



# Nonemergency Acute Care: When It's Not the Medical Home

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The American Academy of Pediatrics (AAP) affirms that the optimal location for children to receive care for acute, nonemergency health concerns is the medical home. The medical home is characterized by the AAP as a care model that “must be accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.” However, some children and families use acute care services outside the medical home because there is a perceived or real benefit related to accessibility, convenience, or cost of care. Examples of such acute care entities include urgent care facilities, retail-based clinics, and commercial telemedicine services. Children deserve high-quality, appropriate, and safe acute care services wherever they access the health care system, with timely and complete communication with the medical home, to ensure coordinated and continuous care. Treatment of children under established, new, and evolving practice arrangements in acute care entities should adhere to the core principles of continuity of care and communication, best practices within a defined scope of services, pediatric-trained staff, safe transitions of care, and continuous improvement. In support of the medical home, the AAP urges stakeholders, including payers, to avoid any incentives (eg, reduced copays) that encourage visits to external entities for acute issues as a preference over the medical home.

## INTRODUCTION

The American Academy of Pediatrics (AAP) is committed to the medical home model. The medical home is the optimal setting to provide comprehensive, continuous, coordinated, compassionate, and culturally effective care for infants, children, and adolescents, maximizing clinical outcomes that support long-term health while also providing family-centered care.<sup>1</sup> Recently, the notion of the service system has been extended to include the locus of health care provided outside, but in

## abstract



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coordination with, the medical home, known as the medical neighborhood. The medical neighborhood has been defined as “a clinical-community partnership that includes the medical and social supports necessary to enhance health, with the [medical home] serving as the patient’s primary ‘hub’ and coordinator of health care delivery” (Patient-Centered Primary Care Collaborative).<sup>2</sup> Patients’ medical neighborhoods may include actively participating providers of acute care services outside the medical home, as described in this statement. Resources for the comanagement of patients with subspecialty physicians with whom a relationship has been established to jointly care for a patient are available via the AAP’s National Center for Medical Home Implementation.<sup>3</sup>

Although the medical home is the ideal place for primary care and care for most acute illnesses, it must also serve the important role of coordinating acute care when these services cannot be received in the medical home because of access, after-hours timing, or other constraints. It may be helpful for the medical home to become familiar with acute care entities to guide patients to the most appropriate acute care entity when the medical home is not available. This process is similar to how specialty and emergency care is coordinated by the medical home. The recommendations in this statement may be used to evaluate available acute care entities, so that the medical home can play an active role in determining when a patient is best served by acute care entities. The AAP realizes that, in some communities, a medical home is not an option because of available local resources and that pediatricians and those caring for children should make every effort to support a medical neighborhood with the same goals.

Acute care for children outside the medical home, as a segment of the current health care industry, continues to grow in number of facilities, service paradigms, and scope. This type of care often provides more evening and weekend access, less travel and wait times, and sometimes less out-of-pocket and/or insurance copay costs, compared with acute care received in the medical home. Care received both in the medical home and provided by acute care entities is traditionally less expensive than care received in an emergency department. Many pediatric practices have expanded access by increasing hours of operation as well. Rapid innovation and growth of corporate acute care entities in health care contribute to the growth of acute care entities outside the medical home. These innovations in acute care models are evolving too quickly to be enumerated, but all should adhere to the same principles of high quality, appropriate, and safe care, with timely and complete communication with the medical home and are meant to be included in the principles and recommendations described in this statement.

Types of acute care services under the umbrella definition discussed in this document include treatment of children at urgent care centers, nonemergency hospital-based acute care entities, and retail-based clinics (RBCs) as well as via telemedicine encounters for acute care services. Other models of acute care to children outside the medical home, such as community paramedicine (paramedic-provided acute care beyond the scope of the familiar emergency response role), school-based illness clinics, and others, continue to evolve. Recommendations provided in this statement apply to all of these to provide guidance for acute care services for children that are

delivered outside of their medical homes.

Recognizing that the family or child may, in some circumstances and/or in some locations, choose to seek acute care services from these entities, it is important to develop and implement recommendations to avoid potential risks and unsafe situations, such as the following:

- treatment that is not consistent with pediatric best practice;
- fragmentation of care that is disconnected from the medical home;
- lack of access to the child’s complete medical and social history;
- lack of maintenance of a complete, accessible, central health record that contains all pertinent patient information;
- treatment recommendations that do not take into account the child’s previous response to treatment, chronic conditions, special health care needs, and family circumstances such as social determinants of health (eg, inability to afford prescription medications, prescribing opioids in family with parental dependence);
- missed opportunities for identifying unmet needs or delivering preventive services;
- use of tests for the purpose of diagnosis without proper follow-up;
- treatment of physical symptoms without recognition of a behavioral health illness or occult medical condition driving the symptoms;
- failure to maintain an appropriate and predetermined scope of practice for the acute care of children in an acute care setting;
- suboptimal care of children in an adult-focused delivery system, including under- and overutilization of diagnostic testing and medications; and

- failure to appropriately transfer patients who would best be served in the medical home or in an emergency department.

This policy statement presents a set of principles and recommendations for how nonemergency acute care services for children outside the medical home should be structured and operationalized. The core principles and standards outlined in this statement represent minimally acceptable staffing and performance. Meeting these standards alone will not ensure high-quality and appropriate services, and the AAP does not endorse any specific nonmedical home acute care entity.

The AAP recognizes that shifting economic and organizational dynamics of the health care system will support the continued existence and expansion of varying paradigms of acute care delivery to children outside the medical home. The medical home remains the best venue for delivery of pediatric care for chronic or complex conditions including behavioral health issues, for routine well-child care including preparticipation physical examinations and immunizations, and for whole-person care including health care issues affected by social determinants of health.

The AAP is committed to the medical home, optimally as the first point of contact for nonemergency acute care services. The AAP encourages pediatricians to use existing resources such as enhanced access scheduling, extended hours, and telehealth incorporated inside the medical home to improve access and promote the medical home as the first point of contact for acute care. In addition, the AAP supports innovation, peer-to-peer collaboration, and practice change to promote high-quality and accessible care for all children.

Despite the growth in pediatric acute care, there is little existing

literature beyond professional policy statements and industry white papers on the subject. Research on the nature, scope, quality, and outcomes of pediatric acute care outside of the medical home is limited. Given its growing importance, a better understanding of pediatric acute care outside the medical home should be an important focus for health service researchers. With these limitations, the recommendations in this statement represent expert consensus by leaders in pediatric primary care, the medical home, pediatric urgent care, pediatric emergency medicine, telemedicine, and related fields. Regulation of scope of practice for freestanding urgent care centers, RBCs, and telehealth services varies greatly between states. The principles and recommendations contained herein may be optimally applied within the constraints of applicable state and local regulations. This statement is meant to cover any combination of acute care services, such as a visit to an RBC that includes telemedicine-based care by a remote physician, but is not meant to apply to hospital emergency departments.

This policy statement replaces 2 previously published policy statements, “AAP Principles Concerning Retail-Based Clinics”<sup>4</sup> and “Pediatric Care Recommendations for Freestanding Urgent Care Facilities.”<sup>5</sup> Some community emergency departments provide nonemergency acute care services for children. Many of the principles outlined in this statement may be useful in these settings. Additional recommendations from the AAP are available in “Guidelines for Care of Children in the Emergency Department,”<sup>6</sup> which includes important recommendations regarding equipment, quality, and other standards for pediatric emergency departments, and

“School-Based Health Centers and Pediatric Practice.”<sup>7</sup>

## BACKGROUND

### Urgent Care and Nonemergency Hospital-Based Acute Care

Urgent care and nonemergency hospital-based acute care entities typically focus on providing acute assessment and management of mildly or moderately ill or injured adults and children, with an emphasis on rapid service and low cost. Freestanding urgent care facilities typically provide unscheduled visits but also may allow patients and families to make an appointment. Business models include individual businesses, franchises, affiliates of a specific health insurer, or subsidiaries of a hospital, among others. Most urgent care facilities have at least 1 physician on staff.

Urgent care facilities are generally considered a higher level of care than RBCs. Radiography, suturing of uncomplicated lacerations, splinting of uncomplicated musculoskeletal injuries, and simple laboratory tests are commonly offered. There is typically a physician on staff,<sup>8</sup> although the presence of nurse practitioners or physician assistants is common. Settings include after-hours care, freestanding urgent care-specific facilities, and designated areas in a hospital, often physically separate but adjacent to an emergency department. Thus, the scope of the urgent care facility often overlaps with that of an emergency department.<sup>9–11</sup> Urgent care has been cited as a less-expensive alternative to emergency department care for many common conditions.<sup>12,13</sup> Referrals from urgent care centers to emergency departments are common, although not always well coordinated.<sup>14</sup>

Approximately 20 000 physicians practice urgent care medicine in an estimated 9300 facilities<sup>15</sup> in the

United States, and these numbers are growing rapidly. Regulation of urgent care centers varies greatly between states, ranging from little oversight to actual prohibition of the use of the term “urgent care” except by emergency centers.<sup>16</sup>

Although the large majority of urgent care centers welcome patients of all ages, there is a growing number of pediatric-specific urgent care centers. The AAP recently established a Subcommittee for Pediatric Urgent Care, within the Section of Emergency Medicine, which has rapidly attained substantial membership, indicating a large interest in this emerging area of pediatrics.

### RBCs

RBCs, also called convenient care clinics, are typically found in supermarkets, pharmacies, and other similar retail locations. They have existed since the early 2000s, although they have experienced a good deal more growth in the past 7 to 8 years. They provide a limited scope of acute care services for adults and children. Nurse practitioners or physician assistants (often trained in family practice with limited pediatric training) typically staff RBCs, and there is usually not a physician on site. No appointments are necessary, and posted fees are generally less than those at a physician’s office. Most analyses of RBCs do not distinguish children’s care from adult care, although most have included acute care for common illnesses of children as an important piece of their product line. Convenience appears to dominate consumers’ choices to use RBCs.<sup>17</sup> A recent Price Waterhouse Coopers’ analysis of the Health Research Institute Consumer Insight Surveys documents young adults’ (and parents’) views of RBCs as convenient, quick, relatively inexpensive, and of reasonable quality.<sup>18</sup> One pediatric study reported that parents whose children had identified primary

care physicians (PCPs) still chose to use RBCs both for convenience and because they did not want to bother the PCP.<sup>19</sup> Most RBCs are in relatively affluent communities, with few in lower-income locations.<sup>20</sup> Costs of RBC visits are typically lower than for PCPs or urgent care centers, in part because of lower personnel costs (nurse practitioners, not physicians) and lower overhead costs. Many adults who use RBCs lack ongoing primary care; similar data do not exist for children receiving care at RBCs. A number of RBC sites have entered into agreements with local health care providers, often larger systems, to provide medical oversight to the RBCs, share medical records, and provide a source of ongoing primary care for RBC users. For example, the University of California–Los Angeles and CVS Pharmacy entered into a clinical supervision agreement in 2012, in which University of California–Los Angeles physicians serve as medical directors for several CVS Minute Clinics in Los Angeles County. The agreement includes notification of PCPs when their patients visit RBCs. The American Academy of Family Physicians has recently announced a partnership with CVS, which calls for substantial communication between RBCs and PCP offices.

Studies of care quality and costs in RBCs compared with medical homes have shown variable results. For example, ratings for care of otitis media and pharyngitis for children in a Minnesota network indicated high-quality ratings for the RBC visits compared with medical homes and urgent care centers.<sup>21</sup> On the other hand, another study (of Aetna claims data) indicated somewhat less continuity of care and decreased preventive care visits among children and adults who use RBCs.<sup>22</sup> A recent study indicated that more than half of acute care visits reflect new utilization: that is, visits that likely would not have occurred without an

available RBC. In this study, the use of RBCs was associated with a \$14 per member per month increase in costs, not a decrease.<sup>23</sup>

### Acute Care Telemedicine

Telemedicine is defined as the “use of medical information exchanged from 1 site to another via electronic communications to improve a patient’s clinical health status.”<sup>24</sup> The term “telemedicine” typically is limited to the use of these technologies when a provider delivers direct patient health services. The term “telehealth,” although often used interchangeably with telemedicine, is a broader term that includes telemedicine as well as other health-related services that use electronic information and communications technologies, such as health information sharing, health profession and patient education, and remote or mobile patient monitoring. Telehealth, telemonitoring, and other technology-driven innovations are evolving and have a significant impact in how acute care is delivered and communicated.<sup>25</sup>

Ideally, integrated acute care telemedicine is used to extend the medical home and has the ability to connect patients and families to their pediatrician. The medical home has the advantage of having the child’s complete medical history with access to their complete medical records, an established relationship, and the ability to convert a virtual visit to a face-to-face visit when medically appropriate and can arrange for direct follow-up and appropriate consultations within the patient’s community and payer network. Interest and integration of telehealth within the medical home are growing, and this model has great promise to increase access to care as well as patient and family satisfaction. Models have been successful in connecting primary care pediatricians to child care providers, to specialists for consultation, and to

patients in their community or while traveling.<sup>26,27</sup>

In contrast, acute care telemedicine outside the medical home includes direct-to-consumer care, insurance- and employer-sponsored programs, partnerships with RBCs or urgent care centers, and hospital-based programs. The technology used in these visits varies widely and has a direct effect on the type of care that can be provided. Live interactive video combined with diagnostic tools commonly called peripherals (eg, otoscopes and stethoscopes) or store-and-forward imaging and diagnostic tests may provide information equivalent to and conform to the standard expected of in-person care. The use of a telepresenter (defined by the Centers for Medicare and Medicaid Services as a medical professional at the originating site who presents a patient to the physician or practitioner at the distant site) may affect the type and quality of images and other information that is available to the provider; however, the use of a telepresenter is not always medically necessary.<sup>28</sup> Information about the specific technology and personnel used in acute care telemedicine programs outside the medical home must be considered when assessing their role in the provision of acute care services to children.

## RECOMMENDATIONS

Acute care entities serving infants, children, and adolescents outside the medical home must maintain the highest quality of care that is evidence informed and must communicate with the medical home so that optimal clinical and long-term health outcomes are achieved and child and family preferences for care are met. As they meet the following recommendations, providers of acute care services for children should strive to become full

members of their patients' medical neighborhoods, with the goal of providing accountable acute care that coordinates seamlessly with the medical home and other providers.<sup>29</sup>

### Core Principles for Acute Care Entities

Acute care entities that provide care to infants, children, and adolescents must adhere to the principles outlined in the following sections.

#### *Maximize Continuity of Care for the Child by Rapidly Communicating Information to the Medical Home and Referring the Child for Necessary Follow-up in the Medical Home*

The linkages between acute care entities and the medical home must include complete and timely communication, coordination of care, and collaboration. Complete documentation of care provided in acute care settings must be shared with the medical home in a prompt and proactive manner. The critical need for sharing of information should be communicated with families by both the medical home and acute care providers. Communication channels between acute care services and the medical home should be established via mutually acceptable formats. Providers in both the acute care entity and the medical home should be available to provide necessary clinical information to provide continuity of care between settings. In particular, when families contact the medical home for advice regarding tests or medications provided at the acute care facility, a complete set of progress notes, especially when treatment is outside of usual care, or the availability of the acute care entity provider are needed. Of note, some nonmedical home services have reported that documentation to the medical home is not provided because patients/parents do not authorize it. Under the Health Insurance Portability and Accountability Act (Pub L No.

104-191 [1996]), permission to share personal health information with another provider for the purposes of treatment does not require patient/parent authorization. Acute care entities should link children who do not have a PCP to a medical home in their community that is accepting new patients. The medical home should work with families to have access-to-care plans for all children and communicate with families what the preferred locations are for seeking care when the medical home is not available. In addition, acute care entities should ensure that all subspecialty referrals come from the medical home rather than an acute care provider.

#### *Provide Care That Is Based on the Best-Available Evidence and Have Clearly Defined Limits of Scope of Service That Are Transparent to Families and the Community*

Acute care entities for children should clearly provide information about their scope of care and should clearly define situations and appropriate responses that fall outside that scope. Leaders of acute care entities should give careful thought and planning to providing an appropriate scope of pediatric care services. All acute care service providers should adhere to the same standards of care for conditions treated as used in the pediatric medical home. These standards include evidence-informed, patient- and family-centered, predetermined approaches to common pediatric complaints, including fever, asthma exacerbations, lacerations, gastrointestinal tract complaints, potential fractures, and other musculoskeletal injuries. Confidentiality issues with adolescents, particularly around psychological and sexual reproductive rights, should be planned for and should comply with local laws. The availability of child-appropriate equipment, on-site and off-site laboratory testing,

and imaging should be taken into consideration.

Information regarding which conditions are or are not within the scope of the specific acute care setting should be readily available to and easily accessible by the public, including families, referring physicians, and other referral sources, such as triage nurse telephone services. Providing transparent scope-of-care parameters to communities ensures that families and those who refer are able to make safe decisions regarding the most appropriate access to care. Established and written principles for guiding care that fall outside the scope of care are critical to maintaining safe care. Protocols and statements of scope should include guidance on when even a common pediatric complaint is too severe to be appropriate for each type of acute care entity, such as injuries or illnesses that may warrant subspecialty consultation, hospitalization, advanced imaging, or invasive procedures. Scope should be reviewed periodically; changes in scope should be written, on the basis of the best-available evidence, and made clear to the public. In addition, recognition of limits to scope in potentially complex situations should be stated to families at the beginning of encounters.

Safe scope-of-practice guidelines also should include predetermined plans for addressing children with emergency medical conditions, occurring when staff members are physically present as well as before or after usual hours of operation. Statements of scope should include predetermined approaches to handovers of care when limits of care are reached or when a facility is closing. Web-based information, written information on site, and signage and directions to nearby emergency facilities can be especially helpful to those seeking care when no acute care facility staff are present.

Because of the nature of telemedicine services, establishing realistic scope-of-practice guidelines is challenging but remains essential. Where evidence-informed guidelines include diagnostic testing, certain complaints or diagnoses may not be appropriately handled as acute care telemedicine visits for children unless alternate means of reliable testing are available. In addition, telemedicine protocols need to consider that children may not be able to verbalize and explain symptoms to the same degree of reliability as adults. All guidelines for technology-enabled care must recognize and consider the limitations placed on providing safe care, including quality of transmitted information, such as audio and video, in interpreting findings. Acute care telemedicine and innovative new models of care should include distinct guidance on when a virtual visit should be converted to an in-person visit at the most appropriate facility. In addition, before beginning a telemedicine visit, the examiner should have clear plans on how and where to escalate the level of care if deemed appropriate during the context of the encounter. In addition to protocols for assessing a presenting patient's acuity and severity of illness and referring the patient to the appropriate level of care, if needed, the location of the patient should also be documented at the start of the encounter to have available in case of an emergency situation. Telemedicine providers of acute care should eliminate from their scope of practice complaints or diagnoses for which evidence supports the need for testing, unless alternate means of reliable testing are available. In addition, telemedicine providers of acute care should reflect in their protocols the limitations of available technology, including quality of transmitted information. Further information on the scope of practice for acute care telemedicine, as well as state

laws and regulations related to establishment of a physician-patient relationship, can be found in the AAP statement "Telemedicine: Pediatric Applications."<sup>25</sup>

Acute care entities should be prepared to handle the special considerations and complexity of acute illnesses of children with special needs. They should also have the knowledge and expertise to recognize, acutely manage, and appropriately refer in situations of child abuse and neglect and other aspects of interpersonal violence. The optimal location for well-child care, including preparticipation physical evaluations, management of chronic conditions, and immunizations, is in the medical home.

Given the variability of presentation, difficulties in assessment of symptoms, and often unpredictable response to treatment, the management of acute care for children younger than 2 years requires special expertise. Therefore, the AAP recommends that RBCs, telehealth services not directly connected with the medical home, and acute care services that lack pediatric expertise should not provide care to children younger than 2 years.

*Ensure That Staff Have Pediatric Training and Experience to Provide the Scope of Services Offered by the Entity*

Care for children in acute care settings outside the medical home should be provided by staff who have the training and experience to manage children with acute health problems and to initially assess and manage, initiate resuscitation if needed, and transfer patients who need emergency care. Educational opportunities directed at clinicians providing or administrators responsible for acute care for children are needed and are beginning to appear. Pediatric-trained, qualified physicians should provide meaningful oversight for

nonphysician providers, even when not legally required. Scope of care should be determined by the level of skill and competence of those staffing the entity. A clinician manager (a physician or physician-designee) who is empowered to address off-hours questions about imaging, laboratory tests, or prescriptions should be available to provide care coordination.

*Establish Protocols for Both In-Person and Technology-Enabled Care for Transitions of Care During Emergencies, During Situations Outside of Scope of Care, and for After-Hours Coverage*

Acute care entities, including telemedicine, serving children outside the medical home should have policies and procedures with pediatric-appropriate equipment<sup>30</sup>; provide staff training and enable system-level competency that ensures timely assessment and initial resuscitation and stabilization of children, as necessary, during emergencies; and be able to initiate transfer of children who need a higher level of care, including children with medical, traumatic, and behavioral or mental health emergencies. Protocols and prearranged agreements for appropriate triage, transport, and transfer to facilities capable of providing the appropriate level of care on the basis of the acuity of illness or injury of the child should be in place. This requirement for safe transitions of care includes access to written operations manuals inclusive of this information and sharing of information with emergency medical services (EMS), entities referring to the acute care entity, and emergency care providers receiving transfers.

Programs to monitor and improve the quality of care for children with emergencies should be in place for all acute care entities. Although written for the primary care provider, the AAP policy statement "Preparation for Emergencies in the Offices of

Pediatricians and Pediatric Primary Care Providers"<sup>30</sup> offers excellent guidance on the preparation, recognition, and response to children who need emergency care in an acute care facility setting. Simulation or mock codes, with scenarios that are complete from patient presentation to departure, are often an important component of preparing for emergencies. Telemedicine services also need to be prepared to address emergencies, including contacting local EMS near the patient. When a patient is determined to require transfer to an emergency setting, the transfer process should be prompt, without delays related to additional evaluation or treatments. Acute care entities should be ready to provide emotional support to patients requiring emergency care and their families.

Planned coordination with local EMS is essential. Providers in acute care entities should be able to distinguish, ideally via predetermined criteria and in conjunction with families, which patients need pediatric transport teams (if available), emergency ambulance transfers, or nonemergency ambulance-based transfers and which patients may be transferred by other means, such as personal vehicle. Many acute care facilities have benefitted from familiarizing local EMS providers with the facility's physical plant and familiarizing the acute care facility's staff with their local EMS's pediatric capabilities. Transfer arrangements with area hospitals capable of providing pediatric or adult emergency care, as necessary, are critical. Acute care entities may be important participants in local and regional disaster plans by providing public health surveillance to assist in the identification of disasters and epidemics, countermeasures, and patient education in the case of actual or potential outbreaks and pediatric primary care services when disaster disrupts the medical home.

*Implement Strategies for Continuous Assessment and Improvement for Quality of Care and Patient Safety*

An acute care entity must implement strategies for systematic and ongoing assessment of the care it provides to achieve safe, effective, and family-centered care.<sup>31,32</sup> It is challenging to provide care in these settings that are typically high volume, provide episodic care in the context of no previous knowledge of the child, and may be more geared to providing adult medical care. Because of this situation, it is imperative to have a comprehensive quality-improvement effort focusing on child health. Avoidance of medical errors that are of particular concern for children should be central to quality-improvement efforts.

**Recommendations for Research Agenda**

With new paradigms of nonemergency acute care being introduced and grown in a rapidly developing service environment, research will be needed to ensure that the recommendations mentioned above are effectively implemented and deliver desired outcomes. Key areas of focus that the research agenda should encompass include the following:

- benchmark data research on clinical practice parameters;
- research on quality metrics and outcomes;
- comparative research between different categories of nonemergency acute care services, including academic urgent care centers, RBCs, telemedicine, nonprofit versus for-profit providers, etc;
- research on patient satisfaction (eg, wait times, time and distance to access, hours of operation, etc);
- best practices and protocols;
- demographic and socioeconomic impacts on utilization of

nonemergency acute care services outside the medical home and associated outcomes;

- research on transfer protocols and outcomes of children transferred to a higher level of care from nonemergency acute care entities;
- health policy and regulatory research (eg, optimal models for care delivery and cost analysis);
- comparative analysis of state standards and regulations beneficial to optimized nonemergency acute care in synergy with the medical home; and
- the effects of acute care providers' participation in the medical neighborhood.

## CONCLUSIONS

The AAP believes that every child deserves a medical home. The medical home is the ideal place for primary care and care for most acute illnesses as well as serving the role of coordinating acute care when these services cannot be received in the medical home because of access, after-hours timing, or other constraints. The AAP encourages pediatric practices to use innovative ways to meet patient and family needs within the medical home. Some families choose to seek acute care outside of the medical home, in an environment of increasing availability of choices for families to access such care.<sup>33</sup> To provide high-quality, safe, and appropriate care, acute care entities serving infants, children, and adolescents must adhere to key principles, including rapid communication of information to the medical home and provision of care based on the best-available evidence. The management of acute care for children younger than 2 years requires special expertise. The AAP recommends acute care entities that lack pediatric expertise should not provide care to children

younger than 2 years. All acute care service providers should adhere to the same standards of care for conditions treated as used in the pediatric medical home. The scope of care offered to children should be appropriate, well defined, and well communicated to families and the community. Additional guidance for patients and families may be found in the Supplemental Information. Providers and staff must have the training and experience to manage ill and injured children. Providers within acute care entities must be able to rapidly assess, begin resuscitation and stabilization, and initiate transfer of children with emergencies. Consistent oversight, planning, and quality monitoring and improvement in acute care entities are crucial for patient safety.

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## ABBREVIATIONS

AAP: American Academy of Pediatrics  
EMS: emergency medical services  
PCP: primary care physician  
RBC: retail-based clinic

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## REFERENCES

1. American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110(1 pt 1):184–186
2. Patient Centered Primary Care Collaborative. Definition of medical neighborhood. Available at: <https://www.pcpcc.org/content/medical-neighborhood>. Accessed June 12, 2016
3. American Academy of Pediatrics. AAP medical home resources. Available at: <https://www.aap.org/en-us/professional-resources/practice-support/medicalhome/Pages/home.aspx>. Accessed June 12, 2016
4. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. AAP principles concerning retail-based clinics. *Pediatrics*. 2014;133(3). Available at: [www.pediatrics.org/cgi/content/full/133/3/e794](http://www.pediatrics.org/cgi/content/full/133/3/e794)
5. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Pediatric care recommendations for freestanding urgent care facilities. *Pediatrics*. 2014;133(5):950–953
6. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians Pediatric Committee. Joint policy statement—guidelines for care of children in the emergency department. *Pediatrics*. 2009;124(4):1233–1243
7. American Academy of Pediatrics, Council on School Health. School-based health centers and pediatric practice. *Pediatrics*. 2012;129(2):387–393
8. Weinick RM, Bristol SJ, DesRoches CM. Urgent care centers in the U.S.: findings from a national survey. *BMC Health Serv Res*. 2009;9:79
9. Conners GP, Hartman T, Fowler MA, Schroeder LL, Tryon TW. Was the pediatric emergency department or pediatric urgent care center setting more affected by the fall 2009 H1N1 influenza outbreak? *Clin Pediatr (Phila)*. 2011;50(8):764–766
10. Conners GP, Doyle SJ, Fowler MA, Schroeder LL, Tryon TW. System stresses in two pediatric emergency departments and two pediatric urgent care centers during the 2014 Enterovirus-D68 outbreak [published online ahead of print September 23, 2016]. *Pediatr Emerg Care*. 10.1097/PEC.0000000000000856
11. Yard EE, Comstock RD. An epidemiologic comparison of injuries presenting to a pediatric emergency department and local urgent care facilities. *J Safety Res*. 2009;40(1):63–69
12. Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Aff (Millwood)*. 2010;29(9):1630–1636
13. Montalbano A, Rodean J, Kangas J, Lee B, Hall M. Urgent care and emergency department visits in the pediatric Medicaid population. *Pediatrics*. 2016;137(4):e20153100
14. Gardner R, Choo EK, Gravenstein S, Baier RR. “Why is this patient being sent here?”: communication from urgent care to the emergency department. *J Emerg Med*. 2016;50(3):416–421
15. American Academy of Urgent Care Medicine. Future of urgent care. Available at: <http://aaucm.org/about/>

- future/default.aspx. Accessed June 12, 2016
16. Williams M, Pfeffer M. Freestanding emergency departments: do they have a role in California? Oakland, CA: California Healthcare Foundation; 2009. Available at: [www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FreestandingEmergencyDepartmentsIB.pdf](http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FreestandingEmergencyDepartmentsIB.pdf). Accessed June 12, 2016
  17. Chang JE, Brundage SC, Chokshi DA. Convenient ambulatory care—promise, pitfalls, and policy. *N Engl J Med*. 2015;373(4):382–388
  18. Health Research Institute. Primary care in the New Health Economy: time for a makeover. Available at: <http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-primary-care-new-economy-2016.pdf>. Accessed October 4, 2016
  19. Garbutt JM, Mandrell KM, Allen M, et al. Parents' experiences with pediatric care at retail clinics. *JAMA Pediatr*. 2013;167(9):845–850
  20. Iglehart JK. The expansion of retail clinics—corporate titans vs. organized medicine. *N Engl J Med*. 2015;373(4):301–303
  21. Mehrotra A, Liu H, Adams JL, et al. Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses. *Ann Intern Med*. 2009;151(5):321–328
  22. Reid RO, Ashwood JS, Friedberg MW, Weber ES, Setodji CM, Mehrotra A. Retail clinic visits and receipt of primary care. *J Gen Intern Med*. 2013;28(4):504–512
  23. Ashwood JS, Gaynor M, Setodji CM, Reid RO, Weber E, Mehrotra A. Retail clinic visits for low-acuity conditions increase utilization and spending. *Health Aff (Millwood)*. 2016;35(3):449–455
  24. American Telemedicine Association. What is telemedicine? Available at: [www.americantelemed.org/learn/what-is-telemedicine](http://www.americantelemed.org/learn/what-is-telemedicine). Accessed June 12, 2016
  25. Burke BL Jr, Hall RW; American Academy of Pediatrics, Section on Telehealth Care. Telemedicine: pediatric applications. *Pediatrics*. 2015;136(1):www.pediatrics.org/cgi/content/full/136/1/e293
  26. Gans D, Battistelli M, Ramirez M, Cabezas L, Pourat N. *Assuring Children's Access to Pediatric Subspecialty Care in California*. Los Angeles, CA: UCLA Center for Health Policy Research; 2013
  27. Herendeen N, Deshpande P. Telemedicine and the patient-centered medical home. *Pediatr Ann*. 2014;43(2):e28–e32
  28. US Department of Health and Human Services. Medicare Carriers Manual. Part 3—claims process. Washington, DC: US Department of Health and Human Services; 2003. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r1798b3.pdf>. Accessed June 12, 2016
  29. Pham HH. Good neighbors: how will the patient-centered medical home relate to the rest of the health-care delivery system? *J Gen Intern Med*. 2010;25(6):630–634
  30. Frush K; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Preparation for emergencies in the offices of pediatricians and pediatric primary care providers. *Pediatrics*. 2007;120(1):200–212
  31. Dudley N, Ackerman A, Brown KM, Snow SK; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians Pediatric Emergency Medicine Committee; Emergency Nurses Association Pediatric Committee. Patient- and family-centered care of children in the emergency department. *Pediatrics*. 2015;135(1). Available at: [www.pediatrics.org/cgi/content/full/135/1/e255](http://www.pediatrics.org/cgi/content/full/135/1/e255)
  32. Krug SE, Frush K; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Patient safety in the pediatric emergency care setting. *Pediatrics*. 2007;120(6):1367–1375
  33. American Academy of Pediatrics. Managing the practice. Available at: <https://www.aap.org/en-us/professional-resources/practice-transformation/managing-practice/Pages/patient-access-management.aspx>. Accessed October 4, 2016