Trillium
Primary Health Care Research Day

Conference Program

Friday, October 13, 2023
Conference

Presented by INSPIRE-PHC

INSPIRE-PHC

*This event will be recorded

Welcome

On behalf of our organizing and planning committees, 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 plenaries on two timely issues: attachment and human health resource challenges. New this year is a specific session on patient oriented research and a networking session to the end of the day. Thank you to the Ontario SPOR Support Unit and 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

INSPIRE-PHC

Ontario

MINISTRY OF HEALTH

Trillium Primary Health Care Research Day 2023 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 2023 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.

Program Contents

Welcome i
Acknowledgements i
  About INSPIRE-PHC i
  Program Sponsors ii
  History of Trillium Primary Health Care Research Day ii
Program Agenda 1
Martin Bass Lecture 2
Oral Presentations… 3
Poster Presentations 4
Panel Discussion 6
Patient Oriented Research Session 7
Evaluation 8
Abstracts: Oral Presentations 9
Abstracts: Poster Presentations 17
Trillium Primary Health Care Research Day 2023 Registrant List 36

Program Agenda

8:00 AM	**Networking, Registration, and Light Refreshments**	
9:00 AM **Provincial North**	**Opening Remarks & Land Acknowledgement** Dr. Rick Glazier and Dr. Michael Green	**Virtual Available**
9:10 AM **Provincial North**	**Martin Bass Lecture - Primary care in crisis: Data-driven insights and solutions** Featuring: Dr. Kamila Premji Introduction & Moderator: Dr. Rick Glazier, Co-Lead, INSPIRE-PHC **Dr. Kamila Premji** is a family physician practicing community-based, comprehensive family medicine in Ottawa. She is an Assistant Professor with the University of Ottawa, where she holds the Junior Clinical Research Chair in Family Medicine. She is also completing a PhD in Family Medicine through Western University. Inspired by her practice, she is passionate about research examining primary care access, care continuity, and health system integration.	**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**	**Panel Discussion - How to address attachment during a time of HHR challenges** Introduction & Moderator: Dr. Michael Green This panel will focus on primary care attachment and the ongoing health human resource challenges in primary care. The panel features **Dr. Jane Philpott,** co-author of the report *Taking Back Healthcare*; **Dr. Elizabeth Muggah,** the Senior Clinical Advisor at Ontario Health; **Dr. Mekalai Kumanan,** President of the Ontario College of Family Physicians; and **Dr. Michael Green** who will speak from his perspective as President-Elect of The College of Family Physicians of Canada.	**Virtual Available**
3:15PM **Provincial North**	**Break**	
3:30 PM **Provincial North**	**Patient Oriented Research Session: Working with patients as primary caregivers: From vision to action** Introduction & Moderators: Dr. Rebecca Ganann and Dr. Maggie MacNeil This session features a presentation from **Dr. Antoine Boivin** and **Ghislaine Rouly** – Patient Partner, Co-directors of the Canada Research Chair in Partnership with Patients and Communities. Following the presentation, attendees will engage in facilitated small-group discussions to brainstorm ways to integrate patients as partners in primary health care design, delivery, research, and education.	**Virtual Available**
4:45 PM **Provincial North**	**Trillium: Concluding Remarks** Dr. Rick Glazier	**Virtual Available**
4:55 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.

Primary care in crisis: Data-driven insights and solutions

Dr. Kamila Premji is a family physician practicing community-based, comprehensive family medicine in Ottawa. She is an Assistant Professor with the University of Ottawa, where she holds the Junior Clinical Research Chair in Family Medicine. She is also completing a PhD in Family Medicine through Western University. Inspired by her practice, she is passionate about research examining primary care access, care continuity, and health system integration.

Discussion

Conference participants will be given the opportunity to ask questions and respond to Dr. Premji's talk. 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 10

Theme	#		Presentation Title	Presenter	Affiliation
OHT Data and Support Moderator: Catherine Donnelly Evaluator: Rebecca Ganann Room: Wentworth	1	Wentworth 1045	A learning health system in Northwestern Ontario: A case study in cancer screening improvement	Brianne Wood	NOSM University
	2	Wentworth 1100	Sharing information about rates of attachment to primary care with the public: Working with patients to coproduce visuals using the Primary Care Data Reports (PCDR)	Maggie MacNeil	McMaster University
	3	Wentworth 1115	Patient and caregiver experiences on the role of virtual care in Ontario's primary care system: A mixed-method study	Rachelle Ashcroft & Alexis Aomreore	University of Toronto, Bruyère Research Institute
	4	Wentworth 1130	The routine collection of patient-reported data in primary care: Supporting Ontario Health Teams to achieve the Quadruple Aim	Catherine Donnelly	Queen's University
Issues in Family Medicine Moderator: Onil Bhattacharyya Evaluator: Ashley Chisholm Room: Kenora	5	Kenora 1045	Family physicians in health system design and implementation: What constitutes meaningful involvement	Cathy Thorpe	Western University
	6	Kenora 1100	Health utilization and costs of unattached individuals by length of time without a family physician	Jonathan Fitzsimon	University of Ottawa
	7	Kenora 1115	Family Medicine training during COVID-19: What was the impact on practice choice?	Sharon Bal	McMaster University
	8	Kenora 1130	System-based interventions to address physician burnout: A qualitative study of Canadian family physicians' experiences during the COVID-19 pandemic	Samina Idrees	Western University
Policy/Program Improvement Moderator: Maria Mathews Evaluator: Peter Sheffield Room: Huron	9	Huron 1045	Transforming primary healthcare: Technology Effects on Compassion in Primary HealthCare (TEC-PHC)	Bridget L Ryan	Western University
	10	Huron 1100	Utilization patterns and impact of the chronic pain self-management program in Eastern Ontario	Isabella Moroz	Bruyère Research Institute
	11	Huron 1115	Journey mapping of a primary care visit	Anna Chavlovski	Queen's University
	12	Huron 1130	Supporting the uptake of primary care research evidence among policy makers	Amanda Terry	Western University
Innovations in Primary Care Moderator: Andrew Pinto Evaluator: Simone Dahrouge Room: Kent	13	Kent 1045	SPIDER, a structured approach to quality improvement for deprescribing: Feasibility evaluation	Michelle Greiver	University of Toronto
	14	Kent 1100	Utilization of Ontario eConsult by primary care providers in correctional facilities	Danica Goulet	Bruyère Research Institute
	15	Kent 1115	Scaling up the ARC Social Prescribing model – The ARC/211 Partnership	Kiran Saluja	Bruyère Research Institute
	16	Kent 1130	Building the Canadian Primary Care Trials Network: Lessons from other jurisdictions	Andrew Pinto	UpStream Lab

Poster Presentations

Provincial South, 12:30-1:30PM

A listing of posters is provided below; abstracts are included beginning on PAGE 18

#	Presentation Title	Presenter
1	Impact of the COVID-19 Pandemic on the roles, responsibilities and health of Medical Office Assistants working in Family Medicine Clinics in Ontario: Implications for primary care access and quality	Jennifer Johnson
2	An Evaluation of physician retention bonuses in Newfoundland and Labrador	Gillian Young
3	A mixed-methods examination of the role of social work in primary care teams in Ontario, Canada	Rachelle Ashcroft & Alexis Aomreore
4	The 6C approach: Principles for interventions addressing the provider retention crisis in primary healthcare	Peter Sheffield
5	Identifying barriers and facilitators to screening for depression among newcomers	Devyani Premkumar
6	Job satisfaction associated with different payment models amongst family physicians: A rapid scoping review	Devyani Premkumar
7	Primary health care Registered Nurses as facilitators of healthcare access for recent immigrants in Ontario: An interpretive descriptive study	Eugenia Ling
8	Comprehensive family medicine under construction	Judith Belle Brown Presented by Cathy Thorpe
9	An exploratory sequential mixed methods study on health system transformation in health professions education	Ashley Chisholm
10	A comparative policy analysis of medical care provider commitment in Canadian and international long-term care homes	Ashley Olah
11	Developing a measure of Ontario long-term care physician commitment and how commitment influences resident outcomes	Darly Dash
12	Family physicians' roles in long-term care homes and other congregate residential care settings during the COVID-19 pandemic: A qualitative study	Maria Mathews
13	Task shifting and skill mix innovation in interprofessional, team-based primary health care: A realist review protocol	Q. Jane Zhao
14	First Line of Defense: The vital role of family physicians in preventing acute mesenteric ischemia in high-risk patients	Sara Arfan
15	Examining geographical disparities in breast cancer screening and primary care attachment: Prioritizing FSAs for primary care intervention	Payton Rix
16	Primary care for all: Lessons for Canada from OECD countries with high primary care attachment	Heba Shahaed
17	Exploring the health complexity and demographics of Ontario's unattached patients	Fatima Ali
18	Primary health care utilization in All Nations Health Partners Ontario Health Team: Assessing preventative services, COVID-19 impacts and recommendations for improving access	Paige Stevenson
19	Exploring Interprofessional Primary Care (IPPC) Teams' impact on chronic disease management: A narrative review on IPPC Team guiding features and reported outcomes	Melanie Dissanayake
20	Exploring the lived experiences of women with chronic obstructive pulmonary disease	Madeline Dougherty
21	Exploring experience using a novel patient reported experience measure - The PREM-C9+	Floriana Sherifi
22	Developing an online questionnaire to investigate the COVID-19 pandemic's impacts on social isolation and health in older adults living with multimorbidity: A pilot study	Patricia Nistor
23	Examining diabetes data in the Primary Care Data Reports (PCDR)	Aya Tagami
24	Chronic disease risk prediction models and their impacts on behavioural and health outcomes: A systematic review and meta-analysis	Megan Harley
25	Developing quality indicators for the primary care of older adults: Findings from a RAND/UCLA appropriateness method study	Rebecca Correia
26	Developing the Social Housing in Ontario, Canada (SHOC) cohort with administrative data for future use in epidemiological studies	Kumindu Gamage
27	Environmental scanning to inform a mobility-promoting integrated care model: EMBOLDEN	Abbira Nadarajah
28	Health-related social housing characteristics in Ontario: A descriptive survey in Hamilton and Niagara Regions	Seth Walvinz Quimson

Poster presentations continue on next page

Poster Presentations

#	Presentation Title	Presenter
29	Experiences of chronic pain in social housing residents, aged 55 years and older, in Ontario	Sahar Popal
30	Perspectives on Screening for Poverty And Related Social Determinants and Intervening to Improve Knowledge of and Links to Resources (SPARK) from an Ontario Family Health Team	Ayodeji Odedeji
31	The impact of a legal health clinic on the social determinants of health of attendees	Jasdeep Brar
32	Considerations for building a patient advisory committee for practice-based learning and research networks	Marissa Beckles
33	Public priorities for primary care in four provinces: Findings from the OurCare Priorities Panels	Rachel Thelen & Maryam Danesh
34	Experiences and preferences of older adults about primary care in Canada	Maryam Danesh & Rachel Thelen
35	Scoping review on Primary Care Teams and their impact on clinician capacity to see more patients	Rachel Thelen & Kanya Rajendra
36	Stakeholder reflections on implementing promising practices for improving cultural safety and accessibility of mainstream healthcare institutions for Indigenous patients in Southeastern Ontario	Natalie DiMaio
37	Patient reported wait times and the impact of living with chronic pain on their quality of life: A waiting room survey in chronic pain clinics in Ontario, Manitoba, and Quebec	Isabella Moroz
38	Co-Creation of knowledge mobilization strategies: Findings from a collaborative symposium	Amanda Terry & Judith Belle Brown
39	Team-based care and Ontario Health Teams: Where are the priority areas?	Paul Nguyen

Panel Discussion

How to address attachment during a time of HHR challenges

This panel will focus on primary care attachment and the ongoing health human resource challenges in primary care. The panel features Dr. Jane Philpott, co-author of the report Taking Back Healthcare; Dr. Elizabeth Muggah, the Senior Clinical Advisor at Ontario Health; Dr. Mekalai Kumanan, President of the Ontario College of Family Physicians; and Dr. Michael Green who will speak from his perspective as President-Elect of The College of Family Physicians of Canada.

Moderator: Dr. Michael Green

The session will conclude with a question and answer session moderated by Dr. Michael Green.

Panelists:

Dr. Jane Philpott is the Dean of the Faculty of Health Sciences, Director of the School of Medicine at Queen's University, and CEO of the Southeastern Ontario Academic Medical Organization. She is a medical doctor, a Professor of Family Medicine, and former Member of Parliament. Prior to politics, Jane spent the first decade of her medical career in Niger, West Africa. She was a family doctor in Markham-Stouffville for 17 years and became Chief of Family Medicine at Markham Stouffville Hospital in 2008. From 2015 to 2019 she served as federal Minister of Health, Minister of Indigenous Services, President of the Treasury Board and Minister of Digital Government. She is currently the Chair of the Ontario Health Data Council and was recently appointed as a Commissioner to the Global Commission on Drug Policy.

Dr. Elizabeth Muggah is the Senior Clinical Advisor for Primary Care at Ontario Health. She is an Associate Professor in the Department of Family Medicine at the University of Ottawa and her research and educational contributions have focused on enhancing primary care quality and equity and advancing physician wellness. She completed her medical degree at McMaster University, her Family Medicine residency at the University of Ottawa and received her Master of Public Health at Harvard University. Dr Muggah has held senior leadership positions including President of the Ontario College of Family Physicians and Assistant Dean Wellness for the Faculty of Medicine at the University of Ottawa. A bilingual physician, Dr. Muggah has been practising comprehensive family medicine for 20 years in a variety of settings in Canada, the US and abroad and is currently practicing with the Bruyère Family Health Team in Ottawa. She has two teenage daughters and when not working can be found skiing or biking in Gatineau Park.

Dr. Mekalai Kumanan completed her undergraduate studies, Master of Health Administration degree and medical school at Dalhousie University before completing her residency at the University of Western Ontario. Since 2008, Dr. Kumanan has served the community of Cambridge, Ontario as a family physician with Two Rivers Family Health Team. Dr. Kumanan is also the current Chief of Family and Community Medicine at the Cambridge Memorial Hospital. She has served as an OCFP board member since 2016 and was installed as the 64th President of the OCFP in September 2022. Dr. Kumanan has spent the first year of her term supporting family physicians through meaningful and impactful initiatives. As Dr. Kumanan begins the second year of her term, she looks forward to continuing to advocate for primary care transformation while supporting her family physician colleagues across the province.

Dr. Michael Green is the lead for INSPIRE-PHC and was appointed as the Brian Hennen Chair and Head of the Department of Family Medicine on July 1, 2017. He is Professor of Family Medicine Public Health Sciences, and Policy Studies at Queen's University and a Senior Adjunct Scientist at the ICES. In 2018 he was elected as a Fellow of the Canadian Academy of Health Sciences. In November 2022 he was elected as President-Elect of the College of Family Physicians of Canada. He has served on many professional and government expert committees including the AMS Healthcare Board of Directors.

Patient Oriented Research Session

Working with patients as primary caregivers: From vision to action

Dr. Antoine Boivin and Ghislaine Rouly Co-directors, Canada Research Chair in Partnership with Patients and Communities; University of Montreal will deliver a lecture, titled: '*Working with patients as primary caregivers: From vision to action*', which will be followed by facilitated small-group discussions to **begin** brainstorming priorities about how to integrate patients as partners in the primary health care system of the future.

Brainstorming ideas from the workshop will provide a foundation for a dynamic research exercise that will take place after Trillium PHC Research Day, which will involve brainstorming, sorting, and prioritizing areas for action.

The ideas generated during this workshop can help strengthen the primary health care system through patient partnership in Ontario and beyond.

Moderators: Dr. Rebecca Ganann & Dr. Maggie MacNeil

Presenters:

Antoine Boivin, MD PhD is a practicing physician and the Canada Research Chair in Partnership with Patients and Communities. Working as a family physician in the community of Center-South Montreal, he completed his MSc and PhD in health services research in the United Kingdom and Netherlands. His research program for the past 15 years has focused on patient and citizen engagement in community care, health services delivery, science and policy. He published in the British Medical Journal, the Milbank Quarterly (article of the year), Implementation Science (distinguished article of the year by the North American Primary Care Research Group) and Health Expectations (most quoted articles in 2018). Co-founder and scientific director of the Center of Excellence for Partnership with Patients and the Public, one of the largest organizations dedicated to partnership science and practice in Canada, he is co-director of the Quebec SPOR-SUPPORT Unit, where he leads national initiatives on patient and public engagement evaluation. In 2020, he was awarded the Donald I. Rice award for vision and leadership by the Canadian College of Family Physicians.

Ghislaine Rouly has been a patient since birth, living with two orphan genetic diseases surviving three major cancers. In collaboration since 2016 with Dr. Antoine Boivin, she contributes to all of the Chair's scientific projects in primary care, homelessness, mental health, Indigenous' health, women's health, migrants, youth, seniors and end of life. She works as a partner in the entire research and knowledge creation cycle (strategic orientations of the Chair, hiring, student co-supervision and mentoring, protocol development, ethics, intervention design, data collection and analysis and knowledge transfer). She has published 6 articles in international peer-reviewed journals and given more than 70 lectures (including 10 invited international conferences). She is also co-founder of the Caring Community action research program on peer integration in community care. Her expertise as a patient researcher is solicited by several organizations in North America (MSSS, INESSS, FMOQ, CPCRN, (Canadian Primary Care Research Network), Patient-Centered Outcome Research Institute in the United States) and internationally (France, Ireland, United Kingdom and Japan). In 2023, she became co-director of the Chair with Dr. Antoine Boivin.

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

A learning health system in Northwestern Ontario: A case study in cancer screening improvement

Brianne Wood, Paige Stevenson, Roya Daneshmand, Barb Zelek

Background Clinicians, decision-makers and researchers co-designed a project that aimed to understand and improve cancer screening participation within the All Nations Health Partners Ontario Health Team (ANHP OHT) in Northwestern Ontario. Our team aimed to understand how to use population-based data to improve participation opportunities for cancer screening in primary health care.

Approach Semi-structured interviews were conducted with health professionals who deliver, organize, or manage cancer screening in ANHP OHT. Members of the project team were interviewed, and snowball sampling was used to elicit additional perspectives of the cancer screening landscape. The interviewer took notes during the interview, which were analyzed using codebook thematic analysis. The codebook was pre-populated using learning health system framework. Additional codes were inductively identified.

Results Respondents identified substantial data-oriented challenges that prevent optimal cancer screening delivery. Many of these challenges were unique to the ANHP northern and rural contexts. Data governance and lack of interoperability of electronic medical records posed challenges for providers to identify potential screening participants at the point of care. Respondents also expressed mistrust of population-level data reports because of population characteristics and models of care delivery.

Conclusions OHTs are accountable to report on cancer screening participation. Our case study of cancer screening in ANHP OHT illustrates several opportunities and challenges that ANHP clinicians and decision-makers face when trying to address these quality improvement indicators. To realize a learning health system, and ultimately improve Quadruple Aim outcomes and health equity, funders and policy-makers must acknowledge how context significantly influences performance measurement.

bwood@nosm.ca

Sharing information about rates of attachment to primary care with the public: working with patients to coproduce visuals using the Primary Care Data Reports (PCDR)

Maggie MacNeil, Joan Barker, Jennifer Boyle, Clare Cruickshank, Angela Frisina, Anita Gombos Hill, Melissa McCallum, Peter Sheffield, JoAnn Stans, Murray Walz & Rebecca Ganann

Background: Having a primary care provider is associated with better care experiences and lower costs of care. Administrative data that compose PCDRs can provide deeper understanding of the population in Ontario Health Teams [OHTs], including how attributed patients engage with primary care.

Approach: Participatory design is characterized by three stages: initial exploration of work; discovery processes; and prototyping. Over a series of meetings with patient/caregiver advisors, OHT representatives, trainees, researchers provided orientation to the PCDR, shared early findings about primary care locally and provincially, facilitated group discussions about infographic design, and iteratively refined prototypes. Meeting minutes were shared with attendees, ensuring an accurate reflection of the conversation. Honoraria were provided to patient/caregiver partners, acknowledging their expertise.

Results: Up to 14 patient/caregiver partners, three researchers, three OHT staff and two primary care trainees were involved in four 90-minute participatory design sessions conducted virtually. Discussion included perspectives on the strengths and limitations of administrative data in describing patients' ideal involvement with primary care and contrasted that with the reality of their primary care experiences. Design sessions helped to: refine the audience and scope of work; prioritize parts of the data to highlight; identify aesthetic infographic design features; co-create key messages; and, discuss venues to share this work.

Conclusions: Patient engagement in research is becoming widespread, but co-developing knowledge products with patient and health system partners is less common. Co-developed infographics contribute to data-driven public discussions about attachment to primary health care.

macnem18@mcmaster.ca

Patient and caregiver experiences on the role of virtual care in Ontario's primary care system: A mixed-method study

Rachelle Ashcroft, Alexis Aomreore, Simone Dahrouge, Simon Lam, Kiran Saluja

Background: Previous studies demonstrated Ontarians valuing synchronous, virtual primary care services (VC). We seek to contrast patient and caregiver experiences with VC (telephone (Tel)/video (Vid)) and in-person appointments.

Approach: Mixed-methods study with a provincial-wide survey and focus groups. Adult patients and caregivers in Ontario with 1+ VC in past 12 months eligible to participate. Survey questions (T:20/V:20) used 5-point Likert scales covering 6 dimensions (Communication, Patient-Provider Relationship, Quality of Care, Whole-Person-Care, Self-Efficacy, and Privacy-Confidentiality). Experience scores computed for each dimension (range -100% (favouring in-person) to +100% (favouring VC), and an overall experience score (mean). We assessed association between overall score and patient factors (t test/ANOVA).

Results: 14 focus groups with n=73 from November 2022 to February 2023. Survey administered from December 2022 to March 2023 with n=1,513. Respondents reported preference for VC in 23/24 dimension assessments. Factors associated with difference > [10%] in overall scores were: 1) Favouring in-person: not in workforce, preferring French services, Non-French or English speaking, > 65 years of age, and non-binary; 2) Favouring VC: lower-income, identify as Black or non-White, low self-efficacy, and having mental health condition. Participants indicated virtual care increases access to care and emphasized importance of patient choice. Challenges include decrease in whole-person care and difficulties for people with disabilities. Asynchronous communicating seen as beneficial.

Conclusions: VC remains highly valued by Ontarians, with differences emerging for VC or in-person preference across patient factors. Effectiveness of virtual care can be enhanced by improving provider communication and integrating asynchronous sharing of information.

Rachelle.ashcroft@utoronto.ca

The routine collection of patient-reported data in primary care: Supporting Ontario Health Teams to achieve the Quadruple Aim

Morgan Slater, Catherine Donnelly

Approach: We conducted a pilot study, using a multiple methods case study design, to implement routine collection of patient-reported experience within primary care in the Frontenac, Lennox & Addington (FLA) Ontario Health Team (OHT). The survey captured three domains: encounter experience, health and well-being, and demographics. Each participating clinic developed a mechanism to distribute the survey that worked within their existing workflow.

The Consolidated Framework for Implementation Research and Process Design (CFIR-PR) informed data collection, including two sets of focus groups. Within and across case analysis was used with descriptive statistics for quantitative survey data and thematic analysis for qualitative data.

Results: The survey was implemented in four primary care clinics and in vaccination clinics run by public health; a total of 1,222 patients completed the survey over 5 months. Different mechanisms were used to deploy the PREM, including weekly emails and posted QR codes. Overall patient experience was high, but respondents reported higher than expected rates of depression, isolation, and financial need. Clinics reported that the patient survey provided data for ongoing quality improvement, boosted staff morale, provided a voice for patients, and identified resources needed for ongoing use.

Conclusions: Not only is patient-reported data needed to ensure OHTs are meeting the Quadruple Aim, but collection of this data provides an opportunity to also collect information on wellness, demographics, and other social determinants of health, which can inform equity-based work.

morgan.slater@queensu.ca
catherine.donnelly@queensu.ca

Family physicians in health system design and implementation: what constitutes meaningful involvement

Cathy Thorpe, Judith Belle Brown, Amanda L Terry, Bridget L Ryan, Catherine George, Saadia Hameed Jan, Rebecca E Clark

Background: Family physician (FP) participation is increasing in health system design and implementation in Ontario. Therefore, it is important to explore the activities and processes that constitute meaningful involvement (MI). Objective: The purpose of the study was to elicit primary healthcare leaders' definition of MI in the conception, design and delivery of integrated care planning and implementation, and to identify means to measure MI. Approach: Grounded theory study using interviews via Zoom, with individual and team analysis. Participants: twenty-two primary healthcare leaders (FPs and decision-makers) affiliated with Ontario Health Teams (OHTs). Results: Participants found it challenging to provide a clear definition of MI. A few offered definitions that consisted of different levels of involvement, ranging from being aware/informed; to participating in some activities; to more active involvement, including leading activities/being at the decision-making table; and some participants highlighted another level -- using the clinical services/being integrated into the clinical pathway within the OHT. All participants offered ideas about how to measure meaningful involvement of FPs, ranging from relatively easy items to measure, such as attendance at meetings and counting opened emails to a more comprehensive set of activities such as involvement in the co-design/evaluation of programs. Participants believed that involving FPs in the co-design of program implementation activities fosters ownership and empowerment, leading to improved health care delivery in Ontario. Participants articulated that the foundation for MI of FPs in health system change is relationship building; trust and respect are paramount. Conclusions: This study illuminates the challenges in defining and measuring MI of FPs in health system design and implementation.

ssccat@uwo.ca

Health utilization and costs of unattached individuals by length of time without a family physician.

Jonathan Fitzsimon, Shawna Cronin, Lise Bjerre

Background: The issue of low rate of attachment to family physicians is an important challenge in rural areas. The Ottawa Valley Ontario Health Team (OVOHT) is a model of integrated care that is accountable to a rural population, and partners with primary care to provide supports and programming.

Approach: This study sought to describe the health and demographic profile, health utilization, and total health care costs of unattached and attached individuals in OVOHT and in Ontario, and to compare unattached individuals in OVOHT and in Ontario by the length of time the individual was not attached to a family physician.

We conducted a population based descriptive study using health administrative databases, comparing the population of Ontario to the attributed population of the OVOHT. Then we examined the length of time individuals were without a family physician and identified differences in sociodemographic and health utilization variables.

Results: OVOHT had a higher proportion of individuals who were unattached, a higher proportion of individuals who were long-term unattached and a higher burden of chronic disease and health utilization compared to Ontario. Overall, those who were unattached had lower rates of chronic disease and costs compared to those who were attached.

Conclusion: Understanding how individuals may be treated or prioritized for supports based on the length of time unattached may be an effective way to support those with higher health needs and manage the health of the population.

Jfitzsi2@uottawa.ca

Family Medicine training during COVID-19: What was the impact on practice choice?

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

Background: There is a significant decline in family physicians practicing comprehensive care. Objective: To explore the impact of COVID-19 on the training and practice of early career family physicians and its influence on their decision-making process to practice comprehensive care. Approach: Grounded theory study using interviews via Zoom, with individual and team analysis. Participants: 38 family physicians practicing in Ontario, who completed their residency training within the last 5 years. Results: Family Medicine (FM) residents experienced varying levels of COVID-19 related disruptions, including an abrupt change to virtual care and fewer in-person community and clinic opportunities during training. The impact of COVID-19 on participants included isolation from other residents and staff and less exposure to some procedures which impacted confidence to perform these skills on graduation. Conversely, some described increased skills in acute care through additional hospital-based rotations. Concurrently, new graduates experienced challenges during workforce entry such as reliance on virtual care, less on-site support and needing to adapt to system disruption. They were simultaneously exposed to focused FM opportunities such as vaccine clinics and assessment centres which they described as relatively highly remunerated, lower stress, and offering socialization with colleagues. Conclusions: Findings reveal the impact of COVID-19 on new graduates at a critical juncture in professional identity formation. Disruptions in the health system presented challenges to comprehensive FM care and offered attractive focused practice choices. The findings have implications for educators and health workforce planning and need further exploration to ensure comprehensive FM remains a viable choice going forward.

sharon.bal@medportal.ca

System-based interventions to address physician burnout: A qualitative study of Canadian family physicians' experiences during the COVID-19 pandemic

Maria Mathews, Samina Idrees, Dana Ryan, Lindsay Hedden, Julia Lukewich, Emily Gard Marshall, Judith Belle Brown, Paul Gill, Madeleine McKay, Eric Wong, Richard Buote, Leslie Meredith, Lauren Moritz, Sarah Spencer

Background: Medical professionals experienced high rates of burnout and moral distress during the COVID-19 pandemic. In Canada, burnout has been linked to the growing number of family physicians (FPs) leaving the workforce, increasing the number of patients without a regular doctor. This study explores the different factors impacting FPs' experience with burnout and moral distress during the pandemic.

Approach: We conducted semi-structured qualitative interviews with FPs across four health regions in Canada. Participants were asked about the roles they assumed during different pandemic stages, and encouraged (through probes) to describe their well-being, including relevant supports and barriers. We used thematic analysis to examine themes relating to FP mental health and well-being.

Results: We interviewed 68 FPs and identified two overarching themes related to moral distress and burnout: (1) inability to provide appropriate care, and (2) system-related stressors and buffers of burnout. FPs expressed concern about the quality of patient care, as pandemic restrictions limited access to critical preventative and diagnostic services. Participants also described factors that alleviated or exacerbated burnout, including workload, payment model, locum coverage, and team and peer support.

Conclusions: The COVID-19 pandemic limited FPs' ability to provide quality care to patients and contributed to increased moral distress and burnout. These findings highlight the importance of implementing system-wide interventions to improve FP well-being during public health emergencies. These could include the expansion of interprofessional team-based models of care, alternate remuneration models for primary care (i.e., non-fee-for-service), organized locum programs, and the availability of short-term insurance programs to cover fixed practice operating costs.

sidrees2@uwo.ca

Transforming Primary Healthcare: Technology Effects on Compassion in Primary HealthCare (TEC-PHC)

Judith Belle Brown, Thomas Freeman, Madelyn daSilva, Moira Stewart, Amanda L Terry

Background During the pandemic, Family Physicians (FPs) moved rapidly to virtual visits, uncertain how compassionate care could be delivered. Any future role for virtual care must ensure compassion remains at the centre of patient-FP relationships. Our objective is to co-create with patients and FPs a framework for virtual and in-person interactions that inspires and safeguards compassion.

Approach Constructivist Grounded Theory (CGT) study using semi-structured interviews to explore how participants received or provided compassion during virtual interactions. Across the province of Ontario, we interviewed patients with multimorbidity (n=18) who had at least two virtual visits and FPs who had provided virtual care (n=14). Data collection and analysis was iterative using constant comparative analysis with three coding phases (line-by-line, focused and theoretical) and continued until data sufficiency was reached.

Results We identified four main themes. (1) The importance of actions to convey compassion including attentive listening and spending time; patients talked about the need to be understood and FPs described the importance of being present and intentional. (2) How personal and external factors could influence compassionate care including distraction and fatigue. (3) The patient-FP relationship was perceived as the bedrock for compassionate care. (4) The ability through virtual care to extend the provision of compassionate care, especially alleviating anxiety and suffering.

Conclusions These findings are informing upcoming collaborative discussions between patients and family physicians with the aim of developing a framework of virtual family physician care. These findings will inform future research and education interventions for FPs and residents in Family Medicine.

bryan@uwo.ca

Utilization patterns and impact of the chronic pain self-management program in Eastern Ontario

Isabella Moroz, Emily Hum, Rachel Davidson, Sathya Karunananthan, Clare Liddy

imoroz@bruyere.org

Journey mapping of a primary care visit

Anna Chavlovski, Monica Labarge

Background: This study aims to understand the current primary care service experience from a community member's perspective using journey mapping, a visual engagement tool increasingly employed in service and product design to identify pain points and barriers, and to explore opportunities for improvement.

Approach: This is a two-part qualitative study completed within the Frontenac, Lennox & Addington Ontario Health Team (FLA OHT) attributed region. Members of the FLA OHT Community Council (CC) were invited to participate as a convenience sample and asked to refer other participants for snowball recruitment. The study had 16 participants, 13 of which were CC members.

In part one, six phenomenological interviews were conducted to elicit participants' primary care experience, guided by an iterated journey map. In part two, two focus groups were conducted to further iterate the journey map. The data from the interviews and focus groups were summarized in a final patient journey map model organized by journey phases and touchpoints, and themed according to functional, social, emotional, and cognitive experience dimensions. Potential opportunities for improvement were identified.

Results: The resultant journey map elucidates thick qualitative feedback on a community member's experience during a primary care visit and identifies pain points and barriers throughout the journey. It explores opportunities for improvement, both at individual practice and system levels.

Conclusions: Primary care service transformation and co-design require community participation. Journey mapping can be a key input in patient-centered quality improvement processes to generate change ideas that improve the individuals' primary care experience.

annachavlovski@yahoo.ca

Supporting the uptake of primary care research evidence among policy makers

Amanda L Terry, Judith Belle Brown, Tim olde Hartman, Jeannie Haggerty, Emily Marshall, Moira Stewart, Liz Sturgiss, Chris van Weel

Background: The Canadian Transdisciplinary Understanding and Training on Research-Primary Heath Care (TUTOR-PHC) is a unique program that develops capacity for interdisciplinary PHC research. The TUTOR-PHC curriculum includes a workshop for trainees to gain skills and knowledge in engaging with policy-makers for the purposes of knowledge mobilization. Our objective is to share learnings about engaging with policy-makers to promote the use of PHC research.

Approach: A thematic analysis of the summaries from TUTOR-PHC workshops over the last 4 years was conducted using the SPIRIT Action Framework to frame the themes.

Results: Themes included practical actions researchers can take as follows: adopt the mindset of creating knowledge and also creating change based on the evidence we produce; strive to understand policy-maker's context, describe the alignment between your research and the policy-maker's reality; develop ongoing relationships with policy-makers to facilitate the uptake of evidence and co-creation of questions; and understand that policy-makers bring experiential knowledge; anticipate the policy-maker's knowledge needs and provide solutions; develop trusting relationships; invite the policy-maker to be part of the research; use your own knowledge to place research findings in context; bring evidence from other jurisdictions to enhance the knowledge of the policy-maker; and present information on what is feasible, actionable, alternatives and costs.

Conclusions: PHC researchers can enhance their engagement with policy-makers through understanding context, relationship building and skillful synthesis of existing evidence. TUTOR-PHC recognizes this essential component of PHC research and is committed to capacity building in this area.

aterry4@uwo.ca

SPIDER, a structured approach to quality improvement for deprescribing: feasibility evaluation

Michelle Greiver, Dahrouge S, O'Brien P, Wang J, Jean-Xavier C, Manca D, Singer A, Lussier M-T

Background: A quarter of Canadians aged 65 years or older are prescribed ten or more different medications yearly. Polypharmacy, the use of more medications than beneficial, is associated with higher healthcare use, reduced quality of life and increased health care costs.

Aim: Reduce the prevalence of targeted potentially inappropriate prescriptions (PIPs) for seniors prescribed ten or more medications. Intervention: A Structured Process Informed by Data, Evidence and Research (SPIDER), a 12-month intervention in primary care practices that includes validated EMR data for audit and feedback reports, learning collaboratives (LCs), and support through quality improvement coaching. Main outcome: PIPs prevalence. Feasibility was evaluated in three Practice-Based Learning and Research Networks in three provinces. We are currently conducting a cluster Randomized Controlled Trial comparing SPIDER to usual care in seven provinces.

Results: 17 practices were recruited (67% of target), with 94% retention. 78 family physicians and 53 non-physicians participated. The approach was acceptable and practices accessed coaching. 51% of physicians completed surveys Only one network was able to send surveys to patients; seventy surveys were sent; and three were returned. Barriers to multi-site LCs included scheduling difficulties for providers' participation. Some practices had very small numbers of eligible patients. It was difficult to obtain surveys from patients.

Conclusion: SPIDER's approach was found to be feasible, and its implementation can be applied across multiple practice settings in several provinces. It needs to be adapted to reflect the context and needs of practices. Additional efforts will be needed to obtain patient reported measures.

Michelle.greiver@nygh.on.ca

Utilization of Ontario eConsult by primary care providers in correctional facilities

Danica Goulet, Tracy Deyell, Claire Sethuram, Erin Keely, Clare Liddy

Background: Offenders in correctional facilities experience poorer health outcomes than the general population. In Canada, this population has higher rates of latent tuberculosis, sexually transmitted infections, hepatitis C, and HIV. Many of these diseases require specialist care; however, offenders face significant challenges accessing it. Electronic consultation (eConsult) has the potential to address this issue.

Approach: Ontario eConsult is a secure online platform that allows primary care providers (PCPs) to seek specialist advice for their patients. We conducted a retrospective, cross-sectional descriptive analysis of eConsults submitted by PCPs in federal and provincial correctional facilities using the Ontario eConsult Service between April 2019 and March 2023.

Results: 1026 eConsults were submitted by 31 PCPs in correctional facilities, with 96% (N=990) submitted by PCPs in federal prisons. The top three specialties sent to were cardiology (42%, N=429), dermatology (16%, N=164), and endocrinology and metabolism (8%, N=78). The median specialist response time was 0.9 days. The median time specialists spent responding to each case was 15 minutes. PCPs received advice on a new or additional course of action in 35% of eConsult cases. In-person specialist appointments were avoided in 81% of cases.

Conclusions: Ontario eConsult has a positive impact in correctional facilities and reduces the need for face-to-face referrals. This valuable tool is cost-effective, improves access to specialist care for offenders, and eliminates unnecessary transportation with potential security concerns. Future studies should include an economic analysis to evaluate the cost savings and benefits of eConsult in correctional facilities.

dagoulet@toh.ca

Scaling up the ARC Social Prescribing model – The ARC/211 Partnership

Kiran Saluja, Simone Dahrouge, Pam Hillier, Sherry Teeter

Background: Social prescribing (SP) consists of the referral of patients with unmet health and social needs and, most commonly, the provision of navigation services to overcome access barriers and enable access to the needed resources. Beginning in 2014, when SP had not yet been introduced in Canada, in partnership with patient partners, service providers and health planners, we created the Access to Resources in the Community (ARC), established that it was effective and highly valued by patients and PC providers, and significantly reduces access gaps across population. Since 2015 the 211 Community Connection (211-CC), a regional 211 Ontario service provider has been piloting a SP model and is seeking to enhance its performance and measures its impact rigorously. The 211-CC has a bi-directional digital integration with an EMR, secure cloud-based technology for healthcare referrals. Approach: 211-CC members and the ARC research team have partnered to build on our respective experience and assets to produce a highly performant SP model- the ARC/211 SP model. The ARC program outputs (https://www.arcnavigatorproject.com/sp-toolkit) are used to inform navigator training, practice recruitment and engagement strategy, navigation processes, and multipronged evaluation approach and tools. We will first evaluate the ARC/211 SP model feasibility, and then assess its impact across the quintile aim. Conclusions: This initiative exemplifies the potential synergies that can be achieved through a knowledge exchange and collaboration effort between researchers/service providers. We intend for this initiative to serve as a blueprint for the wider adoption of SP provincially.

Ksaluja@bruyere.org

Building the Canadian primary care trials network: Lessons from other jurisdictions

Andrew Pinto

Background: While randomized controlled trials are only one type of study, they have enormous influence on clinical practice, guidelines, policymakers and other researchers, and typically are amongst the largest grants awarded. Primary care trial networks can support efficient and effective trials, support primary care research capacity and career development, and change the perception of primary care research.

Approach: We explored primary care trials networks in United States, the United Kingdom and Australia. Lessons across existing networks were brought together, including the time required to establish and grow networks, how engagement of clinics and providers happens, how research findings are shared back to clinics and providers, and how compensation supports engagement.

Results: Primary care trials networks can improve the efficiency of trials, reduce work, save time and funds, and accelerate science. The common objectives of networks included: 1) supporting primary care researchers to lead trials; 2) standardize and share approaches to recruitment, consent, compensation and data collections; 3) support knowledge mobilization, and 4) serve as a point of connection to other trial networks and training initiatives.

Conclusions: A number of lessons can be learned from primary care trial networks in other jurisdictions. Three key challenges face the Canadian Primary Care Trials Network: 1) How can primary care trials networks best sustain the engagement of clinics and providers? 2) How can funding be used to sustain primary care trials networks, and what are the key operating considerations? 3) How should primary care trials networks be governed?

andrew.pinto@utoronto.ca

Abstracts: Poster Presentations

Impact of the COVID-19 Pandemic on the roles, responsibilities and health of Medical Office Assistants working in Family Medicine Clinics in Ontario: Implications for primary care access and quality

Jennifer Johnson, Judith Belle Brown, Amanda L Terry, Bridget L Ryan

Background: Medical office assistants (MOA) are the most accessible members of health care teams and often patients' first point of contact. Much of the burden of pivoting to new ways of delivering primary care was borne by MOAs during the COVID-19 pandemic yet little is known about the role they played in supporting patients and health care providers.

Approach: Grounded Theory study using semi-structured interviews to explore experiences of MOAs during the pandemic and the perception of their role by family physicians. Data analysis was iterative and occurred alongside data collection. Interviews until saturation of themes was reached.

Results: Eight MOAs and nine family physicians were interviewed across nine communities in Ontario. Independent analysis and a first round of team analysis have occurred. Team members are in the process of consolidating themes. Analysis thus far has found that the roles and responsibilities of MOAs expanded during the pandemic including additional responsibility for triaging and providing compassion to anxious and upset patients which sometimes led to increased stress for MOAs. Despite experiencing greater demands and challenges during the pandemic, MOAs valued most the relationship they have with patients. Family physicians expressed appreciation for MOAs during the pandemic, often realizing during this crisis the pivotal role MOAs play in patient care.

(Preliminary) Conclusions: Most family physicians employ MOAs, yet historically they have been overlooked in research despite their central role in providing access to the services of family physicians. This study addresses this research gap and illuminates the role of MOAs during the COVID-19 pandemic.

jjohn382@uwo.ca

An Evaluation of physician retention bonuses in Newfoundland and Labrador

Gillian Young, Maria Mathews, Lindsay Hedden, Bridget Ryan

Background: Physician retention, particularly in rural areas, is a huge challenge facing the Canadian healthcare system. Regions both within Canada and globally have implemented financial incentives for physician retention but there is very little research examining their effectiveness. Newfoundland and Labrador (NL) implemented the Rural Fee for Service Retention Bonus program in 2008, the retention bonuses are divided into three tiered levels based on geographic location.

Approach: Data from the Medical Practice Registry from the Newfoundland and Labrador Department of Health and the Canadian Institute for Health Information (CIHI) were analyzed to 1) describe the physicians who work in NL, 2) examine physician-level retention in a community, and 3) examine community-level retention.

Results: 1707 physicians who worked in NL between 2000 and 2015 were included in the study. We conducted ARIMA analyses to assess the effectiveness of the retention bonus programs and found no significant impact of the 2003 retention bonus. We found a significant increase in physician retention for specialists in Category 2 communities and a decrease in Category 3 communities following the 2009 retention bonus. The retention bonus was not significant for any other Category levels or for family physicians.

Implications: Implementing retention bonuses in NL did not improve physician- or community-level retention. Study findings suggest that resources could be better invested in other supports to increase physician retention. The results of our study have implications for other jurisdictions in Canada facing similar physician workforce challenges.

gyoung57@uwo.ca

A mixed-methods examination of the role of social work in primary care teams in Ontario, Canada

Rachelle Ashcroft, Alexis Aomreore, Simon Lam, Catherine Donnelly, Nele Feryn, Sally Abudiab, Keith Adamson, Deepy Sur, Jennifer Rayner, Judith Belle Brown

Background: Social workers are important members of primary care teams in Ontario, Canada. The COVID-19 pandemic had significant impacts on social work practice, resulting in the need to examine the evolution and changes to social work roles within primary care teams.

Approach: Mixed-methods with an online, cross-sectional survey consisting of open and closed-ended questions, as well as descriptive qualitative focus groups. Eligible participants were Ontario social workers working in primary care teams.

Results: We conducted 10 focus groups with 57 participants and our survey had 170 respondents. Participants preferred in-person collaboration within teams but also recognized the importance of virtual communication. There was a higher demand for social work services due to increasing case complexities and mental health needs among patients. Participants noted the need to more accurately capture social work contributions and acknowledge time spent on non-clinical work. Social workers also engaged in many informal leadership activities, with a strong desire for more formal leadership opportunities and recognition of leadership work. Participants also shared the importance of feeling valued through access to supervision, fair compensation, and work flexibility.

Conclusion: During the COVID-19 pandemic, social workers in primary care had a crucial role in leading and contributing to addressing increased patient needs and enhanced team collaboration. Ongoing challenges with retention of primary care social workers will be important to address as well as continued optimization of the role of social work in primary care settings.

Rachelle.ashcroft@utoronto.ca

The 6C approach: Principles for interventions addressing the provider retention crisis in primary healthcare

Peter Sheffield, Rachelle Ashcroft

Background: Provider retention in interdisciplinary primary health care (PHC) teams is in crisis. Existing interventions to address this crisis target mid-level constructs (e.g., burnout) instead of retention directly. These interventions are typically provider-level, focusing on profession-specific challenges instead of system-level improvements. Herein, we propose a conceptual model for developing PHC retention interventions that 1) does not rely on these constructs, 2) emphasizes practice- and system-level interventions, and 3) applies across professions to advance provider retention research.

Approach: Bronfenbrenner's developmental theory, the social determinants of health perspective, and third-wave positive psychology were applied as a conceptual framework to a literature review of interventions for improving burnout, moral distress, resilience, and/or well-being in PHC. Thematic analysis was used to identify guiding principles common to effective interventions across constructs.

Results: 14 review articles and 16 additional primary studies were identified that addressed multi-scale interventions relevant to the retention of physicians, nurses, pharmacists, and social workers in interdisciplinary PHC settings. Six themes describing what successful retention interventions do were identified: 1) Celebrate diversity, 2) Center clinician autonomy, 3) Commit to shared care, 4) Compensate equitably, 5) Cull administrative tasks, and 6) Cultivate close and longitudinal patient relationships. These principles were often combined and applied at multiple (provider, practice, and system) levels simultaneously.

Conclusions: This framework highlights what successful PHC retention interventions can accomplish. By orienting clinicians, researchers, and policymakers to relevant, PHC-specific goals, these principles may guide more effective intervention development. Collaborating with providers to identify context-specific targets during intervention design remains imperative.

peter.sheffield@mail.utoronto.ca

Identifying barriers and facilitators to screening for depression among newcomers

Devyani Premkumar, Amrita Roy

Background: Clinical depression among newcomers (immigrants, refugees, and/or asylum seekers) is a significant concern, and guidelines remain unclear on effective screening methods. There are patient-level, provider-level, and system-level factors that contribute to screening challenges, such as (among others) lack of time in appointments, limited community services for positive screens, and unavailability of language translation services. This study aims to survey office-based family physicians in the Kingston, Frontenac, Lennox, and Addington (KFL&A) region to identify potential facilitators and barriers to screening.

Approach: A 10-minute online survey was created using the Qualtrics platform. To enhance content validity and clarity, the survey was formally pre-tested using a structured pre-test guide with three experts in the field of newcomer medicine and three other family physicians working in different practice models. The final survey link is being sent out to family physicians who are currently practicing or have practiced office-based primary care in KFL&A within the last 12 months.

Results: Research in progress; preliminary results to be presented.

Conclusions: Previous studies have evaluated the efficacy of screening, but there is limited research on the implementation of screening and understanding the barriers family physicians face when investigating mental health among diverse populations. The results generated from this survey can push for reform to improve local, culturally-appropriate, resources and explore improved or alternative screening approaches. Newcomers represent an equity-deserving group facing significant challenges in both health and social status; thus, this research is meaningful from an Equity, Diversity, and Inclusion (EDI) lens.

devyani.premkumar@queensu.ca

Job satisfaction associated with different payment models amongst family physicians: A rapid scoping review

Devyani Premkumar, Patrick Kim, Sophy Chan-Nguyen, Jane Philpott, Colleen Grady

Background: The shortage of family physicians in Canada has prompted concerns about career attractiveness and sustainability. Payment model reform could enhance recruitment, retention, and job satisfaction. There are various models implemented in family medicine, but limited research on its feasibility. With an international scope, this study aims to identify the payment model associated with optimal job satisfaction.

Approach: We conducted a scoping review using the Arksey and O'Malley methodological framework. An early literature search assessed papers surrounding family physicians, payment models and job satisfaction. Relevant studies were included if they qualified under a predetermined inclusion and exclusion criteria. During both abstract and full-text review, each study was reviewed by two independent reviewers and conflicts resolved by a third reviewer. Relevant findings were grouped by theme and content.

Results: 6625 studies were included in the initial review. After abstract review, 156 studies progressed to full-text review, of which 29 studies were selected for final data extraction. Preliminary results highlight five predominant compensation types: fee-for-service, salary, capitation, loan repayment incentives, and performance-based schemes. Though other payment models had mixed results, there appeared to be some preference for capitation, which was associated with greater job satisfaction.

Conclusion: Though there are different justifications towards provider preference for a payment model, this review did not find consensus on which model leads to greater job satisfaction. A further analysis on the individual and systemic factors that result from compensation can help determine the optimal payment model and its relation to provider satisfaction.

devyani.premkumar@queensu.ca

Primary health care Registered Nurses as facilitators of healthcare access for recent immigrants in Ontario: An interpretive descriptive study

Eugenia Ling, Rebecca Ganann, Melissa Northwood, Olive Wahoush

Background: Research has shown that recent immigrants experience unique challenges when accessing health care. Registered Nurses (RNs) working in primary health care (PHC) have the competencies and are well-positioned to facilitate healthcare access for immigrants. This study aims to explore how PHC-RNs in Ontario address barriers and support healthcare access among recent immigrants. Approach: A qualitative, interpretive descriptive approach was used. Purposeful sampling was used to recruit 10 PHC-RNs practising in Toronto, Ottawa-Gatineau, Hamilton, Kitchener-Cambridge-Waterloo, and London where the majority of recent immigrants live in Ontario. Data were collected using one-to-one, semi-structured interviews informed by Levesque et al.'s (2013) access framework. Data were collected and analyzed concurrently.

Results: Preliminary findings show that PHC-RNs play instrumental roles in supporting recent immigrants in facilitating healthcare access. Notably, PHC-RNs:

- Holistically assessed patient needs and connected them to appropriate resources;
- Provided education on accessing health and complementary services;
- Tailored and utilized strategies to address language barriers;
- Translated health information into accessible language to promote health literacy; and
- Coordinated affordable health service options within or beyond the PHC setting.

The PHC-RN role could be optimized by:

- Delivering preventative care through outreach activities or programs in local communities; and
- Conducting needs assessments for immigrants immediately upon arrival and connecting them to appropriate health services.

Conclusions: PHC-RNs are key facilitators of healthcare access for recent immigrants by coordinating their care, educating, and connecting this population to services across the health system. However, there are opportunities to optimize nursing roles to promote the health of immigrants.

Linge6@mcmaster.ca

Comprehensive family medicine under construction

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

Background: There is a critical decline in family physicians practicing comprehensive care. Objective: To explore early career family physicians' (FPs) decision-making process in their choice to practice comprehensive care. Approach: Grounded theory study using interviews via Zoom, with individual and team analysis. Participants: 38 family physicians practicing in Ontario, who completed their residency training within the last 5 years. Results: Participants' stories revealed their journey in establishing a comprehensive care practice. Many participants began this journey doing locums. Reasons for locuming included: 'testing the waters' by experiencing different practice types; flexibility of hours worked, no management responsibility and not ready to assume a patient roster. The next juncture in their journey was deciding to commit to a practice and this settling into providing care from 'cradle to grave' took on a new definition, described as a 'hybrid model'. They had much smaller patient rosters, often working 3 days per week (office-based comprehensive care) and 2 days a week practicing in a specific area of interest (e.g. dermatology, hospitalist). The hybrid model of practice offered variety and for some mitigated burnout. Like any traveller on a journey, participants faced many contextual challenges that threatened the practice of comprehensive care, including the burden of administrative tasks; deteriorating specialist-family physician relationship; lack of access to team-based models; inadequate remuneration; and a pervasive feeling that Family Medicine is undervalued. Conclusions: Findings reveal how the definition and practice of comprehensive care is currently under construction influenced by both individual needs and expectations of early career FPs as well as the current context in which they practice.

jbbrown@uwo.ca

An exploratory sequential mixed methods study on health system transformation in health professions education

Ashley Chisholm, Douglas Archibald, Katherine Moreau

Background: With health professions experiencing increasingly formal expectations to be accountable to health systems transformation (HST), we require systematic knowledge about the current state of HST in the context of health professions education (HPE).

Approach: A two-phase, sequential, exploratory mixed-methods study was conducted on the current state of HST in HPE and considerations for future curriculum development and programs of research. In Phase I, a one-time online survey was administered to stakeholders (n=77). In Phase II, 23 stakeholders were interviewed. Survey data were analyzed using SPSS and interview data were coded following reflexive thematic analysis.

Results: In Phase I, 56% of stakeholders disagreed that HST is supported by the current culture of HPE, 70% disagreed that HST concepts are well defined and described in HPE, and 75% disagreed that faculty/preceptors have in-depth knowledge about HST. In Phase II, five themes arose related to the current state of HST in HPE: 1) the current role of health professionals in HST; 2) the influence of clinical and basic sciences in HPE; 3) a strong understanding of the content but not the context; 4) recent progress and challenges; and 5) the implementation of HST in HPE. Two themes arose related to future curricula development and programs of research: 1) the need for comprehensive and inclusive education; and 2) the need for research that addresses complexity in a changing system.

Conclusion: This research provides direction to stakeholders on the resources and activities needed to ensure that informed health system transformation training decisions are made.

achis016@uottawa.ca

A comparative policy analysis of medical care provider commitment in Canadian and international long-term care homes

Ashley Olah, Ava Poirier, Darly Dash, Nathan M Stall

Background: The COVID-19 pandemic exposed discrepancies in medical provider commitment in long-term care (LTC) homes. Medical provider commitment has been conceptualized as: 1) proportion of medical practice dedicated to LTC, 2) number of LTC residents cared for, and 3) time spent on individual resident encounters. It is not known what standards exist for medical care provider commitment in Canada and internationally.

Approach: We performed a comprehensive literature review of medical provider commitment models for each Canadian province and territory, and fifteen other Organisation for Economic Co-operation and Development (OECD) countries with above average LTC spending. Two reviewers independently searched and abstracted data from the peer-reviewed and gray literature, LTC association websites, and consulted with experts in the field. Information was synthesized, and models of commitment were compared across jurisdictions.

Results: We found limited information for standards of medical provider commitment in Canada and internationally. There are no Canadian standards for medical provider commitment, and no information available for five provinces and territories. Most information was related to expectations concerning remuneration, and only New Brunswick, PEI, and Saskatchewan detailed expectations about physical presence in the LTC home and/or frequency of regular visits. Our international review also yielded limited information, with only Belgium, France, Netherlands, New Zealand, and the United States having national standards, with varying details on medical provider commitment.

Conclusion: In Canada and internationally, there is limited information on standards for medical provider commitment in LTC homes, highlighting a need for consensus-based quality standards for optimal provider commitment.

ashley.olah@sinaihealth.ca

Developing a measure of Ontario long-term care physician commitment and how commitment influences resident outcomes

Darly Dash, Henry Siu, Aaron T Jones, Andrew P Costa

Background: Long-term care (LTC) physician commitment has been proposed as a predictor of quality. Commitment is conceptualized as the proportion of medical practice devoted to LTC, time spent with residents, and time spent within a LTC home and working with the team. However, no measure exists quantifying LTC physician commitment to understand its impact on quality of care and resident outcomes.

Approach: We analyzed existing secondary data sources from Ontario health administrative databases to practically measure commitment. We engaged a LTC physician expert panel to review data and obtain guidance on measuring LTC physician commitment. An updated measure of commitment is under development along with regression analyses measuring how commitment is associated with important resident outcomes (e.g., medication usage, hospitalizations, and transfers).

Results: The initial measure of LTC physician commitment was operationalized as the proportion of LTC residents from within a physician's overall practice and overall workload. The expert panel found this conception satisfactory and suggested describing commitment with other factors such as geographic location (rural or urban practice), panel size of the LTC and other medical practice, the practice and compensation models used by LTC physicians, and the clinical complexity of the resident and patient roster.

Conclusions: This work is the first to study LTC physician practice to measure commitment and how commitment influences resident outcomes. Measuring commitment of LTC physicians supports epidemiological monitoring at a population level to evaluate the level of commitment at which standards of care will be optimal and the quality of medical practice in LTC homes.

dashd@mcmaster.ca

Family physicians' roles in long-term care homes and other congregate residential care settings during the COVID-19 pandemic: A qualitative study

Maria Mathews, Jennifer Xiao, Lindsay Hedden, Julia Lukewich, Emily Gard Marshall, Richard Buote, Leslie Meredith, Lauren Moritz, Dana Ryan, Sarah Spencer, Shabnam Asghari, Paul S Gill, Jamie Wickett, Eric Wong

Background: The COVID-19 pandemic disproportionally affected long-term care (LTC) homes and other community-based congregate residential settings. Although family physicians (FPs) play important roles in the care of residents in LTC homes, provincial pandemic plans make few references to their specific roles in LTC.

Approach: The project examined the experiences of FPs providing care in LTC homes and other congregate care settings in four jurisdictions (Vancouver Coastal Health region of British Columbia, The Eastern Health region of Newfoundland and Labrador, the province of Nova Scotia, and the Ontario Health West Region) during the first year of the COVID-19 pandemic (2020-2021). We utilized a multiple case study design using semi-structured qualitative interviews to explore FP roles during each pandemic stage, and their experience performing these roles, and employed a thematic analysis approach to identify recurring themes and concepts within the data. FPs were recruited along a wide range of characteristics using maximum variation sampling.

Results: Sixty-eight FPs completed interviews. Along with responsibilities at their primary care clinics, many FPs also provide care in community-based congregate residential settings. We identified three major themes related to FPs providing care in these settings during a pandemic: 1) the roles of FPs, 2) modifying the delivery of routine care, and 3) special workforce considerations in pandemic response for these settings.

Conclusions: FPs have a unique understanding of the populations they serve and are well-suited to plan and implement community-adaptive procedures. Future pandemic plans should implement LTC-related FP roles during the pre-pandemic stage of a pandemic response.

maria.mathews@schulich.uwo.ca

Task shifting and skill mix innovation in interprofessional, team-based primary health care: A realist review protocol

Q. Jane Zhao, Alison Flehr, Elizabeth Molloy, Lena Sanci, Sara Allin, Rick Glazier, Fiona Webster, Monica Aggarwal, Andrew Pinto

Background: Exacerbated by the COVID-19 pandemic, primary care systems worldwide face a health human resource crisis. Task shifting and skill mix innovations are two potential strategies to address this problem. Task shifting is defined as the "rational redistribution" of care tasks among health workforce teams. Skill mix is defined as "changes to the skills, competencies, roles or tasks" within and across health workers. Task shifting is a form of skill mix innovation, along with the addition of new tasks or roles.

The objective of this study is to conduct a realist review of all task shifting and skill mix innovation literature in high-income countries with universal health systems, ensuring comparability and generalizability of findings.

Approach: We will follow the RAMSES publication guidelines for realist reviews. After developing and refining our search strategy, we will use DistillerSR to manage citations and extract data. All citations and full-texts will be double-reviewed. Screeners will be trained and evaluated iteratively. We will group together papers with the same context (by country and time period).

Results: From our review, we will identify examples of task shifting and skill mix innovation within team-based primary care and examine health systems outcomes. We will examine cases of task shifting and skill mix across diverse Contexts to identify the underlying Mechanisms that resulted in success (Outcomes). Our findings will guide future program and policy development in primary care.

Conclusions: This study will be the first of its kind and offer insights into health workforce planning and development.

jane.zhao@uhn.ca

First Line of Defense: The vital role of family physicians in preventing acute mesenteric ischemia in high-risk patients

Sara Arfan, Lavanyah Anbazhagan

Background: Acute mesenteric ischemia (AMI) is a life-threatening condition with a mortality rate of 60-80%, despite surgical interventions. The morbidity and mortality are especially high in those with risk factors which include diabetes mellitus, hypertension, coronary artery disease, recent myocardial infarction and rheumatic autoimmune diseases among others.

Approach: We present the case of a 70-year-old Caucasian woman diagnosed with AMI.

Results: The patient presented acutely to the emergency department after nine episodes of vomiting and was admitted to the surgical floor the same day for emergent exploratory laparotomy. She presented acutely with an atypical presentation and without any progressive symptoms despite various comorbidities. This patient was classified as "very high risk", however, she had not been on any medications nor monitored for any of her comorbidities.

Conclusions: We highlight the essential multifaceted role of primary care physicians in the prevention of bowel ischemia and recommend the use of routine outpatient monitoring with clinical examination, blood testing, and imaging. These along with a high index of suspicion has clinical utility in preventing hospitalization, surgical intervention (bowel resection) and other serious sequelae of AMI. Timely detection, management and specialist referrals from a family medicine physician can lower the overall burden on healthcare resources and personnel.

saraarfan92@gmail.com

Examining geographical disparities in breast cancer screening and primary care attachment: Prioritizing FSAs for primary care intervention

Payton Rix, Lynn Roberts, Paul Nguyen, Eliot Frymire

Background: This study examined the relationship between primary care attachment Forward Sortation Areas (FSAs) with low breast cancer screening rates. FSAs are geography regions identified by the first three characters of a Canadian postal code1. This research focused on eliciting the role that primary care attachment can play in improving cancer screening rates in under screened FSAs.

Approach: This study utilized attachment data from selected FSAs to analyze cancer screening rates among different geographic locations in Ontario2. The 25 FSAs with the lowest breast cancer screening rates were compared with the primary care attachment rates to identify patterns and gaps in coverage. The insights gathered from low cancer screening rates and attachment patterns should influence policy development and resource distribution across Ontario.

Results: Results indicate a linear relationship between low cancer screening rates and primary care attachment style, with lower average FSA screening rates exhibiting lower rates of attachment to physicians. Of the 25 FSAs with the lowest breast screening rates, 10 of these were among the 25 FSAs with lowest primary care attachment rates. All but 3 FSAs fell within the bottom 50% of FSAs for primary care attachment.

Conclusions: Findings identify disparities in cancer screening rates in FSAs with decreased attachment. By distinguishing regions acutely affected by low cancer screening rates, this study advocates for targeted support and resources to address healthcare inequities. The ways in which attachment style impacts cancer screening rates support policy development which aims to increase team-based primary care access and promote attachment in FSA's experiencing these disparities.

payton.rix@queensu.ca

Primary care for all: Lessons for Canada from OECD countries with high primary care attachment

Heba Shahaed, Richard H Glazier, Michael Anderson, Erica Barbazza, Véronique LLC Bos, Ingrid S Saunes, Juha Auvinen, Maryam Daneshvarfard, Tara Kiran

Background: Strong primary care enables better outcomes for patients, lower costs and better equity. In Canada, approximately 15% of the population reports not having access to a family doctor or other regular care provider. In addition to this, there are fewer medical students choosing to pursue family medicine, and more graduating family physicians are choosing not to practice generalist office-based care.

Approach: We conducted an analysis to determine which OECD countries have high primary care attachment rates and what strategies they use to enable this. We consulted the 2020 Commonwealth Fund Survey, European Observatory reports, and Commonwealth Fund Country Profiles and identified nine countries with primary care attachment rates higher than 95%. These countries were compared to Canada on a range of country, health and health system characteristics.

Results: The UK, Norway, Netherlands and Finland were selected for a further deep dive supported by literature and health system experts. These OECD countries have stronger contractual agreements and accountability for family doctors including where they practice, their scope of practice and who they accept. They also have a higher proportion of total health spending that is public, fewer family doctors who work in walk-in clinics or specialized areas, and a highly organized network for after-hours primary care. Payment is through capitation or salary, and there is highly effective use of interprofessional teams along with digital tools and information systems.

Conclusion: Lessons learned may help guide reforms in Canada to enhance the current state of our primary care systems.

heba.shahaed@mail.utoronto.ca

Exploring the health complexity and demographics of Ontario's unattached patients

Fatima Ali, Lyn M Sibley, Yin Li

Background: There is evidence that the number of unattached people in Ontario is increasing. Better understanding of the characteristics of unattached people provides insight into the nature and urgency of the attachment crisis and informs targeted policy interventions.

Approach: Using a modified version of a published patient attachment algorithm, we classified Ontario residents in 2021 as attached or unattached. We evaluated health complexity using the CIHI population grouper and compared complexity by demographic and sociodemographic factors. We did further analysis to characterize the subset of highly complex but unattached patients.

Results: Of the 14.7 million Ontario residents in 2021, 83.6% were attached, and 16.3% were unattached. More male residents (57%) were unattached than female residents (42%). This sex difference was most pronounced during ages 19-49 (females = 39%). Geographically, we found lower attachment proportions in the Toronto and North health regions compared to the rest of Ontario (~78% vs. ~85%). Additionally, we found a greater proportion of highly-complex-unattached patients residing in the North than expected. Furthermore, we found that a majority of unattached-highly-complex patients lived in neighbourhoods where the percentage of Indigenous residents was above the median (60%), the percentage of recent immigrants was below the median (66%), and the median household income was below the median (60%).

Conclusions: Our analysis shows that highly-complex-unattached patients tend to be young to middle-aged men, live in the North, and live in neighbourhoods with higher proportions of Indigenous residents, lower proportions of recent immigrants, and lower median household income than other unattached patients.

tim.ali@mail.utoronto.ca

Primary health care utilization in All Nations Health Partners Ontario Health Team: Assessing preventative services, COVID-19 impacts and recommendations for improving access

Paige Stevenson, Barb Zelek, Roya Daneshmand, Brianne Wood

Background: More than 1 million Canadians are living with cancer, with Northern Ontario populations experiencing significant health disparities, especially in rural and remote areas. COVID-19 worsened these inequities by affecting Northern communities' social, economic, and health well-being. Health service closures and disruptions during the pandemic, compounded by the burden on primary care providers for cancer screening, posed significant challenges. Our study investigated opportunities for cancer screening improvement in All Nations Health Partners Ontario Health Team (ANHP OHT), with a particular focus on how COVID-19 affected preventive healthcare services.

Approach: We utilized snowball sampling to recruit participants from various ANHP OHT partner organizations, conducting online semi-structured interviews with eighteen participants. Thematic analysis was used to present the findings.

Results: The four central themes were Integrated Data Access and Risk Aversion with emphasis on governance and trust for seamless data sharing and leveraging digital solutions to harmonize EMR data; Enhanced Integrated Care to streamline healthcare services and promote coordinated patient-centred care to optimize resource utilization, especially in resource-constrained health systems; Culturally Competent and Trauma-Informed Care to integrate trauma awareness into healthcare practices and includes culturally sensitive cancer screening initiatives; and Integrated funding and infrastructure including differing regulatory bodies and financial reservoirs.

Conclusions: Collaborating with Northern OHT providers and administrators, our research team developed contextualized recommendations to help offer high-quality evidence supporting primary care enhancement while recognizing ANHP's unique characteristics. Our work addresses systemic barriers to cancer screening improvement and contributes to understanding the COVID-19 pandemic's impact on primary care preventive services.

pstevenson@nosm.ca

Exploring Interprofessional Primary Care (IPPC) Teams' impact on chronic disease management: A narrative review on IPPC Team guiding features and reported outcomes

Melanie Dissanayake, Emma Wardhaugh, Carri Hand, Sheila Moodie, Shannon L Sibbald

Background: Interprofessional Primary Care (IPPC) teams, a model in which at least two health care providers from different disciplines work together, are a suggested approach to support chronic disease management in primary care. However, there is a paucity of literature around the organizational and interpersonal features (guiding features) that facilitate successful IPPC team outcomes, and specifically what these outcomes entail for chronic disease management.

Approach This aim of this review was to examine the guiding features, and clinical, humanistic, and economic outcomes related to IPPC teams and chronic disease management. The databases MEDLINE, Scopus, CINAHL, Embase, and The Cochrane Database of Systematic Reviews were searched for full-text English articles from 2000-2023. Primary studies evaluating outcomes related to IPPC teams in chronic disease management interventions were included. The review looked at the guiding features characteristic of IPPC interventions, as well as clinical, humanistic, and cost outcomes.

Results: 24 studies on IPPC interventions were included. 12 studies reported clinical outcomes, 15 reported humanistic outcomes, and 3 studies reported economic outcomes. IPPC teams were impactful towards improving outcomes for patients and providers. Studies also reported specific interactional components (such as communication, collaboration, knowledge sharing, and shared decision-making) and practice features (such as team meetings, patient education, asynchronous care) that facilitated interventions.

Conclusion: Implementation of interprofessional collaboration is complex owing to the complexity and variety of primary care contexts. The current review offers information for patients, providers, and policy related to the facilitating factors and outcomes related to IPPC interventions for chronic disease.

melanie.dissanayake@schulich.uwo.ca

Exploring the lived experiences of women with chronic obstructive pulmonary disease

Madeline Dougherty, Shannon L Sibbald

Background: Currently, there are many barriers to women seeking diagnosis and treatment for Chronic Obstructive Pulmonary Disease (COPD). These barriers include greater under-diagnosis than men and fewer medical consultations, among others (Gut-Gobert et al., 2019). COPD is a chronic disease that causes obstructions in the small airways of the lungs leading to extreme discomfort and decreased quality of life. COPD can cause a persistent cough with phlegm, persistent wheezing, breathlessness, and tiredness. There is no cure for COPD; treatments for the disease are used to manage symptoms and prevent exacerbations (World Health Organization, 2022). As such, the quality of life of a person living with COPD can depend on the care that is being received (Townsend et al., 2012). Often thought of as a "male smoker's" disease, in the past decade there has been a sharp increase in the number of COPD cases in women (Townsend et al., 2012). This research will aim to explore the lived experiences of women with COPD to support the development of solutions to providing optimal and equitable care for women.

Approach: This study will use Van Manen's hermeneutic phenomenological methodology to explore the lived experiences of women with COPD guided by a critical theory paradigm. This study will be conducted using semi-structured one-on-one interviews.

Results: Information from my literature review will be presented.

Conclusions: By exploring the experiences of women receiving treatment for COPD, this research can be used to help support the development of solutions to allow women to receive equitable care for COPD.

mdoughe5@uwo.ca

Exploring experience using a novel patient reported experience measure - The PREM-C9+

Floriana Sherifi, Shannon Sibbald, Elaine Zibrowski

Background Chronic obstructive pulmonary disease (COPD) is a respiratory disease that causes progressive airflow limitation. Patients are subject to progressive organ failure and experience a gradual decline in their health-related quality of life, physical condition, and functioning. In the Canadian healthcare system, gaps have been observed in the healthcare providers' understanding of their COPD patient experiences. Patient-reported experience measures (PREMs) capture patients' interactions with healthcare systems and the degree to which their needs are being met, however the experience of patients living with COPD and their views on the quality of healthcare they receive has yet to be captured. A COPD-specific PREM was developed in the United Kingdom, however it has not been tested within the Canadian COPD population.

Approach Our study will explore a COPD-specific, 9-item questionnaire, called the PREM-C9+, building upon PREM-C9 with additional demographic probes. This questionnaire has only been tested in the UK, and we want to know whether it is effective for use in primary care in Ontario, Canada. We would like to explore the utility and validity of PREM-C9+ within the context of our Best Care COPD (BCC) Program to help enhance patients' experiences with COPD. BCC is a team-based program that focuses on the management of Chronic Obstructive Pulmonary Disease (COPD).

Results We plan to investigate whether the PREM-C9+ is considered useful and valid for standard-of-care practices for patients with COPD.

Conclusions This study aims to provide insight into the applicability and usefulness of the survey to understand what patients consider is important to them and in relation to their care. Our study hopes to aid clinicians to better understand the patient perspective and to form patient prioritized goals in co-designed management programs.

fsherif6@uwo.ca

Developing an online questionnaire to investigate the COVID-19 pandemic's impacts on social isolation and health in older adults living with multimorbidity: A pilot study

Patricia Nistor, Bridget Ryan, Amanda Terry, Madelyn daSilva, Shehzad Ali, Lorraine Bayliss, Jason Black, Judith Belle Brown, Sonny Cejic, Lauren Cipriano, Tom Freeman, Saadia Jan (Hameed), Jacqueline Keuper, Dan Lizotte, Maria Mathews, Matthew Meyer, Kathryn Nicholson, Sudit Ranade, Jennifer Rayner, Kamran Sedig, Michael Silverman, Mark Speechley, Saverio Stranges, Alex Summers, Amardeep Thind, Evelyn Vingilis, Stephen Wetmore

Background. Social isolation and loneliness are associated with morbidity and mortality and have become an increased concern during the COVID-19 pandemic. Social restrictions preventing spread of COVID-19 possibly increased social isolation and loneliness. Reliability and validity of a questionnaire assessing the COVID-19 pandemic's impact on social isolation, loneliness, and resiliency in community dwelling older adults with multimorbidity was investigated.

Approach. This pilot study will test the methodology for a larger Canadian Institutes of Health Research-funded study, The Untold Story of COVID-19. A conceptual framework was developed, aligning with project objectives and guiding questionnaire construction. Participants were recruited through professional networks and poster advertisement, comprising a purposive sample. Feedback interviews will assess questionnaire usability, face and content validity, along with team meetings assessing face validity, and Content Validly Matrix assessing content validity. Cronbach's α assesses reliability of the validated scales used. Descriptive statistics and logistic regression will be computed.

Anticipated Results. The current pilot study's results will inform the larger project and are anticipated to show validity and reliability of the developed questionnaire. Results from this pilot study will inform the fitting of the statistical models for The Untold Story of COVID-19 project. Results will be available to share at Trillium Health Research Day.

Anticipated Conclusions. This pilot study's results will inform refinement of the questionnaire and data collection prior to implementing the larger study. Assessing the internal consistency of the previously validated scales used in the questionnaire, and validity of the overall questionnaire, will help provide justification for use of the questionnaire in a larger group.

pnistor3@uwo.ca

Examining diabetes data in the Primary Care Data Reports (PCDR)

Aya Tagami, Maggie MacNeil, Rebecca Ganann

Background: Diabetes affects 2.4 million people in Canada and 972,200 Ontario residents. Diabetes is associated with numerous factors including socioeconomic status; its prevention and management are challenging and require extensive resources. Primary Care Data Reports (PCDR) were developed by INSPIRE-PHC researchers to inform health system investments and attachment strategies across Ontario Health Teams (OHTs). Examining the PCDR diabetes data to understand diabetes prevalence across OHTs and attachment rates among those with diabetes may lead to better understanding of OHTs that face socioeconomic disparities and guide informed resource allocation decisions.

Approach: Data on diabetes in attached and uncertainly attached patients receiving primary health care were extracted from the 2020 PCDR for OHTs. OHTs were organized in descending order by numbers and percentages of uncertainly attached patients with diabetes receiving primary care, as well as by the total numbers and percentages of people with diabetes. Provincial data were included for reference.

Results: Scarborough was identified as the OHT with the highest proportion and number of patients with diabetes in Ontario. It ranks within the top 10 OHTs across each metric, ranking number one in three indicators. North Western Toronto also ranked highly in all four metrics, while Mississauga and Central West ranked highly in three. These OHTs had higher rates of diabetes than provincial rates and higher rates of uncertainly attached among those living with diabetes.

Conclusions: Patients with diabetes in Scarborough and North Western Toronto may benefit from attachment strategies to address uncertain attachment and receive comprehensive person-centred care.

tagama1@mcmaster.ca

Chronic disease risk prediction models and their impacts on behavioural and health outcomes: A systematic review and meta-analysis

Megan Harley, Patrick Kim, Jason E Black, Jacqueline Kueper, Kathryn Nicholson, Amanda L Terry, Adrienne T Wakabayashi, Daniel Lizotte

Background: Risk prediction models offer potential support as clinical tools because they are designed to capture combinations of risk factors to determine the risk of a health event. Though these models are routinely developed for use in clinical practice, relatively few studies focus on the impact of risk prediction models in the primary care setting, and there is no consensus on the effects of the use of these models. We sought to identify the impact of risk prediction models on chronic disease on physician behaviour, patient behaviour, and patient health outcomes.

Approach: A systematic review of scientific and grey literature published between 1976 and 2017 was conducted; work is in progress to update this review to 2023. Study designs considered were experimental, observational, and qualitative, while narrative reviews and case studies were excluded. A meta-analysis was conducted using a random effects model. Impact on physician behaviour, patient behaviour, and patient health outcomes were evaluated.

Results: Per the screening criteria, 22 were included. Physician behaviour was positively influenced by the use of risk prediction models, though this was not a statistically significant finding. Changes in patient behaviour were inconclusive. Some patient health outcomes improved; however, these results may lack clinical significance.

Conclusions: Despite methodologic discrepancies among the eligible studies, the original study of literature published up to 2017 indicates some effects of the use of risk prediction tools exist. Future studies are needed to assess the overall impact of risk prediction models in primary care settings.

mharley3@uwo.ca

Developing quality indicators for the primary care of older adults: Findings from a RAND/UCLA appropriateness method study

Rebecca Correia, Henry Yu-Hin Siu, Meredith Vanstone, Aaron Jones, Andrew P Costa

Background: Older adults have high rates of primary care use, and quality primary care has the potential to address complex medical needs. Family physicians have different levels of knowledge and comfort in caring for older patients, which may influence the quality of care delivery and resulting health outcomes. We aimed to establish consensus on practice-based metrics that characterize quality of care for older primary care patients and can be examined using secondary, health administrative data.

Approach: We conducted a two-round RAND/UCLA Appropriateness Method study. We used statistical integration to combine technical expert panellists' judgements and content analysis for open-ended responses. This study presents a case of using health administrative data to understand quality of care within population-based data holdings at ICES in Ontario, Canada, for all publicly funded health services encounters. We recruited 12 pan-Canadian clinicians and researchers who demonstrate expertise relevant to caring for elderly patients. Technical expert panellists completed two questionnaires and one virtual group meeting. Indicators were rated on a nine-point Likert scale.

Results: Our literature search and internal screening resulted in 61 practice-based quality indicators for rating by the technical expert panel. After the first questionnaire, we developed technical definitions for each endorsed indicator using ICES data holdings. We then facilitated a virtual synchronous meeting in which panellists offered feedback on the proposed technical definitions, and completed a second questionnaire.

Conclusions: We achieved consensus on a set of 14 quality indicators to support further research examining primary care provision for older adults using health administrative data.

correirh@mcmaster.ca

Developing the Social Housing in Ontario, Canada (SHOC) cohort with administrative data for future use in epidemiological studies

Kumindu Gamage, Sahar Popal, Seth Walvinz Quimson, Melissa Pirrie, Ricardo Angeles, Francine Marzanek, Jasdeep Brar, Guneet Mahal, Mikayla Plishka, Christie Koester, J Michael Paterson, Francis Nguyen, Gina Agarwal

Background: Social housing residents are a marginalized population exhibiting poor health. We describe the creation of the Social Housing in Ontario, Canada (SHOC) cohort, using innovative methods to identify these residents in administrative data. The SHOC cohort can be used further for novel population health related research.

Approach: The SHOC cohort was created in two steps. Street addresses for social housing locations with ≥10 units were obtained from regional housing providers. Matching postal codes were confirmed with Canada Post. Postal codes that contained ≥50% social housing were linked to ICES datasets. All individuals residing at those locations as of January 1, 2019 were included. Descriptive statistics were used to summarize the number of social housing locations and individual-level demographics of the cohort.

Results: A total of 2850 postal codes were identified that met the eligibility criteria, representing 2,213 social housing building locations (34.6%Western, 24.4% Eastern, 23.0% Central Eastern, 9.5% Central Western, 8.5% Northern). The SHOC cohort comprised 386,790 individuals with 56.4% females and an age distribution of 23.0% under 18 years, 49.6% 18-59 years, 20.6% 60-79 years, and 6.8% 80 years and older.

Conclusions: A large SHOC cohort was successfully established within the ICES administrative data environment, which can facilitate health status and healthcare utilization research focussed on this marginalized population. Future cohorts based on other reference dates will also be established using this method.

gamagek@mcmaster.ca

Environmental scanning to inform a mobility-promoting integrated care model: EMBOLDEN

Abbira Nadarajah, Caroline Moore, Rebecca Ganann, Bruce Newbold, Eugenia Ling, Salwa Siddiqui, Chwen Binkley, Christine Siu, Amanda Kennedy

Background: Environmental scanning is key to informing policy, planning, and program development. An environmental scan was conducted to inform the co-design and implementation of a randomized controlled trial to promote mobility in older adults who reside in areas of high health inequity in Hamilton and Toronto. Iterative environmental scanning was conducted to inform pragmatic implementation and to partner with health and social service organizations in integrated care delivery.

Approach: An environmental scan, utilizing census data, virtual and in-person windshield surveys, and Geographic Information Science (GIS) mapping, was conducted to determine priority neighbourhoods and inform trial implementation. The environmental scan was updated to assess the post-pandemic landscape and include updated (2021) census data. Primary care, public health, and community organizations together with citizen partners were engaged to interpret and expand asset maps and identify additional potential partners to shape program implementation.

Results: Eight Hamilton and two Toronto priority neighbourhoods were identified using the environmental scan and strategic input from organizational partners. Citizen partners provided a more nuanced understanding of available community assets and how people interact with them. Additional information that shaped decision-making included addressing gaps in existing services. Iterative environmental scanning, including reassessment of key census data indicators in 2023, confirmed the chosen priority neighbourhoods and provided insight into future target sites.

Conclusions: Environmental scanning better aligns program design with existing services and leverageable assets. Scanning was critical to understanding the context for the EMBOLDEN intervention, creating a relevant program and informing program implementation and adaptations for each study site.

nadara2@mcmaster.ca

Health-related social housing characteristics in Ontario: A descriptive survey in Hamilton and Niagara Regions

Seth Walvinz Quimson, Kumindu Gamage, Sahar Popal, Melissa Pirrie, Ricardo Angeles, Francine Marzanek, Jasdeep Brar, Guneet Mahal, Mikayla Plishka, Christie Koester, Gina Agarwal

Background: The health and well-being of social housing tenants is influenced by a wide range of contextual factors. Social housing characteristics (i.e., housing conditions, facilities and amenities, accessibility, and available support services) may impact social housing residents' health, but no literature exists on health-related social housing conditions in Ontario. Here we describe health-related social housing characteristics in two large regions of Ontario.

Approach: This was an observational study of subsidized housing sites within the Hamilton and Niagara regions in Ontario. The municipal housing providers for each region were contacted and invited to participate. Data was collected from key housing administrators via self-completed forms and phone interviews, utilizing an environmental scan template. Descriptive statistics were used to analyze the data.

Results: Data was collected for 121 addresses, 59 (48.8%) were apartment buildings, 38 (31.4%) were townhouses, and 12 were semi-detached houses. The majority, 86 (71.1%), were built between 1950-1970, 85 (70.2%) had a history of pest infestation, 68 (56.2%) have asbestos, while 27 (22.3%) had building safety issues. Hamilton reported closer proximity to bus stops, and more available wellness-programs and support services. Niagara reported relatively better housing conditions, more green space and outdoor sitting areas and fewer available programs and support services.

Conclusions: Characteristics were evident in both sites that could affect residents' health. Substantial variability existed in the health-related characteristics between the two regions. Future studies should explore health outcome disparities based on these housing characteristics to inform future social housing planning.

quimsons@mcmaster.ca

Experiences of chronic pain in social housing residents, aged 55 years and older, in Ontario

Sahar Popal, Seth Walvinz Quimson, Kumindu Gamage, Ricardo Angeles, Melissa Pirrie, Francine Marzanek, Jasdeep Brar, Guneet Mahal, Mikayla Plishka, Christie Koester, Gina Agarwal

Background: Chronic pain negatively impacts quality of life and is prevalent among community-dwelling, low-income seniors. We assessed the association between chronic pain and mobility, self-care, ability to perform usual activities, mental health, food and income insecurity, falls, and certain medical conditions amongst low-income older adults.

Approach: A cross-sectional analysis was conducted using the Community Paramedicine at Clinic (CP@clinic) and Home (CP@home) program data between 2019 and 2023. These programs administer health risk assessments to community-dwelling low-income older adults, delivering tailored health education/promotion to address identified health risk factors. Univariate statistics assessed the association between pain severity and the number of pain medications taken, in relation to quality of life and other factors.

Results: There were 1015 program participants, mean age=76.51 (sd=11.80), 70.5% females, and 78.0% lived alone. Around 63% of participants experience pain and 34% take pain medications. Degree of pain severity was significantly associated ($p<0.05$) with mobility, ability to perform usual activities, self-care, anxiety and depression, food and income insecurity, and falls. Number of pain medications was significantly associated ($p<0.05$) with gender, level of physical activity, presence of food and income insecurity, and risk of falls.

Conclusions: Pain severity was associated with quality of life and health-related variables. Further, studies are required to assess the directionality of the association, how to address the issue of chronic pain and improve the quality of life of low-income older adults.

popals1@mcmaster.ca

Perspectives on Screening for Poverty And Related Social Determinants and Intervening to Improve Knowledge of and Links to Resources (SPARK) from an Ontario Family Health Team

Ayodeji Odedeji, Joseph O'Rourke, Archna Gupta, Mélanie Ann Smithman, Itunuoluwa Adekoya, Dana Howse, Leanne Kosowan, Lane Williams, Zita Seshie, Alexander Zsager, Jane Cooney, Marjeiry Robinson, Dorothy Mary Senior, Andrew D Pinto

BACKGROUND: Primary care organizations and clinics are increasingly interested in collecting patient-level demographic and social needs information to tailor patient care, improve health equity, and address social determinants of health. The SPARK Tool, adapted from the TC-LHIN's Health Equity Questionnaire, is a set of questions developed for collecting patient-level demographic and social needs data (e.g., income, precarious employment). We sought to study the feasibility of implementing the SPARK Tool in one FHT, drawing findings from interviews with stakeholders.

APPROACH: We conducted 20 semi-structured interviews in total, with patients, interdisciplinary primary care providers, clerical, operational, and clinic leadership staff at an Ontario-based urban FHT. We analysed transcripts using qualitative description. Interview questions focused on the feasibility, acceptability, and barriers to using the SPARK Tool during a 6-month implementation pilot.

RESULTS: Findings included 3 themes. Theme 1- Most participants perceived the Tool was useful, well-detailed, easy to use, and important for clinical and administrative purposes. Theme 2- More than half of the patients had confidentiality concerns or felt that the Tool's questions were too sensitive or intrusive. Theme 3 – Providers and clinic staff reported barriers to using the Tool such as only English-language format, lack of access or comfort with technology, and conflicting responsibilities among providers and clinic staff.

CONCLUSIONS: Findings will help address barriers to using the SPARK Tool to collect demographic and social needs data in diverse primary care settings. This will guide future efforts to utilize demographic and social needs data collection in other FHTs within and outside Ontario.

ayodeji.odedeji@unityhealth.to

The impact of a legal health clinic on the social determinants of health of attendees

Jasdeep Brar, Gina Agarwal, Dan Edwards, Bethany Delleman, Sharon Crowe, Jayne Mallin, Melissa Pirrie, Hugh Tye

Background: Individuals living in poverty often visit primary healthcare clinics for health problems stemming from unmet legal needs. We examined the impact of a medical-legal partnership on improving the social determinants of health (SDoH), health status, and health-related quality of life of attendees of a Legal Health Clinic (LHC).

Approach: A weekly LHC was established within an urban primary healthcare clinic to provide free primary care and legal consultation in partnership between the McMaster Family Practice, Hamilton Community Legal Clinic, and Legal Aid Ontario. Patients aged 18 years or older were either approached or referred to complete a screening tool to identify potential legal needs. Those identified with potential legal needs were offered an appointment with LHC lawyers who provided legal counsel, referrals, and services. Changes in SDoH and health indicators for LHC attendees were assessed six months after they attended the LHC compared to their baseline scores using binomial tests and paired t-tests.

Results: There were 770 patients who completed the screening tool, of which 84% (n=648) of patients had at least one unmet legal need. Among the 648 patients, 69 patients attended the LHC and 35 (51%) of them completed the six-month follow-up survey. There were statistically significant improvements ($p<0.05$) in income security, housing security, food security, health status, and health-related quality of life six months after patients attended the LHC compared to baseline.

Conclusions: The LHC has the potential to improve the health outcomes of patients in primary healthcare clinics by addressing unmet legal needs and SDoH.

brarj14@mcmaster.ca

Considerations for building a patient advisory committee for practice-based learning and research networks

Marissa Beckles, Michelle Greiver, Jodie, Gerhard Wendt, Kimberly Mitchell, Simone Dahrouge, Catherine Macdonald, Darby Green

Background: Practice Based Learning and Research Networks (PBLRNs) bring together clinicians, academics and patients to research ways to improve our healthcare system; using electronic medical record (EMR) data and evidence-based strategies as part of Learning Health Systems. Integrating patient engagement into the development of a provincial PBLRN, the Practice based Ontario Learning and Research (POPLAR) Network, is key to focusing on the things that matter most to the people who access primary health care in Ontario.

Approach: Funded by Ontario's provincial government through the primary care Research-Policy partnership INSPIRE-PHC, the POPLAR program is committed to ensuring that patients are full members of the provincial network. To achieve this, each PBLRN nominated two patient advisors to represent their regional network at POPLAR's Patient Advisory Committee (PAC). An initial framework for the PAC was proposed by our Stakeholder Engagement Committee, with input from the Patient Expertise in Research Collaboration group, PERC. Patient advisors then defined the PAC's mandate and goals based on their own priorities.

Results: POPLAR's PAC meets every 2 months to discuss issues and items related to POPLAR. The focus to date has been on training, orientation to POPLAR, and development of the Terms of Reference. The group has also selected a chair and chair-elect to represent the PAC at POPLAR's Steering Committee.

Conclusions: The POPLAR PAC provides input into POPLAR's activities, and recommendations to leadership, committees and other stakeholders that will determine POPLAR's strategic direction and research priorities.

marissa.beckles@queensu.ca

Public priorities for primary care in four provinces: Findings from the OurCare Priorities Panels

Rachel Thelen, Maryam Danesh, Tara Kiran, Jasmin Kay, Peter MacLeod, Mylaine Breton, Mandy Buss, Amanda Condon, Alan Katz, Neb Kovacina, M Ruth Lavergne, Goldis Mitra, Katherine Stringer, Kirsten Eldridge

Background - Primary care in Canada is in crisis and millions of Canadian adults do not have access to a family doctor. The public is rarely involved in conversations about how to improve primary care.

Approach - OurCare is a national initiative to engage the public on the future of primary care. Deep dialogues about primary care were provincially conducted in 2023 with about 35 members of the public in Ontario, Quebec, British Columbia and Nova Scotia. Participants were selected to match provincial demographics. The members of the public spent 30-40 hours learning about primary care and discussed what values, issues, and recommendations matter most. They wrote four separate provincial reports for better primary care. We analyzed the four reports to find commonalities.

Results - We identified 8 values and 9 recommendations in common. The public members agreed on the values that should underlie primary care: Accessibility, equity, accountability and person-centredness. They recommend scaling up team-based care, legislating interoperability and access to one electronic medical record and addressing upstream factors that impact health. Their recommendations also include strengthening community governance, educating and empowering the public, strengthening and diversifying the workforce and collecting metrics to measure progress.

Conclusions - Diverse members of the Canadian public in four provinces agreed on common values that should underlie primary care and provided several consensus recommendations for improvement. Their values and recommendations provide a roadmap to clinicians, researchers and policy makers for system redesign. Next steps include further dialogue in Manitoba and with members of marginalized communities across Canada.

achel.thelen@unityhealth.to
maryam.danesh@unityhealth.to

Experiences and preferences of older adults about primary care in Canada

Maryam Danesh, Rachel Thelen, Ri Wang, Jasmin Kay, Peter MacLeod, Alexander Beyer, Clifton van der Linden, Tara Kiran

Background: Healthcare use increases as people age and develop more health issues. Understanding the experiences and needs of older adults is important when designing primary care reforms.

Approach: We conducted an online bilingual survey in Fall 2022 to explore Canadian's experiences with and their perspectives for a better primary care. We analyzed completed responses and weighted the data to ensure respondents reflected the demographics of Canada.

Results: People aged 65 and older constituted 31.6% (2,929/ 9,279) of survey respondents. From this, 86.0% reported having a primary care clinician, however only 36.1% were able to see them on the same or next day for an urgent need. Compared to adults 18 to 29, more people in this age group (50.0% vs 26.5%) believed it is very important that their clinician or team of healthcare professionals work close to their home. Relational continuity, care coordination, easy access during the day, and comprehensiveness were other attributes of primary care more important for seniors. In contrast to individuals 18 to 29, more older adults never tried a walk-in clinic (64.3% vs 39.3%) and fewer liked to communicate with their clinician through email (31.5% vs 40.8%), video appointments (25.9% vs 43.0%), and text message (11.7% vs 19.9%).

Conclusions: Our results highlight the different values and preferences for people 65 and older. The unique needs of older adults should be considered when crafting primary care reforms.

maryam.danesh@unityhealth.to
rachel.thelen@unityhealth.to

Scoping review on Primary Care Teams and their impact on clinician capacity to see more patients

Rachel Thelen, Kanya Rajendra, Noah Ivers, Andrea Tricco, Rick Audas, Lyn Sibley, Tara Kiran

Background - Over 6.5 million adults in Canada do not have access to primary care, the front door to the healthcare system. Team-based care can expand access during health human resource challenges. However, it is unclear which health professionals, in what ratios, and what roles can best expand capacity.

Approach - We are conducting a scoping review to understand evidence available on whether and how primary care teams can improve clinician capacity. We define teams as at least one most-responsible clinician and one regulated health professional working together on an ongoing basis with a shared set of patients. We include studies written in English, published during or after 2000, conducted in high-income countries and reporting data on the impact of teams on capacity. We exclude publications that are non-methodological and where the team model is inconsistent with our definition (e.g., physician or consultation-only teams, non-regulated professionals, focus on episodic care).

[Preliminary] Results - Our results will reveal studies assessing team impact on clinician capacity to serve more patients. We are extracting data on various factors including physician payment, team governance and culture of teamwork; types of health professionals, their roles and ratios; basket of services; patient population served and shared; clinician capacity change and measurement; and other outcomes including patient and clinician experiences, cost and equity.

Conclusions - Our analysis will identify literature that can guide implementation of team-based care in Ontario and other jurisdictions. Further research will be needed to understand teams' impact on clinician wellbeing, patient satisfaction and patient equity.

rachel.thelen@unityhealth.to
kanya.rajendra@mail.utoronto.ca

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

Natalie DiMaio, Amrita Roy

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 stakeholders 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. Conclusions: 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.

16nd18@queensu.ca

Patient reported wait times and the impact of living with chronic pain on their quality of life: A waiting room survey in chronic pain clinics in Ontario, Manitoba, and Quebec

Isabella Moroz, Clare Liddy, Rola Hashem, Tracy Deyell, Amin Zahrai, Alexander Singer, Gabrielle Logan, Geoff Bellingham, Jennifer Anthonypillai, Tess McCutcheon, Lynn Cooper, Marie Vigouroux, Melissa Milc, Norman Buckley, Pablo Ingelmo, Patricia Poulin, Regina Visca, Zahra Sepehri

Background Wait times at Canadian multidisciplinary pain clinics have been reported as excessive for nearly two decades. We assessed the needs and experiences of patients in Ontario, Quebec, and Manitoba waiting to access specialty care for their chronic pain, including length of wait time.

Approach A cross-sectional survey of new patients attending or waiting to attend a chronic pain appointment was conducted in 6 multidisciplinary chronic pain clinics between February 2020 and October 2022. Participants were asked about the length of time they waited for their appointment since being referred, their quality-of-life, and other healthcare professionals seen while waiting.

Results Among the 595 patients who completed the survey, 337 (56.9%) reported wait times under 6 months, 137 (23.1%) between 6 and 12 months, and 110 (18.6%) over a year. Participants reported that while waiting, living with chronic pain increased their worry (n=270; 48.1%), limited their ability to perform daily activities (n=336; 58.6%), and/or limited their ability to participate in their usual social recreational activities (n=344; 60.0%) “quite a bit” or “extremely”. The most visited healthcare professionals while waiting for a pain clinic appointment were family doctor/nurse practitioner (n=409; 68.7%), followed by medical specialists (n=295; 49.6%), and physiotherapists (n=283; 47.6%).

Conclusions These findings provide real-time regional snapshots into wait times and their impact on quality of life experienced by Canadians living with chronic pain. Understanding the patient experience is critical for informing regional initiatives for improving access to care for this population, including innovative solutions, such as electronic consultation.

imoroz@bruyere.org

Co-Creation of knowledge mobilization strategies: Findings from a collaborative symposium

Amanda L Terry, Judith Belle Brown, Rachelle Ashcroft, Lorraine Bayliss, Ron Beleno, Onil Bhattacharyya, Mylaine Breton, Catherine Donnelly, Martin Fortin, Rebecca Ganann, Priya Garg, Ruth Lavergne, Annie LeBlanc, Emily Marshall, Ruth Martin- Misener, Maria Mathews, Matthew Menear, Kathryn Nicholson, Andrew Pinto, Marie-Eve Poitras, Vivian Ramsden, Graham Reid, Bridget Ryan, Tara Sampalli, Maxime Sasseville, Moira Stewart, Erin Wilson

Background: Effectively mobilizing the uptake of research findings requires useful strategies and building capacity in primary health care (PHC) research communities. The Transdisciplinary Understanding and Training on Research-Primary Heath Care (TUTOR-PHC) program develops capacity for interdisciplinary PHC research. For the 20th anniversary of TUTOR-PHC, we held a Knowledge Mobilization Symposium which included small group activities and discussion forums focused on how to effectively and actively mobilize the uptake of research findings into policy and practice, in addition to identifying key components of accessible research syntheses in graphic form and impact narratives.

Approach: A thematic analysis of the summaries from the forums was conducted to describe co-created capacity for interdisciplinary PHC research knowledge mobilization.

Results: Sixty-three symposium participants attended from Canada, Australia, New Zealand, UK, France, and India, representing all TUTOR-PHC cohorts as well as mentors, patient-partners, and knowledge users. Common themes on effective uptake of research findings included: the importance of creating meaningful engagement at the outset of the research with key partners, building sustainable long-term relationships based on trust and humility, and creating a safe space for everyone (researchers, patient partners and policy-makers) to have an equal voice. All groups noted challenges in developing creative and engaging syntheses and narratives. Strategies including bar graphs, video games, billboards and podcasts were identified. While infographics were recognized as commonly utilized, it was important to tailor them to the intended target audience.

Conclusions: Researchers require skills in producing research syntheses in graphic form, and in writing impact narratives for effective knowledge mobilization.

aterry4@uwo.ca
jbbrown@uwo.ca

Trillium Primary Health Care Research Day 2023 Registrant List

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

In person registrants

Abebe	Biniyam	Queen's University
Ali	Kishwar	Scarborough Ontario Health Team/ Scarborough Family Physicians Network
Ali	Fatima	Dalla Lana School of Public Health, University of Toronto
Aomreore	Alexis	Bruyere Research Institute
Arfan	Sara	Windsor University School of Medicine
Ashcroft	Rachelle	University of Toronto
Bal	Sharon	Western University, McMaster University
Ball Rigden	Megan	Pozitive Pathways
Baraki	Adhanom	Queen's University
Barker	Joan	McMasters
Bayliss	Lorraine	PERC
Beckles	Marissa	Queen's University
Beleno	Ron	Patient Expertise in Research Collaboration
Bennell	Maria	Ontario Health
Bhattacharyya	Onil	Women's College Hospital
Bhatti	Sara	Alliance for healthier communities
Bolissian	Katie	Ministry of Health
Boyle	Jennifer	PERC
Brar	Jasdeep	McMaster University
Burchell	Ann	Unity Health Toronto
Chavlovski	Anna	Loyalist Family Health Team, FLA OHT
Cheema	Hira	University of Toronto
Chisholm	Ashley	University of Ottawa
Cooney	Jane	Unity Health
Correia	Rebecca	McMaster University
Dahrouge	Simone	University of Ottawa; Bruyere Research Institute
Daneshvarfard	Maryam	Unity Health Toronto
Dang	Janet	Ontario Health
Dash	Darly	McMaster University
Dissanayake	Melanie	Western University
Donnelly	Catherine	Queen’s University
Dougherty	Madeline	Western University
Eltawil	Fatma	McMaster University
Fink	Christopher	Alliance for healthier communities and Poplar
Fitzsimon	Jonathan	University of Ottawa / Institut du Savoir Montfort
Frohlich	Rachel	OH
Frymire	Eliot	INSPIRE-PHC
Gamage	Kumindu	McMaster University
Ganann	Rebecca	McMaster University
Garg	Priya	Western University
Genautis	Carolyn	OSSU

Girdhari	Rajesh	University of Toronto
Goulet	Danica	Bruyère Research Institute
Grady	Colleen	Queen’s University
Greiver	Michelle	University of Toronto DFCM
Guest	Benjamin	
Harley	Megan	Western University
Ho	Julia	Ministry of Health
Holdsworth	Sandra	Patient Advisory
Huma	Khurrum	PCTN
Idrees	Samina	Western University
Ilyad	Ahmad	Ontario Ministry of Health
Johnson	Jennifer	University of Western Ontario
Kemp	Connor	AFHTO
Kennedy	Laurie	MCMASTER UNIVERSITY
Khan	Sher	Unity Health Toronto
Khan	Shahriar	Queen's University
Kulendran	Saranya	Ontario Health
Lambert	Zoe	University of Toronto
Lapointe-Shaw	Lauren	University of Toronto
Lau	Elizabeth	Ministry of Health
Lawson	Jennifer	McMaster University, MUSIC, POPLAR, CPCRN
Liddy	Clare	University of Ottawa
Lin	Nancy	Downtown East Toronto Ontario Health Team
Ling	Eugenia	McMaster University
MacNeil	Maggie	McMaster University
Mah	Ashley	Unity Health Toronto
Maheswaran	Manshi	University of Toronto
Mara	Craig	Western University
Mathews	Maria	Western University
Maybee	Alies	Patient Advisor
Meredith	Leslie	Western University
Mitchell	Kimberly	Alliance for Healthier Communities and Poplar
Moran	Kimberly	OCFP
Moroz	Isabella	Bruyère Research Institute
Nadarajah	Abbira	McMaster University
Nguyen	Paul	Queen's University
Nistor	Patricia	Western University
Nolan Haupt	Hilary	McMaster
Odedeji	Ayodeji	Upstream lab/University of Toronto
Olah	Ashley	Sinai Health
O'Rourke	Joseph	Upstream Lab based at MAP Centre for Urban Health Solutions, Unity Health Toronto
Pinto	Andrew	University of Toronto & Upstream Lab
Popal	Sahar	McMaster University
Pow	Conrad	Diabetes Action Canada, North York General Hospital
Pow	Aneeta	
Premkumar	Devyani	Queen's University - School of Medicine

Quimson	Seth	Department of Family Medicine, McMaster University
Rajendra	Kanya	Temerty Faculty of Medicine, University of Toronto
Riehm	Jessica	Ministry of Health
Rix	Payton	IC/ES & Queen's University
Roberts	Lynn	Queen's University
Robinson	Marjeiry	Unity Health Toronto
Rouleau	Katherine	University of Toronto
Rouly	Ghislaine	Canada Research Chair in Partnership with Patients and Communities - University of Montreal
Ryan	Bridget	Western University
Saluja	Kiran	Bruyere research Institute
Santos	Ana	WeRPN
Scanlan	Shari	Queen's University
Shahaed	Heba	University of Toronto
Sheffield	Peter	Factor-Inwentash Faculty of Social Work, University of Toronto
Sibley	Lyn	Ontario Medical Association
Singla	Arpit	AgeWell
Spiro	Grace	University of Toronto
Stans	Jo-Ann	PERC
Stevenson	Paige	NOSM University
Stewart	Moira	Western University
Tagami	Aya	McMaster University
Terry	Amanda	The University of Western Ontario
Thelen	Rachel	MAP Center for Urban Health Solutions, Unity Health
Thorpe	Cathy	Centre for Studies in Family Medicine, Department of Family Medicine, Western University
Trainor	Ruth	Ontario Health
Valderas	Jose	National University Health System
vanWynsberghe	Lori	Queen's University
Wasim	Abeir	NEXT Canada Alum (2023 cohort), McMaster University, University of Toronto
Weber	Marnie	Ontario Health West Region
Wendt	Gerhard	Queens University POPLAR project
Wong	Ivy	North York Toronto Health Partners
Wood	Brianne	Thunder Bay Regional Health Research Institute and NOSM University
Yehualashet	Fikadu	Queens University
Young	Gillian	Western University
Zelek	Barb	NOSM U
Zhao	Jane	University of Toronto
Zon	Jeffrey	MOH of Ontario
Zsager	Alexander	Upstream Labs / Unityhealth.to

Virtual registrants

Ali	Kishwar	SOHT
Almufleh	Aws	Queen's University
Alsharif	Lubna	POPLAR PAC Member
Armstrong	Alicia	Ontario Health West Region

Atuobi-Danso	Maame	WE RPN
Balciunas	Misha	Health Sciences North
Bettle	Madison	Ministry of Health
Correia	Rachel	Ontario Health
Cruickshank	Clare	
DeMore	Jamie	UBC
Douse	Shona	Ontario College of Family Physicians
Doyle	Sean	Ontario Health
Drebit	Rachel	Ontario Health
Edelstein	Hilary	Ontario SPOR SUPPORT Unit
Elliott	Bethany	McMaster University, Department of Family Medicine
Erwin	Erica	Ontario Health East Region
Eyre	Alison	Centretown Community Health Centre
Foreman	Vanessa	Hamilton Family Health Team
Frisina	Angela	Greater Hamilton Health Network
Gauvin	Francois-Pierre	McMaster Health Forum
Gerrie	Wendy	Ontario Hospital Association - IDS
Green	Darby	Queen's University
Hameedi	Aiman	Ontario Health
Hawn	Morgan	Lanark Leeds Grenville OHT
Helsel	Rebecca	Lambton County LTC (NLL)
Hoque	Ahmedul	Ministry of Health
Huang	Mary	Concorde Cohousing / Canadian Cohousing Network
Janssen	Caitlin	Ontario Health
Jiang	Jenny	Ministry of Health
Johnson	Chris	
Kandukur	Kishan	Ministry of Health
Kapadiya	Sandani	Ontario Health
Katz	Judy	North York Toronto Health Partners
Khatri	Abdul-Razak	Ministry of Health
King	Bernice	Greater HamiltonHealth Network (OHT)
Kropman	Irena	Durham Community Health Centre
Lambrinos	Anna	Ontario Health
Leiva	Karen	OCFP
Lemon	Jessica	KW4 OHT, eHealth Centre of Excellence
Leonard	Brent	Perley Health
Linseman	Melissa	LMPCA
LoGiudice	Andrew	EYRND Ontario Health Team
Ma	Ronald	Oak Valley Health
Mens	Elizabeth	
Mills Beaton	Jennifer	Ontario Health
Ming	Kirsten	Ontario Health
Montgomery	Erin	Great Northern Family Health Team
Ni.	Irene	
Nicholson	Kathryn	Western University / McMaster University
Oloyede	Oyekola	Sefako Makgatho Health Sciences University, South Africa

Osei-Twum	Jo-Ann	University of Toronto
Petricevic	Rebecca	KW4OHT
Pinkerton	David	Kingston Family Health Team
Ramsden	Vivian	University of Saskatchewan
Roman	Sacha	OCFP
Rouleau	Katherine	University of Toronto
Rumleskie	Margaret	
Sich	Katie	Windsor-Essex Ontario Health Team
Siddiqui	Hamnah	
Simic	Jovana	Georgina Nurse Practitioner Led Clinic
Sinnarajah	Aynharan	Lakeridge Health
Sleeth	Lindsay	Ontario Health
Smith	Jeanette	
Stelmach	Dilesha	
Trivedi	Init	
van den Hoef	Gigi	MSL & RN Consulting
Vasanthi	Srinivasan	Ontario SPOR SUPPORT Unit
Walz	Murray	GHHN
White	Robert	
Yong	Chung Hyun (Esther)	EYRND Ontario Health Team
Kiran	Tara	University of Toronto
Roman	Sacha	OCFP
Moore	Caroline	McMaster University
Chan Carusone	Soo	McMaster Collaborative for Health and Aging
Abelson	Julia	McMaster University
Spiro	Grace	University of Toronto
Eubank	Breda	Mount Royal University
Aggarwal	Monica	University of Toronto
Habbous	Steven	Ontario Health