Trillium
Primary Health Care Research Day

2025 Trillium Primary Health Care Research Day

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Exploring experiences and perspectives to implementation of physiotherapist-led primary care models for musculoskeletal conditions: Qualitative studies in progress

Mir Sanim Al Mamun, Geneviève Bacchus, Jordan Miller

Background:

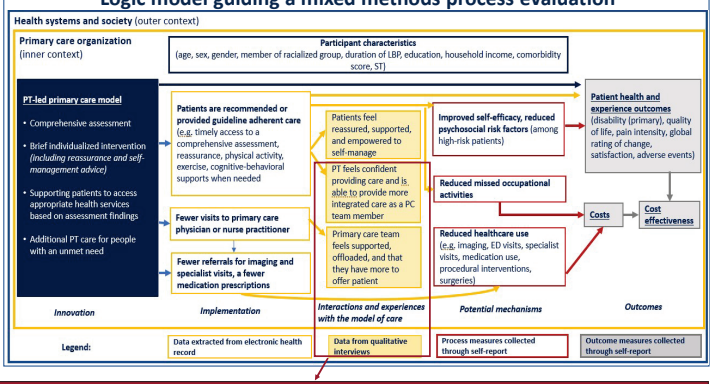
- Musculoskeletal conditions represent a significant portion of primary care (PC) visits
- First-contact physiotherapist (PT) roles for people with musculoskeletal conditions are becoming more common
- Two cluster randomized trials are evaluating the impact of physiotherapist-led primary care models for musculoskeletal conditions with 20 PC teams in Ontario and British Columbia
- Effective implementation of primary care models that integrate PTs hinges on learning from the physiotherapists and primary care team members who have participated in implementing these models of care

Objectives:

Study 1: To explore the experiences and perspectives of physiotherapists participating in & implementing the physiotherapist-led primary care Model

Study 2: To explore the experiences and perspectives of primary care team members with the physiotherapist-led primary care Model

Logic model guiding a mixed methods process evaluation



Preliminary findings related to the PT experiences and perspectives:

a) Potential value of the model for providing faster access to more comprehensive care for musculoskeletal conditions and reducing health system costs;
b) Difficulties maximizing physiotherapist contributions to primary care due to space and resource constraints, operationalizing direct access, and feeling underprepared to connect patients to community resources;
c) Trust and awareness of the physiotherapist's role and abilities takes time;
d) Interprofessional collaboration through electronic health record communication was valuable, but more in-person relationship building and role clarification strategies could further facilitate team-based care;
e) Mentorship in primary care would support physiotherapists enhance their contributions.

Potential Impact:

- Provide important evidence to inform how physiotherapy-led primary care models for musculoskeletal conditions can be implemented, if effective
- To inform physiotherapists adopting primary care roles, primary care organizations, physiotherapy educators, and health system decision makers involved in the expansion of team-based primary care models

Design: Two qualitative interpretive description studies embedded within a mixed methods process evaluation to explore Experiences and Perspectives of Physiotherapists and Primary Care Team members

Methods:

Qualitative Approach: Interpretive Description (Thorne, 1997)

Setting: 10 primary care sites where a physiotherapist was integrated into the team (7 in Ontario (ON), 3 in British Columbia (BC))

Intervention being implemented:
Physiotherapist-led primary care model: integrating a physiotherapist within a primary care setting and making them available to patients as the first point of contact for back, hip and knee pain (for back pain only in BC)

Participants: Physiotherapists (study 1) and primary care team members (study 2) who participated in the implementation of the Physiotherapist-led primary care model. We purposively sampled primary care team members to provide diversity in terms of primary care organization, health profession, and years of experience

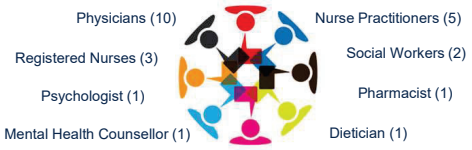
Data Analysis: Constant comparative analysis following Boejie's (2002) steps
1. Comparison within a single interview;
2. Comparison between interviews within the same organization;
3. Comparison between interviews across a) practice models (i.e., team-based models vs non-team-based models), b) provincial contexts (i.e., BC vs ON)

Progress:

Study 1 participants (n=10): We have completed interviews with all 10 PTs involved in implementing the physiotherapist -led primary care model

Study 2 participants (n=24):
We have completed interviews with primary care team members across 10 teams

Primary Care Team Members Interviewed



Acknowledgements:

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The hip and knee pain trial is funded by an Arthritis Society and CIHR STARS Award

Partner organizations and participants: Immense gratitude to our 20 primary care partner organizations and to all our participants.

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What are the types of evidence available and gaps in evidence related to primary care models that integrate physiotherapists within primary care teams? A scoping review

Geneviève Bacchus, Mir Sanim Al Mamun, Sintayehu Wami, Rachel Beyer, Kevin Varette, Lina Elsabbagh, Jiesi Zhang, Mackayla Dabit, Andrews Tawiah, and Jordan Miller

Background

- Globally, health systems are integrating physiotherapists into primary care to improve access, quality, and continuity of care.
- Multiple integration models exist and approaches vary across health settings.
- Despite a growing body of research, evidence has not been comprehensively synthesized.
- Understanding how physiotherapists are integrated within diverse primary care models provides an important opportunity to inform policy, enhance interprofessional collaboration, and improve patient outcomes.

Objectives

- This review aimed to synthesize evidence on primary care models that integrate physiotherapists within primary care teams. The study synthesizes evidence on geography, study types/designs, characteristics of the primary care models identified, and outcomes evaluated.

Methods

Design:

- This scoping review followed the Joanna Briggs Institute framework and was reported according to PRISMA-ScR guidelines.
- Six databases (Ovid MEDLINE, EMBASE, CINAHL, PubMed, SCOPUS, Web of Science) were searched for studies describing, evaluating, or conceptualizing physiotherapists' integration in primary care.
- All study designs were included.

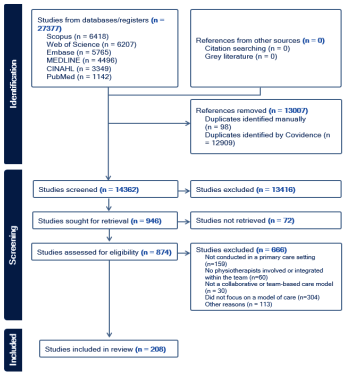


Figure 1: PRISMA flow diagram

Results

In what countries were the studies conducted?

- Studies were primarily from;
  - 👉 UK (86; 41.3%)
  - 👉 Canada (23; 11.1%)
  - 👉 USA (20; 9.6%)
  - 👉 Brazil (15; 7.2%)
  - 👉 Sweden (13; 6.3%)
  - 👉 Netherlands (7; 3.4%)

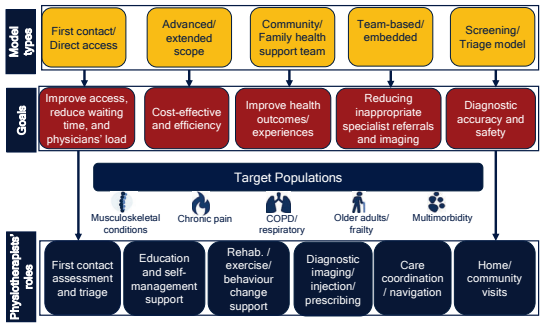
Among the included studies, the publication types include:

- ❖ Primary research articles (107; 51.4%)
- ❖ Conference abstracts (57; 27.4%)
- ❖ Knowledge synthesis (19; 9.1%)
- ❖ Commentaries/Opinion paper/Letter to editor (10; 4.8%)
- ❖ Protocol (7; 3.4%)
- ❖ Physiotherapy association magazine (5; 2.4%)
- ❖ Correction (3; 1.%)

Among the primary research articles, what study designs were used?

- ❖ Qualitative studies (36; 33.6%)
- ❖ Cross-sectional survey (14; 13.1%)
- ❖ Observational cohort (6; 5.6%)
- ❖ Retrospective cohort (12; 11.2%)
- ❖ RCT (14; 13.1%)
- ❖ Mixed Methods (8; 7.5%)
- ❖ Service evaluation (7; 6.5%)
- ❖ Feasibility/pilot study (5; 4.7%)
- ❖ Case study/case series (4; 3.7%)
- ❖ Quasi-experimental (1; 0.9%)

Summary of model types, goals, target populations, and physiotherapist's role



What outcomes were evaluated for the primary care models?

Effectiveness and experiences	• Health outcomes(function/pain/QoL) (19; 17.8%) • Patient experiences (11; 10.3%) • Provider experiences (13;12.1%) • Healthcare utilization (imaging/referral/visits) (14; 13.1%) • Cost/ cost-effectiveness (16; 15.0%) • Health equity (5; 4.7%)
Implementation outcomes	• Adoption (8, 7.4%) • Implementation (13, 12.1%) • Sustainment (0, 0%)
Implementation determinants	• Barriers/facilitators (8, 7.4%) • Stakeholder perspectives on models of care (25, 23.4%) • Implementation supports (0, 0%)

Where does evidence remain limited on physiotherapists in primary care?

- ➢ Limited evaluation of patient and system-level outcomes across models.
- ➢ Few studies examine long-term sustainability or scalability of integration.
- ➢ Minimal evidence on physiotherapist roles beyond musculoskeletal care.
- ➢ Underrepresentation of low- and middle-income or rural primary care contexts.
- ➢ Lack of standardized outcome measures to compare across models.
- ➢ Sparse research on cost-effectiveness and health-economic impacts.
- ➢ Limited exploration of interprofessional collaboration and team dynamics.
- ➢ Few implementation studies applying implementation determinants or outcomes frameworks.

Conclusion and Implications

- There is a growing body of research on primary care models that integrate physiotherapists in primary care.
- While evidence supports their ability to independently manage cases, improve access and reduce physician workload, more robust studies are needed to examine implementation outcomes, health outcomes, patient experiences, health equity, and cost-effectiveness.
- Findings offer practical insights into diverse international primary care models that integrate physiotherapists and highlight key evidence gaps to guide future research, implementation, and scale-up across Canadian and global health systems.

Conflicts of Interest
The authors have no conflicts to report.

Acknowledgments
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Development of a Value-Based Framework for the Evaluation of Interprofessional Primary Care Teams in Ontario

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Funded by Ontario Health

Introduction

- Primary care is the foundation of a strong health system, yet more than 2.2 million Ontarians currently lack a regular provider. Recent investments under Ontario's Primary Care Action Plan demonstrate the province's commitment to expand access and attach 2 million more people to team-based care.
- Persistent workforce shortages, recruitment and retention challenges, and shifting expectations continue to threaten timely access, continuity, comprehensiveness and equity in outcomes.
- Interprofessional Primary Care Teams (IPCTs) – Family Health Teams (FHTs), Community Health Centres (CHCs), and Nurse Practitioner-Led Clinics (NPLCs) – remain central to Ontario's strategy to strengthen access, coordination and quality.
- Existing frameworks for defining and measuring high-quality care are often physician-centric, too narrow, or not tailored to Ontario's team-based primary care context.
- This project developed a **Value-Based Evaluation Framework** to describe how IPCTs create value across Ontario's health system and provide a foundation for performance measurement and accountability (Figure 1).

Methods

Approach: Structured, multi-method design using principles of programmatic logic models and the Donabedian framework which has long guided health care quality by linking structure, process and outcomes.

Evidence review: Conducted a systematic search of national and international primary care models and frameworks relevant to team-based and value-based care (Figure 2).

Data synthesis: Extracted and compared key domains across frameworks using an inductive, iterative mapping process (enablers, inputs, outputs, outcomes) extracting and grouping key concepts.

Stakeholder consultation: Refined the framework through targeted one-on-one interviews and group discussions with academic research team, professional associations, primary care leaders, frontline providers, patients and policymakers.

Expert validation: Subject matter experts reviewed the model for conceptual rigor and alignment with Ontario's policy priorities.

Refinement: Iterative adjustments were made to ensure the model was comprehensive, evidence-informed and practical for Ontario's interprofessional primary care context.

Figure 1. Value-Based Framework for the Evaluation of Interprofessional Primary Care Teams in Ontario

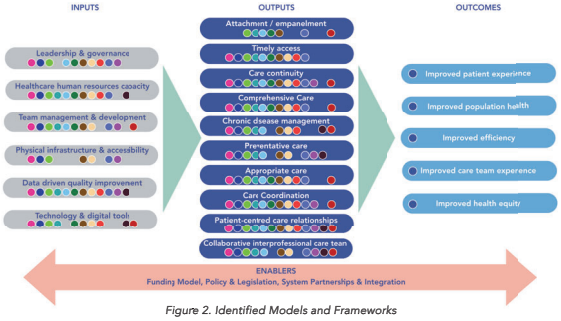
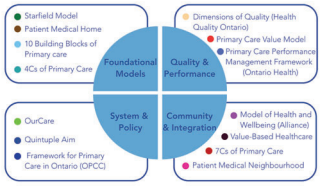


Figure 2. Identified Models and Frameworks



Learn More

If you are interested in learning more about this value framework or any other health system transformation initiatives of the CEP, please feel free to contact us or visit our website at cep.health.

Results

This framework synthesizes 14 national and international models and was validated through broad stakeholder engagement, ensuring relevance to Ontario's evolving primary care system.

The Value-Based Evaluation Framework for IPCTs identifies four essential domains:

Enablers: The critical contextual factors largely outside the direct control of teams but essential for their success.

Inputs: The organizational capacities that teams manage directly. These inputs enable the delivery of outputs.

Outputs: Defined as the day-to-day activities through which teams deliver value to patients and communities. Consistent delivery of outputs leads to the desired outcomes.

Outcomes: Represent the system-level impacts that result when external enablers, team inputs, and care delivery outputs align effectively. Together, these elements drive the outcomes of the Quintuple Aim.

Discussion

- Building on the **Donabedian model,** this framework links organizational structure to service processes which impact health outcomes in a team-based context.
- The framework explicitly integrates external enablers (funding, policy, partnerships) to reflect that **IPCTs cannot succeed in isolation** from broader system supports.
- Ontario's diverse patient population requires inclusive, culturally safe primary care. **Equity and cultural safety must be a cross-cutting theme** reflected across every domain – from workforce capacity and culturally competent care, to accessible infrastructure, to outcomes that reduce disparities.
- **Practical tensions faced by teams** is evident. Meeting attachment and timely access goals must be balanced with other domains like continuity, comprehensiveness, and preventive care.
- Offering a **flexible tool for quality improvement, accountability, and funding reform** in primary care, this framework provides a **shared language** for policymakers, providers, and communities to assess performance and drive system improvement.

Conclusion

- This work introduces the first **Ontario-specific value-based evaluation framework for IPCTs**, defining the enablers, inputs, outputs, and outcomes that show how primary care teams create value.
- Provides a **shared structure** for policymakers, providers, and communities to guide design, measurement, and improvement.
- Supports funding reform and accountability, aligning investments with patient and population needs.
- **Next steps:** translate domains into indicators, pilot with Ontario teams, and test in other contexts.
- By making pathways to value explicit, **this framework advances sustainable, equitable, patient-centered primary care**.

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CENTRE FOR STUDIES IN PRIMARY CARE at Queen's University

Acceptability of a diabetes handout in graphic form

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Department of Family Medicine, Queens University

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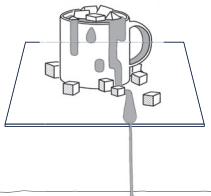
Introduction

There are approximately 11.7 million Canadians living with diabetes or prediabetes[1]



Patient education plays an essential role. Greater understanding of the disease itself and the benefits of adhering to lifestyle changes and treatment plans correlate with better diabetic control.[3-5]

The graphic form is perhaps unique in that words and images are closely juxtaposed to create metaphors, enhance messaging or create new meaning.[6, 7]

Qualitative studies have indicated that comics and graphic art can communicate the health experience in a unique way that usual text-based material cannot.[8]

We wanted to understand how patients would respond to an education handout on diabetes in graphic form and understand any potential advantages of the form.

Method

Direct translation of current diabetes handout cannot fully exploit the graphic form, so we developed one from scratch based upon current handouts.

We employed a visual metaphor of a full warehouse to represent the pathological process.

Patients were recruited by searching our practice EMR for:
- Having more than 2 HbA1c measurements with value >6.5 in the previous 12 months
- A1C measurement between 6-6.5 at any time in the last year.

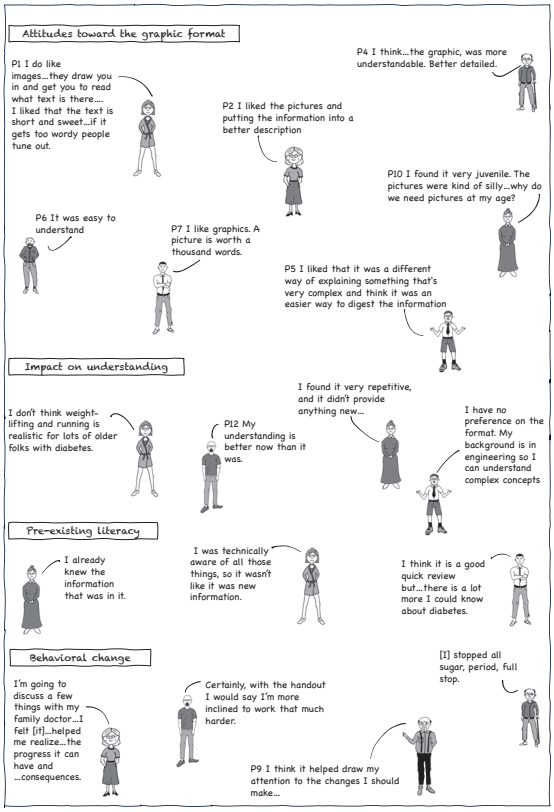
Exclusion criteria:
- type I diabetes
- younger than 18yo
- visually impaired.

Patients were interviewed by phone and responses analysed using phenomenological methods.

Results

We recruited ten patients with ages ranging 48-74, seven males & three females. Five had diabetes and five pre-diabetes. Two had high school education, three college, two university, two masters and one PhD.

We identified four themes:
1. Attitudes towards graphic format
2. Impact on understanding
3. Pre-existing literacy
4. Behavioral change.



Discussion

- Some of our participants expressed a clear preference for the graphic form—certain patients may benefit from information presented this way.
- Patients with prior knowledge of diabetes had more negative opinions on the handout.
- Separating the impact of form from content is challenging—are participants responding to the content, the graphic form or both?
  - when assessing written handouts, the form is not questioned.
- Some participant interpretated images literally—for example, one patient interpreted running and lifting weights as direct advice, rather than as symbols representing exercise
  - this highlights the challenges of developing a handout for a varied audience.
- Developing the handout was a lengthy and challenging process requiring specific expertise
  - consideration must be given to the extra effort required to craft a handout in graphic form versus the potential benefits.

Conclusion

- The graphic form was not universally appealing; however, some expressed a preference for the graphic form.
- Future research could explore which sub-populations benefit most from the graphic form.
- Learning to isolate and assess form separately to content would advance our understanding of the potential benefits of graphic handouts.

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Journey Mapping to Inform Primary Care Transformation: Integrating Provider and Community Perspectives

Anna Chavlovski *MD CCFP MScHQ;* ***Oluwatoyosi Kuforiji****, PhD;* ***Celine Bruce-Lepage*** *MSc;*
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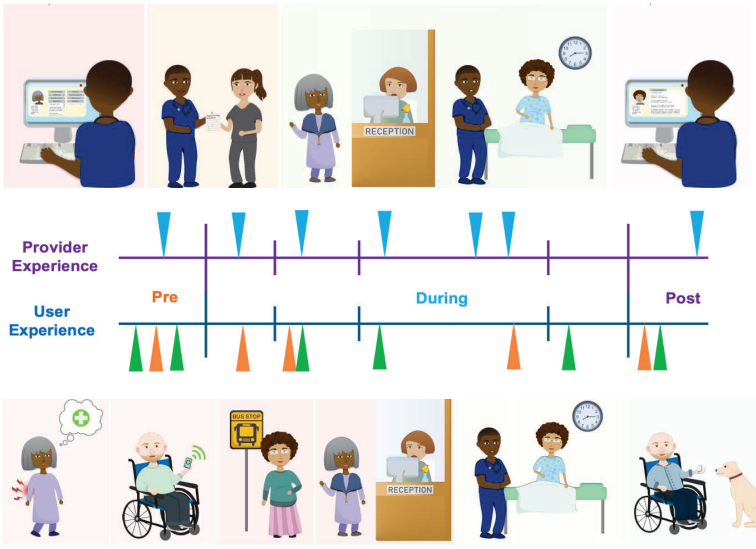
BACKGROUND

- Primary care crisis in Ontario
- 2.1M residents without PCP
- Rising provider burnout, practice changes
- Need to understand experiences of providers & patients to inform and prioritize challenges and opportunities

METHODS

- 3 qualitative studies in FLA OHT region
- Semi-structured interviews and focus groups:
  - 16 individuals attached to a PCP: 6 interviews, 2 focus groups
  - 19 individuals not attached to a PCP: 6 interviews, 2 focus groups
  - 19 primary care providers: 6 interviews, 2 focus groups
- Iterative journey mapping captured emotional, cognitive, social, and functional aspects

Journey mapping **uncovers shared challenges and opportunities between providers and patients** — guiding co-designed solutions for primary care transformation in Ontario.



RESULTS

Shared challenges:
- Distress, fragmented care, poor continuity
- Admin burden, inefficient referrals, EMR frustrations
- Lack of resources, coordination gaps

Opportunities for improvement
- Enhance patient education
- Increase admin supports
- Better integration of digital tools

CONCLUSIONS

- Journey mapping is a powerful co-design tool
- Aligning provider and patient perspectives may lead to person-centered, evidence- based reforms

These studies were funded in part by Center for Studies in Primary Care, Department of Family Medicine, Queen's University and Foundation for Advancing Family Medicine, College of Family Physicians of Canada

Queen's University

FLAOHT
Frontenac Lennox & Addington Ontario Health Team

Services in Canada Supporting Communication Between Primary Care Providers and Specialists for Dementia Care: An Environmental Scan

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Background

- **Persons with lived or living experience of dementia** (PWLLED) face complex needs[1,2]
- **Primary care providers (PCPs)** play a central role in dementia diagnosis and management[3]
- **PCPs experience a burden in caring for PWLLED** and can benefit from timely specialist advice[4]

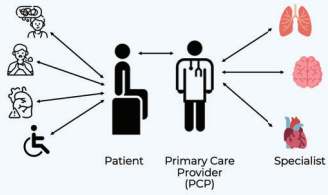

Figure 1. *Example workflow of a primary care provider-to-specialist consultation service*

OBJECTIVE: To map and describe Canadian services that support PCP-specialist communication for dementia care

Approach

LITERATURE REVIEW: Two authors screened articles from PubMed and Embase to identify relevant services

GREY LITERATURE: Google search and national/provincial health websites will be used to further identify missed services

INTERVIEWS: Key informants will be interviewed to fill in gaps about the identified services

Results

We identified a diverse range of services across Canada that support communication between primary care providers and specialists for PWLLED (Figure 2). Details about these services (Figure 3) will be extracted to compare and synthesize the findings.

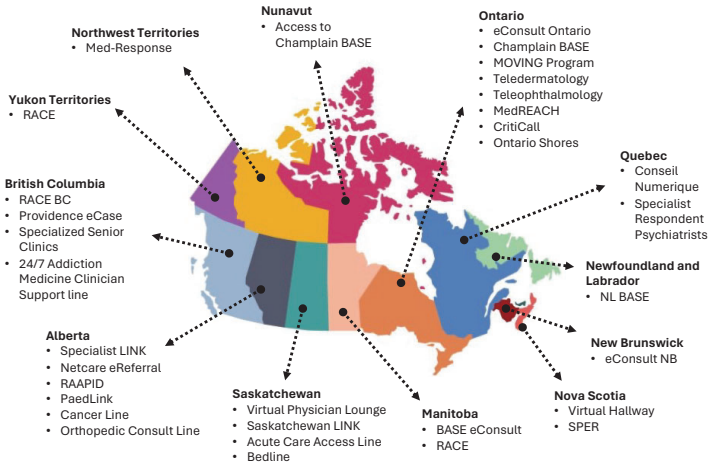

Figure 2. *Geographic distribution of Canadian services identified for physician-to-physician communication suitable for persons with lived or living experience of dementia*

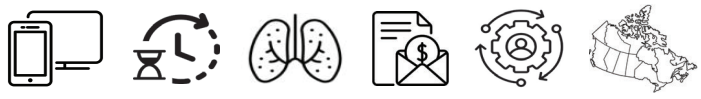

Figure 3. *Details to be extracted about the identified services*

Conclusions

- Communication services between PCPs and specialists vary widely across Canada, leading to **regional differences and potential inequities in access to timely specialist advice**
- The variety of service types (e.g., specialty-specific, regional, or differing billing models) **may pose challenges for physicians to navigate**, potentially limiting uptake and consistency of care
- Insights from this environmental scan can guide policymakers, researchers, and clinicians toward **a more integrated and user-friendly national approach** to specialist communication in dementia care.

What service do you use?

We want to know more about services that you use or are familiar with!

If there are any services we should explore, please fill out this form and let us know!
https://forms.gle/HnffsYcCMDAj3nv17

Scan Me

Or contact Shruthi Sundararaman at ssund013@uottawa.ca

References

1. Sampson EL, Gould V, Lee D, Blanchard MR. Differences in care received by patients with and without dementia who died during acute hospital admission: a retrospective case note study. Age Ageing. 2006 Mar;35(2):187–9.
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This work was supported by: uOttawa | Faculté de médecine Faculty of Medicine | CIHR IRSC | Santé Bruyère Institut de recherche Bruyère Health Research Institute | The Ottawa Hospital | Winchester District Memorial Hospital | Ontario Champlain Local Health Integration Network

Timeliness, continuity or travel time: a discrete choice experiment of public preferences for primary care access in Canada

Tara Kiran[1,2], Maryam Daneshvarfard[2], Alexander Beyer[3,4], Danielle Martin[1,5], Mylaine Breton[6], Rita K. McCracken[7], M. Ruth Lavergne[8], Neb Kovacina[9], Alan Katz[10], Andrew D. Pinto[1,2], Jasmin Kay[11], Peter MacLeod[11], Clifton van der Linden[3,4]

[1]University of Toronto, [2]Unity Health Toronto, [3]McMaster University, [4]Vox Pop Labs, [5]Women's College Hospital, [6]Université de Sherbrooke, [7]University of British Columbia, [8]Dalhousie University, [9]McGill University, [10]University of Manitoba, [11]MASS LBP

BACKGROUND AND OBJECTIVES

While both access and continuity are crucial to patients, it remains unclear which is prioritized more in primary care.

Understanding patient preferences for these attributes can inform the development of healthcare systems better aligned with public needs.

We conducted a discrete choice experiment to understand the Canadian public's relative preferences for three primary care attributes:

1. Timeliness of Care
2. Care Continuity
3. Travel Time to Clinic

APPROACH

We embedded the experiment in the 2022 OurCare national survey, a bilingual online survey representative of Canadian adults aged 18 and older.

Respondents were randomly assigned to one of four scenarios:

- Worsening depression
- New sore throat
- New sexually transmitted infection
- Worsening diabetes

They completed a discrete choice experiment, in which they selected between two hypothetical primary care options, with the order and levels of care attributes randomly assigned.

An example of the healthcare options presented to respondents as part of the discrete choice experiment

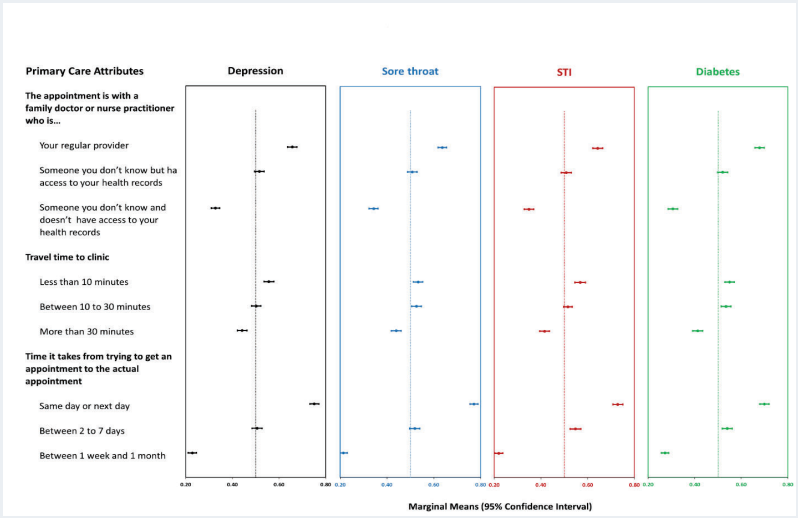
Imagine you feel depressed and want to hurt yourself. You get 2 choices for an in-person appointment. Which would you choose?

Option 1	Option 2
- The appointment is with a family doctor or nurse practitioner who is your regular provider	- The appointment is with a family doctor or nurse practitioner who is someone you don't know but has access to your health records
- Travel time to clinic is between 10 to 30 minutes	- Travel time to clinic is less than 10 minutes
- Time it takes from trying to get an appointment to the actual appointment is between 1 week and 1 month	- Time it takes from trying to get an appointment to the actual appointment is same day or next day

Logistic regression and Marginal Means were used to analyze preferences overall and across socio-demographic groups.

All three attributes significantly influenced decisions; however, timeliness and continuity were consistently prioritized over travel time across diverse groups.

Results of the discrete choice experiment for each of the four clinical scenarios



ACKNOWLEDGEMENT

This project is part of OurCare, a national initiative to engage patients and the public about the future of primary care in Canada, led by Dr. Tara Kiran.

We would like to thank the OurCare members, leads, advisory committee members, Vox Pop Labs, funders and partners for their contributions. For a full list of collaborators, visit OurCare.ca

RESULTS

A total of 9,276 respondents completed at least one choice task. Each participant completed the task three times.

Clinical Scenario	Number of Selections
Depression	6954
Sore throat	6985
Sexually transmitted infection	6904
Diabetes	6767

All three primary care attributes significantly impacted decision-making, with timeliness and continuity being more important for decision-making than travel time.

Participants preferred healthcare options that included an appointment with **their regular clinician**, **travel time to the clinic of less than 10 minutes**, and **same or next day appointments**.

Featuring the middle level of each care attribute in a healthcare option had slight or no effect on whether it was chosen.

Healthcare options including the least preferred levels of each attribute were significantly less likely to be selected.

Preferences did not vary substantially by socio-demographic characteristics.

CONCLUSION

Both attributes of access and continuity were consistently prioritized by respondents, with preferences remaining stable across respondent characteristics.

Our findings highlight the importance of primary care models that ensure timely access to care with a regular clinician, or, alternatively, provide timely access while maintaining continuity through shared health information.

CONTACT

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Creating a Model for Choosing between Virtual and In-Person Family Physician Visits: Incorporating Patient and Family Physician Perspectives

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Western Centre for Studies in Family Medicine

Schulich MEDICINE & DENTISTRY

BACKGROUND AND OBJECTIVE

Background

- Following COVID-19 pandemic, virtual care accelerated to the forefront of family physician care
- Virtual care continues to be used by family physicians and their patients
- Virtual care must be informed by principles of equity and patient-centredness
- We use the term virtual care to include both synchronous and asynchronous modes of care

Objective

To explore how to choose between virtual and in-person family physician care for persons with multimorbidity that is acceptable to both patients and family physicians.

METHODS

- Constructivist Grounded Theory study
- Setting: Ontario, Canada
- Data collection: individual semi-structured interviews between 2022 and 2023
- Participants: Patients who self-identified as having multimorbidity (2+ chronic conditions) and family physicians who have provided care virtually
- Data analysis: iterative using constant comparison

RESULTS

Theme 1
Considerations in choosing mode of delivery

Reason for visit: "When it's a discussion issue, not an examination issue" (Pt15)
Impact on access: "I'd have to take an hour or two off to go to the doctor" (Pt13)
Technological logistics: "My patients very quickly showed me video calls aren't feasible" (FP3)
Reimbursement for virtual care: "It would be hugely backwards for the government to put more rules on restricting virtual access [reimbursement], for those of us that do believe that it's best to have the hybrid models" (FP9).

Theme 2
Process for choosing mode of delivery

Endorsing patient preference when possible: "My job is to provide you with all of the information and help you to weigh the risks versus benefits of the alternatives and then it's your job to make the decisions" (FP4)
Process for scheduling visits:
While the majority of patient and FP participants emphasized the importance of listening to patient preference, participants also expressed that this is often not how the process unfolds in practice.

CONCLUSIONS

- There were four practical considerations for deciding between virtual and in-person care
- Patient choice should be prioritized when the considerations support the ability to do so
- The process for choosing mode of delivery should be embedded within the patient-family physician relationship, and in a way that provides a positive care experience for both patients and family physicians

This study was supported by the Canadian Institutes of Health Research (CIHR)

CIHR IRSC

Evaluating Health Promotion Programs in Community Health Centres in Ontario: Interim Results

Isabelle Fortuna MPH[1], Sara Bhatti MPH[1], Jennifer Rayner PhD[1,2]

1. Alliance for Healthier Communities, 2. Western University, Centre for Studies in Family Medicine

BACKGROUND

The Alliance for Healthier Communities is an association of **comprehensive primary health care organizations** across Ontario, including Community Health Centres (CHCs).

CHCs deliver **health promotion programming** as part of their model of care and approach to prevent and manage chronic disease (CD).

While many conduct their own evaluations, there is a need to

1. Develop a **standardized evaluation approach** across the sector.
2. Demonstrate the **impact of CD management-specific programs** on client outcomes.

APPROACH

Continuous co-design process with CHC Staff and Client Advisory Groups

Inclusion – Programs
- Goal of improving CD knowledge or self-management
- Time-limited

Inclusion – Participants
- Living with CD(s)
- First time participating in the program

Data Collection – Centres
- Program Description survey
- Support recruitment

Data Collection – Participants
- Pre- and post-program surveys
- 6-month follow-up survey
- Optional interview

INTERIM RESULTS

Data was collected from **Jan – Sept 2025:**
- **8 CHCs** and **9 programs**
- **60 participants** completed pre- and post-program surveys

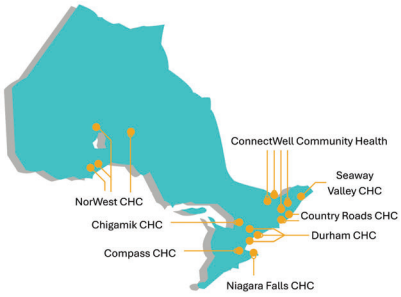


Fig 1. Participating Centres as of Sept 2025

Participant Characteristics
- CDs**: COPD, chronic pain, diabetes, and/or arthritis**
- 73% were **61-80 years old**
- 70% identified as **women**
- 58% had a **high school education** or greater
- 28% had **difficulty paying for basic needs**
- 77% **White,** 15% **First Nations, Inuit, or Métis / Mixed Race (including Indigenous)**

Participant Outcomes
- 95% reported **learning new skills and techniques** to self-manage CD(s).
- 43% reported an increased **sense of community/social support network.**
- Majority reported maintained ratings in all EQ-5D health dimensions, however, the **greatest improvements** in ratings were:
  - **Pain/discomfort** (35%)
  - **Anxiety/depression** (35%)

Fig 2. Change in confidence in ability to self-manage chronic disease

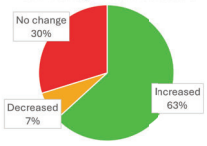
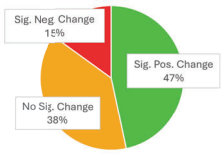


Fig 3. Change in VAS (Overall Health) Score



KEY FINDINGS

- Health promotion programs have a positive impact on health outcomes and managing CD.
- Data collection tools are appropriate for streamlined evaluation.

Alliance for Healthier Communities
Advancing Health Equity in Ontario

Visit alliance on.org to learn more about our work and our Learning Health System

Exploring approaches and interventions that influence patient access and attachment to primary care: A literature review

Karla Freeman[1], MSc, Jennifer Salerno[1,2], MSc, PhD, Bethany Elliott[1], MPH

[1]David Braley Primary Care Research Collaborative, Department of Family Medicine; [2] Health Research Methods, Evidence, and Impact, Faculty of Health Sciences, McMaster University

INTRODUCTION

- Primary care underpins Canadian health care delivery, yet 17% of Canadians lack a regular primary care provider.
- ***Access to care:*** the ability to locate and receive health care when needed without major barriers.
- ***Attachment:*** longitudinal care in a patient-provider relationship or confirmed affiliation.
- Lack of either can lead to:
  - Sub-optimal chronic disease management
  - Increased mortality and emergency department use
  - Persistent changes in health-seeking behaviours e.g., less preventative care.

RESEARCH QUESTION

What are the factors that impact patient access and attachment to primary care?

METHOD

- OVID Medline, PubMed, Overton, and reference lists were searched without date limits.
- Search terms were synonyms of primary care, care models, access, attachment, equity, vulnerable, interprofessional collaboration.
- Included citations were in English, relevant to Canadian healthcare, and were reviews or primary studies.
- Thematic analysis described and narratively synthesized interventions and approaches according to their influence.

EMERGING THEMES IN ACCESS AND ATTACHMENT

RESULTS

- 21 articles were included:
  - 11 reviews
  - 10 primary studies
- Emerging themes for improving patient access and attachment include:
  - Team-based care
  - Coordinated after-hours care
  - Centralized supports & wait-lists
  - Financial incentives and capitation models
  - Equitable access to care via community-based models & outreach services

DISCUSSION

- A single approach is not effective. An integrated, ***multi-pronged approach*** is necessary.
- Primary care access and attachment hinges on ***capacity of primary care*** practices to 'absorb' patients.
- Recommendations include:
  - ***Policy changes*** and ***increasing primary care funding*** to increase number and geographical distribution of primary care teams.
  - Financial incentives and ***alternative remuneration models*** supporting access to collaborative team-based care.
  - Increase primary care system capacity through ***effective use of both physician and non-physician health care providers***.

Having a Regular Family Physician Reduces Mental Health Service Use for Children and Youth with Chronic Health Conditions in Ontario

Presented at the Trillium Primary Health Care (PHC) Research Day, October 17, 2025

Grace Golden [a], Li Wang [b], & Graham J. Reid [a, c, d, e, f]

a. Psychology, University of Western Ontario (UWO); b. Psychiatry and Behavioural Neuroscience, McMaster University; c. Family Medicine, School of Medicine and Dentistry, UWO; d. Paediatrics, School of Medicine and Dentistry, UWO; e. Children's Health Research Institute (CHRI); f. Lawson Health Research Institute

Funding. G.G. supported by Canada Graduate Scholarship-Master's, Social Sciences and Humanities Research Council of Canada (SSHRC), TUTOR-PHC Fellowship, Passerelle; G.J.R. supported by CHRI.

BACKGROUND

- Children (aged 4-11) and youth (aged 12-17) with chronic health conditions (CHC; e.g., asthma, diabetes) are at increased risk of mental health (MH) problems.[1,2]
- Children with CHC should receive ongoing care, but the types of providers and the frequency of visits vary by condition.

Hypothesis

1. More severe CHC and more CHC visits will be related to a higher likelihood of receiving MH care after controlling for known MH service predictors (e.g., sociodemographic factors).
2. Children with a family physician (FP) are more likely to be identified and referred to additional MH services compared to those without one.

METHODS

Secondary analyses

1. Ontario Child Health Study (OCHS) 2014.[3]
   - Cross-sectional, province-wide sample
   - (6,537 households; 10,802 children and adolescents)
2. Ontario Health Insurance Plan (OHIP) data.[4-6]
   - Administrative data for all physician and hospital services
   - (i) physician specialty code, (ii) service fee code, and (iii) ICD-9 diagnostic code.

Excluded: Parents of children (1) who did not agree to link OCHS to OHIP (13.9%); (2) with a developmental delay or intellectual disability (2.9%).

Procedure

- Parents completed at-home interviews (N = 8,985).
- Parents reported whether the target child (i.e., one child randomly selected per family) (n = 5,378) had a FP.

Predictors:
(a) child characteristics, **(b)** PMK/Partner characteristics, **(c)** household characteristics, **(d)** PMK/Partner functioning, **(e)** child MH condition based on clinical cut-offs using OCHS-emotional behavioural scales (OCHS-EBS[7]), **(f)** CHC status based on 3 years of OHIP data and/or parent-report, **(g)** health severity based on health utility index (HUI[8,9]), **(h)** previous physical and MH visits based on 1 year of OHIP data.

Specialized MH Service Outcome:

- Parents reported visits to (1) FP, (2) pediatricians, (3) walk-in clinics, and/or (4) urgent care in the previous 6 months for the child's MH concern.
- **Coded as:** 0 = no visit; 1 = 1 or more visits.

Data Analysis: Hierarchical logistic regressions. MICE was used to handle missing data.

Figure 1. ***Data Coding and Analysis Timeline***

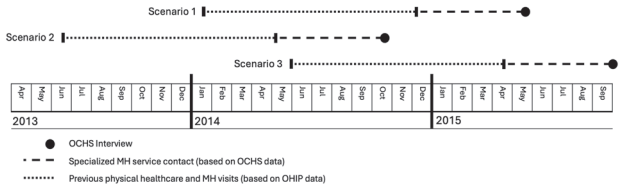


Figure 1. Three scenarios show (1) date of OCHS interviews, (2) time frame for parent reporting on MH specialized service contact "in the past 6 months", and (3) physician OHIP data 1 year before "in the past 6 months". **Note:** Chronic health condition status based on 3 years prior to OCHS interview.

RESULTS

Sample: 56.1% aged 4-11, 49.2% female, 63.4% white, 13.2% MH condition, 7.5% had contact with one or more general health providers for MH.

Table 1. ***Hierarchical Logistic Regression for General Health Service Contact***

General Health Service Contact	Bivariate (OR)	Multivariate (OR)
Child Mental Health Condition (ref: no MH condition)		
Internalizing	**12.01**	**8.52**
Externalizing	**6.75**	**3.71**
Both	**21.74**	**7.25**
Chronic Condition Status – based (ref: no CHC)		
Administrative (OHIP data)	1.46	1.30
Parent-reported	**1.71**	0.93
Both	**2.56**	1.62
Health Severity (ref: no health problems)		
Mild problems	**2.16**	2.15
Moderate problems	**6.03**	**2.99**
Severe problems	**13.32**	**5.44**
Has a family physician (ref: No FP)	**0.34**	**0.19**
Previous Physical Healthcare Use - Number of Visits (OHIP)		
Family physician visit	**1.08**	0.96
Specialist chronic condition visit	**1.15**	1.28
Specialist non-chronic condition visit	**1.15**	0.92
Previous MH Visits - Number of Visits (OHIP)		
Family physician MH visit	**2.70**	**1.78**
Specialist MH visit	**2.43**	**2.19**
FP x Previous Physical Healthcare Use		
Has a FP x FP visits	1.00	1.07
Has a FP x Chronic condition visit (specialist)	0.87	0.73
Has a FP x Non-chronic condition visit (specialist)	1.03	1.15

Note. Significant ORs (p < .05) are bolded. Model is controlling for a) child characteristics, b) PMK/Partner characteristics, c) household characteristics, d) PMK/Partner Functioning.

RESULTS

Background predictors:
Lower odds of accessing MH services if children were:

- **South Asian, Black, and Southeast Asian.**

Mental health predictors:
Higher odds of accessing MH services if children,

- **Had MH conditions** compared no MH conditions.
- Had **moderate or severe** health problems.
- **Had previous MH visits** with any physician.

Children with a FP had **81% reduced odds** of contacting general MH providers.

Supplementary analyses:

- Children with no FP has significantly fewer previous administrative MH visits with a FP than those without (z = -4.311, p < .001).

DISCUSSION

Having a CHC was not significant after controlling for health severity.

- Suggesting that health severity has a greater impact on the increased need for MH services.

FP visits and **CHC specialist visits** were **not** associated with general MH service contact.

Having a FP was associated with reduced odds of general MH service contact.

- Children with a FP may have their healthcare needs, including MH, sufficiently managed within primary care settings, reducing the need for other providers (e.g., urgent care, walk-in clinics)

IMPLICATIONS

- Family physicians play important roles in preventing children with MH problems from needing other healthcare services.
- Children who regularly visit healthcare providers for their CHC present an opportunity to enhance MH identification, treatment, and management.

References and poster:

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The Role of Primary Care Networks in Addressing Workforce Challenges in Ontario Health East.

Colleen Grady, Katie Hurst, Alison Eyre, Sophy Chan-Nguyen

Introduction

The Ministry identifies that primary care is critical to integrated care. They elaborated on this with the development of Primary Care Networks (PCNs) in each OHT. *"PCNs will connect, integrate and support PC providers",* enabling their voice and building on provider experience to affect change. However, primary care is impacted by the HHR crisis throughout Canada with limited capacity for engagement in system change. This study, conducted in OH East, aimed to identify how PCNs can be effective in supporting primary care by addressing workforce challenges.

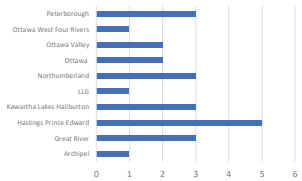
Methods

Qualitative study using semi-structured interviews in 10 Ontario Health Teams, East Region. Four (4) groups of primary care professionals invited to participate: FPs, NPs, IHPs, Administrators.

Results

24 individuals participated in this study

Physicians **(n = 5)** Nurse Practitioners **(n = 3)**
Interprofessional Health Providers **(n = 4)**
Administrative staff **(n = 12)**



Workforce challenges in Primary Care

1) Financial
Stagnant wages, increasing operational costs

"To purchase things with some kind of buying group power would be great." (A_008)

"a PCN could help with hiring front staff. Maybe a PCN could vet technology like AI scribe" (P_007)

2) Recruitment and retention
Physicians and clinic staff especially in rural areas

"Part of the PCN is bringing people together where they can say, Hey, guys, I'm thinking about In 18 months I'm going to be ready to retire. Does anybody have any suggestions?" (A_008)

"I use the primary care network and ways to kind of tell stories and hope that over time, along with the residents that graduate from my program that see a model that hopefully, it implements some change" (P_001)

3) Poor morale and burnout
Feeling devalued, administrative burden

"The PCN hopefully allows us to sort of get a pulse for what's going on, what the pain points are.. prioritize" (P_005)

"to foster a community of of collaboration and well-being and ….show …employees that they're valued" (NP_005)

What do PCNs need to to achieve this?

TO ADDRESS FINANCIAL ISSUES

- **Administrative/technical support staff**
- **Reciprocal communication with MoH**
- **MOUs and protected funding**

TO ADDRESS RECRUITMENT AND RETENTION ISSUES

- **Measurement and tracking support (technical skills, data, real-time updates)**
- **Data support to identify progress toward goals, engagement and activity levels**
- **HR management skills**

TO ADDRESS MORALE ISSUES

- **Support for initiatives that address admin burden, advocacy**
- **Knowledge sharing re: programs (approaches)**
- **Communications, annual conference**
- **Supports to attend wellness, leadership initiatives**

Conclusion

PCNs can be instrumental in focusing on health human resource issues. A strengthened workforce will improve capacity within OHTs to improve population health.

CENTRE FOR STUDIES IN PRIMARY CARE at Queen's University

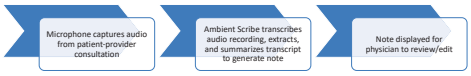
A systematic review of ambient scribe use for physician documentation: A look at primary care

Dylan Grimm, PGY2 Queen's Department of Family Medicine

Introduction

Background

- Ambient scribes have emerged to reduce documentation burden from electronic medical records (EMRs)
- Ambient scribes use techniques such as automatic speech recognition and natural language processing to generate documentation
- Evidence is still emerging as to the quality of notes generated, effect on physician burnout, and overall time savings



Primary objective

- To determine the effects of ambient scribes on provider burnout, productivity, and documentation quality when deployed in real clinical environments

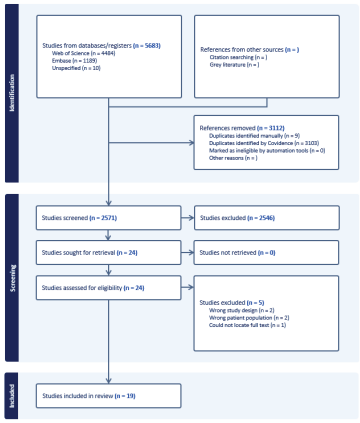
Methods

- Non-registered PRISMA-based systematic review
- Guided by keywords of exploratory search results, a proximity search was developed in collaboration with a health sciences librarian
- Inclusion and exclusion criteria centered on ambient scribe deployment in a real-life clinical encounter, and without modification prior to the note being presented to the clinician
- All medical specialties were included in the search

Database	Search Term
Embase + Embase Classic	((ambient* or "AI" or artificial) adj4 (scrib* or document*))
OVID MEDLINE Ahead of Print/Unindexed Citations	((ambient* or "AI" or artificial) adj4 (scrib* or document*))
Web of Science	((ambient* or artificial) NEAR/4 (scrib* or document*))

- Two independent authors screened abstracts and full texts, and where there was ambiguity a third author was involved
- Data was extracted from full texts and input on to a standard table template used for each study

Search Outcome



Results

- Across multiple studies, most physicians reported reduced stress and burnout after adopting ambient AI scribes.
  - Examples: 55–75% reported improved satisfaction, lower stress, or reduced burnout indicators.
  - Physicians frequently noted improved work-life balance
- Ambient scribes consistently reduced cognitive burden.
  - Several studies quantified this with higher odds of reporting "less mentally taxing work."
  - Qualitative comments indicated clinicians could "engage more with patients" and focus less on typing.
- Decreases in time spent in the EHR (often by 20–40%).
  - One study showed a 20.4% reduction in time per appointment.
  - Others reported subjective time savings of 1–1.5 hours/day.
- Reductions in after-hours charting, often measured via EMR logs or self-report.

Results/Conclusion

- Most studies found slightly longer notes post-implementation (5–20% increases).
  - However, clinicians typed less (typed text dropped by ~30%), with AI generating more of the content.
  - A minority found notes to be "too verbose" or "repetitive."
- Most clinicians felt that ambient scribes produced acceptable quality, structure, and completeness of documentation.
  - Concerns remained about contextual or transcription errors.
- Limitations:
  - Evidence remains limited
  - Selection bias throughout most studies
  - Single country studies
  - Limited randomized control trials
  - Little evidence on patient level effects
- Future work:
  - Should focus on methodological gaps, include diverse settings, and evaluations of patient experience and care quality

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Queen's University
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Emergency Medicine

Queen's University
Department of Family Medicine

PRESENTER
Kate Hurst RN
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Background

Current measures of capacity, such as **panel size and visit volume**, offer valuable insights, but capture only part of the picture of capacity in teams. Capacity is also shaped by **team roles and functions, patient/panel population needs, and system factors** that influence how care is delivered. Understanding these layers is essential to support **workforce sustainability and realistic planning**.

TUTOR-PHC INSPIRE-PHC OSSU

Methods at a glance

- Findings of JBI methodology scoping review
- 2 databases
- Current results reflect themes across 18 studies at full review (see QR code for inclusion criteria + search strategy)

N=18

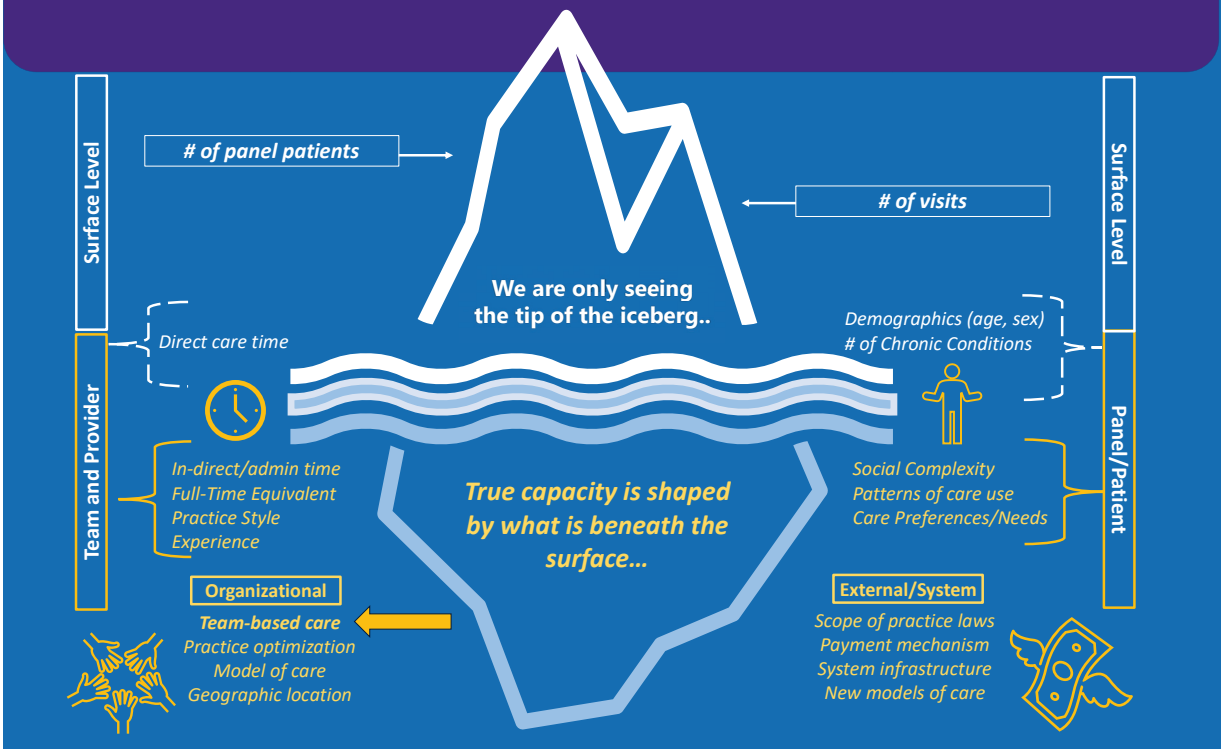
What else was found:

- **Though teams were noted to be an enabler, capacity was always calculated in relation to one provider not the whole team**
- Only 1 study attempted to **quantify the capacity of a non-MD, NP or PA team member**
- Only **2 of the 18 studies were qualitative** and reflected provider experiences and conceptions of capacity
  - There is one protocol (Lavergne et al., 2025) that will look at this in a mixed-methods approach; however, it is focused only on MDs and NPs
- Capacity was mostly based on **uniform assumptions of patient complexity and provider time ('everyone is the same')** – variations in FTE, practice style; or utilization profile were applied in only a few studies

Underexplored areas:

- The capacity of providers or teams to provide certain types of care to meet patient needs, such as **gender affirming or culturally safe care, was not explored in the literature**

Are we seeing the full picture of team-based primary care capacity – or is there more beneath the surface?



Supporting the Frontline: Survey of Medical Office Assistants' Roles and Well-Being in Ontario Primary Care

Amber Khan MPH[1,2], Jennifer Shuldiner PhD[1,3,4], Apira Ragunathan MPH[1], Jawairia Mohammed MPH [1], Noah Ivers MD PhD[1,3,4]

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Background

Medical Office Assistants (MOAs) are essential to primary care, handling key administrative and clinically-adjacent tasks. Despite their importance, their roles and wellbeing remain under-researched.

Objective:
To examine MOA tasks, supports, and burnout to inform workforce planning.

Methods:
- Cross-sectional survey of 958 MOAs in Ontario primary care.
- Recruited MOAs through partner organizations, email lists, and fax outreach.
- Data Collection completed through online and faxed surveys.
- Quantitative Data: Scaled items on job satisfaction, burnout, autonomy, task variety, and social support.
- Qualitative Data: Open-ended responses on workload, supports, and desired changes.

Survey Demographics

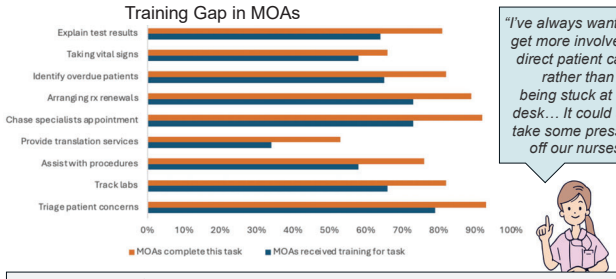
90% MOAs are female

Average Pay Rate **$23.28/hour**

8 years Average MOA experience

Average Age group **42 years old** standard deviation = 11

Key Findings



"I've always wanted to get more involved in direct patient care, rather than being stuck at my desk… It could also take some pressure off our nurses"

77% MOAs expressed **moderate to strong** job satisfaction

"I do feel like I am burnt out at work. I feel that few people understand the pressures of front staff. I no longer feel challenged at my job."

" I feel like I am a very important part of the family medicine health system - being the "messenger" between patient and provider"

1/4 **MOAs report moderate to severe burnout**

Risk Factors for Burnout

Job complexity & **Skill variety =** **Burnout**

Increased burnout when MOAs lacked training & support from physicians & staff

Protective Factors against Burnout

Task identity & **Social Support =** **Burnout &** **Satisfaction**

Encouragement and support from co-workers and physicians reduced signs of burnout

Many MOAs expressed growing patient demands and being at the brunt of patient frustration…

MOAs have experienced patient abuse or aggression from patients

"Patients think everything should be immediate - be it a result, a referral, or an appointment! As the first point of contact, I get the brunt of it"

Top 3 MOA Challenges

1. MOAs being short staffed, despite high workload & high patient demands
2. MOAs not having enough career growth or professional advancement opportunities
3. MOAs feeling unappreciated, unrespected or unsupported by work environment and patients

Next Steps

- Improve staffing levels to reduce burnout and emotional burden on MOAs.
- Implement safety protocols to protect MOAs from patient aggression and abuse.
- Create career development pathways to support MOA growth and retention.
- Explore scope expansion to allow MOAs more involvement in clinical care and further training

This project is funded by a **CIHR Project Grant**

Cervical Cancer Screening with HPV Self-Sampling

Uptake and feasibility at a family medicine clinic in Edmonton, Alberta

Faith Wierenga, Holly Dievert, Bonnie Chiang, Huiming Yang, Oksana Babenko, Michelle Umali, Tina Korownyk, Donna Manca, Elisa Molstad, Roni Kraut

BACKGROUND: HPV self-sampling (HPV SS) is an alternative to clinician collected sampling, where patients collect their own sample. There is limited research of HPV SS in regular family practice.

OBJECTIVE: To determine the uptake and feasibility of HPV SS in a family medicine clinic.

METHODS:

- Conducted Sep – Nov 2024 at a family medicine clinic
- Eligibility criteria: 25-69 years old, with a cervix, no Pap test ≥2.5 years, not pregnant, last Pap normal, not in colposcopy care, no active bleeding
- Eligible patients had the option to complete HPV SS in the clinic after their appointment.
- Outcomes: patient uptake, HPV SS results, patient preference among patients that completed HPV SS, family physician preference, and carbon footprint

CONCLUSION: HPV SS is preferred by patients and physicians. It should be considered for the regular family medicine population.

RESULTS:

Patient characteristics (n=226)	
Median age	43 (IQR 32-56)
Median months since last test	37 (IQR 32-45)
Panelled (has a family physician)	58%
Urban	89%
Immigrants	14%
Indigenous	4%

Physician characteristics (n=12)	
Age	30 - 60
% female	100%
Median Pap tests/clinic day	2 (1-2.5)
Median clinic days/month	8 (IQR 5-18)
Years of independent practice	1 - 20

Patient uptake	Negative HPV SS	Patients prefer HPV SS	Family physician support	Reduction in CO_2 emissions
81%	90%	98%	100%	20%

Shifa Medical Clinic · Queen's University · University of Alberta · Alberta Government · Primary Care Alberta · Alberta Health Services

University of Alberta Ethics PRO00141239

Rapid Action Learning Intensives (RALI): A Framework for Fostering Accessible, Equitable and Sustainable Change in Primary Care

Stéphanie Lamothe MSc[1,2], Sara Bhatti MPH[2], Jennifer Rayner PhD[2,3], Lorri Zagar[4]

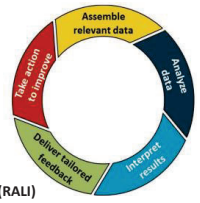
1. Centre de santé Univi Health Centre, 2. Alliance for Healthier Communities, 3. Western University, Centre for Studies in Family Medicine, 4. Independent consultant

BACKGROUND AND APPROACH

A key social determinant of health linked to health equity is: ***access*** to health services. Conversations about **health equity** have increased recently, including a growing policy conversation about the ***importance of taking a system-wide approach to health equity***.

The Alliance for Healthier Communities (Alliance) is a network of team-based comprehensive primary health care organizations across Ontario, Canada. Since 2020, the Alliance and its members have adopted a **Learning Health System (LHS)** model. A **LHS** is a network of healthcare providers or organizations engaged in continuous learning and growth (*see Figure 1*). In this model, information from practice and research is fed back to teams in ways that are meaningful and useable to them, and leads to improvements in care and services, ***including access***.

Figure 1. The LHS expressed as a continuous cycle of learning and improvement.



Recognizing implementation is **HARD** but having the right supports and resources makes it easier; the LHS team at the Alliance developed the **Rapid Action Learning Intensive (RALI)** framework. **RALI** is a ***bilingual***, codified, coach-supported quality improvement framework created to help primary care teams implement new initiatives that improve the *accessibility, equity, and sustainability of their services*.

METHODS

The **RALI** framework is a self-paced and self-directed approach allowing teams to work at a pace that is suited to them. **RALI** offers scheduled learning sessions, recordings and accompanying slide decks, a how-to-guide + workbook, access to quality improvement coaches, and other curated resources and EMR tools. It was successfully applied to two key initiatives to date:

Figure 2. RALI-SDD Intervention: The 7-Step Process

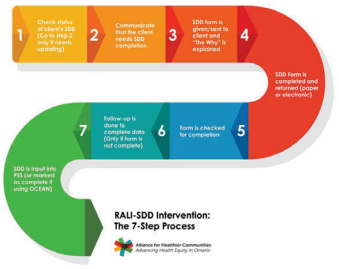
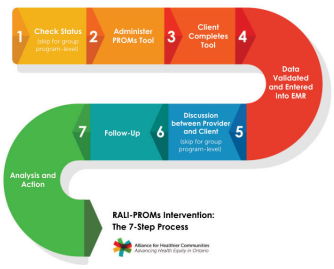


Figure 3. RALI-PROMs Intervention: The 7-Step Process



First, **RALI-SDD** (*see Figure 2*) helps teams improve the collection of **s**ocio**d**emographic **d**ata to better understand the clients and the communities they serve.

Second, **RALI-PROMs** (*see Figure 3*) guides teams in using **p**atient-**r**eported **o**utcome **m**easures to support collaborative care and evaluate program effectiveness.

RESULTS

RALI-SDD helped Alliance members improve their collection rates of usable sociodemographic data (*see Figure 4*) and increase access by:

Removing Barriers to Care

- During the COVID-19 pandemic, Alliance members utilized their SDD to improve vaccine uptake by identifying populations with lower rates of vaccination and implement efforts that were tailored to those specific populations.
- A similar approach has been used to improve cancer screening rates.

Planning Programs that Meet the Needs of Community

- SDD is frequently used by Alliance members to assess gaps in programming. For example, members can plan programs that meet specific cultural or language needs of patients seen within the community.

Understanding System-Wide Healthcare Utilization

- SDD is routinely shared with administrative health databases to understand how patients navigate and use healthcare services beyond primary care (*e.g.*, emergency department use, hospital admissions, etc.) which can provide insight for health system management.

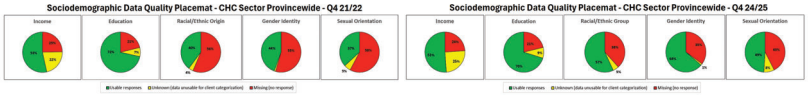


Figure 4. SDD collection rates for five chosen indicators: Income, Education, Racial/Ethnic Origin, Gender Identity and Sexual Orientation. Displayed for the CHC sector provincewide from prior to the implementation of a SDD collection process using the RALI-SDD framework (Q4 2021/2022) and quality improvement coaching supports compared to year-end of 2024/2025.

RALI-PROMs has helped Alliance members implement a process to collect PROMs data, which has helped to inform clinical practice, monitor client health, support collaborative, client-centred care planning, and evaluate program and service effectiveness.

CONCLUSIONS

By progressively building on previous successes and centering ***access and equity***, these initiatives foster applied learning, peer support, and actionable improvements adaptable to diverse primary care settings.

The **RALI** framework demonstrates:

- ✓ Teams focused on building a ***reliable process*** were able to increase their SDD collection rates.
- ✓ Implementation of a PROMs process helped teams monitor changes in health outcomes in a ***standardized*** way.
- ✓ A structured, customizable, QI coach-supported approach can drive meaningful, ***sustainable change*** in primary care.

CENTRE DE SANTÉ Univi HEALTH CENTRE

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Advancing Health Equity in Ontario

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Scaling Up eConsult for Access to Chronic Pain Specialists in Primary Healthcare Across Four Canadian Provinces: A Cross-Sectional Study

eConsult BASE™ Champlain

Background

- Patients with chronic pain in Canada face **long waits** to access multidisciplinary pain clinics for care and treatment.[1]
- Electronic consultation **(eConsult) offers a solution** by enabling primary care providers (PCPs) to securely communicate with specialists, improving timely and equitable access to care.[2,3,4]

Objective

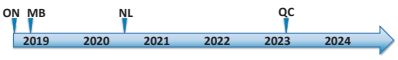
- To examine the process and impact of **implementing an eConsult service for chronic pain across four provinces**: Manitoba (MB), Ontario (ON), Quebec (QC), and Newfoundland and Labrador (NL).

Methods

- **Design:** Cross-sectional study.
- **Setting:** Clinics using eConsult services in MB, ON, QC, and NL.
- **Population:** All eConsult cases submitted to chronic pain specialists in the participating provinces between January 2019 and December 2024.
- **Intervention:** All participating provinces had an established eConsult service. During the study period, chronic pain was newly introduced as a specialty group, with launch timing varying by province. Ontario data excluded the longstanding regional service Champlain BASE™ where chronic pain specialty had been available before the provincial rollout of Ontario eConsult service.
- **Outcome measures:** Indicators of implementation progress and impact, derived from service utilization data and, where available, PCP close-out surveys. Chronic pain eConsult outcomes were presented alongside program-level data for all eConsults submitted to all available specialty groups in each province during the study period.

Study Timeline in each Province:

- **ON:** January 2019 – December 2024
- **MB:** April 2019 – December 2024
- **NL:** November 2020 – December 2024
- **QC:** March 2023 – December 2024



Results

- **Ontario led in uptake**, with 1,706 chronic pain eConsults completed, followed by Quebec (146), Newfoundland (120), and Manitoba (54) (Table 1). Only Ontario showed growth over time in chronic pain eConsults and overall program use (Figure 1)
- **Response and billing times varied**: Chronic pain eConsults had longer specialist response times than other specialties in all provinces except Ontario, which had the fastest response (median 1 day) but longest billing time (median 35 vs. 15 min) (Table 1).
- **Impact on outcomes:** Chronic pain eConsults more often provided new information than other specialties (Ontario: 68% vs. 58%; Manitoba: 62% vs. 53%) but were less likely to avoid referral (Figure 2).

Table 1. Utilization data for eConsult services across participating provinces.

	Manitoba	Ontario	Quebec	Newfoundland and Labrador
Cases completed				
Chronic pain eConsults	54	1,706	146	120
All eConsults	12,031	404,417	102,490	14,462
Specialist response time (days)				
Chronic pain eConsults	25.8*	1*	9.7**	20.6**
All eConsults	2.9*	0.9*	2.9**	8.6**
Specialist billing time (minutes)				
Chronic pain eConsults	15*	35*	30	10.44**
All eConsults	10*	15*	13**	9.28**
# PCPs who submitted chronic pain eConsult(s)	31	1,051	149	93
# Specialists answering chronic pain eConsult(s)	2	24	2	5

*median
**mean

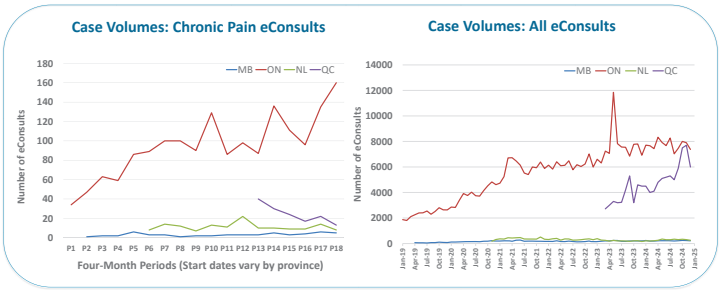


Figure 1. Provincial case volumes for chronic pain eConsult cases (left) and all eConsult cases (right). Note: Chronic pain eConsult volumes are presented in four-month intervals to account for low case numbers in some regions. Start dates are province-specific, aligned with chronic pain eConsult launch.

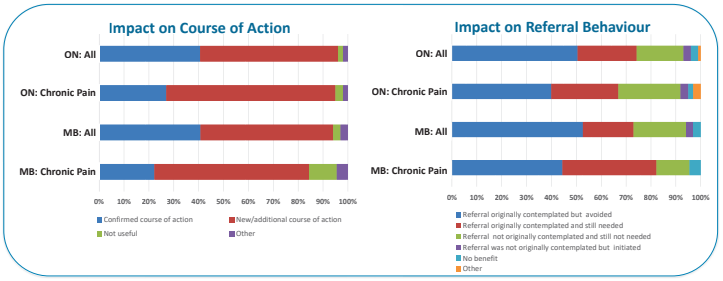


Figure 2. Impact of eConsult on PCP course of action (left) and referral behavior (right) based on PCP response to closeout surveys completed in Ontario and Manitoba.

Discussion

- All provinces were able to add chronic pain as one of the specialist services offered through eConsult.
- **Provincial variation** in chronic pain eConsult uptake and response times may reflect differences in service maturity, implementation strategies, or system capacity, warranting further investigation.
- Specialists in **Ontario and Quebec report spending more time** on chronic pain eConsults, potentially indicating higher case complexity or more comprehensive responses.
- Given the excessive wait times for chronic pain services in Canada, our findings point to an **underutilization of eConsult** for this population and underscore the **need for targeted strategies** to help improve adoption and optimize impact across jurisdictions.

Limitations

- Chronic pain specialty groups became available at different times across provinces, affecting the study's **timeline and comparability**.
- **Differences in service structure and data collection** present a challenge to direct comparisons, as some metrics could not be captured across all participating services.

Conclusion

- Our study highlights **varying degrees of scale-up** of eConsult for chronic pain across the provinces.
- **Lower use and slower response times** in some settings suggest barriers that may need targeted clinician engagement or capacity-building efforts.
- **Continued support** for clinician uptake, along with system-level alignment, may help realize the full potential of chronic pain eConsults in **enhancing access** and care coordination for this population.

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Redefining engagement evaluation using patient impact narratives

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BACKGROUND

People with lived experience of a health issue can offer unique insights about the real-world impact of a project.

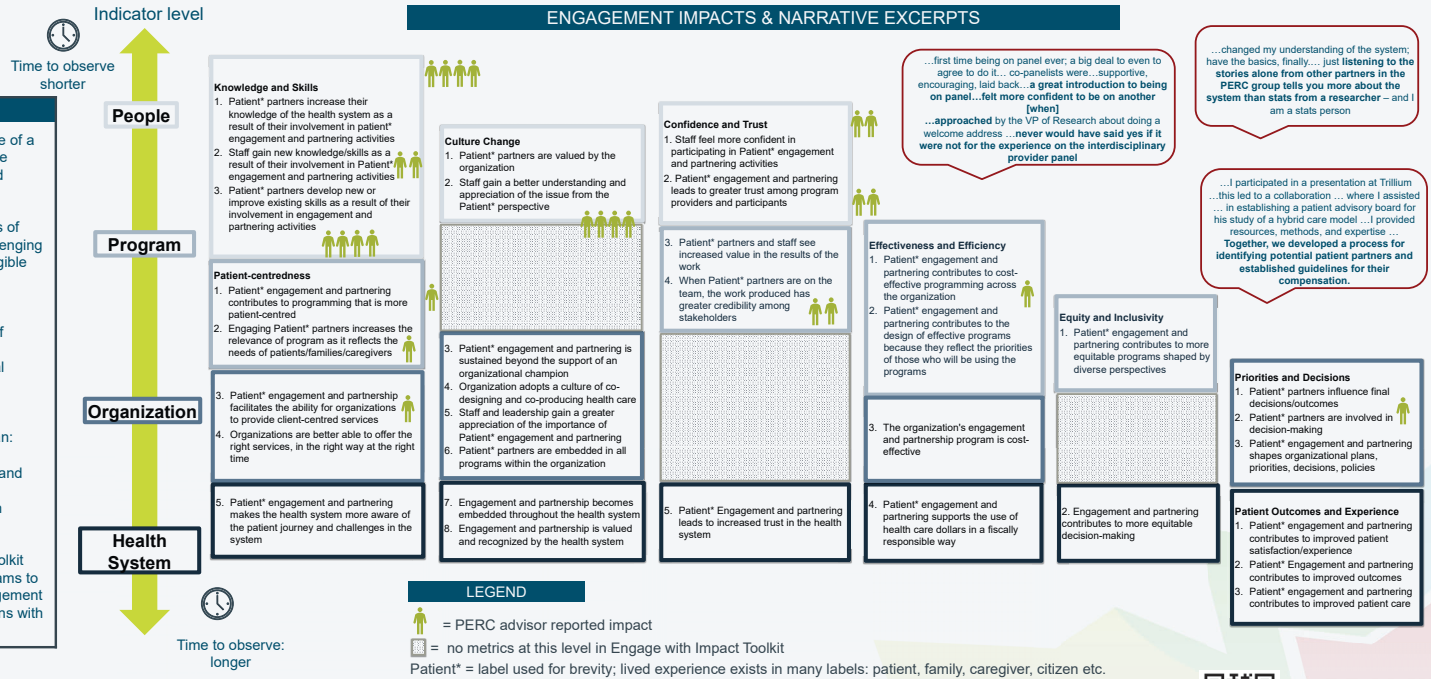
Yet, recognizing the impacts of partnering with can be challenging if input does not lead to tangible changes.

The absence of observable change is not an indicator of absence of impact or effect. Impact narratives can reveal different types of multi-level impact.

Patient impact narratives can:
- illustrate nuance
- bridge between tangible and intangible impacts AND
- be more memorable than statistics.

The Engage with Impact Toolkit supports Ontario Health Teams to plan/measure patient engagement impacts across eight domains with 33 impact metrics.

ENGAGEMENT IMPACTS & NARRATIVE EXCERPTS



> …first time being on panel ever; a big deal to even to agree to do it… co-panelists were…supportive, encouraging, laid back… **a great introduction to being on panel…felt more confident to be on another [when] …approached** by the VP of Research about doing a welcome address …**never would have said yes if it were not for the experience on the interdisciplinary provider panel**

> …changed my understanding of the system; have the basics, finally…. just **listening to the stories alone from other partners in the PERC group tells you more about the system than stats from a researcher** – and I am a stats person

> …I participated in a presentation at Trillium …this led to a collaboration … where I assisted … in establishing a patient advisory board for his study of a hybrid care model …I provided resources, methods, and expertise … **Together, we developed a process for identifying potential patient partners and established guidelines for their compensation.**

LEGEND

= PERC advisor reported impact

= no metrics at this level in Engage with Impact Toolkit

Patient* = label used for brevity; lived experience exists in many labels: patient, family, caregiver, citizen etc.

APPROACH

Patient Expertise in Research Collaboration (PERC) supports and promotes patient-oriented primary health care (PHC) research in Ontario.

The Engage with Impact Toolkit was adapted to support discussions with patient partners about the impact of their involvement in various aspects of PHC.

Impact narratives were co-developed (through interviews and written text) about four PERC patient advisors' experiences.

Patient impacts are indicated by icons beside toolkit metrics.

RESULTS & CONCLUSIONS

Through their involvement with PERC, patient advisors reported:
- increased knowledge and skills,
- more confidence to continue partnering (or begin new partnerships), and
- more credible and equitable, patient-centred outputs

Patient advisors most frequently observed tangible impacts at the individual and program levels, while organizational and system-level changes took longer to emerge.

Narratives helped to identify perceptions of impact; which could indicate downstream effects of partnerships.

Engage with Impact Toolkit

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- Website: https://perc-phc.mcmaster.ca/

PRESENTER
Shary Mahdavi PhD
Kate Hurst RN
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Expanding IPCTs in Ontario: What Milestone Reporting Teaches Us about Expanding Primary Care Teams

Scan this:

Implementation Insights from Ontario's 2023/24 Interprofessional Primary Care Team Expansion

Background

This descriptive analysis examines implementation milestones and challenges reported by 66 teams funded through the 2023/24 Interprofessional Primary Care Team (IPCT) Expression of Interest (EOI) process. Teams were categorized as either net new (new as a result of EOI funding) or expanded (existing team receiving funding to grow). Key indicators include hiring status, and early service delivery, such as initiating care for new patients.

Approach

Data were drawn from monthly narrative milestone reports submitted by funded teams. Expanded teams were further classified as:

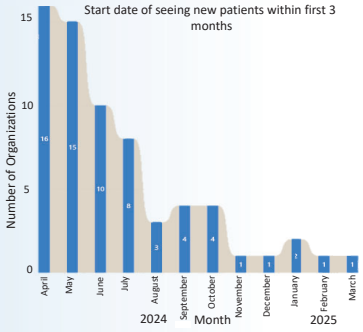
- Expansion – Existing Location
- Expansion – New Site
- Expansion – New Mobile

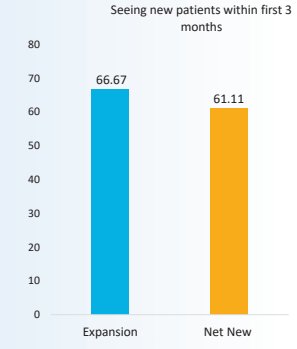
This categorization enabled comparative analysis across team types and settings, highlighting patterns in progress and barriers encountered.

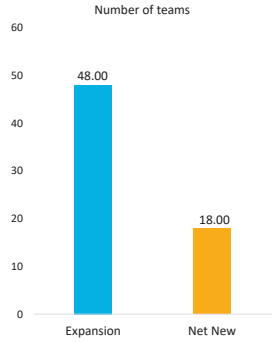
Conclusion

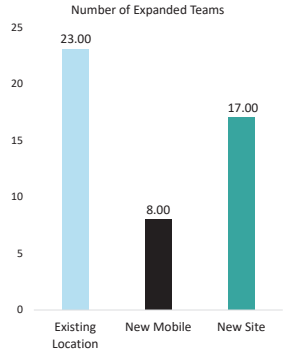
Despite challenges, early service activation and hiring progress reflect strong momentum. Continued and tailored support will be key to sustaining diverse care models.

❑ 62% of all teams began seeing new patients within 3 months.





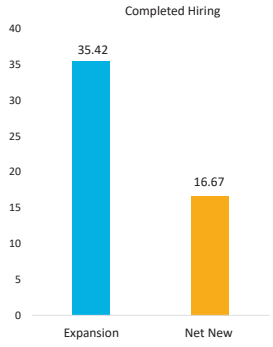




❑ Expanded teams had a higher hiring completion rate (35.42%) than net new teams (16.67%) by August,2025.

❑ Within expanded teams:

- Existing location: 39.13%
- New mobile: 11.76%
- New site: 35.29%



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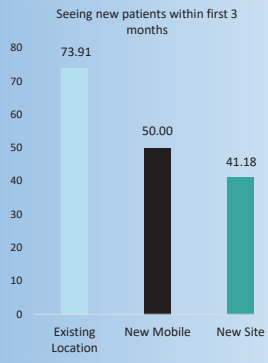
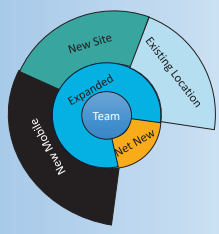
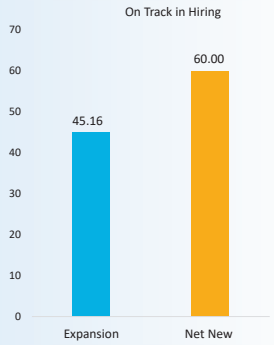
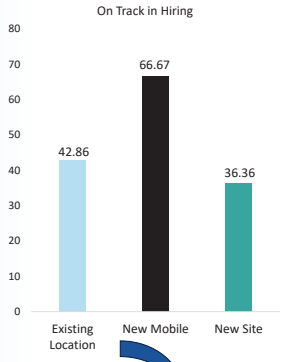
Supplementary Information

Implementation Insights from Ontario's 2023/24 Interprofessional Primary Care Team Expansion

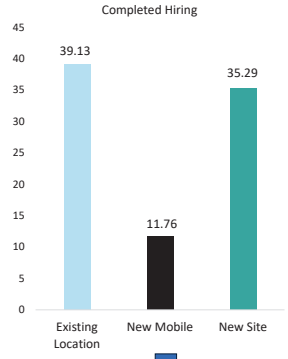








- ❑ On-track hiring rates were:
  - 60% for net new teams
  - 45.16% for expanded teams
- ❑ Within expanded teams:
  - oExisting location: 42.86%
  - oNew mobile: 66.67%
  - oNew site: 36.36%



- ❑ Expanded teams had a higher hiring completion rate (35.42%) than net new teams (16.67%) by August,2025.
- ❑ Within expanded teams:
  - Existing location: 39.13%
  - New mobile: 11.76%
  - New site: 35.29%

Equitable Primary Care Prevention: Co-Evaluation of a Patient-Partnered Educational Intervention

Stella Medvedyuk[1], Zeenat Ladak[1,2], Tatiana Demarco[1,2], Salva Niwe[1,3], Aisha Lofters[1,2], Angus Pratt[1,4], Annemarie Edwards[5], Bikila Amenu[1,4], Christian Finley[6,7,8], Gary Bloch[9,10], Howard Freedman[1,4], Jackie Manthorne[11], Janet Parsons[2], Jean-Claude Camus[1,4], Joyce Nyhof-Young[1,2,9], Shari Dworkin[12], Tara Jeji[1,4], Vanessa Redditt[1,2], Vinesha Ramasamy[1,4], Vanessa Wright[1,2], **Ambreen Sayani**[1,2,12]

[1]Women's College Hospital, [2]University of Toronto, [3]University of Waterloo, [4]Patient Partner, [5]Canadian Cancer Society, [6]Ontario Health, [7]McMaster University, [8]St. Joseph's Healthcare Hamilton, [9]St. Michael's Hospital, [10]Inner City Health Associates, [11]Canadian Cancer Survivor Network, [12]Canadian Partnerships Against Cancer

INTRODUCTION

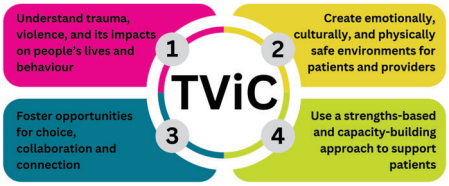
The Problem

- People who are at a greater risk for poor health outcomes face barriers to preventative care.

How We Addressed This Gap

We co-designed an e-learning module, ***'Creating Safe Connections'***.

- ✓Free!
- ✓Co-designed with patient-partners
- ✓Available to ALL primary care providers (PCPs)
- ✓Continuing Medical Education (CME) Accredited
- ✓Builds skills and competencies on how to integrate equity-oriented, **Trauma- and Violence-informed Care (TViC)** strategies into primary care conversations
- ✓Uses lung cancer screening (LCS) as a case example



OBJECTIVE

Co-evaluate the dissemination, reach, and usefulness of the module by measuring uptake and learning experiences.

METHODS

Study Design

Explanatory mixed-methods, process & outcomes evaluation since implementation in Spring 2024.

Learner Audience

Any PCP: physicians, nurses and nurse practitioners, physician assistants, residents, pharmacists, therapists, dieticians, social workers, health promoters, etc.

Data Collection & Analysis

- Surveys (pre-evaluation, module assessment, post-evaluation) & interviews mapped to:

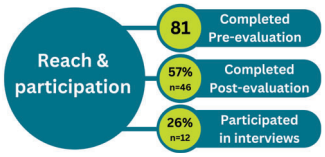
Moore's Framework for Assessing Learners and Evaluating Instructional Activities

Participation | Satisfaction | Knowledge

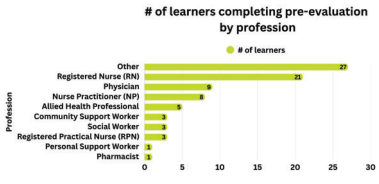
RE-AIM Evaluation Framework

Reach | Effectiveness | Adoption | Implementation | Maintenance

PRELIMINARY RESULTS



52 PCPs completed Module Assessment with an average score of 88%

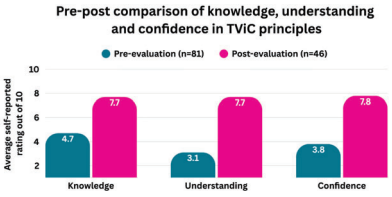


Effectiveness & Knowledge

All PCPs that completed the post-evaluation survey agree/ strongly agree to use their learnings in practice:

"[I will] develop scripts for staff around interaction with patients citing what is TViC and what is not." – PCP2

"I will not refer to [patients] as smokers and non-smokers and will use person first language like someone who currently smokes, people who currently smoke." – PCP1

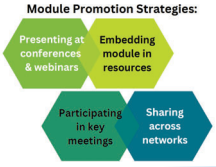


Adoption & Participation

Partner organizations actively promoting the module since January 2025:

Family & Community Medicine, University of Toronto · Canadian Partnership Against Cancer / Partenariat canadien contre le cancer · afhto association of family health teams of ontario · ICHA Inner City Health Associates

Module Promotion Strategies:



Implementation & Satisfaction

Learners suggested adaptations to the module & showed appreciation for the module:

"I didn't like having to click through so many times." – PCP1

"how can we incorporate Indigenous values into the work" – PCP 4

"Loved the format. Love the asynchronous learning, love the videos in it" – PCP 9

"I found the integrated questions helpful for reinforcing my learning." – PCP6

NEXT STEPS & SIGNIFICANCE

- **'Creating Safe Connections' strengthens provider-patient relationships and enhances preventative cancer care outcomes** across Canada.
- **PCPs play a critical role** in advancing **equitable access to care** by creating safer spaces, supporting patient autonomy, and engaging in respectful, collaborative conversations.
- **Next: Development of V2.0 with cervical cancer screening as a case study**

ACCESS THE MODULE

Interested in learning about TViC and applying it within your practice?

ENROL TODAY

ACKNOWLEDGEMENTS

CIHR IRSC · Ontario SPOR Support Unit · SPOR · EQUIP Health Care

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REFERENCES

Scan for references

Co-Designing an Educational Intervention to Support Equity-Oriented Preventative Care in Francophone Communities

Salva Niwe[1,2], Zeenat Ladak[1,3], Tatiana Demarco[1,3], Jean-Claude Camus[4], Aisha Lofters[1,3], Angus Pratt[4], Annemarie Edwards[5], Bikila Amenu[4], Christian Finley[6,7,8,9], Gary Bloch[10,11], Howard Freedman[4], Jackie Manthorne[12], Janet Parsons[3,10], Joyce Nyhof-Young[1,3,10], Shari Dworkin[6], Tara Jeji[4], Vanessa Redditt[1,3], Vinesha Ramasamy[4], Vanessa Wright[1,3], and Ambreen Sayani[1,3,6]

[1]Women's College Hospital, [2]University of Waterloo, [3]University of Toronto, [4]Patient Partner, [5]Canadian Cancer Society, [6]Canadian Partnership Against Cancer, [7]Ontario Health, [8]St. Joseph's Healthcare Hamilton, [9]McMaster University, [10]St. Michael's Hospital, [11]Inner City Health Associates, [12]Canadian Cancer Survivor Network

Background

- Barriers to **preventative care interventions** (e.g., lung cancer screening) include discrimination, stigma, and historical injustice for equity-deserving populations[1]
- For **Francophone** communities, which **represent 22% of the Canadian population**[2], the lack of culturally appropriate care is an added barrier limiting disease prevention efforts[3]

Objective

To address this gap, an interdisciplinary team of researchers, patient partners, and healthcare providers co-designed a French-language intervention promoting equity-oriented preventative care to improve the health outcomes of Francophones in Canada

Intervention

We co-designed a Continuing Medical Education (CME)-accredited French e-learning module, ***Créer des liens sûrs : Vers les soins préventifs axés sur l'équité*** (Creating Safe Connections: Towards Equity-Informed Preventative Care). The module:

- Supports French-speaking **primary care providers (PCPs)** to integrate **trauma- and violence-informed care (TViC)** principles into their preventative care conversations
- Enhances PCPs' understanding of the effects of trauma and system-induced harms on adverse health behaviours and healthcare experiences and promotes strengths-based decision-making

Approach

The English version of the module was released in 2023. In the summer of 2024, we adapted the module:

1 Translation

English module content (e.g., videos and educational material) was translated into French by a Canadian translation vendor

2 Patient Engagement

We engaged with a French-speaking patient partner to support the co-creation of French learning materials and the internal review of translations

3 Cultural Adaptation

Our French-speaking team (i.e., a research student, a patient partner, and a PCP) co-developed a translation review plan to ensure **linguistic accuracy and cultural relevance** of the module content. Review questions included:

- ***Does the translation of this text feel awkward, out of place, or unclear?***
- ***Do any words feel irrelevant to the meaning of the text?***
- ***Is the tone and style of words used consistent?***

Overall,

20,000+ words of module content were meticulously reviewed by our French-speaking team and presented to the larger team for feedback and iterations

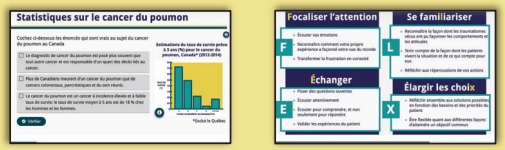

Figure 1. Examples of content and activities in *Créer des liens sûrs : Vers les soins préventifs axés sur l'équité*

Next Steps

- Module user-testing began in January 2025, recruiting French-speaking PCPs through Francophone provider organizations in Canada
- Following user-testing and module adaptations based on user feedback, the module will be implemented and co-evaluated for its dissemination, reach, and usefulness across Canada
- Patient partners will be continuously engaged in the module's implementation and evaluation through bi-monthly advisory meetings

Key Message

By offering a **culturally relevant French module** that reflect the needs and priorities of patients, PCPs are better equipped to **foster trust and collaboration**, improving equity in access to preventative care interventions

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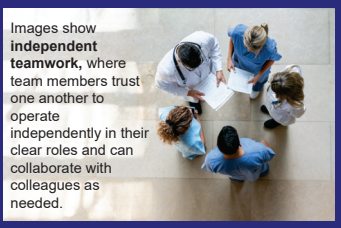
Ambreen Sayani (Ambreen.Sayani@wchospital.ca)

Exploring **how and why** interprofessional primary care teams (IPCTs) can increase **clinician capacity:**

Preliminary results of a rapid realist review

Sydney Pearce[1], Meghan Gilfoyle[2], Jennifer Shuldiner[1,2], Lyn Sibley[3,4], Meredith Vanstone[5], Amber Khan[2,6], Alison Scholes[5], Daphne To[2], Kathryn Petersen[7], Jennifer Schultz[7], Susan Beazley[8], Natasha Kithulegoda[2,9], Danielle Martin[1], Noah Ivers[1,2]

[1]Office of Health System Partnerships, Department of Family and Community Medicine, University of Toronto (UofT); [2]Women's College Hospital Institute for Health System Solutions and Virtual Care; [3]Healthcare Evaluative Research, Ontario Medical Association (OMA); [4] Institute for Health Policy, Management, and Evaluation, UofT; [5]Department of Family Medicine, McMaster University; [6]Dalla Lana School of Public Health, UofT; Patient Partner Program, UPLEARN - University of Toronto's Practice- and Community-Based LEarning And Research Network; [8]Economics, Policy & Research, OMA; [9]Institute for Health Policy, Management and Evaluation, UofT.



Images show **independent teamwork,** where team members trust one another to operate independently in their clear roles and can collaborate with colleagues as needed.

Take-Home Messages

Primary care capacity (access and attachment) can be supported by establishing **independent teamwork** via supportive mechanisms (e.g., trust, role clarity) and strategies (e.g., training, funding)

Health systems can consider interventions such as:

- **Funding complementary roles** to support most-responsible clinicians
- Creating programs to **support IPCT staffing stability** and coverage for abscences/turnover
- Supporting training on **professional scopes/roles**
- **Empowering local leadership and teams to adapt** to their context and patient population needs

Introduction

- High-performing primary care plays a key role in countries' healthcare outcomes, efficiency, & equity[1]
- Approx. 6.5 million people in Canada do not have a regular primary care professional[2]
- Interprofessional primary care teams (IPCTs) are central to some Canadian reforms[3], but their role in increasing capacity needs to be better understood

Objectives

Understand **how and why (or why not)** changing the number and/or role of staff IPCTs can increase capacity (e.g., visit volume, panel or roster size) among most-responsible clinicians (MRC) (e.g., Family Physicians, Nurse Practitioners)

Methods

A **rapid realist review** is an evidence-based approach to understanding how and why complex interventions work in specific contexts.[4] Protocol is available.[5]

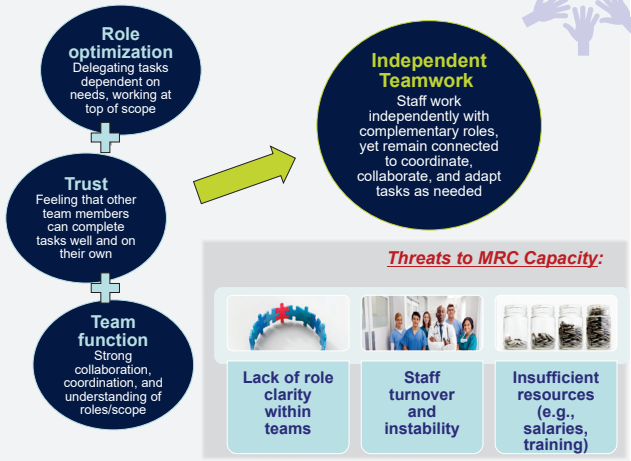
Rapid realist review process:

- Preliminary program theory *(informed by local expertise)* – Screening and critical appraisal – Data extraction – Synthesis – Final program theory

Article eligibility criteria:

Population	Concept	Context	Other
• MRC + • Other certified/ credentialed staff	• Assessing IPCTs via MRC capacity outcomes	• High-income countries	• 2010-current • Empirical studies, peer-reviewed and grey • English

Preliminary Results: Key Mechanisms



Next steps:

- Extraction and synthesis is ongoing.
- Final results will be presented as a program theory. Tailored knowledge translation will be conducted to promote health system change.

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A Portrait of Family Practice Nurses in Canada

Jennifer Phung[1], Maria Mathews[1], Lindsay Hedden[2]; Julia Lukewich[3]; Dana Ryan[1,3]; Toni Leamon[3]; Deanne Curnew[3]; Marie-Eve Poitras[4]; Cloé Beaulieu[4]; Leslie Meredith[1]; Sarah Spencer[2]; Nelly D. Oelke[5]

[1] Western University; [2] Simon Fraser University; [3] Memorial University; [4]Université de Sherbrooke; [5] University of British Columbia, Okanagan

Background

- Family practice nurses (FP-RNs) are Registered Nurses (RNs) who practice in primary care settings.
- Despite being key members of interdisciplinary teams, little is known about FP-RNs' characteristics or the organizations where they work.
- Much of the data on FP-RNs in Canada come from qualitative studies or local surveys. National data combine FP-RNs with other types of nurses.

Objective

- To describe the professional and employment characteristics of FP-RNs in Canada.

Methods

- Online, cross-sectional survey October 2023- March 2024 (via Qualtrics).
- Survey invitations sent by provincial unions, nursing organizations and Canadian Family Practice Nurses Association.

Results

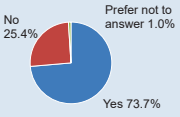
FP-RNs workforce mostly women

15+ years RN experience

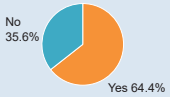
81.4% worked full-time

Largest number of FP-RNs worked in Ontario or Quebec (74.6%)

Part of a Union



Employed by a regional health authority



FP-RNs worked in many settings (% yes):

- 85.4% clinic
- 1.2% long term care
- 25.8% patient home
- 4.7% school
- 4.4% hospital
- 1.3% community outreach

- There were **1092** eligible FP-RNs from across Canada.
- FP-RNs' clinic funding models varied by province: block/global funding most common in BC (34.1%), QC (54.0%), and NL (61.5%), billings in AB (28.9%), and both capitation (28.7%) and block/global funding (28.7%) in ON.
- Unionization, FP-RN years of experience, and patient populations also varied by province.

Discussion

- The survey is most comprehensive portrait of FP-RNs in Canada.
- There are provincial variations in the degree of integration of FP-RNs into primary care, FP-RN employment traits and clinic funding model.
- We cannot assess response rate or representativeness of data, given lack of comprehensive registry.
- Routine data collection needed to improve understanding of FP-RN traits, integration and impacts on patient care in primary care.

Voices from the North:

Provider-Identified Challenges and Supports to Strengthen Primary Care in Northwestern Ontario

Authors

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01 Introduction

Primary care is the first, and sometimes only, point of contact with the health system, particularly for Northern and rural communities.

These settings face persistent challenges such as provider shortages, limited clinical infrastructure, and higher health needs than provincial counterparts.

As a result, the nature and extent of work for primary care providers is different.

02 Objective

To support sustainable access to care, our team sought Northwestern Ontario provider perspectives on supports needed and challenges faced to strengthen primary care.

03 Methodology

We conducted thematic analysis[1] on qualitative data from two sources:

1. open-text responses to the March 2025 regional primary care provider survey (addressing anticipated practice change, cutting back hours, retirement/exit, improvement ideas, and other concerns), and

2. real-time feedback collected via Mentimeter at regional primary care engagement session in May 2025, focused on supports needed for high-performing primary care.

04 Analysis

Data were coded and analyzed to identify key themes reflecting provider experiences and system needs across Northwestern Ontario Health Teams (NW OHTs).

DATA

A total of 224 providers from 4 NW OHTs completed the survey, 147 with open-text responses, and 39 regional partners participated in real-time engagement.

05 Results/Findings

We identified common key challenges, including workforce sustainability, administrative and technology burden, and service access gaps.

Regionally-prioritized supports include enhanced administrative and IT infrastructure, expanded team-based care, leadership training, wage parity, and data-driven quality improvement.

06 Conclusion

Findings highlight the urgent need for coordinated system-level investments in workforce, infrastructure, and interdisciplinary models to strengthen primary care across Northwestern Ontario.

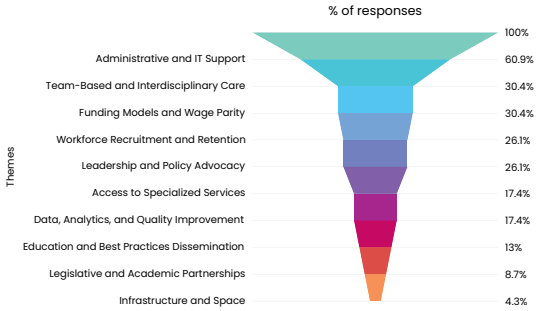
Challenges & Opportunities*
What we have learned

*Source: 1. open-text responses to the March 2025 regional primary care provider survey

Regional Supports*
What we need

PROVIDERS - Family Physicians, NPs, Allied Health Professionals, Midwives, PAs

POPULATIONS - Rural/Remote (esp. Indigenous), Unattached, Complex/High-Needs



*Source: 2. real-time feedback collected via Mentimeter

> *"We are in desperate need of increased funding for our allied health professionals, for both new positions and increased salaries... We need funding for IT in order to maintain appropriate levels of security, efficiencies and oversee the various platforms used... We also need funding for HR support... The overwhelming message is that we are drowning in admin work with minimal time/energy left to serve patients appropriately, and there seems to be a large disconnect between funding bodies and the front lines of primary care that leads to a frustrating lack of positive changes."*

Related Literature

[1] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101.

Acknowledgments

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Retaining the Team-Based Primary Care Workforce in Canada: Consensus Recommendations from a Delphi Study

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BACKGROUND

- **10 million Canadians** are projected to **lack access to primary care** (PC) by **2028**. Canada's **PC system cannot** currently **meet this demand**.[1,2]
- Addressing this crisis requires facilitating retention of current PC providers - but **current practice environments** and the **policy contexts** shaping them mean **providers are leaving PC- if they enter it** at all.[3]
- **Existing guidance** for PC provider retention is **limited**, focuses on ineffective **individual-level efforts**, and **fails to address interprovincial PC variations**[1].
- Generating **expert consensus** local to Canada – using the Delphi process – will help organizations and changemakers address this challenge.

RESEARCH QUESTION

- The question guiding this study was "What do **Canadian** primary care **experts recommend** for **facilitating** team-based **primary care provider retention**?"

RECRUITMENT AND STUDY DESIGN

Primary Care Expert defined as 'having worked in a **titled role** (e.g., clinician, patient partner, leader) for **>5 years** in Canadian primary care, and having **authored ≥1 peer-reviewed primary care** publication.'

N=164 experts contacted via snowball sampling beginning from a) most-cited Canadian primary care researchers[9], b) TUTOR-PHC alumni list, c) patient-partner organizations.

N=34 primary care experts recruited across **N=8** Canadian provinces (BC, AB, MB, SK, ON, QC, NS, NL) for **anonymous consensus-building** using **fixed three-found Delphi process.**

EXPERT PANEL COMPOSITION (N=34)

	Current Role(s) (N)	Previous Role(s) (N)
Primary Care Researcher	23 (67.6%)	9 (26.5%)
Primary Care Clinician	6 (17.6%)	18 (52.9%)
Health System Leader	5 (14.7%)	1 (2.9%)
Educator	5 (14.7%)	3 (8.8%)
Organizational Director	4 (11.8%)	2 (5.9%)
Patient Partner	1 (2.9%)	2 (5.9%)
Other	3* (8.8%)	1** (2.9%)

*Other: "Professional association advocating for its members to be included on primary care teams", "Training internationally educated healthcare professionals", "advocate"
**Other: "decision support staff"

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DELPHI PROCESS

Round 1: April – May 2025 (Completed by **33/34 (97%) Experts**)
Participants completed **open-ended survey** asking how a) **individual primary care organizations**, b) their **province of employment**, and c) the **Canadian federal government** could facilitate retention of team-based primary care

Round 2: May - July 2025 (Completed by **29/33 (88%) Experts**)
Structured survey completed to rate their agreement (using a 5-point Likert scale) with the **21 most-frequent recommendations** from the first round for inclusion in a consensus recommendation list

Round 3: July – September 2025 (Completed by **27/29 (93%) Experts**)
Structured survey completed to a) rate agreement with **9 recommendations** achieving consensus (**≥80% endorsement**), with definitions refined from open-ended feedback, and b) **rank-ordered recommendations** importance

ROUND 1: INITIAL RECOMMENDATIONS

- **Content analysis** (using NVivo 14) used to identify the **N=21*** most frequent recommendations (using line-by-line coding) from open-ended responses
  *N=20 most-mentioned recommendations, including ties
- **Sample recommendation:** "Provide long-term, dedicated, and predictable federal funding via a National Primary Care Act to develop and/or sustain interprofessional primary care in each province" (mentioned N=54 times)

ROUND 2: REMOVED RECOMMENDATIONS

Recommendation	% Endorsement
Prioritize PC **professional development** activities	79.31
Establish a **national-level** primary care **collaborative**	79.31
Dismantle **regulations preventing full-scope** practice	79.31
Facilitate explicit **onboarding** practices and ongoing **mentoring**	79.31
Provide financial and logistical **incentives** for **rural practice**	75.86
Transition to full public ownership, **removing fee-for-service**	75.86
Increase supply (e.g., IEP barriers, training program seats)	75.86
Require **evaluation** of retention **intervention efforts**	75.86
Prioritize funding for implementation of **emerging technologies**.	72.41
Prioritize retention of **equity-deserving groups**	68.97
Transition to **national** versus provincial-level **licensure**	65.52
Pay equity for providers performing similar/identical tasks	58.62

ROUND 3: CONSENSUS RECOMMENDATIONS

- **Empower primary care organizations** to **determine their staffing** through **flexible funding** appropriate to their specific team and community needs, in their context.
- Foster **psychologically safe and inclusive organizational cultures** characterized by **collegiality, trust, and belonging**, by implementing clear, enforceable processes to prevent and **address workplace harassment, violence, and bullying**.
- Implement **shared, team-based decision-making** through **inclusive governance structures** that **do not privilege some providers** over others.
- Establish **integrated partnerships** between primary care organizations, regional systems, community agencies, universities/academic researchers, and patient organizations.
- Implement an **electronic medical record (EMR)** system **interoperable across provinces and territories**, and **primary care and other health sectors**, to reduce administrative burden, support care coordination, and enhance provider retention.
- Provide long-term, dedicated, and predictable federal funding via a **National Primary Care Act**, which includes strong accountability measures, to develop and sustain interprofessional primary care in each province and territory.
- Embed organizational policies that support **flexible work arrangements**, including adaptable schedules, job-sharing, access to primary care, and remote care options, tailored to provider needs and team capacity.
- Co-create a flexible national standard for integrated, team-based primary care that a) defines core deliverables, b) clarifies key terms (e.g., "team", "integration") and c) supports provincial implementation, while respecting local and Indigenous contexts.
- Ensure **compensation equity between primary care** providers and **other health sectors**.

IMPLICATIONS

- **No** primary care **expert recommended individual**-level retention **interventions**.
- No significant differences ($p<0.05$) for relative rankings for each recommendation on Kruskal-Wallis test**: experts agree on what to do, but not what to do *first***

NEXT STEPS

- **Compare and contrast** barriers and facilitators of retention identified by **current practitioners in primary care** with **expert-level consensus** to **generate triangulated guidance** for facilitating retention in team-based primary care.

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No Band-Aids for Papercuts

How administrative workload affects team members and comprehensive solutions to improve processes and wellbeing

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Background and Methods

While administrative burden in primary care is receiving widespread attention, solutions (e.g., technologies, shifting team members responsible) may not be getting at root problems and could be unintentionally creating more work and have inequitable impacts.

Administrative Work
Activities *required* for the operation of primary care, including indirect patient care (charting, forms, referrals) and running a practice or clinic (administrative tasks that maintain core primary care functions, such as continuity and coordination of patient care).

Administrative Burden
The experience of administrative work as a source of difficulty, hardship, or worry.

Objectives		
Determine how the volume of services requiring primary care coordination has changed over time in Canada	Understand experiences of administrative workload among clinicians and staff in New Brunswick and Nova Scotia	Co-identify priority issues and co-develop practical solutions to make primary care administrative work more efficient in Nova Scotia
Methods		
Quantitative analysis of Electronic Medical Record (EMR)CPCSSN data for change in volume of outpatient services requiring primary care coordination and oversight	36 qualitative interviews in New Brunswick and Nova Scotia with 11 family physicians, 11 nurse practitioners, and 14 administrative staff	Four 60-minute virtual expert conversations with 21 people in clinical, administrative, policy, and service planning roles on technology in practice and training, resources, and support for administrative staff

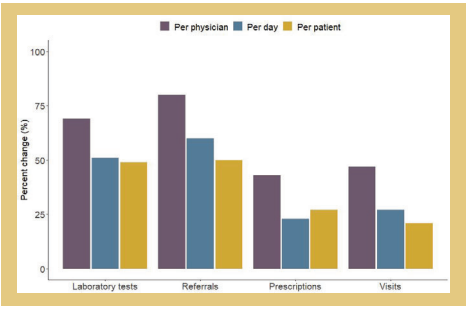
Results

> "I will say like this year was a very difficult year. I've had multiple times this year where I was like, I'm done. And it's all due to [lack of] administrative support."
> Nurse Practitioner, New Brunswick

> "I would say in the last two years, the crisis is hitting a critical point"
> Family Physician, New Brunswick

> "I made quite a few mistakes at the beginning because I didn't know what the proper procedure was. And it felt like there wasn't a lot of dedicated training."
> Medical Office Administrator, Nova Scotia

Figure 1. Change in laboratory tests, referrals, prescriptions, and visits over time, 2011-2021



List 1. Pain Points of Administrative Work

- X **Lack of guidelines**
- X **Interprofessional tensions**
- X **Root causes neglected**
- X **Poor tools**
- X **Burden-shifting**
- X **Low consultation**

Table 1. Types of Administrative Work

Information Management	The responsibility for ensuring information is accurately transferred from one place to another (e.g., filling out referral forms for patients).
Information Stewardship	The responsibility for ensuring confidentiality, data security, and continuity of patient information (e.g., securely transferring patient records, ensuring provider receipt of patient referrals).
Clinical Responsibility	The responsibility for clinical judgement in the management of patient information (e.g., interpreting results).
Moral Responsibility	The responsibility to meet patient needs and accountability for the outcomes of administrative processes (e.g., advocacy for supports needed by patients).

Table 2. Solutions

Simplify and streamline information exchange across health and external systems
- Remove duplicate work created by co-existing paper and electronic processes.
- Develop system-level infrastructure to easily share and access patient information.
- Reconsider the role of primary care in determining eligibility of resources.
- Simplify and streamline processes.

Tailor technology to primary care contexts
- Technology-based tools and improvements for efficient information management:
  - Early and ongoing primary care consultation.
  - Optimize and integrate EMR for primary care workflow.
  - Ensure team members can securely access data needed to do their job.
  - Support record-keeping and information transfer.
- Capacity to implement and learn new tools:
  - Train technology experts in primary care context for tailored support.
  - Recognize unique clinical contexts, needs, and relationships.
  - Provide time to implement technology and learn how to optimize.
  - Provide clear, accessible, and ongoing technology support for primary care users.

Support administrative staff
- Training
  - Expand administrative training specific to primary care.
  - Include information about clinic processes and clinician preferences in onboarding.
  - Offer on the job training time.
- Tools
  - Tailor administrative policies and procedures to individual clinics.
  - Enable access to technologies that make clinic administration more efficient.
- Retention
  - Offer administrative staff regular feedback and mechanisms to raise concerns and contribute to solutions.
  - Include administrative staff in team meetings.
  - Provide fair pay and benefits to administrative staff.
  - Plan opportunities for career development for administrative staff.

Conclusions

Administrative work contributes to continuity and coordination of primary care, but unnecessary or inefficient processes create burden and tensions in teams. Solutions require coordinated action across government, educational institutions, technology companies, and individual clinics to reduce administrative burden and support administrative staff.

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Image credit: Government of Canada; Microsoft 365

Uptake of pharmacist services for common ambulatory conditions: A repeated cross-sectional evaluation of the Ontario Minor Ailment Services program

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BACKGROUND

In January 2023, the scope of practice for pharmacists in Ontario expanded to include **delivering minor ailment services** – this includes prescribing certain medications.

Minor ailments (i.e., common ambulatory conditions) are health conditions that can be **managed with minimal treatment and/or self-care strategies** and:

- Are usually short-term conditions
- Do not usually require lab results
- Are at low risk of serious underlying condition
- Require minimal or short-term follow-up

This policy change has the potential to improve timely access to primary care and reduce inappropriate use of emergency department services.

OBJECTIVES

(1) To describe the uptake of minor ailment services in Ontario.
(2) To describe the characteristics of community pharmacies delivering minor ailment services and patients receiving minor ailment services.

METHODS

Design: Repeated cross-sectional study

Study period: January 2023 – December 2024

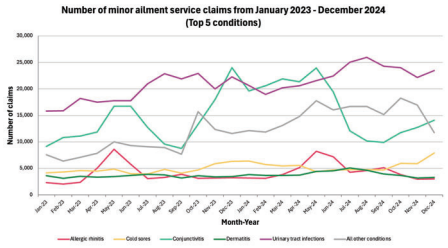
Data source: ICES (Ontario Drug Benefit Claims, Ontario College of Pharmacists, Registered Persons Database, Postal Code Conversion File, Ontario Marginalization Index)

Analysis: (1) Describe overall trends in uptake
(2) Describe claim, pharmacy, & patient characteristics
(3) Compare pharmacy characteristics based on volume of minor ailment claims

RESULTS

Trends in uptake and minor ailment service claim characteristics

- **1,471,459 claims** for **1,098,680 unique individuals** in Ontario
- Number of minor ailment service claims increasing over time
- Claims for UTI and conjunctivitis made up 58.7% of all claims
- 88.4% of services were delivered in person and 88.0% resulted in a prescription



Stratified by volume of minor ailment service claims

Compared to pharmacies with no minor ailment claims, pharmacies with high claim volumes (weekly average > 7) were more often:

- Located in **urban settings** (Std Diff 0.13)
- **Corporate-owned** (Std Diff 2.63)
- Located in areas with **higher neighbourhood income** quintiles (Std Diff 0.16)
- Employing **more (≥ 6) pharmacists** (Std Diff 1.62)
- Employing **fewer male** pharmacists (Std Diff 0.14)
- Employing more pharmacists with **fewer practice years** (< 5 years, Std Diff 0.32; 5-15 years, Std Diff 0.84)
- Employing more pharmacists **educated in Canada** (Std Diff 0.27)

Community pharmacy characteristics

- Located in urban areas (82.7%) and areas with lower neighbourhood income quintiles (48.7%)
- Corporate-owned (59.0%)
- Employed ≥ 3 pharmacists (84.1%)
- Employed < 2 pharmacy technicians (68.2%)
- Pharmacists with > 5 years experience (89.1%)

- **Weekly average number of claims: 2.7 (SD 4.4)**
- **7.6% delivered no minor ailment services**

Patient characteristics

- Living in urban locations (89.9%)
- Aged 25-64 (59.4%)
- Female (73.1%)
- Skew towards higher income quintiles

CONCLUSION

There was **immediate uptake** of minor ailment services driven primarily by claims for UTIs and conjunctivitis. Our data suggests characteristics of community pharmacies **differ based on the pharmacy's volume of claims**.

Pharmacies with high claim volumes were more likely to be corporate-owned; employ more pharmacists, female pharmacists, pharmacists educated in Canada, and pharmacists with fewer practice years; and were in higher-income neighbourhoods.

Acknowledgements

Inclusion of primary care in future pandemic plans: What supports are needed?

Maria Mathews[1], Jamie Wickett[1], Joanne Kearon[2], Leslie Meredith[1], Dana Ryan[1], Alexander Summers[2], Ashley Bilodeau[3], Arianna DiSchiavi[3], Tom Freeman[1], Paul Gill[1], Andrea Gillan[3], Daniel Grushka[1], Lindsay Hedden[4], Erin Kennedy[1], Julia Lukewich[5], Emily Gard Marshall[6], Stephen Wetmore[1], Eric Wong[1], Cole Wyman[1], Gillian Young[1]

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Acknowledgements

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Background

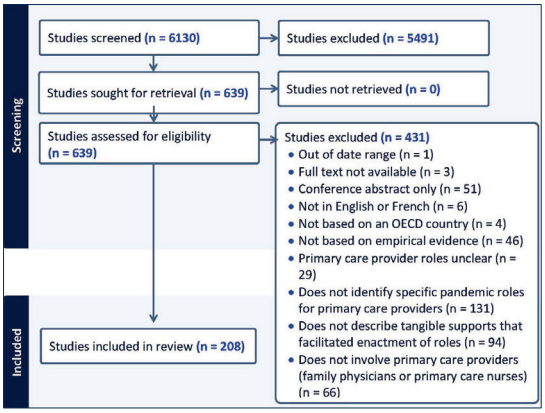
- Primary care providers play critical roles in pandemic response; however, prior to the COVID-19 pandemic, response plans offered minimal guidance for primary care.
- Our project aims to create a locally relevant primary care pandemic plan for Middlesex-London, Ontario.

Approach

- We conducted a scoping review to examine supports enabling primary care providers to enact pandemic roles.
- Eligible articles were empirical studies from OECD countries, published in English or French, and identified specific pandemic roles for primary care providers along with enabling supports.
- 2 reviewers per article identified eligibility and extracted supports
- Included Scopus, Embase, PubMed, and CINAHL databases as well as citation and grey literature searches
- Findings informed a priority setting exercise in which primary care providers, public health officials, and health system managers in Middlesex-London will rate the importance of identified supports for inclusion in a primary care pandemic plan via a Delphi process.

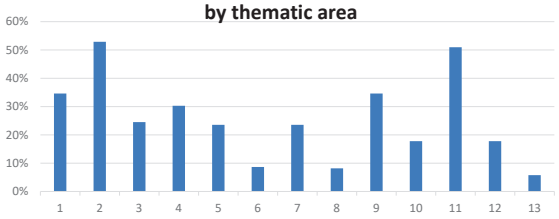
Results

PRISMA diagram



- Most articles included were published after COVID-19, between 2021-2024; examined settings in Canada, USA, Australia and/or the UK; employed a qualitative design; and involved primary care physicians.
- The most used data sources were interviews (56%), survey (30%) and administrative data (8%).
- We grouped identified tangible primary care supports (n=1104) into 13 categories.
- Just over half of the articles described supports for virtual care and communication for primary care providers, with general health system readiness and wellbeing of PCPs described in just over one third.

% of articles mentioning supports by thematic area



	Thematic areas for primary care supports
1	General health system support and readiness
2	Virtual care
3	Involving primary care providers in preparedness planning and response decision-making
4	Remuneration (payment) during a pandemic
5	Limiting the risk of spreading infection
6	Vaccination
7	Increasing capacity in primary care during a pandemic
8	Primary care providers (PCPs) increasing capacity in other settings (redeployment) during a pandemic
9	Wellbeing of primary care providers
10	Clinical issues in primary care
11	Communication for primary care providers
12	Communication for the public
13	Evaluation, quality assurance, quality improvement, and research on pandemic related changes to delivery of care and clinic operations

Conclusions and Next Steps

- Although many articles were identified, few described tangible supports for primary care providers during a pandemic.
- The supports prioritized through the Delphi exercise will be used to develop an evidence-based checklist for a primary care pandemic plan in Middlesex-London and serve as a template for adaptation in other regions.
- A template for the process of co-production of regional pandemic plans as well as a toolkit of supports and a regional plan will be made available to other jurisdictions.

Exploring the Optimal Composition of Primary Care Teams

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Background:

- Team based primary care can help improve the patient-provider experience and improve patient safety

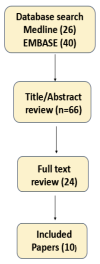
Objective:

- To understand primary care team composition across Canada and explore whether an optimal care team composition exists to improve health outcomes. Other themes include:
  - Patient perspectives on care teams
  - Care team composition impacts on chronic disease management

METHODS:

- Rapid scoping review
- Medline and EMBASE databases searched for English studies from 2014 onward exploring optimal composition/characteristics of care teams
- Excluded non-Canadian articles , protocols or unpublished works, reviews, editorials, commentaries and letters

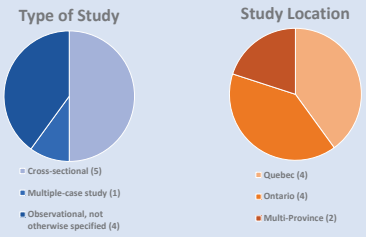
Article Review



There is no optimal composition of primary care teams to improve health outcomes

A focus should instead be placed on team function

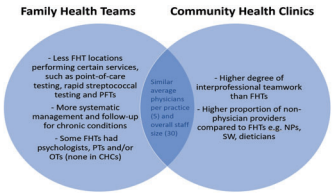
Characteristics of Included Studies



RESULTS

- No optimal composition of primary care teams (8/10 studies focus on function)
- Mixed findings on team size
- Emphasis on role clarity, communication, length of practice establishment, QI

Comparing Different Care Team Structures



Chronic Condition Management

- Continuity important for chronic condition management (GPs see more than NPs)
- Mental health specialists in primary care

Patient Perspectives

- Broader sense of care team membership
- Positive experience with NPs in teams

Limitations:

- Rapid review, limited research on health outcomes & patient perspectives, settings

Conclusions/Next Steps

- Support expansion of interdisciplinary teams with consideration of team size impact on team function
- Support collaboration with NP services with consideration for needed continuity of providers for chronic conditions
- Further research on patient perspectives and direct health outcomes as they relate to team composition

A Bridge over Troubled Waters: Provider Perceptions of the Primary Care Diabetes Support Program

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Background

- Primary Care Diabetes Support Program (PCDSP): an interdisciplinary primary-care led program at St Joseph's Health Care London, ON for patients with diabetes at high risk of complications
  - Unattached
  - Medically complex
  - Socially complex

Methods

- We interviewed 14 providers who referred patients to the PCDSP:
  - 1 Nurse Practitioner
  - 6 Family Physicians
  - 7 Specialists
- Identified **3 themes** of provider perceptions of the PCDSP:

Acts as a bridge between patients' primary and secondary care needs

Models a collaborative, co-management approach between providers

Facilitates transitions between sectors (e.g., from acute to community care)

Preliminary Results

"It's like the ideal team to be caring for people with diabetes… it is the perfect…clinical set-up to care for diabetic patients because they get holistic care…I also think sometimes family physicians hold on to these diabetics much longer than they should, because diabetes has become very, very complicated and…it's getting tougher and tougher for family physicians to be experts in diabetes, and we need to be able to reach out and let our patients have consultations by experts." (Provider 10)

"I had [a patient] where they were a new Canadian, language barrier was an issue, very unmanaged diabetes, so they weren't on any medication for that, and also had had a recent cardiac event... We referred and [the PCDSP] were able to provide that comprehensive primary care *[that was]*…culturally appropriate and language barrier abreast, which is really helpful in the community. And they certainly adjusted their diabetes medications … increased some of the other medications that we would often do too, like their blood pressure medication for example, that's something that both our services would focus on. And so, we were able to… collaborate so the patient was optimized quicker on their, on their secondary prevention medications, like blood pressure for example." (Provider 8)

"I know that if a patient is accepted by the Diabetes Care Program, that they'll get the initial appointment and then someone is going to…give them the bloodwork requisition and tell them to go and do the bloodwork. Whereas, when someone's going to a walk-in clinic, I literally type it all out." (Provider 14)

Conclusions

- The PCDSP is a trusted resource that helps support complex patients at high risk for diabetes complications
- Findings highlight the importance of programs like the PCDSP to support the healthcare system and fill gaps in chronic disease management for high-risk patients

Step 1	Step 2	Step 3	Step 4	Step 5
Case study: understanding how the PCDSP works and who is involved.	**Patient study:** exploring the impact of the PCDSP on patient experiences and quality of life.	**Provider study:** exploring the impact of the PCDSP on healthcare providers.	**Complications study:** comparing diabetes-related complications among PCDSP patients versus regular patients.	**Cost-effectiveness study:** comparing the cost savings of the PCDSP to regular care regarding prevented complications.

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