



PrimaryCare
Network
CALGARY RURAL

Increasing Access To Preventative Screening for the Unattached:

A Team Based and Health
Neighbourhood Approach

Dr. Zachary Levacque MD MSc CCFP

Loralee Cooper, BN RN

Larissa Hughes, RN BN, Director of Clinical Services

Optimal Health in Our Rural Communities

www.crpcn.ca

Conflict Of Interest

Loralee Cooper

- I have no potential, perceived or real conflicts that may influence or have the appearance of influencing the information presented today

Larissa Hughes

- I have no potential, perceived or real conflicts that may influence or have the appearance of influencing the information presented today

Dr. Zach Levacque

- I have been remunerated for the consult work with the RN as part of the project we will discuss today, but I have no other conflicts to declare

Agenda



Background and conceptualization



Implementation overview



Outcomes of the Access Screening Service



Key learnings



Future implications

Primary Learning Objectives



1) Learn to adapt and enhance team-based care using clinical protocols



2) Gain insight on how the integrated health neighbourhood can support the unattached patient population



3) Understand the resources required to provide preventative primary care services to unattached patients



About Us: Calgary Rural Primary Care Network (CRPCN)

14 Communities

115 000 Paneled Patients

42 Provider Sites

3 CRPCN Clinics

163 Family Physicians and Nurse Practitioners

What Does
This Number
Represent?

650 000

*(Alberta Medical Association, 2025)
(CIHI, 2024)*

Local Need Identified

Multiple Inputs

- ▶ Calgary Rural PCN Primary Care Providers raising concerns
 - ▶ Okotoks Urgent Care data, 16.3% unattached patient visits
 - ▶ Limited access to Primary Care Providers in rural areas
 - ▶ No Providers accepting patients in the CRPCN catchment
-
- ▶ Physician-led working group to co-design and address concerns

Guiding Principles

- ▶ Appointment based service
- ▶ Referral only / No walk-ins
- ▶ No duplication of services
- ▶ **Do not ask providers to take on new patients, or take time from their full practices**
- ▶ Team-based care model
- ▶ After-hours support - consider adding in the future
- ▶ Start with simplest way forward, and evolve

Idea Generation

Three avenues to address these concerns were presented for consideration:

Urban-style access clinic

Offering care to attached patients in need of assessment within 24 hours, who are unable to book with their Primary Care Provider.

Screening and chronic disease management

To support for unattached patients without attaching them to a Primary Care Provider.

A blend of options 1 and 2

Access To Preventative Screening: Proof Of Concept Project

- ▶ Goal : To assess the value of operating a PCN service or clinic which offers preventative screening and navigation to chronic disease management for unattached patients

What Services Are Being Offered To The Unattached Population?

Navigation and education for colorectal, cervical, and breast cancer screening

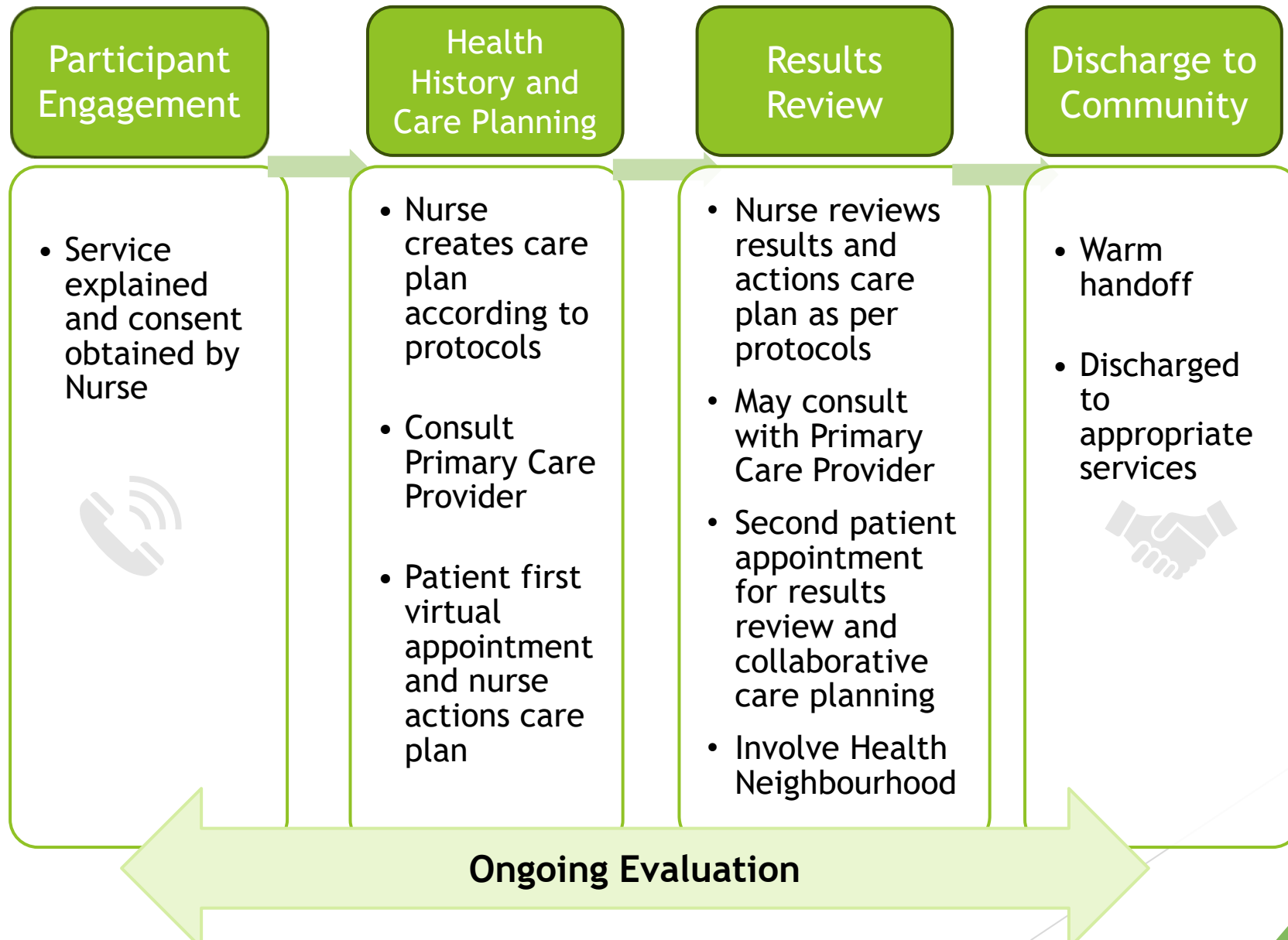
Lipid panel, HbA1C testing

Blood Pressure and Framingham Risk screening

Chronic Disease Education and Navigation to the Integrated Health Neighbourhood

Support connecting with a Primary Care Provider (when possible)

Current Patient Pathway



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Mentimeter

What Do You Think Some Challenges Could Be To Offering Screening To Unattached Patients?

All responses to your question will be shown here

Each response can be up to 200 characters long

Turn on voting to let participants vote for their favorites



Menti

FIRST FORUM MENTI



Choose a slide to present





What Primary Challenges Did We Identify And How Did We Address Them?

- ▶ Who Is The Most Responsible Provider?
- ▶ Limited Resources Available
- ▶ How To Find Unattached Patients?
- ▶ How To Provide Follow Up Care When Patients Have No Primary Care Provider?

Proof Of Concept Implementation To Date

49 patients contacted (CRPCN
waitlist)

Self-referral option
launched via local
promotions

Dec. 2024 - Jan. 2025

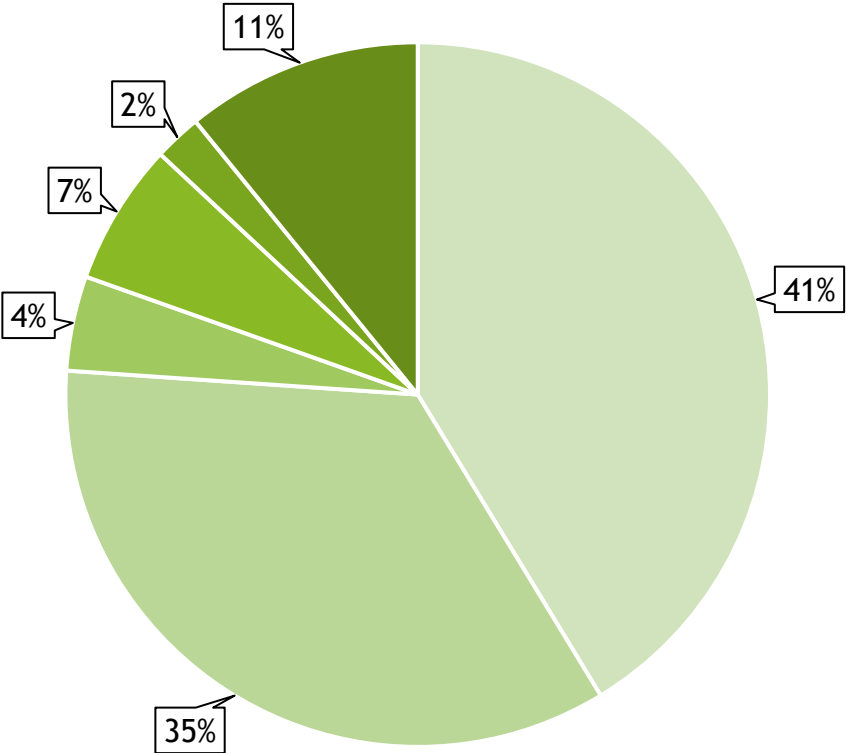
Oct.-Nov. 2024

Mar. 2025

43 patients contacted
(Alberta Find-a-Doc)

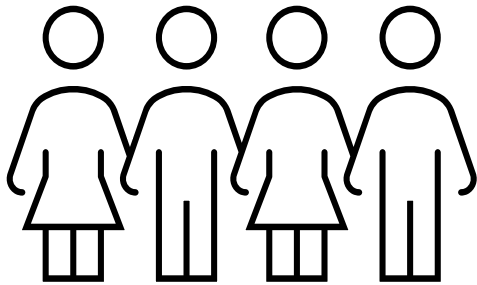
Data To Date: Outreach

92 Outreach Phone Calls Completed

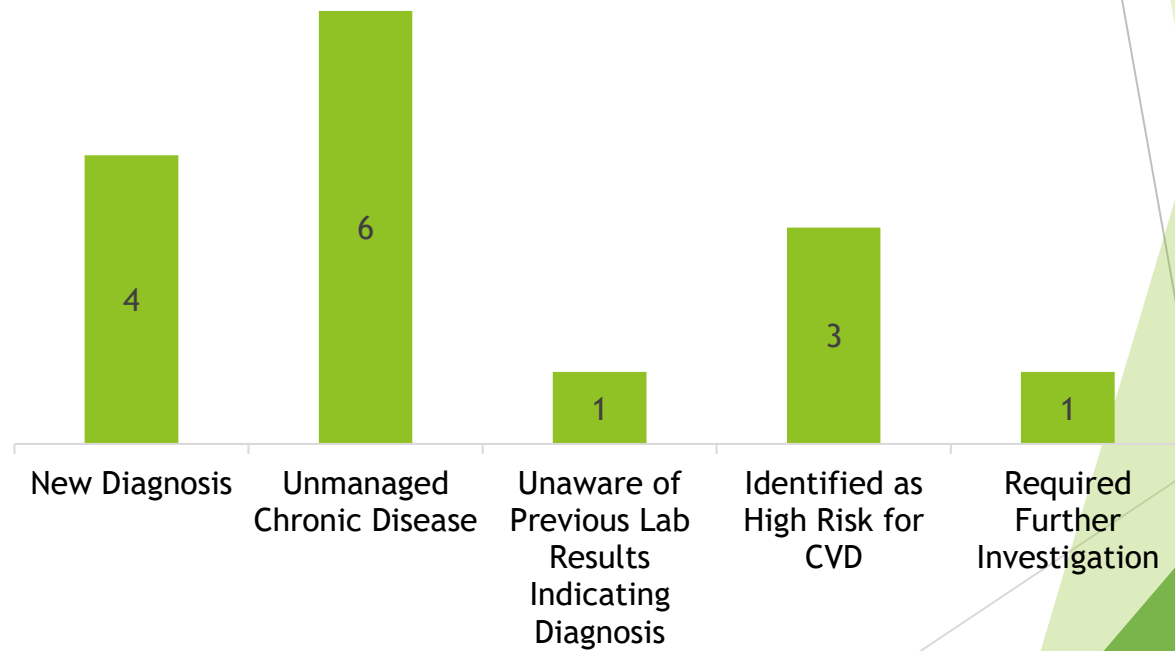


■ No Answer ■ Had Found A PCP ■ Declined the Service ■ Consented But Ineligible ■ Lost to Attrition ■ Completed Program

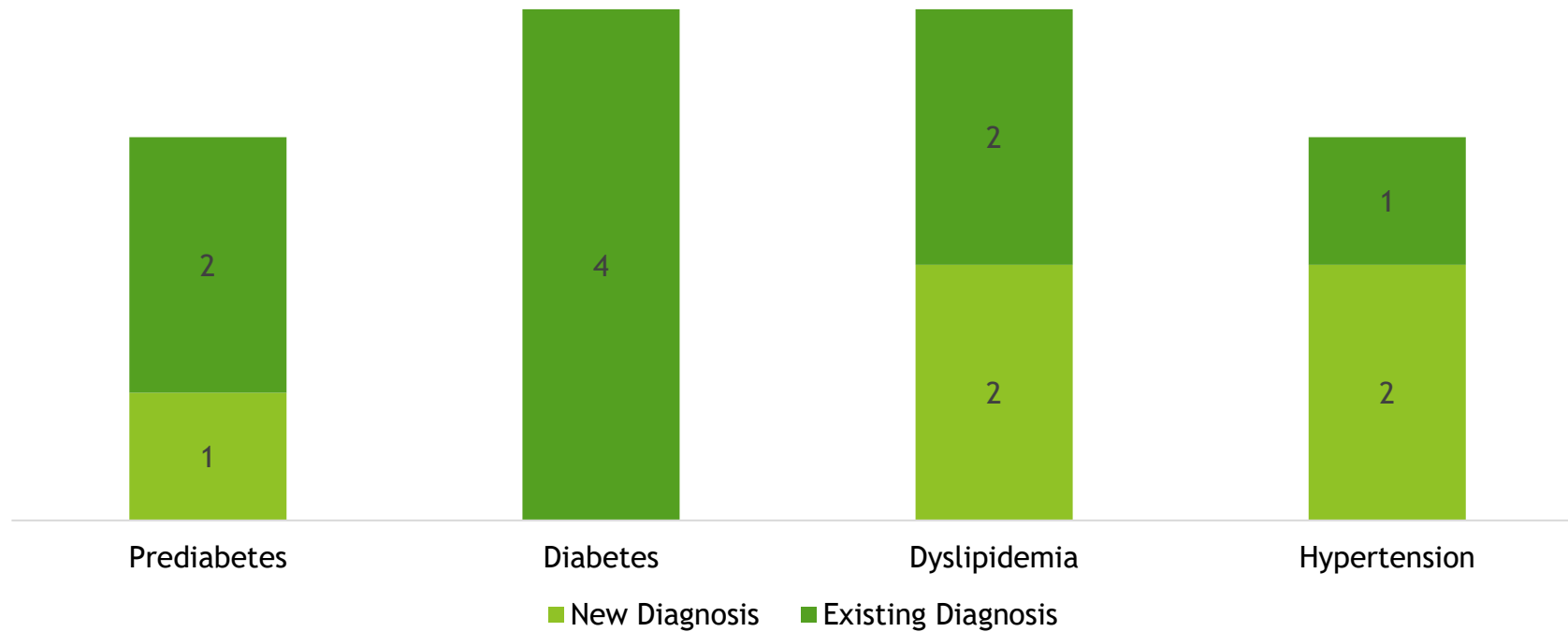
Among The 10 Patients Who Completed The Program:



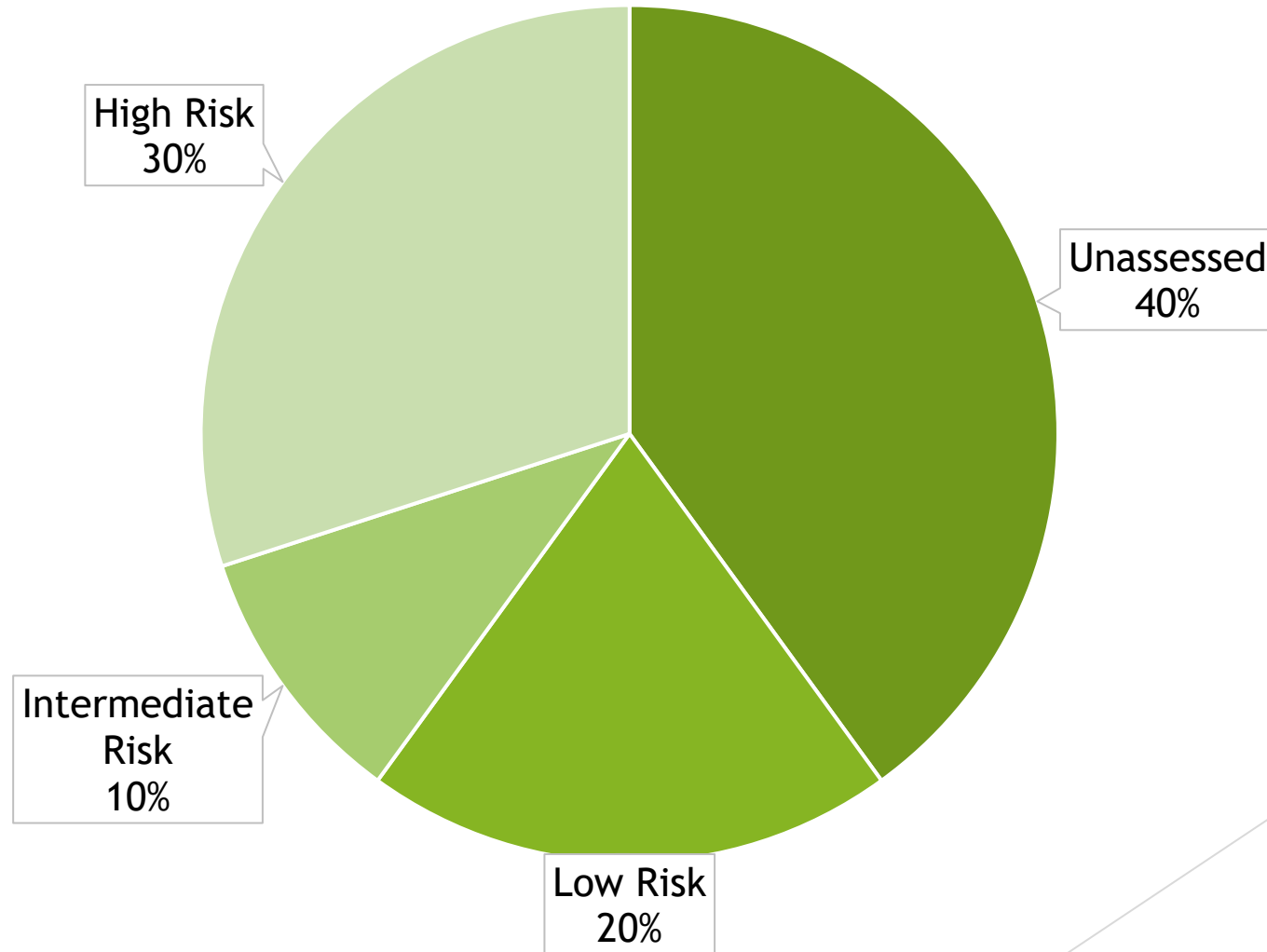
Chronic Disease Findings



New Diagnosis And Existing Diagnosis Requiring Intervention



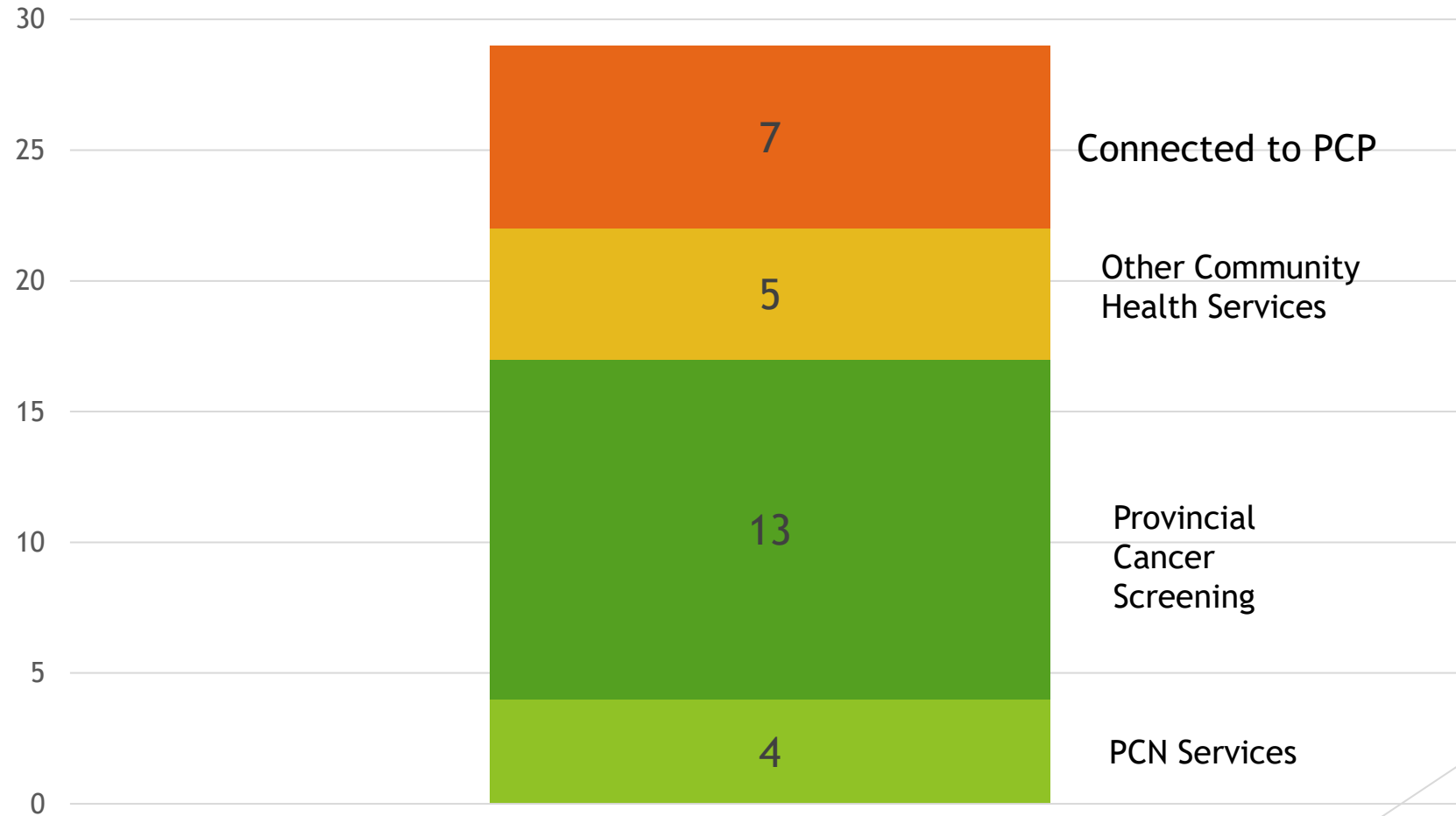
Framingham Risk Assessment For Cardiovascular Event



Other Chronic Disease Concerns Requiring Navigation Support

- ▶ Osteoporosis
- ▶ Temporal lobe tumor
- ▶ Orthopedic post-op concern
- ▶ Hypothyroidism
- ▶ Insomnia

Referrals To The Integrated Health Neighbourhood





LH



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Mentimeter

What Services/ Programs Do You Consider As Part Of The Health Neighbourhood?

leader
bold focus
creative
fast transpiration
inspiration

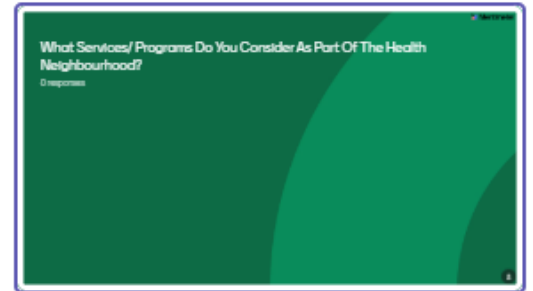


Menti

What Services/ Progra...



Choose a slide to present



Learnings To Date #1

There is more to learn
about how to engage
the unattached
population



Learnings To Date #2

Protocols help optimize team based care, establish trust, and increase access to primary care services



Learnings To Date #3

Navigating the integrated health neighbourhood requires relationships and local expertise

Learnings To Date #4

There is a need for navigation to accessible primary care services for the unattached population



Learnings To Date #5

The health care system can change quickly affecting the needs for the unattached population



Learnings To Date #6

We Were Able To Meet The Demand With Existing Resources However.....

- ▶ Nurse spent ~ 2.5 hour per patient
- ▶ Primary Care Provider spent ~ 8-10 minutes total per patient
- ▶ Building relationships with the health neighborhood requires an initial investment of time
- ▶ Increase in demand would likely require additional funding
- ▶ Potential return on investment and improved outcomes resulting in decreased system costs

Learnings To Date #7

Patients felt the service was of value

"I Found It Extremely Valuable And Learned A Lot "

"A Really Valuable Service For People Who Don't Have Family Doctors And Want Support With Their Health And Finding Health Services In Community "

10/10 Said The Service Was *"Highly Valuable"*

4/5 Would Use This Service If They Did Not Have A Family Doctor

CRPCN Next Steps

1. Continue to PDSA
2. Launch Team Base Care Working Group (June 2025)
3. Expand use of protocols in PCN and provider clinics to optimize team based care
4. Incorporate this service as a permanent offering to patients
5. Offer this service as step-down service to Providers
6. Explore possible funding alternatives to meet demand

Systems Level Implications

Patients as Active Partners in Health

- Understanding attachment preferences
- Preventative screening education for the public

Coordinated And Integrated Care in the Health Neighbourhood

- Invest in local community resource navigation
- Re-evaluate current referral pathways
- Leverage technology for eReferrals and data sharing across system

Pathways for Unattached

- Single registry of unattached with clinical data for targeted interventions
- Use of protocols to enhance team based care for all
- Potential to spread and scale and realize cost savings

Grassroots Leadership

- Co-design promotes effectiveness
- Access to local level data of system utilization

Thank You!

Working Group Members

- ▶ Dr. Anton Nel
- ▶ Dr. Gloria Mazloum
- ▶ Dr. Troy McKibbin, Medical Director
- ▶ Dr. Cassandra Hoggard
- ▶ Jennifer Lezubski, NP

- ▶ And Crowfoot Village Family Practice for sharing existing protocols with the CRPCN

- ▶ Kelly Wood, CRPCN Lead, Access and Attachment
- ▶ Kim Regular RN BN, CRPCN
- ▶ Shantel Hunter, Okotoks Urgent Care
- ▶ Roma Thomson, Project Manager

- ▶ Labana Taqa, Precision Health Student



Thank you!

