EMS) Systems Act. This Section does not prohibit a person, facility, or entity from holding itself out to the public as an 'urgi-' or 'urgent' care center."

Some state regulations mention acceptance of, requirement for, or other reference to the use of accreditation standards. A number of organizations provide accreditation for UCCs including [The Joint Commission](#), the [UCAOA](#) and the [American Academy of Urgent Care Medicine \(AAUCM\)](#). AAUCM classifies UCCs into four levels. The criteria for a Level I center states that it is "[Essentially equivalent of FSED](#)." They outline a number of services that the center must provide but do not require that the UCC be open 24 hours per day. AAUCM states that the purpose of categorization of UCCs is "...providing better clarity for patients who are seeking treatment and/or evaluation for urgent care medical conditions and does not in any way deter patients from going to the nearest emergency department."

Arizona is the only state that has a specific urgent care licensure program that requires a specific license for UCCs. Some states, such as Florida, put UCCs under a more general licensure category, calling them licensed clinics. Florida requires UCCs to publish and post a schedule of charges.

The law in Kentucky requires that any facility that provides urgent care apart from a hospital ED must make available every two years a continuing education course about recognition and prevention of pediatric abusive head trauma.

Utah has a law that defines a "freestanding urgent care center" as a facility that provides outpatient health care (1) without an appointment, on an as-needed basis, (2) to the public, (3) for the diagnosis and treatment of a medical condition that does not require hospitalization or emergency intervention for a life threatening or potentially permanently disabling condition, and (4) includes one or more of: medical history and physical exam, assessment of health status, and treatment for a variety of conditions that are commonly offered in a physician's office. One theory as to the general paucity of state laws and regulation of UCCs is that historically they were an outgrowth of the physician practice, completely different from the development of FSEDs. Now that the urgent care model is proliferating without a

previous relationship to a physician practice, there is likely to be an increase in state legislation and regulation. It will be necessary for the reader to investigate individual states for current regulations.

Conclusion

This paper outlines the similarities and differences between FSEDs and UCCs and delineates some of the related issues relevant to the general practice of emergency medicine. Proliferation of UCCs and FSEDs will likely result in additional state legislation and/or regulation and may also lead to more federal involvement in regulation over time. Emergency physicians, ACEP state chapters, and ACEP national leaders should be directly involved in future legislative and regulatory efforts regarding these entities, particularly FSEDs.

*Created by members of ACEPs Emergency Medicine Practice Committee
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