



Freestanding Emergency Departments: Do They Have a Role in California?

Introduction

The past decade has witnessed a growing trend in the operation of freestanding emergency departments in the United States. The Centers for Disease Control and Prevention has reported that the number of visits to emergency departments has increased by 32 percent in the last decade, while the total number of emergency departments has decreased by 4.6 percent.¹ In a 2007 American Hospital Association survey, 48 percent of hospitals reported that their emergency department was functioning at capacity or over capacity. The increased utilization of emergency departments, coupled with a decrease in the overall number of them, and a heightened government and public focus on quality and performance standards have put great pressure on hospital systems to change their approach to providing episodic health care.

The growth of freestanding emergency departments (FEDs) has provided both opportunities and challenges for health care providers, legislators, and payers, which has prompted discussions regarding their regulation and effect on the health care system. In some states, organizations have concluded that opening urgent care centers and/or FEDs will alleviate emergency department (ED) overcrowding, increase patient access to emergency services, provide a needed public service, and create a source of improved patient flow.

The California HealthCare Foundation retained The Abaris Group to research the extent of FEDs in the United States, inventory their practices, and describe California's experience with FEDs.

This issue brief provides an overview of FEDs and their regulation by federal and state governments. It also presents a short discussion of the environment for FEDs in California.

History and Overview of Freestanding Emergency Departments

FEDs have existed for almost 40 years, yet these facilities have remained largely unknown to the public and many in the health care industry. The concept of a freestanding emergency department emerged in the early 1970s as a result of the need for emergency care in rural or other underserved regions of the eastern United States. In some cases, non-hospital-affiliated FEDs were constructed to fill the need for local emergency care. In other cases, health care organizations could not justify the construction of a full hospital, so they instead built freestanding emergency facilities. Some of the first FEDs have now expanded to full hospitals, while others have remained freestanding facilities.

There is no strict definition for FEDs, although there has been much consideration by many regarding what they look like, the services they offer, and even their hours of operation. An FED is generally a facility that provides emergency

care but is separate from an acute care hospital. This relationship exists in a number of forms:

- The FED may be owned and run by a hospital, but situated in a separate location.
- The FED may be located near an acute care hospital, but is a distinct legal entity operating under different management.
- The FED may be a fully isolated facility that is not co-located with an acute care hospital and is under separate ownership.

These facilities differ from urgent care centers in that they can accommodate additional procedures such as defibrillation, intubation, and conscious sedation. In addition, unlike urgent care centers, most FEDs are open 24 hours a day, 7 days a week, and are staffed by experienced and trained emergency physicians and nurses. Some FEDs also have been permitted by local emergency medical service agencies to receive ambulance patients.

In 1978, there were approximately 55 FEDs in the United States, although most of these facilities could have been classified as urgent care centers.² The number of FEDs grew only slightly in subsequent years, until approximately 10 years ago when health care organizations began demonstrating a renewed interest in them.

The motivations for constructing FEDs most commonly include the following:

- Provide enhanced access to care and meet an increasing demand for emergency services;
- Develop sites and services that differentiate the organization from its competitors;
- Gain increased market share;
- Provide a referral source for affiliated physicians;
- Increase the potential for referring patients to hospital-based services; and
- Increase the potential for mitigating competitive threats.

The State of FEDs Today

An estimated 222 FEDs were operating in at least 16 states in the United States at the end of 2008. The American Hospital Association estimates there are 191 hospital-affiliated freestanding EDs, the majority of which are affiliated with regional hospitals or large health care organizations³ (see Appendix A for a listing of the 16 states). In addition, there are approximately 31 FEDs that are owned and managed by physicians or other private groups, located mostly in Texas. At the time of this report, the only FED that is not hospital-affiliated or physician-owned is the Newark Emergency Center in Delaware. Some states require special licensing for FEDs or allow them to operate under the parent hospital's license. Some FEDs have also received accreditation from The Joint Commission through their affiliated hospitals (174 FEDs) or as an ambulatory care facility (24 FEDs).

While there is some variation among facilities, most FEDs offer the following:

- Urgent and emergency care;
- Laboratories—lab service with the capability to conduct the type of rapid tests that are necessary in emergency care;
- Common radiology services, such as x-rays, computed tomography (CT), and ultrasound; and
- Staffed by emergency medicine physicians and nurses.

According to the American Hospital Association, approximately 70 percent of FEDs are open 24/7; however, there has been a push by the industry and state policymakers for all of them to be open 24 hours a day.⁴ This move is part of a trend in which FEDs are further distinguishing themselves from urgent care centers, thereby looking and acting more like hospital EDs. Table 1 lists some of the characteristics of FEDs.

Table 1. Characteristics of FEDs in the United States*

Characteristic	Description
FEDs	222
States with FEDs	At least 16
Hospital-Affiliated FEDs	191 (86.0%)
Average Size	Approx. 14,000 sq. ft.
Staff	Emergency MDs, PAs, NPs, RNs
Hours of Operation	Approx. 91.2% are open 24/7
Services Offered	Urgent/emergency care, lab, x-ray, CT
The Joint Commission Accreditation	Hospital = 174 Ambulatory Care = 24
Regulation [†]	CMS, EMTALA, state licensing
Billing [‡]	Type A/B dedicated ED or outpatient clinic

* Due to the lack of research/data on FEDs, most numbers are estimated.

[†] Some FEDs are not Medicare or Medicaid providers and are not restricted by the Emergency Medical Treatment and Active Labor Act (EMTALA).

[‡] DED: Dedicated Emergency Department, as defined by Centers for Medicare & Medicaid Services (CMS)

Sources: American Hospital Association, 2009 Survey of Hospital Leaders; CDC, National Center for Health Statistics (NCHS), National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary; The Joint Commission, Quality Check, 2009; The Abaris Group estimates

Additional services at some facilities include the accommodation of:

- Some 9-1-1 transports;
- Observation beds (for up to 48 hours);
- Pediatric care beds;
- Helipad; and
- Co-location with primary care and specialty physician offices, imaging centers, and/or surgery centers.

No FEDs to date offer trauma services to severely injured patients (e.g., severe head trauma). These trauma cases are typically directed by Emergency Medical Service (EMS) authorities to the nearest trauma center.

While not all FEDs receive 9-1-1 ambulance patients, many have interfacility transport services and contracts for patient transfers. In the event an FED receives an acute care patient who requires hospital admission, the patient

is stabilized at the FED and transferred to the nearest hospital. FEDs transfer patients in one of three ways:

- Provide a transport service via FED-owned ambulance;
- Contract with a local ambulance service; or
- Call an ambulance provider for transport.

FEDs are typically within 15 to 20 miles of a hospital, which helps ensure prompt transport for patients who must be admitted.

The Role of FEDs in Health Care

The Centers for Disease Control and Prevention has reported that 32.1 percent of ED visits are non-urgent or semi-urgent, 36.6 percent are urgent, and 15.9 percent are emergency or immediate. This implies that 68.7 percent of ED visits could be adequately cared for at some outpatient non-emergency facilities or FEDs.

Table 2 shows the varying acuity levels of patients visiting emergency departments.

Table 2. Patient Acuity Levels

Triage Acuity	Percentage
Immediate	5.1%
Emergency	10.8%
Urgent	36.6%
Semi-Urgent	22.0%
Non-Urgent	12.1%

Source: CDC, NCHS, National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary.

For a number of reasons, FEDs have the potential to fill a public need in underserved regions and form part of the solution to overcrowding in hospital EDs. An explanation of some of these reasons follows.

Easier Access

FEDs historically have filled a need in rural or underserved regions where EDs or general acute care hospitals were separated by long distances. More recently, many FEDs are open 24/7 and are located in suburban areas that are 15 to 20 miles from the nearest hospital ED. Both the proximity and the hours of operation for FEDs provide the potential for patients to receive prompt care.

Fast Throughput

Because many FEDs do not receive EMS 9-1-1 transports, the majority of their patients “walk” into the FED and thus are lower-acuity patients. In regions where FEDs do receive 9-1-1 calls, the local EMS agencies have created policies that prevent higher-acuity patients who might require admission from being transported to FEDs. Because FED patients’ conditions are generally of lower acuity and they are not waiting for inpatient beds, FEDs have the potential to operate with faster throughput. Some FEDs report a door-to-doctor time of 30 minutes or less, compared with hospital ED door-to-doctor times, which average 55.8 minutes. In addition, FEDs report door-to-discharge times of less than 90 minutes, in contrast to 180 minutes for hospital EDs.^{1, 5-7}

Expedient Admissions

Many FEDs have reported an average hospital admission rate of 5 percent, which is much lower than the average hospital ED admission rate of 12.8 percent.^{1, 8-12} In addition, FEDs have the potential to reduce the time it takes for patients to be placed in inpatient beds for two reasons: Because FEDs presumably have a faster average for door-to-doctor times, patients potentially can be triaged and stabilized more promptly than if they were being treated in a hospital ED. In addition, multiple hospital transfer agreements allow an FED to select hospitals with available inpatient beds, compared with hospital EDs, which typically board a patient until an inpatient bed is available at the same hospital.

Issues for Lawmakers and Health Care Providers

The introduction of FEDs in the health care system can present some challenges for lawmakers and health care providers. Details of these challenges follow.

Licensing

Some states directly or indirectly prevent the operation of FEDs through legislation (see “Legal Considerations” later in this report for more information).

Billing

Only FEDs that comply with the Centers for Medicare & Medicaid Services (CMS) and Emergency Medical Treatment and Active Labor Act (EMTALA) regulations can bill as a dedicated emergency department. All other FEDs bill as an outpatient clinic, which tends to yield a much lower reimbursement amount (see the “Billing and Reimbursement” section for more information).

Admissions

Despite the low average admission rate of most FEDs, a few FEDs have reported admission rates similar to hospital EDs, at 10 and 11 percent.¹³ The Bardmoor FED in Largo, Florida, reports a 14 percent admit rate, which is slightly above the hospital ED average.

High admission rates at FEDs have the potential to create challenges in several ways. First, they can create patient safety issues if the facility is not equipped to stabilize the patient. Second, the time it takes for the patient to arrive at the FED, have the doctor authorize admission, and then transport the patient to a qualified hospital may unnecessarily put the patient at risk. Finally, the necessity for FEDs to transport all patients requiring admission may unnecessarily increase 9-1-1 transports.

Transport

Some FEDs, either through billing or licensing requirements, are required to arrange interfacility transport services when necessary. This includes potential transfer agreements with nearby hospitals and possibly

agreements with local ambulance providers. As a result, patients may experience higher costs because of the transport billing, whereas if they had walked into a hospital ED, this expense would not have been incurred.

Public and Political Pressure

Legislators and health care providers' perceptions of FEDs at times have created challenges for those intending to operate such a center in the community. Concerns have ranged from FEDs' scope of services and potential confusion with hospital EDs to unnecessary competitive advantages and regulatory issues.

In Texas, for example, lawmakers' perceptions of FEDs have affected licensing criteria. And in Florida, lawmakers' perceptions have affected not only licensing criteria, but certificate-of-need requirements as well. Some hospital systems have lobbied to prevent FED construction near their facilities because they are concerned about competition. It can also be difficult to convince both state and local stakeholders that a FED can care for some higher-acuity patients and are capable of accepting some 9-1-1 transports.

While not required to do so, many FEDs have obtained The Joint Commission accreditation to demonstrate their compliance with accepted standards of care.

On-Call Physician Specialists

Hospital EDs rely on on-call physician specialists, but most FEDs do not have on-call specialists. In the event that a patient arrives at an FED and requires a specialist, the FED must stabilize the patient and arrange for prompt transport to a hospital or refer the patient for an appointment with the specialist.

Billing and Reimbursement

FEDs did not receive recognition from the Centers for Medicare & Medicaid Services until 2004, despite the fact that they have existed for 40 years. In January 2004, CMS published new regulations, which provide the following definition of a dedicated ED:

“Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”¹⁴

In the 2008 Federal Register, CMS divided the billing category for dedicated EDs into Type A and Type B. Within these categories, any facility that meets the Current Procedural Terminology (CPT) definition of an ED, and meets the requirements set by the Emergency Medical Treatment and Active Labor Act can bill as a Type A dedicated ED. The CPT definition of an ED is “an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be open 24 hours a day.”¹⁵

ED facilities that incur EMTALA obligations, but do not meet Type A regulations (those that are not open 24/7) are considered Type B. Type A dedicated EDs must fulfill one or both of the first two requirements (1 and 2) of the dedicated ED definition, while Type B dedicated EDs must fulfill at least one of the three requirements. (See Appendix B for the CMS excerpt on dedicated EDs.)

The 2004 Federal Register permitted freestanding emergency departments to bill as a dedicated ED; the more recent CMS regulations further specify the billing practices by dividing them into Type A and Type B. This new rule establishes a significant difference in billing and reimbursement between FEDs and urgent care centers. By allowing FEDs to bill as dedicated EDs, they are able to receive a higher reimbursement from Medicare than an urgent care center. Despite the fact that some urgent care centers provide services for urgent/emergency patients, they still must bill as outpatient clinics. Appendix C provides a comparison of the CMS billing for Type A dedicated EDs and urgent care centers (outpatient clinics). Per patient visit, dedicated EDs are reimbursed between 25 percent and 100 percent more than outpatient clinics, not considering additional procedural or other miscellaneous charges.

Two types of FEDs do not bill as a dedicated ED. FEDs that do not operate under the same provider number as their parent hospital and thus are not required to comply with EMTALA must bill as an outpatient clinic. A number of other non-hospital-affiliated facilities call themselves “emergency centers,” but are not Medicare or Medicaid providers. These facilities either bill the patient or the patient’s private insurer. However, with reimbursement criteria for FEDs having been implemented by Blue Cross Blue Shield in Texas, and with other insurers likely to follow, these types of facilities may soon need to alter their billing and operational practices. (See Appendix F for Blue Cross Blue Shield Texas criteria.)

Legal Considerations

Federal regulations permit the operation of FEDs but leave licensing and regulation to the states. State regulation of FEDs varies in a number of ways. Some states allow FEDs to operate as an offsite facility under the same license as the parent hospital. After an initial pilot program, Florida chose to require FEDs to meet the same criteria as onsite EDs and allows them to operate under their parent-hospital state license.

Other states have passed legislation specifically defining FEDs and their licensing requirements. These requirements are typically similar to hospital ED requirements, including acceptance of all patients arriving at the facility, stabilization, and provision for transport when necessary. Delaware and Illinois have implemented similar policies. (See Appendix C for a Comparison of Type A/B Dedicated Emergency Departments and Outpatient Clinics, and Appendix D for more information about Delaware State Regulations).

In at least one other state, licensing and regulatory requirements have not been established for FEDs. Texas, which has seen a significant increase in FEDs in the past decade, does not currently have licensing requirements for FEDs. In 2007, a bill was introduced to the Texas state legislature providing a set of criteria for FEDs, but the legislation has not been approved because of a dispute about whether to require FEDs to operate 24 hours a day.

The result of no regulation in Texas has led to somewhat of a boom in FED construction. The Houston area now has an estimated 19 FEDs, and the Dallas-Fort Worth area has approximately 11 FEDs. Only five of the Houston FEDs and two of the Dallas FEDs are hospital-affiliated, but most are accredited by The Joint Commission either through their parent hospital or as an ambulatory care center.

Most states that do not have operating FEDs have not passed laws to explicitly prevent them. However, California law indirectly prevents FED construction through a strict definition of an “emergency department” and the requirements associated with the use of the term “emergency.” Table 3 on the following page lists some examples of FED regulation.

Table 3. A Sample of State Regulation of FEDs

	State Examples	Description
FED and Parent Hospital Under Same License	Florida	The FED is permitted to operate as an offsite outpatient facility under the same state license as the parent hospital that owns the FED.
FED-Specific License	Illinois, Delaware	The FED must be licensed by the state as a “Freestanding Emergency Center” and comply with associated state regulations.
No License Requirement	Texas	An FED is permitted to operate without a license.
Indirect Prohibition of FED Operation	California	Because of strict requirements in the Health and Safety Code for emergency facilities, FEDs are indirectly prohibited from operating.*

* California law provides an exception for the operation of a potential look-alike FED for urgent/emergency care in rural areas when the local EMS agency has given approval for such operation (see Appendix H).

Sources: Delaware Administrative Code, 4404; Illinois Register Title 77, Chapter IIa, Section 1110.3230; Florida Agency for Health Care Administration, December 2004; California Health and Safety Code 1798.175.

As of mid-2008, 36 states have some form of Certificate of Need (CON) law in place.¹⁶ CON laws address a range of health care facilities and procedures and vary by state. CON laws vary for FEDs as well. In Texas and Florida, there are no CON laws that address FEDs. But Illinois requires a CON prior to the construction and operation of an FED and Delaware requires a Certificate of Public Review, similar to a CON.

In 1987, Florida removed review of outpatient services from the state CON requirement. In 2002, when Florida began its pilot FED program, it was determined that hospitals could have multiple inpatient premises on one license, and specific offsite outpatient facilities could be listed on the hospital license.¹⁷ This new requirement allows FEDs to operate on the same license as the parent hospital and have virtually no regulations on new construction. In 2003, the Florida state legislature passed a bill that placed a moratorium on construction of new FEDs in the state. The moratorium was lifted in 2007 when a bill to extend the moratorium was vetoed by the state’s governor.

The California Landscape

The California Health and Safety Code does not explicitly allow or disallow the operation of FEDs. However, it does state that any facility using the term “emergency” and claiming to provide “emergency medical services” must comply with specific regulations for Standby, Basic, or Comprehensive services of permitted EDs (see Appendix G).¹⁸ (The State of California uses the term “emergency medical services” to identify licensed hospital ED services.)

To be licensed in California for Standby, Basic, or Comprehensive emergency medical services, the facility must provide the following services onsite:¹⁹

- Intensive care service with adequate monitoring and therapeutic equipment;
- Laboratory service;
- Radiology service;
- Surgical services that are immediately available for life-threatening situations (Basic and Comprehensive);²⁰
- Post-anesthesia recovery; and
- Blood bank.

Any facility that provides all of these necessary services under state law will essentially be a full-fledged hospital and thus not operate like an FED. In addition, California Health and Safety Code Section 128700 (c) states that “emergency department” means “in a hospital licensed to provide emergency medical services, the location in which those services are provided.”²¹

There have been at least two bills introduced in the past five years to modify California law to allow FEDs to operate in the state. In 2003, AB 835 would have required the State Department of Health Services to grant licenses to specific urgent care centers that would be standalone EDs. In 2005, AB 1050 would have allowed up to four hospitals to establish emergency receiving centers that could be in a separate freestanding facility, for testing/demonstration purposes. In both bills, the FEDs

would have had to comply with the same regulations as hospital EDs. Neither of the bills passed out of committee.

State Law Exceptions

California state law provides an exception for the operation of a potential look-alike FED for urgent/emergency care in rural areas when the local EMS agency has given approval for such operation (see Appendix H). There are four facilities in the state known to have been approved as an FED under this exception:

- Western Sierra Medical Clinic in Downieville;
- Community Medical Center-Oakhurst;
- Redwood Coast Medical Services in Gualala; and
- Naval Hospital Lemoore in Lemoore.

These facilities are essentially urgent care centers that (because of their distance from a hospital) are permitted to accept emergency and ambulance patients if they are presented at the facilities. None of the clinics advertise themselves as “emergency centers” and none are open 24/7. They provide basic urgent/emergency care only to stabilize the patient for transport. The California Health and Safety Code requires only that the clinic and local EMS agency “take into account, but not be limited to” having appropriate staff and equipment to care for emergency patients. The specific requirements of the urgent/emergency facilities are determined by the local EMS agency. All of these clinics currently bill the emergency visits as outpatient clinic visits.

Staffing Challenges

In 2005, California initiated a state-mandated nurse-to-patient ratio for hospitals and EDs. The mandate requires that hospitals with a Basic or Comprehensive ED have a 1:4 or fewer nurse-to-patient ratio at all times. The law does not apply to Standby hospitals or outpatient services, even if they fall under the same license as the hospital.

If FEDs were permitted to operate in California, a determination would need to be made regarding whether staffing ratios would also apply to them. In the event that an FED opens, the staffing ratios might apply for an FED that operates under the hospital license; is owned by the hospital, but licensed separately; or is not owned by or licensed through a hospital.

Past Efforts at Operating FEDs in California

Centinela Medical Center reached an agreement with the County of Los Angeles in 2006 to upgrade its Los Angeles International Airport urgent care center to an urgent/emergency facility that receives Basic Life Support ambulances. The California EMS Authority declared that current state law did not permit the operation of such a facility and intended to force the closure of the facility. Los Angeles County disagreed that the state had any authority over Basic Life Support ambulance patients. The pilot project was intended to last two years; however, the FED closed after one year as a result of standards imposed by the County of Los Angeles and low volume that resulted from the restrictive county ambulance triage policy.

The University of California, San Diego Medical Center announced its plans in 2005 to downsize its Hillcrest inpatient campus near downtown San Diego. The initial plan was to transfer all inpatient beds to the La Jolla campus and convert the Hillcrest campus into an FED. The plan drew a great deal of criticism from local public figures and the community, which led the medical center to abandon the plan in 2007.

Characteristics of Successful FEDs

Organizations in other states attempting to construct an FED have encountered resistance from political leaders, local EMS agencies, competing hospital systems, and sometimes the community. A large number of these attempts have succeeded in complying with regulations, and some are well accepted by their communities. This section details common characteristics of the implementation and operations of successful FEDs across the nation.

The Proper Location

The location of an FED can be the most important factor in determining its success. First and foremost, there should be an establishment of public need. Most FEDs are located within 15 to 20 miles of a hospital; however, in some urban/suburban regions, they are closer. Proximity to a hospital should be evaluated by the public need for additional emergency services, as well as the timeliness of interfacility transfers that will be executed from the FED. Second, successful FEDs are located in an area that is currently or is projected to have substantial population growth and a low percentage of Medicaid or self-insured payers for any given FED.

Open Communication and Collaboration

The establishment of many successful FEDs has often been preceded by open communication and collaboration with local EMS agencies, their medical directors, and state and local officials. Clear descriptions of the operations and dedication to quality should be conveyed to stakeholders. And effective marketing and facilitated community gatherings can help ensure that the public has a clear understanding of the services that the FED will offer.

EMS Transport

Many FEDs have an ambulance entrance and provide their own transport service or call local ambulance providers when transport is needed. Other FEDs engage in contractual agreements with the local EMS agency to revise paramedic triage criteria that allow for selected EMS transport to FEDs. The criteria will vary depending on the services offered at the FED. There should also be an agreement with the local EMS agency and regional hospitals for arrangement of interfacility transport.

Services Offered

Most FEDs offer 24-hour lab service and have radiology services, including x-ray and collocated computed tomography (CT), and sometimes magnetic resonance imaging (MRI) and mammography. Additional nonemergency services are sometimes offered at FEDs that are co-located with other outpatient facilities. This can include surgery centers, rehabilitation centers, specialty clinics, and physical therapy.

Staffing

Staffing, especially initially, is a vital component of any successful health care facility, but particularly with FEDs. By equipping the FED with experienced ED clinicians, the facility can ensure quality of care and build public confidence in the abilities of the FED. Having the proper staffing ratio can be just as important as having experienced staff. A recent survey at an academic hospital on patient expectations in FEDs found that 93 percent of patients prefer to see a staff physician, rather than a resident physician or a physician assistant. A higher proportion of respondents also felt it was “extremely important” to be seen by a “competent physician” rather than a “caring physician” (94.4 percent vs. 82.1 percent).²²

Other Factors

Other factors that can help an FED be successful include the following:

- The Joint Commission and/or other accreditation.
- Co-location with specialists, surgery centers, and rehabilitation centers, which provide the potential for specialty consultative services nearby. Having all the additional outpatient facilities in the “mediplex” owned by the same organization yields increased revenues.

Conclusion

FEDs have existed in the United States for decades; however, following a recent resurgence, FEDs are now under more scrutiny. FEDs vary widely in their services offered, and the states vary in their regulation of the facilities. As such, there is no current standard or benchmark for data on quality and performance. Little academic research has been published on the quality and effectiveness of these facilities and whether their use in fact reduces hospital ED visits, lowers health care costs, or fills a public need. Without sufficient data, it is difficult to determine the true effectiveness and public benefit of FEDs, especially for the long term.

FEDs have the potential to meet community need when a community faces the loss of emergency services upon closure of an acute care hospital or when there is an established need in a community that does not have a hospital emergency service. However, developing an FED in order to gain competitive advantage when services are already available may not be an appropriate use of limited health care resources.

Despite these considerations, the number of FEDs has continued to expand in both rural and suburban regions, and the FED model appears to be successful for many organizations. FEDs' potential to provide greater access and faster throughput continues to attract those in the health care industry. As the number of ED visits continues to increase in the United States, those in health care are forced to confront ED overcrowding and patient care issues. In some states, FEDs have been utilized to assist in mitigating such hospital ED issues.

AUTHORS

The Abaris Group

Mike Williams, MPA/HSA, president

Michael Pfeffer, MPH, research assistant

ABOUT THE FOUNDATION

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information about CHCF, visit www.chcf.org.

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Appendix A Case Studies

Many states have allowed the construction of FEDs, and a number of organizations have been successful in implementing them over the years. Examples of both successes and failures in the implementation of FEDs follow. This list is not exhaustive; it is merely a set of examples of FED characteristics in different states.

Arizona

West Valley Emergency Center

- Location: Goodyear, AZ
- 1986–2004
- Closed when parent organization opened a hospital two miles away

Gilbert Emergency Department

- Location: Gilbert, AZ
- Opened in 2006 as an FED advertising door-to-doctor times of less than 30 minutes. The facility has since grown and is now licensed as a general acute care hospital.

Sedona Medical Center (Verde Valley Medical Center)

- Location: Sedona, AZ
- Open 24/7
- X-ray, CT, mammography
- Lab only Mon.–Fri. (7:00 a.m.–5:00 p.m.)
- Cancer center, two primary care offices

California

Centinela Airport Medical Clinic

- Location: Los Angeles, CA
- In 2006, Centinela Medical Center reached an agreement with the County of Los Angeles and its local EMS agency to upgrade the Los Angeles International Airport urgent care center into an urgent/emergency facility that receives ambulance traffic.
- A limited transport procedure (FED accepted Basic Life Support only), extensive staffing rules, and a generally low patient volume prompted the facility to close.

UCSD Medical Center—Hillcrest

- Location: San Diego, CA
- UCSD attempted to close its Hillcrest inpatient campus and replace it with an FED and 23 observation beds.
- The plan was halted as a result of community and political pressure.

Rural Emergency Centers

The following four rural community clinics have taken advantage of the “rural emergency center” exception to the California Health and Safety Code. None are open 24/7, but some do provide 24-hour on-call services:

- Western Sierra Medical Clinic in Downieville
- Community Medical Center–Oakhurst
- Redwood Coast Medical Services in Gualala
- Naval Hospital Lemoore in Lemoore

Colorado

Swedish Southwest Emergency Center (Swedish Medical Center)

- Location: Littleton, CO
- Open 24/7
- 18 rooms, including five 24-hour observation rooms
- Lab, CT, x-ray, ultrasound
- The Joint Commission accredited

Connecticut

Middlesex Hospital Shoreline Medical Center

- Location: Essex, CT
- Open 24/7
- Lab, CT, x-ray, ultrasound, mammography
- Receives ambulance patients

Middlesex Hospital Marlborough Medical Center

- Location: Marlborough, CT
- Open 24/7
- 12 treatment rooms, two of which are dedicated to critical patients
- Lab, CT, x-ray, ultrasound, mammography, bone densitometry
- Receives ambulance patients

Delaware

Newark Emergency Center

- Location: Newark, DE
- Opened in 1973
- No hospital affiliation
- “Non-life-threatening emergencies only”

Florida

Emergency Center at TimberRidge

- Location: Aventura, FL
- Opened in 2002
- Co-located with a mediplex
- 12 miles from the hospital
- Transport provided by the hospital
- Obtained state and county approval prior to construction
- After success of program, Florida Agency for Health Care Administration set criteria for FEDs
- The Joint Commission accredited

Bardmoor Emergency Center (Morton Plant Mease)

- Location: Largo, FL
- Opened in 2008
- 15,000 square-foot facility
- 15 beds, three of which are 23-hour observation beds
- CT, lab, x-ray, pharmacy
- The Joint Commission accredited

North Port Emergency Center & Outpatient Care Center (Sarasota Memorial)

- Location: North Port, FL
- Planned opening, summer 2009
- 25,000 square-foot facility
- 24-hour observation unit
- 18 treatment rooms, some of which are specialized for obstetrics, trauma, and psych
- CT, MRI, x-ray, ultrasound, mammography, bone density

Indiana

St. Vincent Medical Center Northeast—Fishers Emergency Center

- Location: Fishers, IN
- Opened in 2008
- Open 24/7
- Lab, CT, x-ray, MRI, ultrasound
- Co-located with a mediplex
- The Joint Commission accredited

Iowa

Trinity Iowa Health System—7th Street Emergency Center

- Location: Moline, IA
- Opened in 1997
- Open 24/7
- Eight exam rooms
- Lab, x-ray, CT, MRI
- Accepts nontrauma ambulance patients
- Co-located with a cancer center, birthing facility, post-surgical inpatient rooms
- The Joint Commission accredited

Maryland

Shady Grove Adventist Emergency Center

- Location: Germantown, MD
- Opened in 2006
- 17,000 square-foot facility
- Co-located with a 96,000 square-foot medical building
- 21 emergency beds
- Five inpatient beds for low acuity patients, maximum 48-hour stay
- 10 miles from parent hospital
- The Joint Commission accredited

Dimensions Healthcare FED—Bowie Health Center

- Location: Bowie, MD
- Co-located with 60-acre health campus
- Night-Light Program: after hours pediatric ED and urgent care
- The Joint Commission accredited

Michigan

Canton Emergency Department (Oakwood Healthcare)

- Location: Canton, MI
- Opened in 1988 as urgent care/emergency facility
- Since 2006, known as “Emergency Care”
- Co-located with outpatient medical campus
- 25 miles from hospital
- The Joint Commission accredited

Henry Ford Medical Center—Sterling Heights

- Location: Sterling Heights, MI
- Open 8:00 a.m.–5:00 p.m.
- Ultrasound
- The Joint Commission accredited

Henry Ford Medical Center—Fairlane

- Location: Dearborn, MI
- Open Mon., Tues., 8:00 a.m.–8:00 p.m.; Wed., Thurs., Fri., 8:00 a.m.–5:00 p.m.; Sat. 8:00 a.m.–12:00 p.m.
- Ultrasound
- The Joint Commission accredited

West Bloomfield (Henry Ford Health System)

- Location: West Bloomfield, MI
- Opened in 1975
- Ultrasound
- Opened as a full hospital in March 2009

Brownstown Township (Henry Ford Health System)

- Location: Brownstone Township, MI
- Opened in 2006 Co-located with physician offices, same-day surgery center, and medical imaging offices
- The Joint Commission accredited

Nevada

Carson Valley Medical Center

- Location: Carson Valley, NV
- Operated from 1996–2006
- Full hospital built onsite in 2006

Minden Medical Center

- Location: Minden, NV
- Open 8:00 a.m.–8:00 p.m., 7 days
- Dexa scan, CT, ultrasound, mammography, MRI (Tues. only), x-ray,
- Full lab
- Co-located with physician offices (general and specialty)
- The Joint Commission accredited

North Carolina

WakeMed North Healthplex—Raleigh

- Location: Raleigh, NC
- Seven private rooms
- Two pediatric-ready rooms
- 23-hour observation beds
- Co-located with a mediplex
- “Superclinic” offers full imaging, lab, outpatient clinics, surgery, rehab, endoscopy, and physician offices
- The Joint Commission accredited

Ohio

Avon Emergency Department (EMH Regional Hospital)

- Location: Avon, OH
- Open 24/7
- Helipad

Solon Medical Campus ED (St. Vincent Charity Hospital)

- Location: Solon, OH
- Open 24/7
- Lab, x-ray
- Ground/air transport
- Observation beds and critical care beds
- The Joint Commission accredited

South Carolina

Roper St. Francis Medical Center—Berkeley

(Roper St. Francis Healthcare)

- Location: Moncks Corner, SC
- Opened in 1991
- Open 24/7
- 24-hour lab/radiology services
- Co-located with outpatient surgery center, cancer therapy, wound care
- CT, mammography, ultrasound, bone density, X-ray, MRI (Wed. only)
- The Joint Commission accredited

Roper Medical Center—Northwoods

(Roper St. Francis Healthcare)

- Location: Northwoods, SC
- Opened in 1997
- Open 24/7
- 24-hour lab/radiology services
- The Joint Commission accredited

Texas

Community Emergency Center—Woodlands

(St. Luke's Episcopal Health Services)

- Locations: The Woodlands, Pearland, Houston, TX (The Vintage, Holcomb, San Felipe centers are in Houston)
- Open 24/7
- 14,000 square-foot facility
- Lab, x-ray, CT
- Does not accept transport, but provides interfacility transport
- The Joint Commission accredited

East Texas Medical Center, Emergency Centers

- Locations: Gun Barrel City, Rusk, and Tyler, TX
- Staffed by “trauma care specialists”
- Open 24/7
- “Complete radiology and lab services”
- The Joint Commission accredited

E-Care Emergency Center—Frisco

- Locations: Frisco and McKinney, TX
- Physician-owned
- Hours: Mon.–Sat., 10:00 a.m.–10:00 p.m.; Sun, 1:00 p.m.–10:00 p.m.
- Charge \$100 for urgent visit, \$200 for emergency visit

Virginia

Inova Emergency Care Center—Fairfax

- Location: Fairfax, VA
- Opened in 1987
- Open 24/7
- The Joint Commission accredited

Inova Emergency Care Center—Leesburg

- Location: Leesburg, VA
- Open 24/7
- Adjacent to Loudon Hospital
- Lab, x-ray
- The Joint Commission accredited

Inova Emergency Care Center—Reston/Herndon

- Location: Reston, VA
- Open 24/7
- The Joint Commission accredited

Inova HealthPlex Emergency Care Center

- Location: Alexandria, VA
- Open 24/7
- Co-located with HealthPlex
- The Joint Commission accredited

Washington

Swedish/Issaquah Emergency Room

- Location: Issaquah, WA
- Opened in 2005
- 14 exam rooms
- X-ray, CT, ultrasound, MRI
- Lab
- Plans for a full hospital to open 3 miles away (opening set for 2012)
- The Joint Commission accredited

Appendix B
Centers for Medicare and Medicaid
Services, “Hospital Outpatient
Prospective Payment System, Final
Rule.” Federal Register 73, Number 223
(18 November 2008): p. 68680

Dedicated Emergency Department

Section 489.24 of the EMTALA regulations defines “dedicated emergency department” as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

In the CY 2008 OP/ASC proposed rule (72 FR 42756), we reiterated our belief that every emergency department that meets the CPT definition of emergency department also qualifies as a dedicated emergency department under EMTALA. However, we indicated that we were aware that there are some departments or facilities of hospitals that meet the definition of a dedicated emergency department under the EMTALA regulations, but that do not meet the more restrictive CPT definition of an emergency department. For example, a hospital department or facility that meets the definition of a dedicated emergency department may not be available 24 hours a day, 7 days a week. Nevertheless, hospitals with such departments or facilities incur

EMTALA obligations with respect to an individual who presents to the department and requests, or has requested on his or her behalf, examination or treatment for an emergency medical condition. However, because they did not meet the CPT requirements for reporting emergency visit E/M codes, prior to CY 2007, these facilities were required to bill clinic visit codes for the services they furnished under the OP/ASC. We had no way to distinguish in our hospital claims data the costs of visits provided in dedicated emergency departments that did not meet the CPT definition of emergency department from the costs of clinic visits...

...In the CY 2007 OP/ASC final rule with comment period (71 FR 68132), we finalized the definition of Type A emergency departments to distinguish them from Type B emergency departments. A Type A emergency department must be available to provide services 24 hours a day, 7 days a week, and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department, specifically: (1) It is licensed by the State in which it is located under the applicable state law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment... We defined a Type B emergency department as any dedicated emergency department that incurred EMTALA obligations under §489.24 of the EMTALA regulations but that did not meet the Type A emergency department definition.

Appendix C

CMS OPPS Comparison of Type A/B Dedicated Emergency Departments and Outpatient Clinics

Table A. Comparison of Type A and Type B Dedicated EDs in November 2008

Description	CPT	Type A		Type B		Payment Difference	Percent Difference
		RVU	Payment	RVU	Payment		
Level 1 Visit	99281	0.7972	\$52.66	0.6840	\$45.18	-\$7.48	-14.21%
Level 2 Visit	99282	1.3040	\$86.14	0.9302	\$61.45	-\$24.69	-28.66%
Level 3 Visit	99283	2.0694	\$136.70	1.3418	\$88.64	-\$48.06	-35.16%
Level 4 Visit	99284	3.2987	\$217.91	2.4093	\$159.16	-\$58.75	-26.96%
Level 5 Visit	99285	4.9032	\$323.90	4.9032	\$323.90	\$0.00	0.00%
Critical Care	99291	7.3479	\$485.39	—	—	—	—

Source: Centers for Medicare and Medicaid Services (CMS), Outpatient Prospective Payment System (OPPS), November 2008

Table B. Comparison of Dedicated EDs and Outpatient Clinics in November 2008

Description	Type A Dedicated ED			Outpatient Clinic			Payment Difference	Percent Difference
	CPT	RVU	Payment	CPT	RVU	Payment		
Level 1 Visit	99281	0.7972	\$52.66	99201	0.8277	\$54.68	\$2.02	3.69%
Level 2 Visit	99282	1.3040	\$86.14	99202	1.0439	\$68.96	-\$17.18	-24.91%
Level 3 Visit	99283	2.0694	\$136.70	99203	1.3585	\$89.74	-\$46.96	-52.33%
Level 4 Visit	99284	3.2987	\$217.91	99204	1.7192	\$113.57	-\$104.34	-91.87%
Level 5 Visit	99285	4.9032	\$323.90	99205	2.4477	\$161.69	-\$162.21	-100.32%
Critical Care	99291	7.3479	\$485.39	—	—	—	—	—

Source: Centers for Medicare and Medicaid Services (CMS), Outpatient Prospective Payment System (OPPS), November 2008

What does this mean?

The payment difference and payment percent are for Dedicated ED—Outpatient. Therefore, the payment difference is the revenue saved by operating as a Dedicated ED vs. an outpatient clinic. The percent difference is the proportion of the amount saved. This means that FEDs can receive anywhere from 25 percent to 100 percent more revenue per visit by billing as an ED, not counting any additional procedure or other charges.

Appendix D

Delaware State Regulations, 4404

Free Standing Emergency Centers,

Sections 1.0 to 3.1

1.0 Definitions

“Free Standing Emergency Center” means a facility physically separate from a hospital, which uses in its title or in its advertising, the words “emergency,” “urgent care,” or parts of those words or other language or symbols which imply or indicate to the public that immediate medical treatment is available to individuals suffering from a life-threatening medical condition. The facility rendering such care is capable of treating all medical emergencies that have life-threatening potential.

2.0 License Requirement

2.1 No person shall establish, conduct or maintain in this State any Free Standing Emergency Center without first obtaining a license from the Division of Public Health.

2.2 Existing Institutions

2.2.1 No person shall continue to operate an existing Free Standing Emergency Center unless such facility is approved and regularly licensed by the State Board of Health as provided in this chapter.

2.3 Trailblazing Signs

2.3.1 No Free Standing Emergency Center, treatment facility, office or station shall be authorized to exhibit any Trailblazing signs, symbols, or directional signs by the State Highway Department unless such facility has been duly licensed under the provisions of this chapter.

2.4 Transfer Agreement

2.4.1 The Free Standing Emergency Center shall have a written transfer agreement with one or more hospitals, which provides the basis for effective working arrangements in which inpatient hospital care or other hospital services are available promptly to the facility’s patients when needed.

3.0 Application for License and Ownership

3.1 Application for license to establish, maintain or operate a Free Standing Emergency Center shall be made to the Division of Public Health stating the location thereof, the name of the person in charge and all other information necessary to determine the qualifications of the applicant.

Appendix E
Illinois State Regulations,
Section 1110.3230

Freestanding Emergency Center Medical Services, Excerpt

a) Introduction

1) These criteria are applicable only to those projects or components of projects involving the freestanding emergency center (FEC) medical services (FECMS) category of service. In addition, the applicant shall address other applicable requirements in this Part, as well as those in 77 Ill. Adm. Code 1100 and 1130. Applicants proposing to establish, expand or modernize an FECMS category of service shall comply with the applicable subsections of this Section, as follows:

Project Type	Required Review Criteria
Establishment of Service	(b)(1)— Planning Area Need—77 Ill. Adm. Code 1100 Formula Calculation
	(b)(2)—Service to Area Residents
	(b)(3)—Service Demand for Establishment
	(b)(4)—Service Accessibility
	(c)(1)—Unnecessary Duplication of Services
	(c)(2)—Maldistribution
	(c)(3)—Impact on Other Providers
	(c)(4)—Request for Data from Other Providers
	(e)—Staffing Availability
Expansion of Existing Service	(b)(2)—Service to Area Residents
	(e)—Staffing Availability
Category of Service Modernization	(d)(1)—Deteriorated Facilities
	(d)(2)—Documentation
	(d)(3) – Additional Documentation

- 2) If the proposed project involves the replacement of an FEC facility on site, the applicant shall comply with the requirements listed in subsection (a)(1) for Category of Service Modernization.
- 3) If the proposed project involves the replacement of the FEC facility on a new site, the applicant shall comply with the requirements listed in subsection (a)(1) for Establishment of Service.
- 4) All projects shall meet or exceed the utilization standards for the service, as specified in 77 Ill. Adm. Code 1100.
- 5) All projects for an FEC must comply with the licensing requirements established in the Emergency Medical Services (EMS) Systems Act [210 ILCS 50/32.5], including the requirements that the proposed FEC is located:
 - A) *in a municipality with a population of 75,000 or fewer inhabitants;*
 - B) *within 20 miles of the hospital that owns or controls the FEC; and*
 - C) *within 20 miles of the Resource Hospital affiliated with the FEC as part of the EMS system (Section 32.5(a) of the Emergency Medical Services (EMS) Systems Act).*
- 6) The applicant shall certify that it has reviewed, understands and plans to comply with all of the following requirements:
 - A) The requirements of becoming a Medicare provider of freestanding emergency services; and
 - B) The requirements of becoming licensed under the Emergency Medical Services Systems Act [210 ILCS 50].

Appendix F

Blue Cross Blue Shield Texas FED Reimbursement Criteria

The following is a summary of the BCBSTX criteria for a facility to be a free standing emergency care (FED) facility. Currently there are no free standing emergency facilities in Texas that meet these criteria.

1. The Facility complies with Emergency Medical Treatment and Active Labor Act (EMTALA) applicable requirements (whether or not it is subject to EMTALA).
2. The Facility must have and maintain appropriate standing arrangements for the transfer of the member to an acute care hospital with an emergency department if medically necessary.
3. Physicians performing services at the Facility must have additional training in Emergency Medicine and/or be board certified in Emergency Medicine.
4. The Facility must be open 24 hours a day, 7 days a week, with at least one emergency care qualified physician and one licensed nurse on duty at all times.
5. The Facility must have and maintain equipment and supplies suitable for provision of emergency care services.
6. The Facility must be accredited by one of the following programs:
 - The Joint Commission on the Accreditation of Healthcare Organizations
 - Accreditation Association for Ambulatory Health Care

This information is available at <http://www.bcbstx.com/hs/freestandingcriteria.htm>.

Appendix G

California Health & Safety Code 1798.175

Definition of “Emergency”

No person or public agency shall advertise itself as, or hold itself out as, providing emergency medical services, by using in its name or advertising the word “emergency” or any derivation thereof, or any words which suggest that it is staffed and equipped to provide emergency medical services, unless the person or public agency satisfies one of the following requirements:

- (1) Is a general acute care hospital providing approved standby, basic, or comprehensive emergency medical services regulated by this chapter
- (2) Meets all of the following minimum standards:
 - (A) Emergency services are available in the facility seven days a week, 24 hours a day.
 - (B) Has equipment, medication, and personnel experienced in the provision of services needed to treat, life-, limb-, or function-threatening conditions.
 - (C) Diagnostic radiology and clinical laboratory services are provided by persons on duty or on call and available when needed.
 - (D) At least one physician who is trained and experienced in the provision of emergency medical care who is on duty or on call so as to be immediately available to the facility.
 - (E) Medical records document the name of each patient who seeks care, as well as the disposition of each patient upon discharge.
 - (F) A roster of specialty physicians who are available for referral, consultation, and specialty services is maintained and available.
 - (G) Policies and procedures define the scope and conduct of treatment provided, including procedures for the management of specific types of emergencies.
 - (H) The quality and appropriateness of emergency services are evaluated at least annually as part of a quality assurance program.
 - (I) Provide information to the public that describes the capabilities of the facility, including the scope of services provided, the manner in which the facility complies with the requirements of this section pertaining to the availability and qualifications of personnel or services, and the manner in which the facility cooperates with the patient’s primary care physician in followup care.
 - (J) Clearly identifies the responsible professional or professionals and the legal owner or owners of the facility in its promotion, advertising, and solicitations.
 - (K) Transfer agreements are in effect at all times with one or more general acute care hospitals that provide basic or comprehensive emergency medical services wherein patients requiring more definitive care will be expeditiously transferred and receive prompt hospital care. Reasonable care shall be exercised to determine whether an emergency requiring more definitive care exists and the person seeking emergency care shall be assisted in obtaining these services, including transportation services, in every way reasonable under the circumstances.

Appendix H

California Health & Safety Code 1798.101 (b)

Exception for Emergency Services in Rural Areas

“In rural areas, as determined by the authority, when the use of a hospital having a basic emergency medical service special permit is precluded because of geographic or other extenuating circumstances, as determined by the authority, the medical director of the local EMS agency may authorize another facility which does not have this special permit to receive patients requiring emergency medical services if the facility has adequate staff and equipment to provide these services, as determined by the medical director of the local EMS agency.”

Appendix I

California Health & Safety Code Section 1797.221

Local EMS Agency Authority to Approve Scientific or Trial Studies

The medical director of the local EMS agency may approve or conduct any scientific or trial study of the efficacy of the prehospital emergency use of any drug, device, or treatment procedure within the local EMS system, utilizing any level of prehospital emergency medical care personnel. The study shall be consistent with any requirements established by the authority for scientific or trial studies conducted within the prehospital emergency medical care system, and, where applicable, with Article 5 (commencing with Section 111550) of Chapter 6 of Part 5 of Division 104. No drug, device, or treatment procedure which has been specifically excluded by the authority from usage in the EMS system shall be included in such a study. [Added by AB 3119 (CH 299) 1988. Urgency statute: Provisions became effective July 8, 1988. Amended by SB 1497 (CH 1023) 1996.]

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