REUE | Brief report

Post-Emergency consultation: a new resource created by emergency physicians

Esther Álvarez-Rodríguez, Jesús Medina Ortega, Mª Ángeles Martín Laso, Vanesa Abad Cuñado, Cristina Iglesias Frax, Blanca Gómez Rodríguez

BACKGROUND. We describe the creation of a post-emergency consultation (PEC) designed for patients who, after evaluation in the emergency department (ED), are scheduled for a follow-up appointment within the same emergency service to monitor clinical progress or complete diagnostic and therapeutic processes.

METHOD. During 2023, demographic variables, consultation diagnoses, and actions performed in the PEC were recorded, along with indicators of accessibility (time to consultation), safety, and satisfaction among patients and professionals, assessed through an online survey.

RESULTS. A total of 491 patients were included. The most frequent condition was infection (44.6 %), and 66 % underwent laboratory follow-up. The mean time to consultation was 2.5 ± 1.1 days. The process was safe, with no mortality, a hospitalization rate of 4.7 %, and a 30-day emergency revisit rate of 17.9 %. Overall, 81 % of patients reported being satisfied or very satisfied. Emergency physicians rated the utility of the PEC at 8.7/10 and its contribution to patient care improvement at 9.2/10.

CONCLUSIONS. The PEC is a safe and satisfactory resource for both patients and emergency physicians. Its implementation requires no additional infrastructure or human resources, helps avoid unnecessary ED stays, and may serve as a complementary tool to improve urgent care for selected patients.

Keywords: Post-emergency consultation. Clinical management. Emergency care.

Consulta post-urgencias: un nuevo recurso creado por urgenciólogos

INTRODUCTION. Describimos la creación y los resultados de una consulta post-urgencias (CPU) dirigida a pacientes que, tras una primera asistencia en urgencias, son citados de manera programada en una consulta perteneciente al propio servicio de urgencias hospitalario, para control de su evolución clínica o completar el proceso diagnóstico-terapéutico.

MATERIAL Y MÉTODOS. Durante el año 2023 se recogieron variables demográficas, patología de consulta y acciones realizadas en la CPU, e indicadores de accesibilidad (tiempo hasta consulta), de seguridad y de satisfacción de usuarios y profesionales, mediante encuesta *online*.

RESULTADOS. Se incluyeron 491 pacientes. La patología más frecuente fue la infecciosa (44,6 %) y al 66 % se les realizó un control analítico. El tiempo medio hasta la cita fue 2,5 ± 1,1 días. La CPU fue segura en términos de mortalidad (nula), ingresos (4,7 %) o reconsultas a urgencias en menos de 30 días (17,92 %). El 81 % de los usuarios estaban satisfechos o muy satisfechos y los profesionales de urgencias la valoraron con un 8,7 sobre 10 en utilidad, y con un 9,2/10 en cuanto a mejora asistencial para los pacientes.

CONCLUSIONES. La CPU es segura para los pacientes y satisfactoria para éstos y para los médicos de urgencias. Su implantación no precisa de más infraestructura ni recursos humanos. Evita estancias innecesarias en urgencias y puede ser un recurso complementario a implantar, para mejorar la asistencia urgente a determinados pacientes.

Palabras clave: Consulta post-urgencias. Gestión clínica. Atención urgente.

Introduction

Hospital emergency departments (EDs) continually adapt to care demands, primarily by implementing strategies that reduce length of stay without compromising clinical safety. The *Hospital Universitario Severo Ochoa* (Madrid, Spain) is a level-2 complexity hospital located in Leganés (Madrid), serving a reference population of 190,000 people. In 2023, it managed 121,198 emergency visits, and the waiting time for the first outpatient appointment was 70 days.[1,2] In the Community of Madrid, according to the health system barometer, 74% of respondents reported being unable to obtain a primary care (PC) ap-

Author Affiliations: Servicio de Urgencias, Hospital Universitario Severo Ochoa, Leganés, Madrid, Spain.
Corresponding Author: Esther Álvarez-Rodríguez. Servicio de Urgencias. Hospital Universitario Severo Ochoa. Avenida de Orellana, s/n. 28911 Leganés, Madrid, Spain.
E-mail: diabetes@gruposemes.org
Article Information: Received: 13-2-2025. Accepted: 15-7-2025. *Online:* 28-10-2025.
Editor in Charge: Guillermo Burillo-Putze.

© SEMES

pointment the day after requesting one, and 28.7 % reported a delay of more than 11 days.[3]

Certain patients, after assessment in the ED, do not meet admission criteria but do require follow-up of their clinical evolution. Observation in the ED is not always indicated nor comfortable for patients and their families and may consume scarce healthcare resources. Furthermore, given that follow-up in PC or outpatient clinics (OC) could be delayed, providing verbal or written instructions for home observation with return to the ED in 24–48 hours artificially inflated the indicator of "ED revisits," since these encounters represented scheduled follow-up rather than true early reattendance.

For this reason, the Post-Emergency Clinic (PEC) was created to offer a dedicated resource for rapid and efficient clinical reassessment of selected patients discharged from the ED. This study describes the implementation of this PEC and its initial outcomes.

Materials and methods

The project was conceived in 2021, with the development of the care pathway and its IT infrastructure. During 2022, the model was disseminated among ED staff and piloted in 133 patients. After correcting detected issues, full implementation occurred in 2023.

Description of the post-emergency clinic model

Patients evaluated in general ED were included (excluding pediatric and obstetrics/gynecology patients). Admission criteria for PEC are listed in Table 1. The decision to include a patient in this pathway depended exclusively on the physician responsible for discharge, who scheduled the patient's appointment when next assigned to ED duty.

Variables and indicators

During 2023, the following were recorded: Demographics: age and sex, presenting pathology: infectious, cardiac, pulmonary, digestive, neurological, nephrological, genitourinary, metabolic, musculoskeletal, hematologic, and others. PEC intervention type: clinical assessment, laboratory monitoring, imaging follow-up, medication adjustment, parenteral treatment administration, specialist consultation, or other Accessibility was measured by the time from ED discharge to PEC appointment. Safety indicators included 30-day mortality, ED revisits for any reason at 30 and 90 days, and post-PEC disposition (hospital admission, ED observation, discharge without follow-up, discharge with PC follow-up, or scheduling of a new PEC appointment). ED revisits within 72 hours were also recorded.

Patient satisfaction was evaluated through an SMS survey sent by the General Directorate of Citizen Care and Transparency. Physicians completed an anonymous mobile survey evaluating usefulness, frequency of use, impact on patient care and ED function, and operational aspects.

The project was approved by the General Directorate of Humanization and Patient Care of the Madrid Regional Health Authority (Ref: 43/581715.9/23).

Results

In 2023, 491 patients were scheduled in the PEC; mean age was 57 ± 22 years, and 53.2 % were women. All ED physicians used the PEC, with a mean of 15 ± 12.3 referrals per physician (range, 1–45). Mean time to appointment was 3.7 ± 3.6 days (range, 1–33). After excluding extreme cases related to chronic treatment adjustments or replacement of dysfunctional resources, the mean waiting time was 2.5 ± 1.1 days (range, 1–6).

The primary presenting conditions were infectious (44.6 %) and digestive (14 %) (Table 1). Only clinical assessment was performed in 25 % of patients; 66 % also underwent laboratory follow-up, 4.3 % specialist consultation, 2 % imaging, 2 % treatment administration, and 0.4 % drug titration.

After PEC, 4.7 % required hospital observation. The remaining patients were discharged (13.9 %), discharged with PC follow-up (52.6 %), scheduled for OC follow-up (15.9 %), or required a new PEC appointment (12.9 %) (Table 1).

The 30-day mortality rate was 0 %. ED revisits after PEC were 17.92 % at 30 days and 14.26 % between 30 and 90 days. Overall, ED revisits within 72 hours decreased from 1.61 % in 2022 to 1.49 % in 2023.

Patient satisfaction surveys were sent to 138 patients (28.1 %), with a 15.23 % response rate (21 responses). Among respondents, 81 % were satisfied or very satisfied; 90 % rated PEC as useful or very useful; physician rating was 8.7/10; and 85.7% preferred PEC over hospital admission. Among professionals, 87 % responded; 44 % used PEC frequently. Usefulness was rated 8.7/10, impact on patient care 9.2/10, quality of implementation information 8.2/10, and ease of following the pathway 7.6/10.

Discussion

Hospital EDs have developed different models of care as alternatives to conventional hospitalization. These include ED-dependent units such as Observation Units[4] and Short-Stay Units.[5] More recently, a further step has been taken with the development of initiatives within the concept of the so-called "Hospital Without Walls", which integrate in-person and virtual assessments into a new version of hospital-at-home care.[6]

We are aware that establishing a clinic for scheduled patient follow-up within an ED challenges a fundamental principle of urgent care itself. It also departs from the traditional paradigm of Spanish healthcare, which revolves around the family physician and primary care centers. For this reason, the PEC should not be used as a substitute for primary care physicians but rather for acute, time-limited clinical events. Nevertheless, when the same physician evaluates and resolves the clinical problem in two stages, they gain a broader perspective of the care process, leading to valuable learning and reducing uncertainty regarding patient progression.

Furthermore, we observed that the use of additional diagnostic testing does not increase. Workload does not increase either; rather, tasks are reorganized, replacing pro-

© SEMES

Table 1. Criteria for use of the post-emergency clinic and clinical outcomes

Criteria for use			
Inclusion criteria	Social-familial: – Independent patients without cognitive impairment, able to understand all instructions and recognize symptoms that would require urgent medical attention. – Patients with cognitive impairment may be eligible if accompanied by a trained caregiver who is present and assumes responsibility for the patient.		
	Clinical: – Patients presenting with a condition considered mild or moderate, with no potential for rapid progression to severe illness. – Patients with clinical stability according to standard criteria. – No admission criteria identified during initial evaluation.		
Exclusion criteria	– Patients with mobility limitations or those requiring medical transport to attend the clinic. – Frail older adults and/or patients with significant comorbidity. – Patients with cognitive impairment or psychiatric illness that prevents understanding or following medical instructions.		
Reason for consultation (PEC)	**N (%)**	**Patient disposition after PEC**	**N (%)**
Infectious	219 (44.6)	New PEC follow-up	63 (12.86)
Cardiac	16 (3.26)	Discharge without follow-up	68 (13.88)
Pulmonary	31 (6.31)	Primary care follow-up	258 (52.65)
Digestive	69 (14.05)	Specialty clinic follow-up	78 (15.92)
Neurological	25 (5.09)	Observation	5 (1.02)
Nephrological	33 (6.72)	Hospital admission	18 (3.67)
Genitourinary	4 (0.81)	**Safety indicators**	**N (%)**
Metabolic	23 (4.68)	Mortality < 30 days	0
Musculoskeletal	25 (5.09)	ED revisit < 30 days	88 (17.92)
Hematological	4 (0.81)	ED revisit 30–90 days	70 (14.26)
Other	42 (8,55)	Overall ED return rate	1,49 %

PEC: Post-Emergency Clinic; ED: emergency department.

longed ED observation with a scheduled follow-up visit that is more comfortable for patients and equally safe. However, in this preliminary analysis we did not perform a formal cost-effectiveness study of the PEC.

We have confirmed that the PEC is safe for patients and satisfactory for both patients and professionals. The improvement in the ED revisit indicator should be understood as a more accurate measurement of true unplanned returns, since prior to the existence of the PEC this indicator was artificially inflated, something that likely occurs in many EDs across Spain.

Few publications exist on similar units. In 2010 and 2018, 2 groups in the Netherlands reported experiences focused exclusively on patients with abdominal pain of unclear etiology, who were re-evaluated within 30 hours after their initial ED visit.[7,8] They concluded that this re-evaluation was useful for refining both diagnosis and treatment. More recently, a study in pediatric patients evaluated remote (non-in-person) follow-up visits designed to replace scheduled ED revisits. Although telemedicine was widely used, it did not reduce in-person reassessments; however, the tool was considered safe and useful.[9]

Other initiatives are more focused on reducing unplanned ED revisits and inappropriate ED utilization. These include programs aimed at improving the discharge transition from EDs by identifying patients at high risk of reattendance and implementing preventive interventions in primary care, such as nursing visits, virtual consultations, or text messaging.[10,11] While these programs successfully reduce ED utilization, they differ from our model in that they rely on external healthcare resources. The PEC is less focused on discharge transition and more on completing ED assessment in a second stage, thereby improving efficiency. Additionally, primary care may have limitations in managing this type of patient or in performing immediate diagnostic tests or administering certain treatments. With the PEC, referrals to hospital outpatient clinics may also be avoided.

Limitations. This study is retrospective and single-center. Moreover, few patient satisfaction surveys were distributed and the response rate was low, which may have influenced perceived quality results.

Conclusions

Without increasing human resources or requiring additional infrastructure or equipment beyond those already available, we implemented a post-emergency reassessment clinic that avoids unnecessary ED stays and likely reduces outpatient and primary care appointments. It also improves the reliability of ED revisit indicators. Although a PEC does not need to be implemented in all EDs, certain institutional circumstances may justify its adoption.

ARTICLE INFORMATION

Conflict of Interest Disclosures: None reported.

Funding: The authors declare the non-existence of funding in relation to this article.

Ethical Responsibilities: The authors have confirmed the maintenance of confidentiality and respect for the patient rights, agreement of publication, and transfer of rights to Revista Española de Urgencias y Emergencias.

Data Availability: Data are available upon reasonable request to the corresponding author.

Author Contributions (CRediT): EAR, JMO, MAML, VAC, CIF, and BGR: conceptualization, formal analysis, investigation, methodology, original draft preparation, review, and editing.

Use of Generative Artificial Intelligence Tools: The authors declare that no AI tools were used in the preparation of this article.

Article not commissioned by the Editorial Board and with external peer review.

Note of the editors: This is a BOWMAN-generated English translation of the officially indexed Spanish-language article, which should be cited as Rev Esp Urg Emerg. 2026;5:42-45. In this translated version, the editors have supervised the process; however, it cannot be ruled out that some errors resulting from the artificial intelligence translation process may have gone unnoticed.

REFERENCES

1. Memorias e informes del Servicio Madrileño de Salud. (Accessed 5 December 2024). Available at: https://www.comunidad.madrid/servicios/salud/memorias-e-informes-servicio-madrileno-salud#panel-435158
2. Observatorio de resultados del Servicio Madrileño de Salud. (Accessed 5 December 2024). Available at: https://servicioselectronicos.sanidadmadrid.org/LEQ/ConsultaEspecialidades.aspx
3. Sistema de información sanitaria. Barómetro sanitario 2023. (Accessed 21 April 2025). Available at: https://www.sanidad.gob.es/estadEstudios/estadisticas/BarometroSanitario/Barom_Sanit_2023/Barom_Sanit_2023_totales/cru8823ccaa.pdf

© SEMES

4. Rodriguez B, Vinat S, Parada R, Mir M, Bibiano C. Short Stay Unit at Home, an alternative to Conventional Hospitalization. Int J Integr Care. 2022;22(S3):373.
5. Bibiano Guillén C. Ingreso directo desde urgencias a domicilio: factible, eficiente y necesario. Emergencias. 2023;35:163-4.
6. Bibiano-Guillén C, Mir-Montero M, Rodríguez-Rodríguez B, Vinat-Prado S, Sánchez-Pérez M, Pantoja-Zarza MC. Implementación de una unidad de corta estancia virtual domiciliaria: viabilidad, seguridad y satisfacción. Emergencias. 2025;37:312-5.
7. Toorenvliet BR, Bakker RF, Flu HC, Merkus JW, Hamming JF, Breslau PJ. Standard outpatient re-evaluation for patients not admitted to the hospital after emergency department evaluation for acute abdominal pain. World J Surg. 2010;34:480-6.
8. Boendermaker AE, Coolsma CW, Emous M, Ter Avest E. Efficacy of scheduled return visits for emergency department patients with non-specific abdominal pain. Emerg Med J. 2018;35:499-506.
9. Gardner K, Hurley KF. Impact of virtual care on planned rechecks in a pediatric emergency department: a quality improvement project. CJEM. 2024;26:156-63.
10. Tessitore A, Brennan-Cook J. Improving Outpatient Follow-Up Through Innovative Appointment Scheduling at Emergency Department Discharge. Adv Emerg Nurs J. 2021;43:71-8.
11. Jiang LG, Zhang Y, Greca E, Bodnar D, Gogia K, Wang Y, et al. Emergency Department Patient Navigator Program Demonstrates Reduction in Emergency Department Return Visits and Increase in Follow-up Appointment Adherence. Am J Emerg Med. 2022;53:173-9.

© SEMES