TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Disaster Preparedness and Response Considerations for Freestanding Emergency Departments

The American College of Emergency Physicians (ACEP) describes a freestanding emergency department (FSED) as a "licensed facility that is structurally separate and distinct from a hospital and provides emergency care[1]." They can either be independent or operate as a hospital-based or satellite emergency department (i.e., owned and operated by hospital systems or medical centers). ACEP notes that FSEDs must provide all FSED patients "an appropriate medical screening examination…to determine whether an emergency exists" and should:

- Provide stabilizing treatment
- Arrange transfer as appropriate (regardless of ability to pay)
- Have the same standards as a hospital emergency department

In 2025, an author found that more than 30 states have operational FSEDs, concentrated in Texas, Colorado, and Arizona.[2] While preparedness and response operations for FSEDs are often incorporated into parent health system plans and documents, licensing requirements vary, and key details about and unique features of each facility may be overlooked. In addition to coordinating their planning and operations with their parent hospital/system, FSEDs can be integrated into regional health care disaster planning. Following a mass casualty incident (MCI), many patients self-refer to the closest health care facility they can find. FSEDs can agree to accept both self-referred, non-triaged patients from a nearby MCI and overflow patients with minor injuries from area hospitals. FSEDs should also understand the local emergency medical services (EMS) distribution plan, as they may be designated to receive minor casualties directly from the scene.

This document provides considerations that can help FSEDs evaluate their risks and resources against a variety of scenarios and determine whether there are gaps that need to be addressed through additional planning or training and exercising. These considerations are key, but not comprehensive. They can support facilities in assessing their preparedness and ability to care for patients in an MCI and can be woven into FSED disaster plans as part of their parent organization plans and/or overall local emergency preparedness efforts. While ASPR TRACIE recognizes that not all FSEDs are part of a larger health system, considerations are included for those that are due to the increased coordination required and support available.

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[1] *American College of Emergency Physicians. (2020). Freestanding Emergency Departments. Annals of Emergency Medicine. 76(4): e89-90.*

[2] *Leone, J. (2025). The Rise of Freestanding Emergency Departments: Expanding Access, Challenges and the Role of EMS. Journal of Emergency Medical Services.*

Risk Assessment

Although the FSED may be included in a community or health system hazard vulnerability analysis (HVA), the following factors can guide additional consideration of risk and preparedness:

- ☐ How close are hospitals or other health care facilities that provide acute medical care in the area?
- ☐ Are there congregate (e.g., schools, churches, entertainment or sporting venues, transportation hubs) or other at-risk settings close to the facility that could predictably generate walk-in/privately transported patients after an MCI?
- ☐ Are there local industrial, agricultural, rail, or other potential hazardous materials release threats?
- ☐ Is the facility designated to receive casualties from EMS or an affiliated hospital during a disaster?
- ☐ Has the facility's staff been trained and exercised on how to respond to emergency situations?
- ☐ Are staff available with competencies to care for more severely injured or ill patients than typically seen in the FSED?
  - What advanced procedures are staff trained to perform?
  - Are supplies available for trained staff to provide initial and stabilizing treatment until patients can be transferred to a higher level of care?

Incident Management

- ☐ Does the FSED have a designated leader/authority for onsite response decisions during an emergency?
  - Is the onsite leader considered the incident manager or is this a branch role under a parent hospital/system incident command structure?
  - Will the parent system/hospital rapidly activate their incident command system (ICS) in response to a need that is isolated to the FSED?
  - Does the onsite leader know how to rapidly reach the Incident Commander/leadership at the parent system, including if they are not already in a command center?
- ☐ How does the facility command interface with the parent health care system/hospital?
- ☐ Where is the command center located during an incident (e.g., conference room, nursing director's office)? This should be an onsite location even if the facility relies upon decisions from a corporate/hospital ICS structure.
  - Are appropriate communications, documentation, and supplies kept in this location for emergency use (e.g., whiteboards, vests, telecommunications equipment, supplies, and references)?
- ☐ Who has the authority to make decisions about evacuating/closing the facility?
- ☐ Who has the authority to expand staff or hours of operation or use of in-place/stay back personnel?
- ☐ Does the facility have adequate onsite references for a variety of incidents (e.g., flip charts, job aids)?
- ☐ Are the facility materials sufficiently clear and concise for use during an incident?
- ☐ Depending on the size of the facility, how are onsite staff notifications provided (e.g., overhead paging, other systems)?
- ☐ Is there a mechanism to contact offsite staff?

Mass Casualty Incident

- ☐ Does the FSED have a way to receive alerts about MCIs in the area (e.g., EMS radio, web- or app-based notifications)?
- ☐ Are there thresholds for initiating the MCI response?
- ☐ Is there an understood activation process (that includes notifying/being notified by a parent hospital/system)?
- ☐ Does the FSED have staff to recall/a related process to recall them during an MCI?
  - Could staff from the parent hospital/system support the FSED in time? If so, when the FSED activates emergency codes, will the parent hospital/system automatically send pre-designated staff for support?
  - Is there a provision for FSED on- or off-duty staff to redeploy to the parent hospital/system if required during an MCI?
- ☐ Does an MCI response plan for the facility document expectations for operations, such as:
  - Access controls
  - Disaster documentation/registration process, including a process to track patients
  - Rapid movement or discharge of existing patients to free up space for casualty care
  - Triage location and process

- Non-traditional use of space for patient care
- Supply distribution
- External requests for supply/staffing support

☐ Does the FSED have adequate resources based on the risk for self-referred trauma patients to address:
- Airway management, including extra intubation supplies and materials for chest decompression
- Hemorrhage and wounds (e.g., tourniquets, dressings, bandages, suture trays)
- Intravenous access supplies
- Medications, particularly both injectable and oral analgesia
- Triage or quick documentation tags, particularly for patients requiring hospital transport
- Pediatric dosing guides and appropriate sizes, particularly if the facility is proximate to a childcare facility or primary school

☐ Does the FSED have plans for providing medical surge and specialty care, including for mass burn, pediatric surge, and mass fatalities?
- Does the facility have a process for accessing virtual support from specialty providers at the parent hospital/system or a trauma center/specialty hospital?

☐ Has the facility worked with local EMS to ensure coordination during an MCI?
- EMS should understand the capabilities of the facility.
- Emergency transfers from the facility to hospital(s) may be required for critical injury/illness patients that self-refer during an MCI.
- The facility should have a process with EMS for updating their capacity/ability to take patients (e.g., updating web-based system, notifying dispatch of capacity).
- The FSED and local EMS agencies should determine whether EMS personnel may assist with emergency patient care at the facility if they are not needed for other immediate response needs.

☐ Does the facility collaborate with the regional health care coalition and/or local emergency management agency?
- The facility may be in a different jurisdiction or region than the hospital that holds the license for its beds, resulting in the need to collaborate with two emergency management agencies and/or coalitions.

☐ Is there a process for rapidly referring patients to an appropriate trauma center if they cannot be safely cared for at the facility?
- This should include a direct channel to EMS dispatch and the receiving emergency department independent of usual phone systems.
- Plans should consider parent hospital/system transfer expectations and include trauma and specialty care centers outside the geographic area.

☐ Is the "all-clear" process understood and documented?

☐ Are recovery phase responsibilities understood between the facility and its parent system?
- Hotwash debriefs
- After-action report process
- Staff support
- Information management (e.g., patient/public information)

☐ Is the process for MCI decedent management understood?
- Are FSED providers prepared to provide death notifications?
- Is there an onsite evidence preservation process for an MCI?
- Does the FSED have the supplies and space necessary to prepare and temporarily hold bodies for the medical examiner after an MCI?

System Failures

☐ When utility failures affect the wider community, is the facility expected to continue to operate? Do the staff understand this expectation?

☐ Telephone
- Does the FSED have an analog phone line in addition to voice over internet phones?
- Is there at least one alternate method of external communication in the event of phone, internet, and 911 service failure (e.g., public safety radio, satellite phone)?

☐ Electricity
- Does the facility have onsite generator capacity for an extended period?
- Is there a connection for an external generator? Are the kilowatt needs known?
- If cabling/wiring harness is required, are the specifications known?
- Are uninterruptible power supplies (UPS) available for critical equipment?
- Are adequate headlamps/flashlights/battery operated lights available in case of complete power failure?
- How will temperature control be maintained for pharmaceuticals?
- What are the FSED's downtime procedures for laboratory and imaging?

☐ Water
- Is there bottled potable water onsite for short-term use?
- Is non-potable water available onsite for limited toilet flushing?
- Is there a plan to support the facility with water delivery (potable and non-potable) during outages?
- Are plans for fire monitoring in place should sprinkler systems lack water pressure?

☐ Information Technology
- Does the FSED have adequate paper supplies onsite to implement downtime procedures for at least 24 hours?
- Do staff know when to transition to paper downtime procedures?
- In case of laboratory or radiology system downtime, do staff understand the procedures for receiving/recording results?

☐ Heating, Ventilation, and Air Conditioning (HVAC)
- How will the FSED operate if the heating, ventilation, and air conditioning system fails?
- Does the facility have a plan to prevent information technology systems from overheating without air conditioning?

Sheltering/Evacuation

- ☐ Authority/initiation
  - Who can initiate an emergency (e.g., fire, gas leak) evacuation?
  - Who can initiate an urgent (e.g., proximate wildfire or other threat) evacuation?
  - How is the parent system/hospital informed of the situation and involved in decision-making?
- ☐ Is the FSED a designated or potential recipient of patients from other facilities (e.g., hospitals, long-term care facilities) in the event they are evacuated?
- ☐ Do staff understand the initial evacuation process and rally points?
- ☐ Is there a process to request EMS support for patients who require interfacility transfer?
- ☐ Are exits and evacuation routes in the facility clearly labeled, including stairwell labeling?
- ☐ Are adequate wheelchairs, stretchers, and/or fabric carry stretchers available to support a rapid evacuation?
- ☐ What is the process for transferring charts/documentation to the receiving facility?
- ☐ If sheltering is required due to a chemical or smoke plume, can facility staff shut down the air intakes? Is this process described/known?
- ☐ If sheltering from high winds/tornado is required, is there a policy to move patients and staff to specific areas of the building?
- ☐ Is there a policy that addresses when a wildfire is considered sufficiently threatening to the facility to result in its evacuation?

Patient Tracking/Reunification

- ☐ Is the FSED integrated/able to integrate with hospital/community processes for tracking patients and reuniting them with loved ones?
  - What is the process to refer loved ones to the community's family assistance center?
  - Has the FSED identified an onsite area for loved ones waiting to be reconnected with patients?
  - How will the FSED handle increased telephone inquiries from loved ones and the media?
- ☐ What is the process for keeping track of patients and their disposition during an incident, particularly if the electronic health record (EHR) cannot be kept current due to demand?
- ☐ Does the facility generate a master list of patients seen after an MCI or is this addressed via the EHR at the parent hospital/system?

Safety/Security

- ☐ Does the FSED have onsite security?
- ☐ Is there a plan for securing additional support after an MCI?
- ☐ In the event of an MCI, does the FSED plan to provide traffic control for those accessing the site? Are there any onsite resources/policies (e.g., cones, signage, message boards)?
- ☐ Do staff know procedures for onsite fire response?
- ☐ Are FSED staff trained to obtain help, contain risk, and apply appropriate chemical and physical restraints to patients experiencing significant behavioral health events?
- ☐ Is there a designated room or rooms for patients experiencing mental health challenges with appropriate design and stocking restrictions to minimize risk for self/staff harm?
- ☐ What is the process for obtaining additional support for patients in crisis (e.g., security/public safety, psychological/psychiatry consultation, safe transfer)?
- ☐ In case of a security threat:
  - How are access controls implemented?
  - Do staff know which rooms are safe to shelter in?
  - Are staff trained to respond and guide patients to safety/exits?

Hazardous Materials

- ☐ Are supplies available to provide dry decontamination (e.g., redress kits, body wipes)?
- ☐ Is wet decontamination (shower) available? If so, is there containment or diversion for the washwater? Is the shower run at regular intervals to prevent stagnation?
- ☐ What is the process for obtaining support for decontamination activities from the parent hospital/system or as part of an integrated regional strategy?
- ☐ Based on local risk and facility procedures, are staff trained to the appropriate awareness or operations level to safely handle contaminated patients presenting to the facility?
- ☐ Are appropriate barrier and respiratory protection available for any staff expected to provide hands-on patient decontamination?
- ☐ Are staff trained and have references available to assist patients with self-directed dry decontamination?
- ☐ Are there radiation detectors available and is there a radiation safety officer on staff? If so, are they located onsite or off?

Special Pathogens

- ☐ Do FSED staff receive timely communications and support from infection prevention experts during international or community outbreaks that may result in patients presenting to the facility (e.g., implementation of screening questions, surveillance)?
- ☐ Are facility staff trained to "Identify, Isolate, Inform?"
- ☐ Are patient-facing staff fit-tested for N95 respirators and/or have access to powered air-purifying respirators?
- ☐ Are staff trained on appropriate personal protective equipment (PPE) ensembles for initial special pathogen assessment/care?
- ☐ Is there a potential to conduct point of care testing on special pathogens patients for initial evaluation/treatment (e.g., bedside analyzer for Chem8)?
- ☐ Is there a process for isolating any suspect case presenting for further history/evaluation by a provider?
- ☐ Can the facility rapidly access infection prevention/infectious disease consultation to determine next steps?
- ☐ Does the facility understand (and have they practiced with) their regional special pathogen system?
  - Where are the local assessment/treatment centers?
  - What EMS providers are responsible for transfer of potential special pathogen patients? Is their process for patient transfer understood/practiced at the facility?
- ☐ Is there a plan for containment (or transfer with EMS) of potential Category A waste if a viral hemorrhagic fever is suspected?
- ☐ Can trained providers from the parent health system come to the facility to support care if transfer is delayed?

Conclusion

As FSEDs continue to emerge across the U.S., their role in disaster and other MCI response will be refined and tailored to fit their service areas. This document can help FSEDs shape that role and collaborate with their parent organizations, individual hospitals, EMS, and other health care emergency providers in their communities to ensure a more successful response and a more resilient community overall.

Acknowledgements

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