A care transition occurs when a patient moves from one health care provider or setting to another. Successful transitions require timely, accurate, and sufficient communication of clinical information between providers, so that downstream clinicians can immediately assume responsibility for patient care. Well-executed transitions can improve outcomes and patient satisfaction, decrease costs, and ensure that patients understand how, when, and where to seek help. The Joint Commission has developed standards that require ambulatory health care organizations that elect its Primary Care Medical Home certification option to manage “transitions in care” and provide or facilitate “patient access to care, treatment, or services.” Yet a great deal of variability exists among health care facilities in the frequency and effectiveness of communication during transitions.

Such communication is particularly important during and after urgent care center visits, where patients are increasingly seeking nonemergent care. Urgent care centers attract two distinct subgroups of people: those without a regular source of health care who wish to avoid the emergency department (ED), often because of the perceived inconvenience, and those with a primary care provider (PCP) who feel they do not have adequate access to their physician, although more serious health concerns issues might prompt waiting for a PCP visit. In addition to providing patient education and discharge instructions, urgent care centers must develop plans for consults, referrals, and follow-up care for patients who do not have a PCP, so that they can transition smoothly to care at the PCP’s office. Because of an inability to identify any guidelines or research that globally addressed care transitions from the urgent care setting, information was gathered from studies on patient discharge instructions and extrapolated from the evidence base available for related settings. The resulting set of eight best practices for urgent care center transitions focuses on clinician-to-clinician communication and patient activation, which can be implemented to establish measurable, communitywide expectations for communication.

Conclusion: This set of best practices constitutes the first known guidelines to establish expectations and measures tailored specifically to transitions from the urgent care setting to the emergency department or primary care office. They can serve as a resource and a framework for urgent care clinicians expanding their collaboration with community partners, such as emergency departments and primary care providers, particularly in the context of emerging payment models.

Article-at-a-Glance

Background: Although high-quality care transitions require timely and accurate communication of clinical information between providers, such communication is inconsistent, and there are few established guidelines outside the hospital setting.

Methods: Using a systematic, collaborative quality improvement process, Healthcentric Advisors (Providence, Rhode Island) undertook a multistage approach to define best practices for care transitions in the urgent care setting. This approach entailed review of the medical literature to identify processes that improve care transitions outcomes, gathering of information about clinicians’ preferences, and a statewide community meeting with urgent care clinicians and other stakeholders to vet draft guidelines and obtain consensus on the concepts.

Results: Because of an inability to identify any guidelines or research that globally addressed care transitions from the urgent care setting, information was gathered from studies on patient discharge instructions and extrapolated from the evidence base available for related settings. The resulting set of eight best practices for urgent care center transitions focuses on clinician-to-clinician communication and patient activation, which can be implemented to establish measurable, communitywide expectations for communication.

Conclusion: This set of best practices constitutes the first known guidelines to establish expectations and measures tailored specifically to transitions from the urgent care setting to the emergency department or primary care office. They can serve as a resource and a framework for urgent care clinicians expanding their collaboration with community partners, such as emergency departments and primary care providers, particularly in the context of emerging payment models.
tion to increasing access, urgent care centers generally provide a wider array of services than most PCP offices, ranging from x-rays and intravenous fluids to occupational health.10 Importantly, these alternative sites of care can be less expensive for patients and also lower costs for the health care system.11–13 Patwardhan et al. estimated that 45% of urgent care and retail clinic visits occur during PCP office hours.12

Urgent care centers can play an important role in primary care quality improvement efforts that emphasize 24-hour/7-day access, as stipulated, for example, by The Joint Commission,7 the Patient-Centered Medical Home Model,14 and Comprehensive Primary Care initiatives.15 Fewer than a third of PCP offices report having after-hours care arrangements so that patients can avoid the ED,16 and to address this, some offices are entering into contractual relationships with urgent care centers.17 For urgent care centers partnering with primary care practices, establishing expectations for communication is critically important.18 Systematic communication between urgent care centers and primary care offices ensures that PCPs have sufficient information to appropriately follow up after their patients are seen in the urgent care and retail clinic settings (Figure 1, above).19 From an urgent care center perspective, collaboration can strengthen their reputation, generating patient referrals.18

Although communication flow from the urgent care setting is essential, results from a 2008 survey indicate that such communication is inconsistent: A third of urgent care clinicians reported they did not send information to patients’ regular physicians, even when the physician was known.20 Among those physicians who did send information, the type of information varied and the frequency with which this communication occurred was unclear.20 The creation of guidelines that provide detailed care transition processes and definitions can complement Joint Commission standards by helping urgent care centers to operationalize the management of transitions.

In 2008, the Centers for Medicare & Medicaid Services awarded Healthcentric Advisors, the Quality Improvement Organization21 for Rhode Island, a contract to implement a care transitions pilot program. The Safe Transitions Best Practice Measures for Urgent Care Centers was designed to improve the safety of patient transitions by translating effective patient and provider interventions into sustainable systems change. After locally testing evidence-based care transition interventions and systematically gathering input on physicians’ preferences and needs, we collaborated with physicians, health plans, and community leaders to develop care transition best practices for each provider setting, including urgent care centers.

We created the Safe Transitions Best Practice Measures for Urgent Care Centers in collaboration with health care providers and stakeholders, who felt that urgent care differed sufficiently from the ED and primary care settings to warrant definitions specific to its work flow and logistics. The urgent care best practices provide guidance on how to improve clinician-to-clinician communication and patient activation by establishing core expectations based on clinicians’ preferences and the medical evidence (when it is available), and by creating measures that can be tracked over time.

**Methods**

**Approach**

Prior to the development of the urgent care best practices in April 2012, three of the authors [R.R.B., S.G., R.L.G.], along with other members of the Safe Transitions team, developed and disseminated best practices for care transitions for hospitals, PCPs,22 nursing homes, EDs,23 and home health agencies. Each set of best practices focuses on actions within the control of a specific setting, such as urgent care; reflects that setting’s specific care processes and communications issues; and includes operational definitions tailored to that setting’s workflow. The best practices, taken as a whole, are reciprocal and are intended to provide clinicians with the information they need from both their upstream (referring) and downstream (receiving) partners. Following the same systematic, collaborative quality
improvement process that we used to develop previous sets of setting-specific best practices, we undertook a multistaged approach to define urgent care center best practices, which consisted of evidence base review, a consensus process, and endorsement.

1. Evidence Base Review. In early 2012 we reviewed the evidence base (the medical literature, consensus statements, and materials from national quality improvement campaigns) to identify processes that improve care transition outcomes. Two of the authors [R.R.B., R.L.G.] independently searched PubMed and Google Scholar using the following terms, alone and in combination: “urgent care” or “urgent care centers,” “care transitions,” “continuity of care,” “communication,” “discharge,” “hospital readmissions,” “patient safety,” “instructions,” and “patient transitions.” They also reviewed the reference lists of related articles; searched for related national quality improvement campaigns; and used materials identified during our previously developed best practices for PCPs, as well as those for EDs, home health agencies, hospitals, and nursing homes, if those results were clinically relevant to the urgent care setting.

2. Consensus Process. Simultaneously, we gathered feedback about community preferences from a convenience sample, using existing committees and ongoing meetings, of ED and primary care clinicians. The feedback included individual conversations, as well as group discussions with clinicians who refer patients to urgent care centers and those who receive patients seen in urgent care centers. On the basis of these initial discussions with physicians and our review of the evidence base, we drafted a preliminary set of urgent care center best practices.

Next, in April 2012, we invited approximately 25 clinicians to a community meeting to elicit feedback on the draft concepts, feasibility, definitions, and metrics. Our goal was to refine and ensure usability of each best practice within the urgent care setting’s work flow. This meeting included a convenience sample of approximately 15 clinicians; we did not sample participants from the population at large, although we strove to include opinion leaders and representation from all affected settings. Participants included physicians and nurses who work in the urgent care setting, as well as primary care and ED clinicians who refer patients to and receive patients from urgent care centers. We conducted the meeting by providing all participants with the draft best practices, including definitions and metrics, and facilitated a group discussion about each best practice. Our facilitation focused on the desirability and feasibility of each concept; we asked for group consensus on any changes proposed to the concepts, language, or definitions. Following the meeting, we shared an updated draft, incorporating the participants’ feedback, and asked for all invitees (present and absent) to share additional comments.

3. Endorsement. Finally, in May 2012, we vetted the urgent care center best practices with the Safe Transitions project’s community advisory board, which consisted of diverse stakeholders: inpatient and outpatient physicians; pharmacists; and representatives from commercial health plans, Medicaid, and the home health, hospice, hospital, and nursing home settings. We also vetted the revised draft with health plan auditors to assess the feasibility of auditing for compliance. Incorporating successive, step-by-step feedback allowed us to obtain consensus while revising the best practices to their final form.

The Rhode Island Department of Health’s Institutional Review Board reviewed this project and determined that it was exempt.

Results

Evidence Base Review

Our review of the published evidence identified scant reference to care transitions in the urgent care-specific medical literature and no urgent care-specific consensus statements or campaigns. As a result, we extrapolated from the evidence base and best practices we had developed previously for the ED (which also deals with acute, unplanned care and is a downstream partner) and PCPs (an upstream and downstream partner)—the two settings most frequently in communication with urgent care providers.

Consensus Process

After developing a list of proposed best practices, we convened two meetings: one with stakeholders from urgent care, the ED, and primary care, and one with the Safe Transitions project’s community advisory board. These meetings helped ensure that the proposed best practices addressed the needs of clinicians sending patients to urgent care or caring for patients after their urgent care visits, and were realistic within urgent care’s real-world constraints and work flow. We also gathered input on the proposed measure definitions and generated consensus around the resulting measure specifications.

Endorsement: The Eight Urgent Care Center Best Practices

Table 1 (page 322) presents the eight resulting urgent care center best practices. The related measure specifications (Appendix 1, available in online article) provide additional detail about measurement criteria and would enable consistent implementation across providers and payers. The eight best practices
The Safe Transitions Best Practices for Urgent Care Centers represent the first guidelines, to our knowledge, that are tailored specifically to patient care transitions from urgent care to ED or primary care settings. These best practices provide detailed definitions that complement Joint Commission standards regarding transitions of care. They can serve as a resource for urgent care clinicians who wish to be leaders in partnering with their colleagues in the ED or PCP office to improve their patients’ experiences across the care continuum. To develop and refine these best practices, we drew on the medical literature, consensus statements, and input from urgent care clinicians and stakeholders. The resulting best practices provide a basis for feasible standards and performance benchmarks for clinician-to-clinician communication and patient activation. Tracked over time, within real-world logistics and work flow, they offer a useful tool for continuous quality improvement activities.

Little is known about what urgent care centers currently do to communicate systematically with other health care settings. We found no medical literature focused on urgent care center communication with EDs, and limited research on communication with PCPs. The previously cited 2008 national survey showed that about half of urgent care clinicians reported sending a copy of the patient’s chart, when the PCP is known; others may call or send a consult note. A third do not communicate at all. For patients without a PCP, an urgent care center visit may represent an important opportunity to educate the patient

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<tr>
<th>Best Practice</th>
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<tr>
<td>1. Ask patients for the name of their PCP.</td>
<td>• A PCP is defined as any clinician identified by the patient as his or her regular doctor. The PCP’s name should be recorded in the medical record; if the patient does not have a PCP, this should be noted instead.</td>
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<tr>
<td>2. Ask patients for the name of their home care provider.</td>
<td>• A home care provider is defined as any organization that provides home or community-based medical, nursing, social, or therapeutic treatment, including home health agencies and hospice programs. A home care provider’s name should be recorded only if the patient is currently receiving services.</td>
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<td>3. Send summary clinical information to the PCP upon visit completion.</td>
<td>• This information should be sent within 24 hours. It should include the medical diagnosis, updated medication list, results of tests, pending tests, name of the urgent care clinician, phone number to call if more information is needed, discharge instructions, and recommended follow-up.</td>
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<tr>
<td>4. Send summary clinical information to the home care provider upon visit completion.</td>
<td>• Same information as above (No. 3).</td>
</tr>
<tr>
<td>5. Send summary clinical information to the ED physician upon patient referral.</td>
<td>• This information should be sent at the time of transfer. It should include the reason for referral, results of tests, pending tests, and name and contact information for the urgent care clinician. In addition to sending the information, the urgent care clinician should communicate verbally with the ED about the transfer.</td>
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<tr>
<td>6. Perform modified medication reconciliation upon visit completion.</td>
<td>• Medication reconciliation in urgent care is defined as identifying which medications the patient should stop, start, or adjust after the urgent care visit. A more robust definition of medication reconciliation is used in most other health care settings, but may not be feasible in urgent care centers. This best practice excludes patients sent to the ED.</td>
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<tr>
<td>7. Provide patient with effective education upon visit completion.</td>
<td>• Education should include the diagnosis, any medication changes and reason for change, condition-specific “red flags” and whom the patient should call, activity and other limitations, and recommended follow up. Effective education includes assessment of the patient’s understanding of the information provided and incorporates principles of health literacy and cultural competence. This best practice excludes patients sent to the ED.</td>
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<tr>
<td>8. Provide patient with written discharge instructions upon visit completion.</td>
<td>• The instructions should include the information provided verbally as part of effective education (see above) as well as the name of the urgent care clinician and the phone number to call if more information is needed after the visit. This best practice excludes patients sent to the ED.</td>
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PCP, primary care provider; ED, emergency department.
about the importance of longitudinal care and to initiate a referral. About 85% of urgent care centers maintain PCP lists for referral purposes, but a subsequent study found significant variation in PCP referrals.

Our best practices reflect community consensus and standardized definitions and measurement approaches, while affording urgent care physicians broad license to determine how to implement them. In other words, the best practices focus on defining what high-quality transitions entail in the urgent care setting, not how to best incorporate these practices. We recognize that successful implementation strategies depend on unique circumstances, such as existing work flow, staffing, and even physical location. Although these best practices were developed with input from Rhode Island clinicians and stakeholders, we believe that they reflect common communication constraints and desires and will be applicable elsewhere.

We recommend that urgent care centers consider partnering with their upstream and downstream partners, such as PCPs and EDs, to adopt care transition best practices. Clinicians in all settings express frustration when they receive a patient and do not have the clinical information that they need to assume the responsibility for the patient’s care—improving half of the equation would not solve the problem in its entirety. Therefore, bidirectional communication must be implemented between all care settings, including both asking urgent care clinicians to communicate across settings and ensuring that they receive the information they need when patients are referred to them.

LIMITATIONS

We note several limitations. First, we found little research specific to urgent care center care transitions; therefore, we extrapolated from the evidence base available for other settings and the best practices we developed previously for EDs and PCPs. We also drew on ED care transitions programs because the ED is the setting most similar to urgent care in terms of work flow. Second, the urgent care community’s diverse and diffuse nature may impede uptake of the best practices. Although there are approximately 9,000 urgent care centers across the United States, no single regulatory body exists. Despite numerous national campaigns and funding opportunities to improve care transitions and reduce unnecessary health care utilization, there have not been any calls to mobilize urgent care clinicians to focus on care transitions. This creates a leadership opportunity for urgent care clinicians to incorporate the best practices into their clinical practice, evaluate improvement over time, and advocate with policy makers for related contracting and reimbursement.

Third, although these guidelines incorporate the evidence base, where it exists, they largely reflect clinician preferences about information flow following urgent care center clinical encounters. Although research in the hospital and other care settings has established the impact of such communication on patient experiences and outcomes, further research is needed to link increased adoption of these consensus-based urgent care standards, either alone or in combination, with improved provider relationships and patient outcomes. Finally, the consensus process occurred in a single state, which may limit the generalizability of these best practices to other regions of the country and represents an important area for future research.

Conclusion

Patients can choose among many different options for episodic health care, contributing to the popularity and rapid growth of urgent care centers, which provide same-day acute care with shorter wait times and potentially less expense. With projected physician shortages and a likely increase in the number of insured patients because of the Affordable Care Act, urgent care center visits may become even more common. Because urgent care utilization can potentially fragment care, urgent care clinicians play an increasingly pivotal role in the success or failure of health care system integration. The care transition best practices establish core expectations for communication and can facilitate the building of referral relationships with PCPs and EDs, as well as collaboration with these partners to improve their shared patients’ experiences and health outcomes. Implementing the care transition best practices acknowledges the reciprocal nature of the health care system and the collective need for communication between health care providers to ensure delivery of high-quality care.

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Through community collaboration, the CMS–funded Safe Transitions project aims to transform the Rhode Island health care system into one in which discharged patients and their caregivers understand their conditions and medications, know whom to contact with questions, and are supported by health care professionals who have access to the right information, at the right time. This is our vision statement.
References


