2026 Trillium Primary Health Care Research Day

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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 & CONTEXT

A substantial global mental health treatment gap persists, particularly in low-resource settings where nearly 70% of affected individuals do not receive needed treatment. While an integrated Indigenous and Western approach may improve engagement and outcomes, effective implementation requires detailed awareness of Indigenous epistemologies and knowledge systems.



THEORETICAL FRAMEWORK

Ubuntu
A philosophy of shared humanity and collective well-being — "I am because we are."

African Cosmology
Spiritual and relational worldviews that shape understandings of health, distress, and healing.

Decoloniality
Challenging dominant paradigms to reclaim Indigenous epistemologies in health systems design.

Summary Table: Mental Health Workforce in Harry Gwal District[1]

Personnel type	Local workforce	Context
Psychiatrist	0	No psychiatrist at Umzimkhulu Psychiatric Hospital, Harry Gwala District, in 2023–2024
Clinical psychologist	1	Approximately 0.18 per 100,000 district population, based on the 2024 district population
Specialized professional nurses	13	Based at the district's specialised psychiatric hospital; specialty should not be assumed to equal psychiatric nursing registration without further verification
Occupational therapist	1	Mental-health rehabilitation services at Umzimkhulu Psychiatric Hospital
Social workers	2	Psychosocial and social-work capacity at Umzimkhulu Psychiatric Hospital

STUDY OBJECTIVES

(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.

WHY FORUM THEATRE?

Draws on oral traditions- storytelling, performance and collective participation.
Supports expression of embodied knowledge through gestures and images.
Allows participants to project experiences onto characters, thus creating emotional distance; nobody owns the narrative.
Encourages collective reflection rather than individual disclosure.

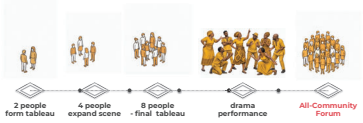
METHODS

Setting: Harry Gwala District, a rural, remote and sparsely populated, with difficult terrain, high multidimensional poverty, and limited connectivity can be difficult to navigate in rainy seasons. Villages are from major centres and health services; there is no formal public transportation, and many residents do not own a vehicle.

Design

48 IsiZulu-speaking participants across 3 groups and 3 workshops

- **Community-based participatory research** in partnership with **Woza Moya,** a local Community Service Organization (CSO).
- **CSO** led:
  village selection
  recruitment of the Community Advisory Board, and
  participant recruitment.
- **Adapted Forum Theatre (*In Your Hands* model[2]) workshops engaged** 16 women (28–59), 16 men (27–66) and 16 youth (18–25). Recruitment ensured inclusion of traditional and faith healers/leaders, and elders in addition to general community members.
- Two male participants were farmers and all other participants had no formal employment.



Forum Theatre process – creating collective narratives.

DATA COLLECTION & ANALYSIS

Forum Theatre workshop and Focus Group discussion for each group.
All workshops were conducted in IsiZulu – the local language.

Research Theme — Invited the participants to illustrate, non-verbally, using only images and gestures, the state of mental health in their community.

Collective narratives — Participants created body-based images and tableaux, added inner monologues, developed skits and performed them in the workshop, and subsequently in an all-community forum. The dialogue in the all-community forum confirmed the workshop narratives.

Multimodal data — Photos, audio recordings and video captured the evolving scenes and reflections. Audio recordings were transcribed verbatim and data processed in NVivo.

Analysis — Constructivist grounded theory was applied with reflexivity across audio, photographs/tableaux and performance video.

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Social Sciences and Humanities Research Council of Canada | Conseil de recherches en sciences humaines du Canada
Canada

FINDINGS: COLLECTIVE NARRATIVES

Cultural explanations shape pathways to care

Explanatory models

Participants described distress through:

- Witchcraft
- Ancestral displeasure
- Unfulfilled rites of passage, such as after a child is born
- A calling to become a healer

When illness was understood as a healing calling, apprenticeship with a mentor healer was the preferred response.



Pathways to care

- Participants sought support from traditional healers, herbalists, diviners, and faith healers.
- Belief that Western medicine could not treat conditions attributed to witchcraft.
- Western-based care was often viewed as a last resort.

Language



Ukuhlanya – madness
Ukuphambana ngekhanda – to have a crossed head (mental illness)
Umdikheyi – decayed brain
Amafufunyane – being possessed – cultural connotations
Ukuthwasa – being called to healing - cultural connotations
Ugqashukile ulayini – the line is broken
Izitezi aziphelele – not all floors are present
Umhlaka 3 – the third of the month is when disability checks are collected



CARE, COMPASSION & COLLECTIVE DISTRESS



- Caring and compassion
- Community support (*ubuntu*)
- Praying
- Expressions of collective distress as mothers – teen pregnancy
- Experiences of caring for family members with mental illness
- Personal disclosures



CHALLENGES

Persistent stigma surrounding mental illness
Knowledge gaps in early identification of distress
Limited access to culturally appropriate services

OPPORTUNITIES

Collective action
People want to help and learn
Recognition that Western medicine could play a role
Traditional healers and leaders as allies

CONCLUSION & NEXT STEP

Co-design a community-led, culturally appropriate programme grounded in local knowledge, language, relationships and pathways to care.

References

1. Malunga S. (2024). *Investigating Factors Associated with Absconding Behaviours Amongst Hospitalised Mental Health Care Users Within Harry Gwala District KwaZulu-Natal Province.* Research Library, University of KwaZulu-Natal; 2024.
2. Mngoma, NF, Ayorinde, OA. (2026). In your hands (Ezandleni Zakho): A theatre-based approach to engaging embodied indigenous knowledge towards collaborative social action. Geopsychiatry, 3, 100059. https://doi.org/10.1016/j.geopsy.2026.100059

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

Carr, K.[1,2], Nguyen, A.[1,2], Usmani, S.[1,2], Tynan, A-M.[3,4], Gozdyra, P.[3,5], Persaud, S.[1,2], Armstrong, M.[6], Kendall, C.E.[1,2,7]

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MAIN FINDING

Adjusting for neighbourhood-level primary care unattachment narrowed the socioeconomic (SES) gap for mental health and substance use (MHSU) emergency department visits and hospitalizations, but not for all-cause encounters.

MHSU emergency visits	MHSU hospitalizations	All emergency visits
2.78 to **1.23**	**2.42** to **1.10**	**1.39** to **1.40**

Rate ratios, most (Q5) vs least (Q1) disadvantaged, before and after adjusting for unattachment

Background

In September 2024, **21.0% of Ottawa, ON residents** (253,781 of 1,207,262) were unattached to primary care.

Ottawa-region Ontario Health Teams (OHTs) partner with the Ottawa Neighbourhood Study (ONS) for primary care planning.

We asked:

1. Is unattachment greater in socioeconomically disadvantaged neighbourhoods?
2. Is neighbourhood unattachment associated with socioeconomic differences in MHSU emergency visits and hospitalizations?

Approach

Ecological, cross-sectional analysis of ONS neighbourhoods: 116 areas defined with the community, following natural barriers such as highways, rivers and the greenbelt. 106 had both attachment and outcome data (104 to 106 per outcome, after OCHPP small cell suppression).

DATA SOURCES

Primary Care Unattachment
Health System Performance Network (HSPN), ICES. INSPIRE-PHC method, September 2024.

Socioeconomic status
ONS index of six 2021 Census measures, in quintiles: Q1 least, Q5 most disadvantaged.

Family physicians
College of Physicians and Surgeons of Ontario (CPSO) register, January 2026, counted at primary practice location.

Hospital encounters
Ontario Community Health Profiles Partnership (OCHPP), 2021 to 2025.

All linked to the same ONS neighbourhoods

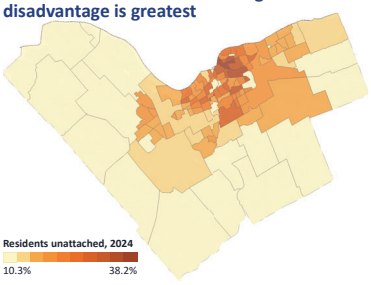
Outcomes. Emergency department visits (2023/25) and hospitalizations (2021/23), categorized as all-cause (all ages) and MHSU (emergency visits ages 20+ years, hospitalizations ages 15+ years).

Analysis. Poisson regression of neighbourhood-level counts by SES quintile, with and without adjustment for percent unattached; presented as rate ratios (RR) with confidence intervals (95% CIs). Narrowing of the gap after adjusting for primary care unattachment: percentage reduction in the log RR.

Sensitivity analyses: we adjusted for age composition and rurality, and excluded the neighbourhood with the highest MHSU emergency visit rate. The MHSU RRs were smaller after adjustment for unattachment in every analysis.

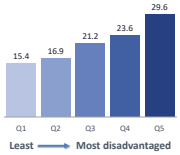
RESULTS 1

Unattachment is uneven and highest where disadvantage is greatest

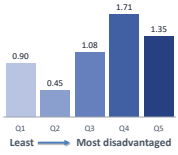


Unattachment ranged from **10.3% to 38.2%** across neighbourhoods and was highest in the urban core.

Residents unattached (%)



Family physicians per 1,000 residents



Q5 residents were almost **twice as likely** to be unattached as Q1 residents (29.6% vs 15.4%), yet **more family physicians practise in Q5** per resident (1.35 vs 0.90 per 1,000).

The gap is present in every age group (% unattached)

Age	Q1	Q5	Q5 / Q1
0 to 17	12.0%	25.5%	**2.1×**
18 to 39	22.2%	37.3%	**1.7×**
40 to 64	14.3%	29.2%	**2.0×**
65+	10.6%	17.8%	**1.7×**

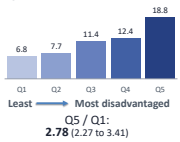
RESULTS 2

The socioeconomic gradient is steeper for mental health and substance use than for all-cause encounters

Crude rates per 1,000 residents per year (OCHPP); bars scaled within each panel. Q5 / Q1: crude rate ratio (95% CI).

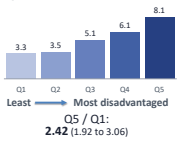
MENTAL HEALTH AND SUBSTANCE USE

Emergency visits
Ages 20+, 2023/25



Q5 / Q1:
2.78 (2.27 to 3.41)

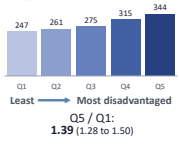
Hospitalizations
Ages 15+, 2021/23



Q5 / Q1:
2.42 (1.92 to 3.06)

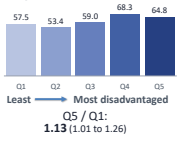
ALL CAUSES

Emergency visits
All ages, 2023/25



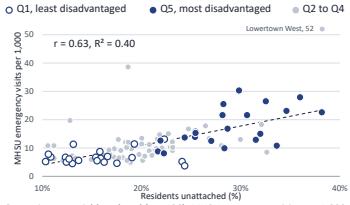
Q5 / Q1:
1.39 (1.28 to 1.50)

Hospitalizations
All ages, 2021/23



Q5 / Q1:
1.13 (1.01 to 1.26)

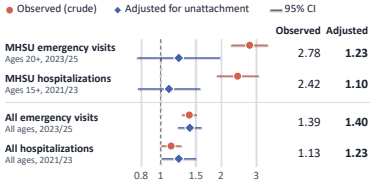
MHSU emergency visits rise with unattachment



One point per neighbourhood (n = 106). MHSU emergency visits per 1,000 residents aged 20+ per year, 2023/25. Dashed line: linear fit. Without Lowertown West, R^2 = 0.37.

RESULTS 3

Adjusting for unattachment narrowed the MHSU gap, but not the all-cause gap



Q5 vs Q1 rate ratio with 95% CI; axis on log scale. Dashed line = no difference (1.0).

After adjustment for unattachment, the socioeconomic (Q5 vs Q1) gap was **80% smaller in MHSU emergency visits** and **89% smaller in MHSU hospitalizations**, while the all-cause socioeconomic gap did not narrow.

Conclusions

1. More family physicians in a neighbourhood did not mean more residents were attached. The most disadvantaged neighbourhoods had more family physicians per resident but nearly twice the unattachment of the least disadvantaged.

2. Adjusting for unattachment narrowed the socioeconomic gap in MHSU emergency visits and hospitalizations, but not in all-cause encounters.

Limitations

- Associations are between neighbourhoods, not individuals.
- Rates of primary care unattachment are from 2024, physician counts from 2026, and outcomes from 2021 to 2025.
- Residual confounders (e.g., unstable housing, comorbidity burden) may be associated with both unattachment and acute care use.
- MHSU rates are crude. Adjusting for age composition alone reduced the MHSU emergency visit ratio from 2.78 to 1.88; further adjusting for unattachment reduced it to 1.23 (0.77 to 1.95).
- Disadvantaged neighbourhoods also had higher unattachment (r = 0.74 between neighbourhood SES factor score and % unattached), which makes the two hard to separate, so the adjusted estimates have wide 95% CIs.
- Physician counts use primary practice location, not where patients live. They do not reflect full-time equivalents, clinical hours, or whether physicians provide comprehensive primary care.

Unattached: residents with uncertain primary care attachment (HSPN, INSPIRE-PHC method, Registered Persons Database (RPDB) denominators). Quintile rates sum events and population within each quintile.
Physician distribution method: Belanger et al. (2026). BMJ Open 16(4): e099965.

This research was funded by INSPIRE-PHC through an Applied Health Research Question (AHRQ).

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



Queen's University | Roni Kraut, Jennifer Noble, Han Han, Mary Martin, Nomusa Mngoma | School of Medicine, Department of Family Medicine

Background: HPV self-collection (SC) allows individuals to collect their own sample for cervical cancer screening. We aimed to determine preferences for HPV SC among patients attached to primary care.

Methods: One-on-one semi-structured interviews. Patients were recruited though a HPV SC quality improvement project.

Demographics n=10

- Median age 49 (IQR 38–59)
- 90% Caucasian
- 90% Urban
- 90% Employed or retired
- 70% Professional occupations
- 70% Screening up to date

Conclusion: HPV SC was highly acceptable. This supports its integration into routine screening.

Themes identified

(1) Clinician-collected screening was physically and emotionally uncomfortable

"It's uncomfortable to be, like, you know, like, even with the regular doctor, just to, I don't know, be there in a room with nurses or with a doctor, just taking a sample is… it's not… well, you feel naked, or… I mean, you have to be naked, but yeah, you don't feel comfortable sharing your body to everybody." (Participant 4)

(2) HPV self-collection was quick, easy, and more comfortable

"It was super easy, kind of cool and yeah, like, way easier than a pap.. (its) 20 seconds, and then you're done. So, yeah, it was pretty cool. Definitely a step up from… from the whole pap experience." (Participant 8)

(3) Awareness of HPV self-collection was limited

"I spoke with my GP that I was not really interested in doing the PAP, …(They) provided this information that you guys were doing this project. And then I said, sign me up if you can…. And that's how it happens, (if they didn't) informed me I would have never found out" (Participant 10)

(4) Participants were open to trying self-collection because of its convenience and privacy

"Well, I… thought that the self-collection felt less invasive" (Participant 1)

"Relieved that it was quick, and that I could do it on my own, and that I didn't have to be on the bed" (Participant 10)

(5) Some participants questioned their ability to collect an accurate sample

"I was comfortable with doing the self-collection. Again, I still do have, like, some wonders if it's… as…effective as…a traditional one, like, if it can catch everything. I just remember my one friend saying that when she had a pap smear, like, a traditional one they had mentioned, oh, that they could see something in there, and that they wanted to check out. So I had wondered if… if it…was as effective." (Participant 3)

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

- Advances in antiretroviral therapy (ART) have transformed HIV into a chronic, manageable condition, resulting in an aging population living with HIV. In Canada, nearly 50% of adults living with HIV are now aged ≥50 years.
- Older adults living with HIV experience multimorbidity, polypharmacy, functional decline, and psychosocial challenges at higher rates and earlier ages than their HIV-negative peers, increasing health care needs and impacting quality of life.
- Primary care providers (PCPs) play a key role in addressing these complex needs. Understanding PCP preparedness and barriers to care can inform strategies to strengthen community-based HIV care.

Objectives

1. To assess PCP knowledge and comfort in managing the complex health needs of older adults living with HIV;
2. To explore perceived barriers to providing optimal HIV care in primary care settings;
3. To identify targeted educational approaches to enhance PCP engagement and confidence in caring for older adults living with HIV.

Methods

Study Design	Cross-sectional electronic survey of PCPs practicing in Ontario.
Survey Development	13-item survey assessing knowledge, comfort, educational needs, and perceived challenges in caring for older adults living with HIV. Co-developed by family physicians and researchers; cognitively tested with 2 experienced family physicians.
Recruitment	Professional networks, primary care listservs, and targeted email invitations.
Data Collection	Anonymous, voluntary online survey; completion implied consent.
Data Analysis	Descriptive statistics using frequencies and percentages; open-ended responses summarized.

Results

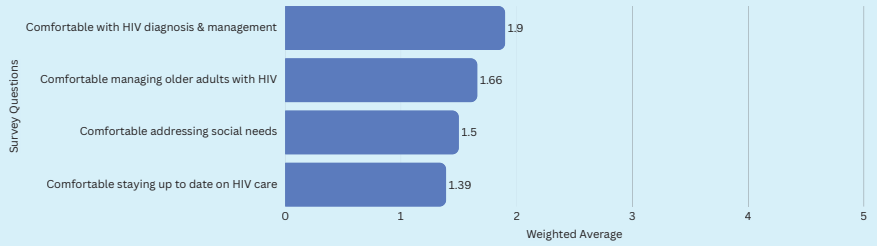


Figure 1. Weighted average responses of PCPs to four survey items assessing self-reported knowledge, comfort, and perceived preparedness in managing older adults living with HIV.

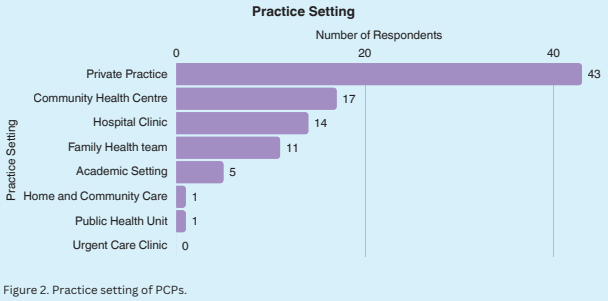


Figure 2. Practice setting of PCPs.

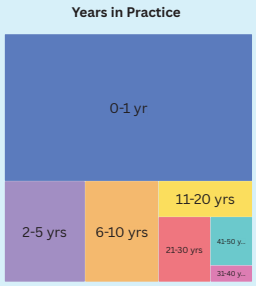


Figure 3. Years in Practice of PCPs.

Discussion & Conclusions

- PCPs reported low preparedness across HIV diagnosis and management, staying current with HIV care, and addressing the health and social needs of older adults living with HIV.
- Findings suggest gaps in training, guidance, and system-level resources to support the complex clinical and psychosocial needs of aging with HIV.
- Targeted education, clinical guidance, and coordinated policy action are needed to support equitable improvements in quality of life for older adults living with HIV.

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This research was funded by the RTOERO Foundation. The RTOERO Foundation had no role in the study's design, data collection, analysis, or interpretation of findings.
The authors have no conflicts of interest to disclose.

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

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Introduction

All.Can Canada is a national, multi-stakeholder network for cancer care efficiency, with a preliminary aim of optimizing people's entry into cancer care through swift, accurate, and appropriately delivered diagnosis.

Problem

- Diagnosis delays lead to late stage cancer detection, reduced survival, decreased quality of life, and 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 screening, diagnosis, treatment, and survivorship (Kelly-Brown et al., 2022) (Fahim et al, 2021).

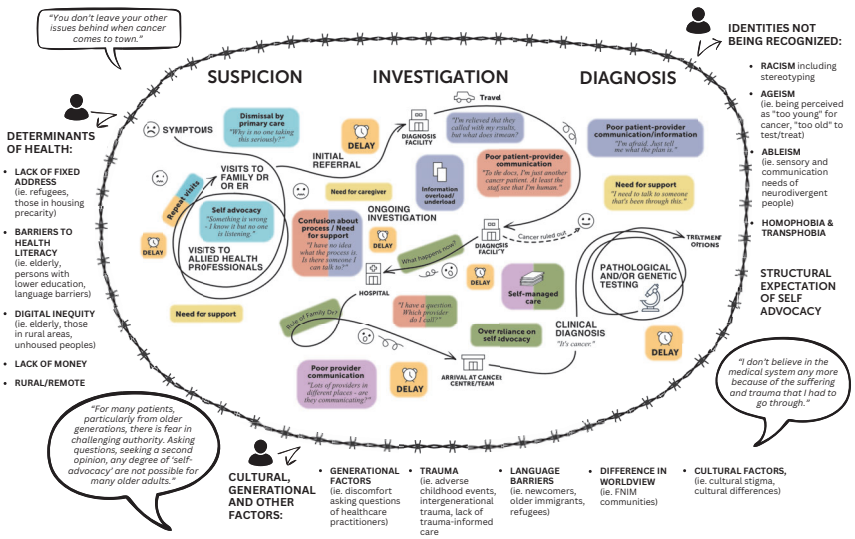
Objectives

Understand the current barriers, inefficiencies, and opportunities in cancer diagnoses in Canada to ensure swift, accurate, and appropriately delivered diagnoses throughout the country.

www.allcancanada.ca

This work was made possible with financial support from Bristol Myers Squibb (main sponsor), Merck, Pfizer, Novartis, Johnson & Johnson, AstraZeneca, Amgen and Medison.

Findings: Current State of Cancer Diagnosis in Canada



Findings: 7 Outcomes Critical to a Quality Diagnosis Experience

1. Swiftness of the diagnosis process
2. Validation of concerns by primary care providers
3. Excellent patient-provider communication
4. Effective provider-provider communication
5. Right information for diagnostic phase
6. Integrated psychosocial support
7. Coordinated and managed care

*Outcomes correspond to the colours on the current state diagram

Methodology

- Structured literature review
- 30 qualitative interviews with cancer survivors
- Survey of relevant healthcare providers across Canada
- Roundtables with 25 structurally underserved community members, including First Nations and Métis, and their healthcare providers

Conclusion

Recommendations

- Ensure seamless care through navigation, pathways, and team-based care
- Enhance primary care knowledge and supports
- Provide appropriate patient information throughout the process
- Enable effective communication between providers and with patients
- Provide psychosocial supports
- Establish quality and performance frameworks

Outcomes

- Identification of the systemic issues during cancer diagnoses, starting from the point of symptom investigation, and how these result in equity gaps that prevent structurally underserved populations from accessing timely diagnoses
- Identification of solutions, opportunities and good practices to optimizing diagnoses by developing case studies
- Mobilization of research findings by developing relationships with stakeholders, including government and healthcare providers (including primary care), both nationally and within different jurisdictions

Co-Designing Recruitment Strategies with Clinicians for a Qualitative Study of eConsult in Dementia Care

Sarah Syed[1,2] Shruthi Sundararaman[1,2], Nalia Gurgel-Juarez[13], Idrissa Beogo[3], Julia Chabot[4], Maxine Dumas-Pilon[5], Claire Godard-Sebillotte[4,6], Erin Keely[7,8,9], Frank Knoefel[1], Stefan de Laplante[7], Clare Liddy[1,9,10], Isabella Moroz[1], Mwali Muray[3], Catherine Richer[5], Laura Visentin[10,11], Amanda Wilson[1], Suey Shuk Yu Yeung[1], Sathya Karunananthan[1,12]

[1]Bruyère Health Research Institute, Ottawa, Canada; [2]Faculty of Medicine, University of Ottawa, Ottawa, Canada; [3]School of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa, Canada; [4]Department of Medicine, McGill University, Montréal, Canada; [5]Department of Family Medicine, McGill University, Montréal, Canada; [6]McGill University Health Centre, Montréal, Canada; [7]Department of Medicine, University of Ottawa, Ottawa, Canada; [8]Division of Endocrinology and Metabolism, The Ottawa Hospital, Ottawa, Canada; [9]Ontario eConsult Centre of Excellence, The Ottawa Hospital, Ottawa, Canada; [10]Department of Family Medicine, University of Ottawa, Ottawa, Canada; [11]Academic Family Health Team, The Ottawa Hospital, Ottawa, Canada, [12]Interdisciplinary School of Health Sciences, University of Ottawa, Ottawa, Ontario, Canada, [13]Faculty of Dentistry, University of Manitoba, Winnipeg, Canada

Background

- **Dementia prevalence in Canada is rising.**[1,2]
- **Inequitable access:** People living with dementia from underserved communities can face barriers to timely specialist care
- **Potential solution:** eConsult (ON) & Conseil numérique (QC) give primary care providers rapid, case-specific specialist advice.[3]



- **Why this study:** Clinicians' perspectives can help us understand eConsult use in dementia care and opportunities to improve equitable access

Who we are recruiting

Providers	Currently Practicing in	Involved in	Language	eConsult Experience
PCPs or specialists	Ontario or Quebec	Caring for Patient with Dementia	English or French	Not required

- **Recruitment Challenge:** busy clinicians can be difficult to recruit for qualitative research.[4]

Objective

To **co-design** practical recruitment strategies for reaching PCPs and specialists in a qualitative study of eConsult for dementia care.

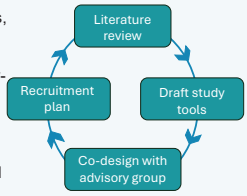


Approach

• Advisory committee: 9 providers (family physicians, nurse practitioners, and dementia specialists)

2 codesign sessions with email follow-up:

- **Session 1:** Refined the semi-structured interview guide.
- **Session 2:** Co-developed recruitment strategies and finalized the recruitment plan



Results

RECRUITMENT STRATEGY	HOW IT HELPS
Snowball sampling	*Referrals from established clinical networks*
Conference recruitment	*In-person outreach at conferences*
Clinical Network	*Advisory committee outreach*
Incentives	*To compensate for their time*
Reduced burden	*Flexible virtual interviews; shorter guide*

Conclusions

- Clinician advisory input clarified barriers to participation and shaped a practical, context-appropriate recruitment approach
- This provides a structured framework for recruiting hard-to-reach clinicians and highlights the value of co-design in health services research

NEXT STEPS



Launch recruitment



Interview PCPs and specialists



Thematic analysis

Would You Like to Participate?

We are recruiting Primary Care Providers and Specialist in Ontario or Quebec to share their perspective on access to specialist advice in dementia care: A study on eConsult and equitable access to dementia care

Scan the QR to sign-up for a 30 minutes interview

Questions? Contact Sarah Syed at ssyed5@uottawa.ca

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This work was supported by:

uOttawa | Faculté de médecine Faculty of Medicine

CIHR IRSC

Santé Bruyère Institut de recherche Bruyère Health Research Institute

The Ottawa Hospital L'hôpital d'Ottawa

Winchester District Memorial Hospital

Ontario Champlain Local Health Integration Network

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

Samaira Husein [1], Umaya Krishnathas [1], Yvonne Tan [2], Alishba Mansoor [1], Bruce Knox [1], Imaan Bayoumi [1], Eva Purkey [1]
1. Department of Family Medicine, Queen's University
2. School of Population and Public Health, University of British Colombia

Background

- Refugees face language and healthcare-system navigation barriers.[1-4]
- **Patient navigators** help refugees overcome these barriers.[5-7]
- **Gap:** Limited evidence on navigation program structures and outcomes.



Research Question: How are refugee patient navigation programs structured and implemented across OECD* healthcare settings, and what roles, needs, and outcomes are reported?

*OECD - Organisation for Economic Co-operation and Development

Objectives:

1. **Characterize** navigator roles, training, and implementation models across OECD healthcare settings
2. **Identify** refugees' healthcare needs and services accessed through navigation.
3. **Map** patient-, provider-, and system-level outcomes, barriers, and facilitators.

About Connecting in Canada



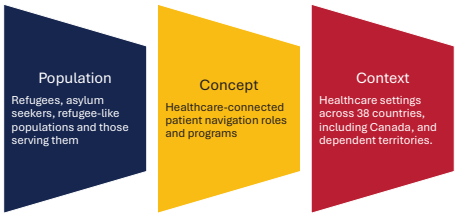
Connecting in Canada: Health Systems Navigation for Refugees is a broader research project that uses co-design to implement a 'health systems navigator' for refugees in two primary care clinics in Kingston, ON which provide refugee healthcare

Methodology

Review Design & Search Strategy
- Joanna Briggs Institute methodology; PRISMA-ScR reporting.[8]
- MEDLINE, Embase, CINAHL, Global Health.
- 38 OECD-member countries, including Canada.

Study Selection
- Two independent reviewers screened studies in Covidence.
- Disagreements resolved by consensus or third reviewer.

Study Eligibility

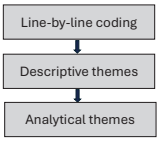


✓ **Include**
Original studies, program evaluations/descriptions.

✕ **Exclude**
Non-healthcare navigation, protocols, and publications without original findings or program descriptions.

Data Extraction & Analysis

Qualitative Synthesis
Thomas & Harden (2008) [9]



Quantitative Synthesis
- Descriptive summary:
  → Tables and narrative summaries

Community Advisory Board (CAB)

Findings shared with CAB to:
- contextualize results,
- identify evidence gaps,
- inform recommendations.

Results

- At this stage, study selection is complete and data extraction is underway

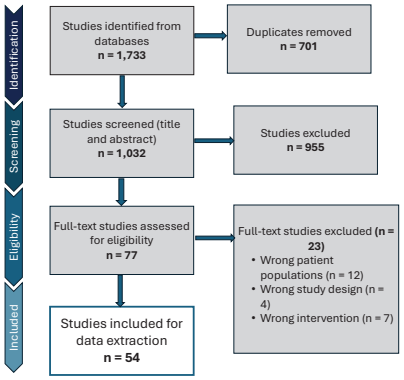


Figure 1*. PRISMA-ScR Flow Diagram*

Next Steps

- Extract and synthesize findings from 54 studies
- Inform refugee patient navigation services and future research

References

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

Olivia Katsnelson, Liam McQuay, Akash Prassana Kumar, Laurie Zawertailo, Scott Veldhuizen, Sri Mahavir Agarwal, Peter Selby, Osnat Melamed

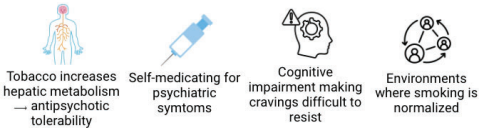
INTREPID Lab, Centre for Addiction and Mental Health, Toronto, ON

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Email: Olivia.Katsnelson@mail.utoronto.ca. Osnat.Melamed@camh.ca

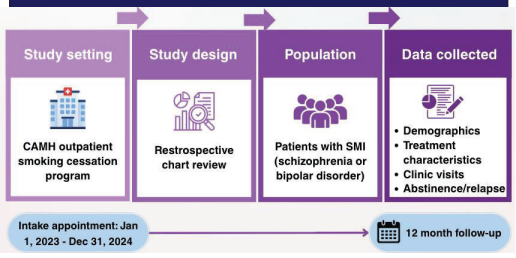
INTRODUCTION

- People with serious mental illness (SMI) have a 5 to 6x higher prevalence of smoking compared with the general population; they smoke younger, more heavily, and have stronger dependence.
- Smoking is the largest modifiable risk factor for premature death in SMI, leading to 15 years of life lost compared to never-smokers without SMI.
- Smoking cessation (SC) outcomes remain poorer among people with SMI, potentially due to:



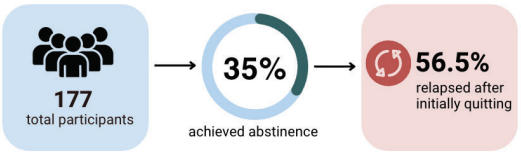
- In order to improve quit outcomes, we need to explore tobacco treatment patterns in this group.
- **Objective:** Characterize the demographic, diagnostic, and treatment profiles of patients with SMI who attended an outpatient SC program at CAMH.

METHODS

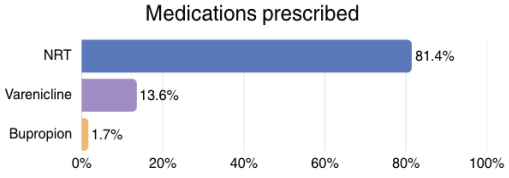


RESULTS

1. Smoking Cessation Outcomes



2. Treatment patterns



**These are not mutually exclusive. Patients may have tried more than 1 medication.

4.39 ± 3.21
mean clinic visits

12.4%
of patients were recommended e-cigarettes as HR

26%
of patients attended at least 1 counselling session (group or individual)

References:

1. de Leon J, Diaz FJ. A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. Schizophr Res. 2005;76(2-3):135-157.
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RESULTS CONT'D

3. Demographics

- 57% had schizophrenia; 43% had bipolar disorder
- Mean age was 46.9 ± 13.6
- 105 males; 72 females

18.6
Cigarettes per day
Mean ± SD: 18.6 ± 14.4

21.6
Minutes to first cigarette
Mean ± SD: 21.6 ± 64.5

CONCLUSIONS

- 35% of patients with SMI were able to quit; over half of those relapsed by 12 months.
- Only about 1 in 7 patients with SMI (15%) wishing to quit smoking was able to achieve and maintain abstinence at 12 months
- Since relapse is common, ongoing follow up and relapse prevention are essential: extended pharmacotherapy courses, longitudinal counselling, and more physician visits.
- E-cigarettes should be considered as a harm reduction tool for those who can't quit with standard treatments.
- Primary care providers may benefit from education on e-cigarettes as harm reduction in this population. Particularly, for those who fail to initiate or maintain abstinence despite trying to quit with approved smoking cessation medication.

Making Sense of Policy: A Mixed-Methods Study of Refugee Healthcare Access

Umaya Krishnathas, Alishba Mansoor, Samaira Husein, Bruce Knox, Imaan Bayoumi, Susan Bartels, Weam Mansoor, Eva Purkey

Department of Family Medicine, Queen's University, Kingston ON, Canada

Background

- IFHP provides temporary healthcare coverage for refugees and asylum seekers in Canada
- In 2026, changes to the IFHP introduced co-payments for medications and supplemental services.[1]
- Understanding healthcare experiences may help identify access barriers following 2026 changes.

Objectives

1. Explore **experiences of healthcare access** following IFHP policy changes.
2. Identify **barriers and facilitators** to accessing healthcare.
3. Demonstrate the **use of SenseMaker** to capture participant perspectives.

Study Design

DESIGN: Pan-Canadian, multi-site, cross-sectional mixed-methods study.

DATA COLLECTION: Trained 16 interviewers conduct multilingual interviews using Sprockler™

SETTING: Active data collection across 12 cities in six provinces.

RECRUITMENT: Community-based recruitment through healthcare providers and settlement agencies.

Eligibility & Data Analysis

Eligibility: Adults ≥18 sharing a healthcare access story involving an IFHP-covered refugee or asylum seeker (May 2026- Jan 2027). Participants may include **refugees or asylum seekers themselves, friends, allies, healthcare providers, or settlement workers**.

Data Analysis: Descriptive statistics and triad visualizations; thematic analysis of translated narratives; integration of quantitative patterns with corresponding stories.

Sensemaker Methodology

Theory behind SenseMaker

Sensemaking recognizes storytelling as a natural way people interpret their experiences. Using a digital storytelling and survey platform (Sprockler), participants share and interpret their own stories. Collectively, these perspectives help reveal patterns and provide a more complete understanding of complex experiences.[2]

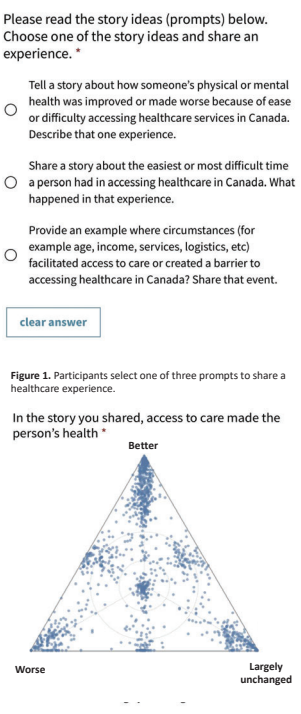


Figure 1. Participants select one of three prompts to share a healthcare experience.

Figure 2. Illustrative SenseMaker triad with simulated responses (not study data).

STEP 1: SHARE A STORY
- Participants share a healthcare experience using one of three open-ended prompts.
- Narratives can be recorded in multiple languages.

STEP 2: INTERPRET THE EXPERIENCE
- Participants interpret their own narratives through quantitative questions.
- Responses capture perceived healthcare access and outcomes.

STEP 3: ANALYZE PATTERNS
- Visualize quantitative responses.
- Examine patterns alongside participant narratives.

Scan to share your healthcare access experience and contribute to our study!

Preliminary Findings

Emerging Experiences: Kingston Pilot (n = 8 narratives)

Financial Barriers
- Difficulty affording medications and dental treatment.
- Delays in care while awaiting coverage approval.

Language & Navigation Barriers
- Limited access to interpretation services.
- Difficulty locating healthcare and mental health services.

Positive Experiences & Uncertainty
- Successful access to specialized and maternity care.
- Concerns about future coverage following IFHP changes.

Strengths & Limitations

Strengths: Rapid multilingual data collection; integration of qualitative and quantitative data; participant-led interpretation; potential to reduce interpretation and social desirability biases.

Limitations: Translation challenges; limited narrative depth and follow-up opportunities; reliance on predefined questions.

Next Steps

Conclusions: Early narratives describe healthcare access barriers and illustrate SenseMaker's ability to capture diverse experiences.

Next Steps: Recruit ≥50 narratives per province, analyze patterns, and share findings with refugee communities, settlement and health organizations, and policymakers.

CTAQ · CSPC Centre for Studies in Primary Care

References:

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

Shurabi Anphalagan[1,2], Dr. Shiraz Malik[3,4], Swathi Anphalagan[1,2], Dr. Daniela Keren[3,5], Dr. Tyler Jervis[3,6], Dr. Shannon L. Sibbald[3,7]

[1]School of Medicine, Toronto Metropolitan University, Toronto ON; [2]Department of Pathology and Laboratory Medicine, Western University, London ON; [3]Department of Family Medicine, Schulich School of Medicine and Dentistry, Western University, London ON; [4]London Health Sciences Centre, London ON; [5]Department of Family and Community Medicine, University of Toronto, Toronto ON; [6]Windsor Regional Hospital, Windsor ON; [7]Faculty of Health Sciences, Western University, London ON

Western

BACKGROUND

Pain Management in Advanced Cancer

- Cancer is the **leading** cause of death in Canada[1]
- Pain management includes **pharmacological** (opioids or painkillers) and **non-pharmacological** (therapy or massages) approaches

Research Gap

- Lack of literature on the impact of psychosocial factors on pain management for patients with advanced cancer in the Canadian context

RESEARCH QUESTION

What challenges are encountered by healthcare providers when managing pain in patients with advanced cancer?



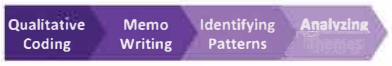
METHODS

Design and Recruitment

- **Qualitative descriptive design**, conducting semi-structured interviews (30–60 minutes) with care providers from two major Southwestern Ontario hospitals

Data Analysis

- **Braun and Clarke's thematic analysis** approach to iteratively code transcripts, employing researcher reflexivity and team discussions to refine key themes[2]



RESULTS

Eleven providers participated in this study (4 general practitioners, 3 oncologists, 2 other specialists, and 2 nurses). When asked about their experiences, **four main themes were** identified:

THEME 1
COMPLEXITIES IN PAIN MANAGEMENT

- Delayed access to pain management
- Discrepancies with patient-reported pain
- Drug prescription use or misuse



> *"Sometimes if the patient doesn't have a moment to ask for pain medication or they don't think to ask for it on time, I think that's kind of where we fall through the cracks a little bit is, instead of things being scheduled, things are as needed.*
>
> **– Inpatient Oncology Nurse (Interview 2)**

THEME 2
PSYCHOSOCIAL DIMENSIONS OF PAIN MANAGEMENT

- Psychological & social impacts of pain management on patients (anxiety, grief, trauma, expectations)
- Socioeconomic factors of cancer care



> *The patient's expectation is they're going to have zero pain; you're never going to fulfill their expectation. If their expectation is just improved functioning, then you can sometimes work with them a little bit easier than someone who says, "I want my pain to be zero, no matter what."*
>
> **– Community Family Physician (Interview 10)**

THEME 3
PROVIDER-RELATED CHALLENGES

- Lack of comprehensive pain management education
- Impact of providers' personal bias on care
- Emotional toll for providers



> *Like I felt, it was my fault. The pain was not caused by the cancer; the pain was a side effect of the treatment.*
>
> **– Medical Oncologist (Interview 3)**

THEME 4
SYSTEM-RELATED CHALLENGES

- Gaps in interdisciplinary teams & communication
- Structural barriers
- Time constraints and lack of incentives



> *I would love to do for all of my patients but being on the surgical side of things I have very short time and clinics are jammed. And if I do take this time, it's sort of pushing all of my appointments later in the day, which stresses everybody else out and it's not ideal.*
>
> **– Urologist (Interview 9)**

DISCUSSION

Psychosocial Factors: Pain experiences are influenced by emotions, social norms, and mental health, requiring holistic approaches that integrate psychosocial support

Interdisciplinary Challenges: Fragmented communication between oncology, palliative care, and primary care delays pain management, while providers highlighted inadequate training in complex cases contributing to role confusion

Access Issues: Systemic barriers like staffing shortages, resource limitations, and socioeconomic disparities delay timely and effective pain management

CONCLUSION

Understanding psychosocial factors in pain management can inform targeted interventions, drive system-level changes, and support integrated care models that address both physical and psychosocial needs

Future Directions:



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2. Braun V, Clarke V. Thematic analysis: a practical guide. London: SAGE Publications; 2022

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

Swathi Anphalagan,[1,2] Shurabi Anphalagan,[1,2] Dr. Shannon L. Sibbald[3,4]

[1]School of Medicine, Toronto Metropolitan University, Brampton ON; [2]Department of Pathology and Laboratory Medicine, Schulich School of Medicine and Dentistry, Western University, London ON; [3]Department of Family Medicine, Schulich School of Medicine and Dentistry, Western University, London ON; [4]School of Health Studies, Faculty of Health Sciences, Western University, London ON

Western

BACKGROUND

Indigenous Health

- Over **1.8 million people** in Canada identify as Indigenous[1]
- In 2015, the Truth and Reconciliation Commission of Canada reported Calls to Action to support Indigenous health reform:

> **"We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients"**[2]

Research Gap

- Limited research about Indigenous partnerships in healthcare and their applicability to Canadian contexts

OBJECTIVES

How can key Indigenous health perspectives and practices be effectively integrated into health systems transformation efforts to address health disparities within Indigenous communities?

1. Explore Indigenous health perspectives and practices that can guide health systems reform
2. Investigate current health systems reform efforts that integrate Indigenous perspectives
3. Provide recommendations for including Indigenous perspectives in healthcare reform to address health disparities within Indigenous communities

METHODOLOGY

- Rapid review on **PubMed** using the **Dobbins (2017) methodology**[3]
- **Critical Appraisal Skills Programme** to assess quality of articles[4]
- **Inductive Thematic Analysis** to summarize patterns in the literature
- **MeSH Headings:** Indigenous Canadians, Healthcare Reform, Canada

INCLUSION CRITERIA

- Primary & Secondary Studies in English
- Published between January 2019 - November 2024
- Includes a keyword in the title or abstract

EXCLUSION CRITERIA

- Inaccessible electronically
- Unavailable in full text
- Unpublished
- Does not contain any keywords



RESULTS

Identification of studies via PubMed

Identification

Articles Identified from:
Databases (n = 1)
Articles (n = 67)

→ Articles removed *before screening*: Duplicates removed (n = 2)

Screening

Articles assessed for eligibility based on inclusion/exclusion criteria (n = 65)

→ Articles excluded *after title and abstract screening* (n = 33)

Articles assessed in full-text review (n = 32)

→ Articles excluded *after full-text review* (n = 2)

Included

Articles included in review **(n = 30)**

THEME 1: Decolonization of Health Systems

- Address **historical trauma** and ongoing discrimination
- Empower **Indigenous knowledge**, language, and traditions
- Prioritize culturally safe, **trauma-informed** healthcare

THEME 2: Holistic Models of Care

- Integrate **Indigenous Medicine Wheel & 4 Directions teachings**
- Blend traditional healing with Western medicine through **Two-Eyed Seeing**
- De-stigmatize traditional medicine

THEME 3: Health System Barriers

- **Limited access** in rural/remote communities
- Lack of transport and **funding**
- Racism, **discrimination**, and language barriers
- **Distrust** and limited traditional healing

THEME 4: Indigenous-led Health System Initiatives

- **Centre Indigenous voices** in decisions
- Support Elders, healers, and **Indigenous staff**
- Build partnerships through community-led programs, councils, and **Talking Circles**

THEME 5: Building Capacity in Health Systems

- Expand culturally responsive **healthcare training**
- Strengthen **representation** within healthcare
- Build infrastructure for traditional healing
- Integrate **strengths-based** approaches



DISCUSSION

Decolonize healthcare: Prioritize Indigenous Ways of Knowing and provide equitable funding to expand community-based/virtual care

Indigenous-led action: Increase Indigenous leadership, partner with Elders/Knowledge Keepers

Holistic & culturally safe care: Combine Indigenous practices (Medicine Wheel, smudging) with Western medicine (Two-Eyed Seeing)



CONCLUSION

Indigenous voices, holistic care, and Indigenous-led initiatives are essential for creating equitable and culturally safe healthcare systems

- **Improve collaboration with Indigenous communities**
- **Integrate Indigenous healing into health systems**
- **Empower Indigenous-led initiatives and representation in health systems**

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Bridging Gaps: Implementing Mobile Primary Care for the Unhoused Population

Linda Frost, PhD, NP[1]; Tehreem Mahmood, MS. Psych[1]; Daphene Francis, PhD, CHC, RN[1]; Fadzai Makwaira, Nursing Student[1]; Johanne Hayes, RN, BScN, MN[1]

Background

- Thousands of people experiencing homelessness remain unattached to primary care.
- Traditional clinic models often create barriers including transportation challenges, limited appointments, documentation requirements and fragmented services.
- Mobile primary care offers one approach to bringing care directly into the community, but little is known about what is needed to successfully implement these models.

Purpose

To understand how mobile primary care transforms healthcare delivery by adapting services to the realities of individuals experiencing homelessness. This evaluation explores how trust, flexibility, partnerships, and responsive care approaches contribute to improved access and engagement.

Methods

Design & Setting	A qualitative study guided by the Consolidated Framework for Implementation Research (CFIR) Mobile Community Health centre in Haltor Region, Ontario
Participants	• Healthcare providers • Social service staff • Organizational leadership
Data Collection	• Semi-structured interviews • Staff involved in planning and deliverirg the mobile clinic (n=7)
Analysis	Deductive thematic analysis CFIR-informed coding using NVivo

Participants


7 Participants


Healthcare Staff


Social Service Staff


Organizational Leadership

What We Learned

Challenges: What Made Implementation Difficult?

Mobile care required teams to rethink how healthcare is organized.

Challenges included:


Coordinating transportation and locations


Medication storage and infection prevention


Staffing models and role coordination


Replicating services usually available in fixed clinics

Care delivery needed to adapt to shelters, encampments, and community spaces.

Facilitators

What Helped Make It Work?

1 — Low-Barrier Care Improves Access

Participants highlighted that clients valued:
- Walk-in access
- No health card requirement
- Flexible appointment times
- Longer visits
- Care that responds to individual needs

2 — Flexibility and Learning Along the way

Teams continuously adapted:
- Where care was provided
- How workflows were organized
- How services were coordinated

Implementation was not a fixed process, it evolved based on community needs.

3 — People and Partnerships Matter

Success depended on:
- Staff experience working with vulnerable populations
- Interprofessional collaboration
- Strong relationships between healhcare and community organizations

WHY THIS MATTERS FOR PRIMARY CARE

Moving Beyond Traditional Attachment Models:

Mobile healthcare offers another pathway for individuals who remain disconnected from traditional primary care, giving access to services traditional primary care systems fail to provide.

It demonstrates how healthcare and community services can work together to improve:

- Access
- Trust
- Continuity of care
- Equity

From Findings to Action

PRACTICAL LESSONS FOR OTHER COMMUNITIES

COMMUNITIES CONSIDERING SIMILAR APPROACHES SHOULD:

Build Strong Partnerships
Connect primary care providers, community organizations, and social services early.

Design Flexible Systems
Mobile care requires adaptable workflows rather than traditional clinic structures.

Invest in the Right Team
Staff experience, teamwork, and shared commitment are essential.

Plan for Sustainability
Implementation requires:
- Stable funding
- Infrastructure support
- Leadership engagement
- Ongoing evaluation

Next Steps: The Implementation Toolkit

These findings inform an adaptable toolkit linking common implementational barriers with evidence-based strategies. The toolkit equips organizations with adaptable, real-world guidance to deliver low-barrier mobile care where it's needed most.

Conclusion

Mobile primary care provides an opportunity to rethink how healthcare is delivered to populations facing barriers to traditional services. Successful implementation depends on flexibility, collaboration, and designing care around the realities of the communities being served.

Contact

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

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I-CREAte

Queen's University Family Medicine

Background

•Indigenous Peoples in Canada possess **rich knowledge systems** that are grounded in language, ceremony, culture and community.

• Increasing access to healthcare and improving health outcomes, through the implementation of **Indigenous Patient Navigators (IPNs)**, builds on these strengths.

• IPNs can help **address the systemic barriers** created by colonialism and anti-indigenous racism in the healthcare system.[1]

Objective

To map **Indigenous Patient Navigation** in diverse healthcare settings through the scope of IPN roles, cultural frameworks, implementation strategies, program evaluation approaches, and impacts on patients, providers, and healthcare systems.

Methodology

- Joanna Briggs Institute methodology[2] and guided by PRISMA-ScR checklist.[3]
- Three reviewers used Covidence software to independently screen references from MEDLINE, Embase, EBSCOhost.
- **Inclusion Criteria:** Academic articles published in English, up to November 2025, from Canada, the United States, Australia, or New Zealand, reporting:
  - (1) IPN implementation strategies or cultural frameworks
  - (2) patient-, provider-, or system-level outcomes
  - (3) implementation barriers or enablers.
- Studies are being analysed using descriptive statistics and thematic analysis in NVivo.

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Results

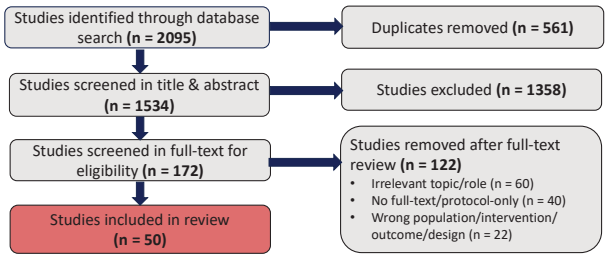


Figure 1. PRISMA diagram depicting selection of included studies.

IPN Roles in Healthcare

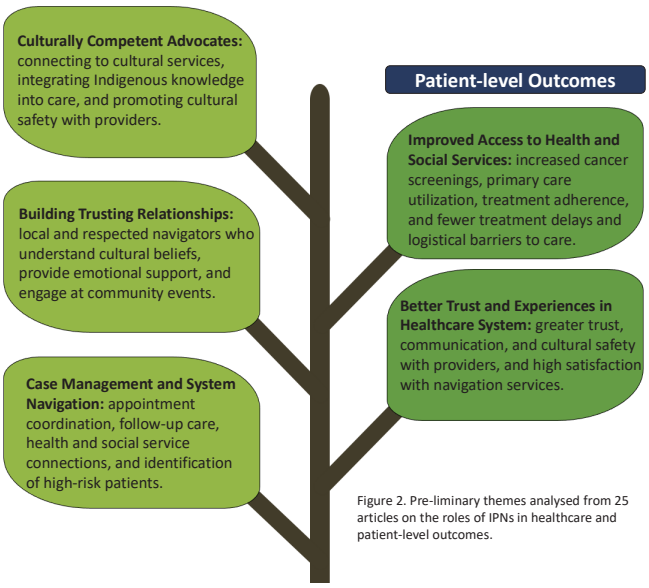


Figure 2. Pre-liminary themes analysed from 25 articles on the roles of IPNs in healthcare and patient-level outcomes.

Study Characteristics – Countries & Settings

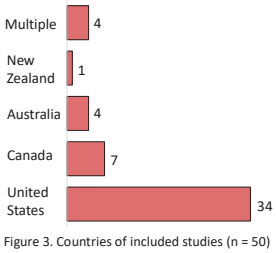


Figure 3. Countries of included studies (n = 50)

Implementation of IPN Program

Enablers

- Navigator from the same community, responding to cultural needs
- Organization supports → funding, IPN well-being
- Training & certifications
- Accessibility of IPN to patients
- Access to patient data and technology (e.g., EMRs)

Barriers

- Lack of organizational resources & program evaluation
- Healthcare team integration challenges → role clarity & recognition
- No access to patient data
- Building community trust & maintaining confidentiality
- Risk of burnout

Next Steps and Future Directions

- Other topics being analysed include: evaluation approaches, culturally-grounded frameworks, provider- and system-level outcomes.
- Findings will highlight strengths and opportunities, supporting the continued implementation and evaluation approaches of I-CREAte's IPN role at Queen's Family Health Team.
- Findings will also inform future IPN program design, policy development, and research that centres Indigenous self-determination in healthcare.

Centre for Studies in Primary Care

References:

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

Gregory Feng[1,2], Melissa Cavallo[1], Abigail Zita Seshie[1], Barjot Gill[1], Karen Li[1], Laure Perrier[3], Aisha Lofters[2,5,6,7], David Blane[8], Navindra Persaud[2,5,9], Lauren Lapointe-Shaw[2], Audrey Laporte[2], Andrew D. Pinto[1,2,4,5,9]

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Introduction

- **Access to primary care** remains a challenge in many high-income countries
  - In 2025, **5.9 million** people living in **Canada** did not have a regular primary care provider
  - **100 million** people living in the **United States** face barriers to accessing primary care
  - In **Australia**, **Sweden**, and **Switzerland**, only **half** of adults have a longstanding relationship with a primary care provider
- **Equity-deserving groups** (e.g., those of lower SES, immigrants, racialized groups, etc.) show persistent and worsening **disparities**
  - Many interventions to increase primary care access fail to consider impacts on equity-deserving groups
  - E.g., COVID-era studies on virtual care transitions highlight how primary care access interventions can worsen disparities
- **Objective**: To provide a timely mapping of the types of interventions that improve access to primary care among equity-deserving groups in high-income countries

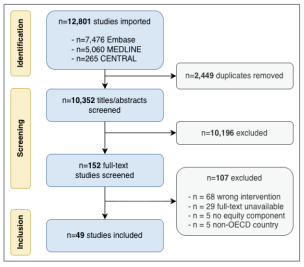


Figure 1. PRISMA flow diagram illustrating the identification and screening of studies.

Methods

- **Protocol and Registration**: Guided by the JBI manual for evidence synthesis (scoping reviews) and prospectively registered on OSF (Identifier: yqx86)
- **Sources**: Ovid MEDLINE, Ovid MEDLINE Daily, Ovid MEDLINE In-Process & Other Non-Indexed Citations, Ovid MEDLINE Epub Ahead of Print, OVID EMBASE, Cochrane Central Register of Controlled Trials
- **Selection and Extraction**: Title/abstract screening and full-text review by two reviewers; Data extracted by two reviewers via standardized extraction form; Discrepancies discussed as a group to reach consensus
- **Analysis and Reporting**: Three-phase qualitative **deductive content analysis**
  1. **Preparation**: develop intervention categories based on Smithman et al. (2020) 18-component typology
  2. **Organization**: sort studies into one of six intervention categories
  3. **Reporting**: evidence tables/descriptive statistics, PRISMA-ScR

Inclusion Criteria

- Studies reporting on interventions that improved access to primary care among equity-deserving groups were included
  - **Improved access**: increased ability to obtain primary care services (e.g., through attachment, removing barriers, etc.)
  - **Primary care**: meeting or demonstrating the ability to meet the core functions of first-contact, continuous, comprehensive, and coordinated care (4Cs framework)
  - **Equity-deserving groups**: any groups facing marginalization, vulnerability, or disadvantage through social mechanisms

Exclusion Criteria

- Articles published in languages other than English
- Articles published before 2000
- Research protocols, conference abstracts, review articles
- Interventions focused on a narrow set of primary care services (e.g., screening only, education only)
- Studies conducted in non-OECD (Organization for Economic Co-operation and Development) countries

Results

- Studies mainly conducted in **North America**
  - **United States** (n=27, 55.1%) and **Canada** (n=11, 22.4%)
- Most studies were **published within the past decade**
  - Either from 2020-2025 (n=27, **55.1%**) or between 2010-2019 (n=16, **32.7%**)
- **Observational studies** (n=18, 36.7%), **mixed-methods studies** (n=9, 18.4%), and **quasi-experiments** (n=9, 18.4%) were the most common designs
- A **range of populations** were targeted
  - From a **specific** equity-deserving group (e.g., veterans) to a **broader** population (e.g., people living in lower-income neighbourhoods, people living in rural/remote areas, etc.)

Discussion

- **Strengths**
  - Focus on equity-deserving groups, timely mapping/useful to systems planners and policy decision-makers, captures evidence from a range of similar health systems, focus on recent literature
- **Limitations**
  - Quality of studies not evaluated, intervention rankings/causal estimates not possible, grey literature excluded, some interventions fit multiple categories
- **Next Steps**
  - Importance of conducting needs/assets assessments prior to implementation, variation in terminology/conceptualization of concepts warrants caution, variation between countries and jurisdictions warrants careful consideration of local contexts

Table 1. Summary of key findings from included studies.

	Definition	Major Interventions	Main Benefits	Considerations
1. Navigation and Information (n=7)	Services providing patients with information and support on where, when, and how to access care.	Transitional care programs, health navigators, centralized waiting lists	Attachment, reduced hospitalizations/ED visits	"Navigation to nowhere" – requires prior needs/assets assessment
2. Intersectoral and organizational care pathways (n=12)	Collaboration between organizations to facilitate timely access to services for equity-deserving groups.	Co-located primary care clinics, integrated health clinics	Primary care visits, attachment, meeting patients where they're at, comprehensive and continuous care	Maintaining continuity in patient-provider relationship vs. providing a range of services to patients
3. Tailored and adapted services (n=15)	Primary care services customized to meet the needs of a specific marginalized group (e.g., by addressing language barriers).	Primary care for specific groups or broader equity-deserving populations	Address specific barriers, provide tailored primary care, primary care visits, reduced use of hospital services	Long-term sustainability, providing tailored care vs reacting to systemic issues, funding
4. Outreach of primary care services (n=5)	Extending beyond the physical limits of primary care clinics to reach equity-deserving groups.	Mobile clinics, pop-up events, outreach to unattached patients	Engagement with primary care system, build rapport between patients and providers, connect patients to the mainstream system	Limited ability to provide comprehensive primary care, establishing continuous relationships with patients
5. Virtual care (n=3)	Use of technology (e.g., video conferencing, phone, email, etc.) to deliver primary care services.	Telehealth, video conferencing	Reduce barriers (e.g., transportation, time), primary care visits	English proficiency of patient populations, digital precarity
6. Defraying costs to patients (n=7)	When costs associated with accessing the primary care system are partially or entirely covered.	Health insurance, low-cost/free clinics	Primary care visits, reduced out-of-pocket costs, increased sense of connection to care	Funding sources

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UPSTREAMLAB

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

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1 - MAP Centre for Urban Health Solutions, St. Michael's Hospital 2 – ICES

Background

The Ontario Community Health Profiles Partnership (OCHPP) project has worked with health and community partners for over 25 years. OCHPP provides free access to high-quality health data and determinants on our website, receiving 4000+ monthly visitors.

OBJECTIVE: We aim to provide meaningful, reliable, small-area data on health outcomes and their determinants for Ontario

Approach

We provide regular data updates, technical guidance, and small-area development expertise to community partners across Ontario. All data and methodologies are openly accessible on our public website.

How to Access our Data

Scan the QR code to visit our website:
www.OntarioHealthProfiles.ca

Data, Charts and Maps
↓
Select Pre-defined or Custom Geography
↓
Select Data Category
↓
Download Data

Select Pre-defined Geography: small area (e.g. City of Toronto), Modified Sub-Region, Ontario Health Region. Data available in .pdf maps and Excel tables.

Select Custom Geography: select data for custom areas (e.g. a few neighbourhoods) from an interactive map to then export in Excel table format.

Data Category Examples: cancer prevention, census profiles, chronic conditions (e.g. diabetes, asthma)

Why We Provide Small Area Level Data

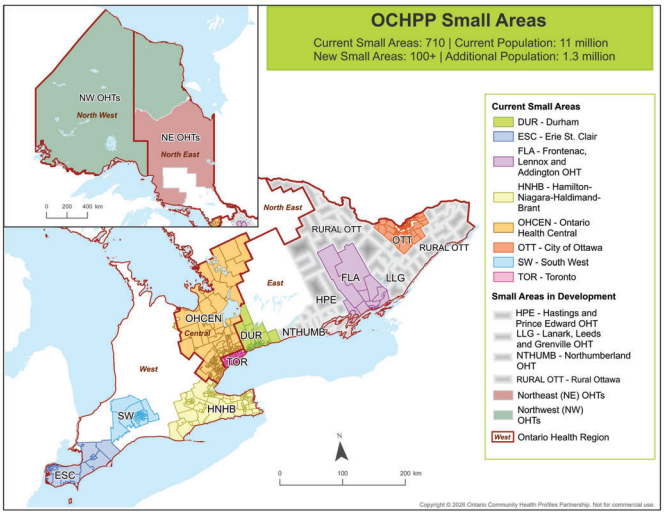
Larger geographies (such as Ontario Health Regions) may overlook the unique health needs of local communities. Small areas are designed to be small enough to provide a detailed picture of a wide range of health-related topics, while being sufficiently large to produce stable estimates.

How We Create Small Areas

- Choose Census building blocks – such as dissemination area (DA) groupings, aggregate dissemination areas (ADAs) and/or census subdivisions (CSDs).
- Adjust blocks to provide meaningful boundary definitions with a population threshold of approximately **5,000 – 30,000** people.

DA — 400-700 people
ADA — 5,000-15,000 people
CSD — Municipality (population varies)

Results



Small Areas in Northern vs. Southern Ontario

Access to health services in Northern and rural Ontario is limited by longer travel times and fewer resources. To support our Northern Ontario partners in their health planning, we are analysing health service locations and community health hubs while prioritizing the specific data needs of the region's Indigenous rights-holders.

Small Area Collaborations

- *Health Commons Solutions Lab*: neighbourhoods in Erie St. Clair, South West and Hamilton-Niagara-Haldimand-Brant
- *Queens University*: communities in Frontenac Lennox and Addington OHT
- *Ontario Health Central*: local areas in Ontario Health Central
- *New partnerships*: small areas in Hastings Prince Edward Ontario Health Team (OHT), Northumberland OHT, Lanark Leeds and Grenville OHT, Northeast and Northwest Ontario OHTs and rural Ottawa

Other Contributions

OCHPP staff have contributed to numerous projects, resulting in:

- Dozens of peer-reviewed publications
- Several atlases and chart books including diabetes atlases for Toronto and Peel Region
- Successful completion of MSA program practicums for dozens of TMU students

For information on becoming a partner, contact our research program manager: **Anne-Marie.Tynan@unityhealth.to**

Our Partners

This work was supported by ICES, which is funded by the Ontario Ministries of Health and Long-Term Care. No endorsement by funders or data providers is intended or should be inferred.



Toward Equitable Patient-Reported Data Collection: A Participatory Qualitative Study of Engagement Strategies for Underrepresented and Vulnerable Populations

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Context

Several healthcare organizations use self-reported questionnaires to assess patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs).[1,2,3]

It has been observed that participation among individuals from underrepresented or vulnerable groups is low. [4,5,6]

Several factors may explain their lower participation in data collection, including language barriers, mistrust, limited literacy, and others).[7,8,9]

However, these populations experience greater health inequities, are at increased risk of adverse healthcare experiences, and report poorer perceptions of their health.[4-5, 10-13]

It is therefore essential that the data reflect their experiences to inform equitable healthcare decisions that are responsive to their actual needs.

Objective

Consultation objective:

To identify preferred communication channels and strategies to support the participation of underrepresented or vulnerable groups in data collection

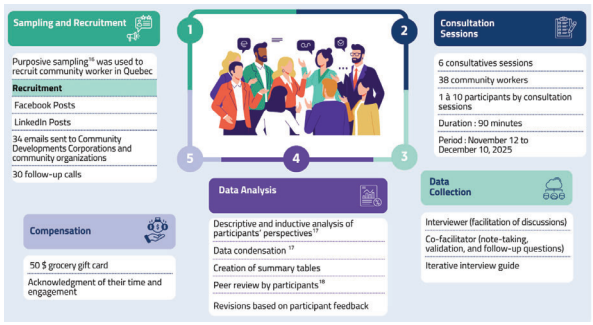
Methods

Design and epistemology

Participatory design[14] informed by a constructivist/interpretivist paradigm[15], which recognizes that knowledge is co-constructed through participants' experiences and the contexts in which they occur.[15]

Particular attention was given to recruiting participants working with diverse underrepresented populations across various community settings in Quebec.

Consultation Session Procedures



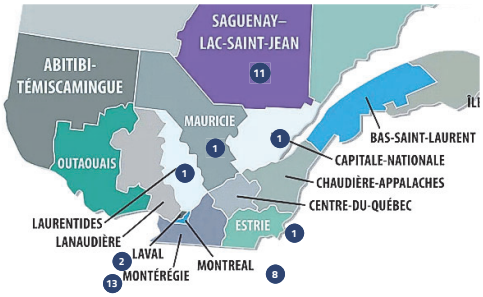
Results

Sample description: 38 community workers from eight regions of Quebec

Type of population served by participant	n
People living with physical, intellectual, or developmental disabilities	6 (15,8)
People living with mental health conditions	2 (5.3)
People living with rare diseases or specific conditions	5 (13.2)
Deaf people	1 (2.6)
Deaf people	1 (2.6)
Older adults	5 (13.2)
People living in poverty	3 (7.9)
People with low literacy	9 (23.7)
Immigrants or members of ethnocultural communities	5 (13.2)
Indigenous people	1 (2.6)
Homeless or disaffiliated people	3 (7.9)
Total	38 (100)

Age group	n
18 to 35 years	13
36 to 45 years	16
46 to 55 years	5
≥56 years	4
Total	38

Gender	n
Woman	31
Man	4
Non-binary	1
Agender	1
Prefer not to answer	1
Total	38



Preferred communication Channels

Population	Communication Channels: In person: Community Organization Office	In person: Living environment/Family	In person: Word of mouth	In person: Trusted intermediary1	In person: Event	In person: Referral by another organization or professional	Remote Voice: Telephone2	Remote Voice: voice/video message3	Remote Voice: Video Call	Written: Text message3	Written: Mail	Written: Email	Written: Local newspaper	Written: Posters / pamphlets
People living with physical, intellectual, or developmental disabilities	X	X	X			X	X			X	X	X		X
People living with rare diseases or specific conditions.	X		X			X	X			X	X	X		
People living with mental health conditions	X	X		X		X	X					X		X
Deaf people		X		X				X	X	X				
LGBTQ+ people												X		
Older adults	X	X	X	X			X					X	X	X
People living in poverty	X	X	X	X		X	X			X			X	X
People with low literacy	X		X			X	X	X						X
Immigrants or members of ethnocultural communities	X	X	X	X	X	X	X			X		X	X	X
Indigenous people	X			X				X		X		X		
Homeless or disaffiliated people	X	X	X	X		X	X	X		X		X		

IMPORTANT : Some communication channels require prior approval or consent and may not be permitted in certain contexts. It is essential to ensure that communication channels comply with your organization's policies and applicable laws.

Strategies to support the participation

Moment	Strategies to support the participation
Selection or development of the data collection tool	Reduce the required literacy level
	Use clear and simple language
	Conduct questionnaire validation sessions with people representing your target population
	Use scales with fewer response options or visual response options
	Use an adapted or tailored questionnaire
	Use open-ended questions to allow people to express themselves more freely
Initial Contact and recruitment	Use simple language
	Provide a glossary
	Provide information in multiple languages
	Use a variety of recruitment materials (not only written materials)
	Promote the project or initiative in person
	Create a video and add subtitles
	Explain the potential benefits of the project or initiative
	Explain the rationale behind the choice of questionnaire
	Acknowledge and value the person's role
	Provide feedback on the project or initiative
	Prioritize in-person contact
	Collaborate with community organizations
	Ensure anonymity when desired
	Adopt an open and attentive approach
	Explain the purpose of the questionnaire and how the collected data will be used
	Collaborate with a trusted person (e.g., peer, patient partner)
Questionnaire completion	Rephrase questions to improve understanding
	Offer the questionnaire in multiple languages
	Emphasize that there are no right or wrong answers
	Be available to answer participants' questions
	Offer assistance with completing the questionnaire
	Allow the questionnaire to be completed orally
	Use a text-to-speech feature
	Use a short questionnaire
	Inform people as early as possible that they may be asked to complete a questionnaire
	Provide the estimated time needed to complete the questionnaire
	Allow responses to be saved and completed later when using an electronic questionnaire
	Provide a safe and appropriate setting
	Provide the questionnaire shortly after the medical consultation
	Offer assistance with entering responses
	Offer the option to complete the questionnaire on site
	Provide free Wi-Fi access
	Provide the necessary equipment to complete the questionnaire
	Offer different options for completing the questionnaire (e.g., paper, telephone)
	Ensure consistency across the organization
	Stagger data collection activities to avoid asking persons to complete too many questionnaires
	Respect each person's pace and allow sufficient time
	Send reminders
	Invite the person to complete the questionnaire immediately after their visit to the healthcare facility

Discussion

Trust in the healthcare system is essential

The involvement of trusted intermediaries not only helps broaden outreach efforts but also strengthens the legitimacy and acceptability of data collection initiatives, particularly in contexts where mistrust of healthcare institutions is prevalent. This is consistent with the existing literature, which highlights the importance of trust and community partnerships in fostering patient engagement and reducing barriers to participation among marginalized populations.[19,20,21]

Communication strategies should be tailored and combined

Our findings challenge one-size-fits-all approaches, highlighting the need to avoid assumptions based on population group membership and adopt communication strategies that are responsive to individual preferences and contextual realities.
This is consistent with studies by Roberts et al. (2020)[4] and Stephens et al. (2025)[5] which suggested that conventional methods of collecting patient experience data may inadequately capture the perspectives of socioeconomically disadvantaged populations, particularly due to non-response bias.

✚ Strenghts

- Practical resource to support the engagement of underrepresented and vulnerable populations
- An approach responsive to population needs (flexibility, openness, and collaboration with community organizations)
- Peer review with participants to ensure credibility[18]

▬ Limitations

- The findings are specific to the Quebec healthcare system and may not be readily generalizable.
- Potential selection bias despite efforts to promote inclusivity.[22]
- No direct consultation was conducted with underrepresented or vulnerable populations.

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

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Background

- Lack of health insurance is a significant barrier to timely and appropriate healthcare in Canada.
- **Uninsured Individuals:** Those that do not have coverage through OHIP, IFHP, or private insurance. Includes:



- One study found that **6% of patients** presenting to an Emergency Department (ED) in Toronto were uninsured.[1]
- Past research suggests that compared to insured patients, uninsured patients are more likely to be:
  - Triaged into a more severe CTAS
  - Leave without treatment
  - Pass away on arrival.[2]
- Ontario has **no regulations regarding hospital charges** for medically necessary care for uninsured patients; hospitals independently determine pricing, typically based on estimated costs plus a premium.[3]
- Uninsured patients have reported being asked for payment before or during treatment, being explicitly refused care, having care discontinued if they were unable to continue to pay, and being repeatedly contacted by hospital collection staff or external collection agencies.[4]
- Following the federal passing of Bill C-12 impacting the IFHP and the 2023 cancellation of Ontario's Physician and Hospital Services for Uninsured Persons Program, the **uninsured population is expected to grow.**[4, 5]

Objectives

I. **Primary** objective is to understand the system of emergency and urgent care for uninsured patients from the perspective of frontline healthcare providers within the Frontenac, Lennox and Addington Ontario Health Team (FLA OHT), a region in Southeastern Ontario

II. **Secondary** objectives of this study are to provide local context to inform the ongoing advocacy work of the Kingston Community Health Centres and Kingston Immigration Partnership and to characterize how this issue presents in mid-sized centres with fewer resources.

Methodology

- **Qualitative descriptive design**
- Semi-structured interviews with frontline healthcare providers across four ED/UCC sites within the FLA OHT, exploring perceived barriers, facilitators, role-specific challenges, and opportunities for future improvement.



- Purposive sampling will be used to recruit 15-20 providers with experience caring for uninsured patients across the four sites; interviews will continue until thematic saturation is achieved. Analysis will follow Braun & Clarke's thematic framework and will be underpinned by the Structural Vulnerability Framework.
- Guided by community-based research principles, the **Kingston Immigration Partnership** and **Kingston Community Health Centres are key partners** in the design and development of this study.

Progress to Date

- Interview guide (19 questions) was drafted with input from community partners and pre-tested with 4 sample participants across all 3 roles.
- Pre-testing identified:
  - 3 redundant questions to be removed
  - 2 questions requiring revision for clarity
  - 1 area of exploration to be added (communities of uninsured populations typically encountered).
- Average interview length was 28.5 min (range 22-34 min).
- Revised guide contains 17 questions; 10 core and 7 role specific.

Next Steps

Data collection in progress. Interviews and analysis to occur iteratively. Partner organizations will be invited to offer feedback on early results to ensure that the final product of the research is valid, trustworthy, and useful for future knowledge mobilization.

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Acknowledgements

I would like to thank Dr. Amrita Roy and Yu Jier Kou for their continued support and guidance, as well as the Queen's School of Medicine McLaughlin Studentship to support this project.

Acronyms
CTAS: Canadian Triage & Acuity Scale
ED: Emergency Department
IFHP: Interim Federal Health Program
OHIP: Ontario Health Insurance Plan
UCC: Urgent Care Centre

Contact:

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

Stéphanie Lamothe MSc[1,2], Denis Tsang RD, MSc, MAN[2,4], Sara Bhatti MPH[2], Kathleen Frame, MSc, MHSc[2], Jennifer Rayner PhD[2,3]

1. Centre de santé Univi Health Centre, 2. Alliance for Healthier Communities, 3. Western University, Centre for Studies in Family Medicine, 4. University *of* Toronto, Department of Family and Community Medicine

BACKGROUND

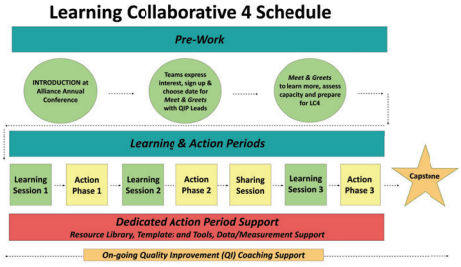
Learning collaboratives (LC) are structured, time-limited quality improvement (QI) initiatives that bring together interprofessional teams from primary care organizations. From September 2025 to June 2026, the Alliance for Healthier Communities facilitated *Learning Collaborative 4: Increasing Attachment Through Intake Process Improvements* to optimize client intake, strengthen attachment to primary care, and advance equitable access.

METHODS

The LC brought together diverse primary-care organizations to build QI capacity and support the testing and implementation of change ideas. Teams completed a readiness assessment to identify their preparedness, priorities, and capacity to participate.

Teams participated in three structured learning sessions and a peer-sharing session, where they shared their experiences, successes, progress, and lessons learned. A final capstone session celebrated achievements, facilitated cross-team learning, and supported participating teams in identifying next steps for continuing their improvement work.

Learning Collaborative 4 Schedule



Following the capstone, participants completed a post-program evaluation survey and participated in semi-structured interviews. Together, these activities supported an assessment of participant readiness, learning, experience, program support, and the LC's contribution to ongoing efforts in QI.

LESSONS LEARNED

From the semi-structured interviews, recommendations can be consolidated into some overarching themes:

- **Strengthen peer-to-peer learning:** more opportunities for sites to learn from each other
- **Engage frontline staff and providers early:** to get buy-in, feasibility, and sustainability
- **Expand practical resources and participation:** provide actionable resources such as digital intake processes

> " Provider involvement is an important factor in supporting implementation and sustaining change. "
>
> **– Unison Health & Community Services**

> " […] focusing on the value of small tests of change, where "failure" is an expected part of the process and a source of information. "
>
> **– Seaway Valley Community Health Centre**

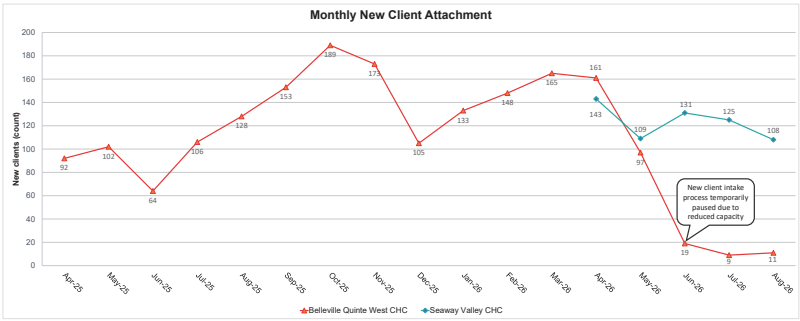
RESULTS

LC participation sparked **innovative change ideas**, including group intake sessions, pre-recorded multilingual orientation videos, and automated EMR waitlist tracking

Pre-capturing health data halved intake appointment times from **60 to 30 minutes**, increasing appointment availability by an **average of 150%**

Organizations streamlined client chart creation by digitizing paper intake forms and digitalizing workflows using OceanMD and EMR custom forms, **achieving pre-appointment form completion return rates up to 85%**

Early and continuous engagement of providers and staff demonstrated QI value, driving **stronger buy-in and long-term sustainability** of intake process changes using flexible standardization



CONCLUSIONS + NEXT STEPS

Equity-based LCs strengthen primary care team QI capacity by combining peer learning, coaching, and practical tools.

To maximize impact, future LCs should build on the evaluation findings by deepening the engagement of frontline teams and offer flexible, targeted support tailored to each organization's context, capacity, and population.

Alliance for Healthier Communities
Advancing Health Equity in Ontario

CENTRE DE SANTÉ Univi HEALTH CENTRE

Full Evaluation Report

QI@AllianceON.org

Indigenous perspectives on palliative and end-of-life care: A qualitative study in Southeastern Ontario

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BACKGROUND and OBJECTIVE

Research suggests that Indigenous peoples face inequities in access to meaningful, supportive, culturally appropriate, and culturally safe palliative care services.

The objective of this study is to identify strategies to improve awareness of, and equitable access to, culturally safer Indigenous-focused palliative care in the region of the Frontenac, Lennox and Addington Ontario Health Team (FLA OHT).

METHODS

- Community-based participatory research centered in the principles of Ownership, Control, Access, Possession (OCAP) in ethical research with Indigenous peoples
  - Study team:
    - Indigenous community members, service providers, and policymakers serving on the Indigenous-focused subgroup of the FLA OHT Palliative Care Working Group
    - University researchers and students
- Three Talking Circles held between October 2025 and August 2026 at:
  - Tyendinaga Mohawk Territory
  - Shannonville, Ontario
  - Kingston, Ontario
- Eligibility criteria:
  - Indigenous adults in Southeastern Ontario
  - Living with a serious illness or approaching end of life OR a family member or community member currently or previously involved in their care
- Members of the study team facilitated the Talking Circles
- Talking Circles were on average 2 hours in length
- Verbal consent was gathered before each session
- Each data collection session started with a collective meal, a traditional opening and smudging, and the construction of a grief medicine bag and/or beading. Participants also received a $25 gift card.
- For cultural appropriateness, audio-recording of Talking Circle discussion was not done. Instead, notetakers recorded participant responses on paper and laptop. Notes were collated and reviewed for accuracy.
- Initial coding and thematic analysis completed by one researcher using NVivo software. Rigour and trustworthiness were further enhanced through team co-analysis and triangulation at fulsome team meetings.

Scan for more information

KEY FINDINGS

A total of 38 individuals participated in the Talking Circles. Participants were mixed in age and gender. The majority of participants were caregivers and older in age.

This project sought to understand 1) individuals involved in palliative and end-of-life care, 2) preference for where to experience the care journey, 3) existing resources and supports known to participants, and 4) supports that patients and caregivers need.

Community Priorities for Palliative and End-of-Life Care

Supported Home-Based Care

- Strong preference by majority of participants to experience end-of-life journey at home with family, familiar objects, places of comfort
- It is noted as the "ideal way to die"
- However, experiencing the care journey at home can place great financial and emotional strain on caregivers ("very hard on family if there is no support"), leading caregivers to place their loved ones in long-term care facilities
- Supporting the end-of-life journey at home is most feasible when caregivers are adequately supported in home care (e.g. home infrastructure modifications, home-based nursing)

Trusted People and Providers

- Family members, particularly daughters, were noted as important persons involved in care
- On Mohawk Territory, allied health professionals such as nurses and pharmacists providing home care were noted to provide high quality of care ("care level is different on Territory")
- Trusted providers understand the importance of traditional and holistic care approaches; providers who only emphasize Western worldviews on death are detrimental to care experience
- Western medical providers must also involve caregivers and trusted persons in care decisions

Limited Awareness of Available Resources

- Majority of participants were not aware of existing resources that could support the end-of-life care journey
- Caregivers felt most resources were explicitly for patients rather than to support caregivers, despite heavy burdens related to caregiving
- Participants mentioned they "did not know what questions to ask" and where to begin the conversation about supports

Importance of Traditional and Cultural Care

- Holistic end-of-life care includes traditional medicines, presence of Elders and traditional care persons, and traditional ceremonies in hospital
- Many participants also wanted a traditional ceremony after death, including drumming, cedar bath, and ceremonial fire

Greater Navigation & Caregiver Support

- Specific supports are needed for caregivers who support their loved ones through end-of-life ("Who is helping me?")
- Support can take place on different levels:
  - Care coordination materials: Easily visible, contact tools, starter resource packs, reminder cards with reliable contact information and follow-up information
  - Social worker who follows up with caregiver specifically on mental health and education on caregiving
  - Navigator who assists with advanced care planning, accessing resources, getting aids for their loved ones, setting up power of attorney

Addressing System Barriers and Gaps

- Disconnects between federally-funded and provincially-funded programs lead to care gaps at the community level
- On Mohawk Territory, qualifying for care is complicated by whether an individual is Indigenous, is Status, and/or if they reside on reserve.
- These overlapping eligibility requirements create uncertainty for both service providers and community members about who is responsible for providing care, leaving some individuals without timely access to needed services.

DISCUSSION

- There is overwhelming preference for palliative and end-of-life care to take place at home. Yet, without adequate home-based supports such as nursing, infrastructure, and respite, caregivers take on disproportionate financial and emotional burden.
- Providing holistic, culturally-relevant end-of-life care requires involving families in decision-making as they are well-trusted individuals. Care professionals trusted by patients to provide care must be willing to recognize traditional views of death and dying and to facilitate incorporation of traditional medicines, ceremonies, and care persons within the care process.
- Jurisdictional complexity at the policy level has profound implications for individuals seeking care at the community level. Confusion and barriers to eligibility for certain care programs produce even more uncertainty for Indigenous patients and caregivers who already face systemic barriers to receiving timely and appropriate care.



Photo credit: Matthew Manor (used with permission)

ACKNOWLEDGEMENTS

Queen's University and FLA OHT are situated on the traditional lands of the Haudenosaunee and Anishinaabek.

This project has received funding from the Canadian Institutes of Health Research.

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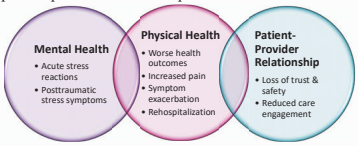
Supporting People with Serious Mental Illness Across Psychiatric Hospitalization: The Role of Primary Care

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Background

- Serious mental illness (SMI) refers to mental health conditions that substantially impact functioning and often persist over extended periods[1]
- Psychiatric hospitalization (PH) is common among people with SMI and may cause psychological harms impacting mental and physical health and the patient-provider relationship[2-8]



- These harms may be especially devastating for people with SMI who already face greater trauma and systemic inequities[9,10]
- Primary care providers (PCPs) may have an important role in supporting people with SMI through PH
  - One of few consistent points of contact[11]
  - Potential to offer continuity across care transitions[12]
  - Trauma-informed, person-centred model of care[13]

Trauma- & Violence-Informed Care (TVIC)

- **Relevance:** TVIC directly considers the intersecting impacts of trauma and systemic inequities on people's lives[14]
- TVIC comprises **four principles**:
  1. Understand trauma, violence, and its impacts on people's lives and behaviour
  2. Create emotionally and physically safe environments for all clients and providers
  3. Foster opportunities for choice, collaboration, and connection
  4. Use a strengths-based and capacity-building approach to support clients

Objectives

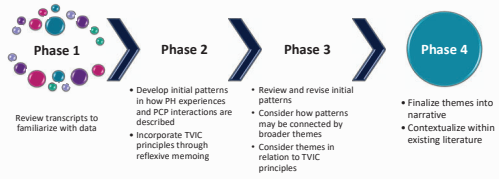
- Understand how people with SMI describe their primary care experiences surrounding PH
- Identify factors contributing to positive and negative care experiences
- Strengthen trauma- and violence-informed person-centred primary care for people with SMI

Methods

- **Secondary Data Analysis:** Utilizes a subset of data from a larger study focused on understanding primary care experiences among people with SMI[1]
- **Descriptive Qualitative Design:** Semi-structured interviews conducted between 2022-2024
  - 79 participants: 50 from Ontario, 29 from British Columbia
- **Sample:** Adults with SMI in British Columbia and Ontario who had seen a PCP ≥ once in the year prior to participation
  - **SMI:** ≥ 1 PH within past 2 years OR client of an Assertive Community Treatment team
- **Recruitment:** Assertive Community Treatment teams and 6 hospitals across BC and ON

Analysis

- Inductive thematic analysis with four iterative phases[15]
- TVIC principles will serve as sensitizing concepts for interpreting participants' perspectives on PCP involvement across the PH process[16]



Results

- REB approval is being sought from the University of Toronto
- This poster explores early findings from phase 1 data familiarization

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Want to learn more? Check out the protocol paper:

1. Understand Trauma & Violence

- Discussions about trauma and violence feel unwelcome in primary care
- Under-recognition of ongoing systemic harms, including stigma
- Being listened to and believed is meaningful ***and*** relatively rare, particularly around mental health medications
- PCPs should regularly self-reflect to ensure care decisions help rather than hurt (e.g., perpetuate stigma)

2. Create Safe Environments

- Building trust is crucial; PCPs should not assume they are seen as safe
- Relational attunement can help people feel understood, enhancing trust
- Judgmental and stigmatizing interactions with PCPs are common
- People with SMI may seek safety in shared identities or communities
- PCPs generally communicate directly and honestly, but sometimes at the expense of comprehensiveness

3. Foster Choice, Collaboration, & Connection

- PCPs are often uninvolved in PH care transitions
  - **Individual-level:** Fear of consequences; mental health perceived as outside PCP scope
  - **System-level:** Breakdowns in communication and information flow
- Respecting autonomy and honouring people with SMI as the experts of their own bodies is important, and not consistently implemented
- Frequent experiences of PCPs being unreceptive to individuals' requests may contribute to adversarial relationships
- Many people with SMI recognize system challenges and temper their care expectations accordingly

4. Strengths-Based & Capacity-Building

- 'One issue per appointment' model may limit opportunities for PCPs to get to know individuals and their strengths

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UNIVERSITY OF TORONTO

ASU Arizona State University

Integrating Patient Voices and Diverse Expertise in Health Research using Team Science Tools and Tactics: A Scoping Review

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Why This Matters

Collaboration is More Than Working Together

Collaboration is often described as bringing people together around a common goal. Yet collaboration involves much more than working alongside one another. It is a **dynamic process** of listening, learning, adapting, negotiating, integrating different forms of expertise, and creating shared understanding.

While we often recognize the outcomes of collaboration, the processes that make those outcomes possible can be difficult to see. As a result, collaboration is frequently assumed rather than examined, making it challenging to understand, practice, improve, and evaluate.

Why is this important for Patient-Oriented Research (POR)?

- POR depends on integrating lived and diverse expertise
- Diverse perspectives do not automatically lead to meaningful collaboration
- Teams need practical ways to support communication, decision-making, relationship-building, and knowledge integration lead to meaningful collaboration

What is Team Science?

Team Science (TS) is the science of collaboration. It studies how diverse groups work together and provides tools, structures, and practices that support effective teamwork across disciplines, sectors, and forms of expertise, for example:

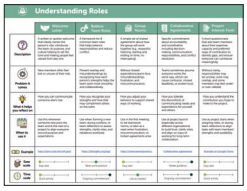
Collaboration Challenge	What TS Makes Possible
Different people see the problem differently	Creates shared understanding across perspectives
Assumptions remain hidden	Makes thinking visible and available for reflection
Power differences shape participation	Creates structures for more equitable contribution
Teams struggle to learn from experience	Supports collective reflection and adaptation
Decisions happen informally or opaquely	Makes decision-making processes transparent

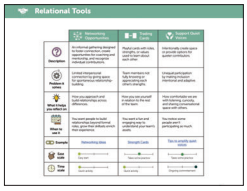
The Pocket Guide

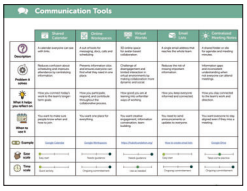
Build the Practice of Collaboration

Team science tools **create opportunities to pause and reflect**, by making collaborative processes more visible so individuals and teams can better understand how they work together and identify ways to strengthen their practice.

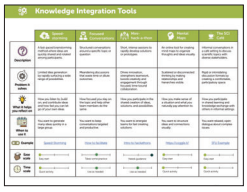
These behaviours are often difficult to recognize in ourselves while we are collaborating. When we can see how we collaborate, we can begin to improve it. The first step begins with noticing how our own behaviours shape the experiences of others and the work of the team.

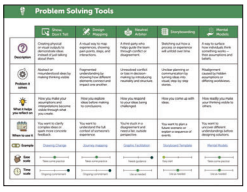




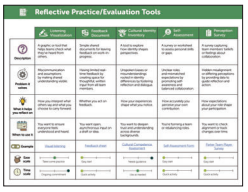


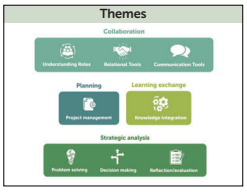












The Key Insight

Tools Do More Than Organize Work

The tools identified in this review do more than support project tasks. They create artifacts that make collaboration visible. Agreements, maps, plans, reflections, decisions, and shared documents provide tangible evidence of how teams communicate, share power, integrate knowledge, navigate differences, and build trust.

Collaboration Artifacts Make the Invisible Visible

Team charter	Expectations & power-sharing
Shared agenda	Priorities and participation
Decision log	How decisions were made
Mental map	Different perspectives
Reflection exercise	Assumptions and learning
Action plan	Shared accountability

Methods

We conducted a scoping review following JBI guidance. Searches across six databases identified **42 studies reporting 125 team science tools and tactics**. Tools were mapped to phases of transdisciplinary research and synthesized into a practical pocket guide for POR teams.

Conclusion

Collaboration is often treated as something that simply happens when people work together. Team science suggests otherwise. By providing practical tools and creating artifacts that make collaborative processes visible, teams can better understand, reflect on, and strengthen how they work together. The pocket guide offers a practical resource for supporting these collaborative practices within patient-oriented research.

Creation and Evaluation of Lori Education: Support the Integration of Patient-Reported Measures in Primary Care

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1-Université de Sherbrooke, **2**-Université de Montréal, **3**-Université McGill, **4**-Université Laval, **5**-Université d'Angers, **6**-University of British Columbia

Context

Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) have great potential to optimize clinical processes and improve practices, yet remain underused.[1] They are effective levers to inform decisions in primary care clinics.[2-5]



Primary Care

- Inequities persist in health outcomes and experience of care
- More vulnerabilities = greater primary care needs[2]
- Family physicians and healthcare professionals are dealing with high burdens[3]: mental and physical health, fulfillment, and meaning at work
- PROMs and PREMs are still unknown, and healthcare professionals need guidance to use these data
- No evidence-based training is available

Global Objective

Create a learning management environment that supports the use of PROMs and PREMs to enhance processes and professional practices in primary care clinics, and assess its effectiveness.

Lori Approach

Longitudinal tailored coaching and support

Present Lori to the clinic members → **Identify a champion[6-9]**

Training - Lori Education

6 online, asynchronous and free modules (4h accredited)

Module 1: Introduction to the approach
Module 2: What are PROMs & PREMs?
Module 3: How to get prepared to the collection of data
Module 4: Analysis and interpretation
Module 5: Implementation of PROM and PREM data in organizational and professional practice
Module 6: Role of a champion

Psst! ***Check out the training demo!***

Organizational readiness assessment for each clinic[10-12]

Implementation of Lori Application for collection, analysis and visualization of PROMs and PREMs data

Creation of Lori Education Based on Knowledge-to-Action[13-15]

- Content developed based on scientific evidence by a scientific committee comprising registered nurses, social workers, physicians, patient-partners and experts in andragogy.
- Developed in collaboration with a private e-learning company selected through a request for proposals.
- Visuals designed and developed using Articulate Storyline.
- Development process included a beta version and a final version of each module, with content and visuals reviewed and refined between versions.
- Includes supplementary resources, exercises, and case-based scenarios.

Methods - Developmental Evaluation with Mixed Data Sources

- Evaluation guided by RE-AIM[16] and New World Kirkpatrick Model[17]
- Studied Population: Family physicians and interprofessional teams in primary care clinics participating in Lori

Data Sources	
Qualitative data	**Quantitative data**
Research team's logbook	Metrics on the learning environment
Post-questionnaires (open-ended questions)	Pre and post questionnaires
Focus groups with trainees and champions	Pre and post knowledge assessment quizzes

Assessed concepts[16]:

- Reach: Number of registrations, number of completed training, characteristics of trainees
- Effectiveness:
  - Reaction (including satisfaction)
  - Level of knowledge, confidence, and intention[17]
  - Impact of tailored support and coaching
- Adoption: Number of modules completed, barriers to completion
- Implementation: Fidelity and adaptation of the implementation strategies[13,16] and organizational readiness toward PROMs and PREMs collection and use[10-12]
- Maintenance: 6-month post-evaluation (to come)

Analysis:

- Descriptive quantitative analysis
- Paired t-tests or paired Wilcoxon tests were performed based on a Shapiro-Wilk normality test, with a Holm correction applied for multiple comparisons
- Statistical significance is indicated as follows: $p < 0.05$ (*), $p < 0.01$ (**), and $p < 0.001$ (***)
- Qualitative analysis guided by Paillé and Muchielli
- Iterative analysis and integration of qualitative and quantitative data[18]
- Data collection: November 14th, 2025 to September 25th, 2026

Training launched on November 14th, 2025



Preliminary Results According to the RE-AIM Framework[16]

Reach

- 48 registrations in 15 clinics
- 36 trainees consented to research in 13 clinics

Table 1. Demographic Characteristics (n=36)

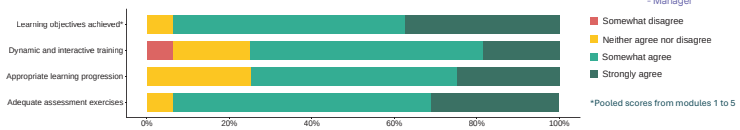
Type of Clinic	
Family Medicine Group (FMG)	3 (8.3%)
FMG affiliated with a University	33 (91.7%)
Role	
Nurse	10 (27.8%)
Physician	7 (19.4%)
Quality improvement facilitator	8 (22.2%)
Other	11 (30.6%)
Years of Experience in Primary Care	
Less than 2 years	6 (16.7%)
2 to 5 years	5 (13.9%)
6 to 10 years	10 (27.8%)
More than 10 years	15 (41.6%)
Sex at Birth	
Female	30 (83.3%)

Effectiveness

Reaction to the training

> *Dynamic content: the way the material is presented keeps you focused on the training!*
> - Quality improvment facilitator 2

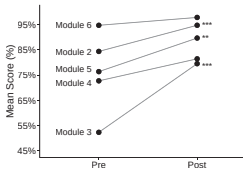
> *I liked modules 2, 3, and 6; these were the most practical for me in terms of promoting the project to the team and patients. They prepare me well for the upcoming stages.*
> - Manager



Graph 1 Distribution of Trainees' Reaction to the training

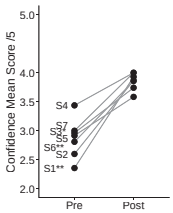


Knowledge

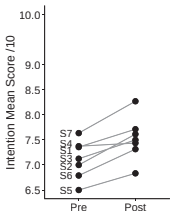


Graph 2 Mean Pre- and Post-Assessment Quiz Scores by Module

Confidence & Intention



Graph 3 Mean Pre- and Post-Assessment Confidence Scores



Graph 4 Mean Pre- and Post-Assessment Intention Scores

S1 : Use PROMs/PREMs data to strengthen service organization (N=14)
S2 : Integrate PROMs/PREMs data to enhace your professionel practices (N=13-15)
S3 : Promote the usefulness of PROMs/PREMs to colleagues or patients (N=24-27)
S4 : Contribute to the organization of a PROMs/PREMs collection (N=16)
S5 : Understand and interpret PROMs/PREMs results (N=12)
S6 : Prioritize solution pathways to improve PROMs/PREMs results (N=19-21)
S7 : Describe the champion's role / Support the champion within your team (N=11)

Pre-training
19 participants had low confidence (2/5 or lower) in their overall capacities to use PROM and PREM data.
Reasons provived: 16 answered they did not have the necessary skills or did not clearly understand what was expected of them.

Post- training
Only 2 still had low confidence.



> *I really liked module 6; it gives me a good idea of what my role will be, with the right tools.*
> - Quality improvment facilitator 3

> *My favorite was module 5, because once you truly grasp the meaning of PROMs and PREMs, it is fascinating to see the positive impact they will have on our practice and the service provided to patients.*
> - Registered Nurse

Adoption

- Asynchronous format, interactivity, support structure and accredition are facilitators
- 97% completed module 1
- Trainees completed a mean of 2.6 modules
- Champions are helpful to mobilize trainees

> *Fortunately, our champion seems to understand it well. They can explain it to me, putting me in a better position to guide and support the team in decision-making*
> - Manager

Implementation

- Development of additional resources
- Module capsules were divided into two parts following beta testing
- Tailored training: Recommendations for specific modules based on clinical role
  - Accreditation of module groups rather than the full training program



Discussion

- Significant knowledge and confidence gains occurred mainly in modules and statements with higher completion rates, possibly reflecting greater statistical power. Findings must be interpreted cautiously.
- Collaboration with e-learning and adult learning experts may have supported positive feedback on interactivity, learning progression, and assessment exercises.[20]
- High baseline intentions likely reflected voluntary participation, clinic champions' involvement[6-9], and early adopter engagement.[21]

Conclusion

Asynchronous training improved participants' knowledge and confidence, while the accompanying support was well received. The training helped participants feel prepared for the next steps in implementation. This approach offers a promising way to prepare healthcare teams to implement PROMs and PREMs as an innovation in clinical practice.

References

Funding for this project was made possible by the Canadian Medical Association, MD Financial Management Inc. and Scotiabank.

Family & Community Medicine UNIVERSITY OF TORONTO | Temerty Medicine

2026 Trillium Primary Health Care Research Day
October 23, 2026

Best Practices in Routine Primary Care Patient-Reported Experience Measure (PREM) Surveys across OECD Countries: Preliminary Findings and Emerging Lessons Learned

Emma Wedekind[1], Hina Ansari[1], Umair Majid[2], Jennifer Shuldiner[2], Kamila Premji[3,4,5], Vanessa Wright[2], Shantel Walcott[1], Rick Glazier[6,7,8,9], Tara Kiran[1,6,7,8,9], Noah Ivers[1,2]

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Background

Patient-centred care and patient experience are recognized as **fundamental dimensions of healthcare quality** in Canada[1] and internationally[2, 3]. These data, often captured through **Patient Reported Experience Measure (PREM) surveys**, have been associated with clinical effectiveness[4] and are key in health system transformation towards people-centred, equitable, integrated models of care.[5]

Ontario currently has no provincial primary care PREM mechanism for routinely collecting patient experience data.

The Auditor General of Ontario December 2025 report recommended a jurisdictional scan of best practices in patient experience and feasibility assessment for a clinic-level survey.

Our goal: To learn from international experience and identify lessons that may inform future approaches to primary care patient experience measurement in Ontario, and Canada overall.

What Are We Trying to Learn?

Survey Content

Research Question 1: What do surveys measure and how has content been developed with and for diverse patient populations?

Implementation & Governance

Research Question 2: How are surveys implemented and governed, including payment, administration, sampling, and what supports are provided to clinics?

Reporting & Use of Data

Research Question 3: How are data reported and used, including how clinics receive their results and does data quality improvement and accountability?

Methods

A sequential mixed-methods scan of OECD countries with 2 components:

Scoping Review
15,527 Ti/Ab Screened
451 Full Texts Reviewed
Grey Lit from 38 Countries

Key Informant Interviews
with leaders and users to gather practical insights not found in literature
(Winter/Spring 2027)

Today: Preliminary findings from the Scoping Review and examination of four selected surveys to identify transferable lessons and design trade-offs.

Preliminary Case Selection Criteria

- **Maturity & Scale:** Provide lessons on sustainability, evolution, and scale up.
- **Practice-level measurement:** Relevant to Ontario's interest in actionable data.
- **Demonstrated data use:** Translates into QI, accountability, or system improvement.

Preliminary Findings: Four Surveys in Depth

GP Patient Survey (GPPS)

England, UK · 2007 to present · Every NHS practice, Annual

Content: Access, quality of care, patient health and out-of-hours care, plus dental, pharmacy, and carer questions.

Implementation & governance: NHS England commissions, Ipsos fields. ~3M registered patients (16+) sampled yearly; ~700,000 responses.

Reporting & use: Results are publicly available from practice to national level as interactive dashboards, infographics, slide decks, Easy Read reports for accessibility, and open data (i.e., Excel, CSV data).

Key strength: Largest scale survey that collects multi-level data and publishes rich, accessible data reports. The only case with public cost (~£5.70 per response).

Adult Primary Care Patient Experience Survey (APCS)

New Zealand · 2016 to present · Quarterly, National

Content: Six domains, including cultural safety, plus Hua Oranga, a "by Māori, for Māori" wellbeing outcome measure. Content tested with Māori and Pacific patients groups.

Implementation & Governance: Te Tāhū Hauora runs it, Ipsos NZ fields it. Adults seen in a 2-week window are surveyed; ~30,000 responses a quarter. Intentionally oversamples Māori and Pacific patients.

Reporting & use: Private practice portal ~2 weeks after fieldwork; public results disaggregated by ethnicity and disability.

Key strength: Fastest feedback loop provides clinics meaningful opportunity to act on patient experience data. Equity considerations are built into survey content, implementation, and reporting.

CAHPS Clinician & Group Survey (CG-CAHPS)

United States · 2007 to present · One tool, Three models

Content: 22 items: access, communication, coordination and office staff, plus a 0 to 10 provider rating.

Implementation & governance: AHRQ maintains the tool, but does not field it. Implemented by a variety of organizations and systems, for example:

- Centres for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS)
- Massachusetts Health Quality Partners (MHQP)
- Veterans Health Administration (VHA)

Reporting & use: Star ratings tied to payment (MIPS); public practice results (MHQP); mainly internal (VA).

Key strength: Rigorously validated tool that has been implemented and adapted within the US and beyond. The CMS, in particular, case-mix adjusts MIPS scores.

Primary Care Patient Experience Survey (PCPE)

Alberta, Canada · 2018 to present · Voluntary, Clinic-level

Content: About 25 core questions adapted from CG-CAHPS, plus optional modules, such as EQ-5D-5L.

Implementation & governance: Implemented and governed by Health Quality Alberta, an independent legislated body. Clinicians opt-in (no cost); whole panel invited by email. Used by hundreds of clinics and 10,000+ patients since 2018.

Reporting & use: Confidential clinician reports ~6 weeks after data collection, includes provincial benchmarks and an embedded Quality Improvement (QI) action plan.

Key strength: Arm's-length, confidential model builds provider trust; relevant to FHTs/FHOs. The only survey explicitly described as a quality improvement initiative, supporting responsive and timely adjustments to care based on patient experience data.

Key Takeaways Across Surveys

Survey Content

Surveys converge on the same core domains.
All four surveys cover access, communication, coordination, respect, and overall experience, so practices can be compared. Optional, supplementary modules add local relevance.
Only New Zealand builds equity considerations explicitly into content.

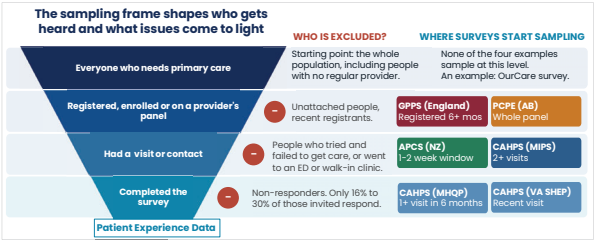
Implementation & Governance

Governance is the central lever.
Examples: Central commissioning (England), a common tool with local delivery (US), or voluntary opt-in (Alberta).
Mandates give full coverage but need authority, funding, and potentially adds burden to clinics; opt-in surveys earn clinic buy-in, but skews toward QI-ready practices and may inadvertently miss collecting important patient experience data.

Reporting & Use of Data

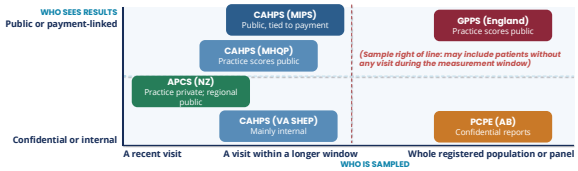
Who sees results shapes how they are used.
Publicly available practice results (England, US) drive accountability and patient choice, but need case-mix adjustment and small-sample rules.
Confidential practice- and clinician-level reports (Alberta, NZ) build trust; fast feedback and QI toolkits help practices act.

The sampling frame shapes who gets heard and what issues come to light



Two Major Design Choices: Where Each Survey Sits

Two major design choices: who is sampled and who sees results. Placement is approximate.



Equity: A Cross-Cutting Gap

1 of 4 surveys build equity into content (NZ)

- **Language:** England offers 14 languages plus British Sign Language (BSL) and phone surveys; MIPS offers English and Spanish; NZ offers te reo Māori; Alberta offers English only.
- **Comparability:** Only CAHPS for MIPS publishes case-mix adjustment before comparing groups.
- **Representation:** Response gaps by language, income, and digital access are rarely reported.
- **Access:** No survey samples those without a regular primary care provider.

Considerations for Canadian Jurisdictions

- **Sampling:** Roster lists could let Ontario and other provinces sample whole practice populations, as England does.
- **Unattached Patients:** Clinic-based surveys miss this important group; a population survey (e.g., OurCare) fills that gap.
- **Governance:** Decide who owns the data, who publishes it, at what level, and who sets content.
- **Reporting:** Publicly available clinic results need case-mix adjustment and small-sample suppression.
- **Indigenous Data Governance:** Build in First Nations OCAP® and Inuit and Métis principles from the start.

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Family & Community Medicine UNIVERSITY OF TORONTO | Office of Health System Partnerships

Patient-Reported Experiences of Family Physician Loss

A qualitative study of free-text survey comments in Quebec

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Background

- Losing a family physician, mostly through retirement, is increasingly common
- Continuity matters for patients' care[1]

Aim — To explore patients' experiences of losing their family physician.

Approach

- Part of a larger project on **primary care discontinuity**
- Patient-reported questionnaire developed by our team
  - Free-text comments (**n=353**) analyzed from the 1327 respondents without a family physician
- **Interpretive descriptive**[3] approach with **hybrid inductive–deductive**[2] analysis
  - Grounded in Haggerty's continuity framework: **informational, management, relational**[1]
- **Two researchers** analyzed comments independently; discrepancies reconciled iteratively by consensus
- Commenters and non-commenters compared on sociodemographic characteristics (Table 1)

Results

Table 1. Sociodemographic characteristics

	With comments n = 353	Without n = 974
GENDER* **		
Female	**63.5%**	50.1%
Male	35.3%	49.1%
AGE* **		
18–34 years	13.1%	29.7%
35–54 years	25.6%	36.3%
55–69 years	**33.6%**	22.5%
70+ years	**27.6%**	11.5%
LIVING WITH A DISABILITY* **		
Yes	**19.0%**	7.7%
BORN IN CANADA*		
Yes	85.2%	78.7%
IN CANADA 10+ YEARS* **		
Yes	98.2%	92.4%
ORIGINS (MULTIPLE POSSIBLE)		
N. American**	77.6%	70.1%
African*	0.8%	3.1%
Asian**	1.4%	5.0%

Note. Statistical significance: *p < .05, **p < .01, ***p < .001. Selected rows; Pearson's χ^2 or Fisher's exact test. Bold: at least 10 percentage points higher among commenters. No significant differences for finances (p = .899), education (p = .105), Indigenous identity (p = .436) or languages (all p > .05).

Table 2. Main themes and 28 subthemes (n = 353 comments)

Navigating discontinuity

- Consequences on personal life
  - Health consequences
  - Work and financial consequences
  - **Emotional distress · 43.6%**
    - "I feel lost and alone"
    - "At this rate, I'll have time to die five times"
- Perceived inequity
- Limited agency
- **Barriers to accessing healthcare · 20.1%**
  - "The problem with the healthcare system is getting that first appointment."
- Duration
  - "I've been on the waiting list for 5 or 6 years, and I'm still waiting."

Informational continuity

- Familiarity with medical history
- Incomplete communication about health and care
  - "I have to start telling my whole story all over again every time."

Management continuity

- Care coordination and management
  - Shift toward urgent care
  - Case coordination
  - Fragmented care
  - Burden of self-managing care
    - "I feel like I'm becoming a doctor myself."
- Clinical case complexity
- Care-seeking alternatives
  - Other healthcare professionals
  - Delayed or avoided care
  - Private care
- Perceived inadequacy of the healthcare system
  - "They tell us to relieve the pressure on the Emergency Department, but […] they can't give us an appointment within a reasonable time frame."
- Consequences for healthcare delivery
  - Medication prescribing
  - Specialist referral
  - Laboratory or clinical testing
    - "No basic tests or exams, such as blood pressure, lung function, or heart function."

Relational continuity

- Established therapeutic relationship
  - "It can range from excellent to mediocre."
- Inconsistent care encounters
- Unfamiliar physician
  - "You see a different doctor at every appointment."

Bold outlines: the two most frequent subthemes. French quotations were translated by the authors.

Conclusion

- Losing a family physician is a **significant emotional burden**
- Consequences affect **all three dimensions** of care continuity
- Health systems must **anticipate** and **address** patients' needs

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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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[1]*Queen's University,* [2]*Kingston Immigration Partnership,* [3]*Kingston Community Health Centres*

Background

- Prenatal and obstetric care is essential for the wellbeing of pregnant individuals and their newborns
- Newcomers to Canada face barriers to accessing maternity care, including linguistic, cultural, financial, and systemic challenges and these barriers contribute to inequities in maternal and neonatal outcomes[1,2]
- In the Kingston, Frontenac, Lennox, & Addington (KFL&A) region, despite an increase in immigration levels over the years, limited research exists on newcomer experiences navigating prenatal care[3]

Why KFL&A?

Smaller but growing newcomer population
Immigration to the region has increased in recent years.

Mixed urban and rural geography
Newcomers live in both urban and rural communities across the region.

20,000+
residents without a primary care provider[3]

Poorly reflected in existing literature
Little research describes how newcomers in KFL&A navigate prenatal care.

This project **maps newcomer-accessible obstetrical services** in KFL&A and identifies gaps and opportunities to improve access.

Objectives

The study will answer: "What prenatal and obstetrical care services are available to newcomers in the KFL&A region"? and "What gaps, barriers, and opportunities exist to improve access"? The objectives are to:

1. identify and map existing prenatal and obstetric care services available in the KFL&A region
2. understand provider and newcomer perspectives on the accessibility, efficacy, and response to these services
3. analyze barriers and gaps in service provision and coordination for this population

Methods

1. **Co-design**
   Advisory Council shapes the surveys and interview guides with KIP and KCHC
2. **Environmental scan**
   Online Qualtrics surveys to partner organizations: services, populations, initiatives
3. **Needs assessment**
   Interviews and focus groups with:
   - Frontline and clinical providers
   - Settlement workers and program staff
   - Newcomer women and birthing people
4. **Analysis**
   Interviews audio-recorded, transcribed, thematic analysis with intersectionality lens
5. **Member checking**
   Participants confirm the findings reflect their perspectives
6. **Knowledge mobilization**
   Advisory Council helps make results usable for KIP, KCHC and health partners

Results

- **Tools drafted** — Survey questionnaires and interview guides, co-designed with the Advisory Council — DONE
- **Pre-testing complete** — With newcomer women/birthing people and healthcare providers — DONE
- **Ethics approval received** — Queen's Health Sciences Research Ethics Board — DONE
- **Interviews underway** — Iteratively with transcription, coding and thematic analysis — IN PROGRESS
- **Final outputs** — Report, quick-reference infographic and visual map of services — NEXT

Instrument pre-testing

Interview guide and survey refined across nine sessions

● Newcomer women ● Social and settlement workers ● Clinical providers

Respondent-driven — Simulated interviews, questions read aloud

1. **Newcomer women** WhatsApp Interview guide
   Rephrased leading questions to reduce bias and simplified language. Suggested Kingston Transit bus ads for knowledge translation.
2. **Newcomer women** Zoom Interview guide
   Further literacy and language edits. Added concrete examples to prompts.
3. **Settlement workers** Zoom Guide + survey
   Added barrier and facilitator options. Moved the survey before the interview.
4. **Clinical providers** Zoom Guide + survey
   No changes suggested.
5. **Clinical providers** Zoom Guide + survey
   No changes suggested.
6. **Settlement workers** Zoom Guide + survey
   Reworded some survey questions. Suggested pasting questions in the chat during interviews.

Expert-driven — Think-aloud review of a Word draft

7. **Settlement workers** Guide + survey
   Added an option to ask questions without probes for non-English-speaking participants.
8. **Clinical providers** Guide + survey
   Refined the definition of "newcomer" to name legal statuses, and questions on provider-patient cultural interactions.
9. **Clinical providers** Guide + survey
   Added barrier options to both tools. Refined the survey question on how many newcomers access services.

9	3	7	2
sessions	participant groups	led to revisions	tools refined

Implications

1. Policy & Practice Impact: Findings from this health needs assessment may offer practical insights to inform policies and healthcare practices that improve maternity-care accessibility and equity for newcomers in the KFL&A region.
2. Service Navigation Tools: Developing a publicly available directory and service map can support newcomer women in navigating prenatal and obstetric care, while also serving as a data-informed tool for providers and policymakers.
3. Identifying Gaps & Barriers: Understanding regional gaps and barriers may help address delays in care, underuse of available resources, and missed opportunities for early prenatal support.
4. Culturally Responsive Services: Strengthening culturally responsive and linguistically accessible services may reduce inequities in maternal and neonatal outcomes.

FINDINGS Gaps & barriers identified → **TOOLS** Directory, map & infographic → **IMPACT** Policy change & culturally responsive care

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ACKNOWLEDGEMENTS: We gratefully acknowledge our community partners, the Kingston Immigration Partnership and Kingston Community Health Centres, for their valuable collaboration and support in informing this work.

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Scan here to fill out your contact information to receive our final deliverables when available!

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

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INTRODUCTION

- Approximately 50% of the population in North America has taken a prescription medication in the past 30 days[1]
- Measuring and optimizing patient experiences are important to ensuring value-based care[2]
- Standardized measures to capture medication-related experiences (patient-reported experience measures; PREMs) are not routinely used in primary care settings
- Understanding factors that influence the implementation of PREMs for medications (PREM-Rx) in primary care is essential to ensure the adoption of tools

OBJECTIVES

- To examine the barriers and facilitators to the use of a PREM-Rx in routine practice in Ontario, Canada
- To examine the optimal delivery of a future PREM-Rx

METHODS

- **Study Design**: Cross-sectional survey
- **Framework**: Theoretical Domains Framework (TDF)[3]
- **Setting**: Ontario, Canada
- **Data Collection**: Electronic survey administered via REDCap
- **Data Analysis**: Descriptive statistics

PARTICIPANTS

- People with lived experience of taking medication (PWLE) — n=197
- Prescribers (physicians, pharmacists, nurses) and decision-makers (PR/DM) — n=200

N=397



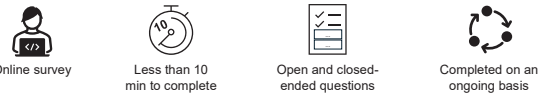
93% of prescribers and decision-makers were pharmacists

RESULTS

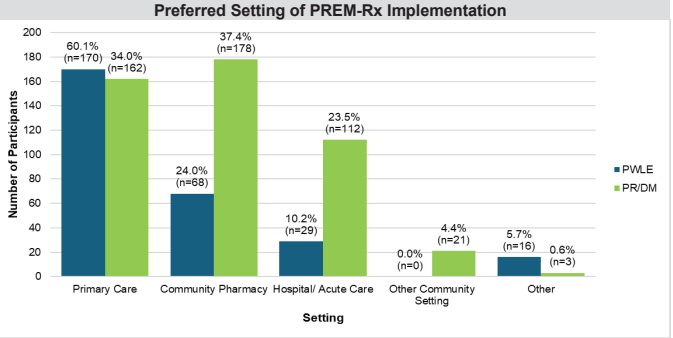
Theoretical Domains Framework – Barriers and Facilitators

TDF Domain	Results
Knowledge	• **26.9%** of PWLE and **40.5%** of PR/DM were familiar with a PREM-Rx • **17.2%** of PWLE had previously completed a PREM-Rx
Skills	• Top three skills needed for PWLE: 1. Knowledge (82.2%) 2. Communication (62.4%) 3. Self-advocacy (52.8%)
Goals	• Top goals of PWLE for reporting medication related experiences: 1. Address ineffective medications (97.0%) 2. Address side effects (96.4%) 3. Make informed decisions (95.4%)
Beliefs about Capabilities	• **91.4%** of PWLE were confident in ability to complete a PREM-Rx • **52.0%** of PR/DM were confident in ability to use PREM-Rx
Reinforcement	• **68.0%** of PR/DM thought that financial incentives for prescribers would facilitate the routine use of PREM-Rx
Environmental Context and Resources	• **97.5%** of PR/DM thought they did **not** have sufficient resources to routinely use a PREM-Rx • Most PR/DM needed more funding (88.0%), staff (77.0%), guidance/training programs (53.5%), and technology (52.0%)

Optimal PREM-Rx Delivery



Preferred Setting of PREM-Rx Implementation



KEY FINDINGS

- Limited knowledge, insufficient resources, and the lack of financial incentives were key barriers impacting PREM-Rx use
- A future PREM-Rx should be delivered online, take >10 minutes for PWLE to complete, consist of open and closed-ended questions, and be offered regularly
- Multi-level barriers exist, across the TDF domains, that need to be strategically addressed to support implementation and use of a PREM-Rx
- **Next Steps**:
  - Integrate qualitative and quantitative findings to identify targeted strategies for implementation

CONCLUSIONS

- We identified TDF domains that act as barriers and facilitators to the implementation and use of a PREM-Rx in routine care in Ontario, Canada
- This will support the development of a PREM-Rx, along with program and policy interventions to enhance implementation and sustainability

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ACKNOWLEDGMENTS

- Funded by the New Initiative and Innovation Award, Network for Improving Health Systems. SJTG was supported by the University of Toronto Centre for the Study of Pain Scientist Salary Award
- Opinions and results are independent of the funders

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UP TO BAT: A research protocol examining the association between 'business arrangement types', family physician compensation, and workforce outcomes using a multiple case study

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BACKGROUND

- Many family physicians (FPs) in Canada operate their practices as independent business owners or sub-contractors
- Modern business arrangements are varied and dependent on factors such as:
  - Payment model
  - Ownership structure
  - Incorporation
  - Overhead
  - Academic or other affiliations
- There is limited research examining how these factors interact to shape FP workforce behaviour (e.g., clinical scope, workload, retirement intentions)

OBJECTIVES

I. To develop a typology of FP business arrangement types (BATs) in Canada

II. To examine how BATs affect FP compensation and workforce outcomes

METHODS

- We are conducting a mixed-methods multiple case study in British Columbia and Ontario

Phase 1. Typology Development

I. Document analysis of regulatory, legal, and organizational materials to define the use and conditions of the different elements that comprise business arrangements

II. Semi-structured interviews
   i. 40-48 FPs
   ii. 19-28 experts (e.g., lawyers, financial advisors)

- We will use content analysis to analyze documents and FP and expert transcripts to identify and describe business arrangement factors
- We will use these data to propose consistent terminology and produce a glossary of business arrangement factors
- We will identify which factors are often used in combination to develop an initial typology of business arrangements

OUTCOMES & NEXT STEPS

- We will confirm results through phase 2 which will include:
  I. A cross-sectional online survey of family physicians
  II. Confirmatory interview with family physicians and experts
- This project will generate evidence to inform policy for primary care reforms, family physician compensation policies, and workforce planning

What are key factors that affect business arrangements for physicians?

Whom should we recruit for our expert interviews?

Questions and suggestions can be sent to: gyoung57@uwo.ca

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

Dr. Janina Mailloux *(CCFP, Assistant Professor Western University, Department of Family Medicine)*; Alyscia Elogio *(Clinical Navigator, SCOPE MLOHT)*; Alexander Smith *(Manager, Hospital-Community Partnerships, LHSC)*; Hanadi Al Sadek *(Project Manager, MLOHT)*; Dr. Gordon Schacter *(Clinical Lead Primary Care, MLOHT)*; Dr. Sarah Jarmain *(Clinical Lead Specialty Care, MLOHT)*

BACKGROUND

Timely access to urgent diagnostic imaging can be challenging for primary care providers, often leaving referral to the emergency department (ED) as the only option, even when emergency care is not required. This contributes to unnecessary ED visits, longer wait times, and increased pressure on acute care resources.

In June 2024, Seamless Care Optimizing the Patient Experience (SCOPE) Middlesex London launched the Urgent Diagnostic Imaging (DI) Pathway to provide primary care providers with expedited access to outpatient imaging (CT & ultrasound) and system navigation support. The Pathway aims to ensure patients meeting program criteria receive timely diagnostics in the most appropriate care setting while preserving ED capacity for those requiring emergency care.

The SCOPE Urgent DI Pathway aims to improve timely access to outpatient imaging for primary care patients, help reduce unnecessary ED visits, and support appropriate escalation for patients requiring urgent treatment.

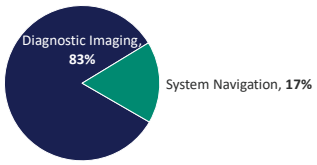
METHODS

A retrospective evaluation of the SCOPE Urgent Diagnostic Imaging Pathway was conducted for the period July 1, 2025, to June 30, 2026. Program tracking data were analyzed to examine referral volumes, reasons for contact, anticipated emergency department (ED) utilization, and patient outcomes following imaging. To validate reported outcomes, SCOPE records were cross-referenced with London Health Sciences Centre (LHSC) decision support data to identify subsequent ED presentations and assess the pathway's impact on ED utilization.

RESULTS

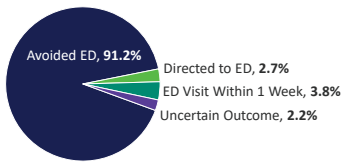
During this period, SCOPE received 546 calls, including 453 (83%) related to diagnostic imaging and 93 (17%) for system navigation.
Based on outcomes documented following the initial SCOPE call, 387 ED visits were avoided, representing 71% of calls. Among 364 patients for whom imaging appointments were 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.

Fig 1. Reasons for Contact (n=546)



More than 4 in 5 SCOPE calls were related to urgent diagnostic imaging.

Fig 2. Post-Imaging Outcomes (n=364)



More than 9 in 10 patients with facilitated imaging and known outcomes avoided an emergency department visit.

Key Findings (July 1, 2025 – June 30, 2026)

91.2%	of patients with facilitated imaging and known outcomes avoided an ED visit
387	emergency department visits avoided
2.7%	appropriately escalated to the ED following imaging findings

CONCLUSIONS

Access to urgent outpatient diagnostic imaging through SCOPE appears to:

- Reduce avoidable ED visits
- Improve access to timely diagnostic services
- Support appropriate escalation for patients requiring emergency treatment
- Optimize use of limited acute-care resources
- Shift care to lower-cost outpatient settings

These findings support continued investment in innovative models that strengthen primary care access to urgent diagnostic services and improve patient flow across the healthcare system.

London Health Sciences Centre

MIDDLESEX LONDON Ontario Health Team

SCOPE A virtual team for primary care providers

CONTACT US
scopenavigator@lhsc.on.ca

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

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INTRODUCTION

- Smoking prevalence among older adults living in social housing is 30.8%, substantially higher than the general population.[1,2]
- Residents often experience barriers to smoking cessation supports due to limited access to care, low health literacy, and socioeconomic pressures.[3]

What is CP@clinic®?

- Evidence-based chronic disease prevention, management, and health promotion program.
- Led weekly by community paramedics in social housing common areas.
- Provides health risk assessments, education, referrals, and individualized goal setting.[4]

Objective: To evaluate a pilot CP@clinic smoking cessation adaptation in Sault Ste. Marie, Ontario.

METHODS

Intervention:
CP@clinic®
Adaptation for smoking cessation at 4 sites in Sault Ste. Marie, ON

Design:
Mixed- Methods Study

Quantiative Data:
- Demographic information
- Smoking status
- Physiological measures
- Perceived support

Collected at baseline, 6 months, and 12 months

Qualitative Interviews:
Exploring barriers, facilitators, and perceived impacts.
(not presented here)

Post-intervention

These findings have the potential to reduce chronic disease risk in a vulnerable population.

At **12 months**, participants reported:

- Better **support access** (e.g, primary care, peer support, Nicotine Replacement Therapy (NRT)).
- Improved building **culture/feeling** about smoking.
- Changes in **smoking behaviour**.
- Improved **shortness of breath**.

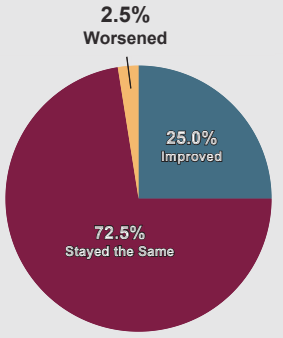


Fig 1. Participant **perception of support for those interested in quitting smoking** at 12 months.

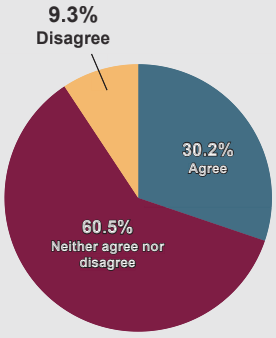


Fig 2. Participant **agreement with seeing fewer people smoking around the building** at 12 months.

RESULTS

At baseline:

137 attendees screened for smoking status

17.5% current smokers

75.0% interested in quitting

At 6 months:

77.8% set quit dates

72.2% had quit buddies

68.8% accessed NRT

At 12 months:

Shortness of breath improved for **72.7%** of building residents.

37.0% decrease in mean number of cigarettes smoked per day.

1862 fewer cigarettes smoked per person, per year.

$1303.05 saved on cigarettes per person, per year.

14 days days of life saved per person, per year.[5]

DISCUSSION

- CP@clinic can deliver tailored smoking cessation supports.
- This program may reduce health inequities among older adults in social housing.

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ACKNOWLEDGEMENT

Financial contribution:
Public Health Agency of Canada / Agence de la santé publique du Canada
The views expressed herein do not necessarily reflect those of the Public Health Agency of Canada.

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 16,876 completed responses 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.

The survey examined experiences with primary care and assessed how well these experiences aligned with the OurCare Standard, including access to care, team-based care, care coordination, health record access, culturally safe care, and accountability.

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.

The primary outcome measures were whether respondents reported any payments for primary care in the previous 12 months, and among those who paid, the reason for payment and total amount paid.

RESULTS

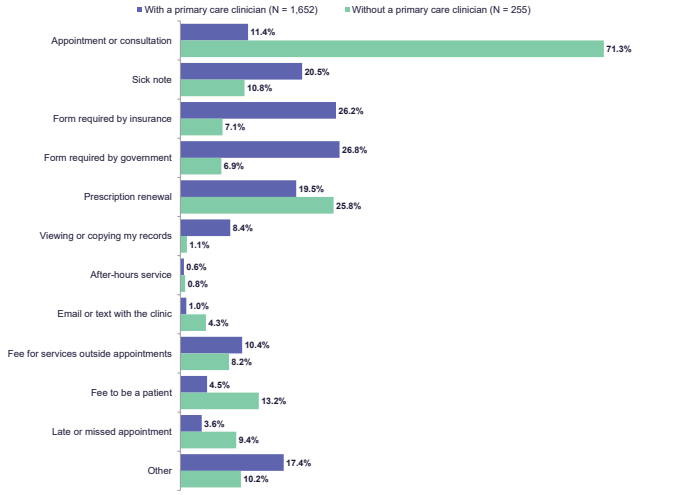
- We analyzed **16876 completed responses**.
- Over the past year, **14.5%** (95% CI: 13.4%–15.6%) of those with a primary care clinician and **11.3%** (95% CI: 9.1%–13.5%) of those without a clinician paid out-of-pocket for primary care.
- **Those with a primary care clinician** most commonly paid for government forms (26.8%), insurance forms (26.2%), sick notes (20.5%) and prescription renewals (19.5%).
- **Those without a primary care clinician** most commonly paid for appointments or consultations (71.3%), prescription renewals (25.8%), and monthly/yearly clinic fees (13.2%).
- **Quebec had the highest proportion** reporting payment among those without a primary care clinician (19.6% vs 11.3%).
- Among respondents who reported paying, 51.6% (95% CI: 47.8%–55.4%) **paid $100 or more** for primary care in the last year. This proportion was higher among those without a primary care clinician (75.9%, 95% CI: 67.0%–84.9%) than among those with a primary care clinician (47.1%, 95% CI: 43.0%–51.2%).
- Among all respondents and compared to the national sample, **more respondents from Quebec paid $300 or more** in the last year (38.0% vs 18.4%).

Many people in Canada pay out-of-pocket for primary care, with unattached residents in Quebec facing the highest costs

13.9% (95% CI: 12.9%–14.9%) of people in Canada reported paying out-of-pocket for primary care. Those without a primary care clinician most commonly reported paying for an appointment or consultation.

Reasons for paying differed among those with and without a clinician

% of those who paid out-of-pocket, by whether they have a primary care clinician. People could report more than one fee, so percentages add to over 100%.



Among those without a clinician

% who paid out-of-pocket:
Quebec 95% CI: 15.1%–24.2%; national sample 95% CI: 9.1%–13.5%



Among all respondents

% who paid $300 or more in the last year:
Quebec 95% CI: 28.9%–47.1%; national sample 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.

ACKNOWLEDGEMENTS

This project is part of OurCare, a national initiative to engage patients and the public about the future of primary care in Canada, led by Dr. Tara Kiran. The 2025 OurCare national survey was conducted in partnership with the Canadian Medical Association.

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

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https://www.ourcare.ca/survey
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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 model of care and approach to prevent and manage chronic disease (CD).

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

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

Interim findings of this evaluation of health promotion programs at Ontario CHCs showed increased participant confidence, social connection, and self-rated quality of life.

APPROACH

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

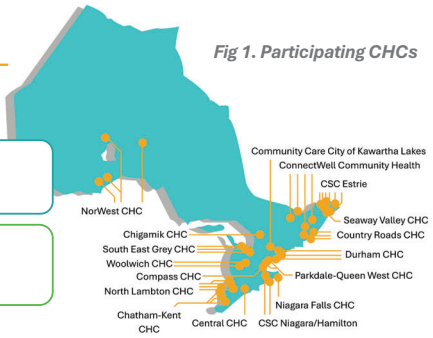
Inclusion Criteria: Programs

- Goal of improving CD knowledge or self-management
- Time-limited

Inclusion Criteria: Participants

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

Fig 1. Participating CHCs



RESULTS: POST-PROGRAM

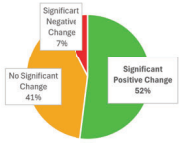
Data was collected from **Jan 2025 – Sept 2026:**

- **28 programs** across **17 CHCs**
- **175** pre- and post-program surveys
- **65** 6-month post-program surveys
- **57** interviews

Improved health outcomes

- Major improvements in the EQ-5D were seen in the **anxiety/depression** (43%) and **pain/discomfort** (39%) dimensions
- 52% reported a significant positive change in their **overall health score**

Fig. 2 Change in VAS (Overall Health) Score



RESULTS: 6 MONTHS POST-PROGRAM

Slight reduction in primary health care use

- Post-program, ~14.9% of participants reported **seeing their primary care provider less** for support in managing their CDs
- At 6-months post-program, this **increased to 27.7%**

Continued use of skills and techniques

- 89.2% of participants reported still using skills and techniques they learned

Connection to other programs and services

- At 6-months post-program, 53.9% accessed other services at the CHC since participating
- **Participants with difficulty paying for basic needs** were accessing services more (63.2%) than the comparison group (46.3%)

Fig 3. Are you seeing your primary care provider less for support in managing your chronic disease(s)?

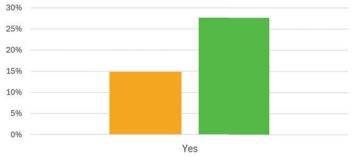
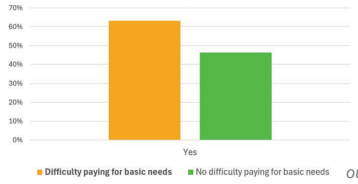


Fig 4. 6 months after completing the program, are you accessing programs and services at the CHC?



KEY FINDINGS

- **Health promotion programs have positive impacts on participant outcomes**
  - Programs may also contribute to reducing primary health care utilization
- **Maintenance of health status can be a positive outcome**, especially for participants with long-term conditions
  - Participants still report improvement in overall quality of life even with varied scores in individual health dimensions
- **Health promotion programs have positive impacts on other aspects of health**
  - When clients enter the CHC for a singular service, there's a higher chance they will be connected to other services

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

Queen's University

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Background: Penicillin allergy labels (PALs) affect 5–10% of the population, yet +95% of labeled individuals are not truly allergic. Little Canadian data exists on PALs.

Objective: Compare attributes and health outcomes of patients in Canada with and without PAL.

Study type: Cross-sectional

Database: Canadian Primary Care Sentinel Surveillance Network.

Eligible patients: Patients with ≥1 primary care visit between July 1, 2020 and June 30, 2025.

Analysis: Attributes between PAL and non-Pal were compared. Associations between PAL and health outcomes were examined through multivariate regression.

	PAL (28,909)	No PAL (582,986)
% Female*	65%	53%
Mean age (SD)*	52 (23)	44 (25)
Eczema*	25%	4%
Asthma*	14%	8%
Mood disorder*	41%	28%
Hypertension*	35%	25%
>=2 comorbidities*	72%	53%

*(p<0.001)

Health utilization
- 25 (PAL) vs. 16 visits (No PAL)*

Antibiotic use
- 16% (PAL) vs. 7% (No PAL)*

C. *difficile*
- 0.2% (PAL) vs. 0.1% (No PAL)*

Patients with PALs received more:
- Macrolides (14 vs. 8%; OR 1.88)*
- Fluoroquinolones (8 vs 4%; OR 1.78)*
- Fosfomycin (3 vs. 2%; OR 1.66)*
- Tetracyclines (13 vs. 9%; OR 1.53)*
- Clindamycin (5 vs 3%; OR 1.53)*
- Nitrofurantoin (11 vs 8%, OR 1.3)*
- Sepra (6 vs. 5%; OR 1.2)*

Patients with PALs received fewer:
- Penicillins (8 vs 23%; OR 0.28)*
- Cephalosporins (12 vs 13%; OR 0.89)*

Conclusions: PALs are common in Canadian primary care and associated with worse health outcomes. Examining whether delabeling penicillin allergies in primary care improves outcomes is the next step.

Measuring Physician Co-Management Relationships: A Scoping Review

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Introduction

- Patients living with chronic conditions often require co-management between family physicians and specialists.
- Measuring this collaboration is important for understanding and improving physician co-management.
- We conducted a scoping review to examine the current landscape of measurement approaches for physician co-management relationships.

Methods

- We searched PubMed, Embase, Scopus, and PsycInfo using keywords for relevant articles; At least 2 research team members screened each article independently.
- We included articles that examined co-management of care for 1+ patients between any 2+ physicians. The articles must have clearly outlined their measurement data and processes.
- We excluded articles which only used qualitative methods or focused on co-management between allied health professionals and physicians.
- We abstracted data related to
  1. Article characteristics
  2. Study methodology and outcome
  3. Characteristics of the co-management relationship
  4. Development of the co-management measurement
- We retrieved 7132 articles, removed 1886 duplicates, and screened 5246 articles; We excluded 5185 articles after title and abstract screening and 43 articles after full-text screening.

Conclusions

- Our scoping review identified three survey instruments and >30 unique measures derived from health claims data to quantify co-management between family physicians and specialists.
- The implementation of survey tools requires physician/patient engagement and resources to administer surveys. In contrast, measures derived from health claims data only require access to sufficient health claims data and the resources to collect and analyse the data.
- We hope that this scoping review can guide research on co-management relationships within Ontario. Next steps should include identifying measures that can be analyzed using ICES data.

Results

- We screened 5246 articles; 18 articles met the inclusion criteria.
- 15 articles reported on retrospective observational studies using data derived from health claims records, two reported on cross-sectional surveys, and one reported on a mixed methods study using survey and health claims data.
- Studies were from: USA (10 studies), Australia (2 studies), Germany (2 studies), Brazil (1 study), Canada (1 study), China (1 study), and the Netherlands (1 study).

Studies Using Health Claims Data

- Studies using health claims data were able to identify tracked physician co-management by identifying physicians treating the same patient. They used this information to analyse one-to-one co-management relationships and larger networks of physician collaboration.
- Across the 16 studies, we identified >30 unique measures related to co-management relationships.
- Basic requirements for these measures include health claims data identifying patient visits/interactions with physicians.
- The outputs from each study can be organized into three groups based on the insights they provide. These groups are described below:

Descriptions of collaboration

Measures that describe the structure and characteristics of the shared patient relationship (e.g., number of shared patients, persistence of relationship year-to-year).

Networks of care

Measures that describe characteristics of the broader shared care network (e.g., how concentrated is patient care within a health system).

Patterns of practice

Measures that describe the care provided to patients of co-management relationships (e.g., how often is a physician following-up with a patient).

Studies Using Survey Data

- The three survey-based studies each used a distinct survey instrument to collect insights into physician co-management relationships.
- Basic requirements for these measures include resources and access to physicians/patients to administer the questionnaire.
- The three survey instruments are described below:

Provider Co-management Index

A 20-item questionnaire with each item scored on a 4-point Likert scale. The instrument identifies three dimensions:

1. Effective communication
2. Mutual respect and trust
3. Shared philosophy of care

Relational Coordination Survey

A 7-item questionnaire with each item scored on a scale of 1-5. The seven items are:

1. Frequent communication
2. Timely communication
3. Accurate communication
4. Problem-solving communication
5. Shared knowledge
6. Shared goals
7. Mutual respect

Consumer Quality Index

A 22-item questionnaire with most items scored on a 4-point scale. The instrument provides insight into four domains of patient care and co-management :

1. GP Approach to care
2. GP Referral for care
3. Specialist approach to care
4. Collaboration experience

Co-design and acceptability of a bilingual artificial-intelligence-powered chatbot for biopsychosocial data collection among Ontarians living with chronic pain

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Context

Chronic pain (CP) affects approximately 8 million Canadians and substantially impacts quality of life (1). It disproportionately affects vulnerable and minority populations, who may face stigma and barriers to accessing care (1). The biopsychosocial (BPS) approach, which incorporates social determinants of health (SDH) into clinical care, is considered the gold standard for CP management (2). However, SDH are often poorly documented in primary care due to time and resource constraints, limiting the integration of a comprehensive BPS approach into care (3). A bilingual artificial-intelligence (AI)-powered chatbot could automate the collection of SDH prior to the clinical encounter and organize them into a personalized patient BPS profile to promote interdisciplinary and holistic management of CP.

Objectives

This project aims to create and evaluate a chatbot that will be trained to interact with patients in French and English to collect their SDH data and organize it into a personalized BPS profile. This will be achieved through multiple steps:

1. Create the French-language pre-prototype;
2. Adapt the French-language pre-prototype into English;
3. Refine the bilingual prototype, through interactions with multidisciplinary experts and patients, to adapt it to Ontario's cultural and sociodemographic diversity;
4. Evaluate the acceptability, i.e., the perceived usefulness and ease of use by patients, of the bilingual prototype (4).

Expected Outcomes

Expected outcome #1: Development of a bilingual AI-based chatbot to support the management of French- and English-speaking patients living with CP;

Expected outcome #2: Good acceptance of the chatbot by patients living with CP;

Expected outcome #3: Creation of a shareable BPS profile aligned with the priorities and needs of primary care stakeholders.

Methods

Recruitment of participants

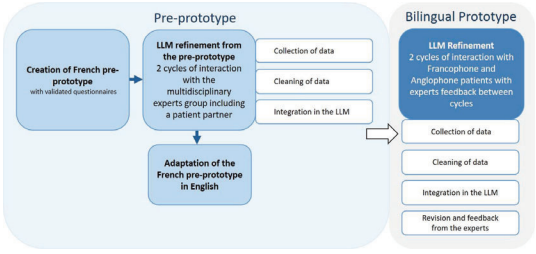
Inclusion: adults (18+), residing in Ontario, with self-reported chronic pain (≥ 3 months), registered with a physician or nurse practitioner in Ontario, and fluent in French or English (self-reported).

Exclusion: inability to travel.

Recruitment method: posters in primary care clinics, hospital recruitment, social media.

Production of the bilingual chatbot

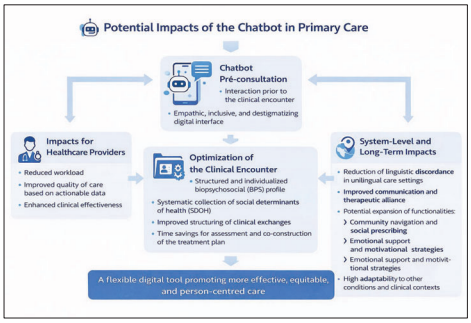
The steps involved in producing the bilingual chatbot will be as follows:



Patient acceptability will be evaluated using :

- Completion of two validated questionnaires on the acceptability of the chatbot (System Usability Scale and User Experience Questionnaire (5-8)
- Participation in a semi-structured interview on the user experience

Impacts



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Montfort Hôpital universitaire Academic Hospital
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uOttawa L'Université canadienne Canada's university
CONSORTIUM NATIONAL DE FORMATION EN SANTÉ Volet Université d'Ottawa
Contribution financière : Santé Canada Health Canada

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

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WHY THIS MATTERS

eConsult is a secure web-based tool that enables access to specialist advice for physicians, nurse practitioners, and midwives[1]

800,000+
eConsult cases completed in Ontario

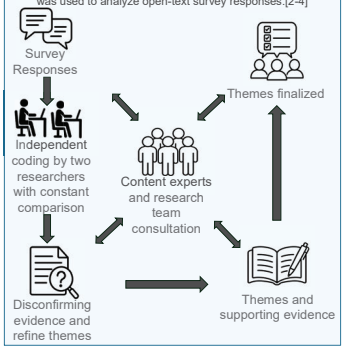
- There is growing interest in exploring how artificial intelligence (AI) could further enhance the efficiency and quality of these interactions.
- **Aim: understand specialist physicians' current use of AI tools and their perceived value, concerns, and risks with regards to AI use in eConsult**

Specialist › AI draft? › eConsult reply

APPROACH

A 19-question survey was distributed and managed by the Ontario eConsult Centre of Excellence.

An inductive thematic analysis approach with constant comparison was used to analyze open-text survey responses.[2-4]



RESULTS & THEMES

1182 **Specialists surveyed** who responded to 5 or more eConsults between April 2025 and March 2026 › **472** Specialists responded › **160** Responded to free text portion › **130** Relevant responses

Free text portion:
"Do you have any additional comments, suggestions, or concerns regarding the use of AI tools to assist with drafting eConsult responses?"

**Quotes are individual participant perspectives, NOT the views of all specialists.*

1 AI as a Tool

Could support efficiency and workflow: finding evidence, organizing information, improving clarity.

Support ↔ authorship

"AI is best used for scanning evidence and guidelines, not to craft responses"
— specialist survey respondent

2 AI Adoption

Depends on beliefs, prior experience, and perceived value. Openness and firm opposition both present.

Time saved ↔ extra workload

"I used to use Open Evidence exclusively, now I have switched to Claude and the quality of the information provided is exceptional."
— specialist survey respondent

"I am efficient with my time and do not see the benefit of AI with my eConsult work"
— specialist survey respondent

3 AI Integration

Wide use needs safeguards for responsible use, and a fit with the purpose of eConsult.

Convenience ↔ purpose of eConsult

"[I am] Nervous about robust adoption without knowing gaps and risks"
— specialist survey respondent

4 Professionalism

Clear boundaries: AI works alongside the physician, who remains responsible and exercises judgement.

Assistance ↔ replacement

"I think it needs to be clearly stated that the clinician is still legally responsible for the advice given. AI should not replace the physician but instead enhance their work."
— specialist survey respondent

5 Trust

Depends on proven accuracy, transparency, and safety.

Usefulness ↔ verification

"Pilot it first and reassess for time and reliability before widespread application"
— specialist survey respondent

KEY MESSAGE

AI in eConsult may help, but adoption will hinge less on availability and more on specialists' perceptions, confidence, and trust.

WHAT IT MEANS

Respondents called for:

1. *Governance and clear guidance*
2. *Privacy and data protection*
3. *Training in effective use*
4. *Requirement for human oversight and accountability to the physician*
5. *Pilot and routinely evaluate accuracy, safety, and value*

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Assessing the capacity of 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.
- **Objective:** Assess the research and learning capacity of Canada's PBRLNs.

Methods

- Survey development: Originally drafted with input from PBRLN directors and staff. Pilot tested by 3 PBRLN directors and their staff. Revised for content to address Learning Health System (LHS) components using the LHS Action Framework.
- Content of the survey asked about structure, resources and functions of PBRLNs to engage in research and learning. Both Likert scale and open-ended questions were in survey.
- PBRLNs identified through PBRLN Director's Table, Canadian Primary Care: Research Network and Sentinel Surveillance Network.
- Answers to open-ended questions were coded using NVIVO 15. We created a code-book, independently coded and conducted thematic analyses based on LHS Action Framework.
- Likert scale answers were assigned a score (e.g., High = 3, Moderate = 2, Low = 1, None = 0). Individual means were computed by dividing the sum of scores by the number of responses. Grand means for each domain were computed by averaging individual means.

Practice-Based Research and Learning Network (PBRLN) Characteristics

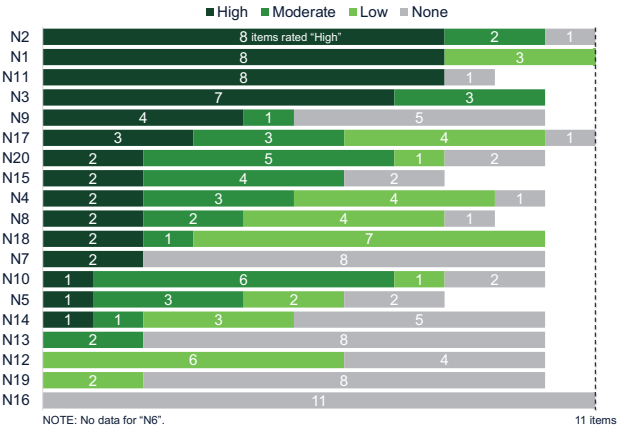
Roles reported in PBRLN leadership, staffing, and advisory structures.

	Western Provinces					Ontario: POPLAR							Québec: Réseau-1				Atlantic Provinces				
	N1	N2	N3	N4	N5	N6	N7	N8	N9	N10	N11	N12	N13	N14	N15	N16	N17	N18	N19	N20	TOTAL
Leadership																					**20**
Science	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Clinical		✓				✓	✓			✓						✓					5
Operations & Admin																					**19**
Manager		✓	✓		✓		✓	✓			✓	✓	✓				✓	✓	✓	✓	12
Coordinator	✓			✓		✓			✓	✓			✓		✓				✓	✓	9
Admin Support			✓		✓											✓					3
Data Infrastructure																					**8**
Data Manager	✓	✓	✓	✓				✓		✓	✓						✓				8
Other(s)		✓		✓						✓	✓										4
Research, QI, Implementation																					**12**
Research Officer/ Associate(s)					✓		✓			✓				✓	✓	✓				✓	7
Research Assistant(s)	✓	✓	✓																	✓	4
Other(s)		✓			✓						✓			✓	✓			✓			6
Advisory																					**17**
Clinical		✓		✓	✓				✓	✓				✓	✓	✓		✓		✓	10
Patient	✓	✓	✓		✓			✓	✓	✓	✓	✓		✓		✓		✓		✓	13
Institutional	✓			✓		✓		✓	✓	✓			✓	✓	✓			✓		✓	11
Provincial								✓						✓		✓		✓		✓	5

NOTE: Networks have been anonymized and randomly assigned a number from 1-20. These numbers are consistent across figures and results.

Data & Technology Capacity

PBRLNs were asked to rate themselves across 11 items related to their capacity to collect, manage, and analyze clinical or research data, and processes to maintain patient privacy and confidentiality.



NOTE: No data for "N6". 11 items

"Our key challenges pertain to funding sustainability, capacity constraints, clinic retention and engagement, and the overall [provincial] healthcare political environment that has overwhelmed our clinicians leaving them with little bandwidth for research and QI activities" [N16]

"Given this broader [health system] restructuring and competing operational priorities, research engagement and practice-based research infrastructure are understandably lower in the immediate hierarchy of system needs." [N19]

Results

- All provinces had at least 1 PBRLN (n=20); Alberta (n=2), Ontario (n=7) and Quebec (n=4) had multiple PBRLNs, dependent on geography.
- PBRLNs reported high scientific capacity (*M* = 2.37) and low data & technology capacity (*M* = 1.43).
- Most PBRLNs rely on funding from grants (infrastructure through CPCRC or matching funds; projects through CIHR, contracts, etc.). Only 35% (n=7) receive any departmental or institutional funding. The majority (80%) estimated the costs of operating a PBRLN required a minimum of $100,000 to upwards of $250,000.
- Top moderators challenging research and learning capacity in PBRLNs were: 1) engagement challenges with practices and clinicians; 2) competing clinical priorities; and 3) funding and financial sustainability.

Conclusions

- These results are the first in Canada to describe our primary care PBRLN capacity for science and learning.
- Understanding how best to bring research and learning into practice is needed. Creating value to clinicians and practices through learning mechanisms such as feedback loops and engagement with their data are needed.

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

Zeenat Ladak[1,2], Bridve Sivakumar[1], Onil Bhattacharyya[1,3], Asiana Elma[1,3], Soheil Dehghani[4], Anja Lanz[5], Alan Katz[6], Shelley Motz[7], Katherine Graham[8], Monique Pollak[9], Canadian Network for Collaboration, Exchange, and Continuous Transformation in Health 8-1-1 (CONNECT 8-1-1), Kendall Ho[4]

[1]Women's College Hospital Institute for Health System Solutions & Virtual Care, [2]TUTOR-PHC Patient & Community Engagement in Primary Health Care Research Fellowship, [3]University of Toronto, [4]University of British Columbia, [5]5atient Research Partner, [6]Manitoba Virtual Integrated Clinical Service, [7]HealthLink BC, [8]Misericordia Health Center, [9]Ministère de la Santé et des Services sociaux

INTRODUCTION

What is a Digital Front Door (DFD)?

A single, seamless, patient-facing entry point that integrates digital tools and services to help people easily access, navigate, and engage with healthcare from anywhere.



What is Health 8-1-1?

- A 24/7 non-urgent care digital health service that allows Canadians to call, chat online, or access information via website, to receive the care they need.
- Supports patients in avoiding unnecessary visits to the emergency department and delays in accessing care.

The Problem to Address

- Currently, **~5 million do not have regular access to a primary care provider** (family physician, nurse practitioner) in Canada
- Health 8-1-1 has the potential to support these patients by functioning as a comprehensive DFD
- An evidence-based definition of a DFD and a framework of components that make up a DFD have yet to be investigated

OBJECTIVES

1. Synthesize an **evidence-based definition for a DFD** within the context of health services.
2. Develop a **preliminary DFD framework** inclusive of a comprehensive list of DFD components.

METHODS

Rapid Review

- Databases: Medline, Embase, CINAHL, & Google Search Engine
- Criteria: **Definition of a DFD** or synonym (e.g., portal, platform)
- Included records: 20 white & 9 grey literature
- Analysis: Identified definitions were consolidated into one AI-synthesized definition

Surveys

- Population: CONNECT 8-1-1 member across 11 provinces/ territories: physicians, managers, health system leaders
- Analysis: **potential DFD components** were organized into a framework

RESULTS

Synthesized Digital Front Door Definition

"A Digital Front Door is a person-centred, coordinated, and continuously available entry point to the health system that enables individuals to access trusted information, navigate services, and connect to the most appropriate care through integrated digital channels."

Figure 1. Preliminary Digital Front Door Framework

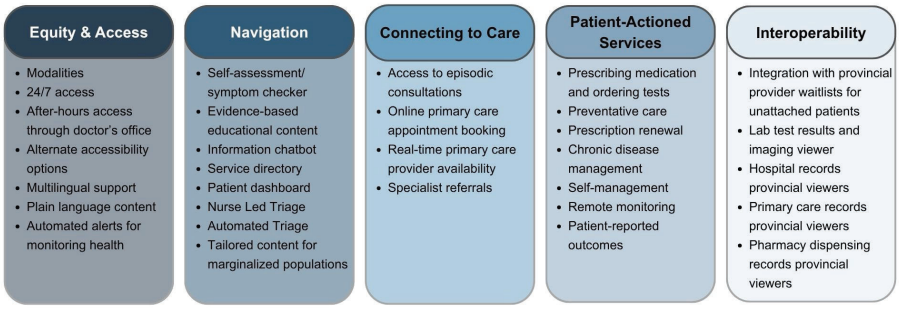


Table 1. A reflexive comparison of what a Digital Front Door "IS" vs what it "IS NOT"

A Digital Front Door to a health system…	
IS	**IS NOT**
• A digital entry point to address patient health concerns	• Focused on continuity of care (e.g., virtual care with one's own provider)
• Where people can be directed to receive care, as appropriate	• Where people go to receive immediate virtual care (e.g., a virtual walk-in clinic)
• Always accessible without time or unique use restrictions	• Restricted to a specific timeline (e.g., 3-month program)
• Available to anyone across healthcare sites/institutions	• Defined by organizational boundaries
• Inclusive of any health/wellbeing issue with and beyond primary healthcare	• Limited to primary healthcare
• Meant to support timely access to care and optimize self-management of care for patients and caregivers	• Meant to restrict alternate care options

CONCLUSION & SIGNIFICANCE

Potential Benefits of a DFD:

- increase health-system efficiency
- improve health outcomes
- increase care and resource focus
- reduce emergency department visits
- reduce inappropriate service utilization

Potential Limitations of a DFD :

- assessing complex patient needs
- fragmented handoffs
- exacerbate the existing digital divide

Our definition and framework can support more robust design and implementation of comprehensive DFDs for health-systems across Canada and internationally.

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

Sharon Johnston[1,2], Audrée Lemieux[1], Stephen A Kutcher[3], Borris Rosnay Galani Tietcheu[1], Gretchen Seitz[4], Nathan Chiarlitti[2], Émilie Dumetz[1], Jason Trickovic[2,5], Douglas Archibald[2,6], Sylvie Grosjean[1,7] & William Hogg[1,2]

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BACKGROUND

- Primary care plays a key role in addressing **health misinformation**.
- As digital tools become more adopted by primary care practices, they can help expand access to health information for diverse populations **without** adding to primary care providers' (PCP) administrative workload.
- However, many practices do not have enough time or resources to share health information **proactively**.
- **Generative artificial intelligence (GenAI)** can quickly support the co-creation of patient education materials, but its outputs must be carefully reviewed by humans to ensure safety and appropriateness.

HYPOTHESIS & OBJECTIVES

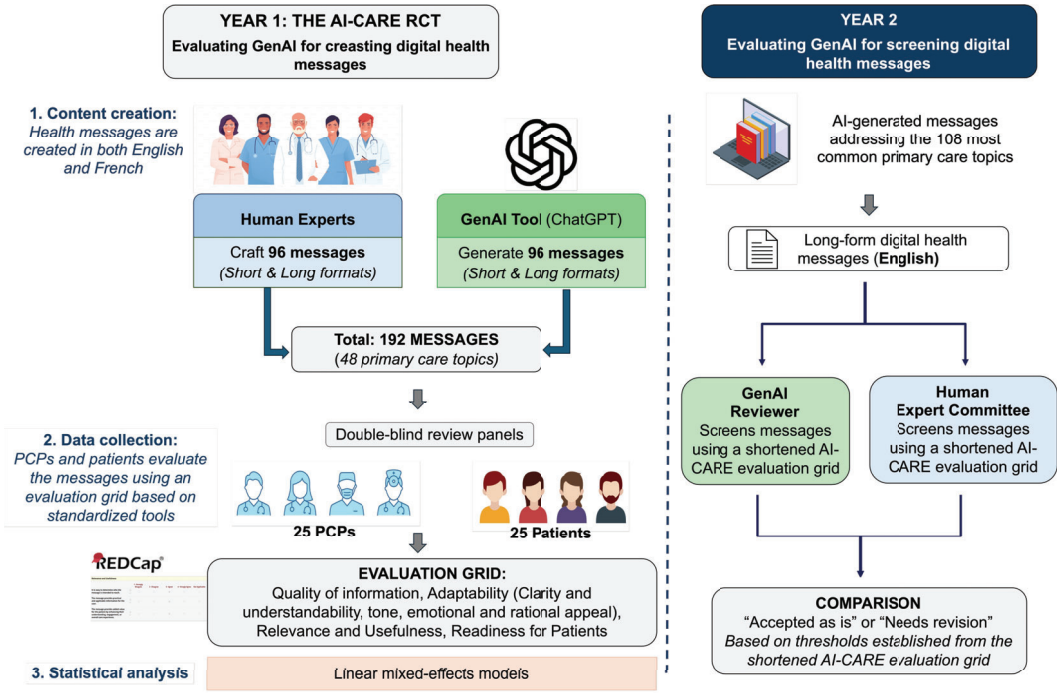
AI-generated digital health messages are evaluated by PCPs and patients as noninferior compared to those created by human experts.

- ✓ **Generate digital health messages** using GenAI and human experts;
- ✓ **Compare the perceived utility** of AI- vs. human-generated digital health messages in terms of quality of information, adaptability, relevance and usefulness, and readiness for patients;
- ✓ **Develop a** GenAI-based screener tool for digital health messages.

METHODOLOGY (1/2)

- **Study design:** Double-blind, crossover, bilingual & noninferiority randomized controlled trial (RCT)
- **Study period:** 2024-2027
- **Participants:**
  - **Content Team: 8** experts specializing in primary care, public health and/or health communication
  - **Review panels: 25** PCPs (family physicians, registered nurses, nurse practitioners, pharmacists, physiotherapists) and **25** patients from diverse backgrounds
  - **Human expert committee: 2** family physicians and **1** health communication expert

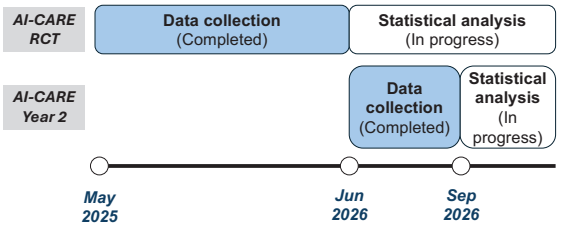
METHODOLOGY (2/2)



PRELIMINARY FINDINGS & PROGRESS

Table 1. Key sociodemographic characteristics of Review Panels.

	Primary care providers (N = 25)	Patients (N = 25)
Age (years old), N (%)		
18-34	2 (8)	6 (24)
35-50	18 (72)	7 (28)
51-69	5 (20)	6 (24)
70+	0	6 (24)
Gender, N (%)		
Man	8 (32)	8 (32)
Woman	16 (64)	17 (68)
Non-binary	1 (4)	0
Province, N (%)		
Quebec	6 (24)	0
Ontario	15 (60)	22 (88)
Manitoba	2 (8)	0
Alberta	1 (4)	3 (12)
British-Columbia	1 (4)	0



ACKNOWLEDGEMENTS

We would like to sincerely thank **all primary care providers and patients** who participated in this study.

IRSC CIHR

SCAN HERE!

AI-CARE study protocol
BMJ Open (2026)

CPIN Canadian Primary Care Information Network | RCIP Réseau canadien d'information pour les cliniques de première ligne

For more information, contact:

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Preventive Check:

A STUDENT-CREATED, OPEN-ACCESS WEBSITE/ APP FOR PERSONALIZED PREVENTIVE CARE CHECKLISTS

AUTHOR: **MATTHEW WONG** McMaster University Undergraduate Student

ACKNOWLEDGEMENT: Nicolette Sheridan, NP

Background

Gap: Millions of Canadians have no access to primary care providers.

Clinical preventive guidelines are complex, updated frequently, and often difficult for the general public to navigate independently.

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

Simplifies dense medical literature into plain language actionable steps.

As an undergraduate student using freely available AI tools, I aim to build 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.

The goal is to develop a free, non-commercial digital tool that translates Canadian clinical guidelines on cancer screening, immunizations, lifestyle counselling, and bone health into a simple, actionable, personalised checklist.

Methodology

Using free online AI tools and a free phone app to create a QR code. The total cost of the website domain is approximately $3 for the first year.

Results

The prototype shows that meaningful health technology can be developed at low cost.

Accessibility:
100% free, open access, accessible without registration, via any smartphone or computer. It requires no technical expertise.

Health Literacy:
The tool produces an individualized, guideline-concordant checklist within seconds, covering cancer screenings, recommended adult vaccinations, lifestyle counselling, and osteoporosis prevention.

Clinical Utility:
Promotes patient autonomy and efficiency during primary care consultations by preparing patients beforehand.

SCAN TO VIEW THE WEBSITE

Conclusion and Future Direction

Expansion

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.

Usability Testing

Constructing user-experience surveys in community clinic settings to measure impact on compliance.

Conclusion

This student-built prototype illustrates that low-cost preventive health tools are achievable and merit institutional investment.

Comparing Data from Regulatory Organizations with Provider Survey Data of Health Care Supply and Accessibility

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BACKGROUND AND RATIONALE

- **Travel time and distance** create inequities in access to mental health (MH) services for children and youth[1]
  - Geographic Information Systems (GIS) can provide a metric of spatial accessibility combining the number of providers, population density, and distance and travel time [2]
- Most research on spatial accessibility uses **regulatory body databases** (college) to locate providers
  - But regulatory databases may have critical gaps such as mailing address differing from practice address and lack of information on hours spend doing clinical work

RESEARCH QUESTIONS

We computed a spatial accessibility index (SAI) using the **Enhanced Two-Step Floating Catchment Area (E2SFCA)** to address the following questions:

1) What is the difference in the SAI between addresses from regulatory (college) databases vs. provider survey data?
2) To what extent do differences between regulatory (college) vs. survey data vary by location (urban vs. rural) and by sociodemographic adversity of the neighborhood?

METHODS AND SPATIAL MODELING

Sample & Survey

- **Psychologists:** Regulatory data: College of Psychologists of Ontario; *N* = 2505; competence with children and/or youth. Surveys completed; N = 1364
- **Psychiatrists:** Regulatory data: College of Physicians and Surgeons of Ontario; *N* = 103; child and/or youth speciality. Survey completed: N = 47

Survey verified practice address(es), direct weekly clinical hours, and % of clients who are children/youth (CYMH)

Spatial Modeling (E2SFCA in ArcGIS)

- SAI at Dissemination Area (DA) level (× 10,000)
- Travel catchment thresholds: 30 min (urban) / 60 min (rural).

Weighting, Imputation, & Equity Analysis

- Survey SAI weighted by: # of offices; clinical hours (35 hrs = 100%); % CYMH cases
  - For providers missing survey data, college address and SAI provincial average used
- SAI difference scores = College SAI – Survey SAI
  - **Positive** scores - College SAI ***overestimated*** spatial accessibility vs survey. **Negative** scores - College SAI ***underestimated*** spatial accessibility vs survey
- Differences scores correlated with 2021 Census Urban/Rural areas & Index of Multiple Deprivation (CIMD) deprivation metrics.

PRACTICE DISCREPANCIES & CHARACTERISTICS

Measure	Psychologists	Psychiatrists
Exact match for address & practice	11.8 %	42.6 %
Practice information only changed	78.2 %	51.0 %
Median % child/youth caseload	50.0 %	96.5 %
Average hours per week at primary site	22.8	28.2

SAI DIFFERENCE MAP: SURVEY VS. COLLEGE

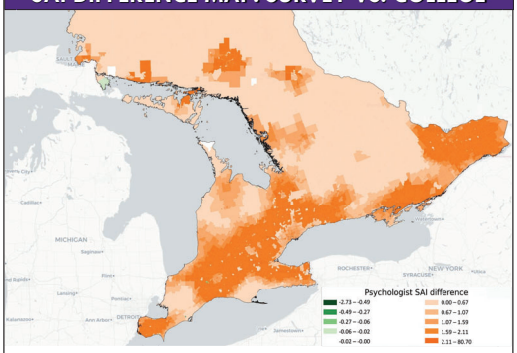


Fig. 1: Psychologists college vs survey SAI differences

*DAs in orange indicate psychologist SAI **decreased** (poorer accessibility) using the survey data (i.e., college data overestimated SAI). The darker the orange color, the larger the decrease using survey data. Green DAs indicate psychologist SAI **increased** after using survey data.*

Widespread Overestimation of Spatial Accessibility:

- Regulatory data **overestimated access** in 96.5% of DAs for psychologists and 73.6% of DAs for psychiatrists

Psychologist differences spanned virtually entire non-remote area of Ontario (Fig 1).

Psychiatrist differences concentrated just outside of urban areas in central and eastern Ontario. (No figure)

- **Psychologists:**
  - Average SAI decreased from **2.81 (College) to 0.71 (Survey).**
- **Psychiatrists:**
  - Average SAI decreased from **0.11 (College) to 0.08 (Survey).**

GEOGRAPHIC AND EQUITY DISPARITIES

Sociodemographic Marginalization (CIMD)

- Regulatory data **overestimated accessibility most in highly ethno-culturally marginalized neighborhoods** (psychiatrists *r* = .29; psychologists *r* = .06). Ethno-cultural composition reflects neighborhoods with higher proportions of populations such as immigrants and visible minorities.

% of DAs College Overestimated SAI by Ethno-Cultural Quintile

Provider	Least Marginalized (Q1)	Most Marginalized (Q5)
Psychologists	91.1 % of DAs	99.8% of DAs
Psychiatrists	47.4 % of DAs	95.4% of DAs

Rural vs. Urban

- Regulatory (college) **data overestimated spatial accessibility significantly more in rural areas than urban areas** for both psychologists and psychiatrists.

DISCUSSION AND POLICY IMPLICATIONS

Flawed Assumptions

- Using data from regulatory bodies and assuming all providers provide clinical services at the location on record is not a reasonable assumption.

Caution for Policy Makers & Researchers

- Racial minorities and immigrants consistently report lower rates of perceived need for MH treatment compared to Whites[3, 4].
  - If policy decisions are made about where to locate MH services based on regulatory data alone, it may create an additional barrier to care, as neighborhoods where the ethno-cultural composition is high already have existing barriers to accessing care.

Recommendations for Regulatory Bodies

- Essential clinical practice parameters should be collected annually, including direct clinical hours worked per week per location, secondary practice site addresses, and specific client age groups services.

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Poster presented at the Trillium Primary Health Care Research Conference, Toronto, Ontario. Oct 23rd, 2026.

Primary Care Physician Job Preferences:
A Systematic Review of Choice-Based Stated Preference Studies

Rachel Walsh[1,2]*, Nicole Falzone[1,2], Rachel Cheung[1,2], June Carroll[2,3], Catherine Devion[1], Aisha Lofters[2,4], Deborah Marshall[5], Sakina Walji[2,3], Cynthia Whitehead[2,4], Bonnie Chow[1], Liisa Jaakkimainen[1,2]

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Family & Community Medicine
UNIVERSITY OF TORONTO

BACKGROUND

- Primary healthcare systems are facing physician workforce shortages globally.[1]
- Understanding the job factors that affect physicians' decisions to practice in primary care can help guide strategies aimed at increasing recruitment and retention of the primary care workforce.
- Choice-based stated preference (CBSP) studies help us understand and quantify preferences, priorities, and trade-offs of decision-makers by asking respondents to place a value on a given option or attribute, quantify priorities in a more realistic trade-off environment and aid in the development of effective policy strategies.
- Sample choice task:

Imagine that you freely and without costs have the opportunity to choose between the types of practices below.

Which type of practice would you choose?

	Job A	Job B
Guaranteed paid locum	No paid locum relief	4 weeks per year
Respect for family medicine as a profession	Low	High
Time spent doing administrative tasks during evenings and weekends per week	2 hours	5 hours
Team-based Care	Yes	No
Ability to obtain services for patients in a timely manner	Easy	Difficult
Yearly earnings (after overhead, before tax)	200,000 CAD	250,000 CAD
I choose:	☐ *Job A*	☐ *Job B*

Figure 1. A hypothetical discrete-choice experiment choice task. In a CBSP study, participants are presented with a series of these tasks containing varying combinations of attribute levels.

- This review provides a comprehensive synthesis of CBSP studies in primary care, to summarize which job attributes matter most to primary care physicians across contexts and how methodological choices influence findings.

METHODS

Searched: MEDLINE, Embase, APA PsychINFO, Cochrane, CINAHL and PROSPERO from Jan 1, 1998-Sep 12, 2025.
Keywords: (1) PCPs, (2) job attributes, (3) CBSP methodology

↓

Data extraction: study demographics, populations studied, recruitment and survey administration methods, response metrics, survey design methods, attributes and levels used, analytical approach, results

↓

Quality appraisal checklists: International Society for Pharmacoeconomics and Outcomes Research (ISPOR)[2] and Mandeville et al.[3]

↓

Analysis: descriptive statistics for study characteristics and content analysis of included attributes. No meta-analysis performed due to context-dependent results.

RESULTS

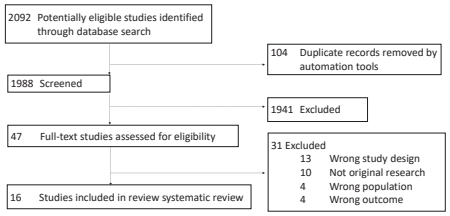


Figure 2. Study-selection flow chart

What makes a primary care physician job more attractive

Higher compensation
Pay and financial rewards
Income • salary • earnings • retention payments • benefits • lower pension taxation

Better working conditions
Day-to-day demands
Lower workload • reduced work hours • fewer on-call/night shifts • optimized consultation length

Supportive practice environment
People and systems around the physician
Practice team • colleague support • locum relief • clinical collaboration • guidelines • adequate facilities

Professional flexibility & opportunities
Control, growth and career options
Autonomy • flexible hours • professional development • training • promotion • special interests

Attractive location & community
Place, relationships and life outside work
Location • community respect • transportation • housing • childcare • partner opportunities • social life

Physicians value the whole job package, not compensation alone.

Figure 3. Preferred job characteristics examined in included studies

KEY FINDINGS

- Studies were published between 2000-2024, representing 19,434 primary care physicians from 10 countries: UK (n=4)[4-7], China (n=3)[8-10], Australia (n=2)[11,12], Germany[13], Norway[14], Thailand[15], Denmark[16], Portugal[17], Vietnam[18], India[19]
- Response rates were lowest with email/electronic recruitment methods (n=3, mean response rate 22.6%, SD 6.8) and highest with in-person recruitment methods, n=4, mean response rate 85.8%, SD 19.5). Postal recruitment had a mean response rate of 52.2% (n=6, SD 21.2; ANOVA F-statistic 3.9, p=0.049).
- Income was the most preferred attribute in 56.25% of studies, followed by workload (25.0%). On-call burden, professional development, flexibility/autonomy, location, and practice supports also ranked highly, with substantial variation across settings.

CONCLUSIONS/FUTURE DIRECTIONS

- Compensation matters, but it is not the whole story.
- 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.
- Using these findings, we are currently developing a CBSP study that aims to examine primary care physician job preferences in the Ontario context, which can ultimately help guide policy change to improve recruitment and retention initiatives in primary care in Ontario.

ACKNOWLEDGEMENTS

Funded by the Sunnybrook Alternative Funding Plan Innovation Fund.

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The study protocol was registered with PROSPERO (CRD42023453787) and was developed in accordance with PRISMA-P guidelines

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

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Background

- The Team Climate Inventory (TCI) and Provider Co-Management Index (PCMI) are used to assess interprofessional team performance in primary care.
- Interpreting TCI and PCMI scores is challenging since both instruments are scored and reported inconsistently across studies.
- We aim to establish benchmarks for TCI and PCMI using the Primary Care Diabetes Support Program (PCDSP) as an ideal case for comparison and a reference for studies using these instruments.
- The PCDSP is a team-based program located at St. Joseph's Health Care in London, Ontario supporting high-risk populations. Qualitative studies have described the PCDSP's high functioning team.

Methods

- We conducted a cross-sectional, online survey of PCDSP staff using the 14-item TCI and the 20-item PCMI (n=12 for TCI and n=10 for PCMI responses)
- We calculated total scores, mean scores, and standard deviations for each scale and subscale
- We identified other primary care studies in high-income countries using the 14-item TCI and the 20-item PCMI.
- Since TCI reporting methods and scale lengths varied across studies, we standardized eligible scores by converting them to a common 5-point scale and used proportion of maximum scaling (POMS) to facilitate comparison of scores.

Acknowledgements

This project is funded in part, thanks to funding from the Canada Research Chairs Program.

Results

Table 1. Conversion of 14-item short form scores to 5-point subscales and proportion of maximum scaling of articles using 14-item short form TCI in primary care settings.

	Conversion to 5-point Scale				
Author, year	**Total TCI**	**Vision**	**Participative safety**	**Task Orientation**	**Support for Innovation**
Howard, 2011	3.800	3.900	3.800	3.500	3.700
Mundt, 2016	NR	3.200	2.850	2.833	2.633
Rayner, 2017	3.874	4.010	4.010	3.738	3.738
Bosch, 2008	1.940	1.840	1.830	1.960	2.160
Brown, 2015	3.870	NR	NR	NR	NR
Arnold, 2023	4.200	NR	NR	NR	NR
Williams, 2025	4.010	NR	3.840	3.750	3.710
Goh, 2009	3.600	3.538	3.793	3.350	3.677
Khazei, 2020	NR	4.310	4.040	4.130	3.970
Phung, n.d.	3.966	4.119	4.150	3.745	3.850
PCDSP	**4.582**	**4.608**	**4.646**	**4.574**	**4.500**

Note: NR = not reported

Table 2. 20-item PCMI using 4-point Likert scale in primary care settings

	Total PCMI	**Effective communication**	**Mutual Respect and Trust**	**Shared Philosophy of Care**
Author, year	Total score; mean; standard deviation			
Norful, 2022a	Median = 73 (IQR 61-79)	Median = 26 (IQR 22-28)	Median = 23 (IQR 19-24)	Median = 25 (IQR = 21-28)
Norful, 2018	NR	Item means ranged from 1.76 (SD = 0.83) to 2.35 (SD = 0.92)	Item means ranged from 1.73 (SD = 0.69) to 2.19 (SD = 0.70)	Item means ranged from 1.78 (SD = 0.67) to 2.41 (SD = 0.87)
Phung, n.d.	Mean = 60.11 (SD = 7.90)	Mean = 3.39 (SD = 0.47)	Mean = 3.39 (SD = 0.54)	Mean = 3.27 (SD = 0.50)
PCDSP	**Mean = 66.60 (SD = 7.46)**	**Mean = 3.79 (SD = 0.31)**	**Mean = 3.68 (SD = 0.53)**	**Mean = 3.63 (SD = 0.51)**

Conclusion

- The PCDSP demonstrated the highest reported total TCI score and subscale scores among the primary care studies examined.
- Inconsistencies in reporting of scores limited direct comparisons of TCI and PCMI scores across studies.
- We suggest using PCDSP scores for TCI (4.582) and PCMI (66.60) as benchmarks for high-functioning primary care teams.

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

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Background and Aim

- Primary care providers (PCP) play critical roles in pandemic response; however, prior to the COVID-19 pandemic, response plans offered minimal guidance for primary care (PC).
- Public health (PH) and PC need to work together to ensure the most effective implementation of pandemic plans.
- Our project aims to create a locally relevant primary care pandemic plan for Middlesex-London, Ontario.

Approach

- We conducted a scoping review to examine supports enabling PC providers to enact pandemic roles, identifying 13 categories of supports, each with 1-6 specific supports.
- Findings informed a priority setting exercise in which PC knowledge users (providers, patient partners, and health system managers) in Middlesex-London (n=23) rated and ranked the importance of identified supports for inclusion in a PC pandemic plan.
- We surveyed public health officials in Ontario (n=14) and asked them to rank pandemic supports that would be most important in PC (1= most important, 5=least important).
- We report top-ranked category of supports, and level of agreement of importance of each support in top-ranked category.
- We compared responses from primary care providers and public health officials.

Acknowledgements

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

Results

- PCP and PH respondents generally agreed on the top 5 categories of supports. Both groups ranked ***1) General health system support and readiness*** first overall.
- Both PCP and PH respondents ranked ***3) Involving primary care providers in preparedness planning and response*** highly (3rd and 2nd respectively) – highlighting the need to include PCPs leadership at planning tables during the next pandemic or other health emergencies.
- PCP and PH showed the greatest difference in ranking for ***6) Communication for the public*** and ***8) Remuneration (payment) during a pandemic***, which PCPs ranked higher than PH.

Table 1: Ranking of the 13 categories of pandemic supports for primary care (1=highest rank)

	PH Rank	PCP Rank
1) General health system support and readiness	1	1
2) Limiting the risk of spreading infection	5	2
3) Involving primary care providers in preparedness planning and response decision making	2	3
4) Increasing capacity in primary care during a pandemic	3	4
5) Vaccination	4	5
6) Communication for the public	10	6
7) Communication for primary care providers	6	7
8) Remuneration (payment) during a pandemic	12	8
9) Wellbeing of primary care providers	9	9
10) Increasing capacity in other settings (redeployment) during a pandemic	7	10
11) Virtual care	8	11
12) Clinical issues in primary care	11	12
13) Evaluation/research	13	13

- Note: Results are based on small sample sizes and PCP rankings are based on a single region.

Table 2: Relative importance of specific supports in the *General health system support and readiness* category

	PH Avg	PCP Avg
1a) Supporting team-based models of primary care. This may be achieved through mechanisms such as nurse-led clinics, hub and spoke models, rural models	3.64	2.88
1b) Expanding availability of electronic medical or health records. This may be achieved through infrastructure, shared records, etc.	3.57	4.92
1c) Expanding integrated networks of primary care, hospital, and other healthcare providers. This may include communication channels (e.g., information sharing) across sectors (e.g., long-term care, hospital care, primary care, public health)	2.29	2.71
1d) Collaboration with community agencies and interdisciplinary healthcare providers to facilitate care. This may be achieved through a patient navigator, as an example	3.21	4.17
1e) Communication channels between hospitals and primary care providers with and without privileges	4.00	3.83
1f) Increasing the overall number of primary care providers and medical office assistants trained	4.29	2.50

- Within the ***General health system support and readiness category***, priorities for PH and PCP differed. PCPs believed increasing the number of provider and medical office assistants was the most important while PH respondents believed expanding integrated networks with PCP was the most important.

Conclusions and Next Steps

- While there may be broad agreement on the categories of support needed for pandemic preparedness for primary care, the relative importance of specific supports suggests PH and PCP have different perceptions of the fundamental role of PC during a pandemic. PCP's ratings of individual supports want plans to emphasize operational continuity through workforce changes while PH perceive PC should support other health sectors and community groups.
- Although there is agreement on areas to prioritize in a pandemic preparedness for primary care plan, disagreement on the role of PCP during a pandemic is evident in the ratings of PH and PCP importance of individual supports.
- We will produce a template for the process of co-producing regional pandemic plans and a toolkit of supports for use by other regions.

Optimizing the Scope of Primary Care Nursing: A Qualitative Study of Nurses in Ontario.

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Introduction

- The scopes of practice of primary care nurses (PCNs) of all designations overlap. PCNs include Nurse Practitioners (NPs), Registered Nurses (RNs), and Registered Practical Nurses (RPNs).
- We sought to understand how PCNs adapted and optimized their roles in teams with different combinations of PCN designations.

Research Questions

1. How do PCN professional scopes of practice overlap and differ?
2. How do characteristics of the clinical setting and the presence of other providers impact activities of PCN?

Methods

This project is a component of a larger study of PCNs in Newfoundland and Labrador, Ontario, Quebec, and Alberta.

We recruited participants through nursing organizations and contacting primary care clinics.

We conducted 26 semi-structured interviews with PCNs in Ontario.

Two team members conducted interviews. We reviewed field notes written immediately following interview to identify preliminary findings.

Acknowledgements

This project was funded by CIHR (PJT198013) and undertaken, in part, thanks to funding from the Canada Research Chairs Program.

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

Preliminary Results

Scope of Practice

- Scopes of practice of RNs and RPNs are increasingly blurred, especially as RPNs are facilitated and encouraged to expand their scope of practice with medical directives and additional training.
- Assignment of tasks and roles among RPNs and RNs is generally based on PCN availability, knowledge, comfort with the task, and interests rather than designation.
- Due to the expansions in their scope, NP scope of practice is increasingly distinct from that of RNs and RPNs. NPs report working largely to scope in their practices.
- Many PCNs of all designations run specialized clinics within their primary care teams. These specialized clinics focus on specific areas of clinical practice, and limit, to some extent, the scope of practice of PCNs to these areas/tasks.

Funding Models

- Funding models influence scope of practice and teamwork both between PCNs and between PCNs and other providers.
- Physician funding models limit RN-hiring on teams, assignment of activities tied to physician financial bonuses (e.g. well-child visits, diabetes management), and sharing of tasks among PCNs funded by physicians in Family Health Teams.
- PCN compensation was a frequent point of discussion.
- Perceived differences in compensation levels of PCN hinders teamwork.
- PCNs' expanded scopes of practice has not accompanied by increased compensation.
- Lower compensation in primary care vs acute care makes PCN recruitment and retention difficult.

Next Steps

- We are developing a coding template that will be used to inductively code transcripts from the four provinces included in the study.
- We will generate node reports and develop themes.

Participant Characteristics

Nursing Designation	Number (n)
Registered Practical Nurse (RPN)	7
Registered Nurse (RN)	8
Nurse Practitioner (NP)	11
Practice Model	
Community Health Centre	4
Family Health Organization	2
Family Health Team	8
NP-led Clinics	8
Other Practice Models	3
Community Size	
Urban	14
Small urban	6
Rural	6
Gender	
Man	1
Woman	25

Discussion

- Preliminary results align with previous studies that indicate the scopes of practice of RNs and RPNs in primary care overlap strongly and that NPs report working to full scope.
- Further, these results align with previous studies that reported funding models have impact on the nature of tasks assigned to PCNs and the extent of teamwork between PCNs and other providers.

Conclusion

- Preliminary findings shed light on the influential role of PCN funding and compensation on enacted scope of practice of PCNs in Ontario.
- While primary care reforms frequently focus on physician compensation or funding models, these preliminary findings suggest policy makers must also consider funding for PCN positions and levels of PCN compensation across all designations.

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

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[1]*Queen's University,* [2]*Kingston Immigration Partnership,* [3]*Kingston Community Health Centres*

Background

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

Key terms

Newcomer
Immigrants, refugees and refugee claimants living in Canada, generally within the first five years after arrival.[1]

Barrier
Any factor or condition that prevents or limits full and equal participation in a service or system.[3]

Facilitator
A person or factor that makes a process, service or experience easier, smoother or more accessible.[4]

Introduction

Prenatal and obstetrical care is fundamental to ensuring positive maternal and infant health outcomes. Timely and appropriate care can reduce risks such as maternal morbidity, preterm birth, and neonatal complications.[1] Newcomer perinatal health is shaped by complex social, economic, and structural factors.[1]

Newcomers often arrive in Canada in better health than Canadian-born residents, but this advantage tends to decline over time.[1] Access to maternity care also depends on immigration status and provincial health insurance rules, which differ across the country. Understanding what makes prenatal and obstetrical care harder or easier to reach is an important step toward more equitable care for newcomer families.

Objectives

CONTEXT In Canada, newcomers (immigrants, refugees, and refugee claimants) represent a growing and diverse population.[1]

GAP There appears to be fragmented evidence across general newcomer health and maternal health literature and limited regional data.

NEED A comprehensive national synthesis of barriers and facilitators to care.

RESEARCH QUESTION

Accordingly, this scoping review is guided by the question

What barriers and facilitators shape access to prenatal and obstetrical health services among newcomers in Canada?

Methods

A comprehensive search was conducted across Embase, MEDLINE, CINAHL, PubMed, Scopus, PsycINFO, and Web of Science. The strategy combined controlled vocabulary and keywords related to immigration, refugees, newcomers, prenatal and obstetric care, maternal health, healthcare access, and Canada.

Study Selection
The search did not use specific terms like "barriers" or "facilitators." Instead, studies were screened for relevance, with barriers and facilitators identified during title/abstract and full-text review.

Table 1. Eligibility criteria for study inclusion.

Inclusion Criteria	Exclusion Criteria
•Newcomers in Canada •Experiences with obstetrical services (prenatal clinics, hospitals, midwifery, community programs) •Interactions with providers and care navigation •Peer-reviewed studies and grey literature •Qualitative, quantitative, mixed-methods studies •Conducted in Canada; published in English	•Non-newcomers (long- term residents/citizens) •Non-obstetrical healthcare •Experiences outside obstetrical care systems •Studies conducted outside Canada •Clinical outcomes only (no access focus) •Editorials, opinion pieces, or non-empirical case studies

Preliminary Results

30 studies were found eligible. Data extraction is in progress, with 16 of 30 studies extracted so far.

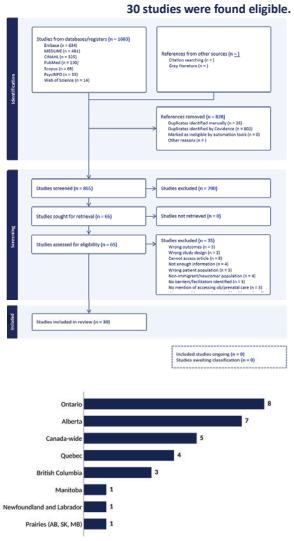


Figure 2. Included studies by province or region (n = 30). Canada-wide studies include reviews and national document analyses.

Barriers to prenatal and obstetric care

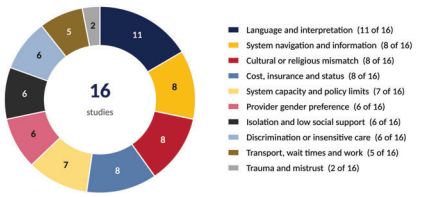


Figure 1. Barriers to prenatal and obstetrical care reported in the consensus-extracted studies (n = 16). Numbers show how many studies reported each barrier.

Facilitators of prenatal and obstetric care

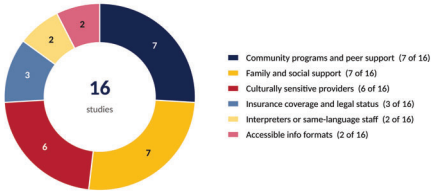


Figure 3. Facilitators of prenatal and obstetrical care reported in the consensus-extracted studies (n = 16). Numbers show how many studies reported each facilitator.

Implications

Focus: How overlapping social, system, and structural factors shape newcomer experiences of prenatal and obstetrical care. Results will be compiled and thematically analyzed due to the need for increasing the understanding of newcomer women's experiences with accessing obstetrical and prenatal care services.

- Findings will help identify gaps in the literature, educate providers and policymakers, and inform future research aimed at advancing more equitable and inclusive maternity care in Canada.

- So far, **language and interpretation** was the most common barrier, pointing to professional interpreter services as a clear priority in maternity care.
- **Community programs and family support** were among the most common facilitators, which shows the value of partnerships between health services and settlement organizations.
- No included studies came from the KFL&A region. **Local data is needed** to understand how these barriers play out in smaller communities.

Current Findings

30 studies included in the review

7 provinces represented, led by Ontario and Alberta

0 studies from the Kingston, Frontenac, Lennox and Addington region

11/16 extracted studies report language and interpretation barriers

Next steps

1. Complete data extraction for the remaining 14 included studies
2. Synthesize barriers and facilitators across all 30 studies
3. Inform the KFL&A environmental scan and needs assessment of newcomer obstetrical care

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We gratefully acknowledge our community partners, the Kingston Immigration Partnership and Kingston Community Health Centres, for their valuable collaboration and support in informing this work.

Interested in our results?
Scan here to fill out your contact information to receive our final deliverables when available!

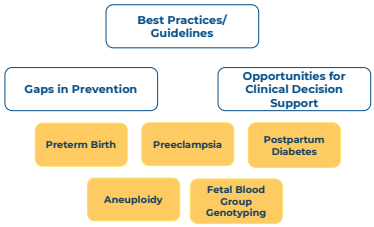
Identifying Gaps in Perinatal Care and Opportunities for clinical Decision Support Tools Through Narrative Review

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Objective & Introduction

Family physicians in Ontario contribute to antenatal care for 26.9% of pregnancies. With several time-sensitive recommendations contingent on gestational age and clinical history during pregnancy, clinical decision support (CDS) tools can potentially support clinicians. These literature review covered the following:



Methodology

- Searched for peer-review academic articles on management of perinatal care for topics above, plus Society of Obstetricians and Gynaecologists Canada's (SOGC) guidelines
- Findings were narratively synthesized around current guidelines, gaps in preventative care, and opportunities for CDS tools to address these gaps

Clinical decision support tools have the potential to **address gaps** in screening and **promote prevention** of negative perinatal health outcomes.



BORN Better Outcomes Registry & Network
Le Registre et Réseau des Bons Résultats dès la naissance

Contact: tbalachandran@bornontario.ca

Results

Gap	Opportunity for CDS Tools
Incomplete or delayed risk identification	Timely reminders for screening, counselling, and follow-up
Inconsistent counselling	
Nonadherence to preventative interventions	
Continuity of follow-up postpartum	
Inequities in care	Tailored, personalized care to support vulnerable populations.
Limited time seeing patients	Provide information in more digestible summaries with prompts to action

Additional considerations included clarifying screening options and informed choice through counselling. Pregnant individuals often disclosed that they were not informed about screening and/or preventative care when asked why they missed out on those opportunities. Postpartum diabetes review findings highlighted continuity of follow-up.

Conclusion

While CDS tools could address perinatal care gaps in primary care and beyond, their ability to do so has not been examined extensively. The evaluation of these novel tools in this setting is essential to determining whether they are effective and worth implementation into primary and perinatal care.