

**QI Power Hour with
Dr. Coralie Darcis, Curtis
Newton, & Dr. Emmett Harrison**

Improving Access to Primary Care in Rural Saskatchewan

Lessons from Two Patient Medical Home Initiatives



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Land Acknowledgement

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Let's chat

Please share your questions, comments, and ideas in the chat during today's session.

| Introducing



Dr. Coralie Darcis

Researcher & Sociologist

Johnson Shoyama Graduate
School of Public Policy



Curtis Newton

Director Primary Health Care

Saskatchewan Health Authority



Dr. Emmett Harrison

Family Medicine &
Emergency Physician

Associate Family Physicians Clinic

Improving access to primary care in rural Saskatchewan

Background and implementation context

Community and service context

SHARED SETTING

Swift Current

Regional Centre in SW Saskatchewan

≈17,000

city population

≈50,000

regional catchment

2 clinics

evaluated in the same community

Baseline clinic structure in Fall 2023

CLINIC A	
Larger physician-owned practice	
OWNERSHIP	Private, physician owner
PHYSICIANS	10 physicians, 5 FTE
INDIVIDUAL PANELS	600 to 1,400 patients
TOTAL PANEL	Approximately 10,000 patients

CLINIC B	
Smaller non-physician-owned practice	
OWNERSHIP	Private, non-physician ownership
PHYSICIANS	5 physicians
INDIVIDUAL PANELS	Not reported
TOTAL PANEL	Not reported but current panel is ~7000

Baseline support team in Fall 2023

CLINIC A

Broader administrative and patient-partner base

- 4 medical office assistants, 3 FTE
- 3 receptionists, 3 FTE
- Office manager
- Behavioural health consultant
- University of Saskatchewan administrator
- Patient Partner

CLINIC B

Lean administrative team with an LPN

- Licensed practical nurse
- 3 receptionists / medical office assistants
- Office manager
- Behavioural health consultant

Key distinction: the clinics began with different scale, ownership and support capacity.

Shared pressures for change

Both clinics entered the initiative with similar access and workforce pressures.

Access for existing patients

Long waits limited timely care for established patients.

Community capacity

Each clinic wanted to serve more people in the region.

Physician losses

Both clinics retained patient panels after physicians left.

Unattached patients

Approximately 3,000 people lacked a regular provider at each clinic.

Physician sustainability

The clinics also sought a more manageable workload and better work-life balance.

Readiness for team-based care

The clinics had several foundations in place before adding new team members.

Behavioural health

An established consultant relationship provided experience with shared care.

Quality improvement

Local physician expertise supported measurement and workflow redesign.

Health-system links

Relationships with Saskatchewan Health Authority primary care leaders supported coordination.

Teaching culture

Both clinics already functioned as clinical teaching sites.

Transferability depends on more than staffing. Existing trust and improvement capability may affect implementation speed.

Initial staffing request

Each clinic requested roles that matched its size and intended model.

CLINIC A

Requested multidisciplinary expansion

- Registered nurses
- Licensed practical nurse
- Social worker (Shared between clinics)
- Additional medical office assistant

CLINIC B

Requested a focused nursing expansion

- Registered nurse
- Additional medical office assistant

Why this matters

The intervention was tailored to local gaps rather than applied as one fixed staffing package.

Funded team and employment arrangements

CLINIC A

Pilot-funded positions

- 2 registered nurses
- Licensed practical nurse
- Additional medical office assistant

CLINIC B

Pilot and parallel non-pilot funding

- Registered nurse
- Additional medical office assistant
- Nurse practitioner, 1 FTE pilot (unfilled) 1 FTE non-pilot funds
- Contracted physician, non-pilot funds

Interpretation

Clinic B’s results reflect changes beyond the pilot alone. The nurse practitioner and contracted physician followed the same implementation timeline.

Leadership and change-management capacity

Both clinics received protected leadership time and operational support.



Physician lead time

Funded time for a physician to guide implementation and resolve barriers.



Team huddle time

Funded physician participation in regular team huddles.



Dyad support

A physician lead partnered with a Saskatchewan Health Authority primary care manager.

Physical and digital infrastructure

Both clinics used agreements and stipends to offset practical costs of integration.

EMR and data sharing

A data-sharing agreement included an electronic medical record stipend.

Clinical space

A space-sharing agreement included a stipend.

Clinical supplies

The funding arrangement reimbursed eligible supplies.

These supports reduced clinic-level barriers that staffing funds alone would not address.

Implementation sequence and maturity

Both clinics built on behavioural health integration, then added clinical roles over approximately three years.

CLINIC A			CLINIC B		
Four staged additions			Four staged additions		
2021	—	BHC	2021	—	BHC
Oct 2023	—	LPN	Oct 2023	—	NP
Nov 2023	—	RN	Apr 2024	—	RN
Apr 2024	—	RN (additional)	Oct 2024	—	MD

The models developed in stages. Outcomes should be interpreted in relation to when each role entered the clinic.

Improving Access to Primary Care in Rural Saskatchewan: Evaluating the Implementation of Two Patient Medical Home Initiatives

Presented by: Coralie Darcis

Report authors: C. Darcis, A. Mahani, M. Sithokozile, H. Mou

Project team and partners

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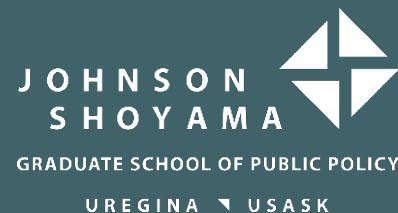
Emmett Harrison (Clinic partner)

Tara Lee (Clinic partner)

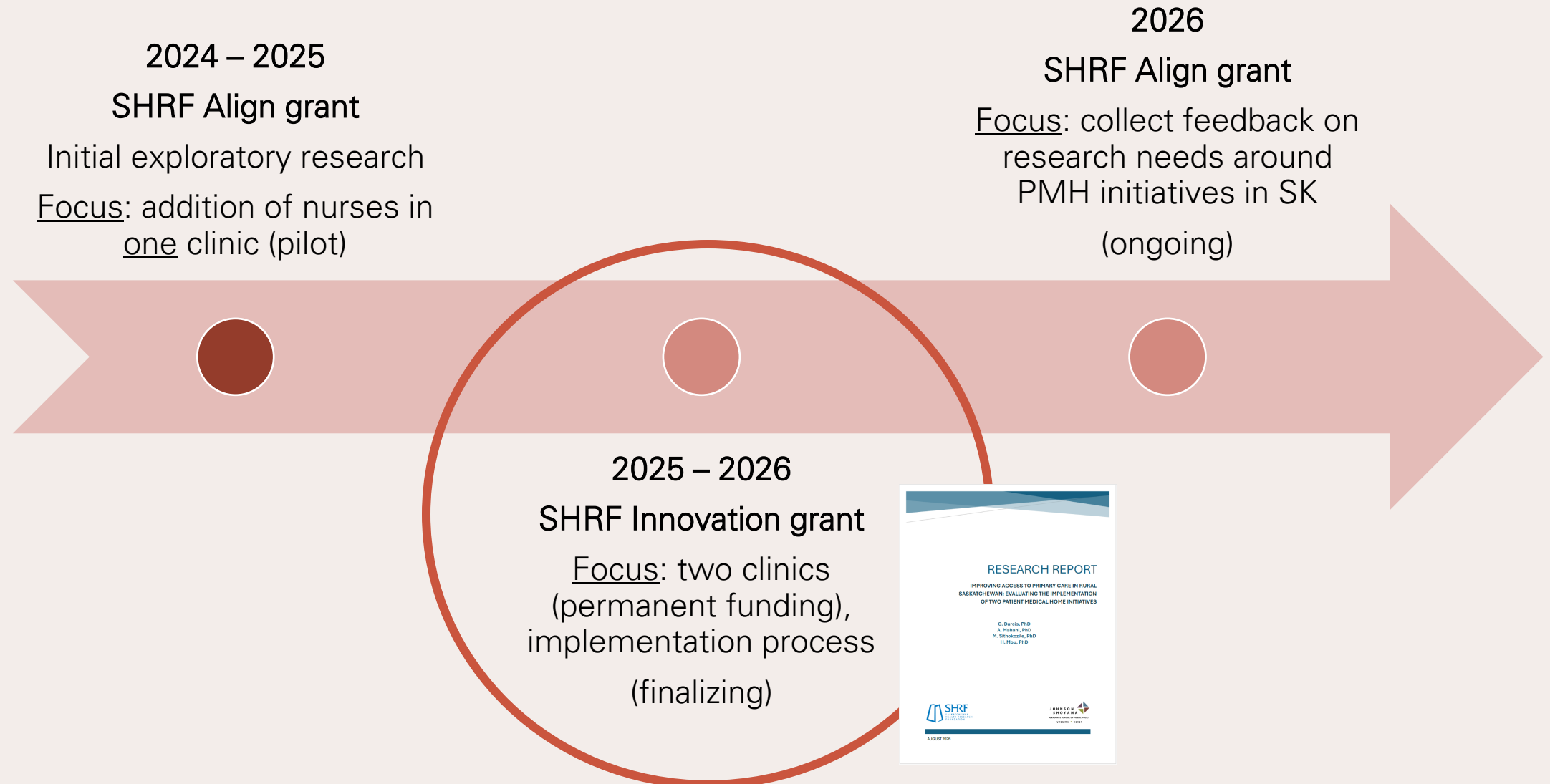
Angelique Botes (Clinic partner)

Curtis Newton (Saskatchewan Health Authority)

Brenda Andreas (Patient partner)



Research context



Methods

Goals of the research



Focus : two PMH initiatives in primary care private practices

Two main research questions:

- ✓ What are the outcomes of the PMH initiatives for patients and family physicians?
- ✓ What are the key factors influencing the implementation of a PMH model in the two clinics?

Goals of the research & clinics context

- Clinics differ considerably in their organizational structures, team composition, and patient populations
- Different rationales for change and different stages of implementation:

	Rationale for change	Implementation stage
Clinic A	Stable environment	Advanced
Clinic B	Lost a physician and change of ownership – Need to stabilize	Intermediate

- Different implementation paths and choices

This study seeks to generate transferable lessons from two **complementary** implementation experiences. It was **not intended or build to be comparative**

Data collection

- Qualitative methodology
 - Semi-structured interviews (N=23)
 - Observations (2.5 day/clinic)
- Patient experience survey
 - 38-item survey
 - Topics:
 - i. Health status and HC service utilization
 - ii. Patient general experience
 - iii. Awareness and perceived impact of the PMH initiative
 - iv. Demographics
 - April - June 2026
 - Convenience sampling
 - 108 valid responses (67 from Clinic A and 41 from Clinic B)

Interviewees	#
Family physicians/Nurse practitioners	9
Nurses (3 registered nurses and 1 licensed practical nurse)	4
Behavioural Health Consultant	1
Front staff (office manager, receptionists, medical office assistants)	4
SHA local and provincial directors	4
Ministry representative	1
Total	23

Data analysis

- Qualitative data
 - Consolidated Framework for Implementation Research (CFIR) as an interpretive framework

Extracted CFIR constructs (see [Figure 1](#))
 - Rapid qualitative analysis (Nevedal et al., 2021)
- Quantitative data
 - Descriptive statistics

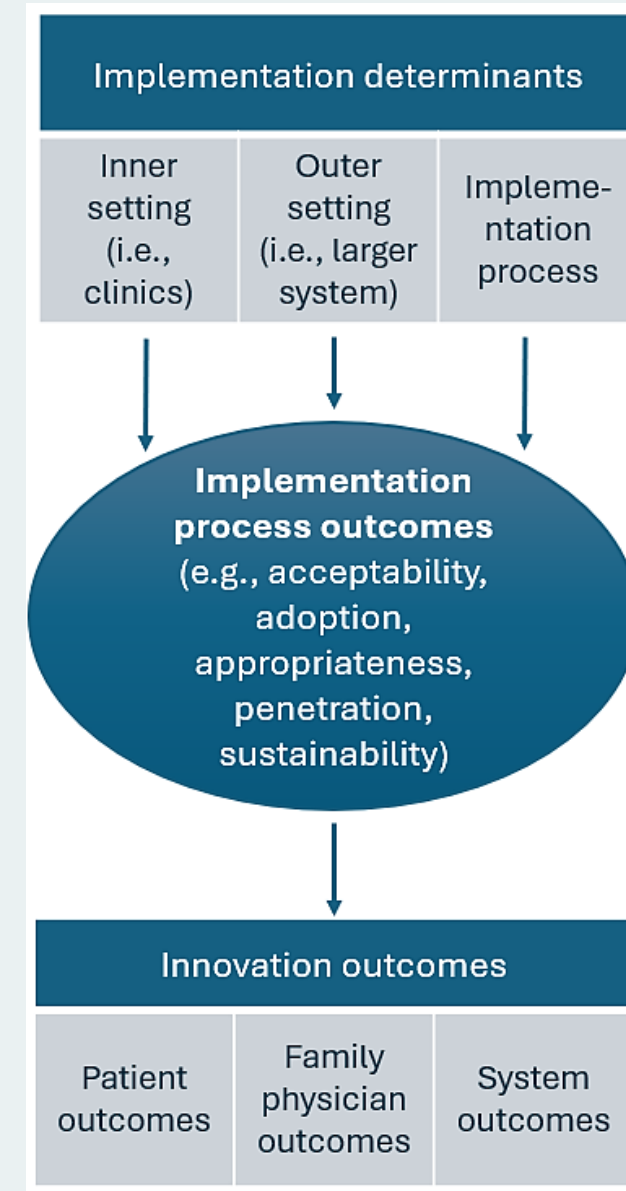


Figure 1 - Analytical framework derived from selected CFIR

Results

Report structure

PART 1 – Outcomes

Patient outcomes

Family physician outcomes

System outcomes

PART 2 – Implementation determinants

Inner setting

Outer setting

Implementation strategy



Part 1 – Outcomes for patients

- Portray of respondents:
 - 80% were women
 - 85% were patients for more than five years
 - 98% indicating they were attached to a family physician or nurse practitioner
 - All respondents had visited their clinic at least once during the previous 12 months.
 - 3-5 visits: 48%
 - 6+ visits : 24%
- Overall, **very positive experiences**
 - General satisfaction – 9/10
 - Trust in doctor – 9/10

Part 1 – Outcomes for patients

Overall perception of change

- Highly positive
- **Improved access**
 - was the most often reported outcomes
- Improved care quality
- **Appreciation for team-based care**
 - 85% reported being comfortable receiving care from other HC prof
 - improved access to advice and new collocated services

“It’s nice to be able to talk to the nurse before seeing the doctor to hear their recommendations. The nurses are very kind and I feel heard and understood by them” (Patient)

Impact on access	%
Easier	59%
No difference	16%
Harder	6%
Don't know	20%

Impact on the quality of care	%
Yes, positively	58%
Yes, negatively	2%
Not at all	11%
Don't know	29%

Part 1 – Outcomes for patients

Impact of the triage

- More patients obtained same-day urgent appointments in clinic A
- Non-urgent appointments were more likely to involve longer waits when triage is being implemented

Most patient appreciate the triage systems, some have concerns

“It takes away from being private when you have to explain to receptionist then to the nurse and then possibly to the doctor if they see fit and have time for you”
(patient)

Table 4 - Patient-reported wait times for urgent appointments among respondents who requested an urgent appointment

Wait time for urgent appointment	Clinic A (n=44)	Clinic B (n=21)
On the same day	61%	33%
The next day	9%	19%
2-3 days	11%	19%
1 week	7%	5%
2-4 weeks	7%	5%
1 month or more	2%	10%
I was never able to get an appointment	2%	10%
Total	100%	100%

Table 5 - Patient-reported wait times for urgent appointments among respondents who requested a non-urgent appointment

Wait time for non-urgent appointment	Clinic A (n=57)	Clinic B (n=35)
Same day	4%	14%
1-2 days	2%	14%
3-7 days	11%	17%
1-2 weeks	26%	17%
2-4 weeks	28%	9%
1-2 months	25%	23%
2 months or more	5%	6%
Total	100%	100%

Part 1 – Outcomes for family physicians

Increased professional satisfaction

Stemming from (among other):

- feeling more supported in their daily practice
- being able to work at the top of their professional scope
- having better interactions with patients
- observing improved patient care, and
- enjoying a more collaborative work environment.

Last week, I was at the hospital on Monday, Tuesday, Wednesday, and I wasn't here [in clinic] at all. So, instead of me stressing about it, I was like, 'Okay, if I need something done, I can message [the nurse], and she will help me out.' Then I'm not going home being like, 'Oh, that lab work was kind of weird, I probably should have called that guy, but I had a really long day, and I didn't.' (Family Physician)

"I do feel like it's easier for me to spend enough time with people that need it too, because I'm not trying to rush and fit a whole bunch of extra things into my day."
(Family Physician)

"I feel like I am able to actually get things done in a more timely manner, than I probably used to be able to." (family physician)

Part 1 – Outcomes for family physicians

Changes in family physicians' role

- Fundamental nature of their work unchanged, BUT still important **changes to their daily practice**:

- Dealing with more complex patient needs
- Increased awareness about patients' needs
- Expanded the coordination and organizational responsibilities

➡ Team-based care may be **changing the composition and distribution of physicians' workload** rather than simply reducing it

When anything changes, especially when a team member changes, that brings a mental load, and it brings actual work. Because when you're the doctor of the day, it is your responsibility, and those people are going to be coming, and the tasks and the questions are going to be coming. (family physician)

"It often is more [of] complexity in my day, with maybe less time for that catch-up from simple things than I had before. [...] So, it's not necessarily the same composition in my day, even though it's my same patients." (family physician)

Part 1 – System outcomes

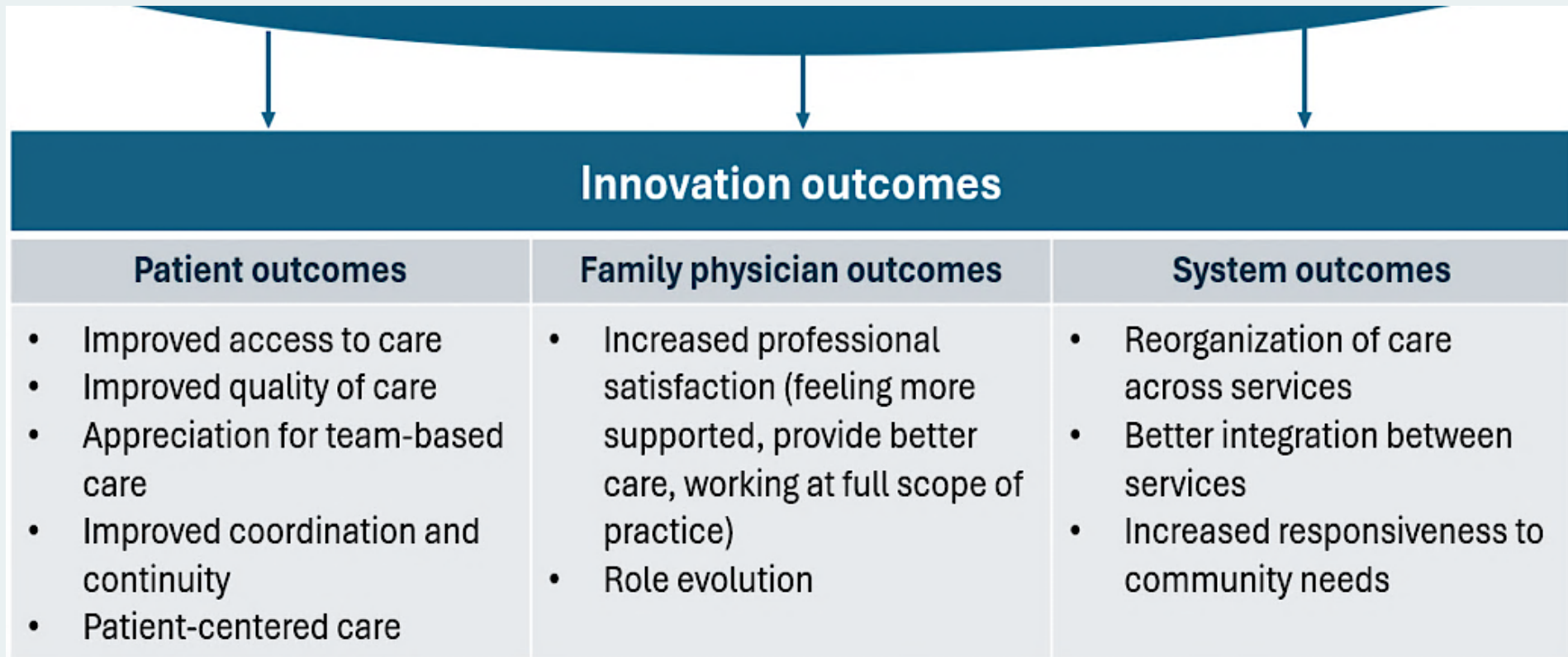
The PMH also had an influence beyond the clinics' walls.

- Reorganization of care across services
 - Home care → Nurses
 - Mental health → BHC
- Improved integration between services
- Emerging signs of greater responsiveness to community needs
 - PMH starts to create capacity for some FPs

“[the PMH] have allowed us to really focus on more specialized training for more complex care... because we're treating everything else in primary healthcare.” (SHA representative)

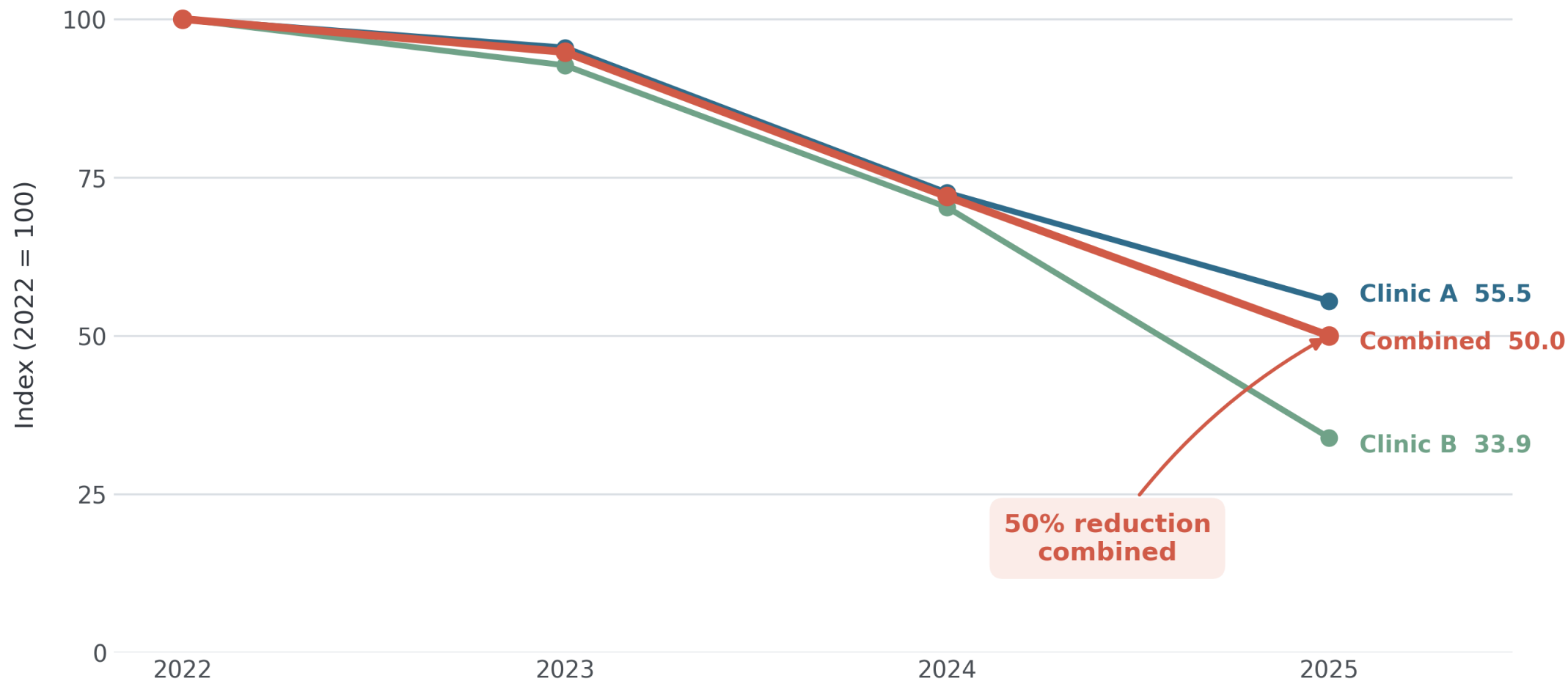
I've been probably accepting [new patients] a little bit more than I would have before. I'm not officially open to new patients, but, you know, somebody's father moves to town and doesn't have a doctor, or I meet someone in [the] emergency room... I accept more of those than I did before. And it doesn't feel quite as burdensome to do so. I kind of feel like I'm on the verge of maybe I could accept a few more. (Family physician)

Part 1 – Summary



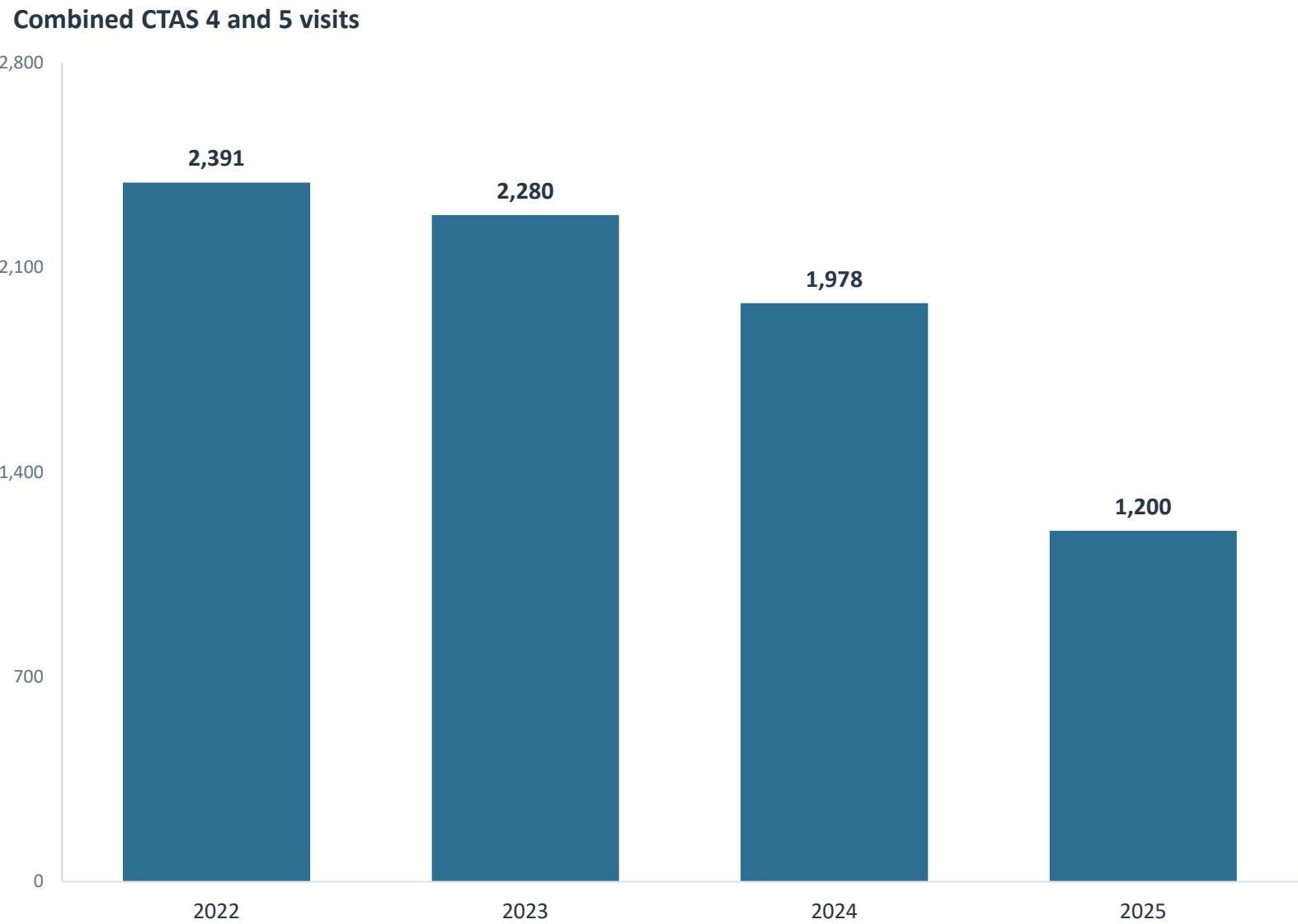
CTAS 4/5 ED visits declined across both clinic populations

Each clinic's 2022 visit count is set to 100, allowing trends to be compared without panel-size data.



Based on annual visit counts; not adjusted for clinic population, physician FTE or patient characteristics.

Lower-acuity ED visits fell by half



50%

**fewer visits in 2025
than in 2022**

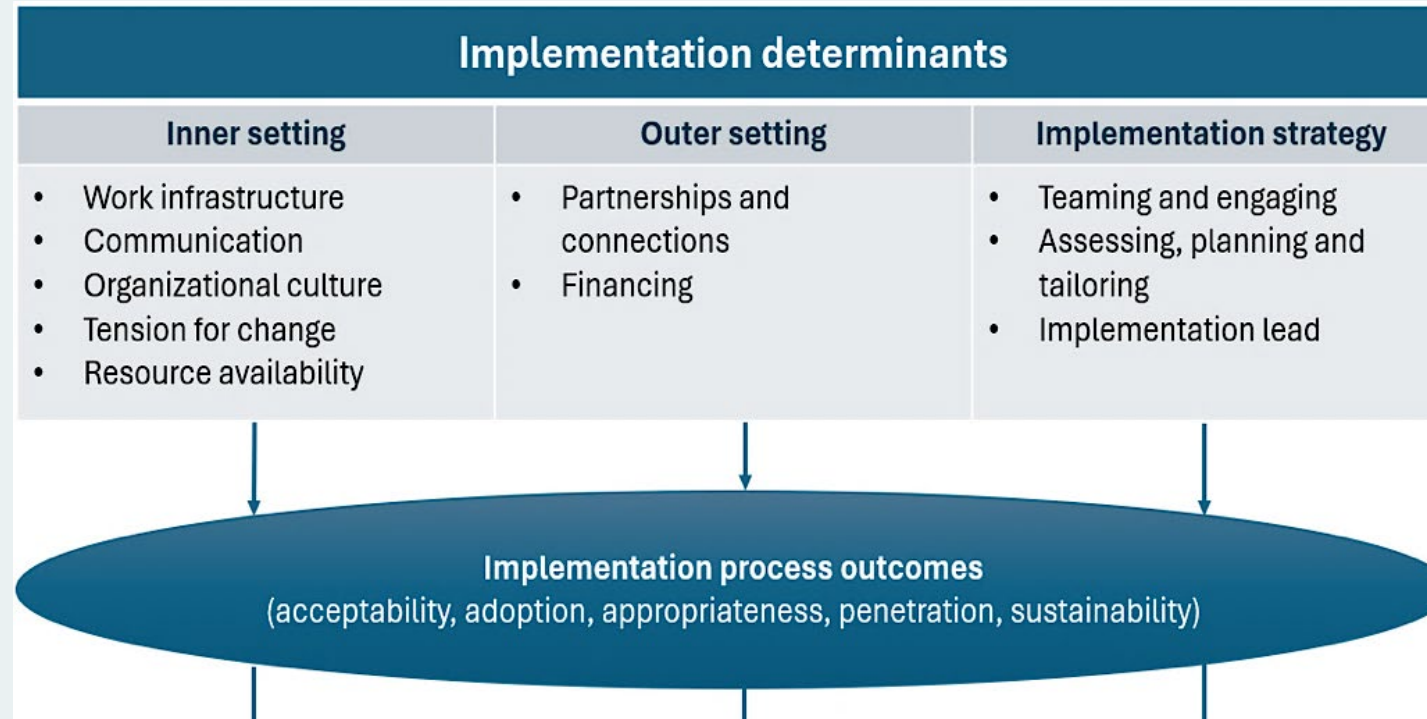
2,391 → 1,200

Pilot began	October 2023
Permanent funding	December 2024

Annual totals include months before and after these milestones.

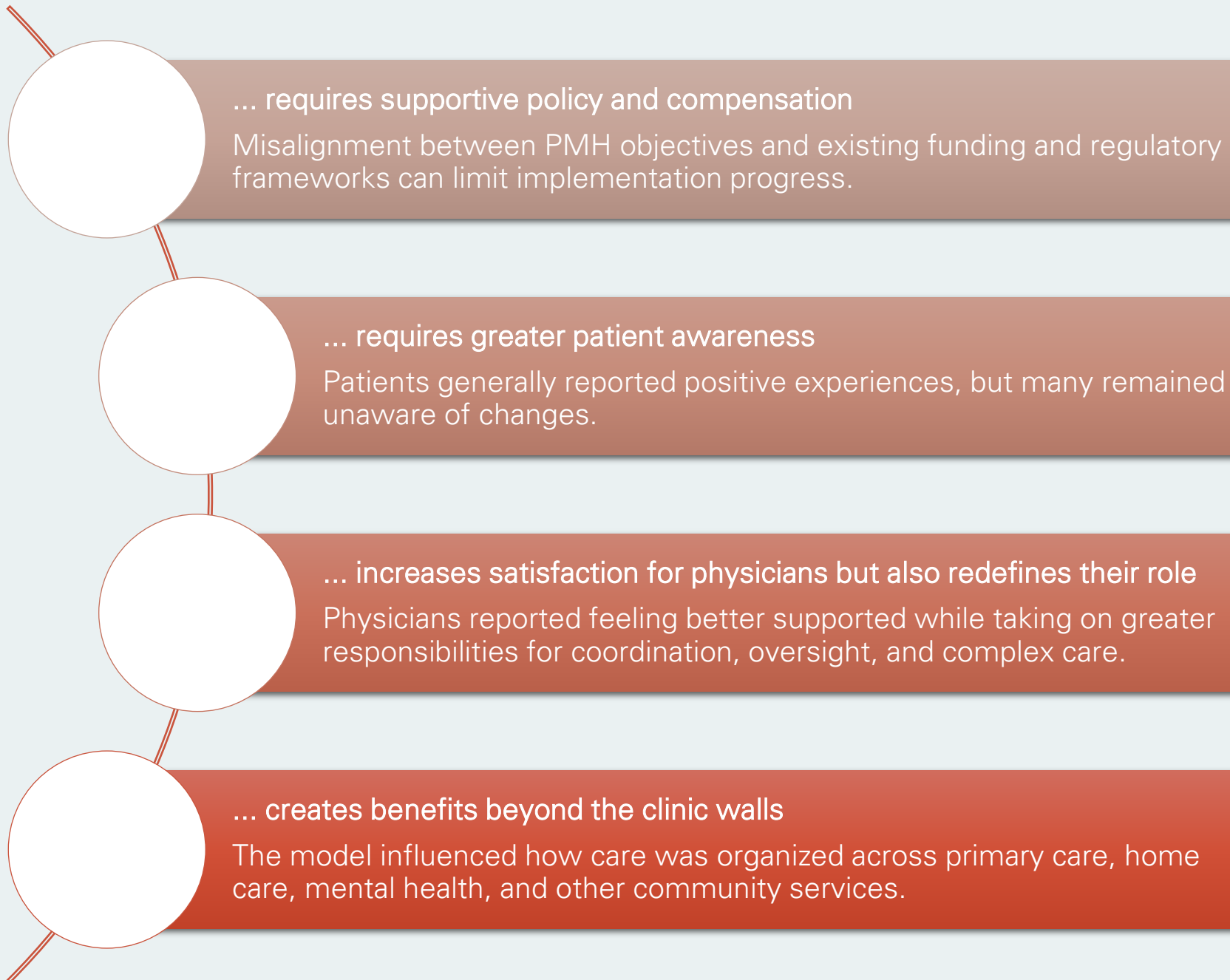
1,191 fewer visits
in 2025 compared with 2022

Part 2 – Key factors influencing implementation



Key take-aways: *Implementing a PMH model in private practices...*





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