

**ACEP Pediatric Committee Statement on
Urgent Care Centers and Retail Clinics**

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ABSTRACT

This paper provides recommendations for pediatric readiness, scope of services, competencies, staffing, emergency preparedness, and transfer of care coordination for Urgent Care Centers (UCCs) and retail clinics that provide pediatric care. It also provides general recommendations for the use of telemedicine in these establishments.

With continuing increases in wait times and overcrowding in the nation's emergency departments (ED) and the mounting challenges in obtaining timely access to primary care providers (PCPs), a new trend is gaining momentum for the treatment of minor illness and injuries in the form of UCCs and retail clinics. As pediatric visits to these establishments increases, considerations should be made for the type of injury or illnesses that can be safely treated, the required level training and credentials of personnel needed, the proper equipment and resources to specifically care for children, and procedures for safe transfer to a higher level of care, when needed. When used appropriately, UCCs and retail clinics can be valuable and convenient patient care resources.

INTRODUCTION AND BACKGROUND

Each year, over 150 million patients visit one of more than 6500 UCCs in the United States (U.S.).^{1,2} Of these, more than 10 million are children less than 18 years.³ Similarly, over 10.5 million patients visit one of more than 1800 retail clinics.⁴⁻⁵ Of these, nearly one million are visits by children less than 18 years.⁶ Currently, more UCCs operate in the U.S. than EDs.^{1,2} Retail clinics have also seen an increase in numbers between 2009 and 2014 from 200 to 1800 clinics⁷⁻⁸ and the number of patient visits to these clinics increased 10 folds from 1.5 million per year to over 10.5 million during the same period.⁹

Most UCCs are staffed by at least one physician,¹⁰ ranging from primary care specialists (pediatrics, internal medicine, and family medicine) to emergency medicine trained. A number of pediatric UCCs are staffed by pediatric emergency medicine fellowship trained physicians.¹¹ UCCs also employ either a medical assistant (MA) or a registered nurse (RN). When after hour telemedicine services are provided by a UCC, the staffing for such services is provided by a RN, a nurse practitioner (NP), or a physician.¹² Retail clinics are staffed by NPs or physician assistants (PA)¹³ MAs typically provide other ancillary services in retail clinics.

DEFINITIONS

An urgent care center (UCC) is defined in this paper as a freestanding facility that offers non-scheduled walk-in acute care to ill or injured children. UCCs that are attached to a full-service hospital, or ED fast track areas are not addressed in this paper, as their access to resources is often connected to the hospital systems in which they are housed. UCCs are also distinguished from freestanding emergency departments (EDs) in that they provide care for *only* minor illness or injury.

Retail clinic is defined as a facility that operates out of a "big box" store, pharmacy, or grocery store, and typically offers care for simple acute or non-urgent services.⁷

Telemedicine is defined as the exchange of medical information from one location to another through electronic communication to provide patient care. It is a two-way communication that uses mobile, wireless, and web-based communication, and may contain video conferencing, electronic mail, or mobile messaging.¹²

SCOPE OF SERVICES PROVIDED

UCCs may operate either as an extension of regular clinic hours or may be designed specifically for after-hour care. Services such as laceration repair, splint application, plain radiography, electrocardiography, and point-of-care testing (rapid *streptococcus* antigen testing, point of care urine studies, mononucleosis screen, and breath alcohol testing) are routinely performed in most UCCs.¹⁴ Some UCCs have additional capabilities for diagnostic testing and imaging. UCCs may provide medical screening examinations as well as standard employee and sports physicals. For lower acuity patients, UCCs costs appear to be lower than a visit to the ED.¹⁵ In this capacity, they might occupy a specific niche within healthcare for children.¹⁶ In case of a more severe injury or illness, UCCs are expected to provide a safe transition of care to a higher level of care (e.g. an ED approved for pediatric care) by using local emergency medical services (EMS), following initial stabilization to the capability of its providers. UCCs are typically not 24-hour facilities and have a limited scope of services. Some UCCs are pediatric-specific, while others offer care for both children and adults.

Retail clinics provide services ranging from simple acute care to a selection of routine services such as sports physicals and vaccinations. Through properly established information sharing with the PCPs, retail clinics can augment and support the healthcare care received at the medical homes.¹⁷ Although retail clinics are billed as a source of low cost and expedited care for minor illness, they have been shown to increase health care spending and utilization in certain situations.¹⁸⁻²⁰ Retail clinics are more effective as an intermediary for providing after-hour care, rather than as an alternative to the medical home.²¹

Telemedicine is becoming a part of the services offered by some UCCs and retail clinics. It can reduce healthcare cost and improve access to care for many individuals in the rural and underserved communities.²² Advice and treatment recommendations can be achieved through proper use of telemedicine for children with acute and chronic conditions.²³ An average cost of a telemedicine visit is approximately \$40 to \$50, when compared to \$136 to \$176 cost for a related in-person visit to an UCC. The most common diagnoses made during telemedicine visits are sinusitis, upper respiratory infection, flu, gastroenteritis, and urinary tract infection.²⁴ Although a specific niche market exists for stand alone telemedicine services, more appropriate use of telemedicine is to serve as an extension of UCC and retail clinic services by providing aftercare communication, follow up, and referrals.²³⁻²⁴ Of note, state laws, can potentially limit provider choice and reimbursement for telemedicine services. Medicare, for example, currently only covers reimbursement for telemedicine in limited settings, which may include UCCs but not retail clinics.²³

REGULATIONS AND POLICY

Regulatory oversight for UCCs vary greatly between states.¹⁵ The Emergency Medical Treatment and Labor Act (EMTALA) for emergency visits generally applies to ED or hospital-based UCCs, but not to UCCs that operate independently from a hospital system or an ED.²⁵ Due to the vague definition of “emergency medical care” as it applies to the scope of services of UCCs, possible

applicable regulations can be difficult to enforce. For example, a patient may not be aware of the severity of his or her illness, or the gravity of the situation may not be apparent until after the patient is evaluated by the provider. For this reason and to ensure patient safety, UCCs must be clear in advertising and on-site postings regarding what type of illnesses and injuries are treated in their facility. Additionally, the provider must be facile and realistic in what is safely managed at the UCC. Many states have specific policies regarding limitations of UCC scope of services and licensing requirement.^{2,9}

Extended hours, convenient location, and ability to visit without an appointment all have led to the expanding popularity of retail clinics. The scope of services typically includes immunizations, health maintenance visits, and simple illnesses.²⁴ The overall scope of service is determined by each state,¹⁵ which may prevent retail clinics in certain states to operate in the same capacity as other states. Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) is responsible for accreditation of retail clinics.^{2,9}

Telemedicine is advertised as providing potentially low cost, on demand, and convenient healthcare.⁴ The establishment of physician-patient relationship with telemedicine is different from in-person relationship. Both the National Federation of State Medical Boards and the American Medical Association (AMA) have defined processes for establishing this relationship when telemedicine is used.²⁵⁻²⁶ Telemedicine services range from information sharing between UCCs/retail clinics and PCPs, to stand alone products offering advice, virtual visits, and follow up care.² A patient treated at an urgent care may have a video follow up from home.

PATIENT AND FAMILY CENTERED CARE

It is an approach to healthcare that recognizes the critical role of family in health promotion and offers the dignity of choice and preference in evaluation, planning, and delivery of health care.²⁷ The Institute for Patient and Family Centered Care lists the core concepts in patient and family centered care as: 1) Respect and dignity, 2) Information sharing, 3) Participation and shared decision making, and 4) Collaboration in policy and program development.²⁷ Patient and family centered care impacts policies, facility design, operations, and staff interactions. It leads to a better patient experience, optimizes allocation of resources, redefines relationships, and leads to better health outcomes.

RECOMMENDATIONS

The American College of Emergency Medicine (ACEP) Pediatric Committee recommendations are outlined below:

Specific Recommendations for UCCs

It is generally recommended that all UCCs caring for children be equipped to care for most minor illness and injuries, be able to initiate work up and stabilize to the best for their capability, and have clear protocols to transfer patients with higher acuity or complexity to an ED approved for pediatrics. It is also recommended that UCCs have competency assessment of staff caring for children, disaster preparedness plans for children, and electronic documentation.

Scope of services: When a UCC operates in a jurisdiction where no specific state laws are in place regarding qualifications to provide pediatric care, it is recommended that each UCC make a decision on whether it is capable of providing service to children based on whether it meets the required pediatric training, equipment and supplies, and appropriate protocols and procedures requirement for care of children. For example, if resource, equipment, and expertise for care of infants and toddlers under two years of age are not available, the UCC should clearly state and post a sign that reflects that it can not provide service to children under 2 years of age, and it should include information on alternative locations that can care for children younger than 2 years. This clarity of scope of services should also be apparent in any advertising materials for the UCC. Furthermore, information should be provided on the type of illness and injury that it can treat. In addition to this, higher acuity transfer facilities information should be available to patients who need emergency care.

Education and training: ACEP recommends the following for physician providers and staff of any UC that treats children:

- Completion of basic life support (BLS) and pediatric advanced life support (PALS) training, including updates and renewal courses for all staff is recommended. When the physician provider has successfully completed formal medical training and board certification in emergency medicine (and/or pediatric emergency medicine), an active BLS and PALS certification requirement can be waived as long as the provider is familiar with the latest recommendations for pediatric resuscitation.
- Periodic pediatric mock code or simulation training to maintain skills and competence.
- Competency assessment for providers and staff based on the scope of services provided is recommended. This can be accomplished through continuing medical education (CME) for providers, continuing education (CE) for nursing staff, as well as other modalities such as telemedicine, simulation, and online training modules. Each UCC group should develop a mechanism for evaluating and establishing such competency assessment and ongoing learning activities.
- Quality improvement measures for care of children, especially when the pediatric patient volume is low.²⁸⁻³⁰
- Pre-planned site-specific written agreements with hospital-based EDs and protocols for staff for safe inter-facility transfer of children who require emergency care. The information for developing this type of protocol may be found through the *Pediatric Readiness Project*²⁶ and the *Emergency Medical Services for Children Innovation and Improvement Center*.²⁸⁻³⁰

Triage, assessment, and disposition: It is recommended that UCC providers and staff be capable of performing a triage and assessment in order to determine each patient's illness severity and resource requirement. Designation of a specific referral center as well as standing agreements and transport protocols to the designated facility is recommended. Specific signs and information should be posted outside the UCC to direct patients to another facility outside of the hours of operation.

Pediatric readiness: The readiness assessment tool kit developed by the Pediatric Readiness Project was intended to allow the EDs to assess their capabilities and provides resources to care for children, and was not designed to apply to UCCs, but the early phases of including UCCs in pediatric readiness have already begun. The protocols, equipment, practice pathways, and competency assessments may provide a useful guide for UCCs that care for children.²⁸ These include:

- Pediatric length-based tape (e.g. Broselow) for medication dosing and equipment sizing.
- Properly sized resuscitation equipment such as pediatric airway equipment should be accessible. At a minimum, proper pediatric bag-mask devices and oxygen set-up should be available.
- Availability of medication supplies such as topical anesthetics, injectable anesthetics, oral rehydration solution, ondansetron, intravenous Normal Saline solution (NS), albuterol, oral steroids, epinephrine (intramuscular injection and inhalation solution), and intranasal fentanyl and midazolam is recommended.
- Pediatric dosing guidelines pre-calculated by weight in kilograms should be available for staff.
- Familiarity with local pediatric transport protocols and EMS structure to understand the level and type of EMS response in the jurisdiction.

Staffing: All providers caring for patients at a UCC that treats children should be familiar with specific pediatric needs and provide a child-friendly environment and provide family and patient centered care. Familiarity with evidence-supported approach to common pediatric illnesses and injuries, pediatric medication dosing, pain management, and age-based differential diagnoses is recommended.

It is also recommended that UCC providers establish relationships with local pediatric specialty care experts in order to communicate, collaborate, and transfer of care, when indicated. Ancillary staff should be comfortable with interacting with, performing tests and procedures on, and providing age appropriate comfort measures for children. Prior experience in pediatric care is associated with improved patient experience and care outcomes in children.¹⁵

Coordination of care: Many children who are treated at a UCC do not seek care at their medical home first. UCCs provide walk-in and after hour care; therefore, patients may prefer them to a scheduled visit to their PCP. The convenience and expedience of UCC services makes them a substitute for the PCP visits. In this regard, UCCs should have a mechanism to share information with the medical home. An electronic documentation for each patient visit and services provided is also recommended. A similar electronic communication trail should ideally be available to allow the UCC to communicate with the ED where higher acuity patients may be referred.

Emergency preparedness: In the event of a natural or man-made disaster, UCC may become an important part of the healthcare delivery system. It is important that the staff and providers of a UCC be familiar with local and regional disaster preparedness protocols and their role in case of a disaster.

The following is recommended for effective emergency preparedness.^{26, 30}

- The plan is developed with input and cooperation of local and state officials. UCCs should establish partnerships with local EMS and healthcare facilities to allow them to be included in regional disaster drills. UCC medical directors should reach out to public health officials and/or their local EMS agency for participation and follow up of their performance in drills that are conducted. Independent party (e.g. local or state disaster preparedness personnel) critique and verification of the UCC's mock drill should be available.
- The emergency preparedness plan is clearly written with key contact numbers provided.
- A written copy of the plan is placed in a central location to ensure that all staff knows how to access the information.
- The plan is practiced with mock drills. It is recommended that the UCC be part of any local or state disaster drills conducted. Independent party (e.g. local or State disaster preparedness personnel) critique and verification of the UCC's mock drill should be available.
- The emergency preparedness plan should have interval revisions and updates as needed.

Resources: Each UCC facility should have access to pediatric specific expertise. This could be either in form of an established telemedicine network or access to a pediatric tertiary care facility for consultation. Adequate supply of pediatric airway and monitoring devices, medications, intravenous catheters, suture material, and splinting material and inventory management system is recommended. In addition to this, a system for evaluating and assessing pediatric readiness should be implemented and periodically updated.

Accreditation: At present, UCCs are accredited by The Joint Commission, which is responsible for accreditation of all urgent and ambulatory care centers. Other accreditation bodies include National Association for Ambulatory Care (NAFAC), and Accreditation Association for Ambulatory Health Care (AAAHC). Urgent care centers are encouraged to become accredited either through one of the above accreditation bodies.

Telemedicine: It is recommended that any UCC or retail clinic that employs telemedicine have specific guideline for its use, including quality control and data security and safety monitoring, and information exchange between providers. Electronic communication (patient portal, mobile messaging, electronic mail) or virtual visits using web-based or mobile device enabled video conferencing are all considered telemedicine. It is recommended that all telemedicine communication be secure, encrypted, and password protected.

Specific Recommendations for Retail Clinics

It is generally recommended that these centers implement quality metrics, carry appropriate pediatric equipment and supplies, provide competency evaluation, and possess electronic communication system for ongoing or follow-up care. Disaster preparedness protocols are also recommended for retail clinics.

Scope of services: Retail clinics are well suited for the management of acute uncomplicated medical problems. It is recommended that each retail clinic establish standards for the type of services they provide. If pediatric care will be provided, clinic providers should be comfortable with pediatric-specific medical care, and the facility should have pediatric-specific equipment, supplies, and expertise. Furthermore, adherence to principles of family and patient centered care are strongly recommended.

Education and training: Site-specific treatment protocols and regular competency assessment is recommended. Basic life support training and ability to use an automated external defibrillator (AED) should be included in staff training. Antibiotic stewardship for providers as well as general familiarity with pediatric literature and evidence base practices is recommended. Therefore, competency assessments of provider and staff based on scope of practice provided should be instituted to ensure proper training and skill maintenance of each clinic's personnel.

Pediatric readiness: ^{25-26,28 -29}It is recommended that any retail clinic that cares for children have a child-friendly environment, including activities and distraction tools, and pediatric medication preparation and dosing guidelines. In addition, it is recommended that basic pediatric equipment such as oxygen delivery system by simple pediatric mask, a length-based resuscitation tool (e.g., Broselow Tape) for pediatric weight-based medication dosing, and AED, as well as clearly stated transport protocols and disaster preparedness strategies be available. Staff training in basic life support is also recommended.

Staffing: It is recommended that each provider caring for children be competent in pediatric physical examinations, diagnosis and treatment of acute and chronic illnesses, childhood immunizations, pediatric medication dosing, and interpretation of pediatric lab tests and radiographs. Successful completion of a certification and licensing examination is also recommended. PAs should be able to provide diagnostic, therapeutic, and preventive care services under physician supervision. They must also pass the certification examination to become licensed by their state of practice.

Coordination of care: The American Academy of Pediatrics (AAP) emphasizes that retail clinics are not an appropriate source of primary care for children.³¹ Retail clinics cannot replace the relationship that develops between a primary care provider and patients.³¹ It is recommended that retail clinics have electronic health records, and to be able to provide information about a patient visit back to the medical home. They should also have a dynamic data sharing system to ensure data accuracy, as well as timely and complete information to drive decision support tools.¹¹

Emergency preparedness: Policies and procedures that allow for evacuation plan, information and procedure for contact with disaster command center and posted signs to divert patients to a designated health facility in the event of a disaster is recommended.³² The training of staff to be familiar with local and regional disaster preparedness is also recommended for retail clinics. The AAP also recently published a policy paper on retail clinics standards on "Preparation for Emergencies in the Offices of Pediatricians and Pediatric Primary Care Providers".³²

Accreditation: The organization involved in accreditation of retail clinics is the Accreditation Association of Ambulatory Health Care, Inc.³ It is recommended that retail clinics be accredited to ensure that they meet standards of quality in healthcare.

Telemedicine: It is recommended that retail clinics that employ telemedicine have a secure and encrypted messaging system, and have safeguards in place to protect patient information.²³⁻²⁴ It is also recommended that full disclosure of the type of telemedicine services be provided to patients. Finally, a closed-looped communication with the PCP (medical home) is essential.

CONCLUSION

Any UCC and retail clinic that offers acute care to children should have proper resources and equipment to manage simple pediatric illnesses. They should also have a defined scope of services, training and competency assessment, and operational processes to triage, assess, and transfer emergent patients safely and efficiently. Collaboration with the local EMS, local EDs, and other resources is essential. Providers and staff of a UCC and retail clinics should also be familiar with pediatric-specific issues such as pain management and antibiotic stewardship. Telemedicine services for UCCs and retail clinics should have a clear scope of services, data safety and security plan, and a closed communication loop with the medical home.

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