

Strength in the gap: A rapid review of principles and practices for urgent care centres

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Healthcare Management Forum
2023, Vol. 36(2) 101–106
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DOI: 10.1177/08404704221143300
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Abstract

Responding to a provincial government decision to develop two Urgent Care Centres (UCCs) in Saskatchewan, we undertook a rapid review of published literature with the objective of determining best practices for their creation and functioning. Two English-limited PubMed database searches combining “after-hours care,” “ambulatory care,” “emergency medicine,” “urgent care,” “minor emergency,” “walk-in,” and “Canada” over the past 10 years were the sources of articles for our review. Articles were independently reviewed by two authors and synthesized collaboratively. From 833 articles, 44 were utilized in the review. Six considerations in the following areas were subsequently outlined: expected impact, preferred location, healthcare services collaboration, available services, staffing priorities, and community partnerships. These principles were considered against the backdrop of currently successful Canadian UCCs. This review indicates that general principles for the successful development of UCCs exist; these may guide the establishment and functioning of UCCs both in Saskatchewan and elsewhere.

Introduction

More than two million Canadians seek immediate care for minor health concerns annually, with over half doing so after-hours.¹ Approximately 15% of Canadians lack a Family Physician (FP), and of those having one, only one-third can arrange a same-day or next-day appointment.² As such, urgent care can be troublesome for many Canadians.

Canadian Urgent Care Centres (UCCs) first appeared in 1989, expanding to approximately 25 facilities nationally by 2000.³ This care option has grown, with 30 provincial centres now in British Columbia alone.⁴ UCCs manage urgent health concerns, typically with efficiency brought about by on-site imaging services and laboratory.⁵ Recognizing similar care provided to urgent-but-non-emergent Emergency Department (ED) presentations, there is belief that UCCs can offload ED patients.⁶

Approximately half of Saskatchewan’s urban ED presentations are of low acuity.⁷ As such, the Saskatchewan government is building two UCCs to provide patients with additional urgent care options while reducing ED wait times and overcapacity. Our objective was to undertake a rapid review of published literature to better understand the roles/relationships such centres should have with other healthcare services and best practices around their functioning. A rapid review is a form of information synthesis that streamlines or eliminates selected aspects of a systematic review to generate evidence for stakeholders in a time- and resource-efficient manner.⁸

Methods

In March 2021, PubMed was searched utilizing combinations of “after-hours care,” “ambulatory care,” “emergency medicine,” “urgent care,” “minor emergency,” “walk-in,” and “Canada.” Searches were limited to English and within the past 10 years.

Two authors separately screened all the review articles followed by the Canadian studies, initially evaluating titles and, if necessary, abstracts. To further increase comprehensiveness, one author repeated this process for all retrieved studies published elsewhere. This subset was then progressively re-evaluated in the above order, including the review of manuscripts that (1) related to practical UCC functioning (e.g. services and communication), (2) evaluated factors related to seeking/accessing unscheduled care, or (3) pertained to UCC roles within healthcare. Reflecting rapid review, not all articles were included; as the review progressed, relevant articles failing to offer additional insights were not retained. Those unrelated to the UCC context or narrow in scope were also excluded. Within the initial groups, articles were reviewed by PubMed-ordered relevance.

Results

The searches returned 833 articles. Of these, 148 were potentially relevant based on rapid title and abstract screen, undergoing further evaluation. Forty-four contributed to our final review.

Urgent care centre impact regarding emergency and primary care

A service gap exists between Primary Care (PC) and the ED, with UCCs previously identified as potentially offering improvement.⁹ Lower-acuity care adequacy for many ED

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presentations is well-established, with up to half manageable outside the ED.^{10,11} Patients seeking care from general practitioner after-hours services have been found to more often be older, female, and presenting with non-injury concerns compared to ED presentations, suggesting that patients do discriminate when selecting services.¹⁰ However, reduced ED demand is inconsistent among alternative care models.^{12,13} Swedish ED personnel, after the formation of a nearby UCC, did report subjective capacity pressure reduction.¹⁴ A Chilean study also reported a minor (2.7%) reduction in ED visits after UCC establishment.¹⁵ A study of six American states demonstrated a 17.2% reduction in ED visits during times when UCCs in the corresponding zip code were open.¹¹ Similarly, areas within the United States with high UCC use have been found to correspond with lower ED use.¹⁶ However, a review of British efforts to increase urgent care availability suggests that individuals do not generally substitute newly established, more appropriate care avenues for older ones, including ED use.⁹ Estimates of ED demand in relation to UCC proximity have been inconsistent between centres within the same study.¹⁷

Multiple literature reviews recognize lack of PC access as a key reason for seeking emergent and urgent services and, as such, UCCs may be a significant PC resource.^{9,18,19} Urgent care facilities have been noted to frequently see patients within PC office hours.^{19,20} Concerningly, PC delivered via urgent care may be incomplete, lacking prevention and long-term chronic disease management.¹⁹ UCCs may also take this role due to deflection from PC providers themselves or patients' insufficient healthcare knowledge.¹⁹

Considerations for urgent care centre establishment and functioning

Recognizing these expectations of UCCs, consideration was given to literature as to how UCCs should function to maximize both quality care and healthcare system benefit.

Location. Convenience and accessibility have been found to be important factors when accessing care.^{18,21-23} As such, accessing UCC services should be as easy as going to the ED. Although not all studies have shown greater efficiency,²⁴ "fast track units" or "rapid assessment zones" within EDs are common and have been relatively successful, further encouraging urgent care situation within or immediately adjacent to emergent care.^{14,25} However, as most facilities cannot be physically expanded, close proximity is a likely concession.

Further illustrating location impact, UCCs within American privatized healthcare have been found to be disproportionately located within geographic areas of higher affluence.²⁶ This has been recognized to potentially widen the gap in health disparity of the underserved.²⁶

Interaction with other healthcare services. UCCs can liaise between EDs and PC.^{14,19,21,23,27} Integration and

collaboration between EDs, Primary Care Networks (PCNs), and UCCs allow appropriate patient flow.^{14,19} Emergency Medical Services (EMS) are pivotal when transferring low acuity patients from homes, long-term care, Walk-In Clinics (WIC), or PC offices, triaging to the UCC when appropriate¹⁴; alternate destinations, such as UCCs, have been found acceptable in many mild-to-moderate acuity ED presentations.²⁸ UCC presentations deemed critical may also require transport to the ED.²⁹ As such, UCCs must be systematically designed to interface with EMS. Protocols, especially those related to time-sensitive conditions requiring ED transfer, are necessary.^{30,31} As communication from UCCs regarding referred patients, both those received from PC providers and those transferred to the ED, is typically suboptimal,^{19,29} efforts to implement best communication practices are necessary.^{19,27,29}

Additionally, well-integrated systems can connect non-emergent but complex PC to the generally broader scope of UCC services.^{19,27} This may avoid ED referral from PC in moments of clinical ambiguity or unavailability.

Walk-in type services have been accused of encouraging unnecessary healthcare demands and service duplication.^{12,32} This can arise from multiple dynamics, including improved accessibility for minor concerns,^{9,12,32} referral from UCCs to the ED,^{33,34} and patient-initiated consultation of multiple providers.³⁵ Consideration must be given to minimizing these outcomes.

Service availability. As UCC roles and responsibilities are broad, UCC capabilities must match. Older adults typically value comprehensive, diagnostic, immediate care at a single location delivered by a familiar physician.^{18,21} Thus, older persons may prefer UCCs over larger EDs, and UCCs must be able to manage their increased complexity.^{21,23} Similarly, paediatric ED presentations are often perceived as urgent; caregivers seek accessible, quality urgent care options for their children.^{36,37} In general, accessibility has been found to be very important in care-seeking decisions^{18,21,23,36,37}; some UCCs have found telemedicine to be useful in improving access.³⁸

As worry is a primary driver of unscheduled healthcare use,^{18,23,36,37} UCCs must have adequate diagnostic capabilities (e.g. ECG, laboratory, X-ray, and ultrasound) and be recognized by patients as a care resource on par with the ED.^{18,21,23,36,37} Additional services offered in a UCC can vary widely,¹¹ with opportunity to meet community-specific needs. For some UCCs, services shared with nearby tertiary hospitals facilitate lateral ED collaboration.¹⁴

Staffing priorities. Although expected to be of lower acuity, UCC presentations may require resuscitation, stabilization, and ED transfer; approximately 4% of non-urgent presentations require hospitalization.¹³ Correspondingly, UCC staff must have skills to address higher acuity, as reflected in the development of urgent care fellowship training.³⁹ Among UCC referrals to the ED, severity ranges from simple to critical,⁴⁰ with potential for

both over and under treatment. As such, staff must have strong emergency assessment and management skills to avoid unnecessary ED transfers or delayed critical care, respectively. However, typically lower acuity, coupled with difficult after-hours PC access, also suggests that UCC staff should be acquainted with PC-sensitive needs and their outpatient management^{10,39}; this includes familiarity with chronic disease concerns frequently presenting for urgent care.⁴¹ PC approaches promote greater relational connectivity and have been found to reduce testing and admission in emergent care settings.⁴²

Urgent mental healthcare was briefly included in this literature.^{43,44} Approaches vary, with examples of clinicians offering specialized single-session counselling⁴³ or screening for major mental health concerns (e.g. suicidality) in usual care provision.⁴⁴ Additional staffing roles, such as social worker⁴⁴ and frequent user support manager,⁴⁵ may enhance mental healthcare and other related aspects of UCC functioning.

Teamwork is a key contributor to quality patient care, patient satisfaction, and staff retention and should be valued within UCCs.⁴⁶ Dynamics facilitating UCC team development include the appointment of leaders, perception of fair workload, education and role/skillset development, shared professional understanding, interdisciplinary working, clinical guidelines, and social interactions.⁴⁶

Community partnerships. Establishing a new UCC provides opportunity for stakeholders to address community-specific needs, which may facilitate better care without ED referral. For example, it has been recognized that innovative partnership between EDs, PCNs, and community resources are needed to address the non-urgent needs of seniors.^{15,21,23} Partnership with patients themselves as stakeholders has also been explored.⁴⁷ Within a large multisite PCN, strategies co-designed with patients improved patient-reported after-hours care access.⁴⁷ Connection with underserved ethnic groups should also be considered.⁴⁸

Awareness of the UCC capabilities and availability requires information dissemination amongst FPs, PC clinics, ED staff, consultant services, and the public. Presenting this information in the ED itself may have impact,⁴⁹ as patients may be unaware of nearby urgent care options and their suitability for relatively complex care.^{50,51} Although patient profiles may vary between healthcare options,¹⁰ it is recognized that patients presenting to the ED are often unable to effectively triage their concern^{18,23,51}; as such, efforts to facilitate appropriate decision-making should be made.²³ Community services like HealthLine, a provincial medical call centre, have been shown to positively affect patient urgent care decisions and therefore need to be both consulted and informed regarding UCCs.⁵²

Discussion

This rapid review suggests that leaders establishing UCCs should thoughtfully consider the multiple roles these facilities play. As an additional care option, it is important that UCCs

clearly communicate to potential users the types and level of healthcare at each location. Communication with both PC and ED physicians is necessary to avoid care fragmentation.

Andersen's model of health services utilization presents three factors influencing patient uptake: enabling resources, level of need, and predisposing characteristics.⁵³ Our findings fit this framework; strategic location enables access, while type of service availability and staffing appropriateness meet perceived levels of need. Developing community partnerships may grant avenues to further provide enabling resources, understand and influence predisposing elements such as user health system perspectives, and identify care needs specific to the community. To some degree, individuals make healthcare decisions based on social and moral perspectives, influenced by others' opinions and the desire to use healthcare resources appropriately.⁵⁴ Patients are, however, challenged by the "work" of an urgent need, requiring them to evaluate concern severity and navigate the healthcare system accordingly, which may incorporate the perspectives of others and of social media.⁵⁴ Additionally, patients' needs often extend beyond the clinical condition itself to elements of risk minimalization, urgency, simplicity, compliance with others' views, quality care, and amelioration of healthcare system frustrations.⁵⁵ These dynamics may all affect UCC use.

Urgent care centres may require broader compliments of community relationships and staff than outlined in the reviewed literature. Considering the greater ED use among Indigenous people and differences in presentation compared to those of non-Indigenous individuals,⁵⁶ one priority unaddressed is that of partnership with Indigenous representatives. However, Berg et al. in their scoping review of Indigenous cultural competency and safety in Canadian hospital EDs promote partnership with Indigenous communities, creation of culturally safe and supportive environments, service re-orientation to Indigenous needs, and discrimination prevention⁵⁷; such approaches are transferable to UCCs. Additionally, there may be opportunity to effectively revise traditional healthcare provider roles to effectively serve the UCC context that were not considered in this literature. One example is the frontline provision of mental health services by registered nurses, a model recognized to be successful within a Calgary UCC.⁵⁸

Interestingly, one article reviewed suggests that women and men select after-hours care differently.¹⁰ Evaluating this, the authors highlight greater health-seeking behaviour among women, potentially driven by differences in health knowledge, health status, and social roles, among other influences.¹⁰ These may result in differing healthcare navigation abilities and selection decisions, underscoring need for UCC accessibility across all genders.

Strikingly variable, clinical settings where urgent care is provided within this literature include after-hours GP co-operatives, walk-in clinics, retail clinics, UCCs, minor injury units, and free-standing emergency centres. Services may be provided within an ED, alongside an ED in a separate area with

or without a common entrance, or in a completely separate facility. Care providers may primarily be Registered Nurses, Nurse Practitioners, Physician Assistants, General Practitioners (GPs), or GPs with urgent care fellowship training, and funding may be private or public. Although the Urgent Care Association of America has criteria for UCCs,⁵⁹ it has been recognized that there is no single operational definition in use for this specific type of facility, either in level of care or services offered.^{5,59} This heterogeneity, present within both the real-world context and the reviewed literature, is undoubtedly confusing for patients and may affect the generalizability of our findings. Additional study limitations include a rapid review process streamlined to English PubMed articles published within the last 10 years with no formal quality assessment.

While future Saskatchewan UCCs may shoulder a noticeable proportion of ED patients, reducing non-emergent presentations will not necessarily fix ED overcapacity.⁶⁰ The Canadian Association of Emergency Physicians believes “access block” (i.e. inability to move patients out of the ED to the healthcare required) is a much greater influence on overcrowding than easily managed low acuity.²⁵ Large catchment areas, low inpatient capacity, and high bed occupancy are suggested contributors.⁶¹

Lastly, successful UCCs in Vancouver, British Columbia⁶² and southern Alberta⁶³ exemplify the principles reviewed. Vancouver’s three “Emerg Lite” UCCs, staffed by ED physicians and FPs with acute care skills, are all within 4 km of a hospital. Public service announcements encourage low acuity presentations. Nevertheless, Vancouver’s UCCs treat all presentations, managing and transferring sicker patients as needed. Among five UCCs in southern Alberta, two are 24-hour facilities. Consultant services are available through the ED, and one UCC has CT capability. Alberta UCCs treat all eligible patients according to urgency (most frequently CTAS-4), with life-threatening conditions stabilized and immediately referred to EMS. In 2019, only 1.72% of visits (n = 3374) were transferred. Across Alberta facilities, UCC and ED presentations have been found to almost overlap completely, suggesting that UCCs offload substantial ED volumes.

Conclusion

UCCs, situated near EDs and in areas of health disparity, should provide comprehensive, quality care straddling PC and emergent concerns, working in solid collaboration with EDs, PC, community services, and stakeholders. Facilities require both basic diagnostics and resources for managing life-threatening emergencies. Prior to initiating services, development of a strategic approach towards predisposing, enabling, and needs-based factors within local social contexts will go a long way towards effective, appropriate UCC utilization.

Acknowledgements

We appreciate the assistance of Mark Mueller, Saskatchewan Health Authority (SHA) clinical librarian, Health Sciences Library, and Colleen

Quinlan, SHA executive director, mental health and addictions, who provided preliminary search strategies for this work. We also appreciate information regarding local UCCs shared by Dr. C. Wong (Calgary) and Dr. A. Khazei (Vancouver). Additionally, we recognize the support of Dr. Jason Hosain within the Department of Academic Family Medicine, University of Saskatchewan for this project.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Ethical approval

Institutional Review Board approval was not required.

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