

Freestanding Emergency Departments Gain Traction
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Editor's Note: In February, 2012, Alan Ayers examined the emerging business model of freestanding emergency rooms and their potential impact on urgent care centers. Since that time, the freestanding ED phenomenon has shown significant growth, particularly among independent, for-profit operators. This article provides an overview of freestanding EDs and explores what their proliferation means for urgent care.

Introduction to Freestanding Emergency Departments

Freestanding emergency departments (FSEDs) are walk-in medical facilities—structurally separate and distinct from a hospital—which hold themselves out to provide emergency care to the general public. While FSEDs claim many similarities to hospital EDs—capabilities to diagnose and stabilize cardiac arrest, stroke symptoms, breathing problems and trauma—there are also significant differences.

Unlike hospital EDs, most freestanding emergency facilities:

- lack trauma level verification by the American College of Surgeons,
- do not receive patients via ambulance diversion or transfer,
- do not have overnight beds or intensive care capabilities,
- lack inpatient referral or admissions capabilities, and
- are unprepared to handle volume influxes from natural and man-made disasters.

In general, FSED patients are ambulatory and present themselves with what would triage as a lower priority level (urgent or semi-urgent) in a hospital ED. If a severely ill patient who presents at an FSED is determined to require a hospital admission, surgery or specialist care, he/she is stabilized and transferred by paramedic to a higher acuity facility.

FSEDs differentiate themselves from their hospital-based counterparts in terms of the patient experience. Hospital EDs have a reputation for long wait times, busy staff, and crowded, uncomfortable waiting rooms. Whereas national studies reflect average 4-hour wait times in the nation's ERs, FSEDs focus on turning patients within 60 minutes. And whereas the average hospital ED sees 150-200 patients per day, depending on the business model, many freestanding EDs often see as few as 35-40 patients per day and some private operators are profitable at less than 20.

Exhibit 1.0: Retail Locations

First Choice Emergency Room in Plano, Texas is located in an upscale strip shopping center with co-tenants that include Whole Foods Market, Barnes & Noble, Verizon Wireless, and Sports Authority. The center is less than 8 minutes from three hospital trauma centers, with the closest accredited trauma center being only 1.6 miles away. These hospitals all aggressively advertise the “short wait times” for their ER services. The Baylor University Heart Hospital down the street has the area's only dedicated trauma room for cardiac emergencies.



Relative to urgent care centers, FSEDs offer slightly more advanced capabilities (illustrated in Appendix A). In addition to digital x-ray and procedure rooms common to urgent care, FSEDs add CT, MRI, ultrasound, CLIA-certified lab, EKG, and advanced life support. Whereas urgent care centers may be staffed with any combination of family or emergency physicians and mid-level practitioners; FSEDs are almost always staffed with board certified Emergency Medicine physicians and ER-trained nurses. And while urgent care centers typically operate 12 to 14 hours a day, FSEDs operate 24 hours a day, 365 days a year.

Like many urgent care centers, FSEDs are typically located in highly visible developments (Exhibit 1.0) and have tasteful décor that includes residential-style furnishings and granite countertops, conveniences like Wi-Fi and exam room cable television, gourmet coffee and refreshment bars, children’s play areas and pediatric-themed rooms. In many cases, the atmosphere is more reminiscent of a “day spa” than a cold, sterile hospital ER (Exhibit 2.0).

Exhibit 2.0: Upscale Design

Private freestanding emergency centers have designed their facilities to resemble boutique hotel lobbies or elegant day spas rather than “sterile” or “clinical” environments common to hospitals. Pictured are Elite Care of San Antonio (left) and Highland Park Emergency Center (right) in Dallas, Texas.



Count and Growth of Freestanding Emergency Departments

In 2009, the last year national statistics for freestanding emergency centers were published, the American Hospital Association counted 241 centers in 16 states¹. This is up from 146 in 2005—applying the same growth rate, the current estimate is between 350 and 400 FSEDs in the United States today.

FSED growth is being driven in large part by hospitals and health systems expanding their footprints into growing suburban areas. This strategy is reflected in states like Delaware and Colorado, where a handful of FSEDs have taken a hybrid approach between a hospital ER and an outpatient clinic. For example, some of these centers offer ambulatory surgery in addition to emergency care, or they have some overnight beds for emergency patients requiring observation and possible referral to a full-service hospital.

Texas is leading the nation in FSED growth, with about 85-90 centers open and a dozen more under construction. The prevailing model in the state is the pure-play emergency center, targeting insured patients with moderately acute conditions, who have other options (hospital ERs and urgent care), but who are willing and able to sacrifice a higher co-pay for the shorter wait time and more personalized service of the FSED.

Texas is unique in that its FSED growth has been driven more by entrepreneurs than hospital operators (Exhibit 3.0), but regardless, the growth and placement of the centers reflects the national trend—to serve affluent family demographics. Despite Texas’ size and number of medically underserved counties, the vast majority of FSEDs have opened in relatively condensed areas—the highly competitive suburbs of Dallas, Houston, San Antonio, and Austin.

Exhibit 3.0: Rapid Expansion of Entrepreneurial Models in Texas

Elite Care 24-Hour Emergency Center, a Houston-based private operator with six locations statewide, recently opened a location in The Colony, Texas (right), in the outlot of Target fronting the affluent 121-Tollway corridor North of Dallas. A second location nine miles away in Coppell, Texas (left)—likewise fronting 121 adjacent to Whataburger—is scheduled to open in the Fall of 2013.



Freestanding Emergency Department Operating Models

Freestanding emergency departments are operated by hospitals, individual physicians and physician groups, and non-physician entrepreneurs. Just as there is variance in the capabilities and offerings of urgent care centers, the operating models of FSEDs vary depending on the ownership, location, size, competition, and target patient demographics of the facility.

Hospitals are turning to this model as a more cost effective way to expand their footprint into new areas without the risky and exponentially costlier investment of building a full service hospital (Exhibit 4.0). FSEDs, like hospital EDs, are an excellent source of referrals for inpatient care. Health systems can expand their revenue base by “capturing” patients from suburban communities into their FSEDs and then “pushing” them to specialists at their urban hospital campus. As a competitive play, FSEDs expand the hospital’s brand presence. That’s why many FSEDs are opened to compete head-to-head against other hospitals or health systems (Exhibit 5.0).

Exhibit 4.0: Non-profit health systems like Columbus-based OhioHealth Corporation use freestanding EDs to establish a competitive presence in fast-growing suburban areas without going through the Certificate of Need process involved with opening a new hospital. The ERs are part of medical campuses that include primary care and specialist offices, pharmacy, imaging, laboratory, physical therapy, occupational health, and even a Tim Horton’s Coffee and Bake Shop. Two facilities—one that opened in 2012 and one under construction—are less than 4 miles from system-affiliated urgent care centers. The urgent care centers refer higher-acuity patients to the ER centers to keep them within the “system.”



According to the Healthcare Financial Management Association (HFMA), five factors are driving hospital systems to utilize freestanding ERs in their strategies to increase market penetration and improve financial performance:

- Increased demand for hospital emergency services, including a steady increase in patients who commonly utilize hospital EDs for their primary health care needs.
- Dysfunction in legacy hospital EDs including inadequate number of beds and treatment areas, poor space configuration, and inefficient operations leading to ED wait times of up to 12 hours or longer in some cases—which cause hospitals to fall short of benchmark measures on ED length of stay.
- Ability to expand the hospitals’ brand and physical footprint without the capital costs and certificate of need requirements of building a new hospital or outpatient campus.
- Ability to expand incremental use of hospital-based services, capture referrals for the hospital and its affiliated providers, differentiate from competing hospitals, and mitigate competitive threats from urgent care centers, retail clinics and other on-demand providers.
- Identical reimbursement for freestanding ER and hospital ED patients.

Although HFMA lists “co-location with complimentary ambulatory services like imaging, laboratory and physician offices” as a critical success factor for freestanding ERs, many new freestanding ERs are stand-alone retail operations, completely separate from any other hospital-affiliated outpatient services.

Exhibit 5.0: Hospital Expansion into Freestanding ERs
Medical Center of Plano, an HCA-affiliated hospital with its own Level II trauma center, has planned a 10,500-sq. ft. “satellite ER” to be located immediately across the highway from Centennial Medical Center—a competing Tenet hospital whose ER has received Advanced Certification as a Primary Stroke Center and is an Accredited Chest Pain Center. Centennial’s website proclaims an “average 20 minute wait to see a healthcare provider” and its ER offers a schedule-ahead service called “InQuicker.” So access and wait times for emergency services are simply not issues being resolved by another ED in this neighborhood.

PLANO
Medical Center breaks ground on new ER

The Medical Center of Plano broke ground last week on its newest facility, a satellite emergency room at 3760 State Highway 121.

The 10,500-square-foot ER will operate 24 hours a day, seven days a week and will have both certified emergency physicians and staff members with specialized training in pediatrics. The ER will also have 12 private patient rooms with two rooms themed for pediatric care.

The facility is scheduled to open in January 2014.

For more information, visit the medicalcenterofplano.com.

Elizabeth Knighten

3760 Texas 121 Frisco, TX 75025

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For entrepreneurs, the FSED model is a way to turn a profit. An often-cited reason for Emergency Medicine physicians to open their own FSEDs is their desire to escape the bureaucratic challenges associated with large health systems and ER staffing groups, especially when their beliefs on how care should be delivered differ from management. FSEDs smaller, less hectic scale allows providers to spend more quality time interacting with patients, educating them and meeting their needs more fully. Working in or owning an FSED provides emergency physicians with much-desired autonomy.

Freestanding Emergency Department Billing Practices

FSED charges can be up to ten times the cost of a comparable visit to primary or urgent care. The primary culprit is the “facility fee”—a fee historically charged by hospitals to cover the high overhead of being prepared to handle any situation that presents while subsidizing charity and indigent care. While FSEDs argue facility fees are necessary and appropriate because FSED capabilities are similar to hospital EDs, patients and payers have questioned the legitimacy of facility fees because the centers—particularly storefront physician-owned FSEDs that resemble “doctor’s offices”—have a very different cost structure than full-service hospitals.

Although most hospital-affiliated FSEDs are contracted with insurance as in-network facilities, many independent FSEDs are not contracted despite advertising they “will bill your insurance.” They’re taking advantage of a “loophole” that requires payers to cover emergency services. What happens is the FSED bills the insurance company as an out-of-network provider and even if the insurance company marks down its payment to “usual and customary charges” or “in-network rates”—because there is no contract with the payer—the FSED can then balance bill the patient. This leads to patient confusion and “fighting” with FSEDs (and their collection agencies) for weeks—especially if the patient went to the center under the impression that their insurance is “accepted by” (contracted with) the center.

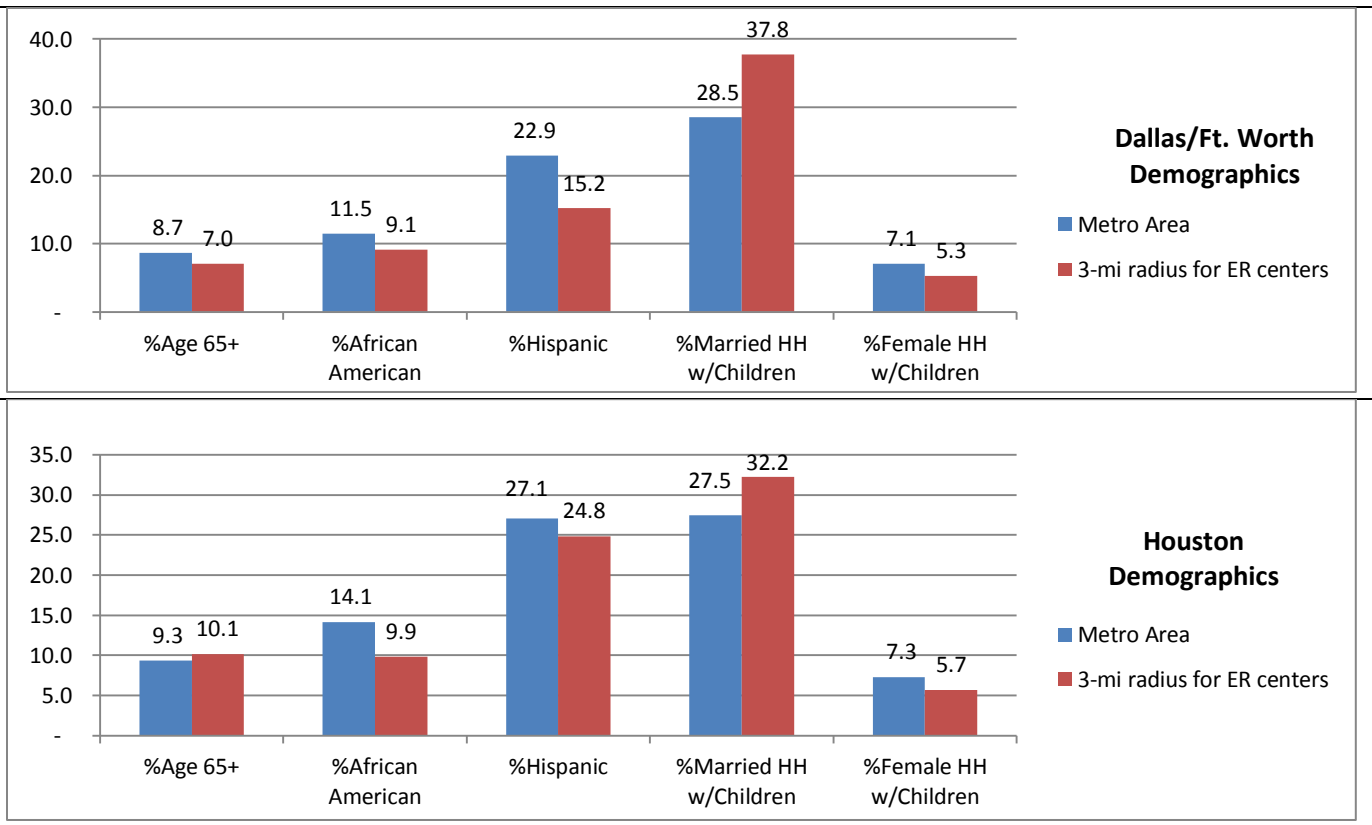
Aetna has filed at least three lawsuits against FSEDs that charge facility fees. Their primary concern is that these centers charge a fee applicable to hospitals when they are not a comparable entity; hospitals have inpatient capabilities and offer a wide range of services, whereas the vast majority of FSEDs offer only emergency care.² Another large insurance provider, Blue Cross Blue Shield of Texas, is warning members about the exorbitant fees charged by FSEDs. On its website, BCBS clearly states that these centers are out-of-network, are not comparable to hospital EDs in level of care, and that treatment there may incur additional expenses to the patient.³

Freestanding Emergency Room Demographics

The physical locations of many FSEDs reveal a clear bias towards affluent, densely populated suburbs of large cities. Although an argument could be made that FSEDs expand access to emergency services—these areas are already hyper-competitive among existing health systems for ED patients. In general, FSEDs are not located to serve the Medicaid and indigent populations who rely on the “safety net” of urban hospital emergency rooms.

Evaluating the residential demographics surrounding each Texas FSED confirms these trends. In the Dallas/Ft. Worth and Houston markets, the average 3-mile radius of an FSED reflects a median household income \$15k and \$20k higher (respectively) than the metropolitan averages. In addition, FSEDs are located in less diverse communities (smaller proportion of Hispanic and African-American residents) with a significantly higher proportion of married households with children (Exhibit 6.0). The same patterns have been noted in Seattle, Washington, where several FSED operators have opened in affluent neighborhoods already served by emergency rooms.⁴

Exhibit 6.0: These charts represent the results of a study analyzing the average demographics around an FSED (3 mi radius) versus the average for the metropolitan area. The communities in which FSEDs are located have higher incomes, more married families, and less racial/ethnic diversity.



So why are FSEDs targeting areas with established competition? Much of the reason lies in the investment to build and operate this type of center. Capital requirements range from \$3.5 million⁵ to \$20 million,⁶ plus the ongoing cost of permanently staffing a center 24/7 with Emergency Medicine nurses and physicians. To turn a profit, centers must be placed in areas where utilization and insurance coverage are high—where consumers are less sensitive to the cost differential of an emergency room co-pay—and that’s typically in suburban areas with high percentages of working professionals with families.

Instead of adding costly capacity to already crowded suburban markets, FSEDs should be located where there is truly a “need”—areas where hospital ER’s are not accessible, but where developing a full-scale hospital is not financially viable.⁷

Federal and State Regulation of Freestanding Emergency Departments

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals participating in government health programs (Medicare, Medicaid, and/or Tricare) provide emergency medical treatment to any presenting patient, regardless of the patient’s ability to pay. Generally a hospital’s obligation under EMTALA is to provide an evaluation as to whether an emergent condition exists; if an emergent condition does exist, to provide treatment until that condition stabilizes; and last, to transfer patients to an appropriate specialized facility if care is required beyond the hospital’s capabilities. A freestanding ED that is affiliated with a hospital is generally subject to EMTALA while independently-owned facilities often forego the EMTALA’s requirements by opting out of federal health programs.

In Texas, legislation regulating FSEDs was passed in 2009 to ensure facilities offering “emergency care” were comparable in capabilities to hospital EDs. Not only does the Texas law impose an “EMTALA-like” standard—a screening exam and treatment of emergency conditions without charge—it requires a license from the state. “Minimum standards” are defined as 24-hour operations, at least one licensed physician and nurse on staff at all times, and a stipulation that the Texas Department of State Health Services can inspect the facility at any time.

Additionally, the Texas legislation requires insurance companies to cover any initial screening exam to determine if an emergent condition exists. And if an emergency is present, insurance must also cover the care given to treat it. Regardless of whether the center is contracted with insurance, care must be covered at the preferred level of benefits.

Prior to the Texas legislation, numerous entrepreneurial emergency centers operated evening and weekend hours but were not open 24-hours. The expectation was that many of these centers would close as the added costs and thin volumes of overnight operations would render the business model unprofitable. While some centers did close (Exhibit 8.0) and others converted to “urgent care,” most centers simply adapted to the regulation. The conclusion is that the margin on billing ER rates is sufficiently high enough to support 24-hour operations, even if nights are slow.

Exhibit 8.0: Adaptation to the Texas Regulations

When Texas passed legislation requiring freestanding ERs to be open 24-hours a day, among other requirements, most ER centers adapted by expanding their hours. A few, like the former physician-owned Town Center ER in Coppell, Texas (right), shuttered their doors, while others re-opened as “urgent care” or relocated to areas more visible for a 24/7 operation.



How Freestanding Emergency Departments Add to Health Care Costs

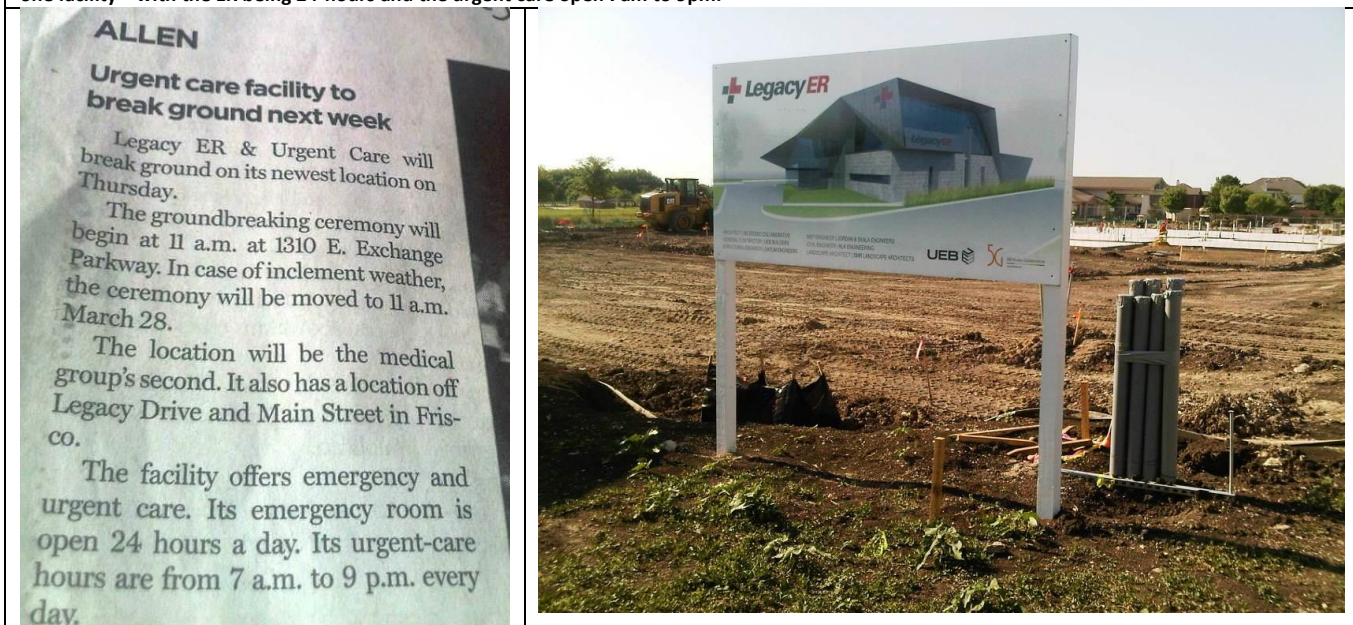
Health care is most efficient when the acuity of the patient’s condition matches the capabilities of the facility and provider. For emergencies that require capabilities beyond that of an urgent care center, but not a full-service hospital, freestanding emergency rooms may be an appropriate “plank” in the health care delivery continuum. The problem, however, is when patients go to an emergency facility for non-emergent conditions. Through a combination of laws and the facility fee, the bill for the non-emergent condition could be many times greater than what the patient anticipated, and certainly higher than what was needed. This is the biggest criticism of FSEDs—that they will treat conditions that could be treated in primary or urgent care, but they’ll charge hundreds of dollars more.

More significant is the 95 to 97 percent of freestanding ER patients who are discharged to the street—just as some studies indicate that up to 85 percent of all hospital ED patients can be treated in lower acuity settings—many if not all of these low-acuity freestanding ER patients could be treated for lower cost in urgent care centers. Especially since freestanding ER’s—by virtue of their suburban retail locations—do not serve the same chronically ill patient base as their urban hospital counterparts.

Consumers are generally savvy in self-triage—they understand when a medical issue warrants calling 9-1-1, going to a hospital emergency department, going to an urgent care center, or simply utilizing over-the-counter products. If a patient exhibits low- to mid-level acuity, he/she should understand the most cost effective care option is an urgent care center or his/her primary care physician—not an ER. For the small number of emergent cases that present at the freestanding ERs, there may be more advanced capabilities present, but the same process occurs as an urgent care center to transfer those patients by paramedic to the nearest hospital. A barrier to patient understanding is likely the co-existence of hospital EDs, freestanding EDs, urgent care, and primary care in a community (Exhibit 9.0).

Exhibit 9.0: Confusion in the Marketplace

Freestanding ER centers are contributing to confusion in the marketplace as to what constitutes “emergency” versus “urgent care.” Providers like Legacy ER & Urgent Care, with two locations in the North Dallas suburbs, exacerbate this confusion by offering both ER and urgent care services in one facility—with the ER being 24-hours and the urgent care open 7am to 9pm.



Freestanding Emergency Department Marketing Strategies

Given that freestanding emergency facilities appeal to upper-income consumers, a conclusion may be reached that time-starved professionals with employer-paid health insurance are undeterred by emergency room co-pays *if they believe* an FSED has shorter wait times, more sophisticated capabilities, and better qualified providers than other options, including urgent care centers—regardless of whether such capabilities are *needed* for their conditions or whether their *perceptions* are even reality.

Exhibit 7.0: Direct Mail Marketing

Freestanding ERs are employing many of the same marketing tactics as urgent care centers. Although one would typically associate emergency rooms with trauma, resuscitation and hospital admissions, in the direct mail piece to the left, Elite Care 24-Hour Emergency Center features a seemingly happy little girl receiving what resembles more a pediatric well-child physical than an emergency situation. While the ad states the center “accepts most insurance plans,” Elite Care is actually out-of-network with the leading plans in its market. To the right, First Choice Emergency Room offers recipients of its direct mail post card a “Free Starbucks Gift Card” just for coming into the center.



To attract insured patients who can afford it, FSEDs market their ability to treat urgent as opposed to emergent conditions, their “cutting edge” technology, their sleek new facilities, and their provider’s board certifications. Additionally, FSEDs place a lot of emphasis on very short wait times. On average, the length of an ER visit in 2010 was just over 4 hours⁸, so affluent patients who place a dollar-premium on their time can be seen in “10 minutes or less” at an FSED. Given their marketing messages, and similar marketing tactics to urgent care centers, it’s obvious why consumers become confused as to when to use an FSED versus primary care, urgent care or the hospital (Exhibit 7.0).

Consumer Education is Key to Controlling Health Care Costs

A recent report for the U.S. Senate by the Center for Studying Health System Change found that only 4% of ED visits in 2008 were triaged as “immediate.” 12% were deemed “emergent” (requiring a treatment in less than 15 minutes); 39% were triaged as “urgent” (15-60 minutes); and 21% were “semi-urgent” (1-2 hours). Interestingly, only 8% of ED patients were triaged as “non-emergent.” This data indicates that most ED visits are not on the extreme ends of the care spectrum, but rather, fall in a gray area between emergency and non-emergency.⁹ The takeaway from this study is that patient education on acuity and appropriate facility choices is the key to minimizing unnecessary ER visits.

Although limited access to primary care is a contributor to ED visits, the report found that lack of access was not the main driver for unnecessary ED visits—utilization is attributed more to a lack of knowledge of alternatives and the acuity of the presenting conditions. For example, the study found that two-thirds of ED visits happened after normal business hours (8am-5pm), meaning patients may be going to the ED simply because they believe it is the only open option during non-business hours.

As the population ages, millions of newly insured seek to establish primary care relationships, and this increased demand will spill over to emergency rooms especially with the PCP shortage exacerbating accessibility. This indicates that providers and payers should play a more active role in educating patients on evaluating their symptoms and identifying the appropriate treatment setting.

Urgent Care’s Response to the Freestanding Emergency Department Phenomenon

Many of the reasons consumers choose freestanding emergency centers likewise apply to urgent care. Urgent care operators should educate the public through media advertising, grassroots activities, and public relations about their hours of operation, clinical capabilities, and the pleasant patient experience provided by their centers.

To make an impact on consumers, urgent care operators should emphasize comparisons between:

- the total cost (and co-pay differentials) of an emergency room visit and an urgent care visit,
- urgent care length of stay of one hour or less versus 3-4 hours on average for hospital EDs,
- the more personalized experience in an urgent care center versus a cold, sterile ED; and
- comparable medical quality, physician expertise, and clinical outcomes.

In addition, because the Center for Studying Health System Change study cited primary care referrals as another reason for emergency room overutilization—urgent care providers should develop relationships with local physicians who will refer patients to urgent care for conditions requiring x-ray or lab, minor procedures, overflow due to seasonality, and during times the office is closed (vacations, evenings, weekends, and holidays). Association with an urgent care center benefits primary care physicians when the urgent care forwards existing patient charts for follow-up and refers new patients for management of chronic or longitudinal conditions. The primary care physician can serve as a “front-line” in educating patients as to the most appropriate treatment options.

Where freestanding emergency centers exist, both FSEDs and urgent care centers can benefit through referrals. Over time, FSEDs will not survive if they have a reputation for treating urgent care-type cases in an urgent care-like environment—but at hospital ED rates. So it’s in the best interest of FSEDs to refer lower acuity cases out to urgent care centers and other lower cost options. Likewise, the FSED can benefit from incoming referrals of acutely rising patients who desire more immediate attention than is available in the hospital ED. Given the relationships that exist between urgent care centers and primary care providers, the transition from initial treatment to follow-up will be much smoother when working with an FSED than if the patient were simply “treated and streeted” by the busy hospital ED.

Improvements to the Freestanding Emergency Center Model

Freestanding emergency departments can certainly have a promising future in our health care system, but they must find a way to limit overspending by unwary consumers looking for a quick fix for a non-emergent condition. FSEDs should be obligated to explain their charges and ensure that patients presenting with non-emergent conditions understand the center’s billing processes. FSEDs should also establish referral relationships with urgent care centers and primary care offices to re-direct patients who do not require the FSED’s level of care. These relationships can be reciprocal and beneficial to the FSED who receives referrals that might otherwise go to the hospital ED. Unfortunately, the efforts to expand ED capacity and volume through FSED construction suggest that many hospitals perceive few incentives or benefits to shift non-urgent care from their EDs to urgent and primary care settings. Once FSEDs begin to refer non-emergent conditions to a more appropriate provider, then their potential for improvement in our health care system will be more easily realized.

Appendix A: Generally freestanding emergency departments differ from urgent care centers in the following ways:

	Urgent Care Center	Freestanding Emergency Center
Insurance Contracting	Typically as an urgent care facility, reimbursing either a flat fee per patient (with carve-outs for high-value procedures) or fee-for-service. May also be contracted as a primary care office.	As an emergency facility with physicians contracted as separate, independent providers.
Net Revenue per Patient	\$95 to \$135 for minor illness. \$150 to 250 for minor injuries.	\$300 to \$600 for minor illness. \$600 to \$1,200 for minor injuries.
Co-Pay Charged	Urgent care co-pay—typically \$25 to \$50.	Emergency room co-pay—typically \$75 to \$100.
Facility Fee Charged	Typically no facility fee is charged, except in certain instances in which the center is part of a hospital complex. Typically one invoice for all services on site.	A facility fee is charged in addition to a professional fee for the providers. Patient is often billed separately by the facility and physician group.
Cases Treated	Typically low- to-moderate acuity, with the bulk of patients presenting with minor infections, flu symptoms, allergies, rash, lacerations, sprains/strains, and fractures.	Typically non-emergent with greater emphasis on musculoskeletal injury and lacerations. Patients self-triage for acutely rising conditions including high fever, automobile accidents, and asthma attack.
Operating Hours	Typically 10-12 hours a day, seven days a week.	Most are open 24-hours a day, 365 days a year.
Square Footage	Typically 2,500 to 4,500 sq. ft.	5,000 to 20,000 sq. ft. depending on whether the center is independent or hospital-affiliated.
Trauma and Resuscitation	Providers typically certified in Basic Life Support although many have advanced life support certification. Center typically equipped with EKG, defibrillator and drug cart. Process is to stabilize patient, call 911, and then EMS transfers patient to hospital emergency room.	Providers certified in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). Capabilities to administer IV medications and perform cardiac enzyme and BNP labs. Process is to stabilize patient and admit to hospital (using contracted paramedic transport) under direct transfer agreement.
Provider Staffing	May be any combination of physicians, physician assistants, or nurse practitioners supported by medical assistants and technicians.	Emergency medicine physician on staff during all operating hours typically supported by an emergency medicine nurse. Ancillaries like lab and imaging supported by cross-trained technicians.
Provider Specialty	Typically family practice or emergency medicine with representation from internal medicine, pediatrics and other specialties. May or may not be certified by an ABMS-recognized board.	Typically board-certified in emergency medicine.
Laboratory	Varies by location. Typically CLIA-waived for point-of-care testing. Labs performed by medical assistants. Collection and send-out to reference laboratory for more advanced labs. Urine drug screening as a revenue center.	CLIA-certification for point-of-care testing plus automation for CBCs, D-Dimer, BNP, and cardiac enzyme testing. Laboratory technician on staff. Physician also utilizes microscope for diagnosis.
Imaging	Typically basic x-ray performed (depending on state law) by trained medical assistant or radiology technician. Consulting radiologist over-reads to validate diagnosis.	X-ray, low-resolution CT, and ultrasound performed by radiology technician, with consulting radiologist on-call to read images.

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