Bridging the Follow-Up Gap: Scheduled Follow-Ups for High-Risk Infections Reduce Emergency Department Escalations in Urgent Care Patients

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Background

Urgent care centers frequently manage conditions requiring reassessment but not immediate emergency care. When patients require close follow-up, lack of access to primary care providers (PCP) creates a critical gap in care that leaves patients vulnerable. Over 100 million Americans lack a PCP,[1] and within the Dallas-Fort Worth market, **66% of patients do not report having a PCP**.[2]

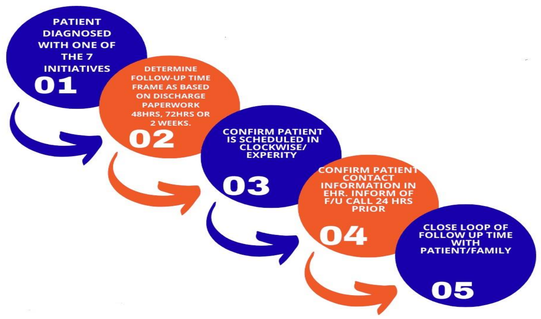
While national guidelines provide general recommendations, they are not tailored to urgent care environment, which can impact continuity of care. Additionally, these providers may assume that patients have an accessible PCP, which is not always the case. Ultimately, these factors create uncertainty when arranging follow-up care. **This gap introduces variability in follow-up planning and may contribute to avoidable emergency department (ED) utilization.**, hospital readmissions, and delays in treatment.[3] This review examines whether implementing standardized, scheduled follow-ups in the urgent care setting can improve provider confidence, enhance patient outcomes, and reduce ED utilization.

Objective

- Evaluate the association between **scheduled follow-up and ED escalation rates**
- Assess **diagnosis-specific follow-up needs**
- Measure **provider confidence with structured follow-up availability**

Methods

- **Design**: Retrospective observational study (March-August 2025) + provider survey + literature review
- **Location**: 57 urgent care clinics (Dallas-Fort Worth Market)
- **Population**: Adult patients ≥18 with select diagnoses (infectious + non-infectious)
- **Key Comparison:**
  - Scheduled follow-up vs no scheduled follow-up
  - Outcome: ED visit after urgent care encounter
  - Follow-up defined as any scheduled revisit within system (not diagnosis-specific)
- **Exclusion criteria**: Immediate ED transfer at time of initial visit
- **Literature review:**
  - A PICOT question was submitted to the HCA Knowledge Center, and an independent literature search was conducted through PubMed.gov, Google Scholar, and professional organization websites.



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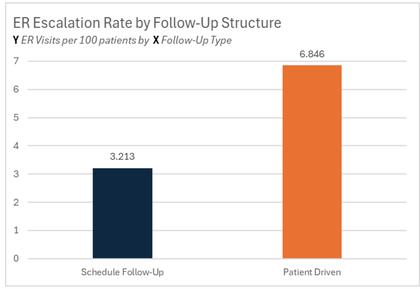
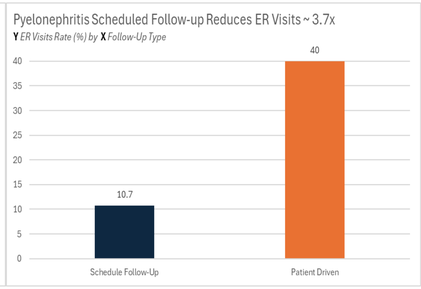
Results

Overall ED Escalation Rates:
- No follow-up: **1.6%**
- Scheduled follow-up: **1.5%**
- Absolute difference was small

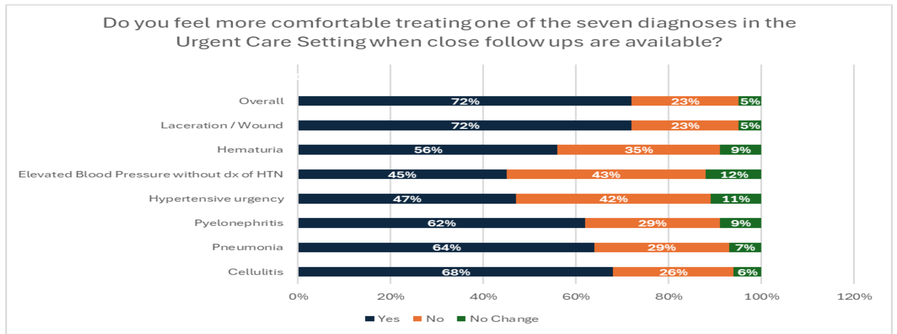
Acute Infection Diagnosis Escalation Rates:
- No follow-up: **3.5%**
- Scheduled follow-up: **2.0%**

- ~ 40% relative reduction in ED escalation with scheduled follow-up for Acute Infection Diagnoses (Pneumonia, Pyelonephritis, Cellulitis)
- Effect appears diagnosis-dependent and was most pronounced in higher-risk infectious conditions.





Provider survey:
- 81 provider responses
- **Increased confidence reported in 6 of 7 conditions when follow-up available**
- Suggests structured follow-up may influence clinical decision making



Literature Review

Community-acquired pneumonia (CAP): Clinical stability typically occurs within 48–72 hours; close follow-up is required to assess antibiotic duration and monitor for deterioration.[4]

Pyelonephritis / Complicated urinary tract infection (UTI): Reassess if not improvement within 24–72 hours;[5] follow up on urine culture to confirm susceptibility and adjust therapy.[6]

Cellulitis: Expect symptom improvement within 24–48 hours and visible improvement by 72 hours;[8] reassess and consider extended therapy if not improvement by day 5.[9]

Hematuria: Repeat urinalysis within 6 months for low/negligible-risk patients without concurrent UTI; re-evaluation after completion of UTI treatment when hematuria is associated with infection.[7]

Laceration: Re-evaluate high-risk wounds at 48–72 hours, low risk wounds follow up at suture/staple removal.[10]

Elevated blood pressure (no hypertension diagnosis): Reassessment within 1 month for BP ≥140/90 mmHg.[11]

Hypertensive urgency (severe hypertension): Requires prompt, frequent monitoring; follow-up based on severity and target organ involvement.[11]

Follow-up interventions: Evidence/outcomes are mixed and are not urgent care-based nor condition-specific. A meta-analysis reported that ED-based care transition interventions increased outpatient follow-up rates but did not significantly reduce ED readmissions.[12] Other meta-analyses do note a reduced 30-day readmission rate with outpatient follow-up. However, this reduction may only be significant in patients 65 years and older. [3]

Key Takeaways

- **66% of urgent care patients lacked a PCP**, highlighting a major follow-up gap
- Scheduled follow-up showed **minimal overall reduction in ED escalation (1.6% → 1.5%)**
- **Acute infections demonstrated the greatest potential benefit (~40% relative reduction)**
- Providers reported **increased confidence when follow-up was available**
- Findings suggest **follow-up strategies should be diagnosis-specific rather than universal**

Limitations

- Unable to capture patients evaluated at non-HCA EDs
- Causality between scheduled follow-ups and reduce ED escalations cannot be established
- Follow-ups were not diagnosis specific; any documented appointment counted toward the metric
- Outcomes were not stratified by PCP status.
- Diagnoses were primarily clinical due to limited urgent care diagnostics.
- The data is limited to 6 months.
- Provider variation and unequal group sizes may introduce selection bias

Discussion

- Scheduled follow-ups were associated with a 40% relative reduction in ED escalations for acute infectious diagnoses,[2] **suggesting potentially clinical meaningful benefits in acute infections**
- Increased provider confidence in 6 of 7 diagnoses when follow-up was available suggests structured follow-up may reduce reflexive ED referrals.
- 66% of North Texas Urgent Care patients lack a PCP,[2] identifying urgent care may serve as a critical follow-up access point in populations lacking PCP access.
- No-show rates among scheduled patients highlight the **need for streamlined scheduling protocols** and adjusted strategies for provider and patient engagement.
- Findings suggest follow-up interventions may need to be **diagnosis-specific rather than universal**

Conclusion

Standardized follow-up processes in urgent care are feasible and supported by providers. While overall impact on ED escalation was modest, findings suggest **potential benefit in select high-risk conditions**, particularly acute infections. Further prospective, diagnosis-specific studies are needed to define optimal follow-up strategies in urgent care populations.

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