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Urgent Care Centres: A Scan of Models of Care and Literature on Their Effectiveness

Corrected version: Some of the findings in this report have been updated based on information received after the jurisdictional survey had closed.

Key Messages

What is the Issue?

- Urgent care centres (UCCs) are medical clinics that provide sameday urgent treatment for non-life-threatening illnesses or injuries. The level of services they can provide is more comprehensive than primary care walk-in clinics but less comprehensive than emergency departments (EDs).
- In Canada, many people do not have timely access to primary care services, and EDs face overcrowding, which results in long wait times and patients leaving without being seen.
- UCCs may fill a gap between primary care and emergency services; however, there is no single definition or specified model for these clinics. There is a need for detailed information about the range and scope of UCCs operating across Canada.

What Did We Do?

- We surveyed health care and administrative professionals about the characteristics and their experiences of UCCs in Canadian jurisdictions.
- We searched key resources, including journal citation databases, and conducted a focused internet search for relevant evidence published since 2015, to examine the effectiveness of UCCs in Canada or countries with similar health care systems.

What Did We Find?

- We received 17 complete survey responses from 7 jurisdictions in Canada. Based on the responses, we found that UCCs vary in their structural and operational components. UCCs typically offer services such as diagnosis and treatment, X-rays, stitches, and lab tests. They are staffed by emergency and family physicians, nurses, allied health care professionals, and administrative staff. Some UCCs operate 24 hours a day, while others have limited hours. The most commonly identified barriers to operating UCCs include staffing and funding. Benefits of these centres were reported to include better access to care and potential relief of some of the burden on EDs.
- We identified 6 articles that met our inclusion criteria. Two articles examined UCCs dedicated to cancer-related concerns, and 4 articles examined general UCCs. The authors' conclusions about the effectiveness of UCCs were mixed.

Key Messages

What Does This Mean?

 The findings of this report can be used as guidance to policy- and decision-makers across Canada who may be in the process of, or considering, implementing UCCs. The findings provide examples of structural and operational components that may suit the needs and contexts of their respective jurisdictions as well as considerations that may help inform implementation.

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Context

UCCs are medical clinics that provide same-day urgent treatment for non-life-threatening illnesses or injuries, such as infections, sprains, earaches, broken bones, and fevers.¹⁻³ These centres may have access to diagnostic equipment and laboratory services on site.³ Urgent care differs from other services such as walk-in primary care clinics and EDs and may be distinguished by the severity of health issues they are best able to address.¹ While urgent care is intended to provide same-day treatment, walk-in primary care clinic services are often used by individuals who require care but can wait 24 to 48 hours to be seen.¹ Walk-in primary care clinics may be used by individuals who do not have a primary care provider or who have a primary care provider but do not have immediate access to their services.¹ Additionally, ED services are typically available at any time of day, to anyone, and have the resources to address the most serious health concerns, including those that are limb- and life-threatening.¹⁻³ UCCs exist in jurisdictions across Canada and internationally, though they may go by different names. Although a general understanding exists of what urgent care entails, there is no single definition. As a result, there may be numerous models of UCC that provide a range of structural and operational components.

In Canada, many individuals face challenges accessing health care services.⁴ As of 2023, 17% of adults in Canada reported that they did not have a regular health care provider.⁵ Furthermore, approximately 74% of adults in Canada are not able to get appointments to visit a doctor or nurse for the same or following day, and 77% report difficulties accessing care outside of regular working hours, including on evenings, weekends, and holidays.^{4,5} These access issues are particularly pronounced in rural and remote areas.⁵ The limited availability of, and barriers to accessing, primary care services can cause individuals to seek treatment in the ED because they are not able to find an alternative care option.⁵⁻⁷ However, EDs across Canada struggle with overcrowding, a situation in which the demand for health services in the ED exceeds the ability to provide care in a reasonable amount of time.^{6,7} This overcrowding results in long wait times, which can cause patients to leave without receiving care.⁶ These issues have been highlighted and discussed in the previous work done by Canada's Drug Agency on <u>Emergency Department Overcrowding</u>.

UCCs may help bridge the gap that exists between primary and emergency care. They can offer unscheduled, timely care to individuals who cannot otherwise be seen by a primary care provider, and they can provide more comprehensive services, such as laboratory testing or diagnostic imaging that patients may otherwise seek out at EDs. As such, UCCs have the potential to both improve access to care and relieve some of the burden on EDs.

Purpose and Objectives

The purpose of this Environmental Scan is to provide a current overview of both the components and experiences of UCCs in Canada and to identify existing literature about the effectiveness of UCCs in Canada and in countries with similar health care systems. This report is intended to provide guidance to health care policy- and decision-makers who are considering implementing UCCs in their jurisdictions.

The key objectives of this Environmental Scan are as follows:

- 1. To identify and describe components of UCCs in Canada
- 2. To describe the experiences of jurisdictions in Canada regarding the implementation and outcomes of UCCs
- 3. To identify and describe the literature that examines the effectiveness of UCCs both in Canada and in countries with health care systems similar to those in Canada.

Research Questions

To address the objectives, we asked and answered the following research questions:

- 1. What is the landscape of urgent care centres operating across Canada?
 - a) What urgent care centres are operating in Canada, where are they located, and what is the model of care?
 - b) What are their structural components?
 - c) What are their operational components?
 - d) What are the implementation and evaluation considerations of these centres?
- 2. What evidence exists about the effectiveness of urgent care centres in both Canada and countries with health care systems similar to those in Canada?

Approach

We conducted an Environmental Scan to capture a variety of information related to UCCs. The Environmental Scan consisted of both a survey component and literature-based component. To address research question 1 (objectives 1 and 2), we conducted a survey to capture information about UCC models, components of care, and implementation and outcome considerations. To address research question 2 (objective 3), an information specialist conducted a customized literature search, balancing comprehensiveness with relevance, of multiple sources and grey literature on February 28, 2025, regarding the effectiveness of UCCs in Canada and in countries with health care systems similar to those in Canada. A more detailed summary of methods is available in <u>Appendix 2</u>.

Findings

The findings presented are based on survey responses received between March 12, 2025, and April 7, 2025, as well as a limited search and review of published and unpublished literature.

We received survey responses for UCCs in 7 of 13 jurisdictions in Canada (i.e., Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia). To the best of our knowledge, at least 1 jurisdiction in Canada does not have UCCs and, therefore, was not able to participate in our survey.

We sent invitations to participate in the survey to a total of 38 individuals across 9 jurisdictions and received 17 complete responses. Respondents included 8 individuals whom we contacted directly as well as 9 individuals who subsequently received the survey invitation from the initial contacts. Respondents reported holding positions such as vice-president, executive director, director, manager, clinician, or professor. A list of participating organizations is provided in <u>Appendix 4, Table 9</u>

We included 6 articles from the literature searches that met our inclusion criteria. We also provide a list of references of potential interest in <u>Appendix 5</u>. This list includes citations from the US that did not meet our inclusion criteria but may still provide useful information to readers. The findings presented here address the research questions and are presented according to the objectives of the report.

Components and Experiences of UCCs in Canada

A narrative overview of the findings related to the components and experiences of UCCs in Canada is presented in the following section. <u>Table 1</u> and <u>Table 2</u> provide a summary of findings regarding the UCCs that were identified in the survey responses. Additional detailed survey findings are available in <u>Appendix 1</u>.

Structural Components

We aimed to understand the structural components of UCCs, including the model, number of years in operation, population served, funding and fees, affiliations, and staffing structure.

Model of UCC

We provided survey respondents with the following definition of a model of urgent care and asked if it aligned with the model they used: "A medical clinic that provides same-day, urgent treatment for unexpected but non-life-threatening illnesses or injuries, such as infections, sprains, earaches, broken bones, and fevers."

Most respondents noted that this definition aligned with the model of care they used. Four respondents noted that their UCCs mostly aligned with the definition but that they also provided some care for more critical or life-threatening conditions. The most notable exception was for a UCC in Manitoba, which respondents noted as regularly providing more acute and complex care that aligned closer to services that would be provided in a typical ED.

Time Operational

At the time of the survey, 1 UCC (Ontario) was preparing an application to reopen a former site that had closed in 2015. All other UCCs were currently operational. The time that each UCC has been operational varies widely. The newest one was established less than 1 year ago, in July 2024, and the oldest has been operational for more than 50 years. Most have been operating from between 3 and 15 years. One of the UCCs was formerly an ED but later became a UCC in 2019.

Population Served

All but 1 of the UCCs surveyed serve people of all ages (i.e., older adults, adults, and pediatric populations). The UCC that is in the planning stage (in Ontario) will serve the adult and older adult populations only. All but 3 respondents noted that their UCCs serve populations that are mostly urban. Two 2 UCCs serve a mixture of both urban and rural populations. The UCCs in Nova Scotia serve mostly rural populations.

Component	Nova Scotia	New Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
Location(s)	 Nova Scotta Annapolis Royal Baddeck Middle Musquodoboit North Sydney Parrsboro Sheet Harbour Tatamagouche Yarmouth 	New Brunswick Bathurst	 Brampton Kingston Toronto 	Winnipeg	Regina	 Alberta Airdrie Calgary Cochrane Edmonton Okotoks 	 Abbotsford Burnaby Chilliwack Langley Maple Ridge Mission Port Moody Surrey
Time operational	1 to 5 years	50+ years	0 to 25 years (1 is in planning stages)	6 years	< 1 year (July 2024)	15 to 18 years	• Victoria 3 to 6.5 years
Ages served	All ages	All ages	 Adults and older adults only All ages 	All ages	All ages	All ages	All ages
Urban or rural classification of population served	Mostly rural	● Urban ● Rural	Mostly urban	Mostly urban	Mostly urban	Mostly urban	• Urban • Rural
Funding	Government	Government	GovernmentHospital	GovernmentHospital	Government	Government	Government
Fees for patients	No	No	No	No	For some services	For some services	For some services
Affiliations	Yes • Dalhousie University • Nova Scotia Health	No	Yes • Humber River Health • Queen's University • Scarborough Health Network	Yes • Concordia Hospital • Winnipeg Regional Health Authority	No	No, but sometimes will be used for teaching opportunities	Some Simon Fraser University University of British Columbia

Table 1: Summary of Structural Components

Component	Nova Scotia	New Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
			 William Osler Health System 				

Note: All data reported in this table correspond to the answers received at the time of survey administration (March 2025 to April 2025).

Affiliation

Some of the UCCs identified have affiliations, whereas others are standalone public operations (e.g., located in medical office buildings, strip malls). The types of affiliations include local universities, hospitals, and health networks. Some, but not all, UCCs with hospital affiliations are physically co-located with the hospital, whereas those with health network affiliations operate in distinct locations but within the same system. For those with university affiliations, medical students and residents may be taught at the UCCs.

Funding and Fees

All the UCCs included in the survey were established through public funding (i.e., via provincial ministries of health or health authorities). Two of the UCCs also received funding through affiliated hospitals. Three respondents noted that they use or will use a fee-for-service model for the physicians working at the UCC.

Fees for patients vary among the UCCs. Seven respondents reported that patients are never charged fees to receive services at their respective UCCs. Five others reported that uninsured patients (i.e., those who are not covered by a mandatory provincial health insurance plan, out-of-country patients) are charged fees for certain services. These services may include completion of certain paperwork (e.g., doctor's notes), facility fees, and access to physicians' services. In some cases, patients are charged a fee for a doctor's note regardless of insurance status. Additionally, out-of-country patients may be required to pay facility and physicians' fees.

Staff

Typically, staff at the UCCs surveyed consisted of clinical staff, such as physicians (both emergency medicine specialists and family medicine physicians), nurse practitioners, registered nurses, and licensed or registered practical nurses. Other common health care staff include social workers and technicians (i.e., lab, X-ray, ultrasound). To a lesser extent, the UCCs surveyed also have pharmacists, phlebotomists, advanced care paramedics, and respiratory therapists. A UCC in British Columbia and a UCC in Saskatchewan both have dedicated staff for mental health and addictions, and a UCC in Ontario has an orthopedic technician.

In terms of nonclinical staff, all but 1 of the UCCs (New Brunswick) reported having reception and clerical staff, and most reported having administrators. Two respondents noted that the UCCs they work at or oversee had directors on staff. Some respondents from Ontario, Manitoba, and Saskatchewan reported that their UCCs had information technology staff. More detailed findings about staff are reported in <u>Appendix 1, Table 4</u>.

Operational Components

We sought to explore operational components of UCCs, including access and triage approaches, hours of operation, wait times, and services offered.

Component **Nova Scotia** New Brunswick Ontario Manitoba Saskatchewan Alberta **British Columbia** Patient • By appointment Walk-in • Walk-in • Walk-in Walk-in Walk-in • By appointment access Walk-in • Ambulance • Walk-in Ambulance transport transport • Transfer from FD Possible transfer from ED (in planning stage) Order of First-come. first-Patients are • Patients are triaged • Patients are Patients are Patients are triaged Patients are treatment served triaged triaged triaged triaged Combination of triage and first- Combination Combination of come, first-served of triage and triage and firstfirst-come. come, first-served first-served Days of Site dependent, 3 to 7 7 days per week operation days per week Hours of Varies by site and 24 hours Varies by site: 24 hours 8:00 a.m. to 9:30 Varies by site: 8:00 a.m. to 8:00 operation day: p.m. p.m. • 24 hours • 24 hours • 8:00 a.m. to 8:00 • 8:00 a.m. to 10:00 • 8:00 a.m. to 10:00 p.m. p.m. p.m. • 8:00 a.m. to 7:30 • 8:00 a.m. to 11:00 • 8:00 a.m. to 8:00 p.m. p.m. p.m. • 8:00 a.m. to 4:30 • 5:00 p.m. to 10:30 p.m. p.m. • 8:00 a.m. to 4:00 p.m. • 9:00 a.m. to 5:00 p.m. • 9:00 a.m. to 4:00 p.m. 2 to 5 hours Typical wait Patients can typically Variable ≤ 2 hours 2 to 12 hours NR 1 to 3 hours time be seen the same day depending on site or the next day

Table 2: Summary of Operational Components

Component	Nova Scotia	New Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
Wait time posting	No	No	Site dependent	Yes	No	Yes	No

ED = emergency department; NR = not reported.

Note: All data reported in this table correspond to the answers received at the time of survey administration (March 2025 to April 2025).

Access and Triage

In all but 1 (in British Columbia) of the UCCs, the primary way that patients access services is on a walk-in basis. Three UCCs accept patients via appointment, 1 of which requires patients to call in when the clinic opens for a same-day appointment. Three UCCs also accept, or are planning to accept, patients via ambulance or ED transfer.

At most of the reported UCCs, patients are triaged and treated in order of acuity (e.g., based on the Canadian Triage and Acuity Scale). UCCs in Nova Scotia serve patients on a first-come, first-served basis, and 3 UCCs use, or will use, a combination of triaging and a first-come, first-served approach.

Hours of Operation

The dates and times that the UCCs operate vary between sites. All but 1 respondent (in Nova Scotia) reported that UCCs identified in this survey are open 7 days per week. In Nova Scotia, the sites are open from 3 to 7 days per week. There is a range in the hours of operation. Four UCCs are open 24 hours a day, other centres open as early as 8:00 a.m. and close from between 8:00 p.m. and 11:00 p.m. Others are open only during daytime hours.

Wait Times

The typical wait times reported for each UCC vary from 1 hour to 12 hours, depending on the day and time. The longest wait time surveyed was at a UCC in Manitoba, where respondents noted that the centre was treated more like an ED (i.e., patients often present to the UCC with care needs that can be more appropriately treated at an ED).

Approximately a third of respondents reported that their UCC posts live wait times (e.g., on their associated websites). The perceived utility of posting these wait times is mixed, according to the administrators and staff who were surveyed. Reported positives include that posting wait times helps with transparency, load levelling, and may help patients decide where they choose to receive care. Conversely, reported negatives of posting wait times include inaccuracies in estimates, a lack of clarity on how wait times are calculated, and that wait times can cause frustration and anger when they are inaccurate. Additionally, posting wait times may push patients away from the most appropriate place to receive care because patients believe they will be seen faster (e.g., a high-acuity patient who requires services provided at the ED may choose to visit a UCC instead because the wait times appear to be shorter than at the ED).

Services Offered

All the UCCs identified in the survey provide diagnosis and treatment, and stitches. Other services provided at most surveyed UCCs include X-ray, ultrasound, laboratory services (e.g., blood work), and casting. Referrals and mental health services are offered at about two-thirds of the identified UCCs. Pharmacy services, eye care, immunizations, and virtual care are offered at about a third of the UCCs. One respondent noted that laboratory and X-ray services are available in the same building through different providers but that they operate under more restrictive hours. Additionally, the respondents noted that the use of point-of-care ultrasound is limited. Sterile procedures (aside from suturing), day surgeries, or ambulatory care are

Findings

offered at some surveyed UCCs in New Brunswick, Ontario, and Manitoba. Examples of some of the specific services are reported in <u>Table 5</u>.

Service	Nova Scotia	New Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
Diagnosis and treatment	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Virtual care	Yes	No	No	No	No	No	Yes
Casting	Yes	Yes	Yes	Yes	Yes	Yes	Some
Eye care	Yes	Yes	Some	Yes	No	Yes	No
Laboratory services (e.g., blood work)	Yes	Yes	Yes	Yes	Yes	Yes	Yesª
X-ray	Yes	Yes	Yes	Yes	Yes	Yes	Yesª
Ultrasound	Yes	Yes	Yes	Yes	Yes	Yes	No
Stitches	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Immunizations	No	Yes	No	Yes	No	Yes	Some
Referrals	No	Yes	Some	Yes	No	Yes	Yes
Pharmacy services	No	Yes	No	Yes	Yes	No	Some
Mental health services	No	Yes	Some	Yes	Yes	Yes	Yes
Dental services	No	No	No	No	No	No	No
Other	NR	NR	No ^b	Yes (procedures, resuscitation)	NR	NR	No

Table 3: Summary of Services Offered at UCCs in Canada

UCC = urgent care centre.

^aAt one UCC in British Columbia, these services are available in the same building but through alternative providers that operate during limited hours.

^bTypes of services offered may differ following the opening of a UCC currently being planned.

Note: "Some" refers to services that are available in at least 1, but not all, the UCCs surveyed in that jurisdiction. All data reported in this table correspond to the answers received at the time of survey administration (March 2025 to April 2025).

Implementation and Data Considerations

Intent of UCCs

The main reasons that most of the UCCs identified in this survey were opened was to help alleviate ED overcrowding and to divert lower acuity patients away from the ED. Many of these UCCs were also opened to provide access to health care services to individuals who do not have a primary care provider. In a few cases, 1 of the reasons for opening the UCC was also to provide resources to patients who live far from other health care services (e.g., hospitals).

In Manitoba, a UCC was opened because of an operational change in which a previous ED was closed and was subsequently repurposed to become a UCC (i.e., focused on serving lower acuity patients). In Nova Scotia, UCCs were opened primarily to provide stable access to urgent care with regular hours in addition to helping alleviate ED overcrowding.

Barriers and Facilitators

In terms of barriers to opening and operating UCCs, the lack of staffing and personnel was a common theme among respondents. Other barriers noted by multiple respondents included limited funding and a mismatch between the needs of patients and the services that UCCs can provide. According to respondents, this mismatch may be related to both structural and financial constraints as well as the need for more effective communication with, and education strategies for, patients about when UCCs are the best care option.

According to respondents, facilitators to opening and operating UCCs may include dedicated funding, community demand for accessible services, and physicians who possess or are trained in certain procedural skills. Additionally, strong patient communication strategies, good transfer pathways to and from EDs and hospitals (i.e., so patients can receive the most appropriate level of care), and government support were identified as potential facilitators to opening and running UCCs.

Drawbacks and Benefits

A frequently reported drawback of UCCs is the demand placed on these centres, both in terms of the number of patients and the needs of patients. Several respondents noted that UCCs are not always functioning within their originally intended purpose of providing urgent, same-day care for non-life-threatening issues. Rather, multiple respondents noted that patients who have care needs that are more appropriate for an ED are presenting to UCCs even though the centres do not have the resources to provide that level of care. For instance, some UCCs are receiving patients experiencing cardiac arrest and other unstable patients who need to be admitted to an intensive care unit, a resource that staff do not have access to at the UCC. Conversely, 1 respondent noted that their UCC is treated more similarly to a primary care walk-in clinic, which reflects the primary care provider shortages in their area and can be costly to the health care system. Similarly, 1 respondent noted that UCCs do not replace the longitudinal health care relationships that patients develop when they have a primary care provider.

Despite these reported drawbacks, respondents noted benefits of UCCs as well. The ability of UCCs to fill a gap in care was 1 theme that was particularly emphasized nearly all respondents noting that UCCs help improve patients' overall access to services. They can provide options for unplanned care that may be geographically easier to visit and may fill a gap for urgent care in areas where there have been ED closures. UCCs were also reported to have the potential to fill the gap between primary and emergency care. Finally, several respondents noted that UCCs may be able to relieve some of the burden from overcrowded EDs.

Data Collection

Seven respondents reported that they collect, or will collect, data about patient encounters. Based on the responses, there did not appear to be a consistent approach to collecting and reporting data. The types of data that are collected and reported include patient demographics, patient volume and wait times, reason for

visit, and transfers to EDs. In Nova Scotia, only some of the collected data are publicly reported (i.e., patient volumes). One respondent (in British Columbia) noted that data reported to the ministry of health primarily come from shadow billing by physicians, and another respondent (in Ontario) indicated that patient data are submitted only through physician fee-for-service claims. Additionally, 1 respondent noted that, in addition to the ministry of health, data from some of the UCCs in British Columbia are reported to the Centre for Advanced Analytics, Data Science and Innovation, which is a part of Fraser Health.

Additional Considerations

There were key themes among respondents when asked about any additional considerations regarding UCCs. Overall, respondents emphasized that UCCs are necessary to support patients, especially in areas where other health care services are limited (e.g., few EDs). Additionally, respondents noted that the lack of education provided to the public about the level of care that UCCs can provide has contributed to centres being relied upon for ED-level services. Widespread advocacy and education were identified as strategies that may help mitigate this issue. Finally, a respondent noted that the needs of UCCs vary based on context and would benefit from funding and resourcing based on specific needs rather than a one-size-fits-all approach.

Literature Examining the Effectiveness of UCCs

We identified 4 pre-post interventional studies,⁸⁻¹¹ 1 health technology assessment¹² and 1 rapid review¹³ that examined the effectiveness of UCCs. Two of the identified studies were from Canada. Author's findings regarding the effectiveness of the UCCs were mixed. A detailed summary of the identified studies is presented in <u>Appendix 1</u>, <u>Table 6</u>.

Two included primary studies (1 from Canada) examined centres that were specifically intended to provide care for individuals with a cancer diagnosis, both of which examined health care utilization before the urgent cancer centre was implemented compared to after its implementation.^{9,10} In 1 study from Canada, authors reported that there was minimal impact on health care utilization, including ED visits, primary care visits, and hospitalizations.⁹ The other study reported that the urgent cancer centre may be cost-saving and positively impact patient satisfaction.¹⁰

Four included studies (1 from Canada) examined general UCCs that were intended for anyone requiring urgent health care services.^{8,11-13} One study investigated length of stay for pediatric patients at an ED with a co-located UCC compared to an ED without a co-located UCC.¹² Authors reported that it was uncertain whether a co-located UCC impacts the length of stay for patients contacting the ED.¹² Two other studies examined health care utilization before a UCC was implemented compared to after its implementation.^{8,11} Authors of 1 pre-post study concluded that UCCs may be a resource-saving treatment option for patients presenting to the ED.⁸ Authors of the other pre-post study concluded that UCCs may help relieve ED overcrowding both during times of heightened use (e.g., pandemics, major incidents, and so on) as well as during typical use.¹¹ Finally, a rapid review examined the effect of various urgent care models on service utilization, patient outcomes, and economic outcomes.¹³ Authors reported that urgent care services did not distinctly reduce ED utilization or costs, and that patient outcomes generally were not reported.¹³

Limitations

This Environmental Scan aimed to provide an overview of the current landscape of UCCs operating across Canada, and the existing literature that examines the effectiveness of UCCs both in Canada and in countries with similar health care systems. Although this scan strived to capture as much information as possible, it is not meant to be a comprehensive review on the topic. As such, not every UCC that exists in Canada is included in this scan, and the results are not intended to be representative of all UCCs in Canada. For instance, all survey responses included information about UCCs that were funded by provincial governments and health authorities. Privately owned UCCs exist and were eligible for this scan; however, we did not receive any responses about these centres. As well, all the UCCs represented in the survey served either patients of all ages or adults only. There may be UCCs that only serve pediatric patients that we did not receive responses from. Furthermore, because we did not receive complete responses from 6 jurisdictions, there are gaps in the data and results. While some of these jurisdictions may not have UCCs, others may have them, but we were unable to reach them with the survey. Additionally, the information from the survey is based on respondents' personal opinions, experiences, and perspectives. Some survey respondents may not be aware of, or have access to, the information sought in the survey, and therefore, the results may not be entirely accurate or representative of the UCCs and the current landscape in Canada. We did attempt to mitigate this limitation by using purposive sampling and snowballing techniques to reach those who are most knowledgeable about UCCs. As well, although the survey for this scan only sought information about UCCs. within Canada, the size and composition of jurisdictions are highly variable. For instance, most of the UCCs identified in the survey serve a primarily urban population. However, Canadian jurisdictions also consist of rural, and often remote, populations as well. As a result, the findings of this survey may not be applicable to the needs of all individuals or communities in Canada. However, the findings can still serve as a starting point for jurisdictions that may wish to implement or make changes to UCCs. Finally, the results of the survey represent a moment in time and may not be representative of the UCC landscape in the future.

Due to time limitations for this Environmental Scan, we did not comprehensively explore the effectiveness results reported in the included literature. Rather, the intention of this report was to provide an overview of the type of literature that is available on the topic of the effectiveness of UCCs. Additionally, we did not perform a critical appraisal of the studies included in this Environmental Scan and, therefore, cannot comment on the risk of bias or certainty of evidence for any comparison outcome. A single reviewer selected studies and extracted data, which may increase the risk of bias and error in study selection and data extraction processes as compared to a dual independent review or single review with pilot testing. Finally, although we use the term "urgent care centre" (UCC) in this report, there are multiple names that may be used to refer to services that fit the same definition (e.g., urgent treatment centres). Although we tried to mitigate this risk by searching for different terms in the literature, this report may be missing some relevant studies and information sources that use alternative names.

Conclusions and Implications for Decision- or Policy-Making

This Environmental Scan aimed to provide a current overview of both the components and experiences of UCCs in Canada as well as the existing literature about the effectiveness of UCCs in Canada and in countries with similar health care systems. We obtained the information through a survey of jurisdictional contacts and a limited search of the published and unpublished literature.

Survey results about the structural components of UCCs indicated that the UCCs reflected in the surveys serve primarily urban populations, are funded by their respective ministries of health, and vary greatly in the length of time they have been operational. There is a mixture of UCCs that do not charge and fees and those that charge patients fees for certain services (i.e., doctor's notes). Similarly, some UCCs surveyed have affiliations (e.g., with local universities), whereas others do not. The UCCs surveyed are generally staffed by both clinical and nonclinical personnel and typically serve all age ranges.

In terms of operational components, most, but not all, UCCs surveyed are open 7 days per week, are accessed on a walk-in basis, and have patients triaged and treated in order of urgency. Some UCCs surveyed operate 24 hours a day, whereas others operate during daytime or extended daytime hours. The services provided at UCCs surveyed vary by site; however, all provide diagnosis and treatment. Other common services include X-rays, stitches, laboratory services (e.g., blood work), and casting. Wait times for UCCs surveyed can vary from less than 2 to more than 12 hours and are posted for some, but not all, UCCs.

Finally, the survey results highlight key implementation considerations around barriers and facilitators, such as staffing and funding, as well as drawbacks and benefits, such as difficulties managing demand and improving access to care.

There were 4 primary studies, 1 review, and 1 health technology assessment (HTA) that met our inclusion criteria for evidence that exists about the effectiveness of UCCs.⁸⁻¹³ Some of these studies focused on UCCs that provided services specifically related to cancer,^{9,10} and other studies examined UCCs generally.^{8,11-13} The comparator groups in these studies included EDs without co-located UCCs and time periods before the implementation of UCCs. The outcomes investigated included health service utilization (e.g., ED visits, length of stay, hospitalizations), patient outcomes (e.g., patient satisfaction, quality of life), and economic outcomes (e.g., costs). Across all studies, authors' conclusions about the effectiveness of UCCs were mixed.⁸⁻¹³ Some found that they may be cost-saving interventions and reduce crowding in EDs, whereas others concluded that they have minimal or uncertain impacts on outcomes such as health care utilization, patient outcomes, and costs.⁸⁻¹³ This review did not aim to definitively conclude on the effectiveness of UCCs versus any comparator, or to comment on the risk of bias and/or certainty of evidence for any comparison outcome.

The findings presented in this Environmental Scan provide insight into components of established UCCs and an overview of the existing literature on the effectiveness of UCCs. This can serve as guidance to policy- and decision-makers across Canada who may be in the process of, or considering, implementing UCCs. Overall, for jurisdictions looking to establish UCCs of their own, this report can help identify examples of structural and operational components as well as implementation considerations that may suit the contexts of their respective jurisdictions, as appropriate. As illustrated by the survey responses, UCCs can vary in their components. In a country such as Canada where the needs of populations can widely differ, a one-sizefits-all model of UCCs may not be the most beneficial approach. Rather, decision-makers may choose to implement the specific components that best fit the unique needs of the populations they aim to serve.

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Appendix 1: Detailed Findings

Please note that this appendix has not been copy-edited.

Survey Findings

Table 4: Summary of Types of Staff at UCCs in Canada

	Nova	New					British			
Staff type	Scotia	Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	Columbia			
Health care staff										
Physicians (emergency medicine)	No	Yes	Yes	Yes	Yes	Some	Yes			
Physicians (family medicine)	Yes	No	Some	Yes	Yes	Yes	Yes			
Nurse practitioners	Yes	No	Some	Yes	Yes	Yes	Some			
Registered nurses	Yes	Yes	Some	Yes	Yes	Yes	Yes			
Licensed or registered practical nurses	Yes	Yes	Some	Yes	No	Yes	Yes			
Social workers	No	Yes	Some	Yes	No	Some	Yes			
Advanced care paramedics	No	No	No	No	No	Yes	No			
Pharmacists	No	No	No	Yes	Yes	No	Some			
Technicians (e.g., lab, X-ray, ultrasound)	Yes	No	Some	Yes	Yes	Yes	Some			
Phlebotomists	Yes	No	Some	Yes	Yes	No	No			
Other	No	No	Some (orthopedic technicians, respiratory Therapists)	Some (respiratory therapists)	Yes (mental health and addiction staff)	No	Some (mental health substance use consultant)			
			Nonclin	ical staff						
Directors	No	No	No	Yes	No	No	Some			
Administrators	No	No	Some	Yes	Yes	Yes	Some			
Researchers	No	No	No	No	No	No	No			
Information technology staff	No	No	Some	Yes	Yes	No	No			
Reception and clerical staff	Yes	No	Yes	Yes	Yes	Yes	Yes			

Staff type	Nova Scotia	New Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
Other	No	No	No	No	No	No	No

UCC = urgent care centre.

Note: "Some" refers to services that are available in at least 1 but not all the UCCs surveyed on that jurisdiction. All data reported in this table correspond to the answers received at the time of survey administration (March 2025 to April 2025).

Table 5: Sterile Procedures, Day Surgeries, and Ambulatory Care Procedures of ServicesOffered at UCCs in Canada

Service type	Procedures and surgeries
Sterile procedures	 Central lines Chest tubes Diagnostic and therapeutic punctures Arthrocentesis Lumbar puncture Paracentesis Thoracentesis
	Incision and drainage
Day surgeries	Orthopedic surgeriesMinor procedures
Ambulatory care procedures	 Procedural sedation Closed fracture reductions Management of febrile neutropenia Holter monitor

UCC = urgent care centre.

Note: All data reported in this table correspond to the answers received at the time of survey administration (March 2025 to April 2025).

Literature-Based Findings

A total of 836 citations were identified in the electronic database searches. Following screening of titles and abstracts, 789 were excluded, and 47 potentially relevant articles were retrieved for full-text review. Of these articles, 3 met the inclusion criteria and were included in this report. In addition to these articles, we included 2 articles from unpublished literature and 1 from a handsearch of the included articles' reference lists.

Table 6: Key Characteristics of Included Studies

Study authors (year) study design	Country of publication	Population	Intervention and comparator	Outcome(s)	Author's conclusions				
Condition-specific: Cancer									
Galloway et al. (2023) ⁹ pre-post	Canada	Individuals diagnosed with cancer and serious blood disorders who	Intervention: Post implementation of an urgent cancer care clinic	Impact on other health care utilization, including: • ED visits	The implementation of the urgent cancer clinic demonstrated				

Study authors (year) study design	Country of publication	Population	Intervention and comparator	Outcome(s)	Author's conclusions
interventional study		are experiencing complications from the underlying disorder or its treatment. N = 18,800	Comparator: Pre implementation of an urgent cancer care clinic	 Primary care visits Hospitalizations 	minimal impact on health care utilization.
Haugstetter et al. (2022) ¹⁰ pre-post interventional study	Australia	Adult patients with a solid tumour cancer diagnosis, who either contacted or were referred to the CUAC and were under the care of a treating medical oncologist at the Gold Coast University Hospital. N = 400	Intervention: Post implementation of a CUAC. The CUAC incorporated a telephone triage process and face-to- face appointments. Comparator: Pre implementation of a CUAC	 Overall use of the CUAC ED avoidance Admission to the ED short stay unit Patient satisfaction 	The CUAC model was efficient and potentially cost- saving in populations of patients with mild to moderate severity of disease and treatment-related concerns. Patient satisfaction was positive.
		Ge	eneral UCC	1	
Habbouche et al. (2024) ¹² HTA with 1 retrospective cross-sectional study	Swedenª	Eligible population: Adults and children who are contacting an ED. Included population: children only. N = 4,783	Intervention: ED with a co-located primary care driven UCC Comparator: ED without a co-located primary care driven UCC	Length of stay	It is uncertain whether ED with UCC compared to ED without UCC leads to a difference in length of stay for patients contacting the ED.
Bessert et al. (2023) ⁸ pre-post interventional study	Germany	Adult walk-in patients admitted for treatment to the ED and adult patients accessing the urgent care walk-in clinic directly or via referral. N = 5,996	Intervention: ED with a co-located urgent care walk-in clinic (post) Comparator: ED without a co-located urgent care walk-in clinic (pre)	 Number of walk- in ED patients Length of stay 	"A GP-led urgent care walk-in clinic next door to an interdisciplinary hospital emergency department is a resource-saving treatment option for walk-in patients who present to the emergency department. Most patients referred from the ED to the urgent care walk-in clinic were able to receive definitive care."

Study authors (year) study design	Country of publication	Population	Intervention and comparator	Outcome(s)	Author's conclusions
Raidla et al. (2020) ¹¹ pre-post interventional study	Sweden	Patients fulfilling the inclusion criteria for visiting the UCC. N = 200	Intervention: UCC at a hospital (post) Comparator: ED at a hospital (pre)	 Treatment quality Length of stay Time to physician Use of medical services (radiology, laboratory analysis) Referrals Revisits Hospitalizations Mortality Costs 	Creating a UCC "in close proximity to hospitals may not only relieve overcrowding of the hospital's ED in peacetime, but it may also provide an opportunity for use during major incidents and disasters, and pandemics[]."
Institute of Health Economics (2020) ¹³ rapid review with 7 SRs, 2 HTAs, and 20 primary studies	Canadaª	Patients seeking immediate medical attention for a range of urgent and nonurgent, non-life-threatening conditions. N = not reported.	Intervention: UCC models that have unscheduled care and extended hours, with or without on- side basic support services and related supplies that are not present in the majority of physician office settings Comparator: Hospital-based EDs, primary care physician offices, before-after comparisons	 Service utilization ED utilization ED wait times Low-acuity ED visits Patient outcomes Safety Efficacy Satisfaction Quality of life Economic outcomes Cost avoidance or cost-saving Cost-effectiveness 	Generally, urgent care services did not clearly reduce ED utilization. Patient satisfaction was not reported in most included studies. No cost reduction was found for services integrated with emergency care or advanced ancillary diagnostics.

CUAC = Cancer Urgent Assessment Clinic; ED = emergency department; GP = general practitioner; HTA = health technology assessment; SR = systematic review; UCC = urgent care centre.

^aIndicates the country where the review was conducted.

Appendix 2: Detailed Methods

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Survey

We conducted a survey to identify UCCs that previously operated, are currently operating, or are being planned across Canada. We conducted a survey to be able to capture a greater level of detail about UCCs than may be available online and to capture information about UCCs that are no longer operating or have not yet opened. Additionally, we conducted a survey as it allows respondents to participate on their own schedules, as opposed to synchronous data collection methods such as focus groups or interviews. This asynchronous approach may, in turn, improve response rates.

The survey comprised of 41 questions, which explored multiple aspects of UCCs, including structural components, operational components, and implementation and evaluation considerations. The questions were both open- and closed-ended and are presented in <u>Appendix 3</u>, <u>Table 8</u>.

Project team members reviewed and piloted the survey, which was distributed using SurveyMonkey (<u>www</u>.<u>surveymonkey.com</u>). Both the English and French versions of the survey opened on March 12, 2025, and we collected responses until April 7, 2025.

We distributed the survey electronically to jurisdictional contacts. We used purposive sampling to identify respondents who were the most likely to be able to provide survey responses, which included managers, directors, administrators, and staff familiar with UCCs in Canada. We identified these contacts through members of the Health Technology Expert Review Panel, expert members involved in related prior CDA-AMC work (i.e., Emergency Department Overcrowding, Alternate Levels of Care), CDA-AMC Engagement Team networks, and internet searching. We made an effort to have representation from as many Canadian jurisdictions as possible by reaching out to contacts in each jurisdiction with at least 1 known UCC. We used a snowball sampling approach to identify individuals who were knowledgeable about UCCs who were not on our original contacts list. To do so, we indicated in the survey invitation that contacts had the option to share the survey with their contacts.

We sent 1 email reminder to nonresponders 1 week after the initial invitation. All respondents provided explicit permission to use the information that they provided in this report. Information about eligible survey respondents is outlined in <u>Appendix 4</u>, <u>Table 9</u>.

Synthesis and Presentation

One reviewer analyzed the findings of the survey. We narratively summarized the findings and presented them based on overarching themes (i.e., structural components, operational components, implementation, and evaluation). As well, we provided additional details with more granular information in supporting tables in <u>Appendix 1</u>.

Literature Search

Search Strategy

An information specialist conducted a literature search on key resources, including MEDLINE, the Cochrane Database of Systematic Reviews, the International HTA Database, the websites of health technology assessment agencies in Canada and major international HTA agencies, as well as a focused internet search. The search approach was customized to retrieve a limited set of results, balancing comprehensiveness with relevance. The search strategy comprised both controlled vocabulary, such as the National Library of Medicine's MeSH (Medical Subject Headings), and keywords. Search concepts were developed based on the elements of the research questions and selection criteria. The main search concepts were UCCs, program models, implementation, program evaluations, and workforce and equipment requirements. The search was completed on February 28, 2025, and limited to English-language documents published since January 1, 2015.

One reviewer also handsearched the reference lists of included literature to identify other potentially relevant studies.

Screening and Study Selection

Two reviewers screened and selected potentially eligible studies from search results of the published and unpublished literature. The reviewers used Covidence software (www.covidence.org) to screen, and did not perform the screening in duplicate. Results that met the inclusion criteria related to research question 2 in <u>Table 7</u> were summarized in the report. Eligible primary studies that were also included in reviews or HTAs that met our inclusion criteria were excluded. We also provide references of potential interest in <u>Appendix 5</u>. This literature did not meet the inclusion criteria because the studies are from the US, whose health care system differs from Canada's, but may still provide useful information.

Criteria	Description
Population	Q2: Any person who requires urgent health care
Intervention	Q2: UCCs
Comparators	Q2: Emergency departments, walk-in clinics, primary care, no comparator
Types of information	Q2: English-language published and unpublished literature that examine the effectiveness of UCCs (any outcome) in Canada or countries with similar health care systems (e.g., OECD countries with primarily single-payer systems, single-payer services, or hybrid single-payer health care systems for people of all ages)
Study designs	Health technology assessments, systematic reviews, randomized controlled trials, nonrandomized studies, clinical practice guidelines, program evaluations, review articles
Time frame	Q2: 2015 to present (10 years)ª

Table 7: Components for Literature Screening and Information Gathering

OECD = Organisation for Economic Co-operation and Development; UCC = urgent care centres.

^aTen years was chosen as the date limit to help ensure we capture studies from long-standing UCCs.

Data Extraction

One reviewer performed data extraction of the published literature in Covidence and then transposed the results into tables created in Microsoft Word. The reviewer extracted data from the unpublished literature directly into the tables in Microsoft Word. The information extracted included the bibliographic details (i.e., authors, year of publication, and country of publication), setting, population, intervention, comparator(s), outcome(s), and authors' conclusions.

Synthesis and Presentation

One reviewer reported relevant findings from the published and unpublished literature. We presented findings in a table outlining the study population, intervention, comparators, and outcome as well as the setting and author conclusions. We also provided a brief narrative summary of the table of findings.

Appendix 3: Survey Questions

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Table 8: Survey Questions

Category of interest	Question	Response options
Respondent demographic information	Your name	Open ended
	Your email address	Open ended
	Your organization	Open ended
	Your position title	Open ended
	In which jurisdiction do you work?	Newfoundland and Labrador Prince Edward Island Nova Scotia New Brunswick Quebec Ontario Manitoba Saskatchewan Alberta British Columbia Yukon Northwest Territories Nunavut
Structural components of urgent care centres	What is the name of the urgent care centre?	Pan-Canadian/National Open ended
	The following is a definition of an urgent care centre: "A medical clinic that provides same-day, urgent treatment for unexpected but non-life-threatening illnesses or injuries, such as infections, sprains, earaches, broken bones, and fevers." Does this align with the model of urgent care centre for which you are providing an answer?	Yes Yes, with some differences No
	Please describe the model of care you use.	Open ended
	Is the centre currently operational?	Yes No, the urgent care centre is no longer operational No, the urgent care centre is being planned and will open in the future

Category of interest	Question	Response options
	How long has the centre been operational?	Open ended
	If the centre is no longer open, please indicate the length of time it was operational before closing.	
	What is the address of the clinic?	Street name and number
	Please provide:	City or town
	 Street name and number 	Province or territory
	City or town	Postal code
	 Province or territory Postal code 	
	What population is served by the urgent care centre? (Select all that apply.)	Older adults
		Adults
		Pediatric population
		All of the above
	How would you classify the population served?	Mostly urban
		Mostly rural
		Mostly remote
		Other (please specify)
	What is the source of funding for the urgent care centre? (Select all that apply.)	Government
		Hospital
		Private donations
		Other (please specify)
	Please briefly describe the funding model.	Open ended
	Are patients charged a fee to receive services?	Yes, always
		Sometimes, depending on the service
		No, never
		Other (please specify)
	If yes, please describe the services for which you	Open ended
	charge a fee (e.g., general access to the clinic, doctor's notes, and so on).	
	Does this urgent care centre have any affiliations (e.g., with a hospital, academic institution, and so on)?	Yes
		No, it is a standalone operation
	If yes, what is the affiliation(s)?	Open ended
	What type of health care staff work at the urgent care	Physicians (emergency medicine)
	centre? (Select all that apply.)	Physicians (family medicine)
		Nurse practitioners
		Registered nurses
		Registered practical nurses
		Advanced care paramedics
		Pharmacists
		Technicians (e.g., lab, X-ray, ultrasound)
		Phlebotomists
		Other (please specify)

Category of interest	Question	Response options
	What is the number of full-time equivalent health care staff employed?	Open ended
	What type of nonclinical staff work at the urgent care centre? (Select all that apply.)	Directors Administrators Researchers Information technology staff Reception and clerical staff Other (please specify)
	What is the number of full-time equivalent nonclinical staff employed?	Open ended
Operational components of urgent care centres	How do patients access urgent care centre services? (Select all that apply.)	By appointment Walk-in Transfer from an emergency department Other (please specify)
	In what order are patients treated at the urgent care centre?	First-come, first-served Patients are triaged Other, please specify
	What services are offered at the urgent care centre? (Select all that apply.)	Diagnosis and treatment Virtual care Casting Eye care Laboratory services (e.g., blood work) X-ray Ultrasound Stitches Immunizations Referrals Pharmacy services Mental health services Dental services Other (please specify)
	Does the urgent care centre provide any of the following: • sterile procedures • day surgeries • ambulatory care precedures	Yes No Unsure
	Please describe or provide examples of the services, where applicable.	Sterile procedures Day surgeries Ambulatory care procedures These services are not offered

Category of interest	Question	Response options
	On how many days per week is the urgent care centre operational?	7 days a week Monday to Friday only Weekends only Other (please specify)
	What are the operating hours of the urgent care centre?	Open ended
	What is the average wait time for patients who visit the centre?	Open ended
	Do you post live wait times for patient use? (e.g., on a website)	Yes No Unsure
	If yes, is this a valuable tool for patients? Please explain.	Open ended
Implementation and evaluation of urgent care centres	What was the primary reason for opening the urgent care centre?	To help alleviate emergency department overcrowding To divert lower acuity patients away from the emergency department To provide access to health care services to individuals who do not have a primary care provider To provide services to patients who live far from other health care services (e.g., hospitals) Other (please specify)
	What are the barriers to opening an urgent care centre?	Open ended
	What are the facilitators for opening an urgent care centre?	Open ended
	What are the drawbacks to urgent care centres?	Open ended
	What are the benefits of urgent care centres?	Open ended
	Are data about each patient encounter reported to the provincial or territorial ministry of health or to the Canadian Institute for Health Information? If yes, where are they reported and what data are collected (e.g., patient demographics, clinical characteristics, wait times)? If the only patient data submitted to the ministry of health are through the physician fee-for-service claim, please indicate this.	Open ended
Final thoughts	Is there anything else you would like us to know about this urgent care centre?	Open ended

Appendix 4: Information on Survey Respondents

Please note that this appendix has not been copy-edited.

Table 9: Information on Survey Respondents

Province	Organization represented by survey respondents
Nova Scotia	Nova Scotia Health
New Brunswick	Réseau de santé Vitalité
Ontario	 Humber River Health Kingston Health Sciences Centre Scarborough Health Network William Osler Health System
Manitoba	Winnipeg Regional Health Authority
Saskatchewan	Saskatchewan Health Authority
Alberta	University of Calgary
British Columbia	Fraser HealthIsland Health

Appendix 5: References of Potential Interest From the US

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