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“WHY IS THIS PATIENT BEING SENT HERE?”: COMMUNICATION FROM URGENT CARE TO THE EMERGENCY DEPARTMENT

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Abstract

Background—Despite patients’ increasing use of urgent care centers (UCC), little is known about how urgent care clinicians communicate with the emergency department (ED).

Objectives—To assess ED clinicians’ perceptions of the quality and consistency of communication when patients are referred from UCCs to EDs.

Methods—Emergency medicine department chairs distributed a brief, electronic survey to a statewide sample of ED clinicians via e-mail. The survey included multiple-choice and free-text questions focused on types of communication desired and received from UCCs, types of test results available on transfer, and suggestions for improvement.

Results—Of 199 ED clinicians, 102 (51.3%) responded. More than four out of five respondents “somewhat” or “strongly agreed” that each of the following would be helpful: a telephone call, the reason for referral, specific concern, a copy of the chart, and UCC contact information. However, ED clinicians reported not consistently receiving these: only a fifth (21.6%) of clinicians reported receiving the specific concern for their last 5 patients transferred from a UCC, and 34.3% recalled receiving a copy of the chart. Overall, 54.9% reported receiving laboratory test results “often or almost always,” 49.0% electrocardiograms, and 44.1% imaging reports. Qualitative analysis revealed several themes: incomplete data when patients are referred; barriers to discussion between ED and urgent care clinicians; and possible solutions to improve communication.

Conclusions—Our findings highlight variation in communication from UCCs to EDs, indicating a need to improve communication standards and practices. We identify several potential ways to improve this clinical information hand-off.

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SUPPLEMENTARY DATA

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.jemermed.2015.06.032>.

Keywords

urgent care centers; communication; care transitions; hand-offs; quality improvement

INTRODUCTION

A care transition, or “handoff,” occurs when a patient moves from one health care setting to another. High-quality transitions require timely, complete, and accurate information transfer, enabling receiving providers to immediately assume responsibility for patient care (1). Such communication is critically important when a patient is referred from an urgent care center (UCC) to an emergency department (ED), given the inherent acuity of the medical condition, the uncertainty in diagnosis or management, and the fact that an initial evaluation has already been performed by a clinician (2). Despite patients’ increasing use of UCCs, little is known about how their clinicians communicate with the clinicians of other health care settings. Our objective was to conduct an exploratory study to assess ED clinicians’ perceptions of the quality and consistency of communication from UCCs to EDs.

MATERIALS AND METHODS**Study Design**

In 2008, Healthcentric Advisors, a Medicare Quality Improvement Organization (QIO), began collaborating with local health care providers to improve patients’ care transitions under the QIO Program’s 9th Scope of Work. As part of this effort, we conducted an exploratory study to assess ED clinicians’ perceptions of communication from UCCs to EDs. As there were no existing survey instruments, questions were developed de novo based on areas of concern identified by ED clinicians in the authors’ prior quality improvement work on communication and care transitions (3).

Survey questions included queries related to the types of communication UCCs could send to the ED, and which of these communication types ED clinicians felt would be helpful. Communication types included telephone calls from an urgent care clinician, a reason for the referral (e.g., a headache), the specific concern to address in the ED (e.g., rule out subarachnoid hemorrhage), a copy of the UCC chart, and contact information for the referring clinician. We asked how often ED clinicians recalled receiving various test results. We also asked how often they contacted UCCs to provide the findings of the ED evaluation. The survey ended with an open-ended question asking for any comments about communication from UCCs. Information was also collected about the respondent’s age category, gender, level of training, hospital, and years working in the ED. Content experts reviewed and piloted a draft survey for content, clarity, time required for completion, and ease of administration. Based on the results of the pilot, we modified survey questions and answer choices prior to administration to the formal sample (Appendix).

We conducted this research in accordance with the Brown University Human Research Protection Program Policy. The Brown University Institutional Review Board determined

that the undergraduate student's survey did not meet criteria for human subjects research, nor did the present analysis, which used data that did not contain personal identifiers.

Study Population and Survey Administration

We administered the survey electronically (SurveyMonkey, Palo Alto, CA) to an anonymous, convenience sample of ED clinicians (attending physicians, fellows, residents, advance practice nurses, and physician assistants) in active practice in Rhode Island EDs. We asked ED chairs at all 13 of Rhode Island's acute-care hospitals to distribute a link to clinicians working in their EDs. Department chairs who sent the link determined whether to adapt our sample e-mail, when to send the e-mail, and whether to send any reminders. The online survey was administered from January 10 to February 6, 2013. No incentives were provided.

Data Analysis

Descriptive statistics were used to characterize respondents, perceptions about communication, and preferences. We calculated the survey response rate by dividing the number of respondents by the total clinician count reported by the ED chairs. Missing data were not imputed. For the qualitative analysis, two of the authors (E.K.C., R.R.B.) independently analyzed free-text responses and then met to reach consensus on major themes.

RESULTS

Respondent Characteristics

Chairs at 11 (84.6 %) of the 13 hospitals agreed to distribute the survey. Approximately half ($n = 102$, 51.2%) of the 199 ED clinicians at these 11 hospitals responded; the number of respondents at each site ranged from 1 to 25. A majority of respondents were attending physicians (62.1%), and most were in their 30s or 40s (68.0%); 47.9% were women and 44.3% had 10 or more years of experience in the ED.

Quantitative Results

More than four out of every five respondents "somewhat" or "strongly agreed" that each of the following would be helpful in caring for patients referred from UCCs: a telephone call, the reason for referral, the specific concern, a copy of the chart, and contact information for the referring UCC clinician (Figure 1). However, 36.3% of ED clinicians reported not receiving a telephone call from UCCs for any of their last 5 patients. One in five clinicians (19.6%) reported not receiving UCC contact information for any of their last 5 patients.

A reason for the referral (e.g., headache) was most consistently provided, with 44.1% of clinicians reporting getting this information for all of their last 5 patients. However, only 21.6% of clinicians reporting receiving the UCC's specific concern (e.g., rule out subarachnoid hemorrhage) for all of their last 5 referred patients; only about a third (34.3%) received a copy of the UCC chart for all of their last five referred patients.

Just over half (54.9%) of ED clinicians reported receiving laboratory test results (when applicable) “often or almost always.” Fewer reported “often or almost always” receiving electrocardiograms, imaging reports, and copies of images (49.0%, 44.1%, and 41.2%, respectively). Only 16.7% of ED clinicians reported contacting the UCC to communicate their findings.

Qualitative Results

Analysis of respondents’ comments indicated frustration with poor information transfer and a desire to formalize communication expectations. Major themes included the need to improve communication, missing or incomplete data for referred patients, and barriers to discussion between ED and urgent care clinicians. Several respondents addressed possible solutions, suggesting ways to improve bi-directional communication, including use and standardization of existing communication models.

In addition, some respondents expressed concerns about reasons for referrals, mentioning unnecessary transfers and unrealistic expectations about consultations or tests to be performed in the ED. Interestingly, several voiced concerns about the competence of urgent care clinicians, questioning their knowledge, skill, and confidence.

DISCUSSION

The United States has approximately 9000 UCCs, and the industry is growing at a rate of 300 to 600 new centers each year (4). To our knowledge, this is the first study to explore ED clinicians’ perceptions of communication from UCCs when patients are referred to the ED for further evaluation and management. We found that current information transfer practices do not meet the needs of ED clinicians. Barriers to communication remain poorly characterized but likely exist on both sides. Establishing and adhering to standards for UCC communication will become increasingly important as more patients seek care in that setting.

Communication may be poor from UCCs due to their busy clinical environment and because most UCCs currently do not have much incentive to improve their communication with EDs (2,5). Alternatively, UCC clinicians may believe that patients can provide the necessary information to ED clinicians. An urgent care clinician who does attempt to call or fax information may not reach the appropriate ED clinician, representing a barrier intrinsic to the ED, rather than the UCC. This explanation may be more likely in larger EDs or at shift changes, when it is difficult to know who will be seeing transferred patients when they do arrive.

Although this is a nascent area of scholarship, some guidelines do exist to direct UCCs’ response to these findings. The Safe Transitions Best Practice Measures for UCCs, created as part of Healthcentric Advisors’ work on care transitions, outline standards for cross-setting communication (6). According to these guidelines, the UCC clinician is responsible for speaking with the ED and for sending summary clinical information, including the reason for the referral and the specific concern to be addressed; the results of diagnostic tests and whether there are any test results pending; and the name and contact information of the

urgent care clinician. These guidelines do not seem to be widely used. Future research should test whether implementing these guidelines results in an improvement in patient outcomes or in clinician satisfaction.

In a similar vein, the urgent care community has outlined its recommendations for communication upon patient transfer to the ED, including identifying the receiving ED physician, transmitting clinical information, and providing UCC visit documentation (7). The Joint Commission also has developed standards for UCCs seeking accreditation, which require that a UCC “manages transitions in care” (8). Because incentives to implement these standards are uncommon, there is an opportunity for commercial health plans to spur uptake of existing guidelines by including these communication practices in their contracts, as has been demonstrated with hospitals in Rhode Island (9).

On the ED side, developing processes to remove barriers to receiving UCC information may help address communication problems, and these interventions should be studied to assess their impact. ED leaders can reach out to the UCCs that most frequently refer patients to create connections and collaborate on improving care transitions in their communities.

Limitations

The study’s strengths include its statewide sample and relatively high response rate. We also note several limitations. First, we did not define the term “urgent care centers” in the survey; we cannot ascertain whether all respondents answered with the same construct in mind, nor do we know how often the respondents see urgent care referrals. Second, we surveyed only Rhode Island clinicians, limiting generalizability to regions of the country with different UCC penetration or health care utilization patterns. Third, as with any survey, our results may be affected by response bias, as well as recall bias. Additionally, the survey assessed clinicians’ perceptions of information transfer; we were not able to review clinical documentation to determine if clinicians’ perceptions correlated with documented communication. The relationship between perceived deficiencies in communication and meaningful outcomes (such as delays in care, redundancy in testing, health care costs, and patient and clinician satisfaction) were beyond the scope of this exploratory study. Last, the dearth of research in this area prevented use of validated survey questions.

CONCLUSIONS

Our findings demonstrate that ED clinicians feel a disconnect between communication from the urgent care setting and the information they feel is necessary to provide care in the ED. Respondents report frustration with poor information transfer and welcome standardized expectations for communication. We hope these results catalyze introspection and debate about how to improve communication and accountability across the care continuum and encourage ED leaders to further collaborate with community health care partners, particularly in the context of emerging value-based payment models. Future research will examine barriers to communication from the perspective of urgent care clinicians and will correlate identified improvements in care with improvements in patient-centered outcomes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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SUMMARY

1. Why is this topic important?

Despite patients' increasing use of urgent care centers, little is known about how well urgent care physicians communicate with the emergency department (ED) when referring a patient for further evaluation and management.

2. What does this study attempt to show?

Our objective was to assess emergency physicians' perceptions of the quality and consistency of communication from urgent care centers to the ED.

3. What are the key findings?

Most emergency physicians "somewhat" or "strongly agreed" that receiving a telephone call, the reason for the referral, the urgent care center's specific concern, a copy of the chart, and contact information from the urgent care physician would be helpful, but these types of information are inconsistently received by the ED. Laboratory results and electrocardiograms, as well as imaging, are also inconsistently received. Many respondents described substantial barriers to bi-directional communication.

4. How is patient care impacted?

Current communication practices by urgent care centers do not meet the needs of emergency physicians. Establishing and adhering to standards for urgent care center communication will become increasingly important as more patients seek care in that setting.

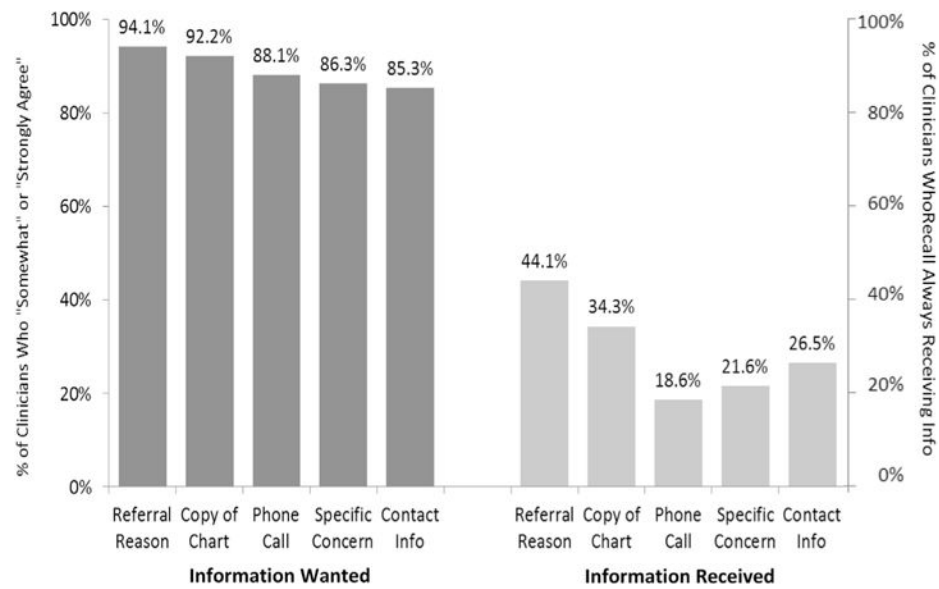


Figure 1.

Comparison of clinical information wanted vs. information received (n = 102). This figure compares the percentage of emergency department (ED) clinicians who “somewhat” or “strongly agree” that each type of communication would be helpful when a patient is referred from an urgent care center to the ED (“Information Wanted”) with the percentage of ED clinicians who recall receiving each type of communication for their last 5 patients referred from an urgent care center (“Information Received”).