Trillium
Primary Health Care Research Day

Conference Program

Friday, October 23, 2026

Presented by

INSPIRE-PHC

*This event will be recorded

Welcome

On behalf of our organizing and planning committee, and scientific research leadership team, we would like to extend a sincere welcome to all attendees of this years' conference. Students and emerging researchers, please take the opportunity to reach out to our experienced researchers in primary health care in attendance. We have focused our conference this year on AI in primary care. Thank you to the Ontario SPOR Support Unit, the Ontario Departments of Family Medicine, and the Ministry of Health for making this day happen.

Trillium Primary Health Care Research Day 2026 is run by INSPIRE-PHC- a research partnership, of primary care Researchers and funders in Ontario.



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Acknowledgements and Program Sponsors

Program Sponsors

Organizers of Trillium Primary Health Care Research Day 2026 would like to acknowledge generous support from the following sponsors:

About INSPIRE-PHC

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

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

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

History of Trillium Primary Health Care Research Day

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

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

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Trillium Program Agenda

8:00 AM Courtyard Foyer	**Networking, Registration, and Breakfast**	
9:00 AM Courtyard ABC	**Opening Remarks & Indigenous Acknowledgement** Dr. Jennifer Rayner and Dr. Michael Green, INSPIRE-PHC Co-Leads	**Virtual Available**
9:10-9:30 AM Courtyard ABC	**Canadian Institutes of Health Research – *CIHR Priorities in Primary Care*** Dr. Richard Glazier, Scientific Director, Institute of Health Services and Policy Research	**Virtual Available**
9:30-10:30 AM Courtyard ABC	***Martin Bass Lecture – Artificial Intelligence in the Service of Humanistic and Compassionate Primary Care*** Featuring: **Dr. Amanda Terry**, Director for Studies in Family Medicine, Western University Moderator: Dr. Michael Green, INSPIRE-PHC Co-Lead Dr. Amanda Terry will discuss how constructive and critical engagement with artificial intelligence connects with the goal of humanistic and compassionate care. Dr. Terry will highlight how the values of family medicine and primary care underpin a research program focused on artificial intelligence.	**Virtual Available**
10:30 AM Courtyard ABC	**Break**	
10:45 AM Courtyard ABC	**Patient Partner Acknowledgement** Dr. Maggie MacNeil, Research Associate, Patient Expertise in Research Collaboration **Plenary Oral Presentations** Moderator: Dr. Richard Glazier, INSPIRE-PHC Co-Lead	**Virtual Available**
11:45 AM Courtyard ABC Courtyard Foyer	**Lunch Break**	
12:45 PM Spadina A & B, Wood A & B	**Concurrent Oral Presentations**	**In Person Only**
1:45 PM Courtyard ABC	**Break**	
2:00 PM Courtyard ABC	**Panel Discussion – *AI in Primary Care: Managing Rapid Spread in Sclerotic Systems*** Moderator: Dr. Onil Bhattacharyya, Chair in Family Medicine Research at Women's College Hospital Panelists: **Jay Shaw**, Acting Director, Joint Centre for Bioethics, University of Toronto; **Will Falk**, Executive-in-Residence, Rotman School of Management, University of Toronto; **Mary Huang**, Patient Advisor, Patient Expertise in Research Collaboration AI is transforming primary care, whether we feel ready or not. Patients arrived first: about half of Canadians already use AI for health information. The pressing question is not how to stop it, but how to manage it responsibly. This panel will explore that tension, balancing the very real risks of AI against its significant benefits.	**Virtual Available**
3:00 PM Courtyard ABC	**Concluding Remarks** Dr. Michael Green, INSPIRE-PHC Co-Lead	**Virtual Available**
3:10-4:30 PM Alexander ABC & Courtyard Foyer	**Concurrent Poster Presentations and Networking Reception**	**In Person Only**

Martin Bass Lecture

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

Artificial Intelligence in the Service of Humanistic and Compassionate Primary Care

Featuring: Dr. Amanda Terry, Director for Studies in Family Medicine, Western University

Introduction & Moderator: Dr. Michael Green, INSPIRE-PHC Co-Lead



Dr. Amanda Terry will discuss how constructive and critical engagement with artificial intelligence connects with the goal of humanistic and compassionate care. Dr. Terry will highlight how the values of family medicine and primary care underpin a research program focused on artificial intelligence.

Discussion

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

4 Plenary Oral Presentations

A listing of oral presentations is provided below; abstracts are included beginning on PAGE 9

	#		Presentation Title	Presenter	Affiliation
Moderator: Richard Glazier Room: Courtyard ABC	1	10:45AM	What drives patient attachment? A provincial analysis of organizational strategies associated with early attachment progress in Ontario interprofessional primary care teams	Katie Hurst	Ontario Health
	2	11:00AM	Restoring joy in practice: What matters to Ontario family physicians – A qualitative exploratory analysis	Rachel Walsh	Sunnybrook Health Sciences Centre
	3	11:15AM	A co-designed integrated care intervention to EMBOLDEN healthy lifestyles among older adults in equity-deserving communities: Results of a multi-jurisdictional randomized controlled trial	Rebecca Ganann	McMaster University
	4	11:30AM	Accelerating and increasing patient attachment to primary care teams: Identifying best practices and successful strategies	Judith Belle Brown	Western University

16 Oral Presentations

A listing of oral presentations is provided below; abstracts are included beginning on PAGE 11

Theme	#	Room	Presentation Title	Presenter	Affiliation
Primary Care Attachment Moderator: Jonathan Fitzsimon Evaluator: Sara Bhatti Room: Spadina A	1	Spadina A 12:45PM	How does Ontario measure up to the rest of Canada when it comes to primary care? Results from the 2025 OurCare national survey	Tara Kiran	St. Michael's Hospital, University of Toronto
	2	Spadina A 1:00PM	Excess Emergency Department visits among Ontario adults losing attachment to comprehensive primary care	Kamila Premji	Institut du Savoir Montfort
	3	Spadina A 1:15PM	Holding the line: How interprofessional primary care team leaders navigate tensions during expansion	Jennifer Shuldiner	Women's College Hospital
	4	Spadina A 1:30PM	Using small geographies to inform equitable primary care planning	Catherine Donnelly	Queen's University
Team Based Primary Care Moderator: Clare Liddy Evaluator: Paul Nguyen Room: Spadina B	5	Spadina B 12:45PM	Turning primary care EMR data into action: Provider-Level variation in access and continuity across Quebec	Mylaine Breton	Université de Sherbrooke
	6	Spadina B 1:00PM	Who does what? Measuring provider contributions in a Family Health Team from EMR Data	Thalia Garvock	Queen's University
	7	Spadina B 1:15PM	The state of governance in Ontario Family health Team: Building governance capacity for a changing primary care system	Jess Rogers	Association of Family Health Teams of Ontario
	8	Spadina B 1:30PM	Mapping the twenty years of evidence generated to support team-based primary care in Ontario, Canada: Narrative review	Rachelle Ashcroft	University of Toronto
Primary Care Delivery Moderator: Doug Archibald Evaluator: Ronnie Kraut Room: Wood A	9	Wood A 12:45PM	Primary care practices digital outreach to address social isolation	Sharon Johnston	Institut du Savoir Montfort
	10	Wood A 1:00PM	The feasibility of COPE_PC: A web-based tool to support discussions of social isolation in family practice	Bridget Ryan	Western University
	11	Wood A 1:15PM	Strategies and facilitators for optimizing registered nurses' roles in primary care teams in Canada: A qualitative study	Maria Mathews	Western University
	12	Wood A 1:30PM	Exploring the role of Medical Office Assistants in primary care: A role theory perspective	Amber Khan	Women's College Hospital
Equity Deserving Communities and Perinatal Care Moderator: Connor Kemp Evaluator: Leslie Meredith Room: Wood B	13	Wood B 12:45PM	Rapid Action Learning Intensives (RALI): A framework for advancing equitable intake, attachment, and access to primary care	Stéphanie Lamothe & Denis Tsang	Alliance for Healthier Communities
	14	Wood B 1:00PM	Walking Together: Community-academic co-design of an Indigenous primary care patient navigator	Imaan Bayoumi	Queen's University
	15	Wood B 1:15PM	Setting the stage for expanded Midwifery Care Models evaluation: Defining program objectives, identifying data sources and developing an evaluation framework	Liz Darling	McMaster University
	16	Wood B 1:30PM	A decade of perinatal health trends in Ontario: Implications for primary care, population health management and point of care tools	Alysha Dingwall-Harvey	Children's Hospital of Eastern Ontario

54 Poster Presentations

A listing of posters is provided below; abstracts are included beginning on PAGE 20

#	Presentation Title	Presenter
1	Exploring explanatory models among the Indigenous Zulu people to improve access to primary mental health care: A community-based forum theatre study to inform equitable health systems	Nomusa Mngoma
2	Improving social needs screening for hard-to-reach patients	Archna Gupta
3	Impact of Virtual Billing Codes on Distance to Primary Care, Healthcare Utilization and Outcomes in Ontario	Archna Gupta
4	Neighbourhood primary care attachment and mental health and addiction health care burden in Ottawa: Health equity implications	Claire Kendall
5	Understanding patient perspectives on HPV self-collection cervical cancer screening in primary care: A qualitative study	Roni Kraut
6	Primary care physicians' knowledge and comfort in caring for older adults living with HIV in Ontario: A cross-sectional survey	Sarmitha Sivakumaran
7	Advancing equity in cancer diagnosis: Patient-centered outcomes and opportunities for improvement in Canada	Leah M. Stephenson
8	Co-designing recruitment strategies with clinicians to understand and advance eConsult's use in dementia care	Sarah Syed
9	Refugee patient navigator roles, supports, and outcomes in OECD countries: A scoping review protocol	Samaira Husein
10	Smoking cessation in people with severe mental illness; A retrospective chart review	Olivia Katsnelson
11	Making sense of policy: Impact of interim federal health program changes on access to care for refugees and asylum seekers in Canada	Umaya Krishnathas
12	Exploring psychosocial factors affecting pain management in advanced cancer patients: Perspectives from care providers	Shurabi Anphalagan
13	From reconciliation to transformation: A rapid review of Indigenous perspectives in healthcare reform	Swathi Anphalagan
14	Bridging gaps: Implementing mobile primary care for people experiencing homelessness	Tehreem Mahmood
15	Exploring the scope of Indigenous patient navigation: A scoping review mapping cultural frameworks, implementation, and outcomes	Alishba Mansoor
16	Heat smart: Empowering primary care providers to safeguard vulnerable populations against extreme heat – mid-study results	William Hogg
17	Interventions promoting access to primary care among equity-deserving groups: A scoping review	Gregory Feng
18	The Ontario Community Health Profiles Partnership: Open health data built around Ontario communities	Leah Czukar, Gary Moloney, Peter Gozdyra
19	Advancing equity in data collection: Strategies to better integrate underrepresented or vulnerable groups	Vanessa T. Vaillancourt
20	Examining healthcare providers' perspectives and experiences of caring for uninsured patients in emergency and urgent care settings within the Frontenac, Lennox & Addington Ontario Health Team: Research in progress	Rhea Saini
21	Streamlining intake to increase access and attachment: Evaluation of an equity-based primary care quality improvement learning collaborative	Stéphanie Lamothe & Denis Tsang
22	Indigenous perspectives on palliative and end-of-life care: A qualitative study in Southeastern Ontario	Amrita Roy
23	Supporting people with serious mental illness across psychiatric hospitalization: The role of primary care	Laura Schmid
24	Team science tools and tactics to strengthen patient-oriented research collaborations	Yvonne Pelling
25	Creation and evaluation of Lori Education to support the integration of patient-reported measures in primary care	Marie-Eve Poitras
26	Best practices in routine Primary Care Patient-Reported Experience Measure (PREM) Surveys across OECD countries	Emma Wedekind & Hina Ansari
27	Patient-reported experiences of family physician loss: A Qualitative study of free-text survey comments in Quebec	Noémie Rancourt
28	Provider and patient perspectives on newcomer obstetrical care access in the Kingston Frontenac Lennox, and Addington (KFL&A) Area: An Environmental scan and needs assessment	Bhargavi Venkataraman
29	Exploring patient-reported outcome measures from individuals receiving care by nurse practitioners and family physicians in Canada	Leanne Kosowan
30	Bringing the patient voice into medication care: Perspectives on implementing a patient-reported experience measure	Sara Guilcher

31	PASSERELLE SPOR National Training Entity: Supporting and promoting capacity building efforts in patient-oriented research	Annie Leblanc
32	Up to BAT: Examining the association between 'business arrangement types', family physician compensation, and workforce outcomes using a multiple case study	Gillian Young
33	Improving access to urgent diagnostic imaging through SCOPE Middlesex London: A primary care pathway to reduce emergency department utilization	Janina Mailloux
34	Community Paramedicine at Clinic (CP@clinic) supporting smoking cessation in social housing: A pilot study in Sault Ste. Marie, Ontario	Audrey Iteka
35	Administrative form completion in primary care: Opportunities for team-based care	Thalia Garvock
36	Out-of-pocket payments for primary care in Canada: Results from the 2025 OurCare national survey	Maryam Daneshvarfard
37	Health promotion programs in Ontario Community Health Centres: Impacts on health outcomes and primary health care utilization	Isabelle Fortuna
38	A closer look at penicillin allergy labels in Canadian primary care: A cross-sectional study	Johnny Earle
39	A comparative study on regional or local-level primary care governance models in three international jurisdictions	Monica Aggarwal
40	Measuring physician co-management relationships: A scoping review	Cole Wyman
41	Codesign and acceptability of an AI-powered bilingual chatbot for biopsychosocial data collection in Ontario patients with chronic pain	Sophie Turcotte
42	Specialist physicians' perspectives on the application of AI tools in eConsult: A thematic analysis	Arman Afkham-Ebrahimi
43	Assessing the capacity of practice-based research and learning networks (PBRLNs) in Canada: Learnings to guide collaboration and shared capacity-building	Thomas Iverson
44	Health 8-1-1 as a digital front door for Canada's healthcare systems	Zeenat Ladak
45	From crafting to evaluating patient education materials: Testing AI for primary care – the AI-CARE Study	Sharon Johnston
46	Preventive Check: A student-created, open-access website/app for personalized preventive care checklists	Matthew Wong
47	Comparing data from regulatory organizations with provider survey data for analyses of health care supply and accessibility	Graham J. Reid
48	Primary care physician job preferences: A systematic review of choice-based stated preference studies	Rachel Walsh
49	Establishing benchmark values for team functioning and co-management in primary care	Olla Hilal
50	Rating and ranking identified pandemic supports for primary care: Results from primary care providers and public health leads	Leslie Meredith
51	Optimizing the scope of primary care nursing in Ontario	Connor Brearley
52	Competencies for social work practice in primary care teams: Results of a consensus Delphi study	Rebecca Bliss
53	Understanding prenatal and obstetric care pathways for newcomers in Canada: A scoping review of barriers and facilitators	Harnoor Bhinder
54	Identifying gaps in perinatal care and opportunities for clinical decision support tools through narrative review	Thaneson Balachandran

Panel Discussion

Panel Discussion – AI in Primary Care: Managing Rapid Spread in Sclerotic Systems

Introduction & Moderator: Dr. Onil Bhattacharyya, Chair in Family Medicine Research at Women's College Hospital

AI is transforming primary care, whether we feel ready or not. Patients arrived first: about half of Canadians already use AI for health information. The pressing question is not how to stop it, but how to manage it responsibly. This panel will explore that tension, balancing the very real risks of AI against its significant benefits.



Moderator: Dr. Onil Bhattacharyya
Chair in Family Medicine Research at Women's College Hospital

Panelists:



Jay Shaw, Acting Director, Joint Centre for Bioethics, University of Toronto



Will Falk, Executive-in-Residence, Rotman School of Management, University of Toronto



Mary Huang, Patient Advisor in Research Collaboration

Evaluation

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



Abstracts: 4 Plenary Oral Presentations

Accelerating and Increasing Patient Attachment to Primary Care Teams: Identifying Best Practices and Successful Strategies

Judith Belle Brown, Amanda L. Terry, Maria Mathews, Cathy Thorpe, Catherine George

Background: To address the crisis of over 2.5 million Ontarians without a primary care practitioner, Ontario has contributed significant funding and is committed to eliminating the waitlist for Health Care Connect (HCC), an unattached patient registry.

Approach: We identified strategies that primary care teams used to increase and accelerate attachment of patients. We used a case study design and qualitative interviews with 15 primary care team members and leaders.

Results: All the organizations shared core principles such as collaboration and relationship building; equitable partnerships; patient-centred care; and sensitivity to context. They identified challenges in working with HCC. Two cases responded to community need, establishing "attachment clinics" prior to receiving funding. Sometimes NPs served as the most responsible provider (MRP) for patients during the assessment process; others used system navigators to complete a complexity score, acquire basic information and then attach to the MRP. Assessment of patient complexity helped balance assignments to the MRP and the need for other providers. Notably, each case used a different patient complexity tool. Implementation of attachment strategies varied including creative outreach as well as attending to specific contexts. All members of the teams were encouraged to work to full scope of practice. All the case studies highlighted the importance of team-based care with equitable distribution. Two of the case studies raised the use of technology (EMRs, AI scribes) for patient care and efficiency.

Conclusions: Findings reveal a multiplicity of strategies and activities used by teams and leaders to enhance patient attachment, while keeping context at the forefront.

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A co-designed integrated care intervention to EMBOLDEN healthy lifestyles among older adults in equity-deserving communities: Results of a multi-jurisdictional randomized controlled trial

Rebecca Ganann, Kathryn Fisher, Stuart Phillips, Ayse Kuspinar, Elizabeth Alvarez, Sarah Neil-Sztramko, Bruce Newbold, Maggie MacNeil, Gary Bloch, Jenn Green Heather Keller, Janet Adams, Aref Alshaikhahmed, Kamal Jain, Penelope Petrie, Dennis Baker

Background: EMBOLDEN is a 3-month integrated care lifestyle intervention to promote mobility, health literacy, and social/community participation. The multi-faceted, group-based program was co-designed and implemented in collaboration with older adults and community-based health and social care providers, targeting older adults in 10 equity-denied neighbourhoods in two cities. EMBOLDEN was delivered by providers from primary care, public health and municipal recreation and tested in a randomized controlled trial.

Approach: Participants at each site were randomized (1:1) to intervention or control groups. The primary outcome was time spent in moderate-to-vigorous physical activity (MVPA), estimated using smartwatch accelerometry. Secondary outcomes included various scales to measure health literacy, mobility change, and social support. Data were collected at baseline, 3 months, and 6 months, and analyzed with intention-to-treat principles using generalized estimating equations and mixed models.

Results: 324 participants were enrolled at baseline (161 intervention, 163 control). Intervention participants increased MVPA by 8.3-22.1 minutes/day, and experienced increased self-reported global mobility and literacy related to nutrition and exercise, compared to control. Intervention participants showed progressive improvements in social network size (6.4 to 8.7) and social interaction scores (29.6 to 39.7). Participants reported enhanced motivation, new exercise adoption, and improved knowledge of low-cost healthy ingredients.

Conclusion: Statistically and clinically meaningful improvements in physical activity, global mobility, health literacy, and social connectedness highlight the real-world effectiveness of EMBOLDEN. Integrating flexible, co-designed health education, physical activity, and system navigation offers a unique, scalable community-based approach to mitigate functional decline and social isolation among community-dwelling older adults in equity-denied neighborhoods.

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What Drives Patient Attachment? A Provincial Analysis of Organizational Strategies Associated with Early Attachment Progress in Ontario Interprofessional Primary Care Teams

Katie Hurst, Sharareh (Shary) Mahdavi

Background: Attachment to a regular family physician or nurse practitioner is associated with improved access, continuity of care, and health outcomes. In Ontario, interprofessional primary care teams are using organizational approaches to complement Health Care Connect and support patient attachment. This study examines non-HCC attachment strategies led by primary care teams and their association with early attachment progress.

Approach: We conducted a mixed-methods analysis of administrative and team-reported data from a selection of interprofessional primary care teams in Ontario actively working on increasing attachment. Narrative reports were thematically coded into six strategy categories: community outreach, partner-based referrals, waitlist-based attachment, program-facilitated attachment, system-enabled attachment, and low-barrier self-referral. Quantitative analyses examined relationships between strategy use and early attachment progress.

Results: Community outreach showed the strongest positive association with early attachment progress and was consistently reported among teams on track to meet or exceed attachment targets. Among teams with substantial outreach activity and at least 90% target achievement, 60% did not report outreach-related roles, suggesting that outreach may be embedded across team functions and partnerships rather than limited to dedicated positions. These teams commonly used low-barrier self-referral and partner referrals. Teams typically reported using approximately three strategies simultaneously; however, outcomes appeared to depend more on strategy selection and implementation than on the number of strategies used. In contrast, greater reliance on internal waitlist-based approaches was associated with slower progress.

Conclusions: Early findings suggest that attachment progress is influenced not only by which strategies are used, but also by how they are implemented within local contexts. Community outreach emerged as a common feature of teams on track to meet or exceed their patient attachment targets, highlighting opportunities to strengthen and scale organizational practices that complement the provincial attachment pathway and support equitable access to primary care across Ontario. katie.hurst@ontariohealth.ca, shary.mahdavi@ontariohealth.ca.

Restoring Joy in Practice: What matters to Ontario family physicians – a qualitative exploratory analysis

Rachel Walsh, Natasha Kithulegoda, Sakina Walji, Cynthia Whitehead, Bonnie Chow, Liisa Jaakkimainen, Aisha Lofters, Deborah Marshall, Risa Freeman, June C. Carroll

Background: Provincial-level system reforms are often proposed to address family medicine (FM) workforce challenges, including difficulties with recruitment, retention, and sustainability. The extent to which these reforms consider clinicians' lived experiences remains unclear. We aimed to explore and understand job characteristics that influenced Ontario family physicians' decisions to practice comprehensive FM, and how these characteristics align with or diverge from health policymaker ideas for primary care reforms.

Approach: Qualitative descriptive analysis of focus groups of family physicians across a range of career stages and practice types, and semi-structured interviews of health policymakers with experience in primary care policy in Ontario, Canada.

Results: We conducted 6 focus groups, including a total of 32 family physicians and FM residents, and 10 health policymaker interviews. Joy in work across multiple domains (patient relationships, autonomy and flexibility, meaningful workload, collegiality, fair remuneration, and feeling respected and valued) was key in decisions to practice comprehensive FM. Family physicians described sadness and frustration when faced with impediments to these sources of joy. While many health policymaker-proposed solutions aligned with family physician-identified sources of joy, several were at odds, potentially affecting family physician autonomy, meaningful workload, and patient relationships.

Conclusions: Ontario family physicians identified multiple sources of and impediments to joy in work that were variably addressed in proposed Ontario primary care reforms. Overall, our findings highlight a central challenge: aligning system-level reforms with the lived experience of family physicians to ensure that efforts to improve access and efficiency do not inadvertently undermine joy in practice. Rachel.walsh@sunnybrook.ca

Abstracts: 16 Concurrent Oral Presentations

Mapping the Twenty Years of Evidence Generated to Support Team-Based Primary Care in Ontario, Canada: Narrative Review

Rachelle Ashcroft, Judy Belle Brown, Stefaniia Martsynkevych, Ben Walsh, Simon Lam, Catherine Donnelly

Background: Interprofessional primary care teams provide comprehensive, holistic care by integrating a range of healthcare professionals, including social workers, occupational therapists, nurses, pharmacists, and physicians. Ontario has a long history of team-based primary care, including Family Health Teams (FHTs), Community Health Centres (CHCs), Nurse Practitioner-Led Clinics, and Aboriginal Health Access Centres. The review sought to: 1) identify characteristics of team-based primary care in Ontario included in research over the last 20-years; 2) examine structures and processes influencing the development, functioning, and sustainability of these teams in Ontario; and 3) identify key themes, gaps, and areas for future inquiry related to interprofessional team based primary care in Ontario.

Approach: A narrative review was conducted to address gaps in the literature and synthesize existing evidence on IPC in Ontario since 2005. Multiple databases were searched. Data were extracted on publication characteristics, study design, participants, equity considerations, primary care models, team composition, geographic context, and reported barriers and facilitators. Findings were synthesized using inductive qualitative content analysis to identify patterns and themes across studies.

Results: A total of 10,792 records were identified, with 7,346 unique citations remaining after duplicate removal. Following screening, 427 articles were included in the final review. 21% of first authors were INSPIRE-PHC researchers. The federal Tri-Council agencies, collectively accounted for 17% of reported funding, the Government of Ontario funded approximately 22% of the studies, and universities were another major source of research funding. Studies focused on a range of primary care models, with FHTs mentioned in 63% of the studies and CHCs mentioned in 29% of the studies. 20% of the studies explicitly mentioned multi-site primary care organizations, while less than 10% of the studies explicitly mentioned a co-located context. Additional results will be shared.

Conclusion: This research provides an overview of IPC research in Ontario and highlights inconsistencies and gaps in the literature that need to be addressed.

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Walking Together: Community-academic co-design of an Indigenous primary care patient navigator

Imaan Bayoumi, Logan Jackson, Monique Gingras, Jake Chaput, Harini Satheeskumar, Sarah Funnell, Eva Purkey, Susan Bartels, Mandy Wilson, Bruce Knox, Alishba Mansoor

Background: Indigenous Peoples in Canada experience substantial health inequities, with ongoing anti-Indigenous racism in healthcare contributing to inequitable access and outcomes. Patient navigators have improved access to culturally safer care for Indigenous patients in cancer care, yet little research has examined the impact and functionality of the Indigenous patient navigator (IPN) role in primary care. The objective of this research is to co-design an IPN role within Queen's Family Health Team, a large primary care team in Kingston, Ontario.

Approach: Using community-based participatory methods, we conducted individual in-depth interviews with service providers from community health and social service agencies serving Indigenous Peoples and research circles led by local Indigenous Elders with Indigenous community members. Data explored Indigenous patients' needs and perspectives on an IPN role and were analyzed using inductive thematic analysis. An IPN role description was co-designed from the findings with feedback from an Indigenous Oversight Circle.

Results: We completed 21 key informant interviews, seven research circles, and one individual interview with an Indigenous community member. Themes included barriers experienced by Indigenous patients; approaches to culturally safer care; desired role scope, skills, and qualifications; organizational supports; IPN well-being (self-care/risk of burnout); and considerations for Indigenous patient self-identification.

Conclusion: Participants look forward to an IPN being implemented in primary care, with the aim of improving Indigenous patients' experiences and health outcomes. Next steps include implementation of an IPN and co-designing an evaluation of the role centering Indigenous evaluation approaches.

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Turning Primary Care EMR Data into Action: Provider-Level Variation in Access and Continuity Across Quebec

Mylaine Breton, Catherine Lamoureux-Lamarche, François Bordeleau, Isabelle Gaboury, Jade Berberi, Élisabeth Martin, Sarah Descoteaux

Background: Primary care (PC) systems increasingly rely on data-driven tools to improve access, quality, and efficiency. PC clinics generate large volumes of data through electronic medical records (EMR), yet these data remain underused for performance monitoring and reflective practice.

Approach: We conducted a longitudinal observational study among 560 family physicians and nurse practitioners practicing in 30 primary care clinics across six Quebec regions. Three EMR-derived indicators were measured from July 2025 to July 2026: the third next available appointment, 48-hour capacity (ability to accommodate urgent requests within a 48-hour timeframe), and relational continuity (proportion of consultations conducted with the patient's own provider). Data were extracted weekly or monthly. Descriptive analyses included means, medians, ranges, and interquartile ranges. An annual average was calculated for each provider.

Results: Across providers, the annual average time to the third next available appointment ranged from 1.1 to 28.0 days, with a median of 20.6 days (interquartile range: 11.2 – 28.0). Relational continuity ranged from 0 % to 99 %, with a median of 20 % (interquartile range: 0 – 74 %). The proportion of urgent requests accommodated within 48 hours ranged from 0 % to 71 %, with a median of 6 % (interquartile range: 4.6 – 13.0). The distributions showed variability across providers for all three indicators, revealing different patterns of appointment availability, responsiveness to urgent demand, and continuity.

Conclusions: Routinely collected EMR data can generate provider-level indicators of primary care access and continuity. The observed variability highlights opportunities for targeted quality improvement and supports longitudinal measurement as a foundation for reflective practice a data-informed improvement. Mylaine.breton@usherbrooke.ca

Setting the Stage for Expanded Midwifery Care Models Evaluation: Defining Program Objectives, Identifying Data Sources and Developing an Evaluation Framework

Liz Darling, Bethy Burray-Davis

Background: Expanded Midwifery Care Models (EMCMs) were established by the Ontario Ministry of Health to improve access to midwifery services, respond to unmet community needs, and strengthen the sustainability of Ontario's maternity and primary care systems. Despite EMCM expansion in number, scope and complexity, no standardized provincial evaluation framework has existed. This project aimed to develop a flexible and scalable evaluation framework applicable across Ontario's diverse EMCMs.

Approach: A mixed-methods approach included qualitative interviews with EMCM leaders, a province-wide survey, and co-design sessions with midwives and other stakeholders.

Results: EMCMs were found to serve populations with complex and unmet needs, including unattached patients, uninsured individuals, newcomers, and those with complex social needs. They also provide diverse clinical services tailored to local contexts, alongside non-clinical work supporting patient navigation, continuity, and care coordination. These findings informed an evaluation framework comprising six domains: Clinical Outcomes, Cost Efficiency, Patient Experience, Provider Experience, Equity, and Access to Care. The framework includes core provincial indicators and customizable indicators reflecting local priorities.

Conclusions: The EMCM Evaluation Framework provides a foundation for provincial evaluation that balances standardized measurement with the flexibility needed to reflect the diversity of EMCMs across Ontario. It will enable the Ministry to generate consistent data on EMCM contributions and supports comparisons across models to identify effective approaches for improving access, equity, and provider sustainability. Overall, the framework will help the Ministry better understand, support, and optimize the role of midwifery in Ontario's health system to enhance access to care and improve community health. darlinek@mcmaster.ca

A Decade of Perinatal Health Trends in Ontario: Implications for Primary Care, Population Health Management and Point of Care Tools

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Background: Primary care provides longitudinal care before, during, and after pregnancy, positioning primary care clinicians to influence reproductive and lifelong health outcomes. Ontario's perinatal population has become increasingly medically complex over the past decade, with rising maternal age, obesity, chronic disease, and pregnancy complications. We examined more than a decade of Ontario perinatal trends to identify implications for the perinatal continuum and across the lifespan.

Approach: A descriptive population-based analysis of provincial perinatal indicators was conducted using data from BORN (Better Outcomes Registry and Network) Information System (2012/13–2023/24), supplemented by linked administrative datasets where appropriate. Trends in maternal demographics, pregnancy risk factors, complications, and birth characteristics were examined over time. Findings were interpreted through a primary care lens to identify opportunities for proactive prevention, longitudinal care, integrated digital health, and population health management.

Results: In 2023/2024, individuals giving birth were older, with nearly 70% aged 30 years or older and births among those aged ≥35 years increasing from 18% to 23% with regional variation. Pre-pregnancy obesity rose to 21.5%, pre-existing medical conditions increased from 17.0% to 25.6%, hypertensive disorders increased from 5.9% to 7.9%, and preeclampsia increased from 1.4% to 2.0%. Excess gestational weight gain affected 58.1% of singleton pregnancies while prevalence of perinatal mental health concerns doubled.

Conclusions: These trends suggest that pregnant individuals have greater chronic disease burden and future cardiometabolic risk, reinforcing the importance of longitudinal primary care across the reproductive life course. The findings highlight opportunities to strengthen preconception optimization, risk-stratified antenatal care, structured postpartum surveillance, and inter-conception care. Integrating population-level perinatal data with primary care electronic medical records could enable automated risk stratification, personalized reminders, point-of-care decision support, and population health management that support prevention, continuity of care, and improved maternal and child outcomes across the reproductive life course and beyond. aharvey@bornontario.ca

Using Small Geographies to Inform Equitable Primary Care Planning

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Background: An estimated 6 million Canadians are without access to a primary care provider. Population-based approaches, including geographically based rostering models, may support more equitable primary care attachment and access. However, meaningful small geographies must first be defined and linked to local population health needs.

Approach: We co-developed small-geography models for three Ontario Health Teams (OHTs) in Eastern Ontario using 2021 Canadian Census geography and linked administrative health data housed at ICES. Statistics Canada geographic building blocks were assessed to define neighbourhood boundaries. Descriptive and spatial analyses examined primary care attachment, preventive care indicators, and hospitalizations. Findings also informed development of a preliminary decision framework to support consistent small-area mapping across Ontario.

Results: Aggregated dissemination areas were identified as the most appropriate geographic unit. The three OHTs were divided into 23, 25, and 22 locally named neighbourhoods, respectively. Neighbourhood-level data were made publicly available through the Ontario Community Health Profiles Partnership. Substantial variation in health care utilization and access was observed. In one OHT, annual hospitalizations ranged from 781 to 2,475 per neighbourhood, while primary care attachment ranged from 73% to 89%. A preliminary provincial decision framework was developed.

Conclusions: Geographically based approaches offer a promising strategy for population health planning and primary care system redesign. This study demonstrates the feasibility of collaboratively developed small geographies that are locally meaningful, analytically robust, and scalable, offering a practical foundation for targeted attachment strategies and more equitable service delivery. catherine.donnelly@queensu.ca

Who does what? Measuring provider contributions in an interprofessional primary care team

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Background: Interprofessional primary care (IPC) teams may help address Canada's primary care crisis by improving patient access and community health. A major barrier to optimizing team performance is the lack of data on individual provider contributions. This pilot study aimed to measure IPC team member contributions using provider-level performance indicators reflecting interprofessional practices.

Approach: A cross-sectional retrospective analysis of electronic medical records (EMR) was conducted using data extracted from a community Family Health Team in Kingston, ON. The study included a random sample of 100 patients aged ≥65 with at least 10 primary care encounters over 12 months. Data on clinical tasks and associated healthcare provider types were collected.

Results: A total of 5,011 EMR entries were identified. 1,495 entries represented direct patient care (appointments; 80.9% attributed to physicians), while 3,516 entries represented indirect patient care (e.g. record management, care planning; 90.8% attributed to physicians). Overall, physicians were involved in 4,408 entries (88.0%), followed by nurse practitioners in 208 entries (4.1%), and registered nurses in 199 entries (4.0%).

Conclusions: Physicians were responsible for most documented care activities, suggesting care delivery remained largely physician-centred despite the team's interprofessional structure. These findings demonstrate the feasibility of using EMR data to quantify provider-level contributions. Future research is needed to evaluate how best to leverage the expertise of IPC team members to optimize care delivery. thalia.g@queensu.ca

Primary Care Practices' Digital Health Outreach to Address Social Isolation

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Background: Social isolation is associated with an increased risk of adverse brain and cardiovascular health outcomes. While primary care guidelines recommend screening and intervention, scalable, low-burden population-level strategies remain understudied.

Approach: This pragmatic randomized controlled trial evaluates a scalable digital intervention delivered through primary care practices across Ontario using the Canadian Primary Care Information Network. Patients receive tailored digital messages and surveys every 3 months for up to 24 months. Providers are randomized to intervention or control groups. The primary outcome is change in social isolation over time, measured using the Revised Digital-Berkman-Syme Social Network Index (RD-BSSNI). The intervention promotes social connection and community engagement, while the control group initially receives general health messages. Patient feedback, survey data, and Community Advisory Board input are used to continuously refine the intervention. Future linkage with ICES administrative data will examine associations between social isolation, social behaviours, and brain and cardiovascular health outcomes.

Results: Preliminary findings show that intervention messages are well received by survey respondents, perceived as more actionable compared to control messages on general health promotion topics, and more likely to prompt engagement. Higher social isolation scores were observed among individuals aged 55 years and older.

Conclusions: Digital health communication delivered through primary care may offer a scalable approach to addressing social isolation. Ongoing follow-up will assess changes in social isolation over time, while future linkage with administrative health data will further examine associations with health outcomes. sharonjohnston@montfort.on.ca

Exploring the Role of Medical Office Assistants in Primary Care: A Role Theory Perspective

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Background: Medical office assistants (MOAs) are non-clinical staff who are central to the functioning of primary care clinics, yet their roles and work experiences remain poorly defined and understudied. Using role theory as a conceptual framework, this study explored how MOAs' beliefs, values, and perceived expectations shape their everyday work experiences within Ontario primary care settings.

Approach: A qualitative study was conducted using semi-structured interviews with MOAs working in primary care clinics across Ontario. Participants were recruited from previous survey respondents who expressed interest in follow-up interviews. Interviews were thematically informed by role theory constructs, such as role expectations, identity, ambiguity, overload, insufficiency, underutilization, conflict, and strain.

Results: Twenty-one MOAs participated (20 female; mean age 42±13.2 years). Participants described a strong care-oriented role identity alongside unclear role boundaries and high expectations from physicians, managers, and patients. These conditions contributed to role overload, difficulty prioritizing tasks, and gaps between expectations and available support, compounded by limited training. Some MOAs reported underutilization, expressing interest in more complex responsibilities but facing organizational constraints. These dynamics contributed to role conflict and strain, including stress, burnout, and challenges managing patient aggression. Supportive team relationships, physician support, and recognition of MOA contributions helped mitigate these pressures.

Conclusions: MOAs experience substantial challenges in meeting the expectations with patients and primary care teams. Addressing role strain may require clearer role definitions, more consistent communication (e.g., regular huddles or check-ins) between physicians and MOAs, and adequate staffing. Strengthening the MOA role may improve workforce sustainability and effective team-based care. amber.khan@wchospital.ca

How does Ontario measure up to the rest of Canada when it comes to primary care? Results from the 2025 OurCare National Survey

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Background: The 2025 OurCare National Survey sought to understand how people's experiences of care measure up to the OurCare Standard, a public-defined vision for primary care in Canada. We analyzed the survey data to understand how Ontario's primary care performance compares to other provinces and territories in Canada.

Approach: The 2025 OurCare National Survey was conducted online between April and November 2025 in English, French and Inuktitut and available to all residents of Canada aged 18 years and older. We used stratified sampling by province and territory and recruited through a proprietary panel and public promotion. We used weighted estimates and 95% confidence intervals to compare Ontario with national results.

Results: Compared to Canada (n=16,876), more respondents in Ontario (n=3,994) reported a regular source of primary care (88.5%, 95% CI: 86.6%-90.3% vs. 82.8%, 95% CI: 81.7%-83.9%), although this still translated to approximately 1.53 million adults without primary care. Among those with a primary care clinician, more people in Ontario reported same- or next-day access for urgent issues (44.6% vs. 37.2%) and access to urgent care outside regular weekday hours (43.4% vs. 31.2%). More people in Ontario with a primary care clinician also reported paying fees for primary care (18.8% vs. 14.5%). Other measures, including continuity, access to non-physician team members and health records, culturally safe care, and satisfaction with primary care did not differ significantly.

Conclusions: Access and attachment to primary care in Ontario is better than in other jurisdictions in Canada despite ongoing challenges and room for improvement. There is opportunity to learn from high-performing jurisdictions in other areas including in providing patients access to their own health records. tara.kiran@utoronto.ca

Rapid Action Learning Intensives (RALI): A Framework for Advancing Equitable Intake, Attachment, and Access to Primary Care

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Background: Timely and equitable attachment to primary care is a persistent challenge. Intake is often viewed as administrative burden, yet it is the front door to access, attachment, and continuity of care. Inconsistent intake, triage, and scheduling can drive delays and inequitable access and care. The Rapid Action Learning Intensive for Access and Attachment (RALI-AA) adapts a proven learning collaborative model developed by the Alliance for Healthier Communities to help primary care teams implement and sustain equitable intake improvements.

Approach: RALI-AA supports primary care organizations in adopting a structured, coach-supported seven-step intake process for unattached clients. The framework integrates standardized information collection, complexity assessment, triage, protected appointment capacity, interprofessional team engagement, and clear referral pathways. Organizations map existing processes, define aims, design future workflows, and convert tested change ideas into standard work—distinguishing core "tight" elements from adaptable "loose" elements. Coaching, peer learning, and sustainment strategies enable spread across diverse settings.

Results: Anticipated outcomes include consistent complexity assessment, clearer triage, enhanced interprofessional coordination, team capacity efficiencies, and reduced wait times from registration to ongoing care. Performance is monitored through completion rates, attachment, and staff experience. The framework also identifies and mitigates barriers related to staff capabilities, workflow, resources, and motivation.

Conclusion: RALI-AA addresses access and attachment by framing intake as a clinical and organizational decision system. Through process mapping, complexity-informed triage, and iterative testing, this model supports reliable, equitable improvements adaptable to various primary care settings. denis.tsang@allianceon.org

Strategies and Facilitators for Optimizing Registered Nurses' Roles in Primary Care Teams in Canada: A Qualitative Study

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Background: Registered nurses in primary care (PC-RNs) are well-positioned to contribute to timely and comprehensive care; however, their roles and scope of practice are often underutilized. Ongoing challenges in primary care access and capacity across Canada call for strategies that facilitate PC-RN role optimization in teams.

Approach: As part of a larger project examining the impact of funding models on PC-RN integration, we conducted semi-structured qualitative interviews with PC-RNs, administrators, and most responsible providers (MRPs; i.e., family physicians/nurse practitioners) in British Columbia, Quebec, Nova Scotia, and Ontario. Interviews explored PC-RN roles, teamwork, and factors influencing PC-RN optimization. We used inductive thematic analysis.

Results: We interviewed 32 PC-RNs, 18 administrators, and 18 MRPs across 25 clinics. Participants identified three strategies for optimizing PC-RN roles and clinic efficiency: 1) triaging unscheduled patient visits, 2) adopting medical directives to enhance scope of practice, and 3) leveraging PC-RN-led appointments. Five factors facilitated role optimization: 1) MRP trust and support, 2) access to an MRP, 3) PC-RNs' skills, knowledge, and interests, 4) role clarity, and 5) clinic funding models. Participants described how these strategies improved access to care, supported preventative care, reduced administrative burden, and enabled more efficient use of MRP time.

Conclusions: Primary care teams need organizational, relational, and financial conditions that enable PC-RNs to leverage their expertise. Policies and funding models should support these conditions to strengthen PC-RN integration and primary care capacity. maria.mathews@schulich.uwo.ca

Excess Emergency Department visits among Ontario adults losing attachment to comprehensive primary care

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Background: Like other jurisdictions, Ontario is grappling with family physician shortages. More losses in primary care attachment are expected as the workforce ages into retirement and interest in a family medicine career remains low. For resource planning, we sought to determine the number and urgency level of excess emergency department (ED) visits among adults following attachment loss, analyzed by patient characteristics.

Approach: Controlled before-and-after analysis comparing the change in ED use among Ontario adults who lost attachment against that of adults who remained attached during the study period. Stratified linear regressions analysed ED use by urgency level and by patients' sociodemographic and medical characteristics.

Results: Over the two years following attachment loss, the adjusted overall mean number of excess ED visits among those who lost attachment was 26 per 1,000 adults (95% confidence interval: 21,30). Those with high comorbidities and those with substance use disorder(s) (SUD) had the greatest excess overall visits (238/1,000 [211,265]; 373/1,000 [287,458]). The highest mean number of excess visits were of lowest urgency, particularly among those with high comorbidities (157/1,000 [141,173]), rural residents (136/1,000 [115,156]), those with SUD (148/1,000 [107,189]), and those with serious mental illness (SMI) (89/1,000 [50,128]), when compared with their stably attached counterparts. Those with SMI or SUD experienced the greatest excess high urgency visits (28/1,000 [1,56]; 65/1,000 [34,95]).

Conclusion: We quantified excess ED visits following primary care attachment loss and identified the visit types and patients most affected. Findings may help resource planning and inform policies to support and expand attachment. kpremji2@uottawa.ca

The State of Governance in Ontario Family Health Teams: Building Governance Capacity for a Changing Primary Care System

Jess Rogers

Background: As Ontario seeks to expand primary care attachment, strengthen interdisciplinary teams and increase integration across the health system, effective organizational governance is increasingly important. Primary care organizations have developed within diverse funding, practice and accountability structures, often shaped by local history. AFHTO undertook a sector-level examination of governance to better understand this landscape and identify opportunities to strengthen governance capacity.

Approach: AFHTO conducted a descriptive analysis of governance data collected through its member surveys, examining governance models, conflict-of-interest practices, board diversity, bylaws and board structures. Findings were considered alongside AFHTO's experience supporting executive leaders and boards through its Governance and Leadership Program.

Results: The analysis demonstrates substantial variation in governance models and practices. In the 2025 dataset, 62% of organizations had mixed governance models, while 20% were purely physician-led and 14% were community-led. These findings challenge the common characterization of team-based primary care organizations as uniformly physician-governed. Formal governance structures and policies are generally well established, but their application and leaders' confidence navigating complex governance issues are more variable. Findings also identify opportunities to strengthen board composition, succession, role clarity and strategic oversight.

Conclusions: Governance excellence requires more than education and training. Organizations need practical supports that strengthen governance capability while creating clear expectations and accountability through policy, funding and contractual levers. A continuum of assessment, education, peer learning, mentorship and targeted coaching, complemented by system-level accountability mechanisms, can help primary care organizations build the governance capacity required to lead transformation while recognizing their different models, contexts and histories. info@afhto.ca

The feasibility of COPE_PC: A web-based tool to support discussions of social isolation in family practice

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Background: Social isolation increases adverse effects including dementia and functional decline for older adults with multimorbidity, requiring exploration in primary care. Our objective was to develop, implement, and assess feasibility of a web-based platform to facilitate social isolation discussions between patients and family physicians (FPs).

Approach: Conducted mixed methods development of Connection Oriented Patient-Provider Exchange in Primary Care (COPE_PC) with companion FP Education Module informed by qualitative interview and survey results. COPE_PC platform has 3 components (Social isolation infographic; COPE_PC Tool exploring risk for social isolation, and Community Resources). Twelve patient/FP dyads used COPE_PC within in-person clinical encounters with feasibility assessed through interviews and questionnaires.

Results: Patients were comfortable using COPE_PC within an encounter due to trusting FP relationship. Patients and FPs found COPE_PC easy to use and believed it empowered patients and FPs to have social isolation discussions. Both indicated meaningful discussions arose from using the COPE_PC Tool. Both identified community resources as helpful. Majority (67%) of FPs reported the Education Module prepared them to use COPE_PC. FPs expressed that time constraints made integrating COPE_PC challenging. Suggestions for improvement: using COPE_PC as screening tool; having COPE_PC Tool available to patients prior to an encounter, and enabling COPE_PC for mobile devices.

Conclusions: Patients and FPs found COPE_PC feasible within a clinical encounter and found that COPE_PC facilitated discussions that might not otherwise happen. FPs cited time constraint as barrier to adoption. bryan@uwo.ca

Holding the Line: How Interprofessional Primary Care Team Leaders Navigate Tensions During Expansion

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Background: Many Ontarians lack a family physician or nurse practitioner. A 2024 provincial investment funded interprofessional primary care teams (IPCTs) to expand attachment, access, and equity, placing new demands on the leaders delivering it. How these leaders experienced and managed the resulting tensions is not well understood.

Approach: We conducted a secondary qualitative analysis of interview data from a nine-case multiple case study of high-performing ("bright spot") IPCTs during the expansion. We analyzed 22 interviews with executive directors, clinical leads, and other team leaders using a hybrid deductive-inductive thematic analysis and applied paradox theory as the analytic lens.

Results: Leaders described their central challenge as competing commitments: to the funder, to their team, and to the people who need care. Ontario Health's attachment targets pushed teams to take on patients quickly, straining staff and care quality. Commitments among patients also competed. Leaders arbitrated which patients to serve, weighing roster growth against protecting the existing panel, and attachment volume against reaching complex, hard-to-reach patients. These reflect performing paradoxes, rooted in competing stakeholder goals, and organizing paradoxes, in how leaders structured work to meet them. Leaders supported and shielded their staff, adjusting workloads and stepping in when needed; pushed back on funder metrics; and made choices about where clinical capacity went.

Conclusions: Successful expansion depended on leaders absorbing and arbitrating tensions the funding model left unresolved. Relying on individuals to carry it raises concerns about sustainability. These findings give policymakers and health system leaders guidance on how to design supports that help leaders carry out expansion. jennifer.shuldiner@wchospital.ca

Abstracts: 54 Poster Presentations

Specialist Physicians' Perspectives on the Application of AI Tools in eConsult: A Thematic Analysis

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Background: eConsult is a secure web-based tool that enables timely and equitable access to specialist advice for all patients in Ontario. There is growing interest in exploring how artificial intelligence(AI) could further enhance the efficiency and quality of these interactions. Therefore, a needs assessment was conducted to understand current use of AI tools, perceived value, concerns, and risks from the perspectives of specialist physicians registered in eConsult.

Approach: Specialists(n=1,182) were invited to complete an online anonymous 19-question survey consisting of open-text responses and other question types. An inductive thematic analysis approach with constant comparison was used to analyze open-text responses. Independent coding and periodic discussions among the research team, including review of disconfirming evidence, facilitated thematic analysis and helped reach consensus.

Results: We received 472 responses to the survey, of which 130 respondents opted to write open-text responses. Five themes were identified: (1)AI could be a helpful tool supporting specialists, (2)adoption depends on prior experience with AI and perceived value, (3)integration requires safeguards for responsible use, (4)need for clear boundaries that do not compromise professional responsibility and integrity of physicians, and (5)trust is dependent on proven accuracy, transparency, and safety.

Conclusions: Alongside potential benefits of AI tools to assist specialists, there remain barriers to adoption and integration. Widespread adoption of an AI tool in eConsult will depend less on availability, and more on the specialist's perception and trust of the tool. These preliminary findings provide early insight into specialist physicians' perspective on the use of AI in eConsults.

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A Comparative Study on Regional or Local-level Primary Care Governance Models in Three International Jurisdictions

Monica Aggarwal, Eric Filice

Background: High-performing primary care depends not only on frontline capacity but on the governance structures that plan, coordinate, and hold providers accountable at a regional or local scale. High-income countries have built diverse meso-level entities -Primary Health Networks in Australia, Primary Health Organizations in New Zealand, and Clinical Commissioning Groups and Primary Care Networks in England—yet Ontario lacks an evidence base to guide its Primary Care Networks, which are responsible for population health planning, coordination, and patient attachment.

Approach: We conducted a JBI-informed scoping review of governance models in England, Australia, and New Zealand, searching PubMed and Scopus (44,617 records; 152 peer-reviewed sources included) alongside targeted grey literature. Data were extracted across twelve domains, including organizational form, governance composition, decision-making authority, and accountability, and synthesized thematically.

Results: All three jurisdictions showed repeated structural reorganization that reset organizational memory without consistent performance gains. Formal governance structures often diverged from actual decision-making, and upward accountability to funders crowded out community and peer accountability. Mandate clarity and real budgetary authority were the strongest determinants of effectiveness; Broad mandates but limited funding show structure alone is insufficient. Practitioner engagement was the central implementation challenge, and nurses, allied health professionals, pharmacists, and Indigenous providers were consistently underrepresented in governance.

Conclusions: Findings converge on actionable design principles for Ontario: co-design mandate clarity with practitioners before scale, measure performance for learning rather than compliance, give clinical representation genuine authority, and embed equity from inception to avoid replicating governance failures affecting marginalized populations.

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From Reconciliation to Transformation: A Rapid Review of Indigenous Perspectives in Healthcare Reform

Swathi Anphalagan, Shurabi Anphalagan, Shannon L. Sibbald

Background: Indigenous peoples in Canada face health disparities, challenges in primary healthcare access, and poorer outcomes compared to non-Indigenous populations. In response, the government issued Calls to Action in 2015 to support Indigenous health through healthcare transformation. While this has emphasized the need for meaningful healthcare reform, primary care organizations continue to face challenges in translating these commitments into practice.

Approach: This rapid review explored literature on Indigenous health perspectives that inform healthcare reform and examined efforts to integrate Indigenous values into care. Studies published between 2019 and 2024 were screened, with 30 articles analyzed. Five themes emerged: decolonizing health systems, holistic care models, systemic barriers, Indigenous-led initiatives, and strengthening health system capacity to support meaningful inclusion.

Results: Across studies, Indigenous-led partnerships were associated with improved trust, stronger community relationships, and more responsive models of care. Key barriers included limited culturally informed dialogue, fragmented services, and insufficient access to Indigenous-centered care. The findings highlight that meaningful Indigenous engagement extends beyond consultation and requires shared leadership, culturally safe care environments, and the integration of Indigenous knowledge and healing practices.

Conclusions: This review highlights how Indigenous knowledge, leadership, and models of care can inform primary care transformation. The findings underscore the importance of moving beyond consultation toward partnership with Indigenous communities in design, delivery, and evaluation of healthcare services. By adopting holistic, culturally safe, and community-driven approaches, care organizations can strengthen patient attachment, improve equity, and build responsive systems that reflect diverse needs and values of the populations they serve.

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Exploring Psychosocial Factors Affecting Pain Management in Advanced Cancer Patients: Perspectives from Care Providers

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Background: Patients with advanced cancer frequently present to primary care with complex pain that remains undertreated despite available evidence-based pharmacologic interventions. In Ontario, primary care providers are central to the delivery of palliative care, yet limited research examines how health system structures and interdisciplinary coordination impact pain management in these settings. This study explored healthcare providers' perspectives on barriers to delivering effective pain management for patients with advanced cancer and the implications for integrated, team-based care.

Approach: This qualitative descriptive study examined provider experiences across Southwestern Ontario. Semi-structured interviews (N=11) were conducted with general practitioners, oncologists, specialists, and nurses. Audio-recorded transcripts were analyzed using Braun and Clarke's thematic analysis to identify patterns and themes across participant responses.

Results: Four major themes were identified: (1) complexities in pain management, including delayed access, discrepancies in patient-reported pain and prescription misuse concerns; (2) psychosocial dimensions of pain, where patient anxiety, grief, expectations and socioeconomic factors impact care; (3) provider-related challenges such as gaps in pain education, and a large emotional toll and (4) health system barriers including fragmented communication between primary and speciality care, time constraints, and lack of incentives.

Conclusions: Findings suggest that effective pain management in advanced cancer requires integrated, interdisciplinary approaches that combine pharmacological and psychosocial care. Strengthening primary-specialty communication, enhancing pain education in medical curricula, clarifying clinical roles, and improving access to community palliative resources are essential to improving care continuity and patient outcomes across Ontario.

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Identifying Gaps in Perinatal Care and Opportunities for Clinical Decision Support Tools Through Narrative Review

Thaneson Balachandran, Sruthy Balakumar, Emma Conway, Anna Chavlovski

Background: Family physicians in Ontario contribute to antenatal care for 26.9% of pregnancies through primary or shared care models (1). Pregnancy care involves several time-sensitive recommendations contingent on gestational age and clinical history. Clinical decision support (CDS) tools could improve timely perinatal care, particularly when recommendations are patient-specific, actionable, and integrated into clinical workflows. Literature reviews were conducted to identify care gaps and where CDS could support clinician decision-making across the perinatal and postpartum health journey.

Approach: Five targeted narrative literature reviews examined Canadian and international literature, clinical guidance, and BORN data. Findings were narratively synthesized around screening, counselling, informed consent, risk identification, treatment timing, adherence, equity, and implementation considerations relevant to clinician decision-making and care provision.

Results: Across conducted reviews, gaps identified included incomplete/delayed risk identification, inconsistent counselling, intervention adherence, and inequitable access, highlighting opportunities for CDS to synthesize information and prompt timely screening and preventative care. Additional considerations included clarifying screening options and informed choice through counselling. Postpartum diabetes review findings highlighted reminders/continuity of follow-up. Opportunities for CDS tools to support clinician judgement through guideline-concordant recommendations were identified.

Conclusion: Several perinatal care gaps can be addressed in primary care using CDS tools to bridge this gap. However, literature on CDS tool use in perinatal settings was scarce. Whether CDS can increase screening and utilization of preventative care to reduce negative pregnancy-related health outcomes should be examined in future studies. These findings support the BORN Ontario and CANImmunize initiative to develop a patient-centered insights application (CDS tool).

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Understanding Prenatal and Obstetric Care Pathways for Newcomers in Canada: A Scoping Review of Barriers and Facilitators

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Background: Newcomer women and gender-diverse birthing people in Canada, including immigrants, refugees, and asylum seekers, face barriers to prenatal and obstetrical care, intersecting with social identities such as gender, race, language, socioeconomic status, and culture. Despite Canada's growing newcomer population, evidence in this area remains fragmented.

Approach: We are conducting a scoping review and have searched seven databases (Embase, MEDLINE, CINAHL, PubMed, Scopus, PsycINFO, Web of Science) for English language peer-reviewed literature in Canada from 1946 to 2025, with reference list screening. Included studies capture newcomers, healthcare providers, and community workers describing barriers and/or facilitators to care access. An Advisory Council of the Kingston Immigration Partnership, Kingston Community Health Centres, and newcomer women are guiding the review.

Results: The search yielded 1,683 records. After removing 828 duplicates, 855 records were screened, 65 underwent full text review, and 30 met inclusion criteria. Preliminary results show barriers such as language and communication gaps, loss of extended family support, financial cost and insurance ineligibility among those with precarious status, and conflict between Western biomedical practices and traditional postpartum or gender related expectations. Facilitators include professional interpreters, culturally matched staff, partners taking on non-traditional caregiving roles, and community-based peer support programs. Data analysis is ongoing.

Conclusions: Findings will provide a Canadian synthesis of factors shaping newcomer access to maternity care, informing provider education and future research, and will inform a regional environmental scan and needs assessment in the Kingston, Frontenac, Lennox and Addington region.

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Essential Competencies for Social Work Practice in Primary Care Teams: Results of a Consensus Delphi Study

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Background: Interprofessional primary care teams continue to evolve and expand, with social workers serving as integral members of these collaborative care models. However, little is known about the specific competencies required for effective social work practice within interprofessional primary care settings. The purpose of this study was to identify the essential competencies for social workers practicing in interprofessional primary care teams and to provide greater clarity regarding their role and contributions within these settings.

Approach: A three-round Delphi study was undertaken with 15 Canadian experts, including social work practitioners, leaders, educators, and a patient partner. Information was gathered through a structured virtual consensus process consisting of idea generation, categorization and clustering, prioritization, and iterative refinement of competency statements.

Results: Two meta-competencies - i) anti-oppressive, anti-racist, and cultural humility; and ii) collaborative practice—were identified as foundational across all domains. Ten core competencies were established: counselling and psychotherapy; biopsychosocial assessment; advocacy; documentation; technology proficiency; iterative problem-solving; collaborative leadership; equity-informed ethical decision-making; continuing education, teaching, and supervision; and evidence-based practice, including program development and evaluation.

Conclusions: This study offers a consensus-driven competency framework to guide education, professional practice standards, and workforce planning, thereby strengthening the integration and contribution of social work within interprofessional primary care settings. rebecca.bliss@hamiltonfht.ca

Optimizing the Scope of Primary Care Nursing in Ontario

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Background: The scopes of practice of primary care nurses (PCN, i.e., nurse practitioners [NP], registered nurses [RN], and registered practical nurses (RPN]) overlap. We sought to understand how primary care nurses (PCNs) adapted and optimized their roles in teams with different combinations of PCN designations.

Approach: As part of a larger project studying PCNs in Newfoundland and Labrador, Ontario, Quebec, and Alberta, we conducted semi-structured interviews with PCNs to explore PCN roles and how the composition of the PCN team, as well as organizational factors affected scopes of practice. We present analysis of field notes and are currently developing a coding template.

Results: To date, we have conducted 25 interviews with 10 NPs, 8 RNs, and 7 RPNs working in Family Health Teams, Family Health Organizations, NP led-clinics, Community Health Centers, and other primary care organizations in Ontario. Preliminary analyses suggest that while NPs have a clearly defined scope of practice, RN and RPN roles overlap, and clinics actively encouraged RNs and RPNs to expand their respective scopes by facilitating education and enacting medical directives. PCN compensation (e.g. salary levels and parity with acute care nurses) influence recruitment and retention, and in turn, composition of teams and scope enactment.

Conclusions: Preliminary findings identify overlapping and distinct roles of PCNs and shed light on the role of PCN compensation on enacted scope of practice among PCNs in Ontario. While primary care reforms frequently focus on physician compensation or practice model. These early findings suggest policy makers must also consider PCN compensation. cbrearle@uwo.ca

The Ontario Community Health Profiles Partnership: Open Health Data Built around Ontario Communities

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Background: For over 25 years, the Ontario Community Health Profiles Partnership (OCHPP) has provided high-quality health and sociodemographic data at the neighbourhood, or small-area level, through a public website. These data and maps support equity-focused planning by helping users identify disparities, populations at risk, and opportunities to improve access to primary care and other health services. OCHPP includes 18 partner organizations and reports on 700 small-area geographies, covering nearly 11 million Ontarians (77% of the population). More than 100 additional areas are in development, representing another 1.3 million residents.

Approach: OCHPP aims to provide meaningful, reliable, small-area data on health outcomes and their determinants. We maintain a data pipeline for existing partners, such as Health Regions and Ontario Health Teams, and offer technical and knowledge support to guide small-area development across Ontario. These areas are designed to be small enough to provide a detailed picture of a wide range of health-related topics, while being sufficiently large to produce stable estimates and protect privacy.

Results: Our website receives more than 4,000 visits each month. Key knowledge users include Ontario Health (Toronto and Central regions), Toronto Public Health, Region of Peel, Ottawa Neighbourhood Study, INSPIRE-PHC, and Ontario Health Teams. Survey results show that OCHPP data and maps are regularly used in health reports, grant applications, service planning, research, and post-secondary education.

Conclusions: Through collaboration and free public access, OCHPP provides health and sociodemographic data in easy-to-use formats that support efforts to identify and address health inequities at the small-area level across Ontario.

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Out-of-Pocket Payments for Primary Care in Canada: Results from the 2025 OurCare National Survey

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Background: Medically-necessary physician services are fully covered under Medicare in Canada, however, nearly 6 million people do not have a regular source of primary care. It is unclear how many people in Canada are paying out-of-pocket for primary care services in the context of access challenges.

Approach: We analyzed data from the 2025 OurCare National Survey, a cross-sectional online survey of residents in Canada aged 18 and over, conducted in English, French and Inuktitut between July and November 2025. Participants were recruited through a proprietary panel and via broad promotion with stratified sampling by province and territory. Data were weighted to be demographically representative. We assessed the prevalence, amounts, and jurisdictional variation in out-of-pocket payments for primary care in Canada.

Results: We analyzed 16876 completed responses. Overall, 13.9% (95% CI 12.9%-14.9%) reported out-of-pocket payments. Among those with a primary care clinician, 14.5% (95% CI 13.4%-15.6%) paid out-of-pocket, most commonly for government forms (26.8%), insurance forms (26.2%), sick notes (20.5%) and prescription renewals (19.5%). Among those without a clinician, 11.3% (95% CI 9.1%-13.5%) paid out-of-pocket, most commonly for appointments or consultations (71.3%), prescription renewals (25.8%), and monthly/yearly clinic fees (13.2%). Among those without a clinician, and compared to the national sample, more respondents from Quebec paid out-of-pocket (19.6%). Among all respondents and compared to the national sample, more respondents from Quebec paid $300 or more in the last year (38.0%, 95% CI 28.9%-47.1% vs 18.4%, 95% CI 15.2%-21.6%).

Conclusions: Many people in Canada reported paying out-of-pocket for primary care. Those without a clinician most commonly paid for appointments or consultations, with this occurring more commonly in Quebec where amounts paid were higher than elsewhere in Canada.

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A closer look at penicillin allergy labels in Canadian primary care: A cross-sectional study

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Background: Penicillin allergy labels (PALs) affect 5–10% of the population, yet over 95% of labelled individuals are not truly allergic. PALs are associated with second-line antibiotic use and adverse outcomes, but their characterization in Canadian primary care is limited. We aimed to characterize patients with PALs and compare antibiotic prescribing, healthcare utilization, and health outcomes by PAL status.

Approach: We conducted a retrospective cross-sectional study using Canadian Primary Care Sentinel Surveillance Network electronic health record data. Patients with ≥1 primary care visit between July 1, 2020, and June 30, 2025, were included.

Results: Among 611,895 patients, 4.7% had a PAL. Compared with patients without PALs, those with PALs were more often female (65.2% vs. 53.2%), older (mean 52.0 vs. 44.1 years), and had greater multimorbidity (28.2% vs. 16.2% with ≥5 comorbidities) ($p<0.001$). PALs were associated with most evaluated comorbidities ($p<0.001$), including asthma (OR 1.89), COPD (OR 1.86), and mood disorders (OR 1.84). Patients with PALs received fewer penicillins (7.79% vs. 23.1%; OR 0.28) and cephalosporins (11.9% vs. 13.1%; OR 0.89), but more macrolides (OR 1.88), fluoroquinolones (OR 1.78), fosfomycin (OR 1.66), tetracyclines (OR 1.53), and clindamycin (OR 1.53) ($p<0.001$). After adjustment for age, sex, location, and multimorbidity, PALs remained associated with greater primary care utilization, more frequent antibiotic prescribing, and documented C. difficile infection ($p<0.001$).

Conclusions: PALs are common in Canadian primary care and associated with different antibiotic prescribing, greater healthcare utilization, and adverse outcomes. Further research on penicillin allergy delabeling in primary care would be valuable. 18JHE1@queensu.ca

Interventions Promoting Access to Primary Care Among Equity-Deserving Groups: A Scoping Review

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Background: Despite decades of evidence linking primary care to health and systems-level outcomes, millions of people have difficulty accessing primary care worldwide. This is particularly apparent among equity-deserving groups (e.g., immigrants, racialized groups, etc.) demonstrating persistent and worsening disparities. This review provides a timely mapping of the types of interventions that improve access to primary care among equity-deserving groups in high-income countries.

Approach: This scoping review includes qualitative, quantitative, multi-methods, and mixed-methods evidence. Six major databases were searched to identify studies published from January 2000 to November 2025. Two reviewers performed screening and data extraction. Results were analyzed via deductive qualitative content analysis to categorize existing interventions by type.

Results: 49 studies were included in this review. Studies were mainly conducted in the United States (n=27, 55.1%) and Canada (n=11, 22.4%). Most studies were published between 2020-2025 (n=27, 55.1%) or 2010-2019 (n=16, 32.7%). Observational (n=18, 36.7%), mixed-methods (n=9, 18.4%), and quasi-experimental (n=9, 18.4%) studies were most common. A range of populations were targeted, from specific equity-deserving groups to broader populations. Interventions were categorized as: Navigation and information (n=7), Intersectoral and organizational care pathways (n=12), Tailored and adapted services (n=15), Outreach of primary care services (n=5), Virtual care (n=3), or Defraying costs to patients (n=7).

Conclusions: A variety of interventions demonstrating improved access to primary care already exist in the literature. Decision-makers interested in improving health equity are encouraged to conduct local needs/asset assessments. Efforts to examine the long-term impacts and sustainability of interventions are warranted.
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Health Promotion Programs in Ontario Community Health Centres: Impacts on health outcomes and primary health care utilization

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Background: Community Health Centres (CHCs) deliver health promotion programming as part of their approach as comprehensive primary health care organizations to prevent and manage chronic disease (CD). Interim findings of this evaluation of health promotion programs at CHCs in Ontario found increased participant confidence, social connection, and self-rated quality of life.

Approach: This evaluation project was co-designed with CHC staff and client advisors and included time-limited programs aimed at improving CD knowledge and self-management skills. Participants completed pre- and post-program surveys and an optional semi-structured interview. Results were analyzed as a whole and stratified by program and participant characteristics.

Results: 28 programs across 17 CHCs were included in this evaluation. To date, 175 participants completed pre- and post-program surveys, and 65 completed the 6-month post-program survey. Results included increased confidence in CD self-management (58.7%), social support (40.6%), and overall health score (52%). The greatest improvements in the EQ-5D Quality of Life Questionnaire were in anxiety/depression (43%) and pain/discomfort (38.9%). At 6 months post-program, 89.2% reported continued use of skills/techniques and 27.7% reported fewer CD-related primary care visits. Additionally, clients who previously reported difficulty paying for basic needs, reported accessing more services at the CHC (63.2%) compared to clients without (46.3%).

Conclusions: This evaluation provides support for the impact of health promotion programs on improving health outcomes and decreasing primary health care utilization within Ontario CHCs. Next steps include working with client and staff advisory groups to validate the findings and finalize the evaluation methods as a standardized tool across centres.

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Administrative form completion in primary care: Opportunities for team-based care

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Background: Administrative burden in primary care contributes to physician burnout. Form completion is a major component of this burden, and many forms could be completed by other members of an interprofessional team. This study identified the most common administrative forms completed in primary care and the professionals who complete them.

Approach: Retrospective descriptive study: data were extracted from electronic medical records within the Queen's Family Medicine Restricted Data Environment (QFAMR), including de-identified electronic medical record data from a single academic primary care team in Eastern Ontario. Free-text descriptions of clinical and administrative activities were analyzed using regular expression searches and billing-linked frequency counts to identify administrative forms and the professionals completing them. A manual review determined which professionals were eligible to complete the most common forms.

Results: A total of 1,818 administrative forms were completed. The five most common forms, related to insurance and benefit eligibility, accounted for 90.6% of forms: Health Status Report & Daily Living Index (n=633), Mandatory Special Needs Benefit (n=631), Limitation to Participation (n=175), Completion of Medical Form Part A (n=144), and Completion of Medical Form Part B (n=65). Physicians completed 1,646 of the 1,648 top five forms; nurse practitioners completed two. All five forms could be completed by at least three other interprofessional team members.

Conclusions: The most common administrative forms were almost exclusively completed by physicians, despite being within the scope of multiple health professionals. More effective use of interprofessional teams for form completion could increase primary care capacity and improve patient access.

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Bringing the Patient Voice into Medication Care: Perspectives on Implementing a Patient-Reported Experience Measure

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Background: Patient-reported experience measures for medications (PREM-Rx) could provide a standardized approach to support medication safety and person-centred care. However, little is known about how patients, prescribers, and health system decision-makers perceive the implementation of PREM-Rx in routine clinical practice. This study aimed to examine perspectives on factors that may influence the implementation of a PREM-Rx in routine clinical practice and identify preferences for its format and delivery.

Approach: This was a theory-informed, cross-sectional survey study guided by the Theoretical Domains Framework. Participants included 200 medication prescribers and health system decision-makers and 197 persons with lived experience (PWLE) of taking medications in Ontario, Canada. The electronic survey was self-administered, and data were analyzed descriptively.

Results: Familiarity with PREM-Rx differed between participant groups, with prescribers and decision-makers reporting greater familiarity than PWLE. A minority of PWLE (n=34, 17.3%) reported previously completing a PREM-Rx, and few prescribers and decision-makers (n=20, 10.0%) reported routinely using one in clinical practice. Prescribers and decision-makers identified insufficient funding, staffing, and technology as potential barriers to implementation. Participants preferred a PREM-Rx that would take less than 10 minutes to complete and include both open- and closed-ended questions. Primary care clinics and community pharmacies were identified as preferred settings for future implementation.

Conclusions: Participants perceived potential benefits of using a PREM-Rx to support medication management, safety, and person-centred care but identified several barriers that would affect its implementation. These findings identify key considerations for the future development and implementation of a PREM-Rx in routine clinical practice.

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Improving Social Needs Screening for Hard-to-Reach Patients

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Background: Social needs screening is increasingly used in primary care to identify unmet needs and guide supportive interventions, yet patients experiencing socioeconomic and structural barriers may be least likely to complete screening through standard approaches. This randomized controlled trial evaluated whether proactive outreach from a Community Health Surveyor (CHS) improved demographic and social needs screening completion among hard-to-reach patients in an academic family health team in Toronto, Ontario.

Approach: Adults who had not previously completed the screening tool and met hard-to-reach criteria were identified using electronic medical records. Criteria included residence in lower-income areas or no fixed address, plus at least one additional vulnerability indicator such as no email on file, income-support-related billing codes, or priority population tagging. In total, 757 eligible patients were randomized to usual care or intervention. Usual care included invitations to complete the tool via email, in person, or with a virtual surveyor. The intervention added proactive CHS outreach to support survey completion in addition to usual care methods. The primary outcome was screening completion; secondary analyses examined equity-relevant subgroups.

Results: 387 were assigned to the intervention and 370 to usual care. Screening completion was markedly higher with CHS outreach than usual care (93/387, 24.0% vs. 2/370, 0.5%; $p<0.05$). All completed surveys in the intervention arm were facilitated by CHS support. Reported needs included financial challenges (21/387, 5.4%) and disability or accommodation needs (56/387, 14.5%).

Conclusions: A dedicated CHS significantly improves the completion of social needs screening among hard-to-reach patients. Proactive, supported screening may strengthen equitable identification of unmet needs and can be integrated into primary care workflows.

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Impact of Virtual Billing Codes on Distance to Primary Care, Healthcare Utilization and Outcomes in Ontario

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Background: Access to primary care in Ontario is declining, and distance between patients and family physicians remains an important barrier to timely, continuous care. Virtual care billing codes, introduced in March 2020 and revised in November 2022, may have enabled patients to remain attached to physicians despite geographic separation. This study examines whether patient–physician distance changed after implementation of virtual billing codes and how these changes relate to primary care use and outcomes.

Approach: We will conduct an annual repeated cross-sectional analysis of approximately 10 million Ontarians rostered to family physicians in Patient Enrolment Models from April 1, 2015, to March 31, 2025. We will link patient and physician postal codes using ICES datasets, including the Primary Care Population Dataset, Registered Persons Database, and Corporate Provider Database. We will categorize straight-line patient–physician distance as ≤10 km, 11–30 km, 31–50 km, 51–100 km, 101–150 km, 151–200 km, and >200 km.

Results: Analyses will compare patterns before and after implementing virtual billing codes. We will examine patient and geographic characteristics, including age, sex, postal code–based neighbourhood income quintile, and newcomer status in Ontario. We will also assess healthcare utilization, including the number and type of core primary care visits, in-person versus virtual care, continuity of care, emergency department visits, and breast, colorectal, and cervical cancer screening. Results will be stratified by year, sex, and Rurality Index of Ontario category: major urban (RIO 0), urban (RIO 1–9), small town (RIO 10–39), and rural (RIO 40+).

Conclusions: Findings will clarify whether virtual billing codes helped sustain primary care attachment despite increasing geographic separation and whether virtual care mitigated or widened access inequities. Results will inform Ontario policy discussions on virtual billing and geographic attachment.

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Establishing Benchmark Values for Team Functioning and Co-Management in Primary Care

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Background: Interprofessional primary care teams create opportunities for shared responsibility of patient care; however, interpreting team functioning and co-management scores is challenging since validated instruments are scored and reported inconsistently across studies. We aim to establish benchmarks for the Team Climate Inventory (TCI) and the Provider Co-Management Index (PCMI) using the Primary Care Diabetes Support Program (PCDSP), a team-based program supporting high-risk populations, as an ideal case (based on interview data) for comparison and a reference for studies using these instruments.

Approach: We conducted a cross-sectional, online survey of PCDSP staff using the 14-item TCI and the 20-item PCMI. We described the sample and calculated total and mean scores and standard deviations for each scale and subscale. We also identified primary care studies using the 14-item TCI and the 20-item PCMI through PubMed and Google Scholar searches. Since TCI reporting methods and scale lengths varied across studies, we are standardizing eligible scores by converting them to a common 5-point scale and using proportion of maximum scaling (POMS).

Results: Preliminary literature extraction demonstrates heterogeneity in TCI scoring and reporting, including the use of 5- and 7-point response subscales and the reporting of both mean and total scores. Standardization using 5-point conversion and POMS is ongoing to facilitate comparisons between PCDSP and published primary care settings.

Conclusions: This study will provide standardized comparisons between PCDSP and other published primary care settings, supporting interpretation of TCI and PCMI scores and establishing meaningful reference values for team functioning and co-management.

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Heat Smart: Empowering Primary Care Providers to Safeguard Vulnerable Populations Against Extreme Heat – mid-study results

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Background: Extreme heat poses a significant health threat in Canada, as demonstrated by the 2021 heat wave that claimed over 600 lives in Western Canada. Most heat-related deaths occur indoors and are preventable. Family physicians and nurse practitioners (FP/NPs), who serve 88% of Canadians, are uniquely positioned to identify and support at-risk individuals.

Approach: A cluster randomized controlled trial in primary care practices to assess the effectiveness of tailored digital messages delivered by FP/NPs in increasing patient awareness, preparedness, and adaptive response to heat waves. Consenting patients completed an intake survey to assess sociodemographic and clinical factors associated with heat vulnerability, level of heat wave concern, and whether the patient has previously prepared for a heat wave. Outcome surveys are sent following each heat wave to assess preparedness, adaptation behaviours, awareness of the heat event and heat-health risks, social isolation, support of at-risk individuals, and burdens associated with the heat wave. (ClinicalTrials.gov: NCT07024628)

Results: As of August 2026, 110 FP/NPs in Eastern Ontario have been recruited. Active patients over 18 years were contacted by email or SMS. 14274 patients have consented to participate thus far (response rate 16%). This poster describes the sample population and presents preliminary results from longitudinal survey data.

Conclusions: The project aligns with Canada's National Adaptation Strategy and the Patient's Medical Home model of primary care, by supporting a pro-active, community oriented, population health approach to extreme heat preparedness, leveraging primary care as a trusted source of information to motivate behaviour change and reduce heat-related illness and death. whogg@uottawa.ca

Refugee Patient Navigator Roles, Supports, and Outcomes in OECD Countries: A Scoping Review Protocol

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Background: Refugees face persistent barriers to healthcare following resettlement, including language, unfamiliarity with healthcare systems, and transportation challenges. Patient navigators may mitigate these barriers through care coordination and communication support. However, variations in navigator roles, training, and implementation models limit understanding of how patient navigation programs can effectively address refugees' needs. This review asks: How are refugee patient navigation programs structured and implemented across OECD healthcare settings, and what roles, patient needs, and patient-, provider-, and system-level outcomes are reported?

Approach: Joanna Briggs Institute (JBI) methodology and the Preferred Reporting Items for Systematic Review and Meta-Analysis for Scoping Review (PRISMA-ScR) were used. MEDLINE, Embase, CINAHL, PsycINFO, Sociological Abstracts, Web of Science, Scopus, and grey literature were searched. Eligible studies examined refugee patient navigation roles, implementation, and/or outcomes within healthcare settings in Organization for Economic Co-operation and Development (OECD) countries. Two reviewers independently screened and extracted data. Qualitative findings will undergo thematic synthesis and quantitative findings descriptive synthesis.

Results: A total of 1,030 articles were screened in title and abstract with 75 articles moving on to full text review. Data synthesis is ongoing and will characterize refugee patient navigation across OECD healthcare settings, including navigator roles and responsibilities, training and professional backgrounds, healthcare and social needs addressed, implementation barriers and facilitators, and reported patient-, provider-, and system-level outcomes.

Conclusions: This review will clarify how refugee patient navigation is operationalized across OECD countries, identify gaps in literature, and highlight the relevance of the navigator role in addressing refugees' healthcare access and care coordination needs. Findings may inform the development and implementation of patient navigation models across refugee-serving healthcare settings.

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Community Paramedicine at Clinic (CP@clinic) supporting smoking cessation in social housing: A pilot study in Sault Ste. Marie, Ontario

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Background: Compared with the general population, smoking is more common among older adults living in social housing, with a prevalence of 30.8%. CP@clinic is a health prevention and promotion program delivered in social housing buildings. In a pilot study, the program was adapted to support residents interested in quitting smoking. This study aims to describe the implementation and outcomes of the CP@clinic smoking cessation program at 12-month follow-up.

Approach: For 12 months, community paramedics provided health education, quit kits, quit buddies, and access to free nicotine replacement therapy (NRT). Data were collected at baseline, 6, and 12 months in the CP@clinic smoking cessation database. Descriptive statistics were used to characterize participant demographics, smoking status, and perceived supports. Changes in smoking behaviour, shortness of breath and building culture around smoking were also assessed.

Results: Among 137 CP@clinic attendees screened for smoking status at baseline, 17.5% (n=24) were current smokers and 40.1% (n=55) were former smokers. Among current smokers, 75.0% reported interest in quitting. At 12 months, 14 participants had a documented quit date, 7 started NRT and 13 had a quit buddy. Since their first visit, 72.7% of participants reported improved shortness of breath, while 30.2% agreed that they saw fewer people smoking around their building and 60.5% reported no changes.

Conclusions: The CP@clinic adaptation can facilitate smoking cessation for social housing residents and improve health outcomes and quality of life with the provision of appropriate supports. itekaa@mcmaster.ca

Assessing the capacity of practice-based research and learning networks (PBRLNs) in Canada: learnings to guide collaboration and shared capacity-building

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Background: Practice-based research and learning networks (PBRLNs) build research and learning infrastructure in primary care. Little is known about Canada's PBRLNs' capacity to participate in or carry out research or learn from each other. The objective of this work was to assess the research and learning capacity of Canada's PBRLNs.

Approach: PBRLNs were identified through primary care research leaders. Each PBRLN was asked to complete a survey about structure, resources and functions to engage in research and learning. Likert scale questions about the PBRLNs' scientific expertise and data and technology capacity were summarized using descriptive statistics. Answers to open-ended questions were coded using NVIVO 15. We used the Institute for Better Health's LHS Action Framework for thematic analyses.

Results: We identified 20 PBRLNs. All provinces had PBRLNs; Ontario (n=7) and Quebec (N=4) having several geographically situated PBRLNs. Scientific expertise varied; some had more resources and established infrastructure to engage in research. PBRLNs had lower capacity in leading whole PBRLN quality improvement initiatives (>5 practices) and having multiple practices participate in clinical trials. Capacity also varied in data collection and use of technology. Almost half of PBRLNs had medium-high capacity for electronic medical record data extraction (n=9/20) and over half had medium-high capacity to implement qualitative studies and collect practice characteristic data (n=12/20). The top challenges for PBRLNs were: 1) competing clinical priorities in practices; 2) clinician engagement and protected time; and 3) funding and financial sustainability.

Conclusions: The number, geographic span and capacity of Canadian PBRLNs is growing. thomas.iverson@ubc.ca

From crafting to evaluating patient education materials: testing AI for primary care – the AI-CARE Study

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Background: Primary care providers (PCPs), already overwhelmed by clinical and administrative duties, face the growing challenge of delivering timely, accurate, and safe health promotion information to patients amid rising misinformation. Generative Artificial Intelligence (GenAI) can assist PCPs in producing patient education materials, but its output must be rigorously evaluated for safety, accuracy, and clinical acceptability before adoption.

Approach: We conducted the AI-CARE study, a bilingual (English and French), double-blind randomized controlled trial. A total of 192 digital health messages on 48 primary care topics were generated in parallel by human experts and a GenAI tool (ChatGPT) in short and long formats. Two blinded review panels of PCPs and patients evaluated the messages using a grid assessing accuracy, clarity, adaptability, relevance and usefulness. Building on the AI-CARE study, we developed a GenAI automated reviewer to screen long-form digital health messages for patient-readiness and compared its evaluations with those of a multidisciplinary expert committee.

Results: Data collection of the AI-CARE study is complete, with 50 participants enrolled between May 2025 and April 2026 (25 PCPs and 25 patients). Data analysis using linear mixed-effects models to evaluate the noninferiority of AI- versus human-generated digital health messages is ongoing. Concurrently, data collection evaluating GenAI's performance as a reviewer is also ongoing.

Conclusions: AI-CARE evaluates AI-generated digital health messages from patient and provider perspectives and explores GenAI as an automated reviewer. This work will provide insight into GenAI's potential to support the development, assessment, and updating of digital health messages in primary care.

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Smoking cessation in people with severe mental illness; A retrospective chart review

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Background: The decline of smoking rates is uneven across populations. People with severe mental illness (SMI), which includes schizophrenia and bipolar disorder, maintain five- to six-fold higher prevalence of smoking, increased progression to daily smoking, and lower smoking cessation (SC) rates than the general population. Although current SC treatments are safe and effective for people with SMI, cessation outcomes remain poorer, potentially due to limited pharmacotherapy access, cost, and underuse of harm reduction (HR) with e-cigarettes. We aimed to assess SC outcomes to inform tailored clinical approaches for patients with SMI.

Approach: We conducted a retrospective chart review of patients with SMI who had attended an outpatient SC treatment program at the Centre for Addiction and Mental Health. Demographic and treatment characteristics, clinic visits, and abstinence and relapse outcomes across 12 months were collected.

Results: Among 177 patients, mean cigarette use was 18.6 ± 14.4 cigarettes/day and mean number of clinic visits was 4.39 ± 3.21. Nicotine replacement therapy was prescribed to 81.4% of patients, while 13.6% received varenicline and 1.7% received bupropion. E-cigarettes were recommended for HR in 12.4% of patients. Overall, 35% of patients achieved abstinence, with 56.5% relapsing after initially quitting.

Conclusions: One-third of patients achieved short-term abstinence, but relapse is common. Extended SC treatment combining pharmacotherapy and counselling may improve outcomes. For the majority of patients who are unable to quit with standard treatment, e-cigarettes should be considered as an HR tool. Primary care providers may benefit from education on e-cigarettes as HR in this population.

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Neighbourhood primary care attachment and mental health and addiction health care burden in Ottawa: health equity implications

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Background: Having a regular primary care provider supports mental health and addiction (MHA) care and may reduce reliance on emergency departments (ED). How this relationship varies by socioeconomic context is poorly described at the neighbourhood level, though such evidence is needed for equity-focused planning. We examined the association between primary care (PC) unattachment and MHA-related ED visit rates in Ottawa, and whether it varies by socioeconomic disadvantage.

Approach: Cross-sectional ecological study of 108 Ottawa neighbourhoods. Ottawa Neighbourhood Study neighbourhoods were linked to Health System Performance Network PC attachment data, ICES administrative outcomes via the Ontario Community Health Profiles Partnership, and census-derived socioeconomic (SES) factor scores. The exposure was neighbourhood PC unattachment rate; outcomes were overall and MHA-related ED visits per 1,000 residents. Analyses included Pearson correlations, ordinary least squares regression, and SES quintile-stratified models.

Results: PC unattachment ranged from 10% to 38% and was highest in the most disadvantaged quintile (Q5, mean 29%) versus the most advantaged (Q1, mean 16%). Unattachment was strongly positively associated with MHA-related ED visits, explaining 44% of variation ($R2=0.44$, $p<0.001$). SES disadvantage explained no additional variation once unattachment was accounted for ($F(1,99)=0.29$, $p=0.59$, $\Delta R2=0.002$). The association was weak in the least disadvantaged quintile (Q1: $R2=0.07$, $p=0.28$) but strong in the most disadvantaged (Q4: $R2=0.45$; Q5: $R2=0.35$; $p<0.01$).

Conclusions: PC unattachment is strongly and independently associated with MHA-related ED burden, concentrated in the most socioeconomically disadvantaged neighbourhoods. Findings support place-based attachment initiatives targeting these communities as an equity-focused strategy to reduce acute MHA-related ED use.

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Exploring Patient-Reported Outcome Measures from Individuals Receiving Care by Nurse Practitioners and Family Physicians in Canada

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Background: Canada has a human health resource shortage and primary care access crisis. Due to rising demand, family physicians (FPs) are facing heavier workloads. Nurse Practitioners (NPs) can help improve access to care and reduce the workload on FPs. This study explores differences in patient-reported outcomes (PROMS) and chronic conditions among patients cared for by NPs and those cared for by FPs.

Approach: A secondary analysis of the PaRIS OECD survey examined patients' self-reported general, mental, and physical health, quality of life, number and type of chronic conditions, and medications. Descriptive (frequency(%), proportions) and inferential statistics (Bivariate analyses, Chi-square, independent sample t-test, ordinal logistic regression models) assessed differences in PROMS between patients cared for by an NP and FP.

Results: 2,941 (86.5%) participants were cared for by FPs and 212 (6.2%) were cared for by NPs. Participants cared for by FPs and NPs reported similar positive views of their overall health, with no statistically significant differences in patient reported outcomes between groups. FPs and NPs cared for participants with multimorbidity (≥2 comorbidities) (FP: 1,743 [59.8%] vs NP: 112 [53.1%]); $p = 0.089$), with participants taking an average of 3-4 medications (FP: 728 [29.9%] vs. NP: 63 [36.4%], $p = 0.073$).

Conclusion: Patients cared for by NPs have similar health status and PROMS to those managed by FPs. These findings underscore the important role of NPs in chronic disease management in primary care and support FP collaboration and expansion of the NP role to enhance access to care and strengthen the primary care workforce.

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Understanding patient perspectives on HPV self-collection cervical cancer screening in primary care: A qualitative study

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Background: As Canadian cervical cancer screening programs transition to HPV testing, HPV self-collection is becoming an increasingly feasible option. While under-screened populations have demonstrated a strong preference for self-collection, less is known about patients attached to primary care. This qualitative study, informed by the Theoretical Framework of Acceptability, explored their perspectives on HPV self-collection.

Methods: One-on-one semi-structured interviews were conducted with patients who completed HPV self-collection through a quality improvement project at a family medicine clinic. Interviews were audio-recorded, transcribed, de-identified, and analyzed using template analysis. Two reviewers independently coded transcripts and refined the coding framework, with all authors reaching consensus on the themes.

Results: Ten patients participated. Median age was 49 (IQR 38–59); 90% were Caucasian, 90% urban, 90% employed or retired (78% in professional occupations), and 70% typically up to date with screening. Five themes emerged: (1) clinician-collected screening was physically and emotionally uncomfortable; (2) HPV self-collection was quick, easy, and more comfortable; (3) awareness of HPV self-collection was limited; (4) participants were open to trying self-collection because of its convenience and privacy; and (5) some participants questioned their ability to collect an accurate sample.

Conclusion: HPV self-collection was highly acceptable among primary care patients, supporting its integration into routine screening. Efforts to promote uptake should focus on increasing awareness and confidence in the accuracy of self-collected samples. roni.kraut@queensu.ca

Making Sense of Policy: Impact of Interim Federal Health Program Changes on Access to Care for Refugees and Asylum Seekers in Canada

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Background: The Interim Federal Health Program (IFHP) provides temporary healthcare coverage for refugees and asylum seekers in Canada. On May 1, 2026, the federal government introduced co-payments for prescription medications and supplemental health services, including dental, vision, mental health, home care, and assistive devices. Subsequent policy adjustments restored full coverage for select services. This study aims to examine the impact of these policy changes on healthcare access among refugees and asylum seekers covered by the IFHP.

Approach: We are conducting a pan-Canadian, multi-site cross-sectional mixed-methods study in partnership with healthcare providers and settlement organizations. Trained interviewers will recruit participants through settlement and community organizations. Using Sprockler sensemaking software, participants will provide narratives describing their healthcare experiences and interpret their own experiences through predefined quantitative questions. Data collection will occur in multiple languages. Quantitative responses will be analyzed using descriptive statistics, alongside thematic analysis of participant narratives.

Results: Data collection is currently in progress across six Canadian provinces, with recruitment of partner sites ongoing in two additional provinces. Analysis will examine experiences accessing healthcare following the 2026 IFHP policy changes, including barriers to prescription medications and supplemental health services. Quantitative patterns will be examined alongside participants' narratives to characterize experiences of healthcare access following these changes.

Conclusions: This study will provide evidence on the impact of recent IFHP policy changes on healthcare access among refugees and asylum seekers in Canada. Findings will identify barriers to care and inform future IFHP policy and advocacy related to refugee healthcare access.

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Health 8-1-1 as a Digital Front Door for Canada's Healthcare Systems

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Background: Healthcare systems are working towards creating easily accessible virtual care platforms for those with and without a regular primary care provider. Within the last 5 years, there has been an evolution of concepts to describe a comprehensive virtual access point for patients seeking care, namely, a "digital front door" (DFD). There is currently no consensus on what defines and constitutes a comprehensive DFD. An example of a DFD is Health 8-1-1, a 24/7 non-urgent care digital health service for Canadians to access the care they need.

Approach: Our objectives were 1) To develop a preliminary DFD framework, and 2) To present a DFD definition within the context of health and healthcare. We conducted a series of surveys and a rapid review of scholarly and grey literature. Survey respondents included 11 representatives from the Canadian Network for Collaboration, Exchange, and Continuous Transformation in Health 8-1-1.

Results: The preliminary DFD framework is composed of five domains: equity and access, navigation, connecting to care, patient-actioned services, and interoperability. The DFD definition covers concepts of what a DFD is (i.e., timely access to care, available to anyone, can be inclusive of multiple health issues) versus what a DFD is not (i.e., not a place to directly receive immediate care, not restricted by organizational boundaries, not meant to restrict alternate care options).

Conclusions: This work outlines the components needed to evolve Health 8-1-1 and other digital health solutions into a comprehensive, robust DFD to meaningfully support patient journeys and health system performance.

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PASSERELLE SPOR National Training Entity: Supporting and promoting capacity building efforts in patient-oriented research

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Background: Patient-oriented research (POR) brings together lived, clinical, research, and policy expertise to address questions that matter in primary care and improve the relevance and impact of health research. Building capacity to work collaboratively across these perspectives is essential as POR becomes increasingly integrated into health and primary care research. PASSERELLE, the Strategy for Patient-Oriented Research (SPOR) National Training Entity, was established to strengthen POR capacity across Canada.

Approach: PASSERELLE uses a collaborative, needs-informed approach to capacity building. Insights from diverse communities, including those from across the SPOR ecosystem, such as the Ontario SPOR SUPPORT Unit, inform the co-design and development of tools, resources, training, and other learning opportunities. PASSERELLE connects these offerings through tailored learning pathways, mentorship, networking, and other supports. This iterative approach responds to diverse contexts and evolving capacity-building needs in POR and primary care research.

Results: PASSERELLE has built a bilingual, national learning ecosystem that responds to identified capacity-building needs across patient-oriented research. This includes a centralized collection of 200+ learning resources, tailored learning pathways, training opportunities, mentorship and networking, and targeted support for learners and teams. PASSERELLE has expanded experiential learning through its Fellowship program and strengthened connections across the POR community. Together, these activities support knowledge exchange and practice across diverse settings, including primary care.

Conclusion: Sustained POR capacity requires infrastructure that connects people, knowledge, resources, and opportunities for learning. PASSERELLE provides this infrastructure nationally. annie.leblanc@fmed.ulaval.ca

Bridging Gaps: Implementing Mobile Primary Care for People Experiencing Homelessness

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Background: People experiencing homelessness face persistent barriers to primary care, including transportation, fragmented services, and stigma. Mobile primary care clinics aim to improve access by delivering care directly in the community, but there is limited known about how these models are successfully implemented.

Approach: Guided by the Consolidated Framework for Implementation Research (CFIR), we conducted semi-structured interviews with seven staff members involved in planning and delivery of the mobile primary care clinic in Halton Region, Ontario. Interviews were analyzed using deductive thematic analysis guided by CFIR.

Results: Implementation was influenced by factors operating at the health system, organizational, care team, and intervention levels. Participants highlighted operational challenges of delivering safe care in community settings, including workforce constraints, transportation issues, and coordination across fragmented services. Success depended on continuous adaptation, with teams refining clinic locations and workflows based on community needs. The mobile model was viewed as a clear advantage over traditional primary care because it reduced barriers, provided flexible, client-centred care, and improved engagement with people who often struggle to access conventional services. Strong community partnerships, experienced staff, and shared organizational values further supported implementation despite funding uncertainty and system-level pressures.

Conclusions: Implementing mobile primary care requires more than a mobile clinic; it requires adaptable teams, trusted community partnerships, sustained funding, and systems that supports flexible, equitable care. These findings offer practical implementation lessons that can help other communities design, adapt, and sustain mobile primary care services for people experiencing homelessness.

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Improving Access to Urgent Diagnostic Imaging Through SCOPE Middlesex London: A Primary Care Pathway to Reduce Emergency Department Utilization

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Background: Seamless Care Optimizing the Patient Experience (SCOPE) Middlesex London launched an Urgent Diagnostic Imaging (DI) Pathway in June 2024 to provide primary care providers with access to urgent outpatient imaging. The pathway aims to reduce emergency department (ED) visits for patients who require timely imaging but not emergency care.

Approach: We evaluated SCOPE utilization from July 1, 2025 to June 30, 2026. Call volumes, reasons for contact, anticipated ED utilization, and ED outcomes following imaging were examined using program tracking data.

Results: During this period, SCOPE received 546 calls, including 453 (83%) related to diagnostic imaging and 93 (17%) for system navigation.

Based on outcomes documented following the initial SCOPE call, 387 ED visits were avoided, representing 71% of calls. Among 364 patients for whom imaging appointments were facilitated and post-imaging outcomes were available, 332 (91.2%) avoided an ED visit. Ten patients (2.7%) were directed to the ED for treatment following imaging, while 8 (2.2%) had uncertain outcomes. Only 14 (3.8%) patients presented to the ED within a week of the call.

Conclusions: Findings suggest that access to urgent diagnostic imaging through SCOPE can reduce ED utilization while ensuring patients requiring emergency treatment are appropriately directed to the ED. By shifting appropriate care to outpatient settings, pathways such as this can improve timeliness of care, reduce healthcare costs, and improve use of limited acute-care resources. These findings support continued investment in programs that strengthen direct access to urgent diagnostic services for primary care.

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Exploring the Scope of Indigenous Patient Navigation: A Scoping Review Mapping Cultural Frameworks, Implementation, and Outcomes

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Background: Indigenous Peoples in Canada experience substantial health inequities, with ongoing anti-Indigenous racism in healthcare contributing to inequitable access and outcomes. Indigenous Patient Navigators (IPNs) have been increasingly implemented to improve access to culturally safer care for Indigenous patients across healthcare settings. IPNs are a promising intervention for Indigenous patients since IPNs can provide culturally relevant advocacy, support and health system navigation. The objective of this research is to map the scope of IPN roles, cultural frameworks, implementation strategies, and impacts on patients, providers, and health care systems in Canada, the United States, Australia, and New Zealand across all healthcare settings[EP1.1][AM1.2].

Approach: The scoping review follows Joanna Briggs Institute (JBI) methodology and is guided by the Preferred Reporting Items for Systematic Review and Meta-Analysis for Scoping Review (PRISMA-ScR) checklist. Included academic articles were published up to November 2025 and included at least one of the following: (1) IPN implementation strategies and/or cultural frameworks, (2) outcomes at patient, provider, or system level, and (3) barriers and enablers to IPN implementation. Databases searched included MEDLINE, EMBASE, and EBSCOhost.

Results: The search yielded 1,536 articles for title/abstract screening, of which 171 underwent full-text screening, and 50 met the eligibility criteria. Data have been extracted from eligible articles and are currently being analyzed using descriptive statistics and thematic analysis to identify key findings related to IPN interventions.

Conclusion: Findings will support future IPN program design, policy development, and research that centres Indigenous self-determination in health care.

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Rating and ranking identified pandemic supports for primary care: Results from primary care providers and public health leads

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Background: Primary care providers (PCPs; i.e., family physicians; nurse practitioners; registered nurses; registered practical nurses) play critical roles in pandemic response. However, prior to the COVID-19 pandemic, response plans did not include concrete steps to develop and implement plans for primary care (PC).

Approach: We conducted a scoping review to identify key elements of pandemic response plans for PCPs in Canada and comparable countries. PC knowledge users (KUs) in London-Middlesex Ontario completed 3 rounds of an online priority setting exercise to rate and rank the importance of identified PC supports. We also surveyed public health (PH) leaders across Ontario and asked them to rank PC pandemic supports.

Results: The scoping review identified 58 pandemic supports for PCPs, grouped in 13 categories. The final ranking included 44 individual supports that met the cutoff criteria. The highest ranked category (1=most important) for both PC KUs and PH was General health system supports and resources (mean=3.9, 3.3 respectively); the second highest ranked was Limiting the risk of spreading infection (mean=4.4) for PC KUs; and Involving PCPs in preparedness planning and response decision making (mean=4.3) for PH. Within the General health system supports and resources, the top ranked individual support for PC KUs was Expanding integrated networks of PC, hospital, and other healthcare providers, while PH chose Increasing the overall number of PCPs and medical office assistants trained.

Conclusion: Using a priority setting exercise, we identified the most important pandemic supports for PCPs. Notably, virtual care was not among the high priorities.

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Exploring Explanatory Models among the Indigenous Zulu People to Improve Access to Primary Mental Health Care: A Community-Based Forum Theatre Study to Inform Equitable Health Systems

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Background: A substantial global mental health treatment gap persists, particularly in low-resource settings where nearly 70% of affected individuals do not receive needed care due to, underfunding, inequitable resource distribution, affordability barriers, language differences, and culturally misaligned services. While an integrated Indigenous and Western approach may improve engagement and outcomes, effective implementation requires detailed awareness of Indigenous epistemologies and knowledge systems. In many African contexts, mental health is understood through interconnected spiritual, relational, and cosmological frameworks that are often lacking in biomedical models of care. Grounded in Ubuntu, African cosmology, and decolonial theory, this study centres Indigenous Zulu understandings of distress, healing, and well-being to inform collaborative and culturally responsive community mental health system design.

Objectives: To (1) Explore community perceptions of mental wellness and distress; (2) deepen understanding of Zulu epistemologies and idioms of distress; (3) identify local terminology and explanatory models of mental illness; and (4) develop a foundation for culturally responsive mental health programming.

Methods: This community-based participatory study engaged 48 isiZulu-speaking rural South African women, men, and youth in forum theatre workshops and focus group discussions (FGD) using In Your Hands approach. Data included socio-demographics, skits and FGDs, and photographs. Audio recordings were transcribed and analyzed using thematic analysis.

Results: Local understandings of mental illness are closely linked to spirituality and ancestral beliefs. Participants identified culturally specific terms and explanatory models of distress not often applied in western concepts of illness.

Conclusions: Integrating Indigenous knowledge systems into mental health frameworks may improve relevance, engagement, and equity in mental health care.

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Team Science Tools and Tactics to Strengthen Patient-Oriented Research Collaborations

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Background: Patient-oriented research (POR) in primary care brings together patients, clinicians, researchers, decision makers and other partners with diverse expertise. However, diverse perspectives do not automatically result in meaningful collaboration. Team science offers tools and tactics to support communication, shared decision-making, relationship-building, and knowledge integration. We sought to identify team science tools and tactics used in health research and examine how they can support POR.

Approach: We conducted a scoping review following JBI (Joanna Briggs Institute) guidance. Six interdisciplinary databases were searched for literature describing tools and tactics used by research teams involving non-academic health partners. The identified tools were categorized using the Four-Phase Model of Transdisciplinary Research.

Results: Of 12,373 records identified, 42 studies met the inclusion criteria, yielding 125 unique team science tools and tactics. Tools were used across the research lifecycle, with most categorized to development and conceptualization and fewer to implementation and translation phases. Tools supported both project coordination and collaboration by making assumptions visible, structuring participation, supporting shared decision-making, and enabling reflection. These findings informed the development of a pocket guide to help POR teams identify, select, and apply tools based on their collaborative needs.

Conclusions: Team science tools can provide practical structures for strengthening primary care collaboration among diverse research partners. The pocket guide translates evidence into an accessible resource to support more meaningful POR and, ultimately, research that better reflects patient priorities and improves patient outcomes.

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Creation and evaluation of Lori Education to support the integration of patient-reported measures in primary care

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Background: Patient-reported outcomes and experience measures (PROMs and PREMs) are valuable data sources for supporting patient-centred decision-making in primary care. PROMs reflect patients' perceived health status, while PREMs capture their experience of care. Despite their potential, these data remain underused in clinical settings. Primary care teams often lack the knowledge, guidance, and practical tools needed to translate PROMs and PREMs into actions that improve professional practice and organizational processes. This study aims to develop and assess a learning management system supporting the meaningful use of PROMs and PREMs in primary care clinics.

Approach: We conducted a mixed-methods study guided by Knowledge-to-Action principles and developmental evaluation. The intervention targeted managers, family physicians, and interprofessional teams in primary care clinics across Québec, Canada. We co-developed Lori Education, a 4-hour online asynchronous training available in French and English. It includes six evidence-informed modules, from an introduction to PROMs and PREMs to their practical application for improving clinical and organizational processes. The training integrates resources, exercises, and case-based scenarios. The evaluation is informed by RE-AIM, Eco-normalization Theory, and Kirkpatrick's model. Pre- and post-training questionnaires assessed knowledge, confidence, and intention, while focus groups explored implementation.

Results: Eighteen clinics were recruited across rural, semi-urban, and urban settings. Nineteen participants enrolled, and nine completed the training. Preliminary results showed increased knowledge, from 77% to 88%. Confidence in using PROMs and PREMs to strengthen service organization increased from 2.5 to 3.8/5, and intention to improve professional practice increased from 6.8 to 7.8/10.

Conclusions: Lori Education appears promising for supporting primary care teams in integrating PROMs and PREMs and contributing to more patient-centred care.

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Patient-Reported Experiences of Family Physician Loss: A Qualitative Study of Free-Text Survey Comments in Quebec

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Background: Continuity of care is a cornerstone of primary care and was central in developing Quebec's family medicine group model. Yet, more patients experience discontinuity following changes in their family physician's practice, with little evidence on its impacts. This study aims to explore patients' experiences of losing their family physician and its perceived consequences on care continuity.

Approach: This qualitative study was part of a larger research project on primary care discontinuity. Data from patients without a family physician (n=1,257) were collected through a patient-reported questionnaire developed by our research team. We used an interpretive descriptive approach with a hybrid inductive-deductive analysis of free-text comments (n=364) grounded in Hagerty's continuity framework (informational, management, relational). Two researchers analyzed comments independently, reconciling discrepancies iteratively by consensus.

Results: Most commenters were women (63%), over 55 years old (61%). Non-commenters were younger, reported less disability, and had a lower proportion of women and of North American origin (all $p<.05$). Twenty-eight subthemes emerged, grouped in four main themes: navigating discontinuity, informational, management, and relational continuity. 'Emotional distress' was the most frequently reported subtheme, appearing in 154 (42.3%) free-text comments, far exceeding the second most common, 'Barriers to accessing healthcare', appearing in 71 comments (19.5%).

Conclusions: Our results suggest that losing a family physician is felt not merely as a logistical disruption but as a significant emotional burden, with consequences affecting all three dimensions of care continuity. These findings highlight the need for health systems to better anticipate and address patients' needs in this context.

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Comparing data from regulatory organizations with provider survey data for analyses of health care supply and accessibility

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Background: Spatial accessibility (distance and time to providers) is a critical determinant of access to child and youth mental health care, yet most spatial studies rely solely on regulatory bodies' databases for information. We compared spatial accessibility to mental health services for children and youth for the province of Ontario based on data from regulatory bodies versus a provider survey.

Approach: Data from the College of Psychologists of Ontario (CPO), and psychiatrists' data from the College of Physicians and Surgeons of Ontario (CPSO), were used. Provider surveys (Psychologists, N = 1364; Psychiatrists, N= 47) assessed practice location(s), provision of clinical services, hours per week delivering services, and percentage of services dedicated to children and youth. Using the Enhanced Two-Step Floating Catchment Area (E2SFCA) method, we computed a Spatial Accessibility Index (SAI) at the Dissemination Area (DA) level using both data sources.

Results: In the surveys, only 12% of psychologists' and 43% of psychiatrists' information was identical when compared to the regulatory bodies data. Compared to survey data, the SAI from regulatory databases overestimated access to psychologists in virtually all (96.5%) DAs, and in the majority (73.6%) of DAs for psychiatrists.

Conclusions: Spatial accessibility based on data from regulatory bodies is problematic. Collection of detailed practice information (e.g., hours of clinical services per practice location) by regulatory bodies would allow for timely, accurate analysis of spatial accessibility.

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Indigenous Perspectives on Palliative and End-of-Life Care: A Qualitative Study in Southeastern Ontario

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Background: Indigenous Peoples experience inequities in access to meaningful, supportive, culturally appropriate, and culturally safe palliative care services. The purpose of this collaborative, community-engaged project is to examine experiences and needs of Indigenous individuals, their families, and their communities to support palliative and end-of-life care for Indigenous Peoples in Kingston and surrounding region.

Approach: Three Talking Circles were held in Tyendinaga Mohawk Territory, Shannonville, and Kingston, Ontario. There were 31 participants in total, including both patients and caregivers. Each Talking Circle lasted around two hours in length, beginning with a shared meal and followed by the creation of a grief medicine bag as the Talking Circle took place. Thematic analysis was done with guidance from Indigenous and policy partners.

Results: Family members, friends, traditional care persons, and individuals who shared traditional values of health and dying are significant sources of support for individuals receiving care. Conversely, healthcare professionals' limited understanding of Indigenous worldviews of death and lack of respect for traditional medicines were identified as barriers to dignified care. Many participants expressed the importance of experiencing the palliative care journey at home, surrounded by loved ones and familiar environments. Participants emphasized the need for traditional medicines, ceremony, and healing rituals to be integrated into end-of-life care. Caregivers noted that greater education about end-of-life care and enhanced system navigation support could reduce caregiving burden and provide meaningful assistance throughout the caregiving journey.

Conclusions: Improving cultural understanding, traditional care access, and caregiver supports is crucial to providing culturally safe palliative care.

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Examining Healthcare Providers' Perspectives and Experiences of Caring for Uninsured Patients in Emergency and Urgent Care Settings within the Frontenac, Lennox & Addington Ontario Health Team: Research in Progress

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Background: Lack of health insurance is a significant barrier to timely, appropriate care. Non-insured individuals, including non-status migrants, migrant workers, and uninsured travelers, are a heterogeneous and vulnerable population who often first enter the healthcare system through emergency departments (ED) and urgent care centres (UCC). Following the 20223 cancellation of Ontario's Physician and Hospital Services for Uninsured Persons Program and recent changes to the Interim Federal Health Program, the uninsured population is expected to grow. Research on provider experiences is limited and primarily focused on large urban centres, with little known about mid-sized regions with fewer supports.

Approach: This qualitative descriptive study explores the perspectives of nurses, physicians, and social workers caring for non-insured patients across four ED/UCC sites within the Frontenac, Lennox and Addington Ontario Health Team. Semi-structured interviews will continue until thematic saturation is achieved (approximately 15-20 participants). Analysis will follow Braun & Clarke's thematic framework, and guided by the structural vulnerability framework. Drawing on community-based research principles, the Kingston Immigration Partnership (KIP) and Kingston Community Health Centres (KCHC) are key partners in study design and development. Partner organizations will be involved in interpreting codes for investigator triangulation, strengthening validity and knowledge mobilization potential.

Results: Data collection is in progress. Interviews will explore day-to-day experiences caring for non-insured patients, perceived facilitators and barriers, role-specific challenges, and areas for improvement.

Conclusions: This study is expected to provide insights into providers' perspectives caring for non-insured patients in ED/UCCs in a mid-sized Ontario centre, adding local context and informing KIP and KCHC ongoing advocacy.

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Supporting People with Serious Mental Illness Across Psychiatric Hospitalization: The Role of Primary Care

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Background: Primary care providers (PCPs) may play an important role in supporting individuals with serious mental illness (SMI) through psychiatric hospitalization (PH), given their potential to provide continuity across care transitions. While PH may be necessary, it can also cause unintended psychological harm, particularly for people with SMI, who already face greater trauma and systemic inequities. PCPs could be one of the few consistent points of contact throughout PH, positioning them to address PH's impacts as part of person-centred care. This study aims to understand how individuals with SMI describe their primary care experiences surrounding psychiatric hospitalization. In doing so, this work may identify opportunities for PCPs to better support individuals with SMI across PH.

Approach: A total of 79 adults with SMI from British Columbia (n=29) and Ontario (n=50) completed semi-structured interviews about their primary care experiences. Data will be analyzed using inductive thematic analysis. Trauma- and violence-informed care principles will serve as sensitizing concepts for interpreting participants' perspectives on PCP involvement throughout the PH process.

Results: REB approval is being sought from the University of Toronto, with data analysis to follow. This presentation will report preliminary results from a subset of the data.

Conclusions: By contributing to a richer understanding of PH experiences and PCP involvement among people with SMI, findings may identify opportunities for PCPs to better support individuals with SMI across PH.

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Primary Care Physicians' Knowledge and Comfort in Caring for Older Adults Living with HIV in Ontario: A Cross-Sectional Survey

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Background: As people living with HIV age, primary care providers (PCPs) increasingly manage the medical and social complexities of HIV and aging. However, little research has examined PCP preparedness to care for older adults living with HIV in Canada. We assessed PCPs' perceived knowledge, comfort, and educational needs in Ontario.

Approach: A cross-sectional electronic survey was administered to Ontario PCPs. The 13-item survey assessed self-reported knowledge, comfort, and challenges related to HIV diagnosis and management, staying current with HIV research and advances in care, and addressing health and social needs of older adults living with HIV. Two family physicians cognitively tested the survey. Descriptive statistics summarized responses. The survey instrument was not validated, and no external benchmarks were applied.

Results: Ninety-four PCPs completed the survey; 57% of respondents were early-career physicians (<1 year in practice). Weighted averages (WAs) for all comfort domains were below 2 on a 5-point Likert scale (1=strongly disagree). Respondents reported the greatest discomfort with staying current with HIV research and management (WA=1.39), followed by addressing the social needs of older adults living with HIV (WA=1.50), managing their health needs compared with the patient population (WA=1.66), and HIV diagnosis and management (WA=1.90). Notably, 79% strongly disagreed that they felt comfortable staying current with HIV research and management.

Conclusions: Findings highlight gaps in PCP preparedness to care for older adults living with HIV. Targeted education, HIV-specific geriatric training, and collaboration among primary care, geriatrics, and HIV specialty services may strengthen provider preparedness and support equitable, high-quality care. sarmitha.sivakumaran@sinaihealth.ca

Advancing Equity in Cancer Diagnosis: Patient-Centered Outcomes and Opportunities for Improvement in Canada

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Background: Diagnosis delays produce later stage cancer detection, decreased survival and quality of life, increased healthcare costs (Botey et al, 2021) (Hanna et al, 2020). Among 17,042 cancer cases, 7% were diagnosed via screening while 64% were identified after symptom presentation in primary care (Swann et al, 2018). People with intersectional identities and from disadvantaged socio-economic backgrounds face more obstacles to the full care continuum (Kelly-Brown et al, 2022) (Fahim et al, 2021).

Approach: ACC undertook mixed methods research, including literature review, qualitative interviews with cancer survivors, provider survey, and roundtables with 25 structurally underserved community members, including First Nations and Métis, and primary healthcare providers. Objectives were to:

- Assess Canada's current state of cancer diagnoses
- Identify outcomes that matter most to patients
- Identify practices in cancer diagnosis that could be adapted, scaled
- Understand successes, enablers, issues, barriers, gaps
- Identify inefficiencies that are improvement opportunities.

Results: ACC's "Current State of Cancer Diagnosis" patient experience map illustrates the harmful diagnosis experience, barriers posed by poor determinants of health, invalidated identities, generational, cultural, and geographic factors. ACC detected three phases within the diagnostic trajectory: suspicion (first medical interaction due to symptoms until first referral), investigation (visits to investigate a possible cancer), and diagnosis (arrival at a cancer team for clinical diagnosis, staging, therapeutic options). ACC learned seven desired patient outcomes that informed an optimised "Future State of Cancer Diagnosis in Canada."

Conclusion: ACC will share the challenges to equitable and swift cancer diagnoses; patients priorities ; a better future state; evaluated practices; and metrics to assess progress.

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Co-Designing Recruitment Strategies with Clinicians to Understand and Advance eConsult's Use in Dementia Care

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Background: The growing prevalence of dementia in Canada is placing increasing demands on the healthcare system. Primary care providers (PCPs) often struggle to access timely specialist input. Electronic consultation (eConsult) offers PCPs rapid, case-specific advice from specialists. We aim to explore clinician perspectives on eConsult in dementia care to improve health outcomes and reduce inequities. However, recruiting clinicians for qualitative research is a recognized challenge that requires well-designed study tools.

Approach: Co-design sessions were held with a clinician advisory group to refine the semi-structured interview guides through virtual meetings and email feedback. During these sessions, recruitment emerged as a central challenge, with the group identifying clinician time constraints as a key barrier. The research team used their suggestions to develop targeted recruitment strategies for PCPs and specialists. These strategies were supported by a review of the recruitment literature and finalized by the research team into a recruitment plan for the study.

Results: Several recruitment strategies were identified through advisory group input, including snowball sampling from established clinical networks, in-person recruitment at conferences, outreach through long-term care call groups linked to primary care, offering incentives, and reducing participant burden through flexible virtual interviews and a shortened interview guide.

Conclusions: Input from the clinician advisory group on recruitment strategies improved understanding of the barriers to clinician participation and helped shape a practical, context-appropriate recruitment approach. This work provides a structured framework for recruiting hard-to-reach clinicians in qualitative research and highlights the value of co-design in health services research. ssyed@bruyere.org

Streamlining Intake to Increase Access and Attachment: Evaluation of an Equity-Based Primary Care Quality Improvement Learning Collaborative

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Background: Learning collaboratives are structured, time-limited quality improvement (QI) initiatives that bring together multi-disciplinary teams across primary care organizations. The Alliance for Healthier Communities facilitated "Learning Collaborative 4: Increasing attachment through intake process improvements" from September 2025 to June 2026 to optimize client intake and increase attachment in in primary care organizations across Ontario, with a focus on equitable access to care.

Approach: 11 participating teams applied QI methodologies—including process mapping and iterative testing—to streamline intake processes and associated workflows. Participatory methods encompassed readiness assessments, structured learning and sharing sessions, peer knowledge exchange, and dedicated coaching from Quality Improvement and Performance Leads. A mixed-methods evaluation gathered qualitative and quantitative data across participating teams.

Results:

•Intake Digitization and Digitalization: Sites digitized paper intake forms and digitalized entire workflows using OceanMD and custom EMR forms, achieving pre-appointment form completion return rates up to 85% and streamlining client chart creation.

•Workflow and Capacity Optimization: Pre-capturing health data enabled sites to reduce initial appointment lengths from 60 to 30 minutes, contributing to a substantial increase in intake appointment capacity – seeing intake appointment availability increase by an average of 150% for the teams who reported on this measure.

•Innovative Intake Models: Teams piloted alternative access strategies, including group intake sessions, pre-recorded multi-language orientation videos, and automated, daily refreshed EMR waitlist tracking.

Conclusions: Coach-supported learning collaboratives drive primary care intake optimization and build local QI capacity. To sustain scale and spread, future efforts will leverage flexible implementation models that balance peer learning with low-burden adaptation.

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Codesign and Acceptability of an AI-Powered Bilingual Chatbot for Biopsychosocial Data Collection in Ontario Patients with Chronic Pain

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Background: Nearly eight million Canadians live with chronic pain, which reduces quality of life, disproportionately affects vulnerable and minority populations, and places a burden on the healthcare system. The bio-psycho-social (BPS) model, which incorporates social determinants of health (SDH), is the preferred approach for chronic pain management. SDH information is often collected informally by providers and remains incompletely documented due to the workload required to assess and update it, contributing to suboptimal pain management.

Approach: Our objective is to co-design an AI chatbot to automate SDH data collection and generate personalized BPS profiles for patients living with chronic pain in Ontario. In line with the Technology Acceptance Model, the chatbot's acceptability will be evaluated through validated questionnaires. An explanatory sequential mixed-methods design, guided by the World Health Organization's practical guide for evaluating digital health interventions, will be used. The interactive algorithm of the large language model will be created using validated SDH questionnaires, then refined through interactions with experts and patients.

Results: This project will explore how empathetic adaptive technology can enhance care experience and reduce inequalities in access, while generating knowledge on human-AI interaction in contexts of vulnerability.

Conclusion: This technology could reduce providers' workload by generating a patient profile without taking up clinical time, supporting more personalized care for patients with chronic pain. Bilingual data collection is particularly valuable in unilingual settings, where communication tools may be limited. The technology could also be adapted to other care settings and clinical conditions and expanded with additional functionalities. sophieturcotte@montfort.on.ca

Advancing equity in data collection: strategies to better integrate underrepresented or vulnerable groups

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Background: Many healthcare institutions use patient-reported questionnaires to assess care experience and perceived health. However, participation remains low among individuals from underrepresented or vulnerable groups. These groups often experience greater health inequities, face a higher risk of negative care experiences, and report poorer perceived health. Ensuring that their perspectives are reflected in data collection is essential to inform equitable, needs-based health decisions. This study aimed to identify preferred communication methods, engagement support strategies, and enabling conditions to increase their participation in patient-reported data collection.

Approach: We conducted a public consultation through six remote consultation sessions with community organizations in Québec. Participants were 38 community workers from eight regions of Québec who work directly with underrepresented or vulnerable groups. A focus group interview guide was used to explore barriers, preferred communication methods, and strategies to support participation. Data were analyzed using an inductive descriptive qualitative approach. Communication strategies preferred by different groups were compiled and then validated by participants to enhance the credibility of the findings.

Results: Forty-seven engagement support strategies were identified. Preferred communication methods varied according to the target group and included voice messages, telephone calls, face-to-face contact, social media, and other tailored approaches. An adapted data collection tool and support for completing questionnaires also emerged as important facilitating conditions.

Conclusions: The identified strategies can enhance the engagement of underrepresented or vulnerable individuals and groups when adapted and combined according to their specific needs. These strategies may strengthen the validity of patient-reported data and support more equitable organizational decision-making centred on people's perceived needs. Trust in the healthcare system remains essential to participation.

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Provider and Patient Perspectives on Newcomer Obstetrical Care Access in the Kingston Frontenac Lennox, and Addington (KFL&A) Area: An Environmental Scan and Needs Assessment

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Background: Newcomer women and birthing people in Canada face barriers to prenatal and obstetrical care, contributing to adverse maternal and neonatal outcomes. KFL&A presents a unique context, with a smaller but growing newcomer population, a mixed urban-rural geography poorly reflected in existing literature, and over 20,000 residents without a primary care provider. This project maps newcomer- accessible obstetrical services, examines provider and newcomer perspectives on barriers and facilitators to accessibility, and identifies gaps and opportunities for improvement.

Approach: This mixed-methods project combines an environmental scan (web searches and key-informant surveys) with a needs assessment (qualitative interviews analyzed thematically through an intersectionality lens), guided by an Advisory Council with the Kingston Immigration Partnership (KIP) and Kingston Community Health Centres (KCHC). Participants include frontline providers, social and settlement workers, community organization leads, and newcomer women and birthing people with lived experience. Interview guides and surveys were co-designed with the Advisory Council and refined through ten pre- testing sessions using expert- and respondent-driven techniques to ensure face and content validity of study instruments.

Results: Instrument pre-testing is complete. Refinements included added term definitions, key probes, and examples of barriers and facilitators within the interview guide, along with expert recommendations to minimize jargon throughout study materials. Ethics approval has been received from the HSREB, and recruitment is now underway.

Conclusions: Findings will inform a regional service directory, updated digital maps, a provider-facing infographic, and policy recommendations for regional health system improvement, with results disseminated to KIP, KCHC, and the Frontenac, Lennox and Addington Ontario Health Team.

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Primary care physician job preferences: a systematic review of choice-based stated preference studies

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Background: Primary healthcare systems are facing physician workforce shortages globally. Choice-based stated preference (CBSP) studies, where respondents indicate their choice of alternative options, are a tool for informing physician recruitment and retention initiatives. There has been no comprehensive synthesis of CBSP studies in primary care regarding which job attributes matter most across contexts or how methodological approaches in CBSP influence findings about job preferences.

Approach: We performed a systematic review of CBSP studies of primary care physician job preferences using descriptive statistics and content analysis. We searched six databases (including MEDLINE, Embase, APA PsycINFO, and CINAHL) from Jan 1, 1998 to Sep 12, 2025 and appraised study quality using the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) and Mandeville et al. checklists. We extracted data related to study demographics, research question, study population, sample size, recruitment and survey administration method, response rate, design process, attributes and levels used, key findings, and study quality.

Results: Of 2,092 studies screened, 16 were eligible, representing 19,434 PCPs. All studies included a monetary/income attribute; other attributes addressed organizational supports, working conditions, professional flexibility, and community. Income was the most influential attribute within 56% (n=9) of studies, followed by workload (25%, n=4).

Conclusions: While income and workload consistently influence preferences, other factors vary across contexts, highlighting the importance of locally tailored policy interventions. By consolidating methodological insights and preference patterns, this review provides a foundation for more rigorous, context-sensitive CBSP research to inform primary care workforce planning.

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Best Practices in Routine Primary Care Patient-Reported Experience Measure (PREM) Surveys Across OECD Countries

Emma Wedekind, Hina Ansari, Umair Majid, Jennifer Shuldiner, Kamila Premji, Vanessa Wright, Shantel Walcott, Rick Glazier, Tara Kiran, Noah Ivers

Background: In December 2025, the Auditor General of Ontario reported that Ontario lacks systematic clinic-level patient experience data across primary care and recommended a jurisdictional scan of best practices and a feasibility assessment for survey implementation. Several OECD countries collect primary care patient-reported experience measures (PREMs), but initiatives vary widely in governance, implementation, reporting, and use. Our objective is to identify and synthesize best practices in routine, institutionalized, clinic-level primary care PREM surveys across OECD countries, focusing on governance, implementation, reporting, equity provisions, and conditions for effective use in quality improvement and patient-centred care.

Approach: This sequential mixed-methods study, supported by an International Advisory Committee, comprises two components. Component 1 is a scoping review of government reports and peer-reviewed literature across all 38 OECD countries, with explicit extraction of equity provisions, following JBI scoping review methodology and PRISMA-ScR reporting. Component 2 comprises semi-structured key informant interviews with implementers, equity leads, and users from surveys identified as most instructive for Ontario. Interview data will be triangulated with scoping review findings, with member-checking prior to dissemination. Ethics approval was obtained from the University of Toronto Research Ethics Board.

Results: 15,527 abstracts were screened across Embase, Web of Science, CINAHL, and Ovid. Preliminary findings from Component 1 suggest lessons for Ontario in equity-informed design, quality improvement, system integration and multi-level reporting, and flexibility and adaptability.

Conclusions: The environmental scan will generate an evidence- and practice-informed synthesis of governance, implementation, and reporting practices across OECD primary care PREM programmes, with key lessons for Ontario.

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Preventive Check: A Student-Created, Open-Access Website/ App for Personalized Preventive Care Checklists

Matthew Wong

Background: Millions of Canadians lack a regular primary care provider, making it difficult to navigate many national preventive health guidelines. Recommendations from Ontario Cancer Screening, the College of Family Physicians of Canada (CFPC), the Canadian Task Force on Preventive Health Care (CTFPHC), the National Advisory Committee on Immunization (NACI), and Osteoporosis Canada are evidence-based but dispersed across multiple platforms, complicating self-directed preventive health management.

Approach: As an undergraduate student utilizing freely available AI tools, a proof-of-concept website/app that generates a personalized preventive care checklist based solely on a patient's age and sex, with no account creation or personal health information required. Canadian clinical guidelines on cancer screening, immunizations, lifestyle counselling, and bone health were synthesized into a single, accessible, printable checklist. The prototype shows that meaningful health technology can be developed at low cost.

Results: The tool produces an individualized, guideline-concordant checklist within seconds, covering cancer screenings, recommended adult vaccinations, lifestyle counselling, and osteoporosis prevention. It requires no technical expertise and is freely accessible without registration, demonstrating feasibility for broad public use.

Conclusions: This student-built prototype illustrates that low-cost preventive health tools are achievable and merit institutional investment. With adequate resources, a similar model could be further developed, validated, and distributed at a population level, helping reduce missed preventive opportunities, support health equity, and empower individuals without primary care access to take an active role in managing their health.

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Measuring Physician Co-Management Relationships: A Scoping Review

Cole Wyman, Connor Brearley, Olla Hilal, Anika Garg, Dana Ryan, Leslie Meredith, Maria Mathews

Background: Patients living with chronic conditions often require co-management between family physicians and specialists. The measurement of this type of collaboration is important to understanding and improving this model of care. We conducted a scoping review to identify existing measurement approaches and/or gaps that require further exploration.

Approach: We conducted a scoping review in accordance with Joanna Briggs Institute methodology and the PRISMA-ScR guidelines. We searched four databases for articles published up to April 2026 that reported on the measurement of co-management, defined as two or more physicians providing healthcare for the same patient.

Results: We screened a total of 5246 articles; 18 articles met the inclusion criteria. Fifteen articles reported on retrospective observational studies using administrative data, two reported on cross-sectional surveys, and one reported on a mixed methods study using survey and administrative data. The retrospective observational studies identified co-management by linking physicians who had clinical interactions with the same patients. These studies described the number of shared patients, the number of physicians sharing patients, and the broader network patterns of co-managing physicians. Across the survey-based studies, three instruments were used to quantify physicians' and patients' experiences with co-management relationships: the Provider Co-management Index, Relational Coordination, and the Consumer Quality Index.

Conclusions: Observational studies using administrative databases and surveys each offer useful insights to patterns and experiences of co-management. Recognition of their respective strengths and weaknesses are helpful to guide implementation of these tools within the Canadian context.

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Up to BAT: Examining the association between 'business arrangement types', family physician compensation, and workforce outcomes using a multiple case study

Gillian Young, Maria Mathews, Lindsay Hedden, Leslie Meredith, Sarah Spencer

Background: Many family physicians (FPs) in Canada operate their practices as independent business owners or sub-contractors. Current research does not reflect the complexity of modern business arrangements which are varied and dependent on factors such as payment model, ownership structure, incorporation, overhead, and academic or other affiliations. There is limited research examining how these factors interact to shape family physician decisions and workplace behaviour (e.g., clinical scope, workload, retirement intentions). This study will develop a typology of FP business arrangement types (BATs) in Canada and examine how they affect compensation and workforce outcomes.

Approach: We will conduct a mixed-methods multiple case study in British Columbia and Ontario. Phase 1 will include the typology development through a document analysis of regulatory, legal, and organizational materials as well as semi-structured interviews with approximately 40-48 FPs and 19-28 subject matter experts (e.g., lawyers, financial advisors, etc.). Phase 2 will consist of confirming the typology, including a cross-sectional online survey and confirmatory interviews with FPs to examine the distribution of BATs and their associations with workforce outcomes.

Results: This study is in progress. We have begun with an environmental scan to identify documents, the analyses of which we will use to inform our semi-structured interviews with FPs and subject matter experts

Conclusions: This project will generate evidence to inform policy for primary care reforms, FP compensation policies, and workforce planning. It will also improve methodological tools to support future research.

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