



Trillium
Primary Health Care Research Day

Conference Program

Friday, October 25, 2024
Conference

Presented by INSPIRE-PHC



*This event will be recorded

Welcome



On behalf of our organizing and planning committee, we would like to extend a sincere welcome to all attendees of this years' conference. Students and emerging researchers, please take the opportunity to reach out to our experienced researchers in primary health care in attendance. We have focused our conference this year on team based care and the interprofessional care providers that are core to these teams. Thank you to the Ontario SPOR Support Unit, the Ontario Departments of Family Medicine, and the Ministry of Health for making this event possible.



Dr. Michael Green, Dr. Rick Glazier

Leads, INSPIRE-PHC

Acknowledgements



Trillium Primary Health Care Research Day 2024 is facilitated by the INSPIRE-PHC research partnership, supported by a grant from the Ontario Ministry of Health.

About INSPIRE-PHC

INSPIRE-PHC is an overarching program focused on primary health care including a research component, a support component, and a network component to serve the primary health care research community. The INSPIRE-PHC research/policy partnership aims to address major health system challenges of equitable access to high quality primary health care (PHC) and better co-ordination and integration of PHC with other parts of the health and social care system (community care, public health and specialty care).

New studies will provide better quality information on patient needs and PHC capacity to deliver care in defined geographic areas and will provide early feedback on the successes and challenges in introducing PHC reforms. This research will help improve access to care, the care experience for patients, and better health outcomes for all Ontarians.

For more information, please visit: <https://inspire-phc.org/>

Program Sponsors

Organizers of Trillium Primary Health Care Research Day 2024 would like to acknowledge generous support from the following sponsors:



History of Trillium Primary Health Care Research Day

From 1989 to 2009, the Ontario Family Medicine Research Day (renamed Trillium PHC Research Day) was hosted and funded on a rotational basis by 3 of the 5 Departments of Family Medicine (Toronto, Western and McMaster). From 2009 to 2013, funding was forthcoming from the Ministry of Health and Long-Term Care Applied Health Research Network Initiative grant to Western, at which point the Research Day expanded to include all disciplines related to Primary Care and became an explicitly provincial meeting in Toronto.

For the past five years the Trillium Primary Health Care Research Day has been funded jointly through COFM, the OSSU, and the MOH. It provides a venue for early career academics including residents and clinicians to present their work, for mid-career Ontario researchers to deliver invited lectures, and is a venue promoting collaboration among researchers, policy makers, and decision makers through networking opportunities and research presentations.

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Trillium Program Agenda

Join virtually here:

[https://encoreglobal.zoom.us/j/95365780079?pwd=DFbl2](https://encoreglobal.zoom.us/j/95365780079?pwd=DFbl2MseCusptTOXHLHAed8w7gEOXG.1)

[MseCusptTOXHLHAed8w7gEOXG.1](https://encoreglobal.zoom.us/j/95365780079?pwd=DFbl2MseCusptTOXHLHAed8w7gEOXG.1)

8:00 AM	Networking, Registration, and Light Refreshments	
9:00 AM Provincial North	Opening Remarks & Land Acknowledgement Dr. Michael Green, INSPIRE-PHC Lead	Virtual Available
9:10 AM Provincial North	<p>Martin Bass Lecture – The Team is In: Transforming Primary Care for Improved Access and Effectiveness Featuring: Dr. Jennifer Rayner & Michelle Carr Introduction: Dr. Moira Stewart, Distinguished Professor Emeritus, Western University Moderator: Dr. Rick Glazier, INSPIRE-PHC Co-Lead</p> <p>Dr. Jennifer Rayner is the Director of Research and Policy at the Alliance for Healthier Communities and supports 100+ community based primary care organizations in Ontario. She is an applied health services researcher with interests in primary health care, interprofessional teams, health equity, and learning health systems. She is a Research Professor at Western University within the Centre for Studies in Family Medicine, an Associate Professor at University of Toronto in the Department of Community and Family Medicine, and the Institute of Health Policy Management and Evaluation and a scientist with ICES.</p> <p>Michelle Carr resides in Northumberland. Diagnosed with Schizophrenia over 20 years ago, her vocation in the creative arts came to an unexpected halt. Now, in recovery, she is thriving by maintaining a healthy and active relationship with her community. She has been serving as a member of the Board of Directors at the Canadian Mental Health Association for Haliburton, Kawartha and Pine Ridge, in strong support of mental health for all, for just over a year.</p>	Virtual Available
10:30 AM Provincial North	Break	
10:45 AM Wentworth, Kenora, Huron, Kent	Concurrent Oral Presentations	In Person Only
11:45 AM Provincial North	Lunch Break	
12:30 PM Provincial South	Concurrent Poster Presentations	In Person Only
1:30 PM Provincial North	Break	
1:45 PM Provincial North	<p>Panel Discussion – Primary Care Access and Interprofessional Health Care Introduction & Moderator: Dr. Catherine Donnelly, Director, Health Services and Policy Research Institute, Queen’s University</p> <p>This panel will focus on primary care access and interprofessional health care. The panel features Dr. Rachelle Ashcroft, Factor-Inwentash Faculty of Social Work, University of Toronto; Dr. Jordan Miller, School of Rehabilitation Therapy (PT), Queens; Dr. Jennifer Lake, Leslie Dan Faculty of Pharmacy, University of Toronto; Clare Cruikshank, Patient Advisor, Ontario Health & Patient Expertise in Research Collaboration</p>	Virtual Available
3:30 PM Provincial North	Trillium: Concluding Remarks Dr. Rick Glazier	Virtual Available
3:45–4:30 PM	End of Day Networking	In Person Only

Martin Bass Lecture

Dr. Martin J. Bass was Chair of the Graduate Studies Program in the Department of Family Medicine at Western University from 1977 to 1980, and the first Director of the Centre for Studies in Family Medicine from 1986 to 1996. His career as a family physician researcher had a major impact on the development of family practice research around the world. This lecture honors Dr. Bass and his strong commitment to family medicine research.

The Team is In: Transforming Primary Care for Improved Access and Effectiveness



Dr. Jennifer Rayner is the Director of Research and Policy at the Alliance for Healthier Communities and supports 100+ community based primary care organizations in Ontario. She is an applied health services researcher with interests in primary health care, interprofessional teams, health equity, and learning health systems. She is a Research Professor at Western University within the Centre for Studies in Family Medicine, an Associate Professor at University of Toronto in the Department of Community and Family Medicine, and the Institute of Health Policy Management and Evaluation and a scientist with ICES. Jennifer works in collaboration with researchers, evaluators and policy makers to improve care for people with barriers. Her community based primary care experience includes leadership roles in policy, planning, performance, accountability and quality improvement. She received her PhD of Epidemiology and Biostatistics at Western and completed post-doctoral training at TMU.



Michelle Carr resides in Northumberland. Diagnosed with Schizophrenia over 20 years ago, her vocation in the creative arts came to an unexpected halt. Now, in recovery, she is thriving by maintaining a healthy and active relationship with her community. Working at the Mission Thrift Store, where she is known for painting the windows, Michelle is also planning to put her efforts into volunteering as a Peer Supporter with her lived experience. She has been serving as a member of the Board of Directors at the Canadian Mental Health Association for Haliburton, Kawartha and Pine Ridge, in strong support of mental health for all, for just over a year. She enjoys writing and walking, although not at the same time. At 51, Michelle is living life to the fullest while keeping gratefulness and humility in her heart. Her message to you today is to never stop believing.

Discussion

Conference participants will be given the opportunity to ask questions and respond to the Martin Bass lecture. This segment will be moderated by Dr. Rick Glazier.

Oral Presentations

Rooms: Wentworth, Kenora, Huron & Kent 10:45-11:45AM

A listing of oral presentations is provided below; abstracts are included beginning on PAGE 8

Theme	#		Presentation Title	Presenter	Affiliation
Family Medicine Perspectives Moderator: Maria Mathews Evaluator: Hina Ansari Room: Wentworth	1	Wentworth 1045	Examining the role of family physicians in COVID-19 surge capacity: Challenges and implications for practice	Maria Mathews	Western University
	2	Wentworth 1100	Characteristics of walk-in clinic physicians and patient in Ontario: A cross-sectional study	Lauren Lapointe-Shaw	University of Toronto
	3	Wentworth 1115	SPIDER* study essentials: Eight Legs of Success- Lesson learned from managing a large multi-jurisdictional PBRN RCT in primary care	Michelle Greiver	University of Toronto
	4	Wentworth 1130	The burden of administrative responsibilities in primary care	Judith Belle Brown	Western University
Team Based Care and Community Perspectives Moderator: Rachelle Ashcroft Evaluator: Yasmin Abdul Aziz Room: Kenora	5	Kenora 1045	Assessing nurse practitioner contribution to primary care within two practice models in Ontario	Jennifer Rayner & Joan Tranmer	Alliance for Healthier Communities & Queen's University
	6	Kenora 1100	Who really works in a primary care team and the programs they provide	Catherine Donnelly	Queen's University
	7	Kenora 1115	Success and challenges from the OurCare community engagement initiative	Rachel Thelen-Botejue	MAP Center for Urban Health Solutions
	8	Kenora 1130	Developing an intervention to support Ontario community pharmacists in delivering minor ailments services	Daphne To	University of Toronto
Access and Attachment Moderator: Jonathon Fitzsimon Evaluator: Leslie Meredith Room: Huron	9	Huron 1045	Impact of primary care unattachment duration: Consequences and implications	Jonathan Fitzsimon	Institut du Savoir Montfort
	10	Huron 1100	Journey mapping of a non-urgent ED visit: Experiences of uncertainly attached patients	Diane Kim	Queen's University
	11	Huron 1115	Accessing language-concordant care: Rethinking the way we measure access to health services for minority language populations	Lise M. Bjerre	University of Ottawa
	12	Huron 1130	Distance to primary care and its association to healthcare use and quality of care: A cross-sectional study	Archna Gupta	Unity Health Toronto
Patient Centred Primary Care Moderator: Sathya Karunanathan Evaluator: Maggie MacNeil Room: Kent	13	Kent 1045	Using eConsult to access specialist advice for persons living with dementia – A cross-sectional analysis	Sathya Karunanathan	University of Ottawa
	14	Kent 1100	Links2Wellbeing Social Prescribing for Older Adults	Josephine Pham	Alliance for Healthier Communities
	15	Kent 1115	Older adults' preferences, expectations, and values for quality family physician encounters: Insights from a systematic review	Rebecca Correia	Dalhousie University
	16	Kent 1130	Exploring emergency department utilization trends amongst housed and underhoused individuals in Windsor, Ontario	Kim Nguyen & Temitope Akintola	Western University

Poster Presentations

Provincial South, 12:30-1:30PM

A listing of posters is provided below; abstracts are included beginning on PAGE 16

#	Presentation Title	Presenter
1	Describing 'Care of the Elderly' family physicians in Ontario: A population-based retrospective cohort study	Rebecca Correia
2	How can optimal communication enhance intersectoral collaborative communication between primary care providers and community mental health workers? Preliminary results.	Stefaniia Martsynkevych
3	The push and pull of the locum trajectory	Cathy Thorpe
4	Health promotion activities in Ontario Community Health Centres	Sara Bhatti
5	Enabling pathways to Flourish – Improving service provider knowledge to strengthen support for female genital mutilation/cutting survivors	Tomilola John
6	Developing guidance for facilitating retention of the team-based primary healthcare workforce in Canada: A multimethod approach	Peter Sheffield
7	Don't tell me what you think I don't know: A tested protocol for building mental health and social care in Family Health Teams	Rebecca Bliss
8	Social prescribing for better mental health project	Natasha Beaudin
9	The implementation of infection prevention and control procedures in primary care during the COVID-19 pandemic: A qualitative study of nursing roles	Leslie Meredith
10	Physician commitment in long-term care practice: Canadian and global perspectives	Maya Potter
11	Care coordination between family physicians and palliative care physicians for patients with cancer: Results of a quality improvement initiative	Aynharan Sinnarajah
12	Minor Ailments and pharmacist management in Ontario, Canada: Attachment and primary care in 2023	Paul Nguyen
13	Diabetes Self-management Coaching in the primary care: Lessons learned for the Ontario context	Fikadu Ambaw Yehualashet
14	Physical multimorbidity among treatment-seeking smokers and its association with quit outcomes in a large publicly funded smoking cessation program	Polina Kyrychenko
15	Navigating invisibility: The experience of adults with disabilities in accessing primary healthcare in conflict-affected Ethiopia (ongoing research)	Biniyam Abebe
16	Predictors and outcomes of heart failure diagnosis in the community compared to acute care settings: Insights from linked administrative health databases	Alex Van
17	Evaluating the impact of a yoga therapy program for residents, family members and staff in Long-Term Care	Ingrid Wirsig
18	Charting new territories: Mapping patient partner roles in primary health care design, research, education, and delivery	Aya Tagami
19	Use of dementia risk assessment in community paramedicine (CP) programming: An observational study of CP@clinic and CP@home	Manasvi Sai Vanama
20	Changes in cervical cancer screening during the pandemic: An international comparative study by INTRePID focusing on South American countries	Maria Carla Lapadula
21	Neighbourhood building blocks: Regional attachment strategies for primary care	Catherine Donnelly
22	Focused practice trends in Ontario, Canada: A population-level study spanning 1993/94 to 2021/22	Hina Ansari
23	Have pulmonary function testing rates recovered after the COVID-19 pandemic?	Javier Silva-Valencia
24	Reflections on implementing promising practices for improving cultural safety and accessibility of mainstream healthcare institutions for Indigenous patients in Southeastern Ontario	Shawna Cronin
25	SPIDER: A structured approach to quality improvement and deprescribing in older patients; Preliminary results of the RCT	Michelle Greiver
26	The state of art Canadian Primary Health Care researcher's scientific productivity for 40 years	Thiago Gomes da Trindade
27	MAiDHouse: A qualitative study on structured community-based support for grief and bereavement	Han Yan
28	Youth crystal methamphetamine contingency management outcomes & lived-experiences in KFL&A: A mixed methods investigation	Maggie McNabb

Poster presentations continue on next page

Poster Presentations

#	Presentation Title	Presenter
29	Accessing language-concordant care: Distribution and language abilities of Ontario physicians, and impact on travel burden for patients	Lise M. Bjerre
30	Improving access to palliative care services through electronic consultations: A study on primary care providers' adoption of an eConsult service to enhance palliative care access	Ramtin Hakimjavadi
31	"I felt like it was geared to each individual patient": Experiences of patients with diabetes utilizing the Primary Care Diabetes Support Program (PCDSP)	Gillian Young
32	How does long-term care physician commitment to practice influence quality of care? A retrospective cross-sectional study in Ontario	Darly Dash
33	Pain care access: Healthcare providers' experiences and perspectives on the provision of chronic pain care in the context of patient-provider language-discordance	Camilia Thieba
34	The quest for inclusive perinatal care services for women with physical disability in primary care settings: Implications for practice and policy in Ontario	Dawit Gebeyehu Mekonen
35	Healthcare utilization following a visit with a within-group family physician vs. with a walk-in clinic physician	Lauren Lapointe-Shaw
36	Experiences and preferences of people without access to primary care: Results from a national cross-sectional survey in Canada	Maryam Daneshvarfard
37	Bridging gaps: Integrating mental health services into primary care in Ethiopia – Lessons and Implications for Primary Care in Ontario	Adhanom Baraki
38	National and provincial policies to support the face of primary care	Apira Ragnathan
39	A qualitative study on the role of community pharmacists in assisting newcomer international students and their families transitioning to the Canadian healthcare system	Yasmin Aboelzahab

Panel Discussion

Primary Care Access and Interprofessional Health Care

This panel will focus on primary care access and interprofessional health care. The panel features Dr. Rachele Ashcroft, Factor-Inwentash Faculty of Social Work, University of Toronto; Dr. Jordan Miller, School of Rehabilitation Therapy (PT), Queens; Dr. Jennifer Lake, Leslie Dan Faculty of Pharmacy, University of Toronto; Clare Cruickshank, Patient Advisor, Ontario Health & Patient Expertise in Research Collaboration



Moderator: Dr. Catherine Donnelly
Director, Health Services and Policy Research Institute, Queen's University

Panelists:



Clare Cruickshank is one of the inaugural members of the Canadian Cancer Society's patient/survivor/caregiver reviewer program and participated as a lead reviewer evaluating grant proposals until starting her first term on their Advisory Council on Research in April. She is also a patient advisor for Ontario Health's CEO Patient and Family Advisory Council, and Patient Expertise in Research Collaboration. Motivated by personal experiences and her commitment to continuous education, she recently participated in the American Association for Cancer Research's scientist↔survivor program. Her formal educational background includes a Master of Science degree in mental health, and bachelor's degrees in social work and business administration.



Dr. Rachele Ashcroft is an Associate Professor at the Factor-Inwentash Faculty of Social Work, at the University of Toronto; and, cross-appointed to the Department of Family and Community Medicine at Temerty Faculty of Medicine at the University of Toronto. She practiced as social worker in multiple settings including primary care, community mental health, and ten years at Winnipeg's Health Science Centre working across programs. She completed her PhD at Wilfrid Laurier University, followed by the Social Aetiology of Mental Illness post-doctoral training program at the Centre for Addiction and Mental Health. A health systems researcher, Dr. Ashcroft has interest in nurturing organizational and policy-contexts supporting delivery of team-based primary care, patient-centred virtual care, interprofessional collaboration, and strengthening social work and mental health services in primary care. Dr. Ashcroft is a core-funded investigator of INSPIRE-PHC. Since 2003, she is an active mentor in the TUTOR-PHC program, a pan-Canadian interdisciplinary research capacity-building program training PHC researchers.



Jordan Miller is an Associate Professor in the School of Rehabilitation Therapy and Member of the Health Services and Policy and Research Institute at Queen's University. He is a health services researcher that leads an interdisciplinary research team focused on advancing team-based primary care and pain management supports for people living with pain.



Jennifer Lake is a pharmacist, educator, and researcher whose focus is on pharmacist practice and collaboration in primary care. She currently leads Interprofessional Education at Leslie Dan Faculty of Pharmacy, working across 14 healthcare Faculties to deliver excellent & topical learning supporting students' delivery of collaborative care to improve patient outcomes and experiences. She also teaches in various other areas for pharmacy, undergraduate medical education, and graduate courses. She completed a PhD and OHT Impact Fellowship with IHPME, her fellowship was working with a team of interprofessionals partnering with primary care clinics to deliver care locally. Her current research focuses on education for primary care practice & a comparative policy analysis regarding integration of community pharmacists in primary care.

Evaluation

Please be sure to complete the evaluation form emailed to you following the event. This will provide the conference organizers with needed feedback going forward.



Abstracts: Oral Presentations

Examining the role of family physicians in COVID-19 surge capacity: Challenges and implications for practice

Maria Mathews, Dana Ryan, Lindsay Hedden, Julia Lukewich, Emily Gard Marshall, Leslie Meredith, Sarah Spencer, Gillian Young

Background: Planning for surge capacity is an essential component of public health emergency preparedness, given the need to address the increased demand on the healthcare system and deliver clinical care during crises. During the COVID-19 pandemic, family physicians (FPs) were called upon to provide surge capacity in various settings while also maintaining the continuity of primary care operations. There is limited research focused on the firsthand experiences of FPs in this role.

Approach: We conducted semi-structured interviews with FPs between October 2020 and June 2021 across four Canadian provinces (BC, ON, NS, NL). FPs were asked about roles they assumed during different pandemic stages and factors that impacted their ability to fulfil these roles. A thematic analysis approach was employed to identify recurring themes.

Results: We interviewed 68 FPs, identifying two overarching themes: 1) mechanisms used to create surge capacity by FPs, and 2) key considerations for an organized surge capacity program. During the pandemic, surge capacity included extending FP working hours, expanding the FP workforce, and redeploying FPs to new roles. Effective implementation relied on organized communication and coordination mechanisms, FPs working within their scope of practice, training and mentorship related to new redeployment roles, the presence of credentialing and hospital privileges, and policies that help to preserve primary care capacity.

Conclusions: FPs make critical contributions to surge capacity, but require structured support to balance their redeployment roles with their ongoing primary care responsibilities. Ensuring adequate coverage for their practices and employing strong communication and coordination mechanisms are essential.

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Characteristics of walk-in clinic physicians and patient in Ontario: A cross-sectional study

Lauren Lapointe-Shaw, Christine Salahub, Peter C. Austin, Li Bai, Sundeep Banwatt, Simon Berthelot, R. Sacha Bhatia, Cheryl Bird, Laura Desveaux, Tara Kiran, Aisha Lofters, Malcolm Maclure, Danielle Martin, Kerry A. McBrien, Rita K. McCracken, J. Michael Paterson, Bahram Rahman, Jennifer Shuldiner, Mina Tadrous, Braeden Terpou, Niels Thakkar, Ruoxi Wang, Noah M. Ivers

Background: Little is known about the characteristics of physicians who work in walk-in clinics in Ontario. This study described family physicians who primarily practice in a walk-in clinic setting and compared them with family physicians who provide longitudinal care.

Approach: We conducted a cross-sectional study that linked results from a 2019 physician survey to Ontario health administrative data. We compared the characteristics, practice patterns, and patients of physicians primarily working in a walk-in clinic setting with those family physicians providing longitudinal care.

Results: Compared with the 9,137 family physicians practicing longitudinal care, the 597 physicians who self-identified as practising primarily in walk-in clinics were more frequently male (67% vs 49%) and could speak a language other than English or French (43% vs 32%). Walk-in clinic physicians had more encounters with patients who were younger (M 37 vs 47 years), had lower levels of prior healthcare utilization (15% vs 19% in highest band), who resided in large urban areas (87% vs 77%), and who lived in highly ethnically diverse neighborhoods (45% vs 35%). Walk-in clinic physicians had more encounters with unattached patients (32% vs 17%) and with patients attached to another physician outside their group (54% vs 18%).

Conclusions: Physicians who primarily work in walk-in clinics saw many patients from historically underserved groups and many patients who were attached to another family physician.

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SPIDER* study essentials: Eight Legs of Success- Lesson learned from managing a large multi-jurisdictional PBRLN RCT in primary care

Michelle Greiver, Celine Jean-Xavier, Simone Dahrouge, Donna Manca, Alex Singer

Background: The Structured Process Informed by Data, Evidence and Research (SPIDER) study is a multi-jurisdictional randomized controlled trial (RCT) in Networks participating in CPCSSN. It needed to address complexities of conducting research across diverse Canadian healthcare settings. This project draws lessons from managing a large, multi-site Practice-Based Learning and Research Networks (PBLRNs) to identify best practices in protocol implementation, data management, and governance.

Approach: Learning from this study, we devised eight core strategies for success: (1) establishing robust administrative and management processes, (2) engaging leadership through clear governance structures, (3) ensuring protocol fidelity with consistent data management, (4) expediting inter-university agreements, (5) adhering to varying Research Ethics Board (REB) requirements, (6) navigating provincial privacy regulations, (7) engaging practices and providers, and (8) leveraging knowledge mobilization including web presence management.

Results: Outcomes of using this approach include improved team coordination, streamlined data collection and quality assurance, and effective cross-jurisdictional communication. The study emphasized the importance of adaptable governance frameworks and legal agreements. Successful engagement of diverse stakeholders, including patient partners, researchers and clinicians can ensure a robust approach to research implementation and sustainability.

Conclusions: The SPIDER study leveraged processes for managing complex, multi-jurisdictional research in primary care. By focusing on strategic administrative processes, stakeholder engagement, and regulatory compliance, the study offers a framework for other large-scale primary care research initiatives. Further application of these strategies can enhance research efficiency and data quality, ultimately supporting better patient outcomes and knowledge translation.

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The burden of administrative responsibilities in primary care

Judith Belle Brown, Cathy Thorpe, Amanda L. Terry, Bridget L. Ryan, Maria Mathews, Catherine George, Saadia Hameed Jan, Sharon Bal, Kamila Premji

Background: For over 25 years, the burden of clinical administrative services has been cited as contributing to the stress and burnout experienced by family physicians (FPs). We sought to explore FPs' experiences of administrative burden in practice. Approach: Constructivist Grounded Theory study using in-depth interviews via Zoom, with individual and team analysis. Thirty-six FPs practicing in Ontario, who completed their training between 2017 – 2022 were interviewed. Results: Participants spontaneously raised the issue of administrative burden, describing it as both the volume of paperwork and “never ending” inbox management decreasing time for direct patient care. They expressed feeling frustrated, stressed, and overwhelmed with the many hours (2-3 hours) per day spent on administrative tasks. Participants strongly emphasized the lack of compensation for this work. Some participants described being “sheltered” from the realities of administrative burden during medical school and residency, leaving them unprepared to manage multiple administrative tasks. Participants perceived administrative burden as contributing to burnout and their declining joy in practicing comprehensive care. Participants offered solutions to address administrative burden at both personal (e.g. creating ‘flex time’ to complete administrative work and setting boundaries) and system levels (e.g. need for compensation for administrative time and funding to increase clinic staff such as physician assistants and nurse practitioners). Conclusions: Study findings highlight the challenges posed by administrative services, including the negative impacts of administrative burden on physician well-being (e.g. burnout) and reduced time for direct patient care. Furthermore, the findings provide personal and system solutions to guide practitioners and policymakers.

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Assessing nurse practitioner contribution to primary care within two practice models in Ontario

Jennifer Rayner, Joan Tranmer, Hannah Willms, Bahram Rahman, Daniel Saliba

Background: Primary care nurse practitioners (NPs) have the capacity to assess, diagnose and manage patients; however, we have a poor understanding of NP contribution, and the influence of different practice models (FHT and CHC). Assessing NP contribution to patient care is difficult, as NPs do not directly bill for their services and their function within team structure varies.

Approach: We utilized existing ICES administrative data that included NP encounter data from CHCs and a subset of NPs working in FHTs to describe and compare patient characteristics and selected outcomes, from 2018 to 2020. Outcomes of interest included: cancer screening, primary care utilization, emergency, hospital and LTC utilization. All analysis were stratified into 3 categories based on the proportion of care provided by the NP: NP majority (> 70% NP), shared (> 30% to < 70%), MD majority (<30%).

Results: The cohort consisted of 103,747 FHT and 185,420 CHC patients. Within the CHC, approximately 68.4% of patients received most of their care from the NP in comparison to the FHT (17.9%). Patients cared for by NPs within the CHC were more likely to be socially marginalized and have slightly more comorbidities in comparison to patients in the FHT. NPs in the FHT were more likely to care for patients with less comorbidities in comparison to their physician colleagues.

Conclusion: We provide a comprehensive description of the patients cared for by NPs within two primary care practice models. With the continuous struggle with access to primary care services, we need to determine primary care practice models that optimize the contribution of team members to the care of patients within their community. Our findings provide a comprehensive picture of the current state and a potential platform to inform future planning.

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Who really works in a primary care team and the programs they provide

Catherine Donnelly, MJ Duggan, Thea Babalis

Background: Interprofessional primary care teams are being seen as the solution to the current crisis in primary care. Family Health Teams (FHTs) have been in place for almost 20 years, however despite this tenure there is surprisingly little known about the teams and the services they provide. The objective of the study was to describe the composition of primary care providers in each team, the programs offered and mechanisms to access team members.

Approach: An environmental scan. The websites of all 186 FHTs were systematically searched. A data extraction template was developed, considering organizational structure and location, team composition, programs provided and processes to access the team. Data was extracted into the excel template by two student researchers (MJD and TB). Open text was categorized, and frequency counts were determined.

Results: We identified 4148 providers working across 186 FHTs. After physicians (n=2135), the most frequent providers were nurses, including RPN, RNs (n=631), followed by nurse practitioners (n=387), social workers (n=249), dietitians (n=193) and pharmacists (n=121). There were a total of 1492 programs being delivered across the FHTs. The most frequent programs focused on providing mental health supports (n=222), supporting people living with diabetes (n=178 programs), lung health/smoking cessation (n= 188) and aging (n=137). Access to teams was a mixture of direct access and referral. The number of FHTs within each of the 58 Ontario Health Teams varied widely, with three OHT's having no FHT's to the Archipel OHT having 13 FHTs. Conclusions: There was wide variability in the data provided on FHT websites, with little consistency in programs offered and mechanism to access team members.

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Success and challenges from the OurCare community engagement initiative

Rachel Thelen-Botejue, Tara Kiran, Maryam Daneshvarfard, Matthew Zhiss, Tara Dwivedi, Cheryl Pritlove

Background: OurCare was the largest-ever pan-Canadian initiative to engage the public about primary care reform, developing consensus recommendations from diverse participants. The aim of the current study was to understand the experiences of OurCare priority panel members to draw lessons for successful public engagement in future initiatives.

Approach: To achieve this aim we conducted semi-structured interviews with 30 members of the public who participated in OurCare priorities panels in either British Columbia, Manitoba, Ontario, Quebec, or Nova Scotia. We asked questions about participant motivations, what worked well, barriers, accessibility, recommendations for improvement, and hopes. Data were analyzed through an Equity, Diversity, and Inclusion (EDI) lens and constant comparative approach.

Results: A key finding from our study is that successful public engagement rests on adherence to EDI principles, including ensuring diverse representation and strong commitment to equitable and inclusive engagement practices. Engagement was supported by intentional strategies in recruitment, strong facilitation during the event, ability to tell one's story, virtual and in-person components, guest speakers, and strong accommodations for accessibility. Challenges included trauma pre-existing the OurCare initiative, losing intricate details and emotions, personal circumstances (e.g., other work commitments), and perceived intensity.

Conclusions: People interested in hosting community engagements in policy-setting can prepare for a successful engagement by incorporating intentional recruitment, strong facilitation, space for storytelling, and flexibility for participants as key strategies to support effective engagement.

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Developing an intervention to support Ontario community pharmacists in delivering minor ailments services

Daphne To, Laura Desveaux, Mina Tadrous, Noah Ivers

Background: The scope of practice for Ontario pharmacists expanded in 2023, allowing them to prescribe medications for certain minor ailments. Community pharmacists have medication expertise and are highly accessible to patients within the community. Ontario pharmacists reported needing strategies to support them in delivering minor ailments services (MAS). This study aims to develop an intervention to support community pharmacists in effective delivery of MAS and reduce variation across pharmacists.

Approach: We will conduct an explanatory sequential mixed methods study. The quantitative phase will use administrative health services data at ICES to describe characteristics and practice patterns of pharmacists delivering MAS. The distribution in number of MAS delivered will depict variation in frequency of MAS delivery; this data will be used to classify pharmacists into groups to determine differences in pharmacist characteristics and practice patterns. These differences will inform sampling for the qualitative phase. We will conduct interviews with community pharmacists to understand factors driving variation in how often and how well they deliver MAS. We will analyse interviews deductively with the Theoretical Domains Framework and map relevant domains to Behaviour Change Techniques to propose intervention strategies. We will present these strategies to participants in electronic surveys (modified Delphi approach) to achieve consensus on strategies that can support pharmacists in delivering MAS.

Results: In progress.

Conclusion: This study will demonstrate a systematic process for intervention development through gaining insight on how and for whom additional supports are needed to ensure the MAS policy has the intended impact.

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Impact of primary care unattachment duration: Consequences and implications

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Background: Primary care unattachment worsens patient experiences, limits access, and leads to poorer health outcomes. While studied as a binary variable (attached/unattached), limited evidence exists on the impact of unattachment duration. Understanding its influence on patient outcomes could inform key policy and program initiatives.

Approach: We are conducting two large-scale ICES studies in Ontario – Phase I has been completed, while Phase II is in its early stages, both exploring the consequences of unattachment and its duration. We have also completed a scoping review mapping the literature on gaining and losing attachment to primary care.

Results: Research on unattachment duration is sparse, but our review identifies multiple factors across patient, provider, clinic, and system levels affecting outcomes. Findings from our Phase I ICES study show that unattachment and lack of primary care access significantly increase healthcare costs and utilization (emergency department visits and all-cause hospitalizations), particularly in patients with high levels of multimorbidity. Long-term unattachment amplifies these effects, with costs rising from \$3,711 for attached multimorbid patients to \$8,177 for those unattached long-term – a 220% increase.

Conclusion: These findings highlight the need for further investigation into the complex relationship between attachment status, unattachment duration, and patient demographic and health characteristics. A recent Australian study reported a concerning 40% increase in preventable mortality among unattached patients, underscoring the urgency of studying unattachment duration and its impacts on hospitalization patterns, with a more detailed analysis of specific hospitalization types, as well as mortality, in our ongoing Phase II ICES study.

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Journey mapping of a non-urgent ED visit: experiences of uncertainly attached patients

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Background: 10.4% of uncertainly attached Frontenac, Lennox & Addington (FLA) attributed patients utilized emergency departments (EDs) for non-urgent visits*. This underlines the issue of uncertainly attached patients relying on EDs as their primary means of accessing healthcare. Given this context, our study employs journey mapping to understand the current primary care (PC) service experience from the perspective of uncertainly attached FLA patients, with a focus on the non-urgent ED experience. Journey mapping is a visual tool used in service and product design to identify pain points, barriers, and opportunities for improvement.

Approach: Uncertainly attached FLA patients were invited to participate in the study via passive recruitment. This qualitative study employed 6 one-on-one interviews and 2 focus groups (n=19) to explore participants' PC experiences. Data from these sessions were thematically analyzed and summarized into a patient journey map, as well as through textual exploration of common themes.

Results: 31% (6/19) of participants used the ED for PC. Emerging themes included: using EDs to resolve primary healthcare concerns, going to EDs as a last resort, frequently reported long wait times, unwelcoming staff and feeling dismissed without proper care, varied experiences from receiving insufficient care to comprehensive care, and frustration from lack of follow-up and support from the healthcare system. Both participant feedback and thematic analysis generated change ideas.

Conclusions: Many FLA community members without a PC provider depend on the ED for their non-urgent PC needs, despite it not being the appropriate setting for these visits. This leads to perceived challenges in accessing adequate services and varied experiences with healthcare. This study highlights the importance of community feedback in improving the uncertainly attached patient's PC experience and explores what these patients encounter during a non-urgent ED visit using journey mapping.

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Accessing language-concordant care: Rethinking the way we measure access to health services for minority language populations

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Background: Providing care in a patient's preferred language improves outcomes and satisfaction. Current methodology using French Speaking Physicians (FSPs)-to-Ontario Francophone ratios compared to all physicians-to-population ratios, inaccurately suggests that Ontario Francophones have better access to language-concordant care, ignoring the fact that FSPs also serve non-Francophone patients. We propose a novel approach to address this issue.

Approach: Using publicly available data containing linguistic variables for the Ontario population (Statistics Canada, 2021 Census) and Ontario family physicians (College of Physicians and Surgeons of Ontario; January 2024), crude ratios were adjusted to reflect competition for care by considering the proportion of FSPs-to-general population. The probability of receiving language-concordant care was estimated.

Results: The unadjusted ratio of FSPs-per-1000 Francophones was 2.42; for general physicians it was 0.67 per 1000 population. After adjusting for the competition effect, the ratio of FSP per 1000 population was 0.09, reflecting actual Francophone access to FSPs. If every physician had full panels, 83.3% of Ontarians would have a family physician. Non-Francophones would have a 100% chance of receiving care in English, while francophones would have an 11.4% chance of care in French, making non-Francophones 8.8 times more likely to get language concordant care.

Conclusions: Crude physician-to-population ratios overestimate Francophones' access to FSPs. After applying our correction method, we find that Francophones are less likely to have access to language-concordant care than non-Francophones (11.4% vs 100%). This novel approach has equity implications for health human resources planning and can be applied to other linguistic minority groups.

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Distance to primary care and its association to healthcare use and quality of care: A cross-sectional study

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Background: In Canada, patients who move increasingly keep their family physician (FP) because no one in their new community is accepting patients, creating long distances to seek primary care. It is unclear how distance to primary care impacts healthcare use and quality of care.

Methods: We conducted a population-based retrospective cross-sectional study in Ontario, Canada using administrative data. We included all patients residing in urban or suburban communities who were formally enrolled to a family physician as of March 31, 2023. The primary exposure was patients' travel distance to their physician. Healthcare utilization outcomes included continuity of care to one's own physician and own group, number of core primary care visits and emergency department visits. Healthcare quality outcomes included rates of colorectal, breast and cervical cancer screening.

Results: We analyzed data for 9,967,955 enrolled patients; 1,261,112 (12.5%) patients lived 31km to 50km from their FP, while 671,545 (6.6%) lived 51km or farther from their FP. Patients who lived farther from their FPs were more likely to have reduced continuity of care, no primary care visits, more emergency department visits and less screening for colorectal cancer, breast cancer and cervical cancer.

Conclusion: Almost one in five patients lived more than 30km from their family physician. Yet, our findings suggest primary care close to home is associated with higher relational continuity, lower emergency department use, and more recommended cancer screening.

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Using eConsult to access specialist advice for persons living with dementia – A cross-sectional analysis

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Background: While dementia is most often managed by primary care providers (PCPs), its complexity and associated multimorbidity often benefit from specialist advice. eConsult is a secure web-based platform that enables communication between specialists and PCPs. Its use for persons living with dementia (PLWD) has never been examined.

Approach: To examine how eConsult is used for PLWD in the Champlain region, we did a cross-sectional analysis of eConsult cases closed in 2021 for PLWD in the community (97 cases) and in long-term care (LTC, 53 cases). We collected utilization data, including the specialty consulted, response time, and the PCP's responses to a close-out survey about their experience. Our clinician team coded questions and responses using validated taxonomies, with iterative discussions for consensus.

Results: Geriatrics was the most frequently consulted specialty for community cases (18%, n=17), and dermatology for LTC (30%, n=15). PCPs' questions were about the patient's dementia in 30% of community cases (n=29) and 15% of LTC cases (n=8). Specialists responded to cases in <1.2 days, and often considered the patient's dementia in their response (community: 46% [n=45], LTC: 38% [n=20]). PCPs indicated that in-person referral was avoided in 39% of community cases (n=38) and 41% of LTC cases (n=22). Resources for caregivers were discussed in 32% of community cases (n=31) and 26% of LTC cases (n=14).

Conclusions: eConsult facilitates prompt responses and supports PCPs in managing PLWD through access to a variety of specialists. Specialists accessed and questions for PLWD in the community were different from those in LTC.

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Links2Wellbeing Social Prescribing for Older Adults

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Background: Links2Wellbeing: Social Prescribing for Older Adults is a 3-year project that ran from 2021-2023 that is now entering Phase 2 with an additional 4 years of funding. As a partnership between the Alliance for Healthier Communities and the Older Adults Centres' Association of Ontario, this project was designed to help connect socially isolated older adults with Seniors Active Living Centres (SALCs) and other community organizations.

Approach: To increase social inclusion for older adults who may be socially isolated, by: creating pathways between primary health care providers and local SALCs across Ontario. Improving understanding of non-clinical interventions on wellbeing and service utilization through data collection and evaluation. Developing infrastructure for scaling up social prescribing (SP), such as communities of practice and learning events.

Results: 93 SALCs and over 200 healthcare providers, including 27 Alliance members, have partnered to make SP referrals for older adults. 1500+ referrals have been documented in the Electronic Medical Record (EMR), as of year 3. Clients reported reduced feelings of loneliness (52% at 6 months and 62% at 12 months), and 40% reported improved connections to the community, better physical and mental health. We created provincial and national Communities of Practice, with 245 members in Ontario and 198 members across Canada. Over 175 presentations have been provided to support SP implementation in various settings, including clinical practice.

Conclusions: Social Prescribing can play an important role in enhancing the wellbeing of older adults.

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Older adults' preferences, expectations, and values for quality family physician encounters: Insights from a systematic review

Rebecca Correia, Darly Dash, Ryan Strum, Zain Pasat, Maya Potter, Komal Aryal, Humayun Kabir, Henry Siu

Background: Older adults (65+) frequently utilize primary care services and often present with unique needs and preferences compared to patients of other age groups. We reviewed existing evidence to understand the main attributes of high-quality family physician care from the perspectives of older adults.

Approach: We conducted a systematic review to identify and synthesize previously published literature. Using keywords and subject headings, we searched three electronic databases (Ovid MEDLINE, Ovid Embase, Web of Science). Seven reviewers screened the titles, abstracts, and full texts of identified literature independently and in duplicate. We used a standardized inclusion form to assess relevance. Reviewers evaluated the risk of individual study bias and extracted relevant data. We narratively synthesized findings across included studies. Three patient partners are actively engaged in all research activities as part of this review.

Results: This review is ongoing, but the findings will be ready to present in October 2024. The literature search yielded 28,460 articles for title and abstract screening. From this, 462 (1.6%) proceeded to full-text review, which is currently underway. Emerging findings suggest the main attributes that older patients value are: trust in their provider, continuity of care (longitudinal relationships), engagement of informal caregivers (family members), and effective communication during medical visits.

Conclusions: As the Canadian population ages, it is important to recognize the factors that older adults value, need, and expect during family physician encounters. These findings from international evidence will highlight what matters most to patients, which can inform family physician training and primary care practice.

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Exploring Emergency Department Utilization Trends Amongst Housed and Underhoused Individuals in Windsor, Ontario

Kim Nguyen, Temitope Akintola, Windsor Shelter Health Team

Background: People experiencing homelessness (PEH) make disproportionately high use of emergency departments (EDs) due to barriers preventing access to traditional healthcare clinics. Windsor Shelter Health (WSH) improves access to healthcare services for PEH by providing medical programming that is more conducive to their unique needs. This study investigates ED utilization trends amongst housed and unhoused individuals in Windsor, Ontario, to understand the clinical reasons for which PEH are visiting the EDs, to then identify alternative pathways, including WSH clinics, that will better support their healthcare needs.

Approach: A retrospective cohort study design will be used to examine patient charts from Windsor Regional Hospital's ED. Descriptive statistics and bivariate analyses will be used to identify any differences that might exist between the housed and unhoused groups in terms of presenting complaints and suggested follow-up.

Results: ED utilization patterns are expected to differ significantly between housed and unhoused individuals, with the latter showing greater variability in their clinical presentations. PEH are anticipated to present with more medical, psychiatric, and social comorbidities, and with more issues that could be effectively treated in primary healthcare settings, highlighting the need for accessible community care for this population. Detailed results will be presented at the conference.

Conclusion: This project will identify potential intervention points for WSH to provide preventive care for the unhoused, addressing diagnoses more appropriate for community care than ED treatment. It will also provide evidence to support advocacy for shelter health initiatives more broadly, highlighting the importance of accessible primary healthcare for unhoused individuals.

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Abstracts: Poster Presentations

Describing 'Care of the Elderly' family physicians in Ontario: A population-based retrospective cohort study

Rebecca Correia, David Kirkwood, Henry Siu, Aaron Jones, Meredith Vanstone, Steve Slade, Ruth Lavergne, Glenda Babe, Andrew P. Costa

Background: Family physicians are central to caring for older adults. Some family physicians pursue additional training to become certified in 'Care of the Elderly,' while others apply for focused practice billing designations to increasingly care for older patients. We aimed to identify and describe the individual and medical practice characteristics of family physicians with 'Care of the Elderly' certification or focused practice.

Approach: We conducted a retrospective cohort study using population-based administrative datasets at ICES. We identified family physicians in Ontario with 'Care of the Elderly' certification from a data linkage with the College of Family Physicians of Canada and those in focused practice using remuneration codes. We assessed differences using chi-square and Wilcoxon rank-sum tests, and performed unadjusted logistic regression to determine factors associated with certification or focused practice.

Results: 242 of 14,123 family physicians had evidence of 'Care of the Elderly' certification or focused practice. These providers mainly practiced in team-based models and often participated in comprehensive practice. A greater likelihood of 'Care of the Elderly' certification or focused practice was associated with female providers, practicing in larger communities, graduating from a Canadian medical school, greater community-level residential instability, exhibiting a focused practice type, and increasingly caring for older patients.

Conclusions: Family physicians with additional training or focused practice comprise a small group of providers who contribute to comprehensive primary care. Their expertise can be leveraged through leadership and scholarship to increase geriatric competence among other providers who will increasingly deliver care to aging populations.

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How can optimal communication enhance intersectoral collaborative communication between primary care providers and community mental health workers? Preliminary results.

Stefaniia Martsynkevych, Faye Mishna, Rachelle Ashcroft
Background: The success of integrating mental health services into primary care is improved by a collaborative model that includes community mental health resources. Effective collaborative care relies on optimal communication between primary care providers (PCPs) and community mental health workers (CMHWs). To date, CMHWs have been underutilized as a source of crucial insights for improving collaboration between community mental health and primary care. The current study aims to explore what constitutes optimal communication from the perspectives of CMHWs when collaborating with PCPs.

Approach: We conducted an exploratory qualitative study using semi-structured interviews for data collection. Eight participants who represented CMHWs shared their perspectives on what they considered optimal communication with PCPs. Participants also shared their perspectives on the barriers preventing effective communication and their recommendations for overcoming these challenges.

Results: Based on preliminary analysis, four themes emerged including: i) role of administrative staff, ii) building trusting relationships, iii) variations of communication approaches, and iv) differences in interpretation and operationalizing of provincial privacy policy. Communication approaches vary depending on the CMHW's role, yet all participants concur that effective collaboration positively impacts patients' mental well-being. Preliminary findings suggest that while it is crucial for PCPs to comprehend community programs, challenges such as limited access to PCPs and inadequate follow-ups present significant barriers.

Conclusions: Addressing barriers to collaboration can strengthen the mental health system and improve patient outcomes. Developing mutual understanding of policies and effective communication with CMHWs can build trust, enhance partnerships, and improve workflow.

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The push and pull of the locum trajectory

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Background: Locums have addressed some of the workforce shortfall in Family Medicine in several countries, including Canada. We sought to explore the factors influencing early career family FPs decision-making process to serve or not serve as a locum.

Approach: Constructivist Grounded Theory study using in-depth interviews via Zoom, with individual and team analysis. Thirty-eight FPs practicing in Ontario, who completed their training between 2017 – 2022 were interviewed. Results: 9 participants were currently working as a locum, 14 had done locums prior to establishing a practice, and 15 did not report locuming, committing to a practice right after graduation. Participants were pulled towards doing locums because they offered opportunities to experience different practice styles and locations, allowed scheduling flexibility, and were viewed as a potential way to enhance work-life balance. Other prominent attractions included the availability of locums and the opportunity to provide needed coverage for their colleagues. Factors pushing participants away from deciding to locum were the inability to provide continuity of care for patients, limited autonomy in altering established clinic protocols, and financial instability. In addition to the pull-push factors influencing their decision-making process, we observed a specific trajectory shared by 14 participants who had initially been drawn to doing a locum following graduation to now having established their own practice. Conclusions: Findings suggest that several push and pull factors influence the decision to do locums following graduation. Understanding early career FPs decision-making process to do locums can assist health care organizations and policymakers working to address FP shortages.

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Health promotion activities in Ontario Community Health Centres

Sara Bhatti, Jennifer Rayner

Background: The Alliance for Healthier Communities (Alliance) is a membership of comprehensive primary healthcare organizations across Ontario including Community Health Centres (CHCs). CHCs provide health promotion as part of their model of care. In 2022, the Alliance embarked on a research project to describe what health promotion looks like in CHCs (aim 1) and to measure the impact of health promotion across our sector (aim 2). Within CHCs, health promotion activities are recorded as Personal Development Groups (PDGs) in the electronic medical record (EMR).

Approach: For aim 1, we created an inventory of all PDGs reported in our EMR in 2021-2022 with additional information on target populations, partnerships, funding sources and evaluation. Focus groups were conducted with over 70 health promotion staff from over 40 CHCs. Participants were asked to share their perspectives on what health promotion looks like in their settings, how they identify program priority.

Results: Over 2500 PDGs were recorded in 2021/22 with the top three priorities for programming being social support, food security and physical activity. Most PDGs were ministry funded, done in partnerships, and evaluated. Priorities were determined using a variety of methods including internal and external data, centre strategic directions, community feedback and needs assessments, stakeholder analysis, etc. Programs are designed to be low-barrier, culturally safe, and inclusive. Conclusions: CHCs provide a model for health promotion programming that ensure programs address the needs of their communities, promote health equity, support volunteers to lead programs, and link primary care with health promotion.

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Enabling pathways to Flourish – Improving service provider knowledge to strengthen support for female genital mutilation/cutting survivors

Tomilola John

Background: Female genital mutilation/cutting (FGM/C) is a harmful practice and human rights violation impacting over 200 million women globally, with an estimated 100,000 survivors in Canada. Healthcare providers play a crucial role in ensuring that survivors receive adequate care that addresses the long-term physical and mental health consequences, yet many lack training to support survivors effectively. To address this gap, the Society of Obstetricians and Gynaecologists Canada (SOGC) encourages its members to strengthen their knowledge and understanding of FGM/C.

Approach: WHIWH CHC implemented an 18-month collaborative project using a community-based participatory approach to raise awareness and implement a service provider framework that applies gender equity, trauma-informed, and culturally sensitive and safe care strategies to strengthen support for women and girls living with or at risk of FGM/C. In partnership with RHCforFGC Gender-Net Plus, we conducted four workshops (n=80), one Facebook Live event (n=40), and two university guest lectures (n=80) to build the capacity of over healthcare and community service providers.

Results: Participants gained valuable insights into FGM/C and a better understanding of providing equitable, quality care in the socio-cultural contexts of experiences related to the practice. In evaluation surveys, 85.71% of respondents expressed satisfaction with the workshops, 86.11% found the knowledge gained to be valuable, and 55.26% intended to apply their newfound insights to enhance their work.

Conclusions: This initiative demonstrates the importance of training healthcare providers to strengthen informed, compassionate care and supportive environments, laying down a foundation for sustainable change by building capacity, raising awareness, and fostering collaboration.

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Developing guidance for facilitating retention of the team-based primary healthcare workforce in Canada: A multimethod approach

Peter Sheffield, Rachele Ashcroft

Background: Increasing turnover rates of team-based primary healthcare (PHC) providers are exacerbating Canada's healthcare provider shortage and harming care continuity. However, guidance on policies and practices that do so in the PHC setting is limited. Understanding current best-practice guidance, developing consensus about facilitating retention from Canadian PHC experts, and examining the practices of high-retention PHC teams are required for developing best-practice guidance. The central question guiding this multi-method study is "What policies and practices may facilitate the retention of Canadian PHC teams?"

Approach: Ongoing multi-method study: i) Document analysis of Government of Canada-supported Psychological Health And Safety Toolkit For Primary Care [N = 87 English-language resources, n = 928 documents] to identify existing guidance ii) Delphi study with [N = 40 target] PHC experts for consensus on "What should a) primary healthcare organizations and b) provincial/territorial governments do to retain team-based PHC providers?", iii) individual interviews [N = 40 target] with providers at higher-retention (≥ 5 years median IHP time-in-role) and lower-retention (< 5 years) PHC teams in Ontario about organizational facilitators of retention. Results: i) quantitative content analysis using emergently-generated coding highlighting strengths/weaknesses in existing pan-Canadian guidance; ii) pan-Canadian Delphi-generated guidance for practices and policies for retaining providers will be provided to policymakers, researchers, and clinicians to facilitate change initiatives, iii) thematic analysis of individual provider interviews will enable dissemination of existing practices of PHC organizations and comparison with documented/Delphi-generated practices. Conclusions: Our findings will provide Canadian-specific guidance for provider retention in PHC that could inform retention efforts internationally.

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Don't tell me what you think I don't know: A tested protocol for building mental health and social care in Family Health Teams

Rebecca Bliss, Rachele Ashcroft

Background: As Primary Care is often the "first point of contact for individuals experiencing mental health difficulties" (Ashcroft, 2021), there is an occasion, responsibility, and direction to address health inequities, strategic direction, and standardization of mental health and social care in the primary care setting (Ashcroft, 2021, Ontario Health Business Plan 2022-23). While ambitious models across the country are currently in practice, there is a need for improved measurement and population health focus within these models and formulas (Aggarwal & Hutchinson, 2013; Jesmin et al., 2012; McLeod et al., 2016). It is time for family health teams to build programs that address and integrate the swells of data and evidence that are now available in strong partnership with the patient voice. This study attempts to build and test a patient, provider, and community-partnered protocol for family health teams to build their own integrated psychosocial programs informed by clinical evidence, population data, and practice-specific provider and patient input.

Approach: The goal of the study is to identify, develop and test an evidence-informed, patient and community partnered protocol to build and adapt psychosocial programs in FHTs.

Study Design and Analysis: 1) Literature review and Delphi study of current health systems and clinical participatory research and program planning methods and applications. 2) Qualitative interviews, both individual and multiple focus groups with patients, providers and community members in selected postal code. 3) Analysis and collaborative knowledge translation and mobilization of partnered protocol within the Hamilton Family Health Team.

Results and Conclusions: As the study is still in progress, results are not yet available. The expected outcome of the study would offer a tested, co-created, equitable and inclusive study and program design for psychosocial care applicable and adaptable to any Family Health Team Setting.

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Social prescribing for better mental health project

Natasha Beaudin, Josephine Pham, Samantha Chater

Background: In 2022, to support people whose mental health was most affected by the COVID-19 pandemic, Public Health Agency of Canada granted \$3.7 million to the Alliance for Healthier Communities to spread and scale up social prescribing across Ontario. Social prescribing connects people with non-clinical programs and services through the familiar process of a written prescription from a health care provider to address diverse determinants of health. In partnership with Ontario 211 – Community Connections, Social Prescribing for Better Mental Health (SPBMH) was an 18-month project that provided training and resources to 28 Community Health Centres (CHCs), and an additional 13 centres who joined a Scale and Spread Learning Collaborative, to support their implementation of social prescribing.

Approach: The SPBMH project had five key objectives: train service providers to implement social prescribing with a health equity lens; identify individuals at risk of poor mental health; navigate individuals to the most appropriate services; co-design locally responsive mental health promotion/illness prevention programs; and iteratively evaluate lessons learned. Eighty service providers were engaged during monthly coaching meetings with each CHC, and 2,935 clients were reached across all project activities.

Results: Key impacts included: 90% of participants reported improved wellbeing after attending community programs, 84% of health care professionals and providers agreed that SP helps address clients' complex needs.

Conclusions: Building on learnings from SPBMH and the Alliance's previous SP work, a health equity-focused online training for SP was designed for health care teams interested in implementing their own SP initiatives (<https://www.allianceon.org/Social-Prescribing-Online-Course>).

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The implementation of infection prevention and control procedures in primary care during the COVID-19 pandemic: A qualitative study of nursing roles

Leslie Meredith, Samina Idrees, Maria Mathews, Lindsay Hedden, Julia Lukewich, Emily Gard Marshall, Kelly Kean, Rhiannon Lyons, Jamie Wickett, Dana Ryan, Sarah Spencer, Emilie Dufour, Paul Gill

Background: During the COVID-19 pandemic, existing infection prevention and control (IPAC) guidelines focused primarily on acute care facilities, leaving primary care practices poorly supported. A lack of personal protective equipment provision limited the capacity of primary care to provide in-person services. Nurses play an integral role in implementing IPAC procedures and providing primary care during a health crisis; however, there is limited literature in this area.

Approach: We conducted semi-structured interviews with primary care nurses across four Canadian regions: British Columbia, Ontario, Nova Scotia, and Newfoundland and Labrador. We asked participants to describe the roles they enacted during different pandemic stages, facilitators/challenges encountered, and potential roles that nurses could have played. We employed a thematic analysis approach and analyzed themes relevant to the implementation of IPAC.

Results: We interviewed 76 nurses across the four regions and identified two overarching themes: 1) nurse-led clinic transformation, and 2) workload changes. Primary care nurses developed and implemented IPAC policies, educated staff, and made critical decisions about patient care, often out of necessity and ahead of regional guidelines. Additionally, nurses adapted workflows, managed supplies, and balanced in-person and virtual care to protect both patients and staff from COVID-19 exposure.

Conclusion: Despite additional responsibilities and challenges faced due to evolving guidelines, nurses' IPAC efforts were pivotal in maintaining primary care clinic operations during the pandemic. Findings demonstrate the need for better pandemic planning to support primary care including creating IPAC guidance documents suitable for primary care settings and informed by COVID-19 pandemic experiences.

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Physician commitment in long-term care practice: Canadian and global perspectives

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Background: The delivery of medical care by primary care providers (PCPS) in long-term care (LTC) homes is characterized by notable inconsistencies. PCP commitment encompasses factors such as the proportion of their practice dedicated to LTC, the number of residents under their care, and the time allocated to individual resident encounters. This study aimed to examine existing models and standards for PCP commitment in Canada and internationally.

Approach: We performed a comprehensive literature review of PCP commitment models across Canada's 13 provinces and territories, alongside fifteen other OECD countries with above-average LTC spending. The review focused on international policy documents, government reports, scholarly works, and other official ministerial or jurisdictional documents. Data were extracted and categorized according to the model of care, service provision, and the financing and remuneration of PCP services.

Results: A paucity of evidence was found pertaining to standards for PCP commitment in Canada and internationally. No Canadian standards were identified, with most information from provinces and territories pertaining to remuneration. Internationally, the United States was the only country to address all dimensions of PCP commitment. Data from other countries were either incomplete, or entirely absent, limiting a robust understanding of existing global practices.

Conclusions: There is a scarcity of regulatory frameworks governing the provision of PCP commitment in Canada and globally, resulting in inconsistencies in how care is delivered, financed, and managed in the LTC home setting. This underscores the need for consensus-building studies to establish a unified definition of PCP commitment.

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Care coordination between family physicians and palliative care physicians for patients with cancer: Results of a quality improvement initiative

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Purpose: At our institution's cancer palliative care (PC) clinic, new referrals from oncologists were scheduled for consultation and ongoing follow-up by PC physicians without input from the patients' family physicians (FPs). FPs reported that they felt out of the loop. We implemented a quality improvement (QI) initiative aimed at systematically facilitating care coordination between FPs and PC physicians.

Methods: A coordination toolkit was sent from the PC physician to the FP whenever the PC physician received a consultation request from an oncologist. The toolkit included an introduction to the PC physician team; an opportunity for the FP to choose how best to collaborate with PC physicians to meet the patient's PC needs; and contact information for access to 24/7 PC physician support. Responses from FPs regarding their preferred level of engagement with PC determined further care planning in the clinic. We measured feasibility, response rate, and qualitative surveys of FPs about the usefulness of the intervention.

Results: Two hundred fourteen new consultations were eligible for a standardized letter over the 6-month implementation period. Feasibility for sending the toolkit was 90.0% and response rate for collaborative care preference from FPs was 86.0%, with median response time of 3-4 days. 78.9% of FPs indicated they would prefer ongoing consultative care by the PC physician, while 18.6% indicated that PC physician consultation was not needed, or that the FP would provide primary PC after a one-time PC physician consultation.

Conclusion: We successfully implemented a QI initiative to improve care coordination between FPs and PC physicians for patients with cancer. The coordination toolkit can protect the patient-FP primary PC relationship and optimize specialist PC resource utilization for complex patients.

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Minor Ailments and pharmacist management in Ontario, Canada: Attachment and primary care in 2023

Paul Nguyen, Lisa Dolovich, Eliot Frymire, Rick Glazier, Kamila Premji, Mina Tadrous, Liisa Jaakkimainen, Tara Kiran, Lynn Roberts, Michael E Green

Background: Minor ailments (MA) are health conditions that can be managed with minimal prescribed treatment and/or self-care strategies. In Ontario, Canada, pharmacists were given authority to deliver service for 13 MAs on January 1, 2023, with an additional 6 MAs on October 1, 2023. This study aims to identify patterns of specific MA services, and describe the relationship of MA service recipients and primary care providers.

Approach: This cross-sectional cohort study used linked health administrative data, including pharmacist billing for MA services, patient demographics, and physician and hospital billing data, collected for 15.6 million residents in Ontario. Logistic regression was used to analyze the delivery of specific MA services prescribed from January 1 to December 31, 2023 with primary care attachment.

Results: In 2023, 547,673 (3.6%) Ontario residents received at least one MA service, with the top 5 services being urinary tract infections (199,282 [36.4%]), conjunctivitis (153,021 [27.9%]), herpes labialis (46,659 [8.5%]), allergic rhinitis (41,521 [7.6%]), and dermatitis (39,365 [7.2%]). Compared to all Ontario residents, MA service recipients were more likely to be attached to a primary care provider (91.3% vs. 84.7%), and have higher incomes (highest income quintile, 23.1% vs. 20.1%) and comorbidity (17.5% vs. 9.7%). In the adjusted logistic regression analyses, receipt of any MA service was significantly associated with primary care attachment (odds ratio [95% confidence interval]: 1.39 [1.37-1.40]).

Conclusion: This study provides insight into early users of this program and enables further understanding of patterns of practice for pharmacists and other primary care providers.

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Diabetes Self-management Coaching in the primary care: Lessons learned for the Ontario context

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Background: Diabetes mellitus has emerged as a leading global public health problem and has affected more than half a billion people. It is the major cause of morbidity, disability, and mortality globally. However, delivering ongoing, client-centered, and evidence-based self-management support remains a significant challenge for healthcare providers and primary care in low- and middle-income countries. Health coaching is an emerging and effective self-management support strategy that plays a pivotal role in enhancing self-efficacy, self-care activities, and quality of life for individuals with type 2 diabetes. This study aimed to examine the impact of diabetes self-management coaching on self-efficacy, self-care activities, and quality of life.

Approach: The study employed a parallel group single-blinded pilot RCT design using a block randomization technique. An external researcher prepared an opaque sealed envelope to conceal group allocation. The study applied six group-based and four individual home-based coaching sessions followed by a brief family orientation. Descriptive methods and student t-tests were used to analyze the data.

Results: A statistically significant difference was observed both within and between groups in diabetes self-efficacy and self-care activities after three months of follow-up. Notable improvements were seen in diet, exercise, medication adherence, and foot care. However, there was no significant change in participants' quality of life.

Conclusion: The diabetes self-management coaching program has positively impacted the behavioral outcomes of individuals with type 2 diabetes in primary care. Therefore, it is crucial to provide effective self-management support. We recommend conducting large-scale, multi-center interventional studies to influence policy and clinical practice.

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Physical multimorbidity among treatment-seeking smokers and its association with quit outcomes in a large publicly funded smoking cessation program

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Background: The prevalence of multimorbidity (MM) has been increasing globally. Smoking is a well-documented risk factor for a variety of health conditions. Patients with MM are a uniquely vulnerable population who face significant barriers to smoking cessation. There is sparse literature on the topic of smoking cessation in patients with MM. This study aims to 1) compare the 6-month quit outcomes among treatment-seeking smokers with physical MM relative to healthy peers and those with a single condition 2) assess whether the presence of mental illness moderates this association.

Approach: We analyzed a sample of 129,444 patients enrolled in a publicly funded smoking cessation program in Ontario, Canada. Patients were classified by the number of physical health conditions they self-reported. The primary outcome was smoking abstinence at 6-month follow-up measured as 7-day point prevalence. We examined the association between MM and quit outcomes using a mixed-effects logistic regression model.

Results: Patients with MM were older, less educated, had greater unemployment, and were more likely to be obese than healthy peers. They showed greater nicotine dependence and despite having a higher motivation to quit, and having made more lifetime quit attempts than healthy peers, had lower odds of smoking abstinence. The presence of a mental health condition predicted continued smoking more strongly among people with MM. Conclusion. The presence of medical comorbidities, particularly if clustered, is associated with reduced odds of successful smoking cessation. This group may benefit from more intensive cessation support clinically and through actionable policy.

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Navigating invisibility: the experience of adults with disabilities in accessing primary healthcare in conflict-affected Ethiopia (ongoing research)

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Background. Conflict and instability exacerbate the existing vulnerabilities of adults with disabilities (AwDs) and create new barriers to accessing primary healthcare (PHC). In Ethiopia, ongoing crises—including the war in the north and widespread unrest—have severely disrupted the PHC system. However, there is limited evidence on how these crises have specifically impacted AwDs' access to healthcare. This study, part of an ongoing dissertation, investigates the experiences of AwDs in southern and central Ethiopia, regions affected by either direct rebel operations or the indirect systemic consequences of prolonged instability.

Approach. Using a constructivist grounded theory approach, I conducted interviews with 37 AwDs and 33 key actors—caregivers, policy makers, PHC leaders and providers—to understand access to PHC within broader social and institutional contexts. Data from all sources were constantly compared to one another to build themes.

Results. As attention shifts to broader humanitarian crises and service provision capacities are stretched thin by prolonged instability, the conflict has introduced a new set of barriers to PHC access for AwDs. This includes, "funding migration," shifting political priorities, rising security risks, and disintegrating social networks. These factors have fostered a sense of invisibility and helplessness among AwDs, leading to adverse and avoidable health outcomes, decreased health seeking behaviours (only in emergencies) and an overall declining trust in PHC services.

Conclusions: These findings offer a rich context to understand PHC access in Ethiopia and preliminary results highlight that "conflict resilience" is a critical dimension of access to PHC in conflict-prone areas.

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Predictors and outcomes of heart failure diagnosis in the community compared to acute care settings: Insights from linked administrative health databases

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Background: Heart failure (HF) diagnosis is associated with worse outcomes when made in acute care settings (emergency department (ED) or during hospital admissions) compared to ambulatory care settings (the community), but little is known about this in Canada which has a comprehensive primary care system. We aim to evaluate the rate, predictors, and outcomes of HF diagnosis when made in acute care settings compared to the community in Ontario.

Approach: This is a retrospective cohort study utilizing administrative databases of HF in Ontario, Canada from 2010 to 2022. We estimated HF diagnosis rates in each setting, patient/provider characteristics, and clinical outcomes.

Results: 597,025 patients had new HF diagnosis; 37% were in acute care settings (Table 1). Patients without a primary care provider (PCP), those with lower income, and with multiple comorbidities were more likely to be diagnosed in acute care settings ($p < 0.0001$). Those diagnosed in acute care settings had an increased risk of all-cause mortality, hospital admissions for HF, and ED visits for HF (rate ratios: 1.82 [1.80, 1.83]; 2.80 [2.75, 2.85]; 2.68 [2.61, 2.75], respectively; adjusted for age, sex, and comorbidities).

Conclusion: Over a third of HF diagnoses in Ontario occur in acute care settings, particularly in comorbid patients of lower socioeconomic status and those without a PCP. This was associated with increased mortality and admissions. The findings highlight the important role of primary care in diagnosis and management of HF.

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Evaluating the impact of a yoga therapy program for residents, family members and staff in Long-Term Care

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Background: The Sunnybrook Veterans Centre (VC) introduced a yoga therapy program for residents to support independence, increase mobility, reduce falls, and improve mood and quality of life. Programs were also offered to family members and staff to alleviate stress and promote well-being.

Primary objective: to evaluate the impact of yoga therapy at the VC. Secondary objective: to provide direction for establishing yoga therapy programs in LTC. Approach: We used mixed methods to evaluate the program's impact on residents who participated in weekly classes. Median Minimum Data Set (MDS) scores of regular resident participants (n=31) were compared longitudinally with median scores of non-participants (n=84) over three time periods (0, 6, 12 mos). We analyzed scores of nine domains including Cognitive Performance Scale (CPS), Depression Rating Scale (DRS), Pain Scale, and ADL Self-Performance Hierarchy Scale (ADL-Self) We also conducted three focus groups (FGs) with residents (n=20) and a FG (n=3) and interviews (n=2) with staff members.

To evaluate family member program, we administered an online survey (n=3). To evaluate staff program, we conducted a FG (n=6).

Results: Residents: mean participant scores for CPS, DRS, Pain, Scale and ADL-Self statistically significant improvements for participants after 6 and 12 mos compared to non-participants. Themes: meaningfulness, improved physical and mental health, independence, social connection, program elements. Family member and staff themes: stress reduction, improved well-being, self-care, positive outlook, increased productivity (staff).

Conclusions: Yoga therapy programs for residents, staff and family members illustrated the holistic impact of yoga therapy in LTC. Results provide rationale and guidance for decision-makers to consider implementing yoga therapy programs.

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Charting new territories: Mapping patient partner roles in primary health care design, research, education, and delivery

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Background: Primary health care (PHC) is a whole-society approach to health and well-being that provides long-term, person-focused, comprehensive, and coordinated care to patients across their lifespan. To support a PHC system that addresses the needs and aligns with the priorities of Canadians, patients and caregivers must be meaningfully involved in PHC research. Patient engagement is more commonly integrated in PHC care delivery, but integration of patient expertise in other aspects of PHC care delivery and policy decisions, education, and research is less common. The aim of this study was to understand how patient partners can best support PHC design, research, education, and delivery.

Approach: A patient advisory board was engaged in the planning and implementation of the study. Group concept mapping, a participatory mixed methods research design with multivariate statistical analyses, was utilized. Concept mapping involved brainstorming, sorting, and rating ideas about how patient partners can be meaningfully engaged in PHC. The study involved Canadian PHC patients, caregivers, researchers, healthcare providers, policymakers, and trainees.

Results: Participants (n = 45-52/stage) identified the most important and feasible ways patient partners can be engaged in PHC design, research, education, and delivery. These included raising awareness about the roles and value of patient partners, advocating for a shared electronic health record, and promoting meaningful patient partnerships and diverse voices. Engaging patient partners in PHC policy, governance, and practice settings was identified as important but difficult to enact.

Conclusions: Patient partners can play diverse roles in supporting a PHC system informed by patients' priorities.

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Use of dementia risk assessment in community paramedicine (CP) programming: An observational study of CP@clinic and CP@home

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Background: Early detection of dementia risk is crucial for timely intervention and management. This cross-sectional study investigated how the evidence-based Community Paramedicine at Clinic (CP@clinic) and Community Paramedicine at Home (CP@home) programs are used to assess risk of potential dementia in community settings. The objective was to assess setting-related differences in dementia risk rates and associated factors using dementia risk assessments.

Approach: Data from 385 adults who participated in the CP@clinic or CP@home programs was analyzed. Statistical analyses included descriptive statistics, chi-squared tests, t-tests, and logistic regression to explore associations between potential cognitive impairment and associated risk factors including demographic variables, chronic disease history, and mental health assessments.

Results: 151 CP@clinic and 144 CP@home participants were assessed for risk of cognitive impairment using the Mini-Cog tool. As expected, these groups were significantly different ($p < 0.05$) in mean age (74.2 vs 78.5 years), living alone status (75.74% vs 43.54%), and mean number of chronic conditions (1.60 vs 2.42). However, there were no significant differences in dementia risk rates between the CP@clinic (18.54%) and CP@home programs (20.14%) ($p=0.8419$).

Conclusion: Despite population differences between the CP@clinic and CP@home programs, rates of dementia risk were similar and high in both programs, which may be attributable to selective assessment practices by paramedics. This study highlights the value of including dementia risk assessments within community-based health initiatives, such as CP@clinic that may detect the risk of dementia in 1 in 5 people and direct them towards treatment or appropriate safety management.

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Changes in cervical cancer screening during the pandemic: an international comparative study by INTRePID focusing on South American countries

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Background: Cervical cancer is the fourth most common cancer in women worldwide, with mortality rates in Latin America three times higher than in North America due to limited access to early detection. Previous INTRePID research showed a decline in cervical cancer screenings during the COVID-19 pandemic in Australia, Canada, the U.S., and Norway, with varying recoveries. This study expands the analysis to Argentina, Brazil, Chile, and Peru. Approach: Negative binomial regression was used to compare observed versus predicted screening visits during the pandemic (April 2020 to December 2021), with January 2018 to February 2020 as the baseline. In Chile, due to biannual data, a linear regression model estimated monthly screening visits. Results were expressed as percentage changes with 99% confidence intervals.

Results: In Argentina, cervical cancer screening visits dropped significantly in the first six months of the pandemic, ranging from -82.8% (99%CI: -52.4%, -93.8%) to -92.4% (99%CI: -80.3%, -97.1%), but recovered in subsequent months. Brazil saw declines between -32.6% (99%CI: -16.8%, -45.4%) and -95.2% (99%CI: -94.4%, -96%) early on, with screening surpassing pre-pandemic levels by late 2021. Chile experienced decreases from -34.0% (99%CI: -15.7%, -45.8%) to -81.5% (99%CI: -75.7%, -85.1%) in the first year, followed by recovery. Peru showed a consistent decline throughout the pandemic, dropping between -47.4% (99%CI: -1.1%, -70.2%) and -94.2% (99%CI: -75.7%, -85.1%).

Conclusion: This study highlights the resilience of Argentina, Brazil, and Chile in recovering cervical cancer screening within the first year of the COVID-19 pandemic. However, Peru faced ongoing challenges, emphasizing the urgent need to restore screening programs to reduce the long-term impact of cervical cancer in the region.

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Neighbourhood building blocks: Regional attachment strategies for primary care

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Background: Primary care is facing a growing crisis, with 2.3 million individuals in Ontario without access to a family physician and only a quarter having access to an interprofessional primary care team. Ontarians have identified that creative solutions are needed to solve this issue and some have called for an automatic rostering system by neighborhoods, similar to the public school system. To conceptualize the impact of automatic rostering, we need to build neighbourhood models and understand the health needs and health utilization patterns of these neighbourhoods.

Approach: This project will make use of modified versions of the Aggregated Dissemination Areas (ADAs) located within the assumed geographical region served by the Frontenac Lennox and Addington Ontario Health Teams (FLA OHT) to develop a descriptive analysis of the sociodemographic characteristics, health utilization and primary care enrolment models by neighbourhood.

Results: The results of this project will describe approaches to developing neighbourhood models for Ontario Health Teams, and provide neighbourhood-level profiles of sociodemographic characteristics, health needs, health care utilization, access to primary care including distance to nearest primary care physician and team and proportion of individuals attached to team-based model of primary care.

Conclusions: Neighbourhood approaches offer a compelling solution to support attachment to primary care. The study will provide an important step by building and applying a neighbourhood model that can be used by policy and decision makers to support primary care planning.

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Focused practice trends in Ontario, Canada: A population-level study spanning 1993/94 to 2021/22

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Background: An adequate supply of family physicians who deliver comprehensive care is critical for addressing evolving population health needs, fostering health equity and ensuring a cost-effective health system. Little is known about current jurisdiction-wide trends in family physicians choosing focused practice, and concurrent changes in comprehensive family physician numbers in relation to population growth.

Approach: We conducted a repeated cross-sectional population-based study using administrative data to understand sex-stratified trends in focused practice between 1993/94 - 2021/22 in Ontario, Canada, accounting for population growth. For each year, we identified all active family physicians and classified them by practice type leveraging a previously published algorithm on comprehensiveness.

Results: The proportion of family physicians in focused practice increased from 7.7% (n=856/11,103) in 1993/94 to 19.2% (n=3351/17,413) in 2021/22. The three most prevalent focused practice types in 2021/22 were emergency (37.0%), hospitalist (26.5%), and addictions (8.3%) medicine. A greater proportion of focused practice physicians were male (60.1% vs 39.9% in 2021/22). The total number of family physicians per capita increased from 104 to 118 per 100,000; however, the number of comprehensive family physicians per capita decreased from 71 to 64 per 100,000. Of the additional 6310 family physicians who entered the workforce, 39.5%(n=2495/6310) were in focused practice.

Conclusions: Over the study period, there was a substantial increase in family physicians working in focused practice, particularly emergency and hospitalist medicine, and a decrease in comprehensive family physicians per capita. Research and policy work is needed to understand and address the complex factors driving these trends.

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Have pulmonary function testing rates recovered after the COVID-19 pandemic?

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Background: Pulmonary Function Tests (PFTs) are critical in diagnosing and managing respiratory conditions such as chronic obstructive pulmonary disease, asthma, and interstitial lung disease. However, because PFTs generate aerosols, their use was restricted in laboratories and primary care medical offices during the pandemic to prevent the spread of the virus. We aimed to determine whether PFT capacity in Ontario had returned to pre-pandemic levels overall and across different demographic groups.

Approach: We conducted a population-based cohort study of PFT use in individuals aged 7 and older from 2015 to 2023 in Ontario, Canada, using provincial health administrative data. Incidence Rate Ratios were used to compare observed PFT rates to rates that would have been expected if the pandemic had never occurred to assess whether PFT capacity returned to pre-pandemic levels. Subgroup analyses were conducted across various demographic characteristics.

Results: 2,683,844 persons received at least one PFT during the study period. As of December 2023, PFT rates had not fully recovered (IRR 0.73, 95%CI 0.63–0.87). Recovery was lower in males (IRR 0.72, 95%CI 0.62–0.86), those aged 18–65 (IRR 0.68, 95%CI 0.59–0.82), urban residents (IRR 0.72, 95%CI 0.62–0.86), and individuals of lower socioeconomic status (IRR 0.68, 95%CI 0.59–0.81).

Conclusions: More than 1.5 years after the end of the public health restrictions, PFT rates had still not recovered to pre-pandemic levels in Ontario, with certain groups being more affected than others. This indicates possible worse quality of care and increased health disparities for people with respiratory disease.

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Reflections on implementing promising practices for improving cultural safety and accessibility of mainstream healthcare institutions for Indigenous patients in Southeastern Ontario

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Background: Numerous obstacles exist for culturally safe and accessible healthcare for Indigenous patients. Following completion of a scoping literature review on promising practices to improve cultural safety and accessibility of mainstream health systems for Indigenous patients, we sought perspectives of key parties on barriers, facilitators, recommendations, and supports needed to implement these promising practices in mainstream healthcare settings in southeastern Ontario.

Approach: Focus groups with key leaders in health services and health policy within a mainstream healthcare system in southeastern Ontario. Results: Major themes for barriers and facilitators were identified and categorized into macro-level (related to organizational policy), meso-level (related to local services), and micro-level (related to individuals within services/systems, such as healthcare providers and other staff). Key barriers included: lack of organizational accountability, leading to a priorities problem and a consequent lack of resources; siloed and episodic efforts; individuals or microsystems being tasked with majority of the workload, leading to staff burnout and turnover; and, individual-level implicit biases, fears, and anxieties. Key facilitators included: increased organizational commitment to projects, hiring more Indigenous peoples, and revamping standard operating procedures; seeking and acting on perspectives of Indigenous peoples and patients; and, at the individual-level, building relationships, being human, and taking accountability for one's own learning. Conclusion: A multi-pronged approach is required across macro-, meso-, and micro- levels in health services, systems, and policy. Top-down action, commitment, and accountability are vital. Mainstream governments and healthcare systems must work collaboratively with Indigenous peoples to help to reduce health inequities.

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SPIDER: A structured approach to quality improvement and deprescribing in older patients; Preliminary results of the RCT

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Background: One quarter of Canadians aged 65 years or older are prescribed ten or more different medications. The Structured Process Informed by Data, Evidence and Research (SPIDER) approach has been applied to deprescribing in primary care for patients over 65 years experiencing polypharmacy.

Approach: Participants: Primary care providers and their practice teams; patients in those practices, aged 65 years or older and on at least ten different medication classes prescribed in the past year.

This is a randomized controlled trial comparing the SPIDER approach to usual care. The intervention, lasting a year, includes participation in Quality improvement (QI) activities and learning collaboratives; support through a QI coach and validated EMR data reports for audit and feedback. We measure changes in potentially inappropriate prescriptions (PIPs) among eligible patients in SPIDER, using EMR data. Secondary outcomes include the proportion of patients on no PIPs, and patient and provider experiences obtained through surveys and interviews.

Results: Preliminary data for 4,120 patients in the practices of 108 primary care providers that participate in 3 Practice Based Research Networks (PBRNs).

PIPs decreased by 12% in the control arm and 13.3% in the intervention arm (NS). By the end of the trial, 9.5% more patients were on no PIPs in the control arm and 10.3% in the intervention arm.

Conclusion: There were reductions in PIPs in both groups, possibly reflecting secular trends or pandemic-related improvements in prescribing. Further analyses are underway. QI tools and processes derived from this work can support future QI activities.

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The state of art Canadian Primary Health Care researcher's scientific productivity for 40 years

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Background: This study aims to evaluate the contribution of Canadian Primary Health Care (PHC) experts to the relevant literature over a 40-year period, to compare their productivity in this area with that of other countries, and to identify the key topics that Canadian researchers have focused on within this domain.

Approach: In this study, documents produced in the field of PHC affiliated with Canadian institutions were analyzed using bibliometric methods, utilizing the Web of Science database on 02/09/2024. Additionally, topic modeling using Latent Dirichlet Allocation was performed for content analysis of the obtained articles. Bibliometric analyses were conducted using Vosviewer, Biblioshiny, and Microsoft Power BI. For machine learning applications, Python libraries such as Scikit-learn, Gensim, and Wordcloud were employed. The types of analyses used in this study included co-authorship analyses; co-occurrence analyses of author keywords; citation and co-citation analyses; as well as various text analyses for author keywords, titles, keywords plus, and abstracts.

Results: Canada ranks as one of the three most productive countries in the field of PHC research, with its universities occupying leading positions in this domain. Particularly in recent years, Canadian researchers have intensely focused on topics such as influenza, COVID-19, young adults, social determinants, social accountability, access to care, delivery of health care, multimorbidity, clinical practice guidelines, and telemedicine.

Conclusions: Canada is one of the key countries influencing and contributing to the development of PHC research. Our study has highlighted Canada's impact on the PHC field by examining its scientific productivity over the past forty years.

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MAiDHouse: a qualitative study on structured community-based support for grief and bereavement

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Background: MAiDHouse is a national non-profit organization that provides a comfortable setting for those eligible to receive medical assistance in dying (MAiD). MAiDHouse's additional supports before, during and following provision may affect grief and bereavement for family and friends in a variety of ways. The goal of this qualitative study was to understand how MAiDHouse's services shape the experience of grief and bereavement.

Approach: We invited primary contacts of individuals who received MAiD at MAiDHouse within a 12-month period to participate. Thirteen participants completed semi-structured interviews over Zoom. An interdisciplinary research group created a codebook after review of the transcripts. Each transcript was coded in duplicate and then analyzed with the qualitative software MaxQDA . We developed themes deductively based on a previously developed framework, as well as inductively based on the data.

Results: Participants' perceptions of MAiDHouse's grief and bereavement supports ranged from net neutral to positive. During the MAiD process, there are many sources of confusion with regards to MAiD access, provider responsibilities, and organizational roles, all of which can affect future bereavement. Participants expressed appreciation for MAiDHouse due to responsiveness of staff, personalized and attentive communication, and facilitation of logistics which in turn shaped the grief experience.

Conclusions: Our study explored the lived experiences of family and friends of individuals who received MAiD at MAiDHouse. Participants generally acknowledged that MAiDHouse's role in their bereavement journey exceeded beyond providing a physical location. MAiDHouse was perceived to be an easily accessible community resource to address multiple factors surrounding grief and bereavement.

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Youth crystal methamphetamine contingency management outcomes & lived-experiences in KFL&A: A mixed methods investigation

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BACKGROUND: In response to the increasing crystal methamphetamine use among youth in the Kingston, Frontenac, Lennox, and Addington area, multiple organizations funded a 16-week contingency management (CM) program for crystal methamphetamine abstinence. The program is administered at the youth hub, which provides wrap-around services.

Psychosocial interventions are the primary intervention for methamphetamine abuse. Pharmacological therapies have not shown effective in treating methamphetamine abuse. CM is a behavioural therapy which rewards evidence of desired behavioural change.

A literature review revealed no other programs offering youth CM in a wrap-around services model. This study investigates the role of CM in situ of a youth hub in supporting youth methamphetamine abstinence and engagement in services.

APPROACH: Participant recruitment occurred from May to August 2024. Nine of the 12 participants registered in the CM program enrolled and completed the study. The remaining three participants were lost to incarceration, fatal overdose, and follow-up. Youth eligible to participate in the CM program were originally recruited by CM staff and local health partners. Participation criteria included: age 12 to 25; current crystal methamphetamine use; no gambling addiction; no prescribed stimulants.

A health professional conducted semi-structured interviews and participants were provided with a \$50 gift card honorarium. The authors completed inductive reflexive thematic analysis and engaged in analysis-enriching and reflexive discussions throughout the coding and theme-identification process.

NEXT STEPS/RESULTS: Finalize identified themes and descriptive analysis.

ANTICIPATED STUDY CONCLUSIONS:

Appreciation of the barriers and facilitators to abstinence, participant experiences, and the role of CM in abstinence and social integration.

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Accessing language-concordant care: Distribution and language abilities of Ontario physicians, and impact on travel burden for patients

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Background: Providing family medicine services in patients' preferred language has implications for patient outcomes and equity. Understanding the distribution and language abilities of Ontario primary care physicians (PCPs) is necessary to identify regions of unmet needs. Travel burden is an additional factor that may contribute to inequity and is important for human health resources planning.

Approach: Combining publicly available data from the College of Physicians and Surgeons of Ontario (CPSO) and Statistics Canada, cross-sectional geospatial analyses were conducted to describe family physician distribution and travel burden to access primary across all Ontario Census Subdivisions (CSD).

Results: We identified 14,754 Ontario family physicians of whom 1,678 (11%) spoke French. Inequity in physician-patient language distribution and travel burden to access language-concordant care were described; these were more pronounced in rural and northern areas, but also present in the urban south. Across all regions, Francophones need to travel farther than anglophones to access language-concordant care. Our online geospatial mapping tool, Docmapper, (www.docmapper.ca) was expanded to cover all of Ontario. Physician-to-population ratios were calculated, but these are inherently flawed for linguistic minorities, therefore, as a result of the present work, a novel augmented probability approach was developed to correct for this (presented separately). Finally, we defined 'Fragility of Access', a novel concept encompassing these and other relevant access to care metrics.

Conclusions: Geospatial and travel burden analyses help to understand gaps in access to language-concordant healthcare for Ontario's Francophone residents, but more refined approaches are needed. These methods are applicable to other linguistic minorities.

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Improving access to palliative care services through electronic consultations: A study on primary care providers' adoption of an eConsult service to enhance palliative care access

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Background: Most Canadians prefer to die at home. While primary care providers (PCPs) play a pivotal role in providing palliative care in the community, only 40% reported feeling prepared to manage palliative care needs. Electronic consultation (eConsult) allows PCPs to submit clinical questions to specialists, but its role in enabling access to palliative care advice has not been studied.

Approach: We conducted a cross-sectional analysis of 78 eConsult cases submitted in the Champlain region by PCPs on behalf of patients to a palliative care specialist between January 1, 2018 and December 31, 2022. In addition to service utilization data, including specialist response time and the PCP's responses to a close-out survey about their experience, three palliative care specialists and one resident physician coded questions and responses using validated taxonomies.

Results: Specialists responded to an eConsult in a median of 3.4 days. In 71% of the cases, a referral was not needed after the eConsult. The primary life-limiting diagnoses of patients were most commonly metastatic (28.6%) or localized (23.4%) cancer. The content of eConsult cases was commonly about pain, nausea and vomiting, and social circumstances including future planning, goals of care, and MAID. PCPs most commonly sought advice for pharmacological management. Specialists answered questions about pharmacological management but also provided additional support with diagnosis, non-pharmacological management, referrals, and community services.

Conclusions: For patients living with life-limiting illnesses, our findings will have important implications for how and to what extent eConsult can be used to facilitate receiving palliative care in the community.

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**“I felt like it was geared to each individual patient”:
Experiences of patients with diabetes utilizing the
Primary Care Diabetes Support Program (PCDSP)**

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Background: Patient-centred care is a hallmark of family medicine, and patient-centred care for diabetes has been associated with better outcomes. The Primary Care Diabetes Support Program (PCDSP) in London, Ontario, uses an inter-disciplinary, team-based approach to diabetes management, and targets three groups of patients at high risk for diabetes complications: 1) medically complex; 2) unattached, and 3) socially complex patients. Few evaluations have been done of primary care led disease focussed initiatives outside of clinical trials. We explore, from the patient perspective, how participants experience patient-centred care at the PCDSP.

Approach: We conducted 17 semi-structured interviews with patients of the PCDSP regarding their experiences with the Program. We asked patients about the PCDSP’s approach to care and its impact on their diabetes management and overall health. We used a thematic analysis approach.

Results: Our interviews found that the PCDSP is a concrete example of patient-centred care in primary care for patients with diabetes. We identified 8 attributes of PCDSP care: 1) positive reassurance, 2) emphasis on education, 3) holistic care, 4) individualized care, 5) ready availability to patients, 6) coordinated care, 7) access to new technologies, and 8) promoting self-efficacy.

Conclusions: The PCDSP provides essential diabetes care to medically and socially complex patients as well as those patients without a primary care provider. This service allows complex patients to manage their diabetes within a team-based primary care setting.

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How does long-term care physician commitment to practice influence quality of care? A retrospective cross-sectional study in Ontario

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Background: Medical care of complex long-term care (LTC) residents is managed by physicians working in LTC. While physician commitment to LTC is thought to impact care quality, its influence on resident outcomes remains unclear. This study aimed to assess commitment among Ontario LTC physicians and its effect on resident care quality.

Approach: We conducted a retrospective cross-sectional study using Ontario health administrative databases for 2022. We describe a cohort of the most responsible physicians in LTC on their LTC and primary care practice, categorizing them by quintiles of commitment. We assessed conceptions of commitment like the proportion of LTC residents, years in LTC practice, and the number of LTC homes worked in. Regression models examined the relationship between continuous commitment and resident outcomes, including medication prescriptions, hospitalizations, and transfers.

Results: Our study identified 1368 LTC physicians in Ontario, each averaging 62 residents. These physicians were generally older, male, had less-than-full-time practices, and practiced in various settings beyond LTC. We observed limited associations between commitment metrics and resident outcomes, with some evidence suggesting higher commitment could be beneficial. Other factors beyond commitment appear to play a role in influencing care quality.

Conclusions: Our work is the first to explore the impact of the Ontario LTC physician workforce on resident care quality. While commitment may be a factor, it is not the sole determinant of care quality. Further research is needed to refine how commitment is defined and measured, and to consider additional factors beyond the physician, such as infrastructure, LTC staff, and team collaboration.

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Pain care access: Healthcare providers' experiences and perspectives on the provision of chronic pain care in the context of patient-provider language-discordance

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Background: Growing evidence is demonstrating the potentially avoidable adverse health outcomes when patients and healthcare providers do not speak the same language (1–3). While the risks of misdiagnosis, underdiagnosis, and inadequate management are high for conditions reliant on patient-reported symptoms, such as chronic pain, there has been limited research on the impact of language discordance on access to care for chronic pain. This study aims to describe primary care providers' perspectives and experiences in delivering chronic pain care in language-discordant contexts.

Approach: Using a phenomenological approach, we conducted virtual, semi-structured interviews with 12 healthcare professionals from a primary care clinic in Ottawa, including family physicians, nurses, allied health professionals, and clinical leads. Participants recruited through snowball sampling shared their experiences managing chronic pain in language-discordant contexts, where patients and providers do not share a common language. They also provided insights on the impact, feasibility and acceptability of tools like interpreters, numerical rating scales and translated validated questionnaires.

Results: Preliminary thematic analysis shows that healthcare providers face significant challenges in managing chronic pain when language barriers exist. Themes include miscommunication fears, complexities in treating pain compounded by cultural discordance and mental health issues, and challenges in accessing alternative treatment options, such as physiotherapy for low-income patients.

Conclusions: This research emphasizes the need to address structural barriers, including the lack of patient-centred multilingual resources, culturally informed pain management strategies, and adequate provider training. Recommendations will be made to improve care access and health equity for linguistic minorities in chronic pain management.

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The quest for inclusive perinatal care services for women with physical disability in primary care settings: Implications for practice and policy in Ontario

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Background: Despite efforts to ensure universal access to perinatal care in developing countries, women in rural areas with lower education and income and those marginalized often lack access. Women with physical disability face unique challenges linked to their intersecting positionalities and lack of support. In Ethiopia, few studies have explored the experiences of women with physical disability accessing perinatal care. This study explores how women with physical disability access perinatal care services in Dembia Woreda primary healthcare units, Ethiopia.

Approach: An instrumental case study guided by Stake's approach was conducted. In-depth interviews, document review, and observations were used to collect data. Twelve women with physical disability, five close persons, and seven maternal healthcare providers were interviewed. Observations included photos of health centers' premises, and documents reviewed included strategic plans and perinatal care guidelines. Reflexive thematic analysis was used to analyze the data.

Result: Three main themes emerged: 1) Journeys to Motherhood: Examined how valuing motherhood, societal expectations, emotional well-being, and perinatal care knowledge influenced experiences of women with physical disability pursuing care. 2) Navigating the Physical Environment: Explored the travel challenges and infrastructural barriers WWPDs faced in health centers. 3) The Quest for Person-Centered Care: Highlighted issues hindering person-centred care, such as priority and attention, informed consent, referral support, and postnatal care quality.

Conclusion: This study underscores the need to support women with physical disability in planning pregnancy and building confidence to access perinatal care services. Improving transportation access, building accessible infrastructure in health centers, and providing person-centred care are essential next steps.

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Healthcare utilization following a visit with a within-group family physician vs. with a walk-in clinic physician

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Background: Primary care access is a key health system metric, but little research has compared models to provide such access when one's regular physician is not available. This study compared health system use following an in-person visit with a patient's own family physician group versus a visit with a walk-in clinic physician who was not part of the patient's family physician group.

Approach: We conducted a population-based, retrospective cohort study using administrative data from Ontario, including all individuals formally enrolled to a family physician between April 1, 2019 and March 31, 2020. We compared those visiting within-group physicians to those visiting walk-in physicians using propensity score matching to account for differences in patient characteristics. The primary outcome was any emergency department visit within 7 days of the initial visit.

Results: Matched patients who visited a within-group physician (N=506,033) were 10% less likely to visit an ED in the 7 days following the initial visit compared to patients who saw a walk-in clinic physician (N=506,033, 20,117 (4.0%) vs. 22,320 (4.4%), RD 0.4%, RR 0.90, 95% CI [0.89-0.92]). Those accessing after-hours within-group physician visits were more likely to have at least one additional virtual or in-person within-group physician visit within 7 days (virtual RR 1.86, in-person RR 1.87).

Conclusions: Compared to visiting a walk-in clinic physician, seeing a within-group physician during after-hours may reduce downstream emergency department visits. This finding could be explained by better continuity of care and can inform primary care service models and the policies that support them.

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Experiences and preferences of people without access to primary care: Results from a national cross-sectional survey in Canada

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Background: 21.8% of people in Canada do not have a primary care clinician, yet little research has been done on what is important for them and whether this differs from the rest of the population. The aim of this study was to understand the healthcare-seeking behaviours and preferences of people who report not having a primary care clinician.

Approach: We conducted an anonymous, online, national cross-sectional survey that was available to people aged 18 years and older from September to October 2022 in English and French. Responses were weighted on sociodemographic factors to approximate the population of Canada. We assessed characteristics of people without primary care, and compared their related healthcare seeking behaviours and preferences towards reorganizing primary care to people with primary care.

Results: We analysed 9,279 completed surveys. 21.8% of respondents said they did not have a primary care clinician. Among these, 83.1% said they were trying to find one and 66.2% of those looking reported doing so for over 1 year. Fewer men (vs. women) (78.0% vs 89.3%; $p < 0.001$) and people without supplementary health benefits (vs. with) (72.1% vs 85.8%; $p < 0.001$) reported looking. More people without a primary care clinician (vs. with) said they tried getting care from a walk-in clinic (71.8% vs. 41.2%; $p < 0.001$), but fewer reported their needs were met (40.6% vs. 55.3%; $p < 0.001$). More people without a primary care clinician responded favourably to potential team- and neighbourhood-based care reforms.

Conclusions: The Canadian healthcare system is not meeting the needs of people without primary care. They value relationship-based care yet are more likely to use walk-in clinics and less likely to be satisfied with that care compared to people with a primary care clinician. Reforms should align with the values and preferences of those without primary care.

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Bridging gaps: Integrating mental health services into primary care in Ethiopia – Lessons and Implications for Primary Care in Ontario

Adhanom Baraki, Sewbesew Yitayh, Nicole Bobbette, Catherine Donnelly

Background: Ethiopia is working to integrate mental health services into primary care to bridge the mental health gap that has left 90% of patients with mental disorders without treatment. However, little is known about how the integration is taking place, and a comprehensive understanding of the process, considering the current system, health care providers, and patients, is needed. This study aims to describe the experience of patients, the available mental health services and system-level support.

Approach: A multiple case study of four purposefully selected primary care clinics in Ethiopia will be conducted. Key-informant interviews with primary care providers and health care administrators have been done. In addition, patient interviews and documents that include national and clinic-level policy documents were reviewed. Currently, data cleaning, a thematic analysis of interviews, and a descriptive statistical analysis of quantitative data are taking place. Health system support for integrating mental health into primary care will be compiled from policy documents and key informant interviews. The availability of mental health services and resources to support its implementation will be assessed from primary care provider's interviews, and clinic documents. Finally, the patient's perception of the care provided will be synthesized from the patient's in-depth interview.

Results: Findings will provide a critical step to understanding the process of integrating mental health services into primary care in Ethiopia.

Conclusion: The findings will provide insights and recommendations to policymakers, programmers, and practitioners for decision-making regarding implementing mental healthcare in a setting close to the community.

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National and provincial policies to support the face of primary care

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Background: Medical office assistants are core members of primary care teams. They perform a range of important duties, including administrative tasks, some clinical tasks and health system navigation. Despite their impact on the clinic, they are under-utilized and underappreciated, and they have little support or resources available.

Approach: We conducted a scoping review to identify regulations, policy levers, and practice supports that support MOAs in primary care. We used the quintuple aim framework to organize the outcomes of these interventions. We also conducted a series of workshops (n=12) with MOAs (n=7) from clinics across Ontario. Workshops explored MOA's current work environment, the ideal MOA experience, and ways to improve the MOA experience.

Results: Our scoping review found interventions that support or increase the role of MOAs across 52 studies. Outcomes primarily impacted areas of patient care, workforce well-being, and population health. Our analysis of MOA workshops found that MOA-patient relationships are challenging but also a core motivator of their work. MOAs need more support and resources as they navigate complex systems and bear the burden of integrating siloed and ill-designed technological solutions. Co-created interventions include: a best practices resource on making the most of and supporting MOAs in primary care, incentivized and standardized training for MOAs, and a provincial wide MOA network.

Conclusions: By analyzing current gaps and opportunities, and co-creating solutions together, this research informs evidence-based strategies to optimize MOAs' roles, enhancing their capacity to meet modern primary care demands and improve overall healthcare system performance.

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A qualitative study on the role of community pharmacists in assisting newcomer international students and their families transitioning to the Canadian healthcare system

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Background: Transitioning to the Canadian healthcare system poses challenges for newcomer international students and their families, as they may lack skills in managing illnesses, understanding treatment options, and navigating insurance coverage. They face barriers to accessing healthcare services, including cost and cultural unfamiliarity. Pharmacists, known for their accessibility and expertise, can play a crucial role in addressing these challenges. Their diverse clinical services, including virtual care, can enhance therapeutic outcomes and reduce medication-related issues, improving healthcare outcomes for newcomer international students.

Approach: This qualitative study aimed to understand the lived experiences of newcomer international students as they transition to the Canadian healthcare system. In-depth virtual interviews were conducted with a purposeful sample of 23 students using a semi-structured guide. Transcripts were analyzed using conventional content analysis to identify key themes and develop a conceptual model.

Results: Four overarching themes were identified: (1) Navigating the Unknown, highlighting participants' initial uncertainties with the healthcare system; (2) Building Bridges, reflecting their efforts to bridge gaps in healthcare access; (3) Pharmacist as a Guide, recognizing pharmacists as key allies in their healthcare journey; and (4) Overcoming Barriers, Building Resilience, and Improving Access, which presented proposed solutions to enhance healthcare access for international students.

Conclusions: The findings suggest that newcomer international students face significant challenges in accessing healthcare services in Canada. Pharmacists play a critical role in bridging these gaps, improving access, and providing valuable support. Their expanding role can help enhance healthcare integration and improve outcomes for this population.

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Trillium Primary Health Care Research Day 2024 Registrant List

Contact us at trillium@inspire-phc.org if you wish to connect with any of the registrants.

Check back following the event for this listing.