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Book of Abstracts – Oral Presentations

Organized by last name of Primary Presenter

Presented by: Sami Aftab Abdul

ID: 35531

The impact of the decriminalization of illegal drug possession in British Columbia, Canada

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Background and Objectives

British Columbia, Canada, implemented decriminalization on January 31, 2023, which allows adults to possess up to 2.5 grams of select illegal drugs without facing criminal prosecution. One of the policy's goals is increased awareness of and comfort with accessing health and social services. This study evaluated the short-term impact of decriminalization on supervised consumption and overdose prevention services (SCS/OPS) visits.

Approach

We sourced population-based health administrative data provided by the regional health authorities to the BC Centre for Disease Control (2017-2023). The data included services operated or funded by the regional health authorities, and encompassed both fixed and mobile services offering witnessed substance consumption. Monthly crude rates of SCS/OPS visits were modeled in interrupted time series analyses using generalized additive models with adjustments made for the unemployment rate. In additional sensitivity analyses, adjustments were made for the impacts of the SARS-CoV-2 pandemic using the COVID-19 Stringency Index. Both immediate level changes and trend changes post-decriminalization were assessed.

Results

There was a steady increase in the rate of SCS/OPS visits leading up to decriminalization (β : 0.015; 95% CI: 0.012 to 0.019). Higher unemployment rate was associated with reduced SCS/OPS visits (β : -0.080; 95% CI: -0.100 to -0.060). However, decriminalization did not result in a significant immediate level change (β : 0.041; 95% CI: -0.193 to 0.274) or trend change (β : -0.00002; 95% CI: -0.020 to 0.020) in SCS/OPS visits. In sensitivity analyses that adjusted for the COVID-19 Stringency Index, findings were consistent with those from the primary analysis. Decriminalization did not lead to a significant immediate level change (β : 0.038; 95% CI: -0.210 to 0.286) or trend change (β : 0.001; 95% CI: -0.015 to 0.017) in SCS/OPS visits.

Conclusion

Decriminalization was not associated with significant changes in SCS/OPS visits in the first eleven months of its implementation. Long-term assessments are required as the policy has evolved over time.

Engaging Communities in Socially Responsible Deployment of Artificial Intelligence: AI4DPP Project

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Background and Objectives

Ethical concerns regarding artificial intelligence (AI) in healthcare limits uptake, and patients and community partners are not usually involved in AI decision-making. The AI for Diabetes Prediction and Prevention (AI4DPP) project aims to achieve socially responsible implementation of risk prediction models for type-2 diabetes (T2D) in Peel, Ontario— an ethnically diverse and high burden region for T2D. We used a participatory approach to identify principles for meaningful community engagement on AI implementation.

Approach

After conducting a rapid review on frameworks and approaches for engaging patients and communities in AI, we organised a co-design workshop with diverse participants from Peel region- patients, caregivers, community organisation representatives, clinicians, and policymakers. We used a modified nominal group technique to facilitate the co-design session during which participants identified and ranked top principles to guide community engagement in deploying two T2D AI risk prediction models at a population level. The session also involved discussions on how these principles could be translated into practice throughout the AI lifecycle- from planning and designing to validation, implementation, monitoring, and evaluation.

Results

We identified ten principles from frameworks and approaches for patient and community engagement in AI for health care from six relevant articles we found during the rapid literature review. Through a ranking exercise conducted during the co-design workshop, which was attended by thirty diverse participants, attendees agreed on the top six principles that reflected their views and values on community involvement on AI - trust, equity, accountability, transparency, co-design, and value alignment. Discussions emphasised that these principles needed to be made tangible and actionable throughout the AI life cycle. Practices for meaningful community engagement on AI included: leveraging existing assets in the community, establishing a centralized decision-making and AI governance framework that is community-based, and co-designing AI solutions with a lens of inclusivity and diversity.

Conclusion

Community engagement is critical to successful adoption of AI to improve population health. The principles and corresponding practices for meaningful community engagement from our project can inform how AI solutions are implemented at a population level in a way that centers the values and perspectives of patients and community members.

ID: 34251

Presented by: Ibukun Abejirinde

Advancing Equity in Cancer Diagnosis: The Engaging Diverse Voices Health System Improvement Project

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Background and Objectives

The time between symptoms, cancer diagnosis and subsequent treatment is detrimentally lengthy in Ontario. Evidence shows that people from structurally marginalized communities are more likely to have poorer experiences and outcomes throughout the cancer care continuum. The division of System Improvement and Implementation at Ontario Health-Cancer Care Ontario (OH-CCO) identified a critical need to understand the unique challenges faced by these communities to inform redesigned diagnostic cancer pathways that are equity-centered.

Approach

Our embedded research project involves system decision makers, researchers and 45 persons with lived experience of the cancer diagnostic phase from Black, Francophone and Immigrant/Refugee communities across Ontario, drawing from intersectionality, community-based participatory research and system-design methodologies. First, we conducted a rapid review of best practices and strategies for engaging members of structurally marginalized communities in health research. This was supplemented by document analysis of OH-CCO's current operating procedures and 16 key informant interviews with regional leads and other health system partners on the opportunities and challenges with establishing a system-driven model for engaging diverse voices in cancer care transformation.

Results

Supported by our teams' experience in health equity theory and practice, and findings from the review and interviews, we have iteratively developed a systematic approach to establishing three engagement tables (15 persons each) of lived experience experts (patients and care partners) from the identified groups, each co-led by a Peer Project Advisor. The accompanying equity-oriented engagement resource includes an intersectionality informed recruitment strategy, best practices for recruitment and selection, considerations for establishing and facilitating system redesign discussions, and considerations for roles, governance, accountability throughout the engagement cycle. This resource is being piloted across the 3 tables, and we are evaluating the experience of participants to understand their experience, refine the engagement model and develop guidelines and recommendations for OH-CCO to institutionalize and sustain these practices.

Conclusion

Despite recognition that equity-oriented approaches are critical to achieving the quintuple aim, there are gaps in system-wide implementation and uptake. Resource guides and toolkits that consider the structural and institutional limitations to scaling equity, can inform how institutions like OH-CCO embed equity in cancer programs and system redesign.

ID: 35248

Presented by: Fakhriyya Aghabayli

Understanding healthcare navigation in Alberta: Results of a peer-to-peer qualitative study

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Background and Objectives

Healthcare navigation services are essential to individuals needing to access appropriate care in increasingly complex health systems especially those facing systemic and other equity-denying barriers. It is important to understand gaps and best practices from the perspectives of both navigators and those being navigated to continue to develop and improve navigation training and delivery programs. To be appropriate to all, perspectives must be derived from individuals with diverse health and socio-cultural-economic backgrounds.

Approach

The Patient and Community Engagement Research team comprised 12 diverse individuals enrolled in a year-long experiential based research training program. Using a specific participatory research process the team designed and carried out a qualitative project looking to understand healthcare navigation in Alberta, Canada. They divided into two groups to better understand the perspectives of healthcare navigators and those who had been navigated. Focus groups and interviews were offered in 11 languages. Data was collectively and iteratively analyzed using thematic analysis. After member-checking, the teams contrasted results and arrived at six recommendations to improve scope and experience of service, and training.

Results

The team identified 15 healthcare navigation programs in Alberta, Canada. These offered services for: (1) cancer care (2) diabetes, (3) mental health, (4) disabilities, (5) life transitions, and (6) newcomers.

Through 8 focus groups and 5 individual interviews, the Navigated team identified three themes: (1) participants situation and circumstances, (2) navigation experience, and (3) participants perspective, and seven subthemes.

Through 8 focus groups and 5 individual interviews the Navigator team identified four themes: (1) need for healthcare navigators, (2) navigator role, (3) current best practices and challenges, and (4) training and support, and 15 subthemes.

Collectively these informed six recommendations related to increasing awareness and continued development of additional condition specific programs, formalized navigation training programs and enhanced program delivery in Alberta, possibly more widely.

Conclusion

The perspectives of healthcare navigators and those navigated are essential to understanding gaps and best practices in existing navigation service delivery and training programs. The results of this peer-to-peer study identify 15 Alberta-based navigation programs and share essential insights from diverse individuals to inform continued development and improvement going forward.

ID: 34744

Presented by: Arman Ali

How to Make Caregiving ‘EASIER’? Synthesizing Knowledge on Caregiver Outcomes and Interventions

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Background and Objectives

Caregivers provide an enormous amount of care, shifting burden away from the healthcare system. Despite forming a supportive backbone for the healthcare system, caregiver needs are often overlooked. For complex chronic conditions like brain injuries (BI), there is a need to examine the current state of caregiver support. Our objective was to synthesize knowledge on caregiver outcomes and interventions using BI as a model and develop policy recommendations that improve support for all caregivers.

Approach

Knowledge was synthesized across several sources, incorporating academic research and the voices of caregivers of persons with BI. Sources of information included: A) Multiple literature reviews with a clear search strategy and inclusion criteria (i) a rapid review on cognitive health of caregivers of people with brain conditions, ii) a scoping review on interventions for BI caregivers, and iii) an umbrella review on mental health and quality of life outcomes in caregivers of persons with BI), B) Focus groups with 20 caregivers that included prioritization exercises where participants ranked the most important challenges faced, and C) Caregiver experience surveys.

Results

All sources of evidence indicated that caregiving for people with BI is a chronic and challenging role that leads to high levels of burden. The ongoing stress caused by caregiving can impact brain health, overall wellbeing, and quality of life in caregivers. Specifically, caregiving-induced stress was often found to affect cognitive health, aging, and mental health. Findings from both the international literature and the focus groups supported the idea that caregiver stress, burden, and emotional load are created by various social and circumstantial factors that need to be understood. Social isolation and financial hardships experienced by caregivers, as well as the lack of understanding of brain injury by general healthcare providers, were common themes. Psychosocial interventions and social prescribing were found to be effective.

Conclusion

There is a clear need for comprehensive healthcare policies and system-level initiatives that consider caregiver health, needs, and personal/situational circumstances as part of patient-centered care. It is crucial to make caregiving ‘EASIER’ through policy changes and system reforms that facilitate Empowerment, Advocacy, Support (multifaceted and evidence-based), Improvement, Education, and Research.

ID: 31487

Presented by: Nasrin Alostaz

The IENs' Workforce and Workplace Integration Experiences During the COVID-19 Pandemic in Ontario

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Background and Objectives

Integrating internationally educated nurses (IENs) into Ontario's healthcare workforce is crucial for addressing nurse shortages, meeting increasing healthcare demands, and ensuring quality patient care. However, internationally educated nurses face numerous challenges during integration. Little is known about their experiences since the registration examination changes in 2015 and the COVID-19 pandemic. This study aimed to understand and describe internationally educated nurses' experiences during their integration processes and the support needed to streamline them.

Approach

This study employed a qualitative description approach, using semi-structured one-on-one virtual interviews with twelve internationally educated nurses. Data collection and analysis were completed concurrently and informed by the Braun and Clark framework and the Transition Theory.

Results

Three main themes with twelve subthemes emerged from internationally educated nurse interview analyses: internationally educated nurse experiences pre-registration, experiences post-registration, and support and call for improvements.

Conclusion

This study highlighted the multifaceted challenges internationally educated nurses face when integrating into the Canadian healthcare system. Collaboration among all stakeholders, including internationally educated nurses, is required to overcome these challenges and facilitate the integration process.

Patient and Public involvement in Systematic Reviews on Perinatal Depression and Anxiety in LMICs

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Background and Objectives

The integration of patient and public involvement (PPI) in health-related research bridges the gap between research and real-world patient needs, fostering better treatment compliance, more relevant findings, and cost-effective healthcare solutions. However, PPI remains underutilized in low- and middle-income countries (LMICs), particularly in systematic review methodologies. Our study showcases the incorporation of PPI in a systematic review exploring the potential role of artificial intelligence (AI) interventions in addressing perinatal depression and anxiety (PDA) in LMICs.

Approach

This systematic review employed an innovative PPI methodology by actively engaging diverse stakeholders including individuals with lived experience of PDA, non-governmental organizations (NGOs), AI experts, health professionals, and maternal health researchers. These persons were involved in the planning, development and knowledge mobilization stages. The process was also enriched by collaboration with a community-based organization to ensure meaningful community engagement and participant recruitment. Stakeholders, including new mothers and healthcare professionals, co-developed search keywords and participated actively in focus group discussions, an in-person workshop and a webinar. Feedback and dissemination activities further validated and refined the review process.

Results

Stakeholder involvement significantly enhanced the relevance of the review: 1) broadening of scope - stakeholders identified novel keywords that expanded the scope of the literature search, ensuring comprehensive coverage of relevant studies; 2) sense of ownership - engaging stakeholders cultivated ownership of the project, fostering a collaborative and empowering research environment; 3) Improved access - partnership with the NGO facilitated community entry and smooth participant recruitment, strengthening the possibility of long-term research collaboration; 4) The PPI reinforced partnerships with local organizations, laying the groundwork for future collaborative initiatives. Overall, this case study reveals that incorporating PPI in systematic reviews in LMIC contexts is feasible and transformative, driving research tailored to local needs and priorities.

Conclusion

To maximize the potential of PPI in LMICs, policies should mandate stakeholder engagement, support formal partnerships with local organizations, and allocate specific funding for PPI activities. Additionally, the development of guidelines to incorporate diverse perspectives and foster sustainable community-research partnerships is essential for advancing the relevance, equity, and impact of health-related research.

ID: 35599

Presented by: Jillian Antoun

Adopting a Syphilis "Test and Treat" Outreach Model of Care: A Judgment and Decision-Making Lens

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Background and Objectives

Over the past five years, Canada has witnessed a surge in syphilis cases. In December 2022, a public health unit (PHU) in southern Ontario declared a syphilis outbreak. As part of their response, they introduced a “rapid point-of-care test (POCT) and immediate treatment” outreach model of care targeting individuals experiencing houselessness and street involved. We examined the decision-making processes underlying the adoption of this model of care by this PHU.

Approach

Using the implementation science framework, RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance), this research focused on the decision-making processes leading to the adoption of this model of care. An instrumental case study methodology was employed. Potential judgment and decision-making factors were derived from the literature and consultation with experts, informing the development of an interview guide. To capture a range of perspectives, intervention agents that we interviewed included organizational leaders (e.g., Associate Medical Officer of Health) as well as frontline staff members (e.g., Public Health Nurse). The transcripts of six semi-structured interviews and 20 internal reports were analyzed with abductive coding.

Results

Three primary factors influenced the decision to adopt the model of care. 1) Organizational culture: 83% cite the “culture of innovation” at their PHU as integral to adopt the new model of care. 2) Leadership style: 83% indicated the leadership style as an essential factor. When discussing leadership, trust in staff, open communication, and “being action-oriented” were highlighted as key qualities. 3) Urgency: the urgency of the outbreak was a factor that influenced risk assessment and subsequent decision-making. Adopting a new model of care tended to be favoured when cases spread to highly vulnerable populations (rises in congenital syphilis cases identified by 67% of participants). Insights from regional community-based organizations collected through focus groups will be included in the results.

Conclusion

Distinct factors emerged as critical drivers of decision-making in adopting innovative models of care. The identified organizational and contextual variables can help guide understanding of decision-making processes and risk-assessments in other PHUs considering the adoption of similar models of care.

Interprofessional Team Characteristics and Patient Outcomes in CHCs: A Systematic Review

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Background and Objectives

Community health centres (CHCs) are community-governed organizations often located in communities facing significant challenges with social determinants of health and in accessing healthcare resources. To date, no review has summarized the evidence on the effects of interprofessional team characteristics (e.g., type of provider) on patient outcomes in CHCs. The objective of this systematic review was to synthesize the evidence on the characteristics of interprofessional teams practicing in CHCs and their associations with patient outcomes.

Approach

A systematic review was conducted following the guidelines of the Cochrane Handbook for Systematic Reviews of Interventions. In October 2024, an electronic search was performed in five databases and the grey literature using a combination of descriptors and keywords. Screening and data extraction were independently conducted by two reviewers. The included studies focused on interprofessional teams composed of at least three types of providers (e.g., physician, nurse, and nutritionist) practicing in CHCs and addressing at least one patient outcome (e.g., satisfaction). The risk of bias was assessed by two independent reviewers using the Joanna Briggs Institute checklist.

Results

From 6,309 identified papers, 33 studies were included. Most studies focused on team composition (n=18) and staffing patterns (n=8). Adjustments to staffing patterns—such as increasing full-time equivalents, expanding team size, and diversifying skill mixes—were associated with improved patient satisfaction and increased number of visits. Adding a chiropractor reduced opioid prescriptions and patient pain, while including a pharmacist improved hepatitis management and patient satisfaction. Inconsistent findings were observed regarding the inclusion of nurse practitioners and physician assistants in interprofessional teams and their impact on the annual number of visits in CHCs. Specialized interprofessional teams addressing diabetes, pain management, and childhood obesity had better health outcomes and care management, highlighting the value of tailored interprofessional collaboration in achieving improved health outcomes for specific populations.

Conclusion

Team composition in terms of staffing, skill mix, and provider types is associated with improved health outcomes for populations served by CHCs. Future research is needed to deepen the understanding of the associations between team composition, the type of care provided, and patients' clinical and psychosocial needs.

ID: 34774

Presented by: Li-Anne Audet

Pushing the boundaries of knowledge translation capabilities among doctoral nursing students

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Background and Objectives

The growing number of PhD-prepared nurses are well-positioned to drive policy change, lead educational reform, and integrate research to enhance care for patients, families, and communities. Embedding knowledge translation (KT) training in doctoral nursing programs is essential for preparing effective nurse leaders and fostering collaboration among researchers, clinicians, and patients. However, KT capacity-building initiatives remain limited in doctoral programs. This project explored KT content in Canadian nursing programs and offers recommendations from a local initiative.

Approach

A three-step approach was employed. First, a literature scan of two databases was conducted, with one author screening records to identify strategies for improving KT knowledge, skills, and access to resources among nursing PhD students. Second, an environmental scan of 18 nursing doctoral programs reviewed university websites, social media of graduate student associations, and research networks for KT content. Student representatives were contacted to clarify details and share KT activities not publicly available. Finally, a roundtable discussion with 15 nursing doctoral students from one Canadian program explored their understanding of KT, barriers and facilitators, and needs for KT development opportunities.

Results

The literature review retrieved only one article, describing a program to build implementation science research skills. No studies were found on KT research and practice skills for PhD nursing students, highlighting an absence of empirical data supporting KT practices and outcomes in doctoral nursing education. Formal KT training, such as courses and workshops, was scarce in Canadian doctoral nursing programs. Informal student-led initiatives, such as peer workshops and knowledge-sharing events, were more common but less visible. Students highlighted the need to strengthen KT capacity, and to build connections and foster collaborations among peers, researchers, and knowledge users to help bridge academia and clinical practice. Students suggested learning activities such as journal clubs, online KT workshops, and both in-person and online platforms for exchange among peers.

Conclusion

Sustainable strategies are essential for embedding KT training into doctoral nursing programs. Key steps may include appointing a dedicated coordinator to organize and oversee KT activities with faculty and students; integrating KT content into coursework; and evaluating the impact of these efforts on student outcomes (e.g., satisfaction, access to clinicians).

ID: 34680

Presented by: Victoria Babysheva

Transforming Healthcare Human Resources: A Case-Based Analysis of Systems Thinking in Action

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Background and Objectives

Healthcare systems face complex workforce challenges, including staffing shortages and inefficiencies. Traditional human resources management (HRM) often overlooks the interconnections between various elements, leading to fragmented solutions. This study explores the application of systems thinking (ST) in healthcare HRM, aiming to identify holistic strategies that address workforce challenges, enhance collaboration, and improve patient care. By analyzing case studies, the research seeks to demonstrate the transformative potential of ST in optimizing HRM practices and outcomes.

Approach

This study employed a systematic scoping review methodology, adhering to the PRISMA guidelines. A team of three reviewers conducted a search of SCOPUS and PubMed for studies published between 1999 and December 2024 that focused on healthcare interventions or services applying ST perspective, specifically within the context of HRM. The review targeted studies involving nurses and physicians and included descriptions of systems thinking applications related to healthcare workforce management. After reviewing 250 studies, 24 relevant case studies were selected for inclusion. The cases were analyzed to uncover patterns of ST application, identifying effective strategies, challenges, and outcomes in healthcare HRM.

Results

The analysis of selected case studies revealed common themes in the application of ST to healthcare HRM across a variety of global settings, including emergency departments, palliative care, maternal and child care, paramedicine and health promotion. Key findings indicate that ST enables a holistic understanding of workforce dynamics, emphasizing the interdependencies between recruitment, training, retention, and performance. It also highlights the importance of leadership, stakeholder collaboration, and cross-disciplinary efforts in improving HR outcomes. The application of feedback loops and causal loop diagrams was prevalent in visualizing the effects of HR decisions. Overall, ST provided a framework for identifying leverage points, promoting sustainable solutions, and improving collaboration across diverse healthcare contexts. However, challenges such as organizational resistance and limited familiarity with ST tools hinder widespread implementation.

Conclusion

Adopting systems thinking in healthcare HRM offers transformative potential by addressing systemic interdependencies and fostering collaboration. The findings emphasize the need for comprehensive, holistic approaches to workforce management that consider the broader healthcare context, ultimately driving improvements in staffing, retention, and patient care outcomes.

ID: 34549

Presented by: Firoozeh Bairami

The Impact of Retirement Income Support on the Well-being of Low-Income Seniors: A Scoping Review

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Background and Objectives

The growing global aging population presents various challenges, particularly for low-income seniors who are more vulnerable to financial instability. In response, several countries have implemented retirement income support programs to provide financial assistance for seniors. These programs aim to improve the financial security and overall well-being of older adults, especially those with limited resources. This scoping review aims to investigate the impact of such programs on the physical, mental, and social well-being of low-income seniors.

Approach

A comprehensive systematic search was conducted across five key databases: PubMed, Scopus, Embase, PsycINFO, and CINAHL, covering studies published up to September 10, 2024. Following the scoping review framework by Arksey and O'Malley (2005), only studies were included that specifically examined the effects of income support on low-income seniors' well-being, excluding review articles. A total of 12,504 articles were screened, with 26 studies meeting the eligibility criteria for inclusion in the review.

Results

The review found that income supplementation programs had a positive impact on several health indicators, including memory, lung function, and frailty. These improvements were attributed to increased access to healthcare services, nutritious food, and mental health support. Financial support alleviated the stress of economic hardship, allowing seniors to prioritize healthcare needs, potentially reducing chronic stress and its adverse physical effects. Programs that provided frequent monthly payments were found to be particularly effective in promoting healthier aging, as they helped maintain consistent consumption patterns, enabling seniors to access medical care and essential services without financial concerns.

Conclusion

This scoping review underscores the significant potential of retirement income support programs to improve the quality of life and health outcomes for low-income seniors. Tailored financial support plans with regular payments can mitigate the challenges faced by low-income seniors and contribute to their long-term physical, mental well-being and healthier aging.

Mental health service use among perinatal adolescents: a population-based study

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Background and Objectives

Perinatal adolescents appear to be at much higher risk of psychiatric disorders and adverse psychiatric outcomes compared to their adult counterparts. To understand how to improve care for perinatal adolescents, it is important to identify how this population is currently using mental health services. This study aimed to describe the use of outpatient physicians, emergency departments, and inpatient mental health services by pregnant and postpartum adolescents in Ontario.

Approach

All pregnancies to perinatal adolescents (age <19 at conception) were identified using Ontario, Canada population-based health administrative data (2012-2022). Outpatient physician mental health visits were recorded, including provider type, virtual visits, and continuity of family physician and psychiatrist care (proportion of visits to the most regularly seen physician for those with ≥ 3 visits). Psychiatric emergency department (ED) visits and admissions were recorded, including hospital type (academic, pediatric, mental health, small community) and first contact in the ED (i.e., first perinatal mental health service use occurred in the ED). Service use was described using proportions overall, then in pregnancy and postpartum.

Results

Among 27,547 adolescent perinatal periods, 10,548 (38.8%) were associated with ≥ 1 outpatient mental health visit. This included 9459 (34.3%) with ≥ 1 family physician visit, 2592 (9.4%) with ≥ 1 psychiatrist visit, and 525 (1.9%) with ≥ 1 pediatrician visit, and included 1276 (4.6%) with ≥ 1 virtual visit. A minority had ≥ 3 family physician mental health visits (12.0%) or psychiatrist visits (3.7%); for those who did, most had high continuity of care. In total, 2485 (9.0%) of perinatal periods were associated with ≥ 1 psychiatric ED visit, and 616 (2.2%) were associated with ≥ 1 psychiatric admission, most often to small community hospitals. Most initial ED visits represented a first perinatal mental health contact (1377/2485, 55.4%). Outpatient, ED, and inpatient service use were more common postnatally than in pregnancy.

Conclusion

Many perinatal adolescents access physician outpatient and acute care mental health services. Family physicians primarily deliver outpatient care and acute care is often provided in small community hospitals. This information can be used to inform models of care and interventions that meet the mental health needs of perinatal adolescents.

Mortality, Suicide Attempts and Emergency Department Visits among People Experiencing Homelessness

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Background and Objectives

Addiction and other mental health (AMH) disorders pose significant psychosocial challenges and economic costs. Our previous research indicates a higher prevalence of AMH conditions and multimorbidity among people experiencing homelessness. This current study seeks to examine the risk of suicide attempts, all-cause mortality, and emergency visits among individuals with AMH conditions who had a history of homelessness compared to those who did not experience homelessness.

Approach

This longitudinal analysis uses linked administrative data capturing physician visits, hospitalizations and emergency department (ED) visits from Alberta, Canada. We identified individuals diagnosed with AMH conditions between April 1, 2013 and March 31, 2018. We identified individuals experiencing homelessness over the year prior to the index date of April 1, 2018. Using Cox proportional hazards models, we then examined the relationship between homelessness at index and relevant outcomes (suicide attempts, all-cause mortality, and emergency visits for mental health and non-mental health reasons) over the following two years (April 1, 2018 to March 31, 2020) adjusted for age and sex.

Results

Among the 622,614 individuals with AMH conditions, 3,390 (0.54%) experienced homelessness in the past year. During the follow-up period, 441,498 (66.6%) of individuals visited the ED, with 69,164 (10.4%) visiting for mental health reasons. 7,097 (1.1%) of individuals attempted suicide, while 5,558 (0.84%) of individuals died during the follow-up period. Findings suggest that people experiencing homelessness are at greater risk of visiting an ED (HR=3.19, 95%CI=3.08, 3.31), and visiting an ED for mental health reasons (HR=10.04, 95%CI=9.62, 10.48) compared to other individuals in the study population with AMH conditions that were not experiencing homelessness. People experiencing homelessness are also at greater risk of attempting suicide (HR=10.28, 95%CI=9.22, 11.47) and at greater risk of dying from any cause (HR=7.27, 95%CI=6.32, 8.37).

Conclusion

Among people with AMH conditions, people experiencing homelessness are at significantly greater risk of dying, attempting suicide, and visiting EDs for mental health and other reasons. This substantially elevated risk suggests that more intensive interventions are needed to address the needs of this population, such as critical timing interventions.

ID: 35321

Presented by: Kainat Bashir

Deintensifying Diabetes Care in LTC: Exploring Perspectives of LTC Residents and Caregivers

Authors: *Bashir, Kainat (Trillium Health Partners)*

Thompson, Wade (University of British Columbia)

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Conklin, James (Bruyere Research Institute)

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Background and Objectives

Nearly 40% of older adults in Ontario's long-term care (LTC) homes live with diabetes and many are treated to intensive glycemic targets. Deintensification reduces diabetes treatment intensity by lowering medication doses or stopping them. It can decrease hypoglycemia risk, medication burden, and improve quality of life for this population. This study explores residents' and caregivers' views on diabetes deintensification, including reduced medications and testing, to address overtreatment and enhance safety and quality of life.

Approach

We conducted semi-structured qualitative interviews with 13 residents living with diabetes and 14 caregivers from various LTC homes in Ontario. Participants chose their preferred interview method: Zoom, telephone, or in-person. The interview guide was based on the Theoretical Domains Framework (TDF) and existing literature on deprescribing barriers in LTC settings. Our analysis combined pre-defined TDF codes with inductive coding, following Braun and Clarke's reflexive thematic analysis approach. This methodology allowed us to explore the complex factors influencing deprescribing practices in LTC facilities, providing valuable insights into the perspectives of both residents and caregivers.

Results

The analysis is underway, and results will be available at the time of the conference. Preliminary findings reveal diverse perspectives on diabetes management in LTC. Residents generally express satisfaction with their care, but views on deintensification vary. Some residents trust healthcare professionals and are open to recommended changes, while others resist changes to their current management. Many residents struggle to grasp the goal of deintensification, focusing instead on maintaining specific blood sugar levels. Caregivers often perceive LTC staff as lacking specialized diabetes expertise and many advocate for stricter dietary control. However, caregivers also accept easing management near end-of-life, prioritizing quality of life.

Conclusion

Preliminary findings underscore the need for individualized approaches when discussing potential changes in diabetes management with LTC residents, balancing medical needs with quality-of-life considerations. Study findings will inform the design of a diabetes management intervention that respects residents' dignity, involves caregivers and optimizes health resources in LTC homes.

ID: 34256

Presented by: Waldo Beausejour

Interest in and Access to Electronic Personal Health Information: A Logistic Regression Analysis

Authors: *Beausejour, Waldo - Canada Health Infoway;*

Brown, Terece - Canada Health Infoway;

Jaana, Mirou - University of Ottawa

Background and Objectives

Access to personal health information (PHI) is crucial for Canadians to stay informed and engaged in their healthcare. Despite consistently high interest in accessing electronic PHI in recent years, many Canadians continue to face barriers to online access. This study proposes to examine the association between interest in and access to PHI among Canadians while accounting for sociodemographic, socioeconomic, and digital factors, to better understand the gaps preventing high interest from translating into actual access.

Approach

Data from the 2024 cross-sectional Canadian Digital Health Survey of 12,000 Canadians aged 16+ years, which will be conducted online in January-February 2025, will be employed. The survey assesses the use of digital health technologies to access care, including interest in and access to electronic PHI, both measured as categorical Yes/No variables. Logistic regression will examine how interest predicts electronic PHI access, controlling for multiple covariates including demographic characteristics (e.g., age, region), socioeconomic variables (e.g., income, employment), health-related (e.g., regular healthcare provider/HCP, chronic conditions), and digital factors (e.g., digital health literacy). Statistical significance will be set at $P \leq 0.05$.

Results

The survey data will be available in March 2025. Our analysis will include: (1) a summary of the study population's characteristics, interest levels, and electronic access, with lower interest expected from seniors (65+) and higher access among Canadians with regular HCPs; (2) an association matrix to evaluate correlations among variables and anticipate potential multicollinearity, with a high correlation expected between healthcare utilization and online access; (3) interpretations of log-odds coefficients to assess the individual effects of factors on electronic PHI access, with digital health literacy potentially enhancing online access; (4) an appraisal of the model's goodness-of-fit to determine its accuracy in predicting online PHI access. These findings will offer valuable insights into barriers to online health records and inform strategies to translate interest into access.

Conclusion

Secure access to personal health information is crucial for a connected healthcare system. Uncovering the relationship between interest and access to electronic PHI will help identify barriers to improving healthcare connectivity and empower Canadians to actively engage in their care, regardless of their demographic or socioeconomic background.

ID: 35550

Presented by: Waldo Beausejour

Health Data Interoperability Challenges and Physician Burnout: A Critical Link

Authors: *Beausejour, Waldo, Canada Health Infoway;*

Brown, Terece, Canada Health Infoway

Background and Objectives

With the continued digitization of the Canadian health information system and the increasing reliance on electronic medical records (EMRs) and electronic health records (EHRs) to access patient information, interoperability is crucial for efficient healthcare delivery. However, poorly integrated systems and data silos can contribute to clinical inefficiencies and increased workload, which potentially lead to physician burnout. We sought to examine the association between health data interoperability challenges and professional burnout among Canadian physicians.

Approach

Data from the 2024 cross-sectional National Survey of Canadian Physicians, conducted online with 1,145 Canadian Medical Association (CMA) physicians, was analyzed. The survey explored physician adoption and use of digital health technologies. Physician burnout, our dependent variable, was assessed using a five-level ordinal scale (with the lowest level indicating no burnout). Health data interoperability challenges were measured by: time spent accessing patient records outside practice, time spent on EMR after hours, and lack of system integration (categorical yes/no). Bivariate analyses were used to evaluate relationships, including Spearman and Pearson correlations and the Wilcoxon-Mann-Whitney(U) test. Statistical significance was set at $p \leq 0.05$.

Results

Nearly half (44%) of physicians reported experiencing burnout. On average, they spent 86 minutes outside practice seeking patient information. Physicians with access to EMRs/EHRs (95%) worked on them for 107 minutes, on average, after hours. Physicians who can exchange patient clinical summaries electronically spent over 10% less time on after-hours EMR tasks, on average, than those who cannot. Lack of system integration was the most prevalent barrier reported by physicians (73%). While statistically significant, the correlation between physician burnout and the two time-related interoperability variables was weak ($r < 0.5$). Burnout levels were statistically significantly higher among physicians experiencing a lack of system integration ($U = 116,229$, $p = 0.001$). Burnout was statistically different across care settings ($\chi^2 = 7.31$, $p = 0.026$), gender ($\chi^2 = 30.98$, $p = 0.000$), age groups ($\chi^2 = 53.76$, $p = 0.000$) and specialty ($U = 151,184$, $p = 0.007$).

Conclusion

Physicians require patient data for optimal care. Gathering this data electronically across systems creates significant burdens due to interoperability gaps wrought by a lack of system integration. These gaps contribute to increased workload and burnout. Addressing these challenges is crucial for improving physician well-being and optimizing healthcare delivery in Canada.

ID: 35349

Presented by: Jonathan Berges & Marla Banning

Ontario's Mental Health and Substance Use (MHSU) System Transformation: Youth Wellness Hubs Ontario

Authors: *Henderson, Jo (Centre for Addiction and Mental Health)*

Darnay, Karleigh (Centre for Addiction and Mental Health)

Background and Objectives

Youth Wellness Hubs Ontario (YWHO) is Ontario's \$20M+ (annually) Integrated Youth Services (IYS) initiative and has operated as a Learning Health System (LHS) since 2020. YWHO was co-created with youth, families, service providers, and researchers, integrating MHSU, primary health care, housing, education, employment, and other community and social supports for youth. As an LHS, YWHO is committed to providing high-value health care and system transformation through evidence-informed and evidence-generating practices.

Approach

YWHO operates a robust data platform that facilitates measurement-based care (MBC) and system level MHSU learning. Data is collected across 27 Hub Networks, with over 300,000 service visits on almost 60,000 unique youth. As a LHS, YWHO collects evaluation, research and quality improvement data on a continuous basis that helps to facilitate improvements in service quality. Both quantitative and qualitative data are collected.

Results

We will share findings on the strengths and challenges in building a MHSU Learning Health System across the province. We will share data on the growth of YWHO describing the youth accessing services to demonstrate the extent to which YWHO is meeting the needs of youth. The program evaluation study will examine patterns which can be benchmarks of success of YWHO, including numbers of unique youth reached per year, repeated visits by youth, and expansion of YWHO (i.e., increasing number of hubs). The objectives include understanding demographics of youth accessing services and assessing the overall service utilization profile since YWHO initiation.

Conclusion

YWHO's ongoing role as a system leader in MHSU will ensure that youth in the province of Ontario have access to low-barrier, high-quality services that are designed by them and for them in the communities they are a part of.

ID: 34519

Presented by: Joshua Bird

Sharing drug checking results in a Canadian setting: a multi-site analysis

Authors: Bird, Joshua, British Columbia Centre on Substance Use; Tobias, Samuel, British Columbia Centre on Substance Use; Grant, Cameron, British Columbia Centre on Substance Use; Lysyshyn, Mark, University of British Columbia; Tupper, Kenneth, University of Victoria; Wood, Evan, British Columbia Centre on Substance Use; Kerr, Thomas, British Columbia Centre on Substance Use; Ti, Lianping, British Columbia Centre on Substance Use

Background and Objectives

Drug checking services (DCS) have been implemented as a harm reduction measure to address high rates of illicit drug morbidity and mortality. In addition to reducing individual-level risk, there is also potential for DCS to increase community level awareness of drug market conditions through sharing of drug checking results. However, little is known about the patterns of information sharing among people who use DCS.

Approach

Data were derived from a cross-sectional study conducted at 22 community harm reduction sites offering DCS across British Columbia (BC) between March 2021 and July 2024. Elastic net penalized regression modelling was used to explore the relationships between select socio-demographic characteristics, drug use patterns and experiences with drug checking with the main outcome measure: sharing drug checking results.

Results

516 participants were included in the study (34% women, median age 42); 274 (53%) reported that they shared their drug checking results. Factors significantly and positively associated with sharing results in multivariable analysis included drug dealing (odds ratio [OR]: 2.15; 95% confidence interval [CI]: 1.40, 3.30) and using DCS more than once (OR: 5.45; CI: 3.60, 8.27). Among participants who reported they shared their drug checking results, 66% reported sharing results with friends and family and 27% reported sharing results with their drug dealer.

Conclusion

This study revealed that results sharing was positively associated with recent drug dealing and frequent DCS utilization. These findings extend the evidence base of DCS as a harm reduction tool by demonstrating how DCS engagement facilitates information dissemination amongst people who use drugs, their friends and families and drug dealers.

ID: 32231

Presented by: Andrea Bishop

StaffWISE Model: A Regulatory Research Approach to Addressing Understaffing in Community Pharmacies

Authors: *Bishop, Andrea Nova Scotia College of Pharmacists*

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Background and Objectives

The Nova Scotia College of Pharmacists (NSCP) began work in 2019 to explore the impacts of reported low staffing levels and burnout on the quality and safety of care provided to the public, including how the NSCP could leverage their role to address staffing challenges. The objective of this research was to position the NSCP to enforce a staffing level that enables the delivery of quality pharmacy services that can be sustained by pharmacy practitioners.

Approach

The Staffing and Workload Initiative for Safety and Effectiveness (StaffWISE) is a first-of-its-kind regulatory research approach to address community pharmacy staffing levels. Quantitative data was collected across four constructs: (1) staffing, (2) workload, (3) well-being, and (4) quality. Staffing data and workload data were collected from pharmacy managers and the Nova Scotia Drug Information System and Pharmacare billing, respectively. Well-being and quality data were collected from pharmacy practitioners and the public. Linear and mixed effects regressions were used to identify correlations between constructs and to develop a comprehensive staffing model.

Results

Over one million data points were collected across the four constructs. Results indicated statistically significant correlations between staffing/workload and wellbeing ($r = 0.13$ ($p < 0.01$)), staffing/workload and quality ($r = 0.13$ ($p < 0.01$)), and wellbeing and quality ($r = 0.40$ ($p < 0.01$)). The staffing model incorporates over 30 different variables and accounts for sustainable human productivity and variations in workload due to complexity and intensity of tasks, as well as use of automation technology and centralized prescription processing. A unique staffing score was developed for every community pharmacy ($n=314$), enabling the NSCP to identify community pharmacies where risks to patient safety due to understaffing are the greatest. Implementation of the StaffWISE model includes a directed remediation plan, a pharmacy-specific scorecard and guidance.

Conclusion

The StaffWISE model is a sophisticated and comprehensive healthcare staffing model that has application beyond community pharmacy. The initiative showcases the importance of an evidence-driven approach to policy development and a blueprint for how embedded research can be used to strengthen regulatory decision making and interventions.

Quantifying Inequities in Travel-Based Access to French-Speaking Primary Care in Ontario

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Background and Objectives

Patients who receive primary care in their language of choice are happier and healthier. Policymakers must understand and locate care-access gaps for minority-language speakers like Francophones. Studies of French-language access in Ontario generally use regional patient-to-physician ratios. However, patients readily cross invisible administrative boundaries, and may travel farther for language-concordant care. We explore province-wide inequities in proximity-based access to language-concordant healthcare at the level of census subdivisions (CSDs), for Francophones compared to the general population.

Approach

We calculated travel times along road networks from n=13,911 non-overlapping sub-CSD regions to n=5,721 unique family physician locations. Analysis 1 combined travel times with physician language abilities and regional populations, and calculated CSD-level population-weighted average travel times to the nearest English-speaking and French-speaking family physicians, as well as CSD-level mean differences. Analysis 2 computed CSD-level access using variable two-step floating catchment areas, and derived accessibility ratios for French-speakers and the general public. We used publicly available data (including from CPSO and Statistics Canada) and open-source software (including R and the Valhalla routing engine).

Results

For n=548 census subdivisions for which results could be calculated, Analysis 1 found that French-speakers had to travel an average of 3.0 times farther to the nearest 5 French-speaking family physicians compared to English-speakers (general population) to English-speaking family physicians (median 1.79 times; IQR 1.28-2.66), or in absolute terms an average of 29.5 minutes longer (median 12.7 minutes; IQR 3.7-31.7). Because our results are linked to geography, we also found regional pockets of high and low access levels in both Analysis 1 and Analysis 2, which will be reported at the conference.

Conclusion

Distance-based measures of healthcare access can illuminate inequities in access for minority language speakers, and demonstrate that French-speakers in Ontario must travel significantly farther than the general population to access language-concordant care. Our methods use open-source software and public data and can be refined or applied to any linguistic group.

ID: 34489

Presented by: Emily Black

Increasing Access to Care Through Pharmacists Prescribing for Infectious Syndromes

Authors: Black, Emily,¹ Sarah Abu Fadaleh,¹ Larissa Doiron,¹ Andrea Bishop,² Emma Reid,³ Kyle Wilby,¹ Kathryn Slayter,⁴ Jeannette Comeau,⁴ Tasha Ramsey,³ Sarah Burgess³

¹Dalhousie University, ²Nova Scotia College of Pharmacists, ³Nova Scotia Health, ⁴IWK Health

Background and Objectives

Expanded scope has enabled pharmacists in select provinces to prescribe for a range of common infections. Most recently, in Nova Scotia (NS) pharmacists began prescribing for bacterial pharyngitis and early Lyme disease. At designated pharmacy primary care sites, pharmacists also prescribe for sinusitis, otitis media, and otitis externa as part of a research initiative. The objective of our study was to investigate the feasibility, acceptability, and barriers to enabling pharmacist prescribing for these infectious syndromes.

Approach

This study was completed qualitatively, through virtual individual interviews and focus groups, conducted with pharmacists, physicians, nurses, and members of the public in NS. Data collection included demographic characteristics, perspectives on pharmacist prescribing for infections, and barriers or enablers to expanded scope. Using NVivo 14 software, deductive coding was completed using the Theoretical Framework of Acceptability (TFA). Thematic analysis was then completed inductively to determine themes within each domain of the TFA.

Results

Thirty-one individuals participated. Several themes that crossed multiple domains of the TFA emerged. The most dominant was "health system challenges". Most participants felt pharmacist prescribing for select infections would increase access to care; however, to result in benefit, barriers related to workload, referral pathways, and workflow needed to be addressed. Addressing health system challenges through other approaches rather than pharmacist prescribing was also suggested. "Scope of practice" also emerged as a major theme with differing perspectives on the extent to which diagnosis falls within a pharmacist's scope. Preventative approaches and prescribing for infections with objective measures of assessment that did not involve physical assessment were generally considered acceptable. Education and training and clarifying public expectations were highlighted as key components of successful implementation.

Conclusion

With appropriate education and training, most participants felt that pharmacist prescribing may be acceptable for some specific indications and may increase access to care, but several barriers must be addressed to ensure expanded scope is sustainable and addresses patient needs.

ID: 35638

Presented by: Nicole Bobbette

Brain Health-IDD: Co-Designing a National Program with Older Adults with IDD, Families and Providers

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Background and Objectives

Adults with intellectual and/or developmental disabilities (IDD) face unique aging-related health challenges and barriers to accessing health services that support optimal brain health. To address these issues, adults with IDD and families must be engaged in, and lead, health services research focused on their own health needs. In May 2024, our team of adults with IDD, family caregivers, and providers co-designed “Brain Health-IDD”, a national program aimed at supporting brain health for adults with IDD.

Approach

Our team of co-researchers, including older adults with IDD and family caregivers, collaboratively co-designed and co-delivered six-week virtual education courses for service providers, families and adults with IDD, aged 40+. Each course was supported by a core team that worked together to develop essential content, facilitate and teach sessions, and create knowledge products for participants. Weekly planning meetings and debriefs allowed for reflections, and the identification of opportunities to improve on workshop delivery and content. The core teams are also involved in course evaluations, including reviewing participant-facing documents for accessibility and clarity, data analysis and knowledge translation activities.

Results

Older adults with IDD and families co-led the creation of an educational program that identifies and respects their priorities, concerns and needs. This inclusive approach has fostered a lively learning environment, skill development, and a deeper understanding of brain health and aging within the IDD community. Two 6-week cycles have been completed, with participation from 151 service providers, 94 family caregivers, and 19 adults with IDD. Pre-, post-, and follow-up data collection is being completed and analysis is underway. Preliminary results highlight that participants value the shared leadership model, feel less isolated and more confident to manage their brain health and access health services. Feedback from participants continues to help refine the courses to better meet the needs of older adults with IDD and families.

Conclusion

Through intentional co-design and collaboration, our Brain Health-IDD program is building capacity amongst people with lived experience and the healthcare workforce to manage aging-related health concerns and support optimal brain health for older adults with IDD. This is an important step forward for this equity-deserving group.

Identifying guideline-concordant care after a severe acute exacerbation of COPD (AECOPD) in Alberta

Authors: *Solmaz Bohlouli¹, Grace Lam¹, Ngoc Khanh Vu¹, Phuong Uyen Nguyen², Jason Randall¹, Michael Stickland¹, Scott W Klarenbach¹*

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Background and Objectives

To optimally manage severe Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD), evidence-based guidelines recommend treatment escalation after exacerbations. We assessed concordance with guideline recommended escalation of COPD-related medication use after hospitalization or emergency visits for acute exacerbations of COPD. Secondary objectives included identifying factors associated with not receiving guideline-concordant care, assessment of adherence to COPD medication, and factors associated with suboptimal medication adherence after discharge.

Approach

We conducted a retrospective observational study using administrative data from Alberta. Individuals aged 35 years and older with hospitalization or emergency room (ED) visit for a COPD exacerbation between January 2017 and September 2019 were identified. We measured baseline COPD medication use and adherence in six months pre-index and six months post-discharge and determined if guideline concordant COPD medication escalation occurred. Medication adherence was determined by a prescription-based medication possession ratio (MPR) ≥ 0.80 . Multivariate logistic regressions assessed factors associated with not receiving guideline-concordant care and adherence to medications. Independent variables included demographic, socioeconomic, and clinical characteristics.

Results

Among the 11,458 subjects mean age was 73 years (SD = 11), 51.0% were female, and 76.2% lived in urban areas. Hospitalization occurred in 72.6% (mean stay: 6.9 days, SD = 12.6), while 27.2% had emergency visits only. Before the index date, 24.0% had no COPD medication dispensation, and 34.5% were on triple inhaler therapy. Post-discharge, 71.0% did not receive escalation, and 77.0% were non-adherent. Non-concordance with therapy escalation was associated with hospitalization vs presentation at the ED only (OR:0.76, 95%CI: 0.69–0.85), ≥ 5 comorbidities vs none (OR:1.83, 95%CI: 1.55–2.16), while geographic variation across healthcare zones was also observed. Low adherence to medications was associated with hospitalization vs ED only (OR:1.29, 95%CI: 1.16–1.43), pre-index low-adherence (OR:3.09, 95%CI: 2.77–3.44), and ≥ 5 comorbidities vs 1 to 2 (OR:1.42, 95%CI: 1.21–1.66).

Conclusion

We found concordance in AECOPD patients occurred in a small proportion of subjects. This treatment gap may contribute to poorly controlled symptoms, higher-exacerbation risk, and increased healthcare burden. Our findings highlight the need to improve guideline-based knowledge transfer, medication adherence, and addressing barriers to optimal treatment.

ID: 35666

Presented by: Jolianne Bolduc

Associations between nurse staffing profiles and patient safety: the case of intensive care units

Authors: *Borgès Da Silva, Roxane, Université de Montréal*

Background and Objectives

For several years, numerous studies have attempted to verify the association between nurse staffing and quality of care or patient safety in hospitals. Most of these studies have operationalized staffing in terms of specific indicators, such as patient-to-nurse ratios or nursing team composition, but very few have operationalized this concept in a more comprehensive way, using staffing profiles. The aim of this study was therefore to evaluate the effect of different nurse staffing profiles in Quebec intensive care units on patient safety.

Approach

This study used a retrospective longitudinal design, collecting data from October 2017 to September 2018, from 10 care facilities in Quebec (representing 14 intensive care units). Human resources data were collected from clinical-administrative human resources management data (Virtuo or Logibec software) and patient census (in-house or MedEcho software), then operationalized as staffing profiles. Patient safety data were collected from incident and accident reports (by type of adverse event and level of severity). Regression analyses were used to link these different profiles to patient safety.

Results

In all, nearly 15,000 shifts were analyzed for this project. Mixed nurse staffing profiles, i.e. those including some staffing indicators (e.g. patient-to-nurse ratios, team composition) following recommendations and others not following recommendations, were the most represented profiles in the sample, followed closely by inadequate profiles and then ideal profiles. The most frequently reported adverse events in the shifts studied are related to medication errors. Regression analyses are underway, but we anticipate that the less well-endowed profiles and certain mixed profiles will be associated with a greater number of adverse events and higher severity.

Conclusion

The results of this study will make it possible to identify the nurse staffing profiles most associated with the occurrence of adverse events, and will support managers in their management of nursing human resources in the current context of nursing shortages.

This presentation can be given in French or English.

ID: 35567

Presented by: Clara Bolster-Foucault

Disparities in Avoidable Hospitalizations Among Older Adults: Implications for Aging in Place

Authors: *Bolster-Foucault, Clara - McGill University; Vedel, Isabelle - McGill University; Sourial, Nadia - Université de Montréal; Godard-Sebillotte, Claire - McGill University; Quesnel-Vallée, Amélie - McGill University*

Background and Objectives

Aging in place is a nearly-universal preference for older adults as well as a global policy priority in the context of aging populations. Potentially-avoidable hospitalizations are an important early indicator of difficulties aging safely in place as they indicate unmet need for home and community-based care which often triggers a cascade of care leading to long-term care admission. Our objective was to examine social inequities in the risk of hospitalization among older adults in Quebec.

Approach

Using data from the TorSaDE Cohort, which includes linked cross-sectional Canadian Community Health Survey data (waves 2007-2016) and longitudinal provincial medico-administrative data from 1996-2016, we created a representative sample of community-dwelling older adults (aged 65 or older) in Quebec (n=24,701). Using logistic regression, we estimated the relative risk of hospitalization for an ambulatory care sensitive condition (ACSC) along four social determinants of health: gender, socioeconomic position (educational attainment), rurality, and racialization, assessing intersectional effects between gender and education using statistical interaction. We adjusted for confounding by health status (age, self-rated health, comorbidities) and social context (marital status, household size).

Results

A total of 1,647 (6.67%) of respondents had an ACSC-related hospitalization during the follow-up period. Men with low educational attainment demonstrated a 51% greater risk of ACSC-related hospitalization than their more highly educated counterparts (OR=1.51, 95%CI: 1.30-1.75), whereas women with low educational attainment had no difference in the risk of hospitalization (OR=0.94, 95%CI: 0.77-1.16). However, women with higher educational attainment demonstrated a 31% lower risk of ACSC-related hospitalization than men (OR=0.69, 95%CI: 0.59-0.81). Rural residents appear to be at a slightly elevated risk of ACSC-related hospitalization (OR=1.11, 95%CI: 0.99-1.24) than urban residents. Racialization (OR=0.91, 95%CI: 0.58-1.36) did not appear to influence the relative risk of ACSC-related hospitalization.

Conclusion

Potentially avoidable hospitalizations can serve as upstream indications of difficulties with aging in place. Socioeconomic and gender-based inequities in potentially avoidable related hospitalizations highlight significant social inequities among older adults in Quebec. These findings provide insights to guide equitable health policy interventions to support aging in place.

ID: 35647

Presented by: Andrew Boozary

Integrating Health and Social Care – A Social Medicine Approach

Authors: *Boozary, Andrew, UHN*

Vitkin, Natasha, UHN

Ragusila, Andra, UHN

William, Jane, UHN

Coyle, Sarah, UHN

Background and Objectives

The Gattuso Centre for Social Medicine and Population Health recognizes that health and poverty are inextricably linked. Based at University Health Network (UHN), the Gattuso Centre is a novel program integrating healthcare services with community-based supports. Through the Gattuso Centre, UHN's most medically and socially complex patients are referred for high-quality wraparound care at the intersection of medical and social issues, including food insecurity, homelessness, social isolation, substance use, and mental health challenges.

Approach

The Gattuso Centre takes a holistic approach to provide integrated, patient-centred, team-based care to address the structural determinants of health. The program integrates health and social care through cross-sectoral partnerships. Patients collaborate with Nurse Practitioners and Community Health Workers to create personalized care plans that address priority needs, such as housing, food security, mental health, and substance use. Initiatives include the Social Medicine Housing Initiative (Dunn House), the Stabilization & Connection Centre (stabilization service for patients experiencing alcohol and/or opioid intoxication), and the Social Medicine Care Model (mobile supports for high needs patients with complex social and health needs).

Results

At UHN, 100 patients without fixed addresses visited UHNN emergency departments (EDs) over 4,000 times in 2023. The Social Medicine Care Model has enrolled 225 patients, collectively accounting for over 2,000 visits to UHN's EDs in the 2023 calendar year. The Stabilization & Connection Centre has diverted 4,600+ admissions from EDs across Toronto since opening in December 2022, reducing patient transfer times from 60 to 6 minutes. The Social Medicine Housing Initiative, in partnership with the City of Toronto, United Way of Greater Toronto and Fred Victor, opened 51 permanent supportive housing units in November 2024. These innovative initiatives are improving quality of care among people with complex health and social needs and improving health system performance writ large.

Conclusion

The Gattuso Centre integrates healthcare with social supports for Toronto's most complex patients. This presentation will use the Social Medicine Housing Initiative and Stabilization & Connection Centre to illustrate implementation plans for comprehensive integrated care and better equip professionals to design interdisciplinary care models addressing the social determinants of health.

Healthcare and Social Service Costs at the end of Life in Quebec using administrative health data

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Background and Objectives

Population aging raises concerns for healthcare systems, particularly due to increasing chronic illness prevalence, which may strain healthcare resources. While research shows healthcare costs escalate in the final months before death, few or no studies in Quebec have examined end-of-life care costs, encompassing a comprehensive range of health and social services. This study aims to describe health and social service utilization and costs during the final year of life for residents aged 66 and older.

Approach

We analyzed a cohort of 21,255 individuals aged 66+ who died between April 1, 2014, and March 31, 2018. Data on healthcare and social service use during the last year of life were collected, including medical visits, emergency visits, hospitalizations, community care, long-term care, and social services. Costs were estimated using administrative and financial databases. Of the cohort, 40% were aged 80+ at death, and 53% were women. Primary causes of death included organ failure (50%), cancer (30%), and physical or cognitive frailty (15%).

Results

Service use increased with age, with specific patterns varying by cause of death: terminal illnesses required more healthcare, while frailty demanded more social care. Globally, average cost of services in the last year of life was \$34,467 per individual. Women incurred higher social care costs, while men had higher healthcare costs. Individual healthcare costs decreased with age, while social care costs rose, aligning with our findings that women had greater social needs and died at a later age. Service use intensified in the final three months of life, with increased hospital admissions reflecting challenges in maintaining patients at home or in long-term care. Costs rose sharply before death, increasing by up to \$8,000 between the first and final months, while social care costs declined.

Conclusion

Findings highlight shifting service needs and costs at end-of-life, especially between health and social services, depending on the cause of death and patient characteristics, underscoring the importance of integrating healthcare and social care to address these growing challenges.

Lawfully Collecting and Sharing Standardized Health Workforce Data – it's easier than you think!

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Background and Objectives

There is a growing understanding in Canada and globally of the need for harmonized minimum data standards (MDS) and systems for responsive and proactive healthcare workforce planning. Practices vary across provinces/territories regarding the collection, processing, and use of health workforce data. This lack of consistency poses challenges to more integrated planning by researchers and policymakers. The purpose of this paper is to describe the health professional regulatory and data sharing landscape across seven provinces.

Approach

We undertook an in-depth examination of existing legal frameworks in seven provinces to assess their capacity to implement a pan-Canadian MDS, and to identify barriers and facilitators/actions needed to foster health workforce data standardization. We analyzed the legislative schemes across the case study provinces to identify what data regulatory bodies are required to collect, share and how, and further how relevant privacy legislation applies to these data. We also analyzed case law relevant to professional regulation, data collection and privacy, and the constitutional balance of powers between federal and provincial/territorial governments which can complicate standardization.

Results

We found that Canada's federated regulatory structure necessitates coordination due to the shared provincial and federal jurisdiction over healthcare, professional regulation, data protection, and privacy. Provincially, there are differing approaches to professional regulation and to the data collected by regulatory bodies (if any). With properly crafted legislation and support, however, collecting and reporting data aligned with a MDS is possible. Similarly, privacy and information protection regimes are amenable to integration of an MDS structure fostering data sharing and linkages. Pan Canadian guidance from the national level can assist provinces in developing amending legislation or similar mechanisms to ensure compliance with existing professional regulation and privacy legislation while standardizing and clarifying healthcare workforce data collection and analysis.

Conclusion

Implementing a functional MDS across Canada is one of political exigency. Our analysis reveals that current legal regimes are consistent with data standardisation. With demographic changes and increasing pressures on the health workforce, it is incumbent on governments to facilitate data-driven healthcare workforce planning via a standardized MDS.

ID: 35477

Presented by: Navishka Brahmhatt

Tailoring Retention Strategies to Sustain Nursing Workforces in Rural Northwestern Ontario Hospitals

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Background and Objectives

Rural Northwestern Ontario hospitals face ongoing nursing shortages leading to high rates of burnout, poor patient outcomes, and increased reliance on agency nurses. Retaining nurses is key yet retention strategies are often generic, overlooking the unique needs of the workforce and the challenges of providing healthcare in low-resource environments. This study examines how to target retention strategies based on workforce demographics, employment experience and rural healthcare realities in order to sustain the rural nursing workforce.

Approach

A survey was developed based on a literature review of nursing retention strategies and administered to nurses from 10 rural Northwestern Ontario hospitals. Participants were asked to rate the perceived effectiveness of these strategies. Demographic data and career information including tenure, job satisfaction, and perceived employer support, were collected to assess what influences decisions to remain or leave rural nursing. Survey data will be analyzed using a linear regression model to examine relationships between demographic and career variables and the perceived effectiveness of retention strategies. This will inform the development of data-driven strategies to meet the needs of nursing cohorts.

Results

A total of 106 surveys were completed. Preliminary analyses indicate that retention strategies differ according to age, tenure, job satisfaction, and perceived support from their employer. We hypothesize that younger nurses and those with shorter tenure will prioritize different incentives compared to their more experienced counterparts. Furthermore, job satisfaction, financial incentives, schedule flexibility and perceived level of support from employers particularly in areas such as continuing education and workplace safety may enhance retention efforts by appealing to nurses regardless of demographics and career tenure. We posit early-career nurses will view structured mentorship and student loan forgiveness as effective retention strategies. Retention bonuses that acknowledge service and dedication to the organization may incentivize more experienced nurses to remain in their position.

Conclusion

This study aims to deliver targeted solutions for sustaining the nursing workforce in rural Northwestern Ontario, reducing costs associated with agency nurses and rehiring. Findings will enhance job satisfaction and retention through tailored strategies addressing demographic and career tenure differences, promoting workforce stability and financial sustainability for rural hospitals.

ID: 35544

Presented by: Navishka Brahmhatt

Tailoring Locum Recruitment and Retention Strategies for Rural Northern Ontario

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Background and Objectives

Physician shortages in rural Northern Ontario have increased reliance on locum physicians to fill temporary gaps in healthcare services. Yet strategies designed to recruit and retain permanent physicians often fail to attract locums due to the mismatch between locum priorities and community retention initiatives. This study identifies effective recruitment strategies to retain locums that are feasible for resource-limited healthcare settings. Findings will inform approaches to mitigate physician shortages and sustain healthcare delivery in Northern Ontario.

Approach

A systematic review synthesized evidence on strategies for recruiting and retaining locum physicians. Using a modified Delphi method, stakeholders involved in locum recruitment in rural Northern Ontario evaluated these strategies based on their perceived effectiveness and feasibility. Refined strategies were then reassessed by the same stakeholders. Strategies meeting thresholds of 80% effectiveness and 50% feasibility were then presented to physicians with locum experience in rural Northern Ontario via survey. Physicians evaluated the perceived effectiveness of these strategies for locum recruitment and retention.

Results

The study identified multiple strategies to improve the recruitment and retention of locum physicians in rural Northern Ontario. Stakeholders endorsed approaches addressing financial incentives, flexible scheduling, enhanced professional support, mentorship opportunities, and improved working conditions. Many strategies exceeded 80% perceived effectiveness and 50% feasibility thresholds reflecting their practical value for rural healthcare settings. Locum physicians with rural experience endorsed the same strategies, confirming their potential to address key challenges in recruitment and retention. Notable congruent strategies included tailoring incentives to the unique demands of rural practice, such as remoteness and high workloads, alongside fostering supportive work environments. A discrepancy emerged between stakeholders and locum physicians regarding the perceived benefit of providing support for continuing medical education endeavors as a draw for recruitment and retention.

Conclusion

Findings provide actionable, evidence-based insights for developing a comprehensive framework to mitigate physician shortages to sustain healthcare delivery in rural Northern Ontario. Implementing these approaches will address physician shortages, strengthen workforce sustainability, and improve healthcare access, ensuring consistent, high-quality care for rural Northern Ontario and other resource-limited communities.

ID: 34221

Presented by: Raouaa Braiki

The associations between working overtime and nurse and patients outcomes :A systematic review

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Background and Objectives

To fill the nursing shortage, and to ensure continuous 24h nursing coverage, working overtime has been increasing steadily. Although working overtime has been associated with adverse nurse and patient outcomes, the results of existing studies remain scattered. This study aimed to systematically synthesize evidence on the characteristics (i.e., mandatory or voluntary) of working overtime and their associations with nurse and patient outcomes.

Approach

A systematic review was conducted. MEDLINE, CINAHL, and PsycINFO were examined from March 2014 to April 2024. Two reviewers independently selected and extracted data using a standardized data extraction grid. Narrative synthesis of study findings was performed owing to methodological heterogeneity.

Results

Among 5827 retrieved articles, 71 studies (65 cross-sectional and six longitudinal studies) met our inclusion criteria. These studies examined 27 adverse nurse outcomes and 12 adverse patient outcomes. Eight adverse nurse outcomes were associated with mandatory overtime, whereas three were associated with voluntary overtime. Mandatory overtime was not associated with any beneficial impacts on nurse outcomes. No study showed beneficial impacts of overtime on patient outcomes. 48% of adverse nurse outcomes (eg., burnout, sleep disorder) were inconsistently related to overtime. Missed care and poor quality of care were inconsistently related to overtime.

Conclusion

While evidence suggests that working overtime is associated with numerous adverse nurse and patient outcomes, existing results are inconsistent. Robust research methods and longitudinal designs are required to better ascertain these associations. Stratifying the analyses by the type of exposure (i.e., voluntary vs. mandatory overtime, may also be beneficial.

Using machine learning to identify clusters of prescribing patterns in persons living with dementia

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Background and Objectives

Individuals living with dementia are a heterogeneous population which can make studying optimal medication management challenging. Unsupervised machine learning is a group of computing methods which may help to understand these complex prescribing patterns. Our objective was to determine whether common prescribing clusters exist in older adults living with dementia and to examine the association between individual clinical and demographic characteristics with those clusters.

Approach

We applied an unsupervised machine learning method, hierarchical clustering, to identify groups of community-dwelling older adults (≥ 67 years) newly identified as living with dementia who were dispensed similar medication subclasses in Ontario, Canada between 2014 and 2016. We analyzed data from linked population-based health administrative databases, including medications dispensed through a universal health insurance plan. The hierarchical clustering algorithm iteratively merged individuals with similar combinations of medications, in a stepwise process. The optimal number of clusters was selected through clinical review and fit statistics. We examined the association between individual characteristics and prescribing clusters using bivariate multinomial models.

Results

In 99,046 individuals living with incident dementia, we identified six prevalent clusters of individuals with common medication subclass patterns: higher dispensation of angiotensin-converting enzyme-specific cardiovascular (22.6% of the population), central nervous system active (21.3%), hypothyroidism (22.9%), respiratory (3.9%), and angiotensin receptor blocker-specific cardiovascular (6.1%), and a group with lower dispensation of medications in general (23.1%). Medication patterns were strongly associated with co-existing comorbidities – for example, there were increased odds of asthma and chronic obstructive pulmonary disease in the cluster with higher-than-average respiratory medication dispensation. Demographic characteristics were associated with medication dispensation clusters (e.g., more females in the low cluster) as was health system use (e.g., more home care services, hospitalizations, and emergency department visits in the central nervous system active cluster).

Conclusion

Within individuals living with dementia, prescribing clusters reflected meaningful differences in clinical and demographic characteristics. Our results suggest these methods may be useful in estimating complex comorbidity patterns and future research should examine whether such clusters improve prediction of future health service use, disease progression, and medication related adverse events.

Concurrent emergency department use by a new mother with a disability, and her newborn

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Background and Objectives

Rising rates of emergency department (ED) use have led to overcrowding and escalating healthcare costs. There is a strong connection between maternal and child healthcare use. A mother with a disability, and her newborn, are each at elevated risk of ED use, but the risk of both using the ED – “Co-ED” – is unknown. We compared the risk of Co-ED after birth in women with a pre-existing disability to those without a disability.

Approach

We conducted a population-based study of mother-infant pairs with a hospital delivery in Ontario, Canada, 2008-2023. Maternal physical, sensory, and intellectual/developmental disabilities were measured using algorithms for administrative data (n=221,600), vs. no disability (n=1,548,178). Co-ED was defined as mother and infant both having an ED visit within 90 days of discharge from the birth hospitalization. Other outcomes were maternal ED visit with no infant ED visit, infant ED visit with no maternal ED visit, and no ED visits (referent). Multinomial logistic regression generated odds ratios (OR) and 95% CI, adjusted for maternal age, parity, income quintile, rurality, immigration, and year.

Results

Co-ED was more likely among women with (5.4%) than without (3.4%) a disability (aOR 1.66, 95% CI 1.62-1.71). Comparing women with vs. without a disability, the aOR for maternal ED use without infant ED use was 1.38 (95% CI 1.35-1.40), and 1.20 (95% CI 1.19-1.22) for infant ED use without maternal ED use. Among those with Co-ED, the median (IQR) number of days between the first maternal and first infant ED visit was 19 (4-41) days, and 18.3% occurred within 24 hours of each other. Moreover, the aORs were even more pronounced for 2 or more Co-ED events, especially among mothers with an intellectual/developmental disability (3.69, 95% CI 2.67-5.09) or multiple disabilities (3.35, 95% CI 2.75-4.08).

Conclusion

About 1 in 20 women with a disability, and their infants, experience Co-ED. These dyads may benefit from careful post-discharge planning during the birth hospital stay and enhanced, accessible outpatient healthcare, for example through more frequent outpatient physician visits for mother and infant, or nurse home visits.

Sexual and reproductive health in female adolescents and young adults with disabilities

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Background and Objectives

Sexual and reproductive health (SRH) is an important component of health care for adolescents and young adults (AYA). However, despite decades of efforts to promote AYA SRH, unintended pregnancy, sexually transmitted infections (STIs), and gender-based violence remain important contributors to morbidity in AYA globally. A group facing potential SRH disparities comprises AYA with physical, sensory, and intellectual/developmental disabilities, accounting for 15% of the AYA demographic. We compared SRH in female AYA with and without disabilities.

Approach

We undertook a population-based cohort study using health administrative data from ICES in Ontario, Canada. The cohort included all females aged 12-24 years as of April 1, 2021, who were followed to March 31, 2023 for ascertainment of family planning counselling, contraceptive prescriptions or procedures, recognized pregnancy, management of STIs, and violence resulting in acute care. AYA with physical (n=95,474), sensory (n=29,638), intellectual/developmental (n=7,762), and multiple disabilities (n=12,304) were compared to those without a disability (n=814,127) using modified Poisson regression, with relative risks (aRR) adjusted for age, material deprivation quintile, rurality, immigration status, and comorbidities.

Results

Compared to AYA without a disability, those with physical disabilities were more likely to have a family planning visit (aRR 1.16, 95% CI 1.15-1.18), contraception (1.05, 1.03-1.07), pregnancy (1.26, 1.22-1.29), management of an STI (1.17, 1.13-1.20), and violence resulting in acute care (1.82, 1.70-1.93). There were no meaningful differences for those with sensory disabilities. AYA with intellectual/developmental disabilities were less likely to have a family planning visit (0.69, 0.65-0.73), pregnancy (0.86, 0.77-0.96), and management of an STI (0.65, 0.57-0.74), but more likely to experience violence (1.99, 1.69-2.35). Those with multiple disabilities were less likely to have a family planning visit (0.93, 0.89-0.97) and management of an STI (0.81, 0.74-0.88), but more likely to experience violence (2.16, 1.88-2.47).

Conclusion

Female AYA with disabilities experience significant SRH disparities, including higher risk of violence and, for some, reduced access to SRH care. Findings suggest the need for accessible SRH services, supported by health care provider training and guidelines, to ensure equitable SRH for AYA with disabilities.

Depression in children and youth in BC: an analysis of prevalence and pharmacological trends

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Background and Objectives

Depression often manifests during adolescence or young adulthood. Rates of depression and associated rates of treatment with antidepressants have long been on the rise, but pre-pandemic estimates in Canada in general and British Columbia (BC) more specifically are largely out of date. It is also unknown to what extent prescriptions of antidepressants follow Canadian evidence-based guidelines. Therefore, we studied trends in depression diagnoses and antidepressant treatment in children and youth in BC.

Approach

Using administrative data including medical service payment information and prescriptions, provided by Population Data BC, we describe yearly incidence and point prevalence of depression diagnoses in children and young adults in BC from 2008 to 2019, examining each by socio-demographic characteristics including age, administrative sex, health service delivery area, and neighbourhood income decile. We examined prescribing trends in the same period using descriptive analyses, then utilized a logistic regression model to examine on- versus off-guideline prescriptions by the socio-demographic characteristics of interest. Finally, we explored the sensitivity of the results to an adjusted operational definition of depression.

Results

Yearly incidence of depression increased from 1.2 % of children and young adults in BC in 2008 to 1.9% in 2019 while lifetime prevalence of depression increased from 6.3% to 11.0%. Estimated “active” depression prevalence increased too, affecting 5.8% of BC’s children and young adults in 2019 compared to 3.2% in 2008. Antidepressant prescriptions to children and young adults with incident depression nearly doubled from 27% of newly diagnosed cases in 2008 to 41% in 2019. In line with guidelines, escitalopram and fluoxetine were the most prescribed first line antidepressants, but concordance with guidelines was overall lower than expected at just over 75% from 2008-2019. Concordance with guidelines differed significantly by age, administrative sex, health service delivery area, and to a lesser extent, neighbourhood income decile.

Conclusion

Depression diagnoses in children and young adults in BC increased significantly leading up to the pandemic, as did antidepressant prescriptions. However, not all prescribing followed the best-evidence guidelines, and odds of receiving a best-evidenced first prescription differed by socio-demographic characteristics. Further research into these disparities is warranted.

ID: 35504

Presented by: Julia Burt

Public trust, literacy and health data foundations in Canada

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Background and Objectives

Public trust in health data and data literacy are key priorities in the Joint FPT Action Plan on Health Data and Digital Health. Health Data Research Network Canada, funded by the Public Health Agency of Canada, is developing a foundational paper to: 1) outline principles of public trust and data literacy; 2) highlight health data risks, benefits, and protections; 3) develop a standardized health data lexicon; and 4) illustrate actionable recommendations through real-world case studies.

Approach

The foundational paper is primarily being developed through a review of relevant grey and peer-reviewed literature. Two online focus groups (with 8 individuals each) and five online key informant interviews were also conducted to add real-world perspectives from patient partners and people with expertise in relevant areas including data privacy, trust and Indigenous data sovereignty. Focus group and interview participants were identified based on previous engagements and ongoing working relationships with the study team. Honoraria were provided to patient partners. The health data lexicon was adapted from existing data lexicons as well as through two iterative rounds of public review.

Results

Through existing literature, underlined by feedback from focus groups/ interviews, we note several well-developed principles associated with trust in primary and secondary uses of health data, including transparency and public benefit. Participants underscored the importance of distinguishing trust from related concepts (e.g., dependence) and highlighted that trust is not equal across sub-populations. Health data literacy was identified as one of several pre-conditions for earning public trust.

Findings also highlighted benefits of health data use from increased trust, including health system planning and enabling the use of innovative digital tools. Conversely, risks, such as stigmatization and harm to communities, can also result from data use, thereby impeding trust. Participants noted that effective protections must balance benefits and risks through accountability mechanisms for primary and secondary use.

Conclusion

A common framework for earning public trust and enhancing health data literacy is essential for a consistent approach to policy development across Canada. This work aligns with FPT Action Plan priorities, both informing a coordinated FPT approach and serving as a public resource for understanding the Canadian health data landscape.

Co-designing MedManageSCI: A medication self-management toolkit for adults with spinal cord injury

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Background and Objectives

Medications are one of the most common health interventions. Some populations, such as adults with spinal cord injury/dysfunction (SCI/D), are commonly prescribed multiple medications to manage a number of secondary conditions that arise post-injury. Despite the common use of medications, there are few comprehensive medication self-management resources for this population. As such, the objective of this study was to co-design a toolkit to support medication self-management among adults with SCI/D.

Approach

This participatory, multi-methods study engaged adults with SCI/D, care partners, and healthcare providers. Using the Good Things Foundation Pathfinder Model as a guide, the co-design process followed three main stages. In Stage 1, we understood and defined the problem by conducting a scoping review, concept mapping study, and working group sessions. In Stage 2, we created a prototype of the toolkit through working group sessions and website development meetings. In Stage 3, we tested the prototype through a working group session. Our working group was comprised of 19 members: 9 adults with SCI/D, 9 healthcare providers, and 1 care partner.

Results

In Stage 1, our scoping review highlighted the need for a comprehensive medication self-management resource specific to adults with SCI/D. Our concept mapping study and working group sessions identified the content to include in the toolkit, along with the ideal method of delivery, a website. The content was thematized and prioritized. In Stage 2, the working group provided feedback on visual content, which mapped onto five categories: first impressions, message and purpose, visual elements, layout and flow, and graphics. The name, MedManageSCI, was selected by the working group. An online version of the toolkit was created through an iterative process with the website development company (www.medmanagesci.ca). In Stage 3, participants provided recommendations to improve the website's functionality and navigation.

Conclusion

Co-designed by adults with SCI/D, care partners, and healthcare providers, MedManageSCI is a comprehensive, web-based toolkit to support the SCI/D community. Future work is needed to refine the content, assess the feasibility, acceptability, and appropriateness of MedManageSCI, and examine effectiveness on outcomes related to medication self-management.

A qualitative study to refine the MedManageSCI prototype: A toolkit for medication self-management

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Background and Objectives

Adults with spinal cord injury/dysfunction (SCI/D) commonly take medications to manage secondary conditions and have experienced challenges managing multiple medications. A prototype of a toolkit, MedManageSCI, was co-designed by our research team, adults with SCI/D, caregivers, and healthcare providers to support medication self-management. To finalize the toolkit, the objective of this qualitative study was to further refine the MedManageSCI prototype by examining the clarity, comprehensiveness, relevance, and delivery of the toolkit modules.

Approach

We conducted a qualitative study using cognitive interviews. Participants included adults with SCI/D who were: at least three months post-injury, living in Canada, 18 years of age or older, and able to communicate in English. A concurrent verbal probing approach was followed, using scripted and spontaneous probes. The cognitive interviews were conducted virtually between July 2024 and September 2024. All interviews were approximately one hour in length and were audio-recorded. Data analysis was an iterative process. Data were coded into a pre-established coding matrix that aligned with the scripted probes.

Results

Sixteen adults with SCI/D participated in this study. Participants provided nearly 200 recommendations to improve the clarity, comprehensiveness, relevance, or delivery of the MedManageSCI toolkit modules. These recommendations were categorized into three main areas: Comprehension, Design, and Delivery. The Comprehension category contained three subcategories: Written, Accessibility, and Resources. The Design category contained four subcategories: Format, Layout, Function, and Visuals. Participants perceived the website as an ideal way to deliver the toolkit, noting several benefits of a web-based delivery in comparison to a paper-based toolkit. The majority of feedback provided by participants mapped onto the Comprehension category. Overall, participants found the modules to be comprehensive and highly relevant to individuals with SCI/D.

Conclusion

Our findings highlight several advantages of an online toolkit and the benefit of using cognitive interviews to refine content. Involving individuals with SCI/D in the development and refinement of the toolkit modules will promote the uptake and spread of MedManageSCI during implementation by ensuring the content is tailored and appropriate.

ID: 35406

Presented by: Caroline Campbell & Gail Riihimaki

Defining Patient Experience

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Background and Objectives

Niagara Health (NH) consists of five community hospitals and serves 450,000 residents across the Niagara Region. NH committed to enhancing patient experience as part of the 2023-2028 strategic plan, however, lacks an organizational definition of patient experience. The aim was to develop a definition representing the unique perspectives of patients, families, caregivers, staff/physicians and community members. This was through co-design, an approach to developing a new concept alongside individuals who are impacted.

Approach

This co-design project was led by NH's Patient Experience Steering Committee, with 8 Patient Partners and 11 staff/physicians. A comprehensive engagement campaign was used, asking patients, families, caregivers, staff/physicians and community members what a positive patient experience means to them. Digital and paper postcards were developed in 12 languages, distributed via booths in the hospital and community, unit rounds, community organizations and NH webpage. The responses were analyzed using qualitative content analysis, with the themes mapped against existing documents (e.g., environmental scan of patient experience definitions, NH strategic/core values, the Patient and Family Declaration of Values and Bill of Rights).

Results

A total of 1153 responses were received, of which 929 (81%) were physical and 224 (19%) were digital postcards. Eleven themes were identified, which included, for example, communication, staff attitudes and behaviours, and timely and efficient care. Using these themes, a concise definition of patient experience was created, including six supporting elements to provide a description of how a positive patient experience should look, sound and feel to our patients and caregivers, in keeping with an empathy map. The final definition of patient experience is: "At Niagara Health, Patient Experience is how the process of receiving care feels and is shaped by all the interactions throughout the care journey. It is about being known, respected, listened to, involved, comforted and supported."

Conclusion

The co-developed definition of patient experience will underpin the framework to support organizational change. This will be integrated organization-wide, for example, through NH's staff recognition program, complaint reporting and onboarding practices. The co-design approach could be used by other organizations to develop locally relevant definitions.

ID: 34658

Presented by: Titus Chan

One Call, One Navigator, One Team: Redefining Interdisciplinary Approaches in Homecare Delivery

Authors: *Heer, Trevor, VHA Home Healthcare; Wong, Matthew, VHA Home Healthcare; Providence, Glenda, VHA Home Healthcare*

Background and Objectives

Ontario's homecare system faces structural challenges that can contribute to siloed care, hindering coordination for clients accessing multiple services. Addressing these complexities requires innovative solutions which enhance and bridge care delivery in the sector. VHA Home Healthcare responded to this issue with two objectives: (1) implement and assess the feasibility of a novel integrated care model for publicly-funded homecare within the organization, and (2) evaluate its impact on client and provider experiences regarding interdisciplinary care.

Approach

The VHA One Team model was developed through a multi-stage participatory process involving clients, client partners, clinical providers, administrators, and leaders. This co-design work yielded four transformative model components: (1) a care navigator, (2) integrated supervision, (3) a centralized phoneline, and (4) implementation of an evidence-informed interprofessional framework. Piloted over six months in Toronto during 2024, a theory-based evaluation was undertaken with an exploratory, convergent-parallel design anchored in the Quintuple Aim for Healthcare Improvement framework. Evaluation data included performance metrics, surveys, interviews, and focus groups from both clients and providers.

Results

The One Team model supported 487 clients, of which 53.2% (n = 259) received multidisciplinary services at VHA. Staff groups reported unique experiences pertaining to each of the four model components, with Personal Support Workers (PSWs) showing the highest acceptability and adoption. Summative outcomes revealed meaningful expansion of PSW services to incorporate interdisciplinary perspectives from Nursing and Allied Health; however, inverse integration from Nursing and Allied Health personnel was less consistent, with formative outcomes highlighting implementation barriers rooted in existing public funding structures. Clients reported moderately high satisfaction overall, although lower engagement among care recipients of multiple clinical services underscored the need for targeted changes to enhance participation and equity in interdisciplinary care delivery.

Conclusion

Findings demonstrate the potential for integrated homecare delivery to promote interdisciplinary care coordination while uncovering implementation challenges shaped by public funding structures. Achieving seamless integration across Ontario homecare services is inherently complex; nonetheless our insights provide valuable guidance for advancing innovative care models and supporting meaningfully co-designed solutions sector-wide.

ID: 34930

Presented by: Victoria Chechulina

Healthcare costs after sepsis: A systematic review

Authors: *Victoria Chechulina - Department of Epidemiology and Biostatistics, Western University*

Fatima Sheikh - Department of Health Research Methods, Evidence, and Impact, McMaster University

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Marina Englesakis - University Health Network, Toronto

Kali Barrett - Institute of Health Policy, Management, and Evaluation, University of Toronto

Background and Objectives

Sepsis is a life-threatening syndrome associated with significant health costs. Previous systematic reviews have demonstrated high initial hospitalization costs, but costs after hospitalization have not been characterized. The objective of this systematic review was to describe the healthcare costs and high-cost user status of adults who survived an episode of sepsis. Understanding these costs allows policy makers to identify targets for reducing preventable spending and strain on healthcare resources.

Approach

We searched MEDLINE, Embase, CINAHL, and the Cochrane Central Register of Controlled Trials and Database of Systematic Reviews from inception to November 5, 2023. The search strategy was developed by combining concepts of sepsis and costs and study types and developed countries. Two reviewers independently screened titles and abstracts, followed by full-text review and data extraction. Conflicts were resolved by a third reviewer. Study quality was assessed using the Newcastle-Ottawa scale for non-randomized studies. Narrative synthesis was used to summarize findings.

Results

We identified seventeen observational studies that met inclusion criteria. The methods used to calculate and report healthcare costs varied widely across studies, including the types of costs that were incurred (readmissions, physician visits, medication costs, and others) and the time period over which costs were calculated. Seven studies reported mean healthcare costs for sepsis survivors at one year after discharge, although the exact healthcare costs that were factored into each calculation varied. These costs at one year ranged from approximately \$22,000 CAD to \$180,000 CAD. Four of five studies that included a non-sepsis comparator group reported that sepsis survivors incur higher healthcare costs post-discharge compared to individuals without sepsis.

Conclusion

Our systematic review revealed that sepsis survivors face high healthcare costs that can persist for years after discharge from the initial hospitalization. These results suggest that interventions targeted at post-sepsis sequelae may be an important target for reducing healthcare costs.

ID: 35065

Presented by: Siu Mee Cheng

Post-Treatment Transitional Housing Pilot for Homeless Women on Their Recovery Journey

Authors: *Cheng, Siu Mee with Street Haven*

Background and Objectives

Street Haven, a not-for-profit multi-service women's agency, created a post-addictions treatment transitional housing pilot (PATT) for homeless women to enable continued addictions recovery and housing security and independence for women in need. Homelessness poses greater challenges for women with addictions because it can interfere in treatment and can enhance risk towards relapse for those who have completed treatment because they do not have safe environments to engage in effective coping strategies acquired from treatment.

Approach

An evaluation of the pilot was undertaken to determine the impact that PATT had on the clients. The PATT had operated for 18 months and served thirteen (13) homeless women who had completed Street Haven's three-month residential addictions treatment programming. PATT offered up to a six-month stay in a supportive care housing environment. Clients were offered room and board and included the provision of nutritious meals. Clients continued addictions treatment programming on an outreach basis and offered access to other health and social services. Socio-demographic data and data on their housing security status and recovery status post-discharge were collected.

Results

The evaluation showed that ten of thirteen clients continued their addictions recovery journey one year following discharge from the pilot project. Nine of the thirteen clients achieved greater housing security, and this included longer-stay transitional housing programs, moving back with family members, and moving into the rental market. It was observed that clients who had longer lengths of stay in the post-treatment transitional housing program were more likely to have achieved greater housing security and stayed on their recovery journey. During their stay in PATT, none of the clients had to access acute care. In addition, all clients self-reported expanded social networks resulting from friendships with other project clients. Lastly, all clients self-reported a greater sense of independence based on PATT participation.

Conclusion

The PATT provides further evidence that a housing first model approach for homeless women with addictions can support successful addictions recovery. Addictions recovery requires a social determinants of health perspective with housing security a critical success factor.

ID: 34771

Presented by: Emma Chisholm

Mapping Pharmacy Access in Ontario, Canada: A Geospatial Analysis of Service Distribution

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Background and Objectives

It is widely recognized that rural regions face more barriers than urban areas when accessing healthcare, in part due to fewer allied health and care services. In particular, there is a gap in access to pharmaceutical resources, with rural communities facing increasing challenges as healthcare demand rises. This study maps pharmacy access across Ontario, using a geographic measure of rurality based on pharmaceutical care availability to understand how proximity impacts access to essential healthcare resources.

Approach

This study is one of several recent papers that enumerate travel times and distances to health and care services in Ontario, Canada. By modifying the Accessibility / Remoteness Index of Australia, we developed the Canadian Accessibility and Remoteness Index (CARI+), which measures local-level proximity to services based on population cut offs. Normalized index values were then used to develop groupings of rurality comparable to current measures by Statistics Canada. We focus on access to pharmacies, as there have been recent shifts to increase the range of services offered by pharmacists in Ontario. As such, pharmacies have become vital healthcare resources.

Results

We found that the majority (69.86%) of pharmacies in Ontario are in major metropolitan areas. As population size declines, the number of pharmacies decreases, reflecting that resource distribution largely depends on demand. An important anomaly in the data is that rural and remote communities with populations under 1,000, account for only 0.56% of Ontario's pharmacies. While this follows the trend of fewer pharmacies in less populated areas, it's crucial to consider this in the geographic context. These remote regions, despite their small population, represent a significant portion of Ontario's landmass. The vast distances involved mean that travel times to healthcare services, including pharmacies, are a critical factor in accessibility, affecting residents' ability to access necessary medications.

Conclusion

This study highlights disparities in pharmacy access in rural communities of Ontario, Canada. Less than 1% of Ontario's pharmacies are found in Ontario's most rural communities. Future research should explore how access inequalities impact the availability of services offered by pharmacists, and what may be provided in their absence.

Effective Interventions to Strengthen the Care Workforce: A Realist Synthesis Review

Authors: Dansereau, Lisette, University of Manitoba; Jack, Ellie, University of Manitoba; Pirzada, Salina, University of Manitoba; Oh, Yuns, University of Manitoba; Bhushan, Pranav, University of Manitoba; Pelly, Lorine, University of Manitoba; Linton, Janice, University of Manitoba; McCarthy, Carey, WHO; Cometto, Giorgio, WHO

Background and Objectives

Care workers are in high demand due to a growing need to support populations needing help in daily life. Paid care is largely carried out by women, is often unregulated, and the care workforce is characterized by insecurity, poor pay, and high turnover. There is a global need to support the care workforce in the context of national health care systems. Our research asks: Which interventions effectively strengthen the care workforce?

Approach

Guided by an international advisory group made up of 23 members and 6 alternates from 18 countries, we conducted a realist synthesis review following the RAMESES I and the PRISMA-S reporting and publication standards. Realist reviews aim to explain which intervention strategies work for whom, and in which circumstances, by identifying the context-mechanism-outcome (CMO) configuration. Multiple searches of the academic literature were conducted on seven global and medical databases including EMBASE and CINAHL, and grey literature was identified through Google advanced searches. Using Covidence online software, a team of five screeners performed data extraction and assessed the quality of sources.

Results

): We systematically identified 7396 academic and 481 grey literature sources, and included 151 sources in the final review. Many interventions were highly complex and reported on multiple outcomes, with an emphasis on pre-service education and ongoing training for care workers. Many ambitious interventions aimed to support the care workforce on multiple fronts. We report on effective interventions across 19 thematic areas that address concerns such as governance and regulation, recruitment and retention, working conditions, career advancement, and technological innovation. We also report on potential equity concerns related to gender and public/private employment and the need to improve data collection and evidence on this segment of the workforce. Finally, we provide policy guidance for decision makers to help strengthen the care workforce.

Conclusion

The care workforce is a necessary and valuable aspect of any well-functioning health care system. We encourage policy makers and researchers to pilot complex interventions focusing on legislative structures, educational oversight, and material working conditions such as scheduling and pay as effective avenues for strengthening the care workforce.

ID: 34697

Presented by: Jennifer Coelho & Nicole Obeid

Learning health systems enhance embedded research: FREEDcan and the Eating Disorders Training Hub

Authors: *Co-presenter: Obeid, Nicole (CHEO Research Institute)*

Coauthors: Geller, Josie (St. Paul's Hospital), Obee, Patricia (Ministry of Children and Family Development), Williams, Kim (BC Children's Hospital), Kaufmann, Julia (University of British Columbia), Bain, Tayla (University of British Columbia) & FREEDcan Team

Background and Objectives

FREEDcan is an innovative community-based early intervention model for youth eating disorders care, adapted from the First Episode Rapid Early Intervention for Eating Disorders (FREED) model developed in the UK. Expansion of the model to the community necessitates building the workforce to increase accessibility of eating disorder care. To support this, training and consultation is provided to improve clinician confidence and well-being. We are developing a learning health system to scale a clinician training intervention.

Approach

The FREED model demonstrates good patient, service, system and implementation outcomes and has been scaled internationally. Due to the community focus of FREEDcan, spreadable interventions that can be flexible are needed, utilizing clinical data to inform needs. The Provincial Eating Disorders Training Hub was developed based on emerging needs during the pandemic and is providing real-time data on the implementation of a training and consultation rollout for clinicians in general mental health and specialized eating disorder services. This work represents an innovative national collaboration that addresses the quintuple health care aims (clinician well-being, health equity, patient experience, outcomes, and cost-effectiveness).

Results

The Training Hub offers a 2-day family-based treatment training offered virtually to clinicians from British Columbia and the Yukon at no cost to clinicians, with a focus on supporting clinicians in rural and remote settings. A total of 177 clinicians expressed interest in the training in 2024, with 99 clinicians completing the trainings, and further trainings planned for 2025. Feedback from clinicians is positive, and we are measuring changes to clinician well-being (including self-compassion and professional quality of life) in cohorts participating in training/consultation activities (first year results available May 2025). Measurement across the training intervention allowed for learnings that led to iterations to the training that has increased its impact. The Training Hub has demonstrated feasibility and acceptability as a workforce capacity building offering.

Conclusion

Embedding the Training Hub results within the FREEDcan framework and learning health system principles allowed for implementation learnings between community clinicians, specialists and researchers, speaking to the importance of evidence generation in these types of new offerings. The relevance to policy implications for eating disorder services will be discussed.

ID: 34682

Presented by: Leigha Comer

Unintended Consequences of Opioid Prescribing Guidelines for Chronic Non-Cancer Pain in Canada

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Background and Objectives

While for many people with chronic pain, opioids represent one of the few treatments that relieve their pain, concerns regarding adverse effects abound. This institutional ethnographic study explored the development and dissemination of the 2017 Canadian guideline for opioid prescribing for non-cancer pain, as well as its translation by physicians into clinical practice, to understand how guidelines emerge as social policy measures within contexts of panic around opioid-related harms, including their unforeseen and unintended consequences.

Approach

In addition to a textual analysis of the 2017 Canadian guideline through methods appropriate to institutional ethnography, including tracing the institutional relations made visible through the text (e.g., the organization of committees, the work conducted to review the literature to produce recommendations), interviews were also conducted with people with chronic pain, physicians, and those involved in the development and dissemination of the guideline. This qualitative, ethnographic approach allowed for an analysis from the inception of the guideline to its use in clinical practice and the impacts of changing prescribing habits informed by the guideline on people with chronic pain.

Results

The guideline developers prioritized evidence-based, 'neutral' recommendations. However, given their exclusion of evidence rated low-quality through the GRADE framework, they could not answer most of their guiding questions, as few were amenable to being answered through RCTs. They also invited experts they felt were unbiased, which meant few Canadian experts participated, as they either had ties to industry or published opinions about opioids. Instead, international experts were invited who were unfamiliar with the Canadian context. As such, when translating the guideline into practice, physicians found that it was not relevant to their work. Because most situations they encountered were not addressed by the guideline, physicians chose not to prescribe opioids at all, to the detriment of people who use opioids for chronic pain.

Conclusion

As social policy measures, guidelines have significant and often unintended impacts. Striving for 'unbiased' opioid prescribing guidelines neglects the political context of opioid use in Canada and the clinical realities physicians face, including social determinants and inequities that cannot be captured through modes of knowledge production prioritized in evidence-based medicine.

ID: 35642

Presented by: Emily Cordeaux

Facilitating patient and caregiver voicing in hospital settings: A narrative synthesis and framework

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Background and Objectives

While healthcare organizations increasingly recognize the critical value of feedback and information shared by patients and caregivers during care episodes, patients and caregivers often hesitate to speak up or voice their care preferences and concerns when receiving care. Drawing from voicing literature and using a systematic narrative synthesis, we present a conceptual framework of organizational behaviours and contextual factors (e.g., culture, climate, and tacit rules) that support patient and caregiver voicing in healthcare.

Approach

In this presentation, we draw from the management literature on voicing in organizational settings to unpack why patients and caregivers often hesitate to voice feedback and concerns. We then present findings from a systematic narrative synthesis of the health sciences literature in the form of a conceptual framework for how patient/caregiver voicing can be supported in hospital settings. We systematically searched three bibliographic databases for studies with qualitative data collection that described supportive organizational behaviours and contextual factors. Our team included two patient partners who engaged in data sessions to validate preliminary findings and iterations of the framework.

Results

This narrative synthesis identifies organizational behaviours and factors that, when enacted together, may enable patient and caregiver voice in inpatient hospital settings. Key organisational behaviours include creating deliberate spaces to elicit patient and caregiver voice, acting as a bridge for communication, creating opportunities for patients and caregivers to voice, supporting capacity to voice, and showing care for the full person. At the organisational level, enabling factors include a commitment to person-centered practice, a culture of trust, and supportive work processes and policies. Individual and interpersonal enablers include patient personal resources and preferences, as well as staff motivation, orientation to care, and communication skills.

Conclusion

Creating the conditions for patients and caregivers to speak up in real-time requires a multifaceted approach that prioritizes behaviours and practices that foster trust and shared understanding in therapeutic relationships. Enabling voice is essential for delivering person-centered care and ensuring patient and caregiver perspectives are centered in quality improvement efforts.

ID: 35067

Presented by: Amy Cran

Between (Policy) Lines: Neoliberalism and Community Responsibilization in Alberta's Recovery Turn

Authors: *Cran, Amy. Dalhousie University.*

Background and Objectives

The Government of Alberta is adopting “recovery-oriented systems of care” in the treatment of addiction, as cemented in the 2022 report, “Toward an Alberta Model of Wellness.” Locating this document in the neoliberalization of healthcare in the province, this paper interrogates what is precisely “Albertan” about this model. It further problematizes the slippery concept of “recovery” and the degree of responsibility increasingly placed on individuals and community members to achieve positive health outcomes.

Approach

This research was conducted using ethnographic content analysis methodology. This was an iterative process, which included an initial close reading of the text and manual coding of emerging themes, refinement of codes, and an additional reading and re-coding using the data analysis software NVivo to confirm code alignment. The resulting analysis is contextualized by previous ethnographic fieldwork conducted in partnership with the grassroots, Blackfoot-led outreach organization, SAGE Clan Patrol, which supports people experiencing homelessness and addiction through community patrols in Lethbridge, Alberta. This included three months of participant observation and six semi-structured, qualitative interviews conducted from June to August 2022.

Results

Eleven distinct themes were documented: implied critiques of harm reduction, recovery as a “stage” or metaphors of chronicity, individualization and responsibilization, collective responsibilization, and the use of economic metaphor, among others. The analysis reveals that while purporting to support individual choice, the Alberta Model is better poised to govern “deficient” subjects through the promotion of rational decision-making and the accumulation of “recovery capital.” This falls short of accounting for neurobiological understandings of addiction and the intersection of social determinants of health by instead placing an increased responsibility on individuals and their “allies” to achieve positive health outcomes. The analysis further challenges a rhetorical slippage where addiction “recovery” is transformed into a journey, with abstinence framed as the only acceptable destination.

Conclusion

The Alberta Model, as presented in the analyzed report, fails to address important structural issues impacting individuals experiencing addiction in the province. Coupled with a recent shift toward decentralization and increasing individual/familial responsibilization, it is instead evidence of a greater adoption of neoliberalism within provincial healthcare that must be interrogated.

ID: 34201

Presented by: Alison Lynn Csercsics

Engaging Clinicians as Knowledge Brokers to Move New Tools into Practice

Authors: *Csercsics, Alison Lynn, The University of Western Ontario; Cunningham, Barbara Jane, The University of Western Ontario*

Background and Objectives

Barriers to moving evidence into clinical practice have been widely reported in the literature with challenges existing at clinician, organization, and system levels. Engaging clinicians as knowledge brokers (KB) to disseminate new tools into practice can help address barriers that are experienced directly on the frontlines (Douglas et al., 2022). We aimed to investigate the feasibility of using a KB strategy to support dissemination of a new clinical tool across a large government-funded healthcare system.

Approach

A KB strategy was developed using a health policy framework (Briggs et al., 2012) to support clinicians in Ontario's Preschool Speech and Language program in preparing to use a new data collection tool, the Profile of Preschool Communication (PPC; Cunningham et al., 2022). 1-3 staff from each of the 29 regions participated as KBs and received training on the PPC and strategies to support local dissemination. After teaching staff about the PPC, KBs completed a survey asking about the feasibility, acceptability, and appropriateness of the KB strategy. Quantitative data were analyzed descriptively, and qualitative data with an inductive content analysis.

Results

KBs reported that the KB strategy was a feasible, acceptable, and appropriate way to support clinicians' learning at local levels and felt the KB strategy should be considered for future dissemination initiatives. KBs noted that the strategy was well received by their staff and adaptable to local needs. While KBs noted successes in using the KB strategy to share new information with their staff, they also experienced barriers. Barriers were primarily related to organizational/workplace factors including disagreement with management, program changes, and staffing availability. KB- and KB-strategy specific barriers included increased workload, difficulty answering questions, difficulty reaching staff, and PPC related factors including specific concerns and questions about the new tool. Several considerations for future KB strategy initiatives were identified.

Conclusion

Knowledge brokering is a promising strategy that may help address the barriers that exist across large healthcare systems to support the dissemination of new tools. Future work should investigate use of the KB strategy across other healthcare systems as well as for supporting different initiatives such as clinical implementation.

ID: 35441

Presented by: Darly Dash

Variation in antipsychotic prescriptions in Ontario LTC homes: a multi-level analysis using EMR data

Authors: *Authors: Darly Dash^{1*}, Ahmad Rahim¹, Henry Siu², Aaron Jones¹, Jeff Poss³, Paul Katz^{4,5}, Andrew Costa¹*

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Background and Objectives

The use of antipsychotic medications to manage behavioural and psychological symptoms of dementia (BPSD) in long-term care (LTC) homes remains a concern, with substantial variation in prescribing practices despite existing practice guidelines and quality improvement initiatives. This study aimed to assess the extent of variation in antipsychotic prescriptions across three levels of LTC care (units, homes, and organizations) and to determine whether similar variation exists for other medications.

Approach

We conducted a retrospective cohort study of LTC residents in Ontario from April 1, 2022, to March 31, 2023. We used structured data from a LTC electronic medical record (EMR) data repository, which included resident demographics, facility, bed and census information, medication orders, and assessment data (including the Minimum Data Set 2.0). The primary outcome was the antipsychotic prescription rate, and secondary outcomes included prescriptions for antidepressants, statins, cardiovascular disease (CVD) medications, and trazodone, a common substitution of antipsychotics. We employed multi-level logistic regression, accounting for resident-level factors and clustering at the unit, home, and organizational levels.

Results

We included 16,896 LTC residents across 179 homes and five organizations in Ontario. Of these, 39% were prescribed antipsychotics, 65% antidepressants, 33% statins, 65% CVD medications, and 38% trazodone. We found substantial variation in antipsychotic prescribing, with more variation observed at the home level (median odds ratio [MOR] 1.64; 95% CI 1.50-1.76), than the unit (MOR 1.23; 95% CI 1.10-1.31) and organizational (MOR 1.25; 95% CI 1.00-1.43) levels. This pattern of variation was consistent across all other medication types examined, with more variation at the home level than at the unit or organizational levels.

Conclusion

While variation in antipsychotic use is well-recognized, this study reveals that other medications exhibit similar practice variations in medication prescribing, calling attention to broader quality improvement opportunities in LTC. Future research could explore the underlying causes of this variation, such as differences in clinician practice, resident characteristics, and/or organizational culture.

A Decolonizing Approach to Disseminating & Preserving Indigenous Elder Knowledge in Health Research

Authors: Demedeiros, Sarah (University of Alberta, School of Public Health); Dr. Montesanti, Stephanie (University of Alberta, School of Public Health); The Grandmothers' Wisdom Network: Elder Bromley, Jackie (Kainai Nation); Elder Lee, Muriel (Ermineskin Cree Nation); Elder Spicer, Norma (Métis Nation of Alberta); Elder Albert, Lorraine (Mikisew Cree First Nation); Elder Cardinal, Darlene (Sucker Creek First Nation).

Background and Objectives

This project explored how digital storytelling (DST) supports a decolonizing approach to knowledge translation (KT) in Indigenous health research. Addressing gaps in culturally responsive KT scholarship, this community-based participatory research (CBPR) initiative, grounded in an Indigenous Research Paradigm (IRP), aimed to enhance KT practices that support self-determination and sovereignty. By examining characteristics of culturally responsive KT, this work generated valuable insights into how health research dissemination can better align with the priorities of Indigenous communities.

Approach

The exploration of DST methodology was co-led by a group of culturally diverse Indigenous Elders from Alberta, known as the Grandmothers Wisdom Network (GWN). A conventional DST framework was adapted to align with Indigenous knowledge-sharing principles, cultural practices, and protocols. Whilst creating digital stories for the health and well-being of future generations, the group assessed DST as a culturally responsive tool for sharing and disseminating Elder knowledge. They explored its potential applications within Indigenous communities and examined considerations for the ethical and respectful translation of Indigenous knowledge within academic-community partnerships.

Results

DST offered various benefits such as honouring oral traditions, preserving and enhancing access to cultural knowledge, and supporting personal and intergenerational healing. By centering Indigenous voices in health research and engaging respectfully with local knowledge-sharing practices and cultural protocols, DST emerged as a transformative tool for KT, cultural reclamation, and colonial resistance. DST allowed storytellers to determine what, how and with whom their knowledge was shared and disseminated. It eliminated the role of the 'researcher' from the KT process and positioned storytellers as the knowledge expert. Key ethical considerations, including trust, relationships, respect, ownership, control, and autonomy, were highlighted as prerequisites for culturally responsive KT. The findings emphasized the need for greater accountability from academic partners in prioritizing community healing and reconciliation in research.

Conclusion

Building on relational and reciprocal knowledge-sharing central to Indigenous systems, DST emerged as a culturally respectful, self-determined KT approach that shifts power dynamics in health research. By prioritizing Indigenous voices, DST creates a platform for equitable engagement, preserving Elder knowledge and supporting the health and well-being of future generations.

Highlighting ethical challenges and harms in the patient engagement workforce in Canada

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Background and Objectives

Patient partnership activities are often facilitated by organizational staff who maintain ongoing relationships with patient partners and manage the daily activities of recruitment, facilitation, training and other engagement support. Despite their essential role in patient engagement, the challenges engagement staff face in their work has been underexplored. This paper describes ethical challenges in patient engagement within organizational contexts, focusing on those challenges which staff identify as causing personal harm.

Approach

This sub-analysis is part of a broader grounded theory interview study of staff working with patient partners in health system organizations across Canada. Participants were first purposively sampled for diversity in geography and gender and later theoretically sampled for level of experience, role and type of organization. Individuals meeting these criteria were identified through publicly available information on websites and social media, snowball sampling, and personal networks. We employed a staged, inductive analytic approach which was iterative with data collection. We defined ethical challenges that cause personal harm as those issues which leave emotional or moral residue on staff.

Results

We interviewed twenty-three staff who worked with patient partners. Across organizations and years of experience, participants discussed a lack of engagement staff and inadequate support from leadership as the most significant ethical challenges causing personal harm. For some, these challenges contributed to a sense that engagement can be tokenistic and harm patient partners. Participants noted a misalignment between their personal values which prioritized the quality of engagement and organizational values which prioritized quantity and pace. Due to the relational aspects of engagement work, participants felt responsible for the experience of patient partners, leading to feelings of guilt. Participants also described feeling powerless, exhausted and overwhelmed. Participants' feeling of personal harm due to these challenges was contextualized within a broader recognition of an under-resourced health system.

Conclusion

Engagement staff are essential to the success and sustainability of patient partnership in Canada. However, staff identify ethical challenges in their work that cause personal harm not only to themselves, but also to patient partners. Organizations can respond to these challenges by investing in engagement staff and leadership support.

ID: 35363

Presented by: Kat Dolguikh

Evaluating the impact of Alberta's \$100 COVID-19 vaccine incentive and vaccine passport policies

Authors: *Beall, Reed, University of Calgary*

Background and Objectives

Facing an impending influenza season with Canada's lowest vaccination coverage, rising COVID-19 cases, and a strained healthcare system, Alberta's Kenny Administration introduced a \$100 debit card incentive for adults receiving a first or second vaccine dose starting September 3, 2021. As cases continued to surge, the administration resorted to a vaccine passport policy on September 15, 2021. This study evaluates the relative impact of these policies on vaccine uptake, respectively, including their effectiveness across sociodemographic subgroups.

Approach

We conducted a population-based retrospective cohort study using administrative data (July - October 2021) from the Alberta Health Care Insurance Plan population registry. Vaccine uptake data were obtained from the Immunization and Adverse Reaction to Immunization repository. The cohort included Alberta residents aged 12 years and older, excluding those ineligible or with missing data. Interrupted time series analyses, using generalized estimating equations (GEE) with a Poisson distribution, evaluated the effects of two policies: (1) a \$100 reward and (2) private indoor gathering restrictions (vaccine passport). Robustness checks used a generalized least squares (GLM) model for validation.

Results

The vaccine passport had the largest impact, more than doubling vaccine uptake (IRR: 2.40, 95% CI: 2.09–2.75), though its effect decreased over time. This finding was statistically significant across all models. The \$100 reward showed a modest, statistically significant effect (IRR: 1.08, 95% CI: 1.01–1.14), but this result was not supported during robustness checks. Vaccine uptake varied by gender, age, and visible minority status, with males and individuals aged 30–39 consistently showing significantly lower uptake across all models.

Conclusion

The \$100 reward showed minimal impact within the limited timeframe observed before the vaccine passport policy, as new vaccination rates were arguably within pre-policy trends. The vaccine passport had a considerable effect, but subgroups with lower vaccination rates before these policies, like younger white males, continued responding at lower rates.

ID: 35577

Presented by: Catherine Donnelly

The landscape of primary care teams in Ontario

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Background and Objectives

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

Approach

A descriptive study, that employed an environmental scan, was used to examine the breadth and extent of primary care services provided by Family Health Teams. Websites of all 186 Family Health Teams were systematically searched. A data extraction template was developed and included governance structure, location, team composition, programs provided, and processes to access team members. Data was extracted into the excel template by two trained student researchers. Open text was categorized, and frequency counts were determined.

Results

We identified 4148 providers working across 186 Family Health Teams. After physicians (n=2135), the most frequent providers were nurses, including RPN, RNs (n=631), followed by nurse practitioners (n=387), social workers (n=249), dietitians (n=193) and pharmacists (n=121). There were a total of 1492 programs being delivered across the Family Health Teams. The most frequent programs focused on providing mental health supports (n=222), supporting people living with diabetes (n=178 programs), lung health/smoking cessation (n= 188) and aging (n=137). Accessing interprofessional team members included a mixture of direct access and referral. The number of Family Health Teams within each of the 58 Ontario Health Teams - a model of regional integrated care - varied widely, with three Ontario Health Teams having no Family Health Teams to one having 13.

Conclusion

There was wide variability in the data provided on Family Health Team websites, with little consistency in programs offered and mechanism to access team members. We propose five principles to ensure consistency across teams and support access to quality interprofessional primary care services.

ID: 35641

Presented by: Catherine Donnelly

Integrating health and social care into naturally occurring retirement communities: Oasis Program

Authors: *DePaul, Vincent; Nguyen, Andrew; Nuri, Reshma; Ryland, Erin; Toi, Megan; Cestra, Katia; Garganta, Kiana; Malvern, Riley; Luzius Vanin, Christina; Oasis Collective*

Background and Objectives

Naturally occurring retirement communities (NORCs) are geographical areas that have a high proportion of older residents. NORCs offer an opportunity to integrate health and social care to support aging in place. Oasis is an example of NORC-based program that has been implemented in 18 NORCs across Canada. The objective was to describe the nature of and extent to which health and social care was integrated into Oasis programs and understand contextual features that supported integration

Approach

A multiple case study design, using mixed-methods was employed. Case studies are ideal for complex and real-life phenomenon, leveraging multiple data sources. A single 'case' was considered a NORC with an Oasis program. We described the macro, meso, and micro features of each of the 18 cases. At the macro level we identified provincial and municipal aging policies. At the meso level we described neighbourhood features, mapped core amenities and demographics using Statistics Canada data. At the micro level we identified building features and described and cataloged 1 year of programming for each case/Oasis. Descriptive statistics were calculated.

Results

Four cases were located in Vancouver, BC, 12 cases in Ontario including urban and rural areas in southern and northern ON, and 2 in the Halifax Regional Municipality. All but two cases were located in cities with specific aging initiatives (e.g. Age Friendly Communities). Within a 500-metre radius, large cases had greatest access to amenities such as shopping, health services, and transportation. Each case offered diverse programming including nutrition, socialization and physical activity, with socialization being the most common activity. In total there were 270 health and wellness-focused program activities across the cases, including wellness clinics, hearing clinics, health information sessions. Activities were supported by 179 different community agencies including Community Health Centres, Paramedicine programs, Alzheimer's Society and the Arthritis Society. Large urban cases had greater number of community supported programming.

Conclusion

With Canada's rapidly aging population, community-based strategies are needed to support older adults to age in their homes and communities. NORCs are ideally positioned to support the integration of community health and social programs into communities where older adults live and aging policies need to consider NORCs in planning.

ID: 35069

Presented by: Maureen Douglas

Raising Public Awareness of Palliative Care & Advance Care Planning Through Community Partnerships

Authors: *Mary-Ann Shantz (Covenant Health Palliative Institute), Patricia Biondo (Covenant Health Palliative Institute), Tyler Hamil (Covenant Health Palliative Institute), Maureen Douglas (Covenant Health Palliative Institute), Keltie Watson (Covenant Health Palliative Institute), Ellen Mi (Covenant Health Palliative Institute), Louise Kashuba (Covenant Health Palliative Institute)*

Background and Objectives

Canadians are living longer, with 90% expected to die from serious illness. Improving public understanding of palliative care and advance care planning is essential to better prepare people for serious illness, dying, caregiving, and grieving. Compassionate Alberta is a multi-year, multi-sectoral initiative to increase public awareness and understanding of palliative care and advance care planning in collaboration with community partners.

Approach

We began with several stakeholder engagement activities to both inform the work and identify potential community partners. Engagement activities included nominal group technique, surveys, focus groups, webinars, public forums, advisory committees, and working groups. Five public-facing resources were adapted to the local context in collaboration with expert working groups. These resources support conversations around death and dying, understanding palliative care, building community support for people living with serious illness, and engagement in advance care planning. The resources were disseminated widely and implemented by several community partners.

Results

Our engagement activities have led to strong partnerships with organizations from five key sectors: hospice/palliative care societies, libraries, senior-serving groups, legal, financial and business professionals, and faith and cultural groups. Resources developed are: Understanding Palliative Care online module for the public; PalliLearn facilitated public education courses to build community support for people living with serious illness; My Wishes Alberta fillable workbook to help people identify their values and wishes for care; Plan Ahead Toolkit for facilitating public education on health, financial and estate planning; and Death Cafe facilitator resources. Process measures show we have created change in six of eight Healthy End of Life Program evaluation framework domains, and outcome measures show increased awareness of palliative care and advance care planning.

Conclusion

The Compassionate Alberta initiative fulfills an important public education gap in Alberta. The province-wide implementation of a Compassionate Communities initiative through multi-sectoral collaboration provides a framework for other organizations interested in practical examples of this model.

ID: 34515

Presented by: Janet Durbin

Research to Practice: Implementing NAVIGATE model of Early Psychosis intervention in Ontario

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Background and Objectives

Early psychosis intervention (EPI) is an evidence-based, comprehensive treatment model for youth experiencing early psychosis. Implementation, however, is variable. In Ontario past fidelity monitoring found low adherence to some model components, including psychosocial treatment delivery. NAVIGATE is an EPI model that uses manualized protocols and specifies staff roles. The present study assessed whether implementation of NAVIGATE in Ontario programs improved fidelity to EPI standards. It was part of a larger effectiveness-implementation hybrid type III trial.

Approach

The study start coincided with the COVID-19 pandemic. Six Ontario EPI programs implemented NAVIGATE; a central team provided training and facilitation. Fidelity was rated at three points in time (T0, T1, T2) using the First Episode Psychosis Services-Fidelity Scale Revised. Twenty-nine items assessed five domains: psychosocial treatment delivery, team practice, access and continuity, care planning, pharmacotherapy. Items were rated on a 5-point scale; four indicated good adherence. Mean item, domain and total scores, and percentage items with good adherence were calculated for the sample and per program. Staff complement per assessment and reasons for rating changes were documented per program.

Results

Sample total fidelity ratings were stable over time. Domain ratings varied. Fidelity for team practice and psychosocial treatment domains improved at T1 but dropped slightly at T2. Access and continuity dropped at T1 and remained low. Care planning improved at T2. Pharmacotherapy remained high throughout. Despite improvements, at T2 almost half of items still did not reach good adherence. Fidelity ratings varied at the program level. Programs linked improvements to NAVIGATE role training and manualized protocols, especially for psychosocial treatments and team practice. However, turnover, vacancies and unfunded team positions created persistent delivery challenges, especially for access and continuity. Overall, programs that experienced less staff turnover and had consistent, committed leadership showing better results and ongoing improvement. Fidelity ratings stimulated discussions for improvement.

Conclusion

NAVIGATE model provides a foundation for building better EPI practice. Despite being implemented during the COVID pandemic, NAVIGATE was associated with improved adherence to EPI standards in a number of areas. Adequate resourcing, ongoing training and ongoing quality monitoring are among areas where policy can support continued improvement going forward.

ID: 35546

Presented by: Cathy Eastwood

Applying Outcome Predictions after Heart Failure Hospitalizations for Precision Health

Authors: *Eastwood, Cathy A, Martin, Elliot A, Lee, Seungwon, Walker, Robin, Quan, Hude. University of Calgary*

Background and Objectives

Despite ongoing research, predicting and managing readmission post-heart failure (HF), hospitalization remains a challenge in Canada, where around 20% of HF patients are readmitted within 30 days. Our four-phase project utilizes electronic medical records (EMR) to enhance discharge planning and develop predictive tools. This includes incorporating phenotype algorithms, risk models, and visualizations to forecast the risk of readmissions, emergency department (ED) visits, and mortality, thereby advancing precision health and clinical decision support.

Approach

In phase one, we conducted a Delphi Panel, including patients and physicians, to identify key variables for readmission. In phase two, we assessed the availability of identified variables within an inpatient EMR system before developing models to predict readmissions, ED visits, and deaths within 30, 90, and 365 days. These variables were extracted from free-text clinical notes using data extraction algorithms, and machine learning was applied for prediction. Phases three and four will involve rebuilding and integrating the algorithms into the Alberta-wide EMR system, testing validity, and co-creating a clinical decision support tool through focus groups with patients and physicians.

Results

Between January 1, 2011, and December 31, 2019, 15,160 patients with a primary ICD-10-CA diagnosis code of HF (I50) were analyzed from the Calgary, Alberta, EMR system. Follow-up outcomes included readmissions, ED visits and deaths and were assessed within one year post-discharge. Key variables identified by the Delphi panel, such as self-care, demonstrated strong associations with readmissions but were not well documented in the EMR system. C-statistics ranged from 64.6-69.0 for readmissions, 63.5-70.1 for ED visits, and 75.7-76.1 for deaths. Collectively, these models provide predictions with 95% certainty of at least one outcome for 88% of the population (e.g., a patient having a 95% chance of readmission). When lowered to 90% certainty, this expands to 94% of the population.

Conclusion

These innovative methods, using co-creation and EMR, personalize readmission predictions among HF patients. Improving the capture of Delphi-identified variables in province-wide EMRs may improve models for the co-created decision support tools.

Offering Pharmacogenomic Testing for Depression in BC: Recommendations from a Public Deliberation

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Background and Objectives

Improving mental healthcare is a key priority for the BC health system. Using pharmacogenomic (PGx) testing to guide antidepressant selection for people with major depressive disorder (MDD) could contribute to this goal. PGx testing involves analyzing DNA, and there are benefits and concerns to offering it. Public input is critical as policymakers decide whether to fund PGx testing for MDD. We sought recommendations from British Columbians for policymakers' consideration.

Approach

A four-day public deliberation was held from November-December 2024. Recruitment was by postal invitation to 15,000 randomly-selected households throughout BC, with over-sampling of rural/remote locations. Participants were selected to ensure diversity of socio-demographic characteristics within all five regional health authorities. In preparation, participants received an information booklet and heard from expert speakers. During small- and large-group facilitated discussions, participants discussed whether and how PGx testing for adults with MDD should be implemented. Participants then deliberated, generated, and voted on a list of recommendations on this topic. Finally, participants engaged with policy- and decision-maker panelists. Sessions were recorded and transcribed.

Results

Thirty individuals (17 women) participated and generated 15 recommendations. Publicly funding PGx testing for MDD was recommended, but under certain conditions. Participants unanimously called for strict test reporting standards in line with evidence-based prescribing guidelines. They specified that healthcare professional (HCP) education was needed, with ongoing access to PGx experts. Current practices for protecting biological samples, DNA, and test results were sufficient. To enhance accessibility, they suggested re-naming this "PGx testing (medication compatibility testing)" and conducting a targeted awareness/education campaign; however, participants wanted more data collected to ensure PGx testing benefited diverse ancestry groups. While they agreed test results could be shared between HCPs directly involved in the patient's care, further engagement was needed on secondary usage of these results with/without consent.

Conclusion

Participants supported funding PGx testing for MDD and re-labelling it "PGx testing (medication compatibility testing)". They called for strict test reporting standards, HCP education with access to PGx experts, and more data from diverse ancestry groups. These recommendations provide guidance to BC policymakers considering offering publicly-available PGx testing.

Family physicians' perspectives on administrative work related to referrals: A systematic review

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Background and Objectives

Navigating complex referral pathways imposes significant administrative work for family physicians. Given the growing attention to the ways that administrative burden contributes to attrition from family medicine due to burnout and stress, it is important to understand the nature of this prevalent type of administrative work to generate effective mitigation strategies. Accordingly, this systematic review aims to examine family physicians' perspectives on managing the administrative workload associated with the referral process.

Approach

We conducted a systematic review of empirical studies that explores family physicians' perspectives on the referral process, using a convergent integrative synthesis approach. Eligible studies were conducted in OECD countries, peer-reviewed, and published in English between January 2012 and April 2024. Five health and social science databases were searched, with screening conducted independently and in duplicate. Data were extracted directly from qualitative studies, while quantitative data were transformed for integrated analysis using Sandelowski's "qualitizing" method. A constant comparative approach across countries and outcomes was employed to identify categories and overarching themes related to family physicians' perspectives on managing referrals.

Results

Twenty articles were included. The referral process is cyclical and repetitive, with each step requiring individualized decisions based on patient needs, presenting problems, available information, and specialist relationships. This cycle is organized into five key steps: determining when to refer, constructing the referral, processing specialist responses, conducting follow-ups, and bridging system gaps. These steps are complicated by a fragmented healthcare system, where increasing patient complexity and workload, ambiguous referral guidelines, inadequate communication between specialties, and unclear boundaries between specialties create additional challenges. Challenges include additional paperwork, unnecessary referrals, delays, and rejections, which contribute to physician burnout, reduced professional autonomy, and job dissatisfaction. Physicians reported adapting by delegating work, leveraging relationships with individual specialists, increasing workups to "build a case," and improving documentation practices.

Conclusion

The current backdrop of a fragmented system complicates the referral process for family physicians, leading to increased administrative burden and burnout. Systemic solutions are needed, including clear referral guidelines, streamlined processes, and enhanced communication between specialties. These improvements can reduce administrative tasks and foster more efficient, coordinated care.

ID: 35266

Presented by: Gaya Embuldeniya

Balancing standardization with local needs: Pioneering new approaches to home care in Ontario

Authors: *Embuldeniya, Gayathri; Institute of Health Policy Management and Evaluation*

McKellar, Kaileah; Institute of Health Policy Management and Evaluation

Wodchis, Walter; Institute of Health Policy Management and Evaluation

Background and Objectives

Seven Ontario Health Teams (OHTs), each a group of cross-sectoral health service organizations, were chosen by Ontario's Ministry of Health (MOH) to lead the modernization of home and community care. We explore how stakeholders across sectors experienced and negotiated the task of balancing standardization and local needs required by this work.

Approach

As part of a qualitative evaluation of OHTs' implementation plans, we conducted semi-structured interviews (26) and focus groups (4) with cross-sectoral participants, monthly interviews with team leads, and monthly observations of key team meetings with a subsection of three teams, from November 2023 to October 2024. Participants included senior managers from hospitals and home care/ community organizations, physicians, care coordinators, patients, caregivers and OHT staff. We also conducted a document review of relevant system-level guidance and OHT-level program proposals. We aimed to understand the key elements of each home care model and what helped and hindered its development.

Results

We focus here on a key theme that emerged – the tension between the need to standardize while simultaneously catering to local needs. This tension manifested at system, sectoral, managerial, provider and patient levels. For example, OHT stakeholders found that while system stakeholders had tasked them with testing new homegrown models of homecare delivery, their transformational ideas for how the care coordinator might work within the new models were circumscribed by homecare accountability agreements, contracts and union regulations. We found that the tension between localization and standardization could be mediated by experienced organizational leaders able to creatively navigate between both impulses, managers able to centre the voices of patients and family members, and patients and family members able to remind people of what mattered to them.

Conclusion

We identified the importance of communication a) across sectors, so that all stakeholders were aware of the pressures facing a specific sector to mitigate the apportioning of blame, and b) with on-the-ground providers so that they understood the rationale for change and the value of them guiding it.

ID: 35268

Presented by: Gaya Embuldeniya

Modernizing care coordination: Ideas for change and their limits in the context of home care reform

Authors: *Embuldeniya, Gayathri; Institute of Health Policy Management and Evaluation*

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Wodchis, Walter; Institute of Health Policy Management and Evaluation

Background and Objectives

Seven Ontario Health Teams (OHTs), each a group of cross-sectoral health service organizations, were chosen by Ontario's Ministry of Health (MOH) to lead the modernization of home and community care. At the heart of this work lay the reconceptualization of care coordination, with a focus on integration. We explore how the MOH sought to modernize care coordination through its guidance to OHTs, OHTs' own innovations, and the potential and limits of these efforts.

Approach

From May to October 2024 we conducted semi-structured interviews (26) and focus groups (4) with cross-sectoral participants, monthly interviews with team leads, and monthly observations of key team meetings with a subsection of three teams. Data analysis was focused on OHTs' care coordination efforts. Participants included senior managers from hospitals and home care and community organizations, physicians, care coordinators, patients, caregivers and OHT staff members. We also conducted a document review of relevant system-level guidance and OHT-level program proposals.

Results

The MOH sought to enact change through three levers: the selection of a single home care service provider organization (SPO) to service home care patients within a jurisdiction at a capitated rate, new modes of care-coordinator accountability, and team access to an information sharing platform previously accessible only to the home care sector. OHTs also proposed changes that included embedding care coordinators in new spaces and the development of bridging roles. While OHT stakeholders welcomed these changes, they were concerned about the impacts of the SPO procurement process, the perceived willingness of the provincial home care coordinator agency (alongside its associated labour union) to meaningfully transform the care coordinator role, and the challenge of innovating given the impetus to standardize care coordination approaches across projects.

Conclusion

These findings indicate the importance of a locally relevant procurement process, the engagement and partnership of all sectors and open conversations in the absence of that engagement, in order to arrive at common ground.

Precarious work, gender-based violence, and migrant women's health: a global scoping review

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Background and Objectives

Gender based violence (GBV) is a public health problem with migrant women at a higher risk due to precarious employment (PE) opportunities available to them during the resettlement process. Despite the risk that the connection of PE and GBV pose to migrant women's health, critical gaps exist in literature. Our scoping review sought to identify and synthesize evidence to the relationship of GBV and PE among migrant women and the associated health impacts.

Approach

The scoping review adopted the Arksey and O' Malley (2005) scoping review methodology. We searched six electronic databases for empirical literature. The inclusion criteria were that articles must: (1) report findings of an empirical research study, (2) be published in a peer-reviewed journal, and (3) be focused on the intersection of GBV in its various forms and employment or work. Two reviewers independently conducted title/abstract and full text screening of studies that met the inclusion criteria. Data extraction was conducted using a pilot tested data extraction form developed on Covidence.

Results

43 articles were included for analysis. Our study found evidence that PE plays both a catalytic and consequential role in GBV, with this relationship particularly pronounced among migrant women working in caregiving and hospitality industries. Factors such as familism, especially among live-in domestic workers, debt bondage to recruitment agents, and the "gratitude trap" to recruiters and employers increase migrant women's vulnerability to GBV. Concurrently, post-migration shifts in gender roles, coupled with harsh working conditions resulting in impulsivity leading to violence, schedule unpredictability at work leading to struggle in balancing family and employment demands, were reported as key factors contributing to domestic violence. Health impacts reported include mental health issues like depression and chronic stress, as well as physical health problems such as injuries, permanent disability, back pain, anemia, and even death.

Conclusion

Our research highlights the underexplored intersection of GBV and PE, particularly in public health, and its adverse effects on migrant women's health and wellbeing. Effective interventions and policies should address this complex intersection, recognizing the diverse needs of migrant women, as a 'one-size-fits-all' approach is insufficient.

ID: 33482

Presented by: Sahar Fazeli

Towards Equity: Insights into Indigenous Patients' Experience at a University Healthcare Centre

Authors: *Sahar Fazeli*^{1,2}, *Ka Man Ho*², *Claudia Mitchell*¹, *Romina Pace*^{2,1}

1 McGill, 2 RI-MUHC

Background and Objectives

Indigenous peoples in Canada face severe health disparities due to systemic barriers rooted in colonialism, including fragmented services, discrimination, language barriers, and mistrust. These issues result in delayed or inadequate care, underscored by tragedies like Joyce Echaquan's death. This study explores the healthcare experiences of Indigenous patients at the McGill University Health Centre (MUHC), focusing on barriers to care, healing experiences, and recommendations for fostering culturally safe and inclusive healthcare.

Approach

This study used participatory methods, Photovoice and semi-structured interviews, in collaboration with the Cree Board of Health and Social Services of James Bay. Participants included 20 patients (aged 40–77) and 11 patient escorts (aged 18–68) from five different Cree communities: Waskaganish, Mistissini, Chisasibi, Waswanipi, and Whapmagoostui. Data for this study comprised participants' images, captions, and transcripts of discussions from Photovoice workshops and individual interviews. Thematic and content analysis of transcripts and visual data was conducted to generate descriptive and thematic analysis and to identify themes and subthemes. Following data analysis, results were presented to participants to ensure accuracy.

Results

Three themes emerged: barriers to care, healing experiences, and pathways for improvement. Barriers included racism, neglect, poor communication due to language gaps, and the lack of interpreters, leading to confusion and delayed care. Isolation from communities, financial burdens, and long wait times for consultations and treatments compounded distress. Despite these challenges, patients reported positive healing experiences when they felt heard and supported by medical staff. Family presence and cultural activities were vital in fostering emotional well-being and a sense of safety. Recommendations emphasize the importance of culturally safe environments, integrating family and community into care, improving communication through Indigenous interpreters and patient navigators, and valuing Indigenous culture as integral to healing.

Conclusion

This study provides insights into the healthcare experiences of Indigenous patients at a university hospital. Implementing cultural safety training, addressing communication barriers, and creating culturally inclusive environments are essential to building a more equitable and respectful healthcare system that acknowledges and integrates Indigenous needs and culture.

ID: 34025

Presented by: Danielle Fearon

Variation in Nursing Time among Individuals with trauma in Inpatient Mental Health in Ontario

Authors: *Perlman, Chris - University of Waterloo*

Background and Objectives

Experiencing traumatic life events is highly prevalent, although commonly overlooked in clinical care settings. Undetected trauma has been associated with reduced quality of life, increased hospital readmissions, and other psychological disorders. Nurses are pivotal in inpatient mental health settings; and time is needed to prioritize compassionate trauma-based care and build therapeutic connections. This study investigates variation in nursing time received by individuals with trauma in inpatient psychiatry.

Approach

Data come from 16,323 individuals aged over 18 from the Ontario Mental Health Reporting System with a full inpatient mental health admission between January 1, 2015 to March 31st, 2023. Using the Traumatic Life Events Clinical Assessment Protocol, participants were identified if they had a history of trauma or immediate safety concerns due to current trauma. Nursing time was derived based on the number of days where interventions (e.g., crisis intervention) were provided for 15 minutes or more. For each intervention, nursing time was grouped into none/low (no intervention), moderate (1 to 4 days), and high (5 days or more).

Results

Bivariate analyses suggested significant associations between nursing time and various sociodemographic characteristics. Individuals that were employed (69.5%, N=3,903) received less (none/low) nursing time related to family support/consultations in the last 7 days. Individuals with greater than high school education (9.7%, N=937) received high nursing time of one-to-one counselling in comparison to those with high school or less education. Nursing time related to family support and consultation was significantly more common among females (35.9%, n=3,492) experiencing trauma. Regression models highlighted additional factors such as severe depression and interpersonal conflict influencing amount of nursing time. This presentation will highlight clinical factors associated with variation, as well as preliminary findings of nursing resources in inpatient psychiatry in Ontario.

Conclusion

Sufficient nursing time is needed to prioritize the distinct and complex nature of trauma in mental health settings. Nurses are uniquely positioned to provide safe and empowering environments for individuals experiencing trauma. Future research may consider resource measurement to validate differences observed in nursing time in inpatient mental health.

Improving Rural Access to Care: Insights from VTAC

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Background and Objectives

Renfrew County, Ontario's largest county (7,600 sq/km), home to about 108,000 residents, faces significant primary care access challenges, as evidenced by high unattachment rates and the absence of walk-in clinics. The Virtual Triage and Assessment Centre (VTAC) addresses this- providing same/ next-day access to family physicians and/or community paramedics through virtual, in-person, or hybrid appointments. This research evaluates VTAC's effectiveness in improving care delivery using the quintuple aim framework for quality improvement.

Approach

This presentation highlights current research, using Ontario's population level health administrative databases, that assesses VTAC's clinical outcomes compared to other methods of accessing care. VTAC provides the entire population of Renfrew County with same or next day access to a family physician. Since March 2020, more than half of the population of Renfrew County has accessed care from a VTAC family physician. VTAC is widely regarded as having transformed rural healthcare access in the region. As well as assessing the comparative efficacy of VTAC, this presentation also summarises prior research evaluating VTAC's clinical, economic, patient and provider outcomes and experiences.

Results

[1] Clinical Impact: Following VTAC's implementation, Renfrew County experienced a significant reduction in ED visits, particularly for low-acuity cases, with declines exceeding those in similar neighboring jurisdictions by over 50%. [2] Economic Impact: Renfrew County's total healthcare spending per 100,000 residents was CAD \$6.5 million lower than its two neighbors, despite nearly identical prior spending levels. [3] Patient Experiences: Surveys and interviews highlighted VTAC as an effective response to the access to care crisis. Before VTAC, under 20% of patients had easy access to a family doctor, whereas 90% now find wait times reasonable and report high satisfaction across all encounter types. [3] Provider Experiences: Providers reported positive experiences, citing VTAC's success in reducing unnecessary ED visits and expressing strong overall satisfaction with the program.

Conclusion

VTAC is well-suited for underserved regions with limited primary care access and has potential for broader applications. Results from the ongoing VTAC-CARE study, comparing VTAC appointments to similar low-acuity encounters across Ontario, will be available for inclusion in this presentation.

ID: 35074

Presented by: Marc-Andre Gagnon & Owen Cober

Challenges in Access and affordability of prescription drugs in Ontario Indigenous communities

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Background and Objectives

No systematic data exists to understand potential issues of access and affordability of prescription drugs faced by First Nations people on reserve. On paper, the federally funded Non-Insured Health Benefits (NIHB) covers in last resort all prescription drug expenditures for any First Nations person who is registered under the Indian Act. However, Native welfare administrators constantly handle and manage issues and problems to help Indigenous people on reserve to access the drugs they need.

Approach

In collaboration with Ontario Native Welfare Administrators' Association (ONWAA) and following OCAP principles, we are performing an environmental scan to better understand existing issues faced by Indigenous communities in Ontario to access prescription drugs. In addition to reviewing scientific and gray literature addressing these issues, we systematically compared NIHB drug formulary with the Ontario Drug Benefit (ODB) formulary and we interviewed Indigenous organizations involved in the health of Indigenous communities to achieve qualitative collection of stories relating lived experiences and issues when it comes to accessing prescription drugs in Indigenous communities.

Results

Research is ongoing and will be completed by March 31 2025. Under the condition of obtaining all necessary authorizations by all Indigenous communities involved in this research, we will be happy to share our preliminary results at CAHSPR 2025. Our results can be divided in four categories: 1)Geographical difficulties to access the necessary medicines in a timely fashion 2)Refusal to dispense prescription drugs due to Indian status 3)Administrative hurdles due to competing insurers refusing to be payers of first resort 4)NIHB not covering all prescription drugs covered by ODB.

Conclusion

By examining more closely issues of access and affordability of prescription drugs on reserve in Ontario, we hope this environmental scan will allow Indigenous communities to voice their concerns about the problems they face in ways that could achieve positive institutional and policy reforms.

Implementation and evaluation of electronic surgical referral and centralized intake in Nova Scotia

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Karen Doherty - Nova Scotia Health

Sarah Miles - Nova Scotia Health

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Robin Lake - Nova Scotia Health

Background and Objectives

Wait times for surgical referrals in Canada continue to surpass target. We implemented a province-wide electronic referral (e-Referral) system for surgical referrals as well as a central intake office to support the review and appropriate routing of referrals. Referral routing is based on surgical specialty, surgeon availability, and patient location and preferences. Our objectives were to have improved oversight and tracking of referrals, improve patient communication, and reduce wait times for patients

Approach

Current wait times by county and drivers of wait times provincially were analyzed. Feedback was sought from clinicians (Primary Care and Surgeons) through the Clinical Advisory Committee to better understand their current workflows, needs, and preferences. Perceived issues with e-Referral implementation were collected and communications targeting common themes were shared. Additional feedback was shared with vendor to facilitate software enhancements. Team members involved in the implementation of e-referral were interviewed to learn about the barriers and facilitators of implementation

Results

Analysis of 2019 data by county revealed marked differences in wait time to consult and wait time to surgery depending on the patient's geographical location of residence. Wait time modelling demonstrated that the most significant drivers of overall wait time were the patient's geographic location of residence and the patient's socioeconomic status, far outweighing the patient's diagnosis or urgency level. Barriers to implementation of e-referral included lack of standardization in workflows between surgeon and PCP offices, challenges with lack of communication and integration of technology, and resistance to change. Facilitators included strong rationale for the implementation, the vendor's willingness to work with NSH to add enhancements to the software, a dedicated implementation team, and strong organizational support

Conclusion

The implementation of e-referral in Nova Scotia has been positive, however, challenges with compliance remain. The use of e-Referral and communication with the central intake team increased awareness of unmet needs and care gaps. Solutions have been introduced including early intervention clinics and additional solutions are currently being explored.

ID: 35355

Presented by: François Gallant

Access to healthcare services in French difficult for francophones in New Brunswick

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Background and Objectives

Language differences between patients and care providers are recognized as a barrier to quality healthcare, but how language concordance varies across care settings is understudied. This is particularly important as provinces introduce new ways of accessing healthcare. We describe citizen-reported access to healthcare in their preferred official language across settings in New Brunswick, Canada's only official bilingual province.

Approach

We report on patient care experience survey data collected by the New Brunswick Health Council. Specifically, surveys include the Hospital Acute Care survey (2023), Home Care survey (2021), and Primary Care survey (2023). We use percentage and 95% confidence intervals to describe New Brunswick citizen self-report access to various access points for healthcare.

Results

Nearly all [95.1 (94.5-95.8)%] New Brunswickers report access to a primary care provider in their preferred official language. However, other ways of accessing health care (e.g., pharmacy, specialists, telehealth) represent significant challenges for minority linguistic groups. Specifically, NB citizens who prefer receiving services in French, reported having interactions with a medical specialist in their preferred official language 68.2 (63.4-73.0) % of the time, compared to 95.7(94.3-97.0) % among NB citizens who prefer receiving their services in English. Similar results can be noted for emergency department visits [prefer French: 69.9(65.7-74.1)% vs. prefer English: 91.0(89.3-92.7)%] and pharmacists [prefer French: 68.9(65.1-72.6)% vs. prefer English: 97.3(96.6-98.1)%].

Conclusion

New Brunswick citizens who prefer receiving their healthcare services in French report lower access to services in their preferred official language compared to those who prefer receiving their services in English. Information presented here could be leveraged to inform policy and practice across other Canadian jurisdictions, even though the breadth and depth of bilingualism varies across jurisdictions.

ID: 35480

Presented by: Judith Gargaro

How can population-based data be used to inform policy? Traumatic brain injury in older adults

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Background and Objectives

The incidence of traumatic brain injury (TBI) in older adults (65 years or older) is increasing due to the aging population and higher rates of falls. Outcomes in this population are often worse compared to younger adults. Studies on TBI outcomes focus on short-term mortality (less than 1 year), however, there is growing concern about long-term survival. There is a gap in policy leadership and such leadership is essential to ensure quality healthcare outcomes.

Approach

A population based retrospective cohort study using data from administrative databases (i.e., CIHI_DAD, NACRS and OHIP) was performed. Ontario residents with confirmed TBI between 2002 to 2012 were identified, and cohort survival outcomes were followed to the end of 2022. The survivorship following TBI was also compared to the general population through age and sex propensity matching. Age and sex adjusted mortality were calculated with 95% confidence limits. The Cox proportional hazard model was used to estimate mortality over 10 years. The variations in mortality were explored by age group, sex, geographic region, and income quintile.

Results

173,776 older adults with TBI were identified between 2002 -2012. Overall survival estimates at 1-, 5- , and 10 years were 87.5%, 60.9% and 38.1%. 10-year survival for age-groups 65-74, 75-84 and 85+years was 66.3%, 32.5% and 7.8%. In adjusted models, increased 10-year mortality was associated with older age (HR 2.57 95% CI 2.54-6.61 for age group 75-84, and HR 5.61 95% CI 5.52-5.71 for 85+ years vs. age-group 65-74), lack of inpatient rehabilitation (HR 1.39 95% CI 1.31-1.49), male, presence of pre-existing comorbidities, and falls as cause of injury . Propensity matched analysis of non-TBI general population, TBI survivors had significantly higher mortality (HR 1.20 95% CI 1.19-1.21). Policy and system implications of these findings were developed by committee, including people with lived experience.

Conclusion

Aging individuals with TBI face significantly higher mortality rates, with survival rates declining over time. There is a role for policy leadership to implement fall prevention strategies and to ensure older people receive rehabilitation and appropriate follow up healthcare to optimize independence and autonomy in the community.

ID: 35481

Presented by: Judy Gargaro

What policy leadership is needed to improve outcomes in older people after a spinal cord injury?

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Background and Objectives

This study aims to evaluate long-term healthcare utilization and mortality outcomes following Spinal Cord Injury (SCI) in older adults in Ontario. Given the growing aging population and rising incidence of SCI in individuals aged 65 or older, understanding long-term health service demands and survival rates in this demographic is crucial for healthcare planning and resource allocation. There is a gap in policy leadership and such leadership is essential to ensure quality healthcare outcomes.

Approach

We conducted a population-based retrospective cohort study using administrative databases (i.e., CIHI-DAD, NACRS and OHIP). The study cohort consisted of individuals aged 65 and older who sustained an SCI between 2002–2012. Key outcomes included:

Healthcare utilization: number of hospital admissions, emergency department visits (ED), rehabilitation services received, length of stay, and outpatient physician follow up.

Mortality: At 30-day, 1-year, 5-year and 10-year post-SCI, adjusted for demographic factors (e.g., age, sex).

The data were analyzed using survival analysis techniques, including Cox proportional hazard regression. The variation in mortality was explored by age group, sex, geographic region, and income quintile.

Results

861 older adults with SCI were identified between 2002–2012. The cumulative utilization rates over 10 years for ED visits (115.5 PY), mental health care (59.0 PY), and falls (7.0 PY) were calculated. Overall survival estimates at 1-, 5-, and 10 years were 65.5%, 46.6% and 15.1%, respectively. 10-year survival for age-groups 65–74, 75–84 and 85+ years were 25.8%, 7.1% and 2.4%, respectively. In adjusted models, 10-year mortality was associated with older age (HR 1.91 95% CI 1.61–2.25 for 75–84 age group, and HR 3.30 95% CI 2.61–4.17 for 85+ years vs. age-group 65–74); lack of inpatient rehabilitation (HR 1.29 95% CI 1.06–1.56), male sex, presence of preexisting comorbidities, falls as cause of injury, lower income quintile, and lack of follow up by specialists.

Conclusion

This study highlights the significantly higher healthcare utilization and mortality rates faced by older adults after SCI. There is a role for policy leadership to implement fall prevention strategies and to ensure older people receive rehabilitation and appropriate follow up healthcare to optimize independence and autonomy in the community.

ID: 34551

Presented by: Bobby Gheorghiu

Patients' experiences with connected care in the Canadian healthcare system

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Background and Objectives

Connected health is a patient-centric model of care that emphasizes care coordination and collaboration among health providers while engaging patients in managing their own health. This model has the potential to empower patients by enhancing their access to personal health information (PHI) and improving their healthcare experience. We sought to uncover Canadians' access to and experience with their electronic PHI and understand their lived experiences with care connection and collaboration in the Canadian healthcare system.

Approach

We analyzed data from the 2023 Canadian Digital Health Survey (CDHS), an online cross-sectional survey of 10,130 Canadians representing all provinces and territories. The survey explored access to and use of digital health services, collecting patient-reported experience measures (PREMs) related to accessing electronic PHI, connected health and care coordination. Sociodemographic, socioeconomic, and health status descriptors were used to identify variations in experiences across sub-populations. Post-survey weights, derived from the 2021 Canadian census, were applied to ensure representativeness (in terms of age, gender, and region) of the Canadian population.

Results

In 2023, 39% of Canadians had electronic access to their PHI online, a steady increase since 2020. Of those with electronic PHI access, 45% used provincial portals, up from 31% in 2022. Patients with access to their online PHI reported positive experiences: 88% felt more informed about their health, 85% were satisfied with the platform where PHI was accessed, and 83% agreed that the online access improved their health management. However, challenges remain: only half of Canadians reported healthcare providers consistently having access to their health history during visits, 25% had to repeatedly provide the same health information across encounters; and 22% experienced communication delays between providers. Furthermore, younger adults, females, and those with chronic conditions faced more gaps in connected health and care coordination.

Conclusion

While Canadians' perceptions and experiences with online platforms used to access their PHI are positive, addressing access disparities requires improving digital health literacy and raising awareness about patient portals. Adopting more interoperable healthcare technologies will improve patient experience with connected health and care coordination, leading to better patient health outcomes.

ID: 34484

Presented by: Catherine Giroux

Organizational Readiness to Implement an LHS: Questionnaire Validation using a Delphi Method

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Background and Objectives

Adopting a learning health system (LHS) is a promising approach to bridging knowledge between policymakers, health professionals and managers, researchers, and patients and their families to collaboratively improve health care. While organizational readiness assessments exist in the quality improvement literature, they do not consider the components of an LHS. This study aimed to establish the content validity of a newly developed measure to assess organizational readiness for LHS implementation.

Approach

A three-round Delphi using online surveys was conducted to establish consensus on the importance, relevance, clarity, and comprehensiveness of the domains and items included in our measure. Purposive sampling was used to recruit a panel of participants with expertise or interests in LHS who are involved in healthcare organizations across Canada and internationally. A minimum of 70% agreement on each question represented consensus. Between Delphi rounds, a steering committee reviewed findings and refined items for clarity. Modified items were re-tested in subsequent rounds. Forty-one researchers, health professionals, and managers participated.

Results

Round 1 tested 85 items. 48% (n=41) achieved consensus, 8% (n=7) were removed, 25% (n=21) underwent major modification, and 11 new items were proposed. Round 2 tested 36 items (n=4 clarified; n=21 modified; n=11 new). 50% (n=18) achieved consensus (n=1 clarified; n=11 modified; n=6 new), 22% (n=8) were excluded, and 28% (n=10) were clarified. Round 3 tested 10 items; 50% (n=5) achieved consensus, and 10% (n=1) were removed. Four items (40%) achieved consensus on importance and relevance and were clarified by the steering committee before inclusion. The final measure assesses four domains: 1) performance to data (n=23 items), 2) data to knowledge (n=14 items), 3) knowledge to performance (n=24 items), and 4) LHS core values (n=21 items).

Conclusion

While existing tools help organizations establish their readiness for change, adopting an LHS approach requires substantial commitment and collaboration from all interested parties. Future research will measure this questionnaire's psychometric properties to prepare for its use by organizations looking to adopt an LHS approach.

ID: 34276

Presented by: Leanda Godfrey

The Impacts of Changes in Primary Care Attachment

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Background and Objectives

Primary care attachment represents an inclusive, equitable and cost-effective way of enhancing health outcomes globally. However, the growing shortage of family physicians threatens to disrupt patient-provider relationships. Understanding the consequences of these disruptions is essential for guiding future research and policy. This study aims to map the existing evidence on the impacts of changes in primary care attachment, identify research gaps, and highlight key priorities for further investigation.

Approach

A scoping review was conducted following Joanna Briggs Institute (JBI) guidelines and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) checklist. Peer-reviewed, English-language articles published between 1999 and 2024 were sourced from PubMed, Scopus, and Web of Science. Two researchers conducted all stages of screening, and study quality was assessed using JBI critical appraisal tools. Key search themes included the causes of attachment change, the direction of these changes, and outcomes aligned with the Quintuple Aim framework. Both qualitative and quantitative findings were synthesized narratively.

Results

Of 2,045 studies screened, 31 met the inclusion criteria, with 60% published after 2020. Most studies originated from high-income countries, particularly the United States (35%) and Canada (29%). Attachment losses and transfers were the most frequently studied variables, while attachment and unattachment durations were less explored. Changes in attachment were consistently shown to impact patients, providers, clinics, and the healthcare system, influencing all dimensions of the Quintuple Aim framework, including clinical outcomes, healthcare utilization, costs, equity, and patient experience. Commonly assessed outcomes included clinical impact (68%), health equity (48%), patient experience (32%), and costs (23%), with no study assessing provider experience.

Conclusion

This scoping review maps the published literature on changes in primary care attachment, introduces clarifying terminology, and highlights their significant impacts across all aspects of healthcare. Key research gaps were identified and outlined. These findings provide valuable insights to inform future studies and guide policy development.

ID: 34813

Presented by: Alyssa Grant

Optimizing Substance Use Healthcare for Problematic Alcohol Use through A Discrete Choice Experiment

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Background and Objectives

Problematic alcohol use (PAU) is a significant global health risk, with care further disrupted by the COVID-19 pandemic. This study used a discrete choice experiment (DCE) survey to identify preferred characteristics of Rapid Access Addiction Medicine (RAAM) clinics for PAU for individuals with PAU and assessed the pandemic's impact on these preferences.

Approach

We used multiple methods to develop a DCE questionnaire. A scoping review and stakeholder meetings were conducted to identify characteristics of substance use health services for individuals with PAU relevant to RAAM clinics in Ontario. We also explored how experiences of PAU individuals differed before and during the COVID-19 pandemic. The eDelphi survey prioritized a final list of attributes, which were incorporated into the final online questionnaire.

Results

The scoping review identified several barriers, including complex care pathway, high costs, long wait times, limited geographically accessible treatment, inconvenient appointment hours, inadequate cultural/demographic sensitivity, and lack of anonymity/privacy. Stakeholder meetings and eDelphi survey refined these findings and include key attributes, such as service delivery modes, operating hours, wait times, the availability of peer support workers, and shared decision-making opportunities. The DCE survey is underway, and its results will be presented at the meeting.

Conclusion

Our review has identified key barriers to accessing substance use health services for PAU. Findings from our studies can highlight which aspects of RAAM clinics, if modified, could more effectively improve the delivery and accessibility of these services.

Patient Health Outcomes for Evaluation of Pharmacist-Led Primary Care: A Scoping Review

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Background and Objectives

Pharmacists' role in primary care has rapidly expanded in recent years, driven in part by pressures on primary care and supported by increased government funding to remove patient fees. To optimize patient health outcomes, the benefits and harms of pharmacist-led primary care in community settings must be evaluated. This scoping review aims to identify patient health outcomes that have been used to measure the quality, effectiveness, and safety of pharmacist-led primary care.

Approach

A comprehensive search was conducted in four databases (July 2023) and Google (July 2024). Database records were screened independently by two reviewers at two levels in Covidence. Google search results were screened by one reviewer, with selections verified by a second reviewer. Studies were included if participants received pharmacist-led primary care and if patient health outcomes related to quality, effectiveness, and/or safety were evaluated. Extracted data on study design, disease state, clinical services, and patient outcomes were further refined into categories by two reviewers. Data are reported descriptively (frequencies, percentages) and will be presented using heat maps.

Results

A total of 236 sources (234 peer-reviewed, 2 grey literature) were included from 9,022 database records and 300 grey literature search results. There were 90 observational, and 146 experimental studies. Studies often evaluated multiple types of care, with the majority focused on education or counselling (n=114), chronic disease management (n=65), medication review (n=47), pharmaceutical care (n=46), and testing (n=45). Patient populations were focused on those with chronic diseases, including cardiovascular health (n=67), endocrine (n=64) and respiratory (n=38) disorders, alongside mental health and addictions (n=22), and acute illnesses (n=13). A wide variety of outcomes were measured, including: clinical measures (n=316), adherence to guidelines (n=218), medication regimen characteristics (n=183), resource utilization (n=170), laboratory measures (n=125), adherence to medication (n=106), patient satisfaction (n=72), and adverse drug events (n=42).

Conclusion

This scoping review identifies patient health outcomes that have been used to evaluate pharmacist-led primary care. These data should be used alongside metrics that are important to patients to develop performance indicators that ensure safe and effective pharmacist-led primary care.

ID: 34916

Presented by: Agnes Grudniewicz

Measuring Comprehensiveness in Primary Care: A Scoping Review

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Background and Objectives

High-quality primary care is considered essential to good individual and population health outcomes. Comprehensiveness has been identified as a key characteristic of strong primary care, yet concerns are growing that comprehensiveness is declining. Efforts to measure the presence and impact of comprehensiveness are hindered by variability in how “comprehensiveness” is defined and measured. Our objectives with this analysis were to summarize how comprehensiveness is quantitatively measured and to describe available data sources.

Approach

This scoping review followed the methods of Arksey and O'Malley and Levac et al. Our search strategy was applied to multiple health databases and grey literature. Two-stage source selection included title/abstract screening and full text review; eligible sources defined or measured comprehensiveness quantitatively within primary care. Data were extracted capturing publication details and characteristics of comprehensiveness. Using a conceptual map of comprehensiveness, we summarize the frequencies of measures within each of the domains, attributes, and enablers of comprehensiveness. Data sources for these measures are also summarized.

Results

127 of over 10,000 screened sources were included in analysis. Almost all (99%) measured an attribute of the breadth of care domain, including services provided (89%), health needs and conditions (40%), patients served (21%), and settings (16%). A subset (23%) operationalized the broader domain of approach to care (e.g., whole-person care) or measured one or more enablers of primary care (7%). Most used surveys (71%), though 19% used administrative data (including EMR) or a combination of sources (10%). Definitions were most frequently operationalized at the level of primary care clinician, though some also considered teams, or framed comprehensiveness as the services available to a patient or community.

Conclusion

Beyond measuring breadth of services, there is substantial variation in how comprehensiveness is operationalized within the published literature. Greater conceptual clarity and attention to context and objectives may support more relevant, robust, and consistent quantitative measurement of comprehensiveness for research, practice improvement, and policy evaluation.

ID: 34865

Presented by: Emily Gruenwoldt

Beyond Band-aids: Delivering Healthcare Fit for Kids

Authors: *Lisa Stromquist*

Background and Objectives

Canada is facing a child and youth health crisis, with declining physical and mental health. Healthcare systems struggle to meet rising demand due to insufficient funding, fragmentation, and a shortage of pediatric specialists. Hospitals are at full capacity, and waitlists for essential care grow. Delays in addressing mental health and developmental disorders will lead to billions in future costs. Decades of underfunding and fragmented systems have failed children and youth, and urgent reforms are needed.

Approach

To help identify solutions, Children's Healthcare Canada commissioned an economic impact analysis, conducted by the Conference Board of Canada, to quantify the financial and human costs of wait times for children and youth accessing essential healthcare. Also, a virtual consultation gathered over 600 insights from health system leaders, family partners, data analysts, researchers and others. The consultation aimed to develop concrete recommendations for improving integrated child and youth health services, enhancing health outcomes, ensuring system sustainability, and guiding policy, advocacy, and investments in healthcare across Canada. These efforts focus on addressing the systemic issues facing child health in the country.

Results

Right-Sized health systems for kids are accessible, equitable, connected healthcare services designed for the needs of children, youth and families in Canada.

A series of recommendations targeting governments (federal, provincial and territorial), child health advocates, and child healthcare delivery organizations were articulated to achieve this vision. These recommendations lay the framework to improve healthcare experiences, and outcomes of children and youth in Canada.

Foundationally these recommendations require dedicated funding for child health research and services, accessible child health data and a strategy for a specialized health workforce.

Collective action is necessary to facilitate needed change, with the federal government catalyzing action to support systems transformation, provinces and territories as system administrators and child health advocates as subject matter experts.

Conclusion

Improving the health and wellbeing of children, youth and families requires efforts, investments and collaborations beyond healthcare systems. System transformation

Children's Healthcare Canada, our members and partners continue to raise awareness and elevate the recommendations for systems transformation to the public and governments through various channels.

Exploring patient-reported experience measures for medications: A theory-based qualitative study

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Background and Objectives

Medications are the most common therapeutic intervention in healthcare, but formal measures to capture patients' experiences with their medications are not routinely used (patient-reported experience measures; PREMs). Measuring and optimizing patient experiences are critically important to ensuring patient-centered and value-based care. The objective of this study was to explore barriers and facilitators to the routine use of PREMs for medications in primary healthcare in Ontario, Canada.

Approach

We report qualitative findings from an ongoing theory-based, mixed-methods study. We conducted semi-structured interviews and focus groups with three key interest groups: adult persons with lived experience of taking medications (PWLE), medication prescribers (physicians, pharmacists, nurses), and health system decision-makers. We purposefully sought representation of participants from different demographic characteristics (e.g., age, sex, gender, professional role). Data collection and analysis were guided by the 14 behavioral domains outlined in the Theoretical Domains Framework (TDF). We conducted a rapid deductive directed content analysis. The research was informed by an advisory council consisting of five PWLE representatives.

Results

Participants included 21 PWLE, 20 medication prescribers, and 9 decision-makers. Overall, participants discussed the need for more support regarding where and how to report experiences related to medications [Knowledge]. Participants reflected on several skills needed for reporting medication-related experiences, including self-advocacy and communication [Skills]. All participant groups reflected on barriers to a PREM for medications including: lack of resources, staff burnout, language and cultural barriers, and fear of negative repercussions on care [Environmental Context and Resources; Emotion; Beliefs about Consequences; Beliefs about Capabilities]. Several solutions to address these challenges were identified, such as: staff and patient training and education, use of technology to support seamless integration, and access to standardized forms [Knowledge; Environmental Context and Resources].

Conclusion

Aligning with domains from the TDF, we identified several barriers and facilitators to the use of PREMs for medications. These data can be used to inform the development of a PREM for medications to be used in routine practice, along with how to support its implementation and uptake.

ID: 35334

Presented by: Priya Gupta

Providing Palliative Care Navigation to Refugee Claimants in Ontario: An Innovative Approach

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Background and Objectives

Palliative care is restricted for marginalized populations, including refugees. This is further complicated as refugee claimants are only eligible for the Interim Federal Health Plan (IFHP), which provides basic medical and social coverage until provincial healthcare coverage begins. While IFHP provides some home-based palliative support, it is restrictive and often inaccessible due to significant administrative burdens for community professionals. Limited access to home-based supports has demonstrated an over-reliance on acute care services in Ontario.

Approach

To mitigate limitations from IFHP, a non-profit navigation program (GPS Health Navigators) was launched in January 2024 in the Toronto region. This program models care coordination provided through provincial homecare, by reducing the administrative burden and time to service initiation that is typically experienced. Patients are seen virtually by a palliative care physician and nurse navigator who assess care needs and connect patients to appropriate services, with the aim of reducing acute care admissions. A multi-year collaborative was formed between GPS Health Navigators, local hospices, and a community health centre to design, evaluate, and expand this navigation service.

Results

Since the launch of our program, we have successfully serviced refugee patients with a palliative care need in the Greater Hamilton and Toronto area, with an expanded network of collaborators and professionals. With the servicing of our clients, we have been able to build capacity around refugee health and IFHP amongst healthcare professionals in hospital and community settings, by running educational sessions to healthcare provider groups most likely to encounter refugee patients with palliative care needs. Early program successes include expanding our network of providers and support, early capacity building of our common referral sources, and increasing the ability for our clients to die in their preferred setting (including at home and hospice). Early challenges include fluctuating human resources and finding reliable and consistent care providers.

Conclusion

This collaborative aims to address a significant gap in palliative care access for refugee claimants through the creation of a unique and innovative community-based navigation service. Equitable access through compassionate and dedicated healthcare navigation is essential in ensuring that quality palliative care is available to all.

ID: 34844

Presented by: Babita Gupta

Canada's Shared Health Priorities: Measuring progress and bridging data gaps with common indicators

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Background and Objectives

Canada's health care systems are under enormous strain, requiring improvements in several areas. To address current challenges, federal, provincial and territorial governments are working together to improve care and to measure progress via common indicators in areas of shared health priority: primary health care; health workforce and surgeries; mental health and substance use; and electronic health information. This presentation will provide an overview of priorities and findings from some of the common indicators.

Approach

We consulted many stakeholders including ministries, system experts, data partners and Canadians to support the selection of common indicators that were endorsed by governments across the country. We then leveraged existing health administrative data, national surveys and provincial/territorial databases to source the data and develop common indicators.

The results, which were released in October 2024, provide a baseline measure for select indicators to track improvements over time. Reporting also includes patient and healthcare provider voices to add meaningful context to the findings.

Results

Findings from the October release show:

83% of Canadian adults report having access to a regular health care provider. But, more than 5 million Canadian adults, or 17%, struggle to access care.

Wait times to access care persist. Half of Canadians referred to publicly funded community mental health counseling waited 25 days or more for their first scheduled session.

Electronic sharing of health information remains a challenge. While 4 in 5 (81%) Canadians were interested in accessing their health information online, only 2 in 5 (39%) had done so.

Conclusion

Strong health care systems rely on strong data. Pan-Canadian data will be key to measuring progress on Canada's Shared Health Priorities and will support decision makers in developing population-specific policies and programs, monitoring progress and learning from each other.

ID: 34066

Presented by: Jillian Halladay

Mental health and substance use disorder symptom profiles of young adults accessing treatment

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Background and Objectives

Young adults (aged 17-25) experience the highest rates of substance use and concurrent mental health disorders, necessitating tailored treatment. Young adults often also experience poorer treatment engagement and outcomes compared to other groups, with limited understanding of their predictors. This study aims to: (1) identify and characterize profiles of substance use and mental health symptoms in an outpatient Young Adult Substance Use Program (YA-SUP), and (2) explore whether these profiles predict treatment engagement and outcomes.

Approach

Data comes from 349 young adults attending the St. Joseph's Healthcare Hamilton YA-SUP between February 2021 and May 2024 (~3 years). Preliminary analyses related to patient characteristics, engagement, and clinical outcomes have been conducted. A latent profile analysis, using substance use disorder symptom scores (alcohol, cannabis, drug use) and emotional disorder symptoms scores (depression, anxiety, post-traumatic stress disorder [PTSD]) is underway. The resulting profiles will be: (1) compared based on demographic and other clinical characteristics, and (2) used to predict program engagement and symptoms outcomes.

Results

Of the 349 attending an intake, 263 fully enrolled in the program, and 122 completed the core motivational interviewing components of the program. Patients were most commonly seeking treatment for alcohol (61%) and/or cannabis (60%) use, with near universal (95%) co-occurring mental health problems (e.g., 76% moderate-severe depressive symptoms, 65% moderate-severe anxiety symptoms, 60% moderate-severe PTSD symptoms). Statistically significant ($p < .001$) and clinically important (per minimal clinically important differences) changes were present for substance use, depression, anxiety, PTSD symptoms, and quality of life, however, persistent clinical elevations were nonetheless commonly present. Few independent demographic, substance use, or mental health factors predicted program engagement or persistent clinical problems when explored in isolation. Identification, characterization, and modelling of profiles of substance use and mental health symptoms are underway.

Conclusion

We anticipate substance use and mental health symptom profiles of young adults will emerge that will predict differential engagement and clinical outcomes. This work will inform targeted treatment pathways for young adults presenting with particular clinical profiles related to mitigating disengagement risk and offering more intensive treatment.

ID: 34775

Presented by: Emily Hamovitch

Identifying bots in health experience surveys

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Background and Objectives

Misinformation impacts the quality of online data, including survey responses. In health contexts, bots pose challenges to data reliability. This study, part of an Ontario Health Teams (OHT) evaluation, presents a systematic approach to identifying bots in a patient experience survey and evaluates their impact. Findings demonstrate how bot-provided data can distort results, underscoring the importance of bot-detection strategies to ensure the reliability and validity of health informatics research.

Approach

We analyzed survey data on patient-reported experiences and outcomes. The survey was distributed electronically from July, 2023 – November, 2023 and was open to patients within a particular OHT. Criteria for identifying bots included response patterns (e.g., generic or repetitive text), location issues (e.g., invalid postal codes), and suspicious timing. Bots were identified using a tiered system: tier 1 (classified as a bot if any single criterion met), tier 2 (two or more criteria met), and tier 3 (one tier 3 criterion and at least two tier 2 criteria met). Bar charts and chi-square tests evaluated differences between human and bot responses.

Results

The total study sample included 1154 respondents, of whom 668 (58%) were classified as bots and 486 (42%) as humans. Bots were significantly less likely to report favourable health outcomes and more likely to select responses in the middle of the scale (e.g., “sometimes”). Their inclusion diluted the strength of favourable responses reported by humans and skewed averages toward neutral or mid-scale responses. Bots often generated nonsensical or counterintuitive responses, distorting study findings and undermining construct validity, as their answers failed to reflect real-world experiences.

Conclusion

These findings highlight the substantial impact bots can have on survey results, emphasizing the importance of identifying and excluding suspect data to maintain the accuracy and reliability of health informatics research. Findings will be applicable to those conducting electronic surveys -highlighting approaches to limit and identify bot responses.

ID: 35508

Presented by: Bisola Hamzat

Trends in opioid prescribing prior to opioid toxicity inpatient hospitalizations and ED visits

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Background and Objectives

Despite evidence of changing role of pharmaceutical opioids in opioid-related harms in Canada, little is known about patterns of opioid prescribing prior to opioid-related toxicity harms and how it varies provincially. Therefore, we sought to characterize patterns of prescription opioid exposure at the time of opioid toxicity hospitalizations and ED visits.

Approach

We conducted a population-based repeated cross-sectional study of opioid toxicity (i) acute inpatient hospitalizations and (ii) ED visits in 5 and 6 Canadian provinces, respectively between January 1st, 2018 and December 31st, 2022. We linked pharmacy dispensing data across included provinces—British Columbia (BC), Alberta (AB), Saskatchewan (SK), Manitoba (MB), Ontario (ON) and Quebec (QB)—to determine active prescription opioid dispensations at the time of opioid toxicity, overall and stratified by patient characteristics and type of opioid dispensed. In our secondary analyses, we examined recent prescription opioid dispensations in the prior (i) 30 days and (ii) 180 days.

Results

Active prescription opioid exposure at the time of opioid toxicity hospital admission was relatively uncommon and declined across provinces over the study period, apart from BC (range, 20.0% in BC to 47.5% in QB in 2018; 19.7% in BC to 36.5% in QB in 2022). Active opioid exposure was even less common at the time of opioid toxicity ED visit and similarly declined over time in most provinces (range, 11.0% in BC to 28.5% in QB in 2018; 14.9% in AB to 26.0% in QB in 2022). Generally, people older than 65 and females were proportionally more likely to have an active opioid exposure. We observed a shift towards active exposure to OAT across provinces, while active exposure to opioids for pain declined over time.

Conclusion

On average, pharmaceutical opioid exposure at the time of opioid-related toxicity has declined over time when measured in relation to overall opioid toxicity events. Our findings highlight increasing harms of the unpredictable, potent unregulated drug supply across the country as well as important differences in prescription opioid exposure across demographics.

Opioid Agonist Treatment Prescribing Trends Between 2018 and 2022 Across Six Canadian Provinces

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Background and Objectives

Opioid agonist treatment (OAT) is recommended first-line for individuals with opioid use disorder (OUD). The prescribing guidance for OAT use and the availability of different products has rapidly evolved in recent years. However, information on regional variations in OAT prescribing is required to inform policy and programming decisions on access to treatment for OUD in Canada. Therefore, the objective of this study was to investigate national patterns in OAT use across Canada.

Approach

We conducted a population-based repeated cross-sectional study of OAT recipients (i.e., methadone and buprenorphine-containing products) between January 2018 and December 2022, across six provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Québec, and Ontario) using pharmacy dispensing records, regardless of payer (apart from Québec, where only claims insured by Quebec's public drug insurance plan were available). We calculated population-adjusted rates of prevalent and incident OAT recipients for our primary and secondary outcomes, respectively. We reported trends in monthly rates stratified by province and annual rates for each province stratified by age, sex, neighbourhood income quintile, location of residence, and OAT type.

Results

We observed varying prevalence of OAT use across provinces and over time, ranging from 1.38 to 5.29 per 1,000 in Quebec and British Columbia, respectively in 2022. Growth in annual prevalence rates was observed in Alberta (3.00 to 3.75 per 1,000) and Manitoba (1.68 to 2.39 per 1,000) between 2018 and 2022 while rates remained relatively stable in other provinces. OAT use was concentrated among people aged 25-44, males, and residents of lower income quintile neighbourhoods. In Ontario, Saskatchewan, and British Columbia, 1 in 100 individuals aged 25-44 were dispensed OAT in 2022. A shift towards buprenorphine prescribing occurred across all provinces, with 45% to 74% of OAT recipients prescribed a buprenorphine-containing product in 2022. Aforementioned patterns were generally consistent with incident OAT rates.

Conclusion

Cross-provincial differences in OAT rates may denote different underlying rates of opioid use disorder and access to treatment. The shift towards buprenorphine use should be considered carefully due to emerging evidence for improved treatment retention among methadone recipients in the context of Canada's fentanyl dominated unregulated drug supply.

ID: 35267

Presented by: Lindsay Hedden

Cases of private financing and for-profit delivery operating in Canadian healthcare: a document scan

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Background and Objectives

Privatisation through the expansion of private payment and investor-owned corporate health care delivery in Canada raises potential conflicts with equity principles on which Canadian public health insurance is founded. Some cases of privatisation are widely recognised, while others are evolving and more hidden, and their extent differs across provinces and territories. We sought to identify cases where privatisation has emerged or increased in Canada over the past decade and explore their effects.

Approach

We conducted a document search, starting with structured string searches of various databases, followed by snowballing and citation searching. Our combined searches identified 2911 sources; after removing 1347 duplicate sources and 1408 sources that did not meet our criteria, we extracted the following information from 156 sources: mechanisms of privatisation; relationships between financing and delivery of services; jurisdictions where cases are occurring; the affected health sectors and services; the populations of service users affected, whether the general public or specific groups; who is paying (financially) for privatisation (e.g., patients, governments, other); and any noted impacts or equity implications.

Results

Some cases of privatisation are thoroughly documented and described; others are only vaguely referenced with few details to fully understand how they operate. The most frequent form of privatisation we observed was outsourcing of care by the public system to private, for-profit providers. Several of the cases we captured involved multiple, intersecting mechanisms of privatisation, such as Nurse Practitioners-led private clinics that offer virtual care for which patients are billed directly. Our findings are limited to mechanisms and cases that have been documented over the past decade; we anticipate there are other forms of privatisation which our scan has not captured due to a lack of publicly documentation, awareness of their presence, understanding of how they operate, or perceptions related to their relationship to privatisation.

Conclusion

Cases of privatisation are challenging to identify because of a lack of systematic data collection. While emerging and increasing forms of privatization across Canadian jurisdictions vary, data sources point to their harmful effects on access to care, equity, population health, and cost efficiency – for individuals and the health system.

Effect of universal no-cost coverage on contraception use: population-based interrupted time series

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Background and Objectives

Access to contraception is essential for reproductive population health. Cost-related barriers reduce contraception use, especially for long-acting reversible contraception (LARC). In April 2023, the Canadian province of British Columbia introduced universal, first-dollar coverage for prescription contraception. We estimated the effect of this policy on use of LARC and all prescription contraception in the provincial population of reproductive-aged females.

Approach

We used a rigorous quasi-experimental design, including a controlled interrupted time series analysis of a national prescription database using a synthetic control and an interrupted time series analysis of population-based administrative health data. Introduction of the universal contraception coverage policy served as the study exposure. Outcomes were monthly: dispensations for LARC and for all forms of prescription contraception, percent of reproductive-aged (15-49) females in the population using LARC and using all forms of prescription contraception, and the fraction of prescription contraception users using LARC (LARC market-share).

Results

We found an additional 1,273 (95% CI: 963-1,698) monthly LARC dispensations 15-months post-policy compared with the expected volume, representing an estimated 1.49-fold (95% CI: 1.34-1.77) increase. Overall, prescription contraception dispensations increased by 1,981 (95% CI: 356-3,324) per month, representing a 1.04-fold (95% CI: 1.01-1.07) increase. Among the 859,845 reproductive-aged females in the population, 9.1% were using LARC in April 2021. Fifteen-months post-policy, there were an additional 11,375 (95% CI: 10,273-13,013) LARC users than expected absent the policy, representing an additional 1.3% (95% CI: 1.2%-1.5%) of reproductive-aged females. The policy led to an additional 1.7% (95% CI: 1.5%-2.3%) of the population using any prescription contraception. At 15-months post-policy, the LARC market-share was 1.9% (95% CI: 1.2%-2.3%) higher than expected.

Conclusion

Universal, first-dollar coverage increased prescription contraception use and prompted shifts to LARC. This suggests that cost is an important contributor to contraception use and method selection at the population level.

Contraception prescribing practices among pharmacists in BC in the first year after scope expansion

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Background and Objectives

In June 2023, British Columbia (BC) pharmacists gained authority to independently prescribe contraception. However, the experiences and perspectives of Canadian pharmacists regarding contraception prescribing are underexplored. The objectives of this study were to 1) understand BC pharmacists' practices, knowledge, and perspectives related to contraception prescribing and 2) identify barriers to contraception prescribing and potential mitigation strategies.

Approach

We conducted a cross-sectional survey of pharmacists practicing in community and primary care settings across BC (June-August 2024). We summarized contraception prescribing practices, perspectives, barriers and facilitators, and personal and professional demographics using descriptive statistics. We validated participants' professional status as pharmacists using a knowledge check survey question and cross-referencing participants' full names with the College of Pharmacist of British Columbia's public registry. Incomplete surveys (n=333), responses from hospital pharmacists (n=89), duplicate responses (n=31), and responses from unvalidated individuals (n=24) were excluded from this analysis.

Results

918 complete responses from validated community or primary care pharmacists were retained. Most respondents reported prescribing emergency (91.7%) and oral contraceptives (83.8%). Two thirds reported prescribing patches/rings (66.8%), and half (57.1%) prescribed injectable contraceptives. In contrast, prescribing long-acting reversible contraceptives (LARC), the most effective methods, was less frequent: less than half (42.3%) reported prescribing intrauterine devices and less than one third (30.0%) reported prescribing subdermal implants. Two thirds (63.0%) reported greater comfort prescribing non-LARC vs LARC methods. Among participants who did not prescribe LARC, the most frequently reported reason was the need for additional training and support (58.3%). Among all respondents, the potential barriers to contraception prescribing ranked "important" or "very important" were inadequate compensation (90.2%), need for additional education/training (75.8%), and liability concerns (74.1%).

Conclusion

This study describes BC pharmacists' experiences over the initial year of autonomous contraception prescribing. These findings can inform professional development for pharmacists, guide policy discussions on structural barriers and supports, and identify opportunities to enhance pharmacists' roles in improving contraception access and supporting reproductive public health.

The Canadian Palliative Care Atlas: The Alberta, British Columbia and Ontario Editions

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Background and Objectives

Palliative care atlases map the status of palliative care across different internationally-identified standardized domains and indicators, including policy, funding, infrastructure, services across different settings, resources, education, and focused populations. Atlases help identify successes and gaps across the indicators and inform policy and service development, ongoing quality improvements, and resource allocation. Starting with three provinces, British Columbia, Alberta, and Ontario, this large study aims to develop the first Canadian Atlas of Palliative Care.

Approach

International domains and indicators were adapted to the Canadian context and mapped at three levels: a) Federal, b) Provincial/Territorial, and c) Regional. A mixed-methods approach was used, including: 1) review of publicly-available information; 2) surveys to provincial and regional healthcare leaders and educators; 3) key informant interviews; 4) focus groups with health leaders and frontline clinicians; and 5) final verification by palliative care leaders. The study was approved by Research Ethics Boards. Surveys were completed online and data across the other sources were extracted using standardized data collection forms and field notes. Qualitative analyses were by research team consensus.

Results

All three provinces have strategic plans to advance and coordinate palliative care and there is partial public funding for medications, hospice, and home-based care with workforce, funding, and geographic challenges to access homecare in rural/remote regions. Most urban centres have access to specialist palliative care with primarily virtual support in rural regions. In Ontario and Alberta, there are regions with no specialist support and one region in British Columbia with minimal access. In Alberta, there are generally high levels of primary palliative care, while in British Columbia and Ontario it varies significantly across regions. In all three provinces, the number and adequacy of palliative care and hospice beds varies. Pediatric palliative care services are limited to major urban centres with virtual care outside these regions.

Conclusion

While there is excellence across indicators, considerable variability across provinces and regions exist. These atlases identified areas for celebration and for improvement that can guide health care leaders, planners and policymakers. This includes improving access to specialist-level palliative care services and strengthening of primary-level palliative care across care settings.

ID: 35118

Presented by: Saima Hirani

Parenting women's insights for mental health support: Recommendations to healthcare providers

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Background and Objectives

Women's mental health is often compounded by its association with their children's health. Research shows a positive role of social support in promoting maternal mental health. However, in order to determine the effect of mental health support interventions, it is essential to assess the perceived support of mothers. Our study aimed to better understand mothers' perceptions of their existing healthcare support while accessing care for their own and their children's mental health.

Approach

We recruited a diverse group of 24 mothers and pregnant mothers who self-identified as women and living in British Columbia (BC), Canada. Participants were recruited through our community collaborator, a community organization working for mothers' mental health in BC. We conducted two 90-minute virtual focus group discussions (FGDs) using a semi-structured guide. FGDs were audio-recorded, transcribed and analyzed using inductive coding, in accordance with a thematic analysis.

Results

Our findings revealed five key themes: i) lived realities of motherhood, ii) types of social support women access, iii) barriers while accessing support, iv) impact of the pandemic on support services; and v) women's recommendations to improve mental health support services. Our findings explain that mothers living in vulnerable situations and navigating health care services face a myriad of individual, social, and systemic barriers. The findings also inform an inclusive approach and a need for mothers-oriented tailored interventions that focus on enhancing women's awareness and accessibility, and the efficacy of these resources for mothers' and their families' well-being.

Conclusion

Our findings bring mothers' voices to healthcare providers to inspire change for improving the quality of interventions that not only improve mothers' mental health but their children too. The findings also inform future research to focus on co-designing customized interventions that align with mothers' mental health needs, so their mental health can be protected and promoted.

ID: 35672

Presented by: Mabel Ho

The changing characteristics of long-term care residents across Canada between 2019 and 2023

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Background and Objectives

The long-term care (LTC) population is diverse and has changed over time, recently and largely due to the COVID-19 pandemic. However, the changes in the composition of residents in LTC have not been examined at the population level. This study examines residents' age composition and health conditions before, at the peak, and following the pandemic. By understanding the emerging and changing trends, we can provide better care with and for people living and working in LTC.

Approach

Using publicly available Continuing Care Reporting System (CCRS) data, LTC residents' demographics, clinical and functional characteristics, treatments and medications, and resource utilization from Alberta (AB), British Columbia (BC), Manitoba (MB), Newfoundland and Labrador (NL), New Brunswick (NB), Ontario (ON), Saskatchewan (SK), and Yukon (YT) were studied. By tracking and analyzing the emerging and changing trends over time, this study aims to answer the following research questions:

1. What were the annual changes in the characteristics of LTC residents across Canada between 2019 and 2023?
2. How did the changes differ across provinces and territories?

Results

Although there was a 16.0% decrease in the number of residents reported in 2020 (189,662 residents in 2019, 159,284 residents in 2020), it gradually returned to 189,285 residents in 2023. There was a notable increase (+1.3% to +7.4%) in residents aged 75 to 84 and a decrease in those aged 85 and older (-2.8% to -6.5%). In terms of the prevalence of diseases, there was increasing anxiety (+0.9% to +3.1% from 2019-2023 across most jurisdictions, except in SK and YT), bipolar disorder (+0.1% to +0.5%, except in BC and YT), and schizophrenia (+0.1% to +0.8%, except in BC, NB, and SK), and a decrease in congestive heart failure (-0.7% to -4.7%), dementia (-1% to -3.8%, except in NL and YT), and stroke (-0.2% to -5.3%) compared to the pre-COVID-19 era.

Conclusion

The observed changes in residents' age composition and health conditions demonstrate that residents are slightly younger and have different care needs than previous resident cohorts. Implications related to funding, care provision, infection prevention and control, public health support, training, staffing, and research directions will be discussed.

ID: 35464

Presented by: Mary Rita Holland

Do structural inequalities lead to HC clients receiving less support when a caregiver is present?

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Background and Objectives

The public home care system in Canada is reliant on family/friend caregivers to enable clients to stay in the community. When caregivers are present, there are concerns that formal home care aide (HCA) services are less available. Using a critical ecological framework, we investigate what factors contribute to underservice for clients receiving informal care in Winnipeg and Nova Scotia.

Approach

Using data from the Resident Assessment Instrument for Home Care (RAI-HC), we examined caregiver and client characteristics in relation to HCA service amounts. Our cohorts were individuals aged 60+ receiving an initial RAI-HC assessment in 2011-2013, and one subsequent assessment in two provincial jurisdictions: the Winnipeg Regional Health Authority (n=5,251) and Nova Scotia Health (n=5291). We measured weekly HCA hours and constructed a predictive model for hours of care controlling for client need. To identify the most underserved client population, we calculated the ratio between predicted to actual received hours of care ascertaining the lowest client quintile.

Results

In both jurisdictions, the adjusted odds of being underserved were higher when the client co-resided or had a spouse. Clients living alone at initial intake were least likely to be underserved. Caregiver characteristics increasing the risk of being underserved in Winnipeg included providing IADLs/ADLs support, caring more than 14 hours per week and being unable to continue. Rurality increased risk of underservice in Nova Scotia. Caregivers in both Nova Scotia and Winnipeg also provided more informal care when the care recipient was living with dementia, suggesting higher caregiver burden.

Conclusion

While clients living alone might benefit most from formal home care services, it is nevertheless important to understand the extent to which the historical and cultural traditions of providing care at home might influence the overreliance on informal care. Our findings suggest that underservice for clients with informal caregivers perpetuates gaps in equity and health.

Establishing Definitions and Indications of Integrated Palliative Care Across Subspecialties.

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Background and Objectives

To meet population needs, a palliative approach to care must be integrated across the system with basic care provided by all relevant medical specialties. The goal of this research is to describe the extent to which a palliative approach is occurring, using health administrative data. As a first step, we are exploring whether current definitions and algorithms for health administrative data reflect such patient populations and health system characteristics of integrated palliative care.

Approach

To better understand specific elements of integrated care, and index health events which may trigger a palliative approach to care, key informant interviews and expert consultations will be conducted with primary care and palliative care healthcare professionals, subspecialist physicians, and knowledge users. We will present disease definitions and approaches to describing care using administrative data to seek feedback on their representativeness of integrated palliative care and whether specific physician and patient populations are characterized appropriately. We will analyze the content of conversations to summarize advice on how to identify relevant patient populations and care patterns for different specialties.

Results

We anticipate healthcare providers and knowledge users will help refine our analysis and interpretation of results. This will include characterizing appropriate patients (e.g. those with an indicator of disease progression) and providers (e.g. cardiologists with a focus on heart failure, comprehensive family physician for an older population), where a palliative approach to care would be applicable. Given it is difficult to prognosticate end-of-life trajectories for some conditions, key index health events and treatments will be identified. Medications and diagnostics that could signal a shift to conservative or palliative approach will also be queried. We also anticipate some limitations to identifying a palliative approach in health administrative data and will better understand the implications via narrative inquiry and feedback.

Conclusion

Indicators of a palliative approach need further development if health system performance is to be measured. This preparatory phase of the study will enable optimal use of health administrative data, understand limitations and ultimately create knowledge products that have the potential to influence primary care and specialist health professional organizations.

Bereaved caregivers' perceptions of patterns of continuity and discontinuity of care at end of life

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Background and Objectives

Continuity of care (CoC) is integral to patient health outcomes and experiences. Approaches to measure CoC are underdeveloped for the end-of-life (EoL) context, yet important for understanding the quality of EoL care. Our objectives were to elicit perceptions and experiences of bereaved caregivers with respect to CoC at EoL, and explore how patterns of healthcare provider involvement impacted EoL outcomes. This qualitative study comprised phase three of a four-phase mixed methods project.

Approach

We conducted semi-structured interviews with bereaved caregivers with experience caring for a patient at EoL. We explored patients' EoL CoC experiences, alongside participants' own desired EoL experiences. Participants reviewed findings from earlier project phases (population-level cohort study/participatory installation) and reflected on the alignment of those findings with patients' experiences and/or their desired experiences. We probed participants regarding ideal care models for CoC at EoL and elicited suggestions to achieve desired models. We recorded/transcribed the interviews, and analyzed them using grounded theory as developed by Corbin and Strauss. To ensure coding reliability, we group-, consensus-, and double-coded transcripts.

Results

Analysis is ongoing and we anticipate having a fully refined theory to present at CAHSPR. Our emerging theory centres around the core phenomenon of patterns of CoC and discontinuity of care at EoL. In line with the Corbin and Strauss method, we are finalizing causes of the phenomenon, strategies, contextual/intervening conditions (i.e., factors that influence strategies), and consequences from using the strategies. Causes include health-human resource shortages, siloed healthcare systems, and healthcare provider coordination. Strategies include aligning care with cultural and/or religious considerations, identifying a single point of contact, and appropriate information delivery. Conditions include capacity-feasibility tensions and resource richness. Consequences include high-quality consistent care delivery, comprehensive care delivery, and patients/family caregivers feeling prepared for next steps in care.

Conclusion

We will triangulate our qualitative findings with the other project phases to further refine and enhance our holistic, comprehensive theory of CoC. We intend to employ this theory to inform development of quality indicators and provide the basis upon which the quality of EoL care can be advanced.

ID: 35324

Presented by: Michelle Howard

Primary care for depression during the COVID-19 pandemic in Canada: a retrospective cohort study.

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Background and Objectives

Depression is common in Canada, with a lifetime prevalence of 14% among primary care patients, and treatment is primarily managed in primary care. During the initial months of the SARS-CoV-pandemic, overall contact with primary care declined while mental health stressors increased. This study compares primary care patterns for patients diagnosed with depression early in the pandemic to those diagnosed pre-pandemic and measures the association between timing of diagnosis and care patterns.

Approach

We conducted a quasi-experimental retrospective cohort study using electronic medical record data from the Canadian Primary Care Sentinel Surveillance Network. Patients with a validated case definition for depression between 2018 and 2021 were categorized into groups representing different waves of the early pandemic. Encounters with primary care, overall psychotropic prescriptions and selective serotonin reuptake inhibitor (SSRI) prescriptions were measured within 3-months and 12-months of diagnosis. We conducted multivariable negative binomial regression with a log-link function to measure the association between patients' depression diagnosis timing and mental health care within 3- and 12-months of diagnosis, adjusted for demographic and clinical characteristics.

Results

91,453 patients with depression were identified, of whom 53% were diagnosed pre-pandemic. Patients diagnosed during the pandemic were younger and less comorbid than those with pre-pandemic diagnoses. The percentages of patients with any encounter, psychotropic prescriptions and SSRI prescriptions were higher for patients diagnosed during each pandemic period compared to patients diagnosed pre-pandemic. After adjusting for patient characteristics, the incidence rate ratios (IRR) of the number of encounters (IRR=1.15; 95% CI 1.13-1.17), psychotropics (IRR=1.11, 95% CI 1.09-1.13) and SSRIs prescribed (IRR=1.12; 95% CI=1.10-1.15) within 3-months of diagnosis, were higher amongst patients diagnosed during the first wave the pandemic compared to the those diagnosed pre-pandemic. Sociodemographic characteristics had weaker associations with outcomes compared to timing of diagnosis. Results were similar within 12-months of diagnosis.

Conclusion

Primary care for depression was maintained during the pandemic despite challenging circumstances and access was relatively equitable for patients across demographic characteristics. Our findings highlight the Canadian primary care systems' adaptability during the pandemic and the importance of maintaining access to comprehensive care during times of intense pressure.

Policy impacts and recommendations for enhancing health data interoperability

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Background and Objectives

Health information legislation is outdated in many Canadian provinces/territories, which hinders true data interoperability (i.e., bidirectional flow of patient health information between care settings). Alberta introduced its Health Information Act in 2001, prior to widespread digital health technology, but is in the process of revising it. Our team assessed legislative and policy-related barriers and facilitators to achieving health data interoperability in order to develop recommendations for governments, technology vendors, providers and key organizations.

Approach

Multiple approaches were used, including conducting semi-structured interviews with experts from key organizations across Canada (e.g., health ministries, medical associations, national standards organizations) to identify barriers to health data interoperability and suggestions for overcoming these challenges. We also completed a legislation/policy scan to understand where health information policies in Canada align/differ and examined legislation in other countries where high quality interoperability has been achieved. From this, we identified overarching themes and drafted recommendations to inform policy and legislative changes that will enhance health data interoperability and contribute to improved patient care and safety in the healthcare system.

Results

Twelve virtual interviews were conducted. The interview results and legislation/policy scan collectively produced twelve themes that identified specific areas for optimizing health data interoperability. This included reimagining the custodial model, collective data governance, delegated data responsibilities, Indigenous data sovereignty, team-based care, patient rights, process efficiencies, health data ecosystems, innovation, technical interoperability, policy harmonization and overarching accountabilities. Our presentation will discuss these themes in more detail, as well as outline tangible steps that governments, policymakers and technology vendors can take to improve health data interoperability in Canada. We are publishing these findings in a report that will be publicly available and disseminated across Canada in spring 2025.

Conclusion

Improving health data interoperability is a complex issue requiring a multi-sectoral approach. This work aims to enhance interoperability by addressing legislative, technological and human factor barriers, and is intended as a roadmap to be used by any province/territory wishing to support better interoperability through legislative change.

ID: 35234

Presented by: Liudmila Husak

Patterns in mental health care for children and youth

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Background and Objectives

Mental health is a significant concern for Canada's children and youth. An estimated 10-20% may develop a mental disorder. This analysis examines trends and patterns in hospitalizations, emergency department (ED) visits and physician visits by children and youth in Canada from 2018 to 2023.

Approach

Using clinical administrative databases from the Canadian Institute for Health Information (CIHI), we calculated rates of hospitalizations, ED visits, and physician visits per 100,000 children and youth 5-24 years of age. We examined trends by age, sex and patient neighbourhood income quintile.

Results

There were noticeable differences in the rates of hospital care and physician visits by sex, age and neighborhood income quintile. In particular, females between 15 and 17 years of age had the highest rates of ED visits and hospitalizations compared to males and females of other age groups. They most frequently visited ED or were hospitalized for mood disorders, trauma and stressor related disorders, and anxiety disorders.

Children and youth residing in the lowest income neighborhoods had almost twice the rate of hospitalizations compared with those residing in the highest income neighborhoods. However, children and youth from the lowest income neighborhoods had the lowest rates of physician visits, potentially suggesting difficulties with accessing mental health services in the community.

Conclusion

As jurisdictions implement various programs and initiatives to address children and youth mental health disorders, the results of our analysis will help to understand the emerging trends and patterns in healthcare use and access, as well as to target services to children and youth most in need.

ID: 35308

Presented by: Dina Idriss-Wheeler

How Intimate Partner Violence shaped access to formal and informal supports during COVID19 lockdowns

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Background and Objectives

The COVID-19 lockdown measures implemented in Ontario, Canada, led to widespread economic impacts, isolation, reduced availability of social and health supports, and increased instances and severity of intimate partner violence (IPV). This study investigated the association between experiences of IPV and barriers to accessing both formal services (i.e., healthcare, transportation, counselling, addictions) and informal supports (i.e., family, friends) during the lockdowns, comparing individuals who experienced IPV to those who did not.

Approach

This quantitative cross-sectional study included Ontario residents (aged 18+) who were in an adult relationship during COVID-19 lockdowns. Data were collected through a structured online survey that gathered information about reported barriers to formal supports, changes in communication (increased/decreased/no change) with informal supports, and sociodemographic factors. Key variables included experience of IPV and barriers to service access. Descriptive statistics and multivariate logistic regression were used to compare IPV survivors and non-survivors and to identify predictors of barriers to formal and informal supports, including key confounders and covariates (i.e., socioeconomic status, geography perceived health, caregiving roles and substance use).

Results

Nearly one in four participants (23.4%) reported experiencing IPV during COVID-19 lockdowns in Ontario. Among those seeking services, the IPV group consistently reported more barriers compared to the non-IPV group across key areas such as healthcare, mental health, transportation, housing, and counseling. The IPV group was also more likely to report decreased communication with friends and family, highlighting additional challenges in accessing informal supports. Multivariate analysis revealed that having experienced IPV, lower income, and being a caregiving were significant predictors of barriers to formal supports. Furthermore, reduced informal support was associated with IPV, poorer physical and mental health, and substance use. These findings emphasize the compounded difficulties faced by the IPV group in accessing both formal services and informal networks during the pandemic.

Conclusion

Findings illustrate how macro level structural factors, such as COVID-19 lockdown mandates, disproportionately and negatively affected IPV survivors. During public health emergencies or disasters, it is important to ensure that marginalized and isolated communities, such as IPV survivors, are proactively prioritized in emergency planning, management and recovery.

ID: 35303

Presented by: Sameer Imtiaz

The Impact of Decriminalization of Illegal Drugs on Drug Poisonings in British Columbia, Canada

Author: Sameer Imtiaz

Background and Objectives

Canada is in the midst of a public health crisis featuring escalating drug poisonings. Decriminalization of personal possession of select illegal drugs was implemented in British Columbia, Canada on January 31, 2023 as one element of a public health response to reduce the drug-related harms. We evaluated the short-term impacts of decriminalization on paramedic responses to opioid poisonings and drug poisoning deaths to detect if there were early signals of change.

Approach

We sourced population-based monthly counts of drug poisonings from the provincial emergency services provider and coroners service to compute total and sex-specific age-standardized rates per 100,000 (January 2015-December 2023). Generalized additive models in an interrupted time series design were used to evaluate the short-term impacts of decriminalization on rates of paramedic responses to opioid poisonings and drug poisoning deaths while adjusting for the unemployment rate. Both immediate effects (i.e. upshift or downshift in the levels of drug poisonings that occurred immediately in the month post-decriminalization) and trend changes (i.e. changes in slope of drug poisonings that occurred post-decriminalization) were considered.

Results

The rate of paramedic responses to opioid poisonings increased prior to the onset of decriminalization. Decriminalization was not associated with an immediate effect (β [95% CI]: 0.109 [-0.234, 0.452]) or trend change (β [95% CI]: -0.018 [-0.051, 0.015]) in the rate of paramedic responses to opioid poisonings. Unemployment rate was not associated with the rate of paramedic responses to opioid poisonings. Similarly, the rate of drug poisoning deaths increased prior to the onset of decriminalization.

Decriminalization was not associated with an immediate effect (β [95% CI]: -0.221 [-0.583, 0.141]) or trend change (β [95% CI]: -0.017 [-0.052, 0.018]) in the rate of drug poisoning deaths. Unemployment rate was positively associated with the rate of drug poisoning deaths. These findings were consistent after stratification by sex.

Conclusion

Decriminalization of personal possession of illegal drugs was not associated with significant changes in drug poisonings in the first eleven months of its implementation in British Columbia. However, the direction of effects was encouraging from a public health standpoint.

ID: 35197

Presented by: Alyssa Indar

A Provincial Realist Evaluation of Internationally Educated Nurse (IEN) Integration in Nova Scotia

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Background and Objectives

Across Canada, the recruitment and retention of internationally educated nurses (IENs) has been implemented as a viable strategy to address critical nursing workforce shortages. In 2022, Nova Scotia (NS) developed the NICHE program to support IEN recruitment and integration into the NS healthcare system and community (NSH, 2022). The NICHE program is a hub that connects system actors within practice, policy, and education with shared interests in supporting IEN integration.

Approach

We used a realist evaluation approach to examine the integration of IENs into the NS healthcare system and community (Pawson & Tilley, 1997). Perspectives were elicited from IENs and individuals supporting IEN integration at macro-, meso- and micro-levels. Our participants included the NICHE program leadership [macro-level]; organizational leaders, managers and administrators [meso-level]; and IENs from a variety of cohorts [micro-level]. We conducted interviews with 26 individuals and collected a variety of program documents, pertaining to the planning, implementation and evaluation phases of this initiative. Data were analyzed inductively and organized using the realist evaluation constructs of context, mechanism and outcome.

Results

From the interview and document data, we constructed themes related to (1) the IEN experiences of transition – inclusive of workplace integration and community integration, (2) the organizational factors that support or hinder a “successful” transition into the workplace, and (3) the system-level factors that prime workplace and community environments to support IEN integration. A key finding from this work is the high degree of intersectoral collaboration required by influential stakeholders such as high-level leadership from the sectors of healthcare, provincial government, immigration, and community/housing support to successfully support IEN integration into the healthcare workforce and local communities.

Conclusion

The findings will inform the provincial Nursing Workforce Strategy and provide strategies to better facilitate IEN integration into the Nova Scotia healthcare system and communities. This work may be of interest to decision-makers seeking to improve their programs to support IENs, particularly in ways that address workforce retention.

Perspectives on Pharmacist-Physiotherapist Collaboration for Acute Musculoskeletal Injuries

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Background and Objectives

Acute musculoskeletal (MSK) injuries are prevalent, with many patients experiencing challenges in accessing timely primary care. Barriers surrounding access often lead patients to seek support from community pharmacists or physiotherapists. This study aimed to evaluate the perspectives of patients and healthcare providers on a collaborative practice framework between pharmacists and physiotherapists to enhance equitable access to MSK care by optimising and aligning scopes of practice.

Approach

This qualitative study involved two rounds of semi-structured focus groups. Patient focus groups explored patients' experiences and expectations of a collaborative MSK care model. Separate focus groups with pharmacists (RPhs) and physiotherapists (PTs) examined their current practices, views on collaboration, and the feasibility of implementation. Data was analysed deductively using the APEASE criteria (Affordability, Practicability, Effectiveness, Acceptability, Safety, and Equity) to evaluate the intervention design. An inductive analysis was then conducted to identify key themes and framework components.

Results

All participant groups indicated strong support for a collaborative framework, identifying reduced emergency department utilization and expedited access to care as potential benefits. Recommendations included: implementing the framework in community pharmacy clinics (RPhs) and mobile clinics (patients), and utilizing virtual care platforms (RPhs, patients) to enhance accessibility, particularly in underserved rural areas. Identified barriers and potential solutions included: lack of understanding of each professional's scope of practice requiring educational materials to clarify (RPhs, PTs); lack of seamless communication requiring secure, electronic communication tools (RPhs, PTs); privacy concerns in pharmacy settings requiring private consultation rooms (patients), physician referral requirement for physiotherapy necessitating education around when referrals are not required/eliminating referral requirements (PTs, patients), and financial concerns around physiotherapy requiring funding changes (PTs, patients).

Conclusion

This study provides support for a pharmacist-physiotherapist collaborative framework to address gaps in primary care for acute MSK injuries. The findings indicate that collaboration has the potential to enhance access, reduce system strain, and improve patient outcomes while offering actionable strategies for implementation that may improve equitable access to care.

ID: 35174

Presented by: Jennifer E. Isenor

Patient Perceptions of Pharmacist-Led Primary Care

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Background and Objectives

Pharmacists play an important role in delivering primary care (e.g., prescribing, immunization), but there is limited understanding of how this care impacts patient experiences and outcomes. Existing literature focuses on patient willingness to seek care from pharmacists and their satisfaction with the care received. This study aims to identify and describe the patient-reported experience and outcome measures that matter most to patients when receiving pharmacist-led primary care.

Approach

A qualitative study design, using virtual interviews and focus groups, was carried out with diverse populations who received clinical care from a pharmacist or pharmacy primary care clinic in Atlantic Canada in the last year. Interviews aimed to understand experiences with pharmacist-led care, the perceived value of care, other primary care services patients would like from pharmacists, and to identify outcome measures that are most important. An inductive thematic analysis was carried out to identify themes, which were further refined through focus groups.

Results

Findings from interviews (n = 8) identified six main themes: access to care (e.g., accessibility, cost), clarity and consistency of experience (e.g., types of services offered, role clarity), coordination of care (e.g., navigating the healthcare system, follow-ups), medication expertise and accuracy (e.g., thoroughness, problem-solving), connection and trust (e.g., friendly, attentive), and primary care delivery (e.g., one-stop shop). Focus group (n = 5) findings supported interview themes, and introduced new perspectives on accessing care for children and rural experiences. Participants in rural areas reported needing to travel for various services or risk facing longer wait times compared to urban participants who described having many pharmacies in close proximity. Concerns were also raised about broadening pharmacists' scope without providing additional system support.

Conclusion

Centering primary care reform around patient experiences and outcomes ensures that health system transformation responds to patient needs. Findings suggest there are several dimensions of quality that policymakers should consider in primary care redesign. This work will generate frameworks and tools to assess pharmacist-led primary care and improve patient experience.

Exploring conceptualizations of impact in patient partnership from the patient partner perspective

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Background and Objectives

As the patient partner role, described as the longitudinal and bi-directional involvement of patients, becomes more commonplace in health system organizations, understanding the impacts of this role is imperative. This study aims to understand how patient partners conceptualize and aspire to achieve impact through their partnership work, as well as to identify social and organizational factors that may facilitate these impacts.

Approach

We used interpretive description methodology to conduct semi-structured interviews with 35 patient partners working with health system organizations across Canada. Eligible participants self-identified as a patient, family member, or caregiver with over two years of experience partnering with a Canadian health system organization. Participants were recruited through a previous survey, newsletter advertisements, and the team's network. This analysis focused on interview data describing how respondents conceptualize and aspire to achieve impact. Analysis was iterative with data collection, involving staged coding and the development of a thematic template consisting of themes and sub-themes.

Results

Participants conceptualized the impacts of their involvement in both tangible and intangible ways. Tangible impacts included structural changes within the organization such as increased inclusion of patient partners and engagement staff, or products resulting from their work. Intangible outcomes involved positive sentiments attributed to sharing their experience, feeling valued and heard by their organization, and greater enthusiasm for engagement efforts. Impact was not always experienced; participants frequently mentioned feeling that their engagement resulted in no change. Various organizational supports were noted as essential facilitators of impact, such as onboarding and discussion of the patient partner role, effective collaboration with staff, and having dedicated engagement personnel. Regarding aspirational impacts, participants hoped their work would influence policy or system changes and improve engagement processes and structures.

Conclusion

Patient partners conceptualized their impact in multiple ways and commonly discussed impacts in relation to their personal work within their organization, whereas broader system and policy change were discussed as aspirational impacts. By recognizing the ways patient partners perceive and strive for impact, organizations can optimize impactful partnership work.

ID: 34622

Presented by: Liisa Jaakkimainen

Using natural language processing on free-text notes found in family medicine EMRs for research

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Background and Objectives

Information about care provided by family physicians (FPs) is available in their electronic medical records (EMRs). FP EMRs contain many non-structured free-text notes and this challenges its use for research and quality improvement. Our objective was to assess the feasibility of using natural language processing (NLP) on FP EMR notes to identify 1) the index date for abnormal results amongst cancer patients and 2) develop an algorithm to identify patients living with chronic pain.

Approach

The study cohort was a convenience sample of 385 FPs across Ontario, who consented to have their EMR linked to health administrative data. In prior studies we had a trained abstractor review the entire EMR to identify 1) the index date for patients having colon, endometrial, bladder or melanoma cancers which represented the first indication of an abnormal symptom, sign or radiological result found in their FPs EMR (results below) and 2) to identify patients living with chronic pain. Transformer models were trained using progress notes, consults and referrals in the FP EMR using the labels identified by the abstractor.

Results

For NLP model training, EMRs not identified as containing any reference to cancer signs or symptoms were matched to EMRs which did contain the abstracted labels (10%) by age, sex, and contained the same proportions of progress notes, referrals and consults (90%). 30% of each dataset was used as a test set to evaluate the models and 70% used for training. 20% of the training set was used as a validation. ClinicalBERT was best model for bladder (precision 0.73, recall 0.94, F1 0.82 and accuracy 0.96), colon (precision 0.72, recall 0.74, F1 0.73 and accuracy 0.94) and melanoma cancers (precision 0.87, recall 0.93, F1 0.90 and accuracy 0.98). Longformer was the best model for endometrial cancer (precision 0.68, recall 0.85, F1 0.75 and accuracy 0.95).

Conclusion

The NLP models used existing FP EMR data and had reasonable precision and recall in identifying cancer index dates and chronic pain patients. Since these models were trained on small datasets and tested on an internal test set, next steps will be to evaluate them on external FP EMR data.

Leveraging Artificial Intelligence for Early Identification of High-Risk Events in Long-Term Care

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Background and Objectives

Long-term care (LTC) residents with cognitive impairment are at greater risk of falls and often exhibit responsive behaviours (e.g., wandering/aggression) leading to complications/hospitalizations. In Canada, 60% of these hospital admissions are avoidable, costing \$3.4 billion annually (Barker et al., 2018). We present a case study on the implementation and evaluation of an Artificial Intelligence (AI) powered technology (Esprit-AI) that uses pressure-sensing mats and motion sensors to predict and early notify LTC staff of high-risk situations.

Approach

Guided by the Implementation Roadmap (Harrison & Graham, 2021), a systematic implementation approach for Esprit-AI was employed on one unit (20 beds, residents with mid-late stage dementia) over an 8-month period (i.e., February-October 2024). Staff (i.e., personal support workers and nurses) training occurred over two weeks (10 sessions). Pre-post design was used to survey staff (n=26) ([1-5 Likert scale]; 1=strongly disagree, 5=strongly agree) before and 12-weeks post implementation. Secondary data collected in Esprit-AI (e.g., sleep patterns, resident elopement events, within room motion, bed exiting, etc.) will be collected to analyze how Esprit-AI impacts residents' care. Post-implementation data collection is underway.

Results

The implementation stage necessitated considerable changes to the physical and work environment (e.g., installing computer monitors and sensors, adjusting workflows, etc.). Pre-implementation, staff perceived Esprit-AI would be easy to use and useful in identifying high-risk situations and providing clinical insight (median=5 on all questions). Eight weeks post-implementation, 2658 resident elopement alerts occurred (835 high-risk), enabling staff to timely intervene and prevent adverse events which may have otherwise not been detected. The facilitators to the technology implementation/use included the collaborative relationship with the vendor (e.g., providing implementation support) and availability of funding (e.g., technology purchasing, project manager to support implementation, etc.). Barriers included existing technical infrastructure (e.g., upgrades to the call bell system) and interoperability constraints (e.g., issues integrating with other technologies).

Conclusion

This case demonstrates that AI-powered technology may help address challenges related to timely health services delivery that can impact resident safety and quality of care. In the absence of evidence on AI technology implementation approaches in LTC, it serves as a benchmark for other LTC homes to guide future implementations.

ID: 34282

Presented by: Mirou Jaana & Bobby Gheorghiu

The Interoperability Landscape in Canada: Clinicians' Insights and Implications for Practice

Author: *Gheorghiu, Bobby*

Background and Objectives

Clinicians, health care organizations and governments have significantly invested in innovative technologies supporting digitally enabled health services. As digital transformation progresses, interoperability is crucial for clinical decision-making, care coordination, and improved patient experiences. However, it remains a complex construct to evaluate with a scarcity of information on its state. This research assesses Canada's progress toward interoperability across two domains: clinician point-of-care systems use; and use of digital tools for clinical communication/patient information sharing.

Approach

Two nation-wide cross-sectional surveys (i.e., 2023 Canadian Survey of Nurses, 2024 National Survey of Canadian Physicians) were used as secondary data sources. These surveys were conducted by a third-party market research firm (French/English) using multi-method promotion/recruitment strategies and web-based panels. A total of 1,145 physicians, and 1,907 nurses completed the population-specific surveys (weighting by region, age, and gender was applied for representation of the respective /clinician populations). Relevant questions on systems uses and attitudinal variables related to the two domains considered were extracted and analyzed to quantitatively assess the current state of interoperability.

Results

Most physicians (95%) and nurses (90%) use electronic medical records (EMR) for patient documentation, but patient information sharing outside their practice is limited. While most have access to patients' medication summaries and diagnostic tests (e.g., provincial repositories), only 29% and 24% of them, respectively, can exchange patient summaries (e.g., medical history/health condition summary) across care settings. They spend on average 86 and 60 minutes/day searching for necessary patient information. Physicians spend on average 107 minutes/day on EMR after hours, and nearly half showed symptoms/reported burnout. 66% of nurses reported dissatisfaction with time spent on non-patient-facing tasks. Both groups (34% of nurses and 73% of physicians) cited lack of integration with/among current systems as a frequent barrier to accessing/optimal use of digital health technologies.

Conclusion

There is continued growth in digital health technologies adoption across the Canadian landscape. Despite the high level of EMR adoption, patient data sharing across care settings (clinical interoperability) remains a challenge and may contribute to inefficiencies and burnout, necessitating further research and broader information technology strategic planning and policy attention.

ID: 32558

Presented by: Olivier Jacques

Assessing Public Demand for Mental Health Insurance: The Role of Self-Interest and Ideology

Author: *Gosselin, Gabriel*

Background and Objectives

Despite the spike in mental health disorders since the disruptions caused by the pandemic, most OECD countries are still lacking a comprehensive public coverage of mental health care. We study if a lack of public demand represents one of the reasons explaining the absence of public mental health insurance programs. There are few studies of public preferences for the expansion of public coverage for mental health care in a context of fiscal trade-offs.

Approach

Previous studies have shown that stigma against mental health disorders is associated with weaker support for public spending on mental health. However, most previous studies do not analyze the interplay of self-interest and ideology to explain individuals' willingness to pay for the expansion of public coverage for mental health. We rely on an original survey conducted with a representative sample of the Quebec population that will be conducted in February 2025. We use survey experiments to analyze individuals' priorities regarding the expansion of the public health insurance coverage to mental health and their willingness to pay for psychological insurance.

Results

We hypothesize that support for the extension of mental health insurance is relatively weak in Quebec, particularly among the constituencies of the governing party. This is because the groups whose self-interest aligns with the expansion of public coverage for mental health care, such as women, those without private insurance and the youth, tend not to vote for the center-right. However, we expect to find that ideology trumps self-interest as respondents on the left of the ideological spectrum support public mental health care regardless of their self-interests to do so. We also expect to find that a relatively large share of the population that exhibit some stigmatization of mental health problems and that stigma is associated with unwillingness to pay for public mental health insurance.

Conclusion

Hence, our study contributes to research by highlighting the role of ideological factors in explaining preference for public mental health care and by mapping the coalition for and against the extension of public insurance.

Meaningful engagement of residents and families in Long-term Care Research: A Co-design Study

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Background and Objectives

Long-term care (LTC) research often lacks meaningful resident and family involvement, despite its crucial role in shaping policies, research, and care. The Centre of Excellence in Frailty-Informed Care™ (CoE) is addressing this gap by co-developing a citizen engagement framework. Using a co-design approach, this project aims to create a framework and associated tools to facilitate meaningful engagement of residents, families, and care partners in LTC research, ultimately enhancing the quality of care and decision-making processes.

Approach

The CoE employed a multi-faceted, co-design approach to develop the framework. This process included a literature review, a nationwide survey of 33 experts, and a one-day "Partnering for Progress" engagement event with 37 stakeholders, including residents, families, researchers, and staff in LTCs. The event focused on identifying what matters most to residents for meaningful engagement in research. In close collaboration with the project advisory committee, data from the phases were thematically synthesized to create a comprehensive framework and guide for meaningful engagement of residents, families, and caregivers in LTC research.

Results

The project resulted in a comprehensive understanding of meaningful engagement in LTC research, highlighting key elements such as barriers to engagement, guiding principles, and engagement strategies for the research process. The study identified eight barriers, such as knowledge gaps and linguistic and cultural considerations. Seven guiding principles were identified to foster meaningful engagement, including accessibility, flexibility, collaboration, open communication, trust, respect, and continuous improvement. The framework outlines effective strategies for engagement, including co-creation in research, multimodal communication, collaborative decision-making, and the creation of supportive environments. This holistic approach ensures diverse perspectives are incorporated throughout the research process. The resulting guide offers practical, actionable strategies for researchers and LTC administrators to facilitate meaningful engagement, ultimately enhancing the quality and relevance of LTC research and care.

Conclusion

This engagement framework marks a significant advancement towards inclusive and effective LTC research in Canada. Aligning with growing trends in healthcare research, it provides practical tools for meaningful engagement. The framework aims to improve future research initiatives, foster collaboration across the LTC sector, and guide implementation in other LTC homes.

ID: 35561

Presented by: Harpreet Jaswal Kieran Quinn

Use of healthcare & homecare services among Ontarians discharged alive from hospital with COVID-19

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Background and Objectives

Patients discharged alive following hospitalization for COVID-19 demonstrate greater health care use and risk for development of new comorbidities. The patterns of this utilization, specifically the types and intensity of home and health service use, are currently unknown. Our objectives were to characterize home care and other healthcare service use for up to one year among survivors of COVID-19 when compared to those with other acute infectious illnesses.

Approach

A matched cohort study was conducted using Ontario population-based administrative data. The propensity-weighted study population included adults discharged following hospitalizations for COVID-19 (HCOVID-19) or sepsis between April 1, 2020 and March 31, 2022, and influenza and sepsis historical cohorts who survived hospitalization between January 1, 2014 and December 13, 2019, with propensity score-based overlap weighting balancing baseline characteristics. The main outcome was homecare utilization, at 30, 90-days, and 1-year post-discharge, expressed as rates and rate ratios (RR) generated through Poisson regression. Secondary measures included mortality, and rates of post-acute inpatient rehabilitation (PARA), emergency department visits, hospitalization, and ambulatory care use.

Results

There were 53,895 people who survived HCOVID-19, 56,842 historical controls (10,596 influenza and 46,246 sepsis), and 93,271 contemporary sepsis (CS) controls. People with COVID-19 were younger (mean age \pm SD 58.46 \pm 18.96 years vs. 66.66 \pm 17.22) and less frail (frailty risk score (9.0+) 5.2% vs. 23.9%) than CS individuals. CS individuals had more homecare visits, but intensity and duration of different visit types for the COVID-19 cohort were comparable. HCOVID-19 was significantly associated with increased PARA risk compared to all three groups: CS (RR:1.30, 95%CI:1.23-1.36), influenza (RR:2.83, 95%CI:2.32-3.43) and sepsis-historical (RR:3.25, 95%CI:3.013-3.52). The COVID-19 cohort had a comparable level of overall homecare visits (mean total \pm SD 47.73 \pm 106.07 vs 43.48 \pm 97.46), but more visits by different types (e.g., nursing) than influenza.

Conclusion

Adults discharged following HCOVID-19 demonstrated lower overall homecare service utilization than CS individuals, but comparable levels of homecare service intensity (i.e., number of visits and duration) one-year post-discharge. These findings indicate significant disability among COVID-19 survivors, which may necessitate increased resource allocation for multidisciplinary home/healthcare services beyond the post-discharge period.

ID: 35443

Presented by: Aaron Jones

Disruptions in primary care home visits in Ontario: an interrupted time series analysis

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Background and Objectives

Primary care physician home visits are an important service for older adults with difficulty reaching a primary care office. In October 2019, Ontario restricted enhanced payments for home visits. In March 2020, the COVID-19 pandemic disrupted the health care system and led to widespread uptake of virtual primary care. We sought to understand how the rate of home visits for older adults changed in Ontario due to these regulation changes and the COVID-19 pandemic.

Approach

We conducted a population-based interrupted time series analysis using multiple health administrative databases from Ontario between January 2014 and December 2023. We calculated monthly, seasonally-adjusted, age and sex-standardized rates of primary care physician home visits per 10,000 persons aged 65 and older. We used autoregressive, segmented, generalized least squares regression to estimate the change in the level and temporal trend of home visits at the time of the policy change and onset of COVID-19 pandemic. We set the interruption point at the time of the policy change (October 2019) with a washout period until start of the COVID-19 pandemic (April 2020).

Results

The 65 and older population in Ontario increased from 2.1 million in 2014 to 2.7 million in 2023. The age and sex-standardized and seasonally-adjusted monthly rate of home visits per 10,000 older adults varied from a maximum of 106.5 in July 2019 to a minimum of 49.6 in May 2020. Before October 2019, the monthly rate of home visits was increasing at a rate of 0.14 (95% CI: 0.023-0.26) visits per month. Between October 2019 and April 2020 the monthly visit rate dropped by 37.1 visits (30.1, 44.2), or 36.1%, with the majority of the drop occurring during March and April 2020. There was no significant change in the temporal trend and home visit rates remained well below pre-pandemic levels as of the end of 2023.

Conclusion

The rate of primary care physician home visits by older adults in Ontario dropped sharply after the regulation change and the COVID-19 pandemic. This reduction has endured with no significant signs of recovery. Further research should examine the impact of these changes on patient outcomes.

ID: 35170

Presented by: Karolina Kaminska

Reassessing the Assessment: A Scoping Review of Substance Use Severity Assessment in Adolescents

Author: *Kaminska, Karolina, University of Waterloo*

Background and Objectives

Given the high rates of substance use issues in Canadian youth and the lack of access to treatment, improving detection and early identification of at-risk youth is crucial. While various assessment instruments exist, there is limited understanding of how substance use severity should be conceptualized to enhance their effectiveness. This scoping review aims to explore existing methods and constructs for assessing substance use severity in adolescent populations.

Approach

This scoping review employed the JBI Methodology and PRISMA-ScR checklist for rigour and transparency. Systematic searches were conducted in PubMed, CINAHL, and Scopus for peer-reviewed studies, with ProQuest and Google used for grey literature. Inclusion criteria focused on English psychometric literature on instruments measuring substance use severity in youth aged 12 to 21. Data extraction charted tool characteristics, key constructs, and their applications across diverse samples and settings.

Results

Preliminary findings highlight a variety of instruments used to assess substance use severity in youth, showcasing diverse conceptualizations, including multidimensional and unidimensional constructs. These constructs address areas such as substance use patterns, consequences, and psychosocial factors. Psychometric testing indicates which constructs effectively identify at-risk adolescents, though many instruments emphasize detecting severe substance use (e.g., substance use disorder). This suggests a gap in identifying less severe but still potentially harmful substance use, highlighting the need for tools sensitive to early intervention thresholds in addition to diagnosable conditions.

Conclusion

This review provides critical insights into the constructs and methodologies used in assessing substance use severity in youth. Findings can inform the refinement of assessment instruments to ensure their applicability across diverse contexts and populations, contributing to improved early detection, targeted interventions, and better outcomes for adolescents facing substance use challenges.

ID: 35179

Presented by: Karolina Kaminska

Mapping the Optimal Path: Logic Model Co-Design to Enhance Concurrent Disorder Assessment for Youth

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Background and Objectives

Canadian youth with concurrent mental health and substance use disorders face systemic barriers to care due to the complexity of their needs. Comprehensive assessment tools, like the interRAI Child and Youth Mental Health (ChYMH) suite, can address these gaps. This study aims to co-design a logic model for the optimal implementation of the ChYMH suite, providing a visual representation and a stepping stone toward further system improvements and enhancing its impact on the adolescent population.

Approach

This study employs program evaluation, implementation science, and co-design. A logic model is being co-developed with practitioners, administrators, and people with lived experience through a series of interactive workshops to define optimal implementation strategies for the ChYMH suite. These workshops aim to identify key implementation challenges and strategies tailored to diverse service contexts. The study will focus on defining how substance use severity should be integrated into the ChYMH framework to improve assessment practices and ensure more effective interventions for youth with concurrent mental health and substance use disorders.

Results

We expect that co-design sessions will reveal key challenges, such as the need for tailored implementation strategies to address diverse service contexts. We anticipate that the logic model will highlight opportunities for optimizing the integration of substance use severity into the ChYMH suite, helping to improve assessment practices and service delivery. The development of the logic model is expected to guide the implementation of more effective and consistent assessment strategies across service providers, improving the accuracy of identifying youth at risk and ensuring that interventions are timely and aligned with their unique needs.

Conclusion

This study demonstrates how participatory evaluation methods can optimize assessment systems, bridging gaps in care for youth with complex needs. The findings will emphasize the importance of integrating stakeholder perspectives to transform assessment practices, ultimately improving outcomes for youth with concurrent mental health and substance use challenges.

ID: 35636

Presented by: Swati Kanwal

Understanding the Potential of Machine Learning to Improve Telephone Triage Decisions

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Background and Objectives

British Columbia's 8-1-1 telehealth and virtual care service offers patients with urgent health concerns 24/7/365 access to information and advice. With over 100,000 calls every year, machine learning (ML) models could help nurses provide effective and efficient triaging. We applied ML methods to help nurses and physicians triage the urgency of patient's health concerns by rapidly summarizing decades of triage category results from electronic medical records.

Approach

We analyzed 140,000 anonymized caller records from 2020–2024, with logistic regression, random forest, elastic net, and XGBoost models that consider age, sex, nurse problem category and caller symptoms, as predictors of triage categories. Then, we engaged with 811 nurses and physician knowledge users in a learning health system discourse to identify the optimal clinical workflow reviews to integrate the ML model.

Results

Using the decision-tree based XGBoost model achieved the best accuracy, with an F1 score of 0.79, demonstrating its ability to predict triage outcomes. However, its simplicity—relying on basic predictors like age, sex, and symptoms—limits its performance. Feedback from the discourse with nurses, physicians, and policy makers who staff the 811 program highlighted the model's potential as a decision support tool, while indicating a preference for human-in-the-loop ML approaches to support nurses and call navigators in triaging callers with complex needs (i.e. paediatric calls, mental health and substance use concerns) and any safety-enhancing features that may be offered by ML approaches that could rapidly accelerate calls to virtual physicians or emergency departments.

Conclusion

This study demonstrates ML's potential to be used as a decision support tool for the 8-1-1 tele-triage service in British Columbia. The XGBoost model demonstrates satisfactory triage prediction performance and can complement orthogonal data sources such as those from callers spoken text or vital sign sensors.

ID: 35515

Presented by: Sathya Karunanathan

Exploring the use of eConsult to Enhance Pediatric Orofacial Health: A Study Protocol

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Karunanathan, Sathya. *University of Ottawa*

Background and Objectives

Primary care providers (PCPs) such as physicians and nurse practitioners often need to address the dental, mouth, and facial concerns of children. Yet, they may encounter challenges with management or referrals for this population due to limited dental care access. Electronic consultation (eConsult) services offer PCPs timely access to pediatric dentist advice. Our objective is to explore how PCPs have used eConsult to address children's oral health and orofacial conditions in Eastern Ontario.

Approach

This cross-sectional study will include eConsult cases submitted to pediatric dentists in the Champlain BASE™ service closed in 2024. Data collected includes patient demographics, referring PCPs, response time, communication records, and close-out surveys. Two independent dental experts will code eConsults following predefined criteria: i) PCP questions will be categorized using the Taxonomy of Generic Clinical Questions, ii) clinical content of questions will be coded per ICD-11, iii) specialist responses will follow an established Champlain BASE™ taxonomy, and iv) specialist referral recommendations will be classified as immediate, elective, or unnecessary. Descriptive statistics of service utilization and taxonomy results will be generated.

Results

Pediatric dentists joined the eConsult service in July 2019. As of October 31, 2024, PCPs submitted 123 eConsult requests to these specialists. We hypothesize that eConsult utilization increased during the pandemic due to restrictions in traditional in-person dental consultations. We anticipate a gradual increase in eConsult utilization over time as PCPs become more familiar with this resource for obtaining specialist dental advice. Aligning with frequently asked questions at the Canadian Dental Association, we anticipate that the common questions from PCPs are related to the timing of the first dental visit and the safety of using fluoride for children. Detailed findings from this analysis will be discussed at the conference.

Conclusion

This study will provide valuable insights into how eConsult supports PCPs in addressing children's oral health needs. Findings will inform strategies to optimize eConsult utilization, enhance communication between PCPs and specialists, and ultimately improve access to timely and equitable oral health care for children in Ontario.

ID: 35326

Presented by: Mahalekshmi C. Kasiviswanathan

A scoping review of conceptual frameworks on physicians' medical career decision-making

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Background and Objectives

Conceptual frameworks are valuable for organizing existing research, furthering discussions about gaps in knowledge, and deepening our understanding of the relationships between concepts of interest. While there is vast primary research examining determinants of medical career choice, few conceptual frameworks have been developed. The aim of this scoping review is to identify conceptual frameworks and models that summarize factors influencing the decisions of medical students, residents, and physicians when selecting a medical specialty or sub-specialty.

Approach

A search strategy was developed and peer reviewed by a medical information specialist. We included studies that focused on the North American medical education system and incorporated multifactorial conceptual frameworks of the determinants affecting medical trainees' and physicians' specialty choices. Studies that did not focus on allopathic medicine were excluded. A comprehensive search was conducted on August 2, 2024, in several medical and health research databases (e.g., MEDLINE, Embase, PsycINFO, CINAHL, Web of Science, and ProQuest Dissertations & Theses Global). Titles, abstracts, and full-text articles were screened independently by two reviewers, with data charted in Excel and results described narratively.

Results

A total of 5,233 articles were identified, after removing duplicates. Of these, 863 articles were included in full-text screening, and 18 articles met the eligibility criteria and are qualified for data extraction. Identified domains in choosing a medical specialty include student and medical school characteristics, attitude towards specialty, specialty profile, personal values, and career needs. Within these domains, some factors will act as general facilitators or barriers influencing specialty choice across all medical fields, while others will serve as specific determinants unique to specialties. Identifying these specific factors can inform targeted strategies to improve recruitment and address workforce shortages in those areas.

Conclusion

This review underscores the value of conceptual frameworks in understanding and summarizing factors that contribute to the career decision-making of physicians. By explicating the relationships among known determinants, this work may contribute to more systematic approaches to studying the physician workforce and developing strategies to support recruitment in underserved specialties.

Optimizing patient engagement and integration in research: Recommendations from a qualitative study

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Background and Objectives

Enhancing patient engagement (PE) and integration in research may be one solution to address health inequities, including people living with diabetes. Despite an increased focus on patient-oriented research, meaningful representation of patient perspectives in research remains tokenistic; patients are seldom prepared or involved at all research stages. This may be due to the lack of systematic strategies to implement PE best practices and the lack of customization to meet their needs and those of researchers.

Approach

We conducted focus groups to understand what patient partners (PPs) from diverse perspectives living with diabetes need to engage in research and how to integrate and engage them meaningfully. Our methods were guided by a qualitative description approach, involving the purposive sampling of diverse (English-/French-speaking, racialized and Indigenous) PPs living with diabetes. The semi-structured interview guide was developed and iteratively refined by our integrated KT team consisting of PPs, researchers, family physicians and trainees. Focus group sessions were audio-recorded and transcribed verbatim. We used thematic analysis outlined by Braun and Clarke to generate a descriptive summary of focus group findings.

Results

35 consenting individuals participated in 13 English and French-speaking focus groups. The mean age of participants was 55 years (range 22-79 years) living with type 2 (46%) or type 1 (37%) diabetes and residing in Ontario (47%) or Quebec (40%). Participants identified as female (77%), English-speaking (69%), and racialized (34%). Six broad themes representing opportunities for improvement were generated: 1) how to join a research project, 2) preparation of PPs to participate, 3) how to appropriately involve PPs, 4) communication between PPs and researchers, and 5) optimizing research meetings. Our analysis also showed that PPs experienced these opportunities for improvement across different contexts (research projects or meetings) and research stages (i.e., before, at the beginning, throughout, and at the end of research projects).

Conclusion

Our study generated a conceptual framework of recommendations that can be used to optimize patient integration across the research continuum. Future work will involve co-designing a strategy with PPs to help support the implementation and use of PE best practices for each research stage and type (i.e., clinical and pre-clinical).

Effectiveness of an eHealth tool (KeepWell) for older adults with multimorbidity: Results of an RCT

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Background and Objectives

The high prevalence of multimorbidity among seniors is a global phenomenon. Self-management strategies can effectively optimize chronic disease management, but they are not usually developed for seniors and are primarily focused on a single disease. In response, we created an eHealth self-management application (“KeepWell”) that supports older adults with multimorbidity in their homes. It has innovative features including customized lifestyle advice for any combination of the most common chronic conditions (e.g., diabetes + osteoporosis).

Approach

We evaluated the effectiveness and uptake of KeepWell in a 6-month, hybrid effectiveness-implementation randomized controlled trial (RCT). Older adults were recruited from older adult organization databases (age ≥ 65 years; ≥ 1 chronic condition; English speaking, able to consent and access to computer or Tablet). All consenting older adults were randomized 1:1 (allocation concealed) to intervention (access to KeepWell) or control (usual care). Primary outcome was self-efficacy. Secondary outcomes included quality of life (QoL), lifestyle, social engagement and connections, eHealth literacy, implementation outcomes (according to RE-AIM). Data was analyzed according to intention to treat using descriptive, Chi-square and Fisher’s exact tests.

Results

Of 485 older adults who were eligible, 432 were randomized to intervention (n=212) or control (n=220). Follow-up data was available for intervention (n=146) and control (n=209) groups at 6-month follow-up. The mean age was 72.3 years (range 64-94 years), 57% female. There was no difference between groups for the primary self-efficacy outcome at the 6-month follow-up (p=0.8146). For secondary outcomes, there was a statistically significant improvement in physical activity at 3-month (p=0.0022) and 6-month (p=0.0075) follow-up. Additionally, there was a significant improvement at the 6-month follow-up for the visual analogue score of the EQ5D QoL (p=0.0024) and eHealth literacy (p=0.0367). Nearly all Intervention participants created an action plan to manage their chronic conditions and most often engaged in tracking their lifestyle changes and Journaling.

Conclusion

Results of our 6-month RCT showed that KeepWell effectively increased physical activity and eHealth literacy in older adults with multimorbidity. Implementation data highlighted features of KeepWell that have the best potential for helping older adults: creating an action plan for disease self-management through lifestyle changes, tracking their progress and Journaling.

Equity-Oriented, Team-Based Cancer Care: An Advanced Practice Nurse-Led Implementation Science in BC

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Background and Objectives

Inequities in care and outcomes persist across the cancer continuum, particularly among people with lived experiences of health and social inequities (PWLE-HSI). These inequities are especially prevalent in the Downtown Eastside of Vancouver, British Columbia (BC)—one of Canada's most densely-populated and underserved health service delivery areas. We sought to build upon the foundations of team-based care (TBC) at BC Cancer – Vancouver, a regional cancer centre, to advance objectives related to equity-oriented cancer care.

Approach

Building on the foundations of TBC and led by a steering committee that includes PWLE-HSI, we have co-designed a quality improvement initiative called the Equity-Oriented Model of Care (E-MOC) Project. This multi-year project (2023-2027) leverages the unique ability of Clinical Nurse Specialists to drive system transformation and aims to equip oncology staff and clinicians with the knowledge, skills, and resources to provide equity-oriented health care, especially for PWLE-HSI. The planning phase (2023-2024) included the consultation and involvement of community-based health and social service providers, cancer care staff and clinicians, and PWLE-HSI through workshop dialogue and clinical observations.

Results

The planning phase resulted in an advance practice nurse-led implementation science project comprised of three novel components: (1) a knowledge mobilization intervention to build knowledge and skills about equity-oriented health care, (2) consultative and at-the-elbow mentorship and support for Registered Nurses who work in TBC at BC Cancer – Vancouver from two oncology Clinical Nurse Specialists with expertise in equity-oriented health care, and (3) interdisciplinary, intersectoral care conferences to plan more equitable, collaborative, and comprehensive person-centred approaches to cancer care for PWLE-HSI. These components will be piloted and evaluated within pre-existing interdisciplinary care teams in BC Cancer – Vancouver's ambulatory systemic and radiation therapy programs, with the aim of iteratively improving and proliferating the intervention across other clinical service delivery areas at the regional and provincial level.

Conclusion

Through engaging PWLE-HSI in the co-design and leadership, and leveraging the advanced practice nursing leadership of Clinical Nurse Specialists to advance equity-oriented goals in the cancer care system using an embedded implementation science approach, we have created an implementation-ready strategy to take action on existing inequities in cancer care.

ID: 35572

Presented by: Krystal Kehoe MacLeod

A comparative policy analysis of regulatory approaches in the assisted living sector

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Background and Objectives

Assisted living (AL) is a housing option for older adults that offers services like meal preparation, housekeeping, personal and medical care. With the increasing demand, yet limited availability of long-term care, AL offers choice to older adults looking for independent living with support. AL regulation across Canada is important to ensure resident safety but it is fragmented, with regulatory models varying by province.

Approach

Our research question is: how do the AL regulatory models in British Columbia and Ontario affect legislative enforcement, care standards, and care integration for AL residents? This project, guided by the Ideas, Interests, and Institutions framework, began with a content analysis of assisted living legislation and policies in Ontario and British Columbia (n=12) to compare regulatory models. We then conducted semi-structured interviews with policymakers, senior care advocates, and private interest groups (n=14) to explore the rationale for selecting each regulatory model and its care implications. Data was analyzed using reflexive thematic analysis. Next steps are a deliberative dialogue workshop with stakeholders to draft recommendations to inform future AL regulatory reform.

Results

Our policy analysis found that while both BC and Ontario prioritize independence in AL, their approach differs. BC regulations for publicly funded AL include clear screening guidelines, the RAI-HC assessment, and transition planning to maintain independence for AL residents. Ontario's regulations lack these specific stipulations but emphasize residents' choice in care and service. We found that requirements for data collection and sharing about AL are limited in both provinces, hindering care integration and regulatory reform. Neither province transparently uses complaints data to improve regulations or AL operations. Interview analysis included themes about barriers to policy reform; tensions between government, regulators, and AL home operators; and challenges in balancing resident safety and independence with government and private sector interests.

Conclusion

Stakeholders identified opportunities for both AL regulatory models to make a positive impact on resident safety and care integration but there remain discrepancies in how regulations are interpreted and operationalized that limit its effectiveness as a policy tool.

ID: 35580

Presented by: Krystal Kehoe MacLeod

Improving Care Delivery for People with Heart Failure and Mental Health Challenges

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Background and Objectives

Brain and heart conditions rank among the top causes of illness and mortality in Canada, yet few care directives address the interconnectivity of cardiac and mental health conditions. Partnering with Ontario Health Teams (OHTs) and communities, our research aims to map resources within our regions supporting adults with heart failure at risk of mental health challenges and document their experience navigating care services. This project is important to health services and policy research because it emphasizes the need for holistic strategies to address interconnected conditions.

Approach

This qualitative, community-based participatory action research study is led by a coalition of patients, caregivers, physicians, and OHT partners. Our research aims to identify gaps and opportunities to improve integrated care for individuals managing heart failure and mental health challenges.

We conducted asset mapping in two OHT regions (Archipel and Great River) to identify services supporting heart failure and/or mental health management, such as exercise programs, mental health services, social support, and self-management programs. Additionally, we conducted 20–40-minute interviews with adults with heart failure and caregivers (n=22), care providers (n=8), and service organization members (n=4) to explore their knowledge, experiences, needs, priorities, and recommendations regarding available services.

Results

Through asset mapping, we developed six asset maps and an inventory of services, which were used in interviews to explore patient, caregiver, and provider awareness of identified services and potential gaps. The mapping highlighted various self-management programs, support groups, and healthy lifestyle initiatives. While participants were familiar with hospital-linked programs, such as rehabilitation and dietitian-led nutritional services, awareness of community-based offerings was low.

Some participants expressed reluctance to engage with services like community exercise programs or support groups, preferring to manage care independently. Notably, most services targeting cardiac patients, apart from support groups, did not address mental health risks or their management. This was echoed in interviews, where patients, caregivers, and providers reported that mental health was rarely discussed during cardiac care appointments.

Conclusion

This project has important implications for health outcomes and practice as our findings highlight gaps in addressing mental health needs within cardiac services for patients and their care providers. These findings will guide our research coalition in identifying priority areas for care improvement to better support for this patient population.

ID: 35500

Presented by: Nimrit Kenth

Health Professionals' Language Capacity in Canada: Equity implications of registry data

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Background and Objectives

Assessing Canada's health workforce's language capacity requires collection and access to linguistic data, often through provincial or territorial regulatory authorities, mandated to collect this data. This paper aims to examine how linguistic data collection varies across jurisdiction and profession, and how this has changed through a comparison of a 2017 and 2024 environmental scan. This analysis provides insights into policy improvements and the effectiveness of measures supporting linguistic proficiency in health professionals.

Approach

This study employed a mixed qualitative design, collecting data from seven health professions' regulatory authorities across thirteen provinces and territories through a follow up survey of registrars. Surveys focused on the collection and release of linguistic data of registrants, supplemented with data from a 2024 environmental scan of publicly available information. The surveys captured linguistic data collection practices, language proficiency requirements, as well as data public availability. The health professions included: medicine, nursing, occupational therapy, pharmacy, physiotherapy, psychology and social work. Data were analysed qualitatively in a comparative table (2024 vs 2017) to assess data quality and accessibility.

Results

In 2024, 35 (42%) of the regulatory authorities collected health workforce language data while only 16 (19%) included language data on their public registries. In 2017, 44 (63%) of respondents collected health workforce language data but only 9 (26%) included language data on their public registries. Barriers to data collection and public dissemination included personal information protection legislations and inconsistent legislation requiring data collection - in 2017 only 10 (14%) of regulatory authorities were required to collect linguistic data whereas in 2024 none who responded were required to collect linguistic data for public dissemination. The Ontario minimum data standard was a key facilitator for the collection of health workforce data, which is a testament to policy being the cornerstone of health linguistic equity in Canada.

Conclusion

The variability of linguistic data collection and public availability demonstrates the need for deeper exploration into linguistic policy and legislative challenges. Policy reforms, leveraging models such as Ontario's minimum data standards act, are essential to improving healthcare access and quality for linguistic minorities across Canada.

ID: 34837

Presented by: Maryam Khan

Disabled IBPOC 2S/LGBTQ+ Individuals' Experiences of Chlamydia Testing & Care

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Background and Objectives

The history of 2S/LGBTQ+ STBBI research in Canada has often overlooked the unique experiences of disabled Indigenous, Black, people of color (IBPOC) who are trans and cis queer women, femme-presenting Two-Spirit, and non-binary individuals. This research gap is particularly concerning for marginalized populations who face intersecting forms of discrimination, including ableism, racism, sexism, and cisheteronormativity.

Approach

In partnership with Community-Based Research Centre, a community-based mixed methods (qualitative and Critical Discourse Analysis) research project informed by Wholistic, disability justice, and critical feminist perspectives was undertaken to explore the experiences of IBPOC disabled trans and cis queer women and femme-presenting Two-Spirit and non-binary individuals in accessing Ontario chlamydia screening and care. The presentation will focus on themes generated by the qualitative data with approximately 25 participant interviews using a semi-structured format.

Results

Presenters will share preliminary data on the participants' lived experiences, including barriers to care, experiences of discrimination, and recommendations for improving access for IBPOC disabled trans and cis queer women and femme-presenting Two-Spirit and non-binary individuals. Preliminary findings on accessibility, discrimination, and the need for culturally relevant and inclusive approaches to chlamydia prevention and care will be discussed.

Conclusion

From this presentation, attendees will gain an understanding of the unique challenges faced by marginalized 2S/LGBTQ+ disabled individuals; identify barriers to chlamydia screening and care; and will learn about strategies to improve access to chlamydia screening and care, including culturally relevant and inclusive approaches.

ID: 35646

Presented by: Mya Kidson

Food Insecurity and Chronic Health Condition: Red River Métis Regional Health Survey Insights

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Background and Objectives

Colonial impacts on health and political systems have led to an overrepresentation of Red River Métis (RRM) experiencing health disparities and a lack of RRM-specific research. This project used a distinction-based lens to investigate the intersection between food insecurity and chronic health conditions affecting RRM. Additionally, it highlights innovative health intervention initiatives led by the Manitoba Métis Federation's Health & Wellness Department (MMF-HWD), emphasizing culturally tailored solutions to address these challenges and improve health outcomes.

Approach

A comprehensive cross-sectional survey containing 163 questions across 25 sections was conducted, with results offering insights into various aspects of RRM health. Recruitment was done through various means in order to obtain an appropriate samples size. A total of 1191 RRM Citizens from all 7 MMF Regions participated. Descriptive data analysis examined food security status and its association with health conditions, such as diabetes, anxiety disorders and mood disorders, offering a deeper understanding of these interconnected issues.

Results

Among surveyed participants, 69.4% experienced severe or moderate food insecurity (SoMFI), while 14.3% indicated marginal food insecurity. The results show that 18.2% of participants with SoMFI reported having diabetes, compared to 14.6% of food secure (FS) respondents. Anxiety disorders were reported by 23.8% of those with SoMFI, contrasting to 13.2% of FS participants. Similarly, 28.4% of participants with SoMFI reported a mood disorder in comparison to 11.4% of FS participants. Hypertension was reported by 30.2% of those with SoMFI, compared to 24.3% of FS individuals, while heart disease affects 10% of those with SoMFI, compared to 8.3% of FS participants.

Conclusion

HWD-MMF has been incorporating food insecurity into health programming aiming to address chronic health conditions. The data from this research underscores the importance of this approach in both health programming and research about chronic health conditions to improve overall health outcomes and wellbeing of RRM.

ID: 34736

Presented by: Hannah Kohler & Carolina Chadwick

A Guide for Quality Improvement: Dismantling MHSU-related structural stigma in healthcare

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Background and Objectives

Structural stigma in healthcare happens when laws, policies, and systems of care embed negative beliefs and biases about people with lived and living experience (PWLLE) of mental health and/or substance use (MHSU) health problems. This presentation will describe how structural stigma becomes enshrined in different systems (e.g. governance, service delivery, training) and showcase a multi-year, mixed-methods research project that provides implementation strategies for quality improvement initiatives to address MHSU-related structural inequities in healthcare.

Approach

The MHCC and its structural stigma research team worked with six champion organizations within the Canadian healthcare system to learn from their innovative quality improvement initiatives, changes in models of care, and other interventions, programs, policies, or practices related to reducing structural stigma. The project involved more than two years of research and interviews. It facilitated participatory workshops to identify and analyze real-world strategies for successfully overcoming mental health and/or substance use (MHSU)-related structural stigma. Using a realist review, the team sought to synthesize key features for transformative change and produce a resource for others seeking to address structural stigma.

Results

This highly collaborative research project produced an implementation guide that draws on real-world insights from the six exemplary organizations and provides practical tips, advice, tools, and resources on the components of structural change. Shifting attention to structural aspects of stigma (vs. targeting interpersonal aspects of stigma) has powerful potential to advance stigma reduction into the future. The principles and recommendations outlined in the guide can help health-care organizations, institutions, or agencies reflect more critically and challenge existing practices and policies that may be perpetuating structural stigma.

Conclusion

Combating MHSU-related structural stigma in health care is a complex and multi-layered endeavor that can be targeted through multiple intersecting avenues and approaches. The resulting implementation guide developed through this research project is a valuable resource that can support improving access to quality health care for PWLLE.

“It’s still a man’s world”: Towards gender equity in advancement in the academic health sciences

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Background and Objectives

Research has identified that women experience gender-based inequities in promotion and leadership in the academic health sciences, including significant lags in time to promotion, limited leadership opportunities, and pay gaps. However, few studies examine underlying reasons for these inequities. Comprehending the complexities shaping gender inequity is necessary to create change. The purpose of this study was to explore influences creating differences in promotion and leadership trajectories among health sciences faculty at a Canadian university.

Approach

Our team conducted a qualitative study guided by intersectionality, feminist standpoint theory, and Bourdieu's Theory of Practice. We invited health sciences faculty to participate, limiting eligibility to professorial stream faculty who had previously been promoted to associate or full professor. Twelve participants volunteered. Following informed consent, we conducted semi-structured, virtual interviews where participants shared their experiences of seeking and obtaining promotions. Digital recordings were transcribed. De-identified transcripts were uploaded to a qualitative data software program. We completed a reflexive thematic analysis, with two coders/transcript and analytic team discussion to advance interpretation.

Results

We heard descriptions of gender inequities whereby women were not equally valued and/or supported, which impacted promotion and leadership experiences when going up the ranks. Participants described unwritten criteria in the promotion and leadership process. Ten participants explained the promotion process and leadership opportunities as challenging and haphazard, while two participants (one man and one woman) denied the existence of gender inequities. In our reflexive interpretation, the unwritten code was patriarchal, swaying advancement and access to supports away from women, especially women in clinical practice. We found that participants who were members of a visible minority – including but not limited to women – also experienced multiple challenges in career advancement that represents systemic racism.

Conclusion

Sexism and racism continue to be expressed through promotion and leadership processes in the academic health sciences. The rich descriptions of the unwritten codes and haphazard processes of promotion, wherein sexism and racism are enacted, highlight potential strategies to improve consistency in advancement in the local university's academic health sciences.

ID: 34523

Presented by: Ellen Kuenzig

Models of outpatient inflammatory bowel disease care delivery: a scoping review

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Background and Objectives

The rapidly increasing prevalence of inflammatory bowel disease (IBD) in Canada, combined with an aging population at higher risk of age-related comorbidities, will place a significant strain on gastroenterology clinics and the healthcare system. Changes in care delivery are necessary to meet the growing demand for care among people living with IBD. We conducted a scoping review to understand the extent and type of evidence related to models of outpatient care delivery for IBD management.

Approach

A scoping review was conducted by searching MEDLINE, EMBASE, CINAHL, and PsycINFO (to March 4, 2024) to identify studies describing or evaluating models of care for managing people with IBD in outpatient settings. We included English language published studies of any type (primary studies, reviews, and opinion pieces) focusing on any age group, specific timepoints in care (e.g., preconception, transition from pediatric to adult care), or delivery mode (e.g., remote care or monitoring). Studies were screened for eligibility and conflicts were resolved by consensus. We synthesized the evidence and recommendations from published literature.

Results

Our search yielded 13,146 records, of which 210 met our inclusion criteria. These included 77 studies evaluating a model of care, 122 describing models of care without formal evaluation, and 11 consensus statements or guidelines on the composition of care models or the roles of healthcare professionals (HCPs). Models of care included multidisciplinary teams (with either biomedical or biopsychosocial approaches), care provided by nurses and other allied HCPs, remote monitoring and healthcare delivery, and rapid access clinics. Care models increased patient satisfaction, enhanced collaboration between patients and HCPs, reduced health services utilization (e.g., emergency department visits, hospitalizations), and improved patient outcomes (i.e., disease activity, mental health, quality of life). Gastroenterologists, nurses, mental health professionals, and dietitians were consistently identified as key members of multidisciplinary teams.

Conclusion

Several innovative outpatient models of IBD care have been proposed in the literature to address the changing needs and increased burden of IBD internationally. These can guide modifications to IBD care in Canada and help to address the increased complexity of care in a resource-limited setting.

ID: 34978

Presented by: Maude Laberge

Unmet needs following the use of Primary care access points for unattached patients in Quebec

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Background and Objectives

Unattached patients experience more challenges accessing primary care. To address these barriers, Primary care access points for unattached patients (Guichet d'accès à la première ligne; GAP) were implemented province-wide in Quebec. This organizational innovation is designed to orient unattached patients to the most appropriate primary care professional or service. This study aimed to document unmet healthcare needs following GAP service received and assess associated factors.

Approach

This cross-sectional study included 20,291 patients who used the GAP. Data were collected from self-reported online patient questionnaires between April and July 2024. All patients with a valid email address registered on the centralized waiting list for unattached patients in the three local health territories (LHTs) under study were invited to participate. Unmet healthcare needs were measured in relation to the GAP service received: Did this [professional, service or information received] meet your health needs? Predisposing, enabling and need factors were identified using Andersen's behavioral model. Multivariable logistic regressions were conducted to assess factors associated with unmet needs.

Results

Unmet healthcare needs varied widely, from 18% for patients who received an appointment with a family physician to 72% for those who received information or advice only from the GAP. The findings showed that younger age (<70 years old), reporting poor/fair self-rated physical and mental health, receiving services in LHT 2 and 3 as well as reporting an emergency department visit were associated with an increased likelihood of reporting unmet needs. Compared to those who received an appointment with a family physician, patients who were referred to a community pharmacist, the emergency department or other resource and those who received information or advice only were more likely to report unmet healthcare needs.

Conclusion

This study enables a better understanding of unattached patients' experiences using primary care access points. The results showed high unmet needs for specific orientations. The next step will be to dig deeper into the reasons for patients' unmet needs, leading to more accurate strategies for reducing them.

ID: 35574

Presented by: Maude Laberge

Expérience des professionnels de la santé sur la transition des personnes âgées en hébergement

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Background and Objectives

Il devient impératif d'améliorer les soins et services en Centre d'hébergement et de soins de longue durée (CHSLD) puisque les demandes d'hébergement augmenteront en raison du vieillissement de la population. Le but du projet est de documenter l'expérience de transition des personnes âgées de la Côte-Nord en CHSLD en comprenant comment est réalisée et est utilisée le questionnaire histoire de vie pour faciliter leur transition et leur adaptation.

Approach

Nous avons réalisé des entrevues individuelles semi-dirigées avec des membres du personnel de soins et services impliqués dans la réalisation et l'utilisation du questionnaire histoire de vie. Pour le recrutement, c'est la méthode boule de neige a été utilisée. Des membres de la direction ont envoyé un courriel à des personnes pouvant participer et celles-ci ont transmis l'invitation à leur équipe. Les entrevues ont été faites par Teams ou en personne dans les établissements de la Côte-Nord et étaient enregistrées. Nous avons fait une transcription des verbatim et une analyse thématique.

Results

L'histoire de vie est un document qu'il est recommandé de remplir avec la personne âgée (et un proche) à son arrivée en CHSLD. En Côte-Nord, les travailleuses sociales ont commencé à remplir le questionnaire en amont de l'arrivée, alors le partage de l'information contenue dans le document avec l'équipe de soin permet à celle-ci d'apprendre des informations précieuses et de mieux préparer l'arrivée personnes âgées. Les personnes rencontrées estiment que cette pratique est bénéfique pour l'expérience des personnes âgées, mais également pour elles-mêmes. Elles se sentent mieux outillées pour comprendre et répondre aux besoins des nouveaux résidents et peuvent ainsi éviter des crises, surtout avec des personnes ayant des troubles neurocognitifs.

Conclusion

Des résultats obtenus, il est possible de conclure qu'ils permettent de clarifier le processus de réalisation et d'utilisation de l'histoire de vie. Les personnes impliquées, les moments clés, les moyens utilisés, les facilitateurs et obstacles, les bénéfices ainsi que des suggestions d'amélioration ont été identifiés.

ID: 35634

Presented by: Nathan Lachowsky

New Gender-Neutral Sexual Behaviour-Based Blood Donor Screening: 2S/GBTQ+ Community Attitudes

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Background and Objectives

In 2022, there was a significant shift in Canadian policy on blood and plasma donor screening. The historic time-based deferral for “men who have sex with men” (MSM) was removed and replaced with a new gender-neutral sexual behaviour specific screening policy (e.g. all potential donors are now asked if they had multiple sexual partners or a new sexual partner). We studied the impact of this policy change on the attitudes of 2S/GBTQ+ community across Canada.

Approach

We used a community-based participatory research approach to implement an online cross-sectional survey (all provinces and territories were represented). Eligibility criteria included Indigenous Two-Spirit people; all gay, bisexual, queer, and non-heterosexual men (inclusive of trans men), and all nonbinary people (herein “2S/GBTQ+”). Participants also had to be aged 15+, live in Canada, and be able to consent to and self-complete the online questionnaire in English, French or Spanish. We recruited participants from March-May 2024 via social media, community-based organizations, and advertisements on sociosexual websites/apps/media. We undertook participatory data analysis and implemented diverse knowledge translation strategies.

Results

Of 2,227 eligible participants, 71.5% identified as gay, 21.8% disabled, 18.3% racialized, and 10.5% trans. Most (91.3%) were aware of historic MSM deferrals. 64.2% were aware of new gender-neutral screening, which 50.9% felt was justified. Most (84.9%) agreed blood operators must do more to repair their relationships with 2S/LGBTQ+ communities. Only 3.0% had donated blood since 2022. Top barriers to donation were ineligibility (53.9%), disagreement with historic treatment of 2S/LGBTQ+ within blood donation (25.0%), and perceived stigma within blood donation centres (18.2%). Top motivations for donating were looking after other Canadians (55.8%), looking after their community (57.0%), and knowing about blood product shortages (52.7%). Future desired changes include more precise screening of sexual practices (62.9%) and improved sexual/gender diversity training for donation staff (37.2%).

Conclusion

New gender-neutral screening of blood and plasma donors was only known by two-thirds of 2S/GBTQ+ people. 2S/GBTQ+ community largely articulated that this new policy was not justified and further reparations by blood operators are needed. Concerns about stigma/discrimination in blood donation centres also remains a barrier to donation for 2S/GBTQ+ people.

ID: 33393

Presented by: Zeenat Ladak

Adequacy of prenatal care and maternal and newborn emergency department use

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Background and Objectives

Maternal and newborn well-being starts with adequate prenatal care. Insufficient prenatal care is associated with greater emergency department (ED) use during and prior to pregnancy, especially among those residing in rural areas. The association between insufficient prenatal care and postpartum ED use has not been extensively investigated. This Canadian study determined whether receipt of adequate prenatal care is associated with maternal and newborn postpartum ED use.

Approach

This population-based cohort study included all hospital singleton births in Ontario, 2012-2020. The primary exposure was adequate prenatal care, using the Revised-Graduate Prenatal Care Utilization Index. Standardized differences (SD) compared females from exposure groups. The primary outcome was postpartum maternal ED use up to 42 days after birth. The secondary outcome was a newborn ED visit up to 27 days after birth. Modified Poisson regression generated relative risks (aRR) adjusted for maternal age, rural residence, income quintile, caesarean delivery, perineal laceration, type of conception, maternal co-morbidities, stillbirth, and pre-pregnancy ED use.

Results

A total of 924,773 females received adequate prenatal care, and 31,041 inadequate. Relative to those receiving adequate care (9.5%), mothers with inadequate care had a higher rate of ED use postpartum (10.8%) (aRR 1.07; 95% CI 1.03-1.10). The rates of newborn ED use were 10.0% and 10.9% (aRR 1.05; 95% CI 1.02-1.09). Females with inadequate care tended to reside in the lowest-income quintile neighbourhood (SD 0.35) and were more likely to visit the ED postpartum (aRR 1.06; 95% 1.01-1.12). Overall, more females living in rural areas (13.4%) were likely to have an ED visit compared to urban areas (9.25%). Compared to those who had adequate care, females with inadequate care in urban areas, were more likely to visit the ED (aRR 1.10 95% CI 1.06-1.15).

Conclusion

Receipt of inadequate prenatal care is associated with greater ED use after birth. The association is most apparent among those living in urban areas and in lower income neighbourhoods. Targeted initiatives seeking to improve prenatal care within these populations should be tested to reduce the frequency of postpartum ED use.

ID: 34129

Presented by: Zeenat Ladak

Exploring patient experiences of prenatal healthcare in Ontario: An equity-oriented study

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Background and Objectives

The health and wellbeing of mother and child starts with quality prenatal care. Despite the indication of Canada's universal healthcare system being equally available, access/use of prenatal care is impacted by inequities which include geographical proximity, financial barriers, lack of cultural safety, and stigmatization. These barriers negatively impact the short and long-term health of mothers and children. This study aims to explore patients' prenatal care experience and the impact of inequities, in Ontario.

Approach

This explanatory mixed-methods study is guided by Cochrane's PROGRESS-Plus equity framework. Our research is patient-oriented as defined by CIHR, and our team includes a patient partner involved from grants to knowledge mobilization. Purposeful sampling is used to recruit individuals (aiming for n=20) who have been pregnant or experienced pregnancy loss within the last 12-months, across Ontario. Participants completed a 5-min survey about demographic and pregnancy characteristics, which informed a 1-hour interview exploring participant's experiences with healthcare professionals (HCPs) and how their care was impacted by PROGRESS-Plus factors. Analysis included descriptive statistics, inductive coding, and deductive coding to PROGRESS-Plus.

Results

Preliminary results (n=7) indicated the majority of participants were born in Canada (85.7%), worked full-time (71.4%), and/or identified as a racialized minority (71.4%). All participants interacted with their family doctor, while approximately 50% also interacted with an Obstetrician, Nurse, and/or Midwife. Themes emerged including the importance of continuity of care with the same HCP from prenatal to postpartum. Participants reported that race contributed to power dynamics with HCPs. Patients' trust in their HCPs influenced their decision-making to seek care with the same HCP again. Individuals who lived in rural areas experienced challenges including driving over an hour to deliver their baby. Those with large or close-by support systems of family/friends experienced a sense of security during their pregnancy.

Conclusion

This study provides a narrative of individuals' journeys as they receive care during pregnancy. Findings can inform HCPs and decision-makers about prenatal patients' expectations of care delivery (e.g., establishing trust) and equity factors (e.g., distance to care), along with potential solutions to improve the patient experience during pregnancy.

ID: 34722

Presented by: Poland Lai

Measuring Performance of Ontario LTC Homes

Authors: *Lai, Poland. Faculty of Liberal Arts and Professional Studies, York University.*

Background and Objectives

In the long-term care (LTC) context, there are several mechanisms for monitoring performance, but they are not always aligned to integrate data and evidence to support a learning health system. Taken together, these measures should provide a more comprehensive understanding of the performance of the LTC system. This study's objective is to examine the relationships (if any) between different types of measures (such as regulatory compliance, access and quality of care) using Ontario data.

Approach

The first stage entails the creation of a dataset of about 626 LTC homes: 1) background information about the homes (e.g. size, location, and ownership); 2) information extracted from LTC home inspection reports in 2024 (e.g. sanctions issued by inspectors); and 3) CIHI indicators (e.g. restraint use) in 2023-2024. Descriptive and analytical statistics are conducted to present the state of LTC home compliance with legislation. Next the relationship between health system performance indicators and inspection results will be examined, for example, which indicators are good predictors of regulatory performance and vice versa. The analysis will be complete by March 2025.

Results

The majority of inspections are reactive in nature (i.e., they are in response to complaints from residents or their families or reports filed by homes). A small percentage of homes have significant larger number of sanctions than the average. The preliminary results illustrate variances in terms of regulatory intensity (e.g. number of inspection days and reports), types of inspection (e.g. complaints) and outcomes (e.g. sanctions) across homes (the data of each home are adjusted by the number of beds). The variances do not occur by chance and can be explained by size, location and ownership of the home. Other results will be available by March 2025.

Conclusion

This study has implications for integrating other forms of evidence (inspection reports) into policy and delivery decisions. Policymakers will be better positioned to anticipate performance gaps at the institutional and system level and respond more confidently to support system transformation. This study supports greater accountability to patients and the public.

ID: 34974

Presented by: Leah Lambert

Optimizing the Clinical Nurse Specialist Workforce in BC: An Integrated Knowledge Translation Model

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Background and Objectives

Canada faces critical nursing shortages, emphasizing the need for workforce transformation. In British Columbia, the Clinical Nurse Specialist (CNS) role has significant potential to improve patient and system outcomes but remains underutilized and sub-optimally deployed. While some factors influencing CNS effectiveness are understood, clear recommendations on how to optimize and sustain these roles are still needed to fully leverage their impact.

Approach

This study explored factors influencing the optimization, integration, and sustainability of Clinical Nurse Specialist (CNS) roles. Using a multi-method approach grounded in integrated knowledge translation (iKT), we conducted an environmental scan of recent peer reviewed literature and policy reports (n=27), a provincial survey (96 respondents covering over 90% of BC's CNS workforce), and qualitative interviews with 23 CNSs and 12 senior health leaders. Insights were further refined through an invitational policy-setting workshop with CNSs, healthcare leaders, and stakeholders, culminating in evidence-based recommendations to support CNS workforce development and sustainability.

Results

This research highlighted persistent challenges in optimizing CNS roles, including insufficient role clarity, inconsistent integration into healthcare teams, and limited access to professional development opportunities. Key drivers of job satisfaction and retention were strong role definition, alignment with organizational priorities, and access to professional networks. The study underscored the importance of organizational investment in CNS workforce development, such as establishing clear reporting structures, offering robust orientation programs, and funding continuing education and certifications. The policy-setting workshop with stakeholders deepened understanding of these challenges, resulting in strategic recommendations to enhance CNS role integration, improve workforce sustainability, and maximize their impact on patient outcomes and health system performance. These findings have informed a set of new policies to strengthen the CNS workforce in British Columbia.

Conclusion

This presentation emphasizes the opportunity to strengthen CNS roles by addressing organizational and structural factors. Through an iKT approach, actionable policy recommendations were developed to optimize CNS contributions, ensuring their full potential in improving patient outcomes and driving transformative healthcare change.

ID: 34845

Presented by: Rachel Latus

Access to primary health care for all Canadians: A Shared Health Priority

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Background and Objectives

Primary health care is the foundation of Canada's health systems. In 2023, Canada's federal, provincial and territorial governments committed to prioritizing improvements in access to primary care for all Canadians and publicly reporting on common indicators to measure progress.

In this presentation, we will share findings from some of these indicators. We will also discuss recent changes to practice patterns for family physicians and incorporate lived experiences from Canadians accessing care.

Approach

Our approach was as follows:

Identified indicators via extensive consultations with experts, jurisdictional representatives and the general public.

Leveraged existing administrative and survey data to begin reporting on the selected indicators.

Incorporated patient and health care provider experiences to provide meaningful context to the findings.

Results

Key findings include:

83% of Canadian adults report having access to a regular health care provider. But more than 5 million Canadian adults, or 17%, struggle to access care.

In 2023–2024, 281 of every 100,000 Canadians younger than 75 were admitted to a hospital for a problem that potentially could have been avoided with access to appropriate care in the community.

Almost all provinces and territories had a net increase in the number of family physicians (2021–2022) compared with the year prior, but their practice patterns might be changing.

Conclusion

We will continue to work with partners to report on updated results, as well as to identify and develop new indicators to measure progress on the shared health priorities.

ID: 34531

Presented by: Celia Laur

Learning from policy-driven evaluations to inform spread and scale of digital health initiatives

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Background and Objectives

Background: Governments make rapid funding decisions about digital healthcare initiatives to ensure uninterrupted service, meet population needs, and promote health system efficiency. Alongside evaluations of program effectiveness, evaluations focused on spread and scale can inform implementation of digital healthcare initiatives in additional contexts. Our aim is to share our reflections from conducting evaluations where government agencies are the primary knowledge users. This work can inform research on how to spread and scale digital healthcare initiatives.

Approach

Methods: Three evaluations of digital healthcare initiatives conducted by the Centre for Digital Health Evaluation and the Office of Spread and Scale, at an academic teaching hospital in Ontario between 2022-2024, were used as case examples. These evaluations aimed to inform provincial-level sustainability, spread, and scale of digital healthcare initiatives. Reflections from the multidisciplinary evaluation teams including implementation scientists, evaluators, health services researchers, and patient partners/people with lived/living experience (PWLE), were used to develop recommendations on future work to improve scale and spread planning, contributing to knowledge in the field of digital healthcare.

Results

Results: Future research about spread and scale should include: 1) Development of a “shared language” for spread and scale that could make it easier to draw on the literature and apply more generalizable learnings. 2) Exploration of strategies for achieving efficiencies when scaling impact, while prioritizing patient care. 3) Increased engagement of PWLE by providing more opportunities for building long-term relationships with research teams. This could include offering capacity-building opportunities, and engagement in foundational research on spreading and scaling innovations, such as engagement in developing a shared language. 4) Integration of health equity considerations in decisions about what should be spread and scaled, and maintaining that focus throughout spreading and scaling to help mitigate the risks of perpetuating or exacerbating existing disparities in access to care.

Conclusion

Conclusion: By learning from practice to inform research, this work can enhance our understanding of how to spread and scale digital healthcare initiatives and support government decision-makers to achieve stronger population-level benefits.

ID: 34504

Presented by: Celia Laur

Developing the program theory behind an interdisciplinary team-based rheumatology care model

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Background and Objectives

Interdisciplinary team-based models of rheumatology care have demonstrated potential in enhancing access to care and improved outcomes for individuals with rheumatic and musculoskeletal disorders. However, an understanding of the key components of this model of care, and the mechanisms through which they achieve these effects, remains unclear. Our objective was to develop the program theory underlying a successful model of team-based rheumatology care being delivered in Ontario, Canada.

Approach

We employed a case study approach with data from semi-structured interviews (patients n=15, health professionals n=11), three naturalistic observations (12-hours), and document reviews. We conducted framework analysis using the Consolidated Framework for Implementation Research 2.0 to organize barriers and enablers to optimal rheumatology care and suggestions for how to replicate this model. Within the Implementation Outcomes Framework, we focused on acceptability, fidelity, penetration, and sustainability, alongside service and patient outcomes. To describe the program theory, data was triangulated to inform an Implementation Research Logic Model, linking determinants of optimal rheumatology care to implementation strategies, mechanisms of action, and outcomes.

Results

In this care model, interdisciplinary health professionals (IHPs) triaged patient referrals and conducted the initial intake assessments. The patient was then seen by an IHP and rheumatologist concurrently, to collaboratively construct a personalized management plan. Follow-up visits were similar, and patients could ask questions between visits. IHPs delivered formal patient education sessions. The physical space facilitated communication among the team. By practicing in this extended role, IHPs reported greater autonomy. Ongoing training and mentorship were essential for IHP skill development and functioning within the rheumatology environment. Key enablers of optimal rheumatology care included timely, patient-centered, and outcome-driven care; adaptable care models; and interdisciplinary collaboration. Barriers for use of this model elsewhere, included sustainable funding, workforce availability, and insufficient physical infrastructure to deliver comprehensive care.

Conclusion

Developing this program theory provides insights into the critical components and contextual factors that contribute to successful delivery of interdisciplinary team-based rheumatology care. These findings will guide future work to support the implementation, sustainability, spread, and scale of this successful team-based model of care.

Barriers and facilitators to genome diagnostics implementation in Canada: A comparative case study

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Background and Objectives

Unlike countries using a federated model for integrating genome diagnostics into clinical care to enable precision medicine, Canada's decentralized healthcare systems warrant province-specific approaches to implementing clinical genome-wide sequencing (GWS). As health services are delivered through provincial and territorial governments, examining how different jurisdictions approach GWS implementation will help to identify best practices for Canada. This study aimed to understand barriers and facilitators to clinical GWS implementation across four Canadian provinces.

Approach

An embedded, qualitative multiple-case study design was used, with Alberta (AB), British Columbia (BC), Manitoba (MB), and Ontario (ON) serving as the cases. Key informant interviews and document analysis were conducted. Rogers' Diffusion of Innovation theory and the Consolidated Framework for Implementation Research guided the study data collection and analysis. Clinical and laboratory experts and organizational leaders were recruited from genetics clinics, molecular diagnostic laboratories, or organizations involved in decision and policymaking for clinical genomics-related services. Interviews focused on participants' experiences and perspectives on GWS implementation within their province. Data were thematically analyzed using a mixed, deductive-inductive approach.

Results

Forty-one participants were interviewed. All four provinces have either implemented or are developing in-province capacity for clinical GWS. Anticipated benefits of in-province GWS capacity included cost savings, improved access to and oversight of patient genomic data, and bolstering the genomics research ecosystem. Distinct provincial barriers were identified. In ON, the GWS eligibility review process was highlighted as a significant barrier, particularly by genetics providers. The lack of a province-wide genomics strategy was reported as a significant challenge in BC. AB's participants pointed to workforce shortages, while those in MB cited funding limitations and low relative priority of genomics within their healthcare system as primary obstacles. Advocacy by champions in medical genetics was identified across all provinces as a crucial facilitator of GWS implementation.

Conclusion

This study identified distinct barriers and facilitators to GWS implementation across four Canadian provinces. The findings provide valuable insights for jurisdictions aiming to develop local GWS capacity to enable precision medicine. These insights

underscore the importance of tailoring implementation strategies for complex interventions to meet specific local needs and capacities.

ID: 35437

Presented by: Tiffany Lee

Citizen Perspectives on the Role of Pharmacists in Screening for Social Determinants of Health

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Background and Objectives

The role of community pharmacists in screening for social determinants of health (SDH) is not clearly defined. Research from the United States suggests that the expertise and accessibility of pharmacists' can be leveraged to effectively identify social needs at the patient and community level. The primary objective of this public engagement (PE) project is to explore public perspectives on the pharmacist's role—to inform future implementation of SDH screening in community pharmacies.

Approach

Using the deliberative dialogue framework described by McMaster Health Forum, we hosted two citizen panels with a purposive sample of 11 citizens with diverse backgrounds and lived experiences. The Newfoundland and Labrador (NL) SPOR Unit and NL Health Services Patient and Family Advisory Committee supported our recruitment efforts. A plain-language citizen brief was circulated in advance of each virtual discussion. Both sessions were recorded and transcribed verbatim. Qualitative data analysis followed the RADaR—rigorous and accelerated data reduction—technique for applied research. CoLoop was used to facilitate data coding, organization, and reduction. Concepts and themes were developed through team discussion.

Results

The accessibility of community pharmacists was viewed positively and with great potential to tackle SDH. However, many participants acknowledged that social conditioning may negatively impact public acceptance and/or uptake of pharmacists' screening for SDH. Expansions to the provincial MyHealthNL (personal health record) infrastructure to allow for self-reporting of SDH, as well as data collection by pharmacists, were suggested. Inclusive and respectful trauma-informed approaches to care—to improve communication between pharmacists, other health professionals, and their patients—were identified as necessary strategies to move this initiative forward. Findings will be combined with our literature synthesis to develop a comprehensive evidence brief and inform future interest-holder deliberations on the topic, including discussions focused on health policy, regulation, and pharmacist practice.

Conclusion

Generally, citizens believe there is value in leveraging the unique frontline position of pharmacists to improve SDH data collection and referrals to community-based social care services. However, societal acceptance and understanding of the pharmacist's role may serve as barriers to implementation of SDH screening in community pharmacies.

ID: 35640

Presented by: Hajin Lee

Assessing the Impact and Lessons Learned from Wellness Together Canada: A Mixed-Methods Study

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Background and Objectives

The Canadian government funded Wellness Together Canada (WTC), a virtual, population-wide, open-access portal, offering 24/7 free mental health and substance use health support from April 2020 to April 2024. Following the Stepped Care 2.0 framework, WTC provided a continuum of care options, including self-guided resources, self-assessments/mood tracking, peer support, and counselling/crisis services. This presentation will discuss WTC's outcomes/impact and lessons learned, from the viewpoints of users and key informants within the mental health sector.

Approach

A mixed-methods approach was used to collect population-level data from a survey and key informant interviews. Registered users were invited to participate in the survey before WTC closure to capture user experience and perspectives (e.g., satisfaction, perceived impact). A total of 1366 responses (mean age = 48) were collected from March 26 to April 2, 2024. Additionally, interview invitations were sent to key informants who could provide insights into lessons learned from WTC, using a purposive sampling approach. Fifteen informants from various roles (developer/implementer, service providers, promoter, and external support group) were recruited from July 15 to September 24, 2024.

Results

The survey data of 1366 registered users indicated that 60% accessed the portal through the website, compared to 19% via the mobile app, and 41% used it at least once a month. The most frequently used resources were self-assessments (88%), followed by self-guided resources (47%), counselling (22%), crisis services (11%), and peer-led resources (10%). 78% reported satisfaction with the services, while 15% were neutral and 7% dissatisfied. In the absence of WTC, 28% of respondents stated they would have taken no actions to address their mental health needs, and 53% reported high levels of concern regarding WTC closure. Additionally, interviews with 15 informants highlighted key enablers such as cross-sectional collaboration/partnerships, funding and policy support, and platform technology supporting care preferences, user journey, and data-informed decision-making.

Conclusion

WTC demonstrated the potential for universal, nationwide mental health and substance use health services. A user-centered continuum of care, tailored to varying intensity levels, is crucial for designing and implementing digital mental health services. Innovative and flexible approaches are necessary to enhance equitable access while ensuring data-informed decision-making.

ID: 35168

Presented by: Mylene Levesque

Towards a quality-driven learning primary health care system

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Background and Objectives

A Learning Health System (LHS) facilitates the continuous improvement of the quality of healthcare using experiential, scientific, clinical and organizational knowledge. The Ministry of Health and Social Services mandated Quebec's SPOR Unit to contribute to the emergence of a LHS. The Unit developed structuring products to influence provincial health policy and mobilize health care institutions. These included a position statement on continuous quality improvement (CQI) and a framework for learning family medicine groups (FMGs).

Approach

A similar methodology was used to develop these two policy support products. First, a literature review was conducted to establish a strong scientific basis for the proposal. Second, a rigorous consultation process based on a scientific framework ensured that the proposal was firmly rooted in the healthcare field. The work was then synthesized and submitted to a new round of consultation, in the form of a World Café, before being finalized. Finally, the entire process included patient and clinical partnership to support ownership by all stakeholders. A consolidated, consensual and integrative final document was then submitted to the Ministry.

Results

The methodology proposed in this work was appreciated by stakeholders and decision makers. The position paper highlighted recommendations organized around five themes: 1) implementation of CQI initiatives; 2) attitudes and skills; 3) partnership; 4) roles of decision makers and government bodies; 5) access to and use of data. The consensus and robust nature of the recommendations enabled the Ministry to announce their full implementation in a government action plan. The learning FMG orientations were summarized in a six-dimension model: 1) CQI and best practices; 2) patient partnership; 3) interprofessional collaboration; 4) management and co-management; 5) research; 6) support and knowledge transfer. This inspiring and flexible model has already contributed to the evolution of coherent ministerial frameworks for FMGs and is generating interest across the country.

Conclusion

Our initiatives demonstrate the value of a scientific approach combined with a consultative process to influence decision-makers. Our approach fosters stakeholder engagement through transparency and authenticity. A new mandate has been given to the Unit to guide a primary care policy, confirming the appetite for our approach.

Patient Co-Leadership and Co-Creation of Clinical Trials Training: The CANTRAIN Experience

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Background and Objectives

Patient and community co-leadership and co-partnership are imperative for ensuring success in developing training courses for uptake and use by patient/community partners in clinical research. The objective is to present the work undertaken as part of the Canadian Consortium of Clinical Trial Training (CANTRAIN) platform, a 3-year CIHR-funded project. The project focuses on creating innovative clinical trials training programs that are competency-driven, patient-centered, grounded in adult learning principles, and aligned with real-world applications.

Approach

We adopted a participatory approach that established a national Patient/Community Partner Workgroup, known as CanPartner, alongside the development and capacity building of a core training development team. CanPartner co-created a Terms of Reference that guided the work. Our standard operating procedures included engaging with patient and community organizations, conducting a national educational needs assessment survey, and collaboratively designing course outlines and content. This process integrated patient engagement principles as well as equity, diversity and inclusion. By fostering collaboration, this approach enabled us to address challenges and gaps in clinical trial training, culminating in a thematic analysis to identify potential training topics.

Results

Using CanPartner's participatory approach ensured the selection of four key courses - Patient Participation, Partnership, Advocacy, and Leadership in Clinical Trials - by engaging patient and community partners in a national needs assessment. This collaboration identified gaps in knowledge and prioritized educational topics that were both relevant and impactful. The approach yielded significant benefits, including courses tailored to real-world challenges, enhanced accessibility through free, bilingual on-line content, and inclusivity through targeted Patient and Community Personas. Close collaboration with patient subject matter experts and a design team ensured engaging and interactive content. Challenges, such as addressing diverse needs and resource constraints, were mitigated through efficient resource management. Ultimately, co-leading and co-developing these courses improved the relevance, inclusivity, and effectiveness of clinical trials education, empowering patients and communities to engage meaningfully in research.

Conclusion

The involvement of patient and community partners in co-leading and co-developing our clinical trials modules enhanced the relevance, accessibility, inclusivity, and effectiveness of clinical trials education, while fostering trust and empowering patient and community partners to play an active role in the development process of clinical trial training.

A multi-province study of a machine-learning algorithm to de-identify free text in health records

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Background and Objectives

The digitization of health records provides opportunities to use free text from electronic medical records (EMRs) to inform healthcare decision-making. Accurate methods to safeguard sensitive personal identifiable information (PII) are essential for EMR use, but heterogeneity in data and access to de-identification expertise and technologies are potential barriers. Our objective is to describe the process and outcomes of implementing a machine-learning de-identification algorithm for free text from three Health Data Research Network (HDRN) Canada sites.

Approach

Our approach includes: (1) identification of entities, such as names, addresses, and numbers, that require de-identification based on provincial privacy legislation, (2) sampling and annotation of EMRs using open-source software, and (3) application of a pre-trained machine-learning de-identification algorithm to site-specific annotated data followed by federated learning, in which algorithm information (e.g., model parameter estimates) is shared across sites and the machine-learning algorithm is further trained using additional data from each site. Study data include primary care EMRs from Manitoba and Ontario, and hospital EMRs from Alberta. The de-identification algorithm is trained to redact, mask, or retain potentially sensitive information.

Results

To date, the study team has: (1) documented differences in provincial privacy legislation and site-specific access to free text containing PII, (2) trained annotators from all sites, and (3) developed sampling criteria to ensure the selection of sufficient and diverse instances of sensitive and non-sensitive information to train the de-identification algorithm and evaluate performance. Next steps include inputting the annotated information to the pre-trained machine-learning algorithm to produce site-specific accuracy estimates. These results will guide the selection of additional records for annotation; this iterative process will continue until sufficient data are available to optimize performance of a global algorithm through a federated learning approach across sites. The team will present lessons learned through implementation of this multi-site study and algorithm performance results.

Conclusion

Participating HDRN Canada sites are developing expertise in harmonized analyses and federated learning that will be shared broadly to improve free text de-identification practices. This multi-site study is essential to ensure the confidence of data custodians and researchers in using diverse and valuable types of healthcare data for policy-relevant studies.

ID: 35037

Presented by: Emily Lonsdale

Co-Creating an Equity-Oriented Care Model: Engagement with Lived Experience Advisors

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Background and Objectives

Barriers to cancer care disproportionately affect people facing health and social inequities. Our project, funded by the Canadian Partnership Against Cancer's Model of Care Funding Initiative, co-creates an equity-oriented model of care (E-MOC) intervention to pilot at BC Cancer-Vancouver. We recognize the importance of partnering with those who represent, or work closely with, equity-deserving groups and aim to share our synthesized knowledge from the lessons learned through this process.

Approach

An interdisciplinary team of embedded nursing researchers, health system leaders, advanced practice nurses, and the Provincial Lead for Patient and Family Experience at BC Cancer partnered with a diverse range of community members during the initial phase of the project. Lived Experience Advisors (LEAs) were intentionally invited to join the initiative. Throughout the project, we collaborated closely with LEAs to plan, design, and co-facilitate community-facing workshops, ensuring their perspectives were central to the process. Additionally, LEAs contributed their expertise to conduct a baseline equity assessment of the pilot site, ensuring an inclusive and equitable approach.

Results

Over the 12-month planning phase, LEAs played a key role in project governance by participating in the Steering Committee and co-designing a living set of community guidelines for all team members. Next, we co-hosted two workshops with our LEAs to consult community members and service providers in Vancouver's urban core. Centered on the perspectives of people with lived and living experiences of inequities, the project team, alongside LEAs, conducted EQUIP Health Care's Equity Walk Through exercise at the pilot site. We utilized an iterative feedback loop with LEAs to plan and conduct the activity. Throughout the co-design process of this innovative equity-oriented model of care, we carefully embedded a trauma- and violence informed approach to promote trust and safety among participants and BC Cancer staff.

Conclusion

Our project process and outputs have been strengthened by embedding the invaluable expertise of LEAs as members of our project team. Lessons learned through this work have the capacity to foster greater impact across equity-oriented quality improvement efforts, and community engagement practices within BC Cancer.

ID: 35422

Presented by: Elena Lopatina

Co-Designing the Alberta Virtual Pain Program with People with Lived Experience

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Background and Objectives

The Alberta Virtual Pain Program (AVPP) was developed to address gaps in chronic pain care in Alberta. Engagement and co-design with people with lived experience (PWLE) has been a cornerstone of the AVPP's development and implementation. We describe key examples of engagement and co-design with PWLE within the program.

Approach

1. The proposed model of care for the AVPP was directly informed by patient and community engagement research, which produced key recommendations for the health delivery system to improve care and support for individuals living with chronic pain¹, which served as the foundation for the AVPP's design.
2. PWLE provided letters of support, which accompanied the AVPP proposal submitted to the government, and participated in meetings with government leaders to advocate for enhanced chronic pain resources in Alberta.
3. PWLE actively contributed to the co-design of the AVPP as members of the advisory committee and working groups, determining the structure and content of services, reviewing materials, and shaping program delivery.

Results

The AVPP officially launched in April 2024, and within less than six months, over 200 patients have already engaged with its services. A feedback process was established to capture and act on participant experiences through anonymous surveys and open dialogue during Peer Support Worker-led group sessions. This feedback is reviewed by the team to enable timely improvements. To date, participant feedback has been overwhelmingly positive, emphasizing the value and the patient-oriented nature of the program's services.

Conclusion

The success of the AVPP underscores the critical role of PWLE in every phase of health system innovation.

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ID: 35295

Presented by: Alison Luke

Compensating patient partners on health research teams

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Background and Objectives

Health research increasingly relies on patient engagement – including patients as partners on research teams -- to increase quality and applicability of findings. An ongoing challenge is how best to compensate patient partners for their time and expert contributions, considering a range of personal and financial circumstances and institutional barriers. Our study aims to identify frequently encountered barriers and facilitators to compensating patient partners, and to explore how compensation practices impact equity, diversity, and inclusion.

Approach

Our study follows a qualitative descriptive research design, and incorporates full participation of patient partners on our team. We are using maximum variation sampling to recruit geographically and socially diverse representation from four groups from across the spectrum of patient-oriented research: patient partners, health researchers, academic administration and finance employees, and health research funding organization staff. Virtual interviews and focus groups seek to elicit respondents' impressions of the intersections between compensation practices and EDI in health research. We are applying inductive thematic analysis to explore common experiences and identify solutions to compensation practices that challenge equitable patient engagement.

Results

Themes derived from patient partner interviews include 'clarity', 'connection', 'power dynamics', and 'undoing privilege'. Clarity refers to clear communication, connection refers to the social dimensions of research engagement, power dynamics refers to the effects compensation practices have on power imbalances within the research team, and undoing privilege refers to the necessary work of inclusion and the need to relinquish privilege, build capacity in, and be responsive to the needs of equity-owed communities. Preliminary findings from focus groups with researchers, administration and finance staff, and funding body employees call attention to the variation that exists across and within institutions regarding compensation-supportive policies and practices, highlighting the work that is often required to clear institutional hurdles and resolve internal contradictions in order to appropriately compensate patient partners.

Conclusion

Study results are expected to help inform policies and improve practices around patient partner compensation in health research. This will contribute to enhanced diversity in patient engagement and more equitable patient and public research involvement, generating higher quality research outputs and ultimately improvements in health equity and population health outcomes.

ID: 35683

Presented by: Yona Lunsky

Accessibility of COVID-19 vaccine information: Policy directions from a co-designed national survey

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Background and Objectives

Accessible information is one key component of effective vaccination programs. However, there is limited research that explores how people with disabilities engage with public health messaging, and there is a scarcity of demonstrated efforts to work with people with disabilities to develop public health interventions. This co-designed study aimed to understand how adults with intellectual and developmental disabilities (IDD) and their caregivers navigated Canada's public health communications regarding COVID-19 vaccines.

Approach

The research team engaged in innovative research pursuits to facilitate policy change, as being the only known COVID-19 vaccine study to be co-designed with people with IDD, caregivers, and community organizations. A national survey, co-designed with the community, on the accessibility of vaccine information was conducted in 2022. 208 adults with IDD, 102 families/friends, and 54 staff completed the survey. Quantitative data were analyzed descriptively, and qualitative data were analyzed through descriptive content analysis. The team and people with IDD created an accessible research summary, ensuring findings could be understood by the populations who helped us design our study.

Results

Getting vaccinated against COVID-19 was a difficult and inaccessible experience for many people with IDD and their caregivers, from finding and understanding vaccine information, to booking an appointment, attending the appointment, and managing the need for multiple doses. Approximately 75% of adults with IDD found COVID-19-related information challenging to comprehend, followed by 69% of family/friends and 56% of staff. All three groups felt overwhelmed by the amount of information they had to navigate (adults with IDD, 72%; family/friends, 65%; staff, 70%) and experienced difficulties such as finding trustworthy sources and identifying vaccine mis/disinformation. Respondents offered recommendations to improve public health messaging and the accessibility of future vaccine campaigns.

Conclusion

Adults with IDD and caregivers experienced profound challenges when navigating Canada's COVID-19 vaccine campaign. Highlighted by our findings, public health policies should be revitalized to implement mechanisms that mandate working together with marginalized communities, as this collaboration will facilitate responsive interventions. Accessible public health messaging can only be co-created with communities.

ID: 34795

Presented by: Graham Macdonald

A Cross-Provincial Comparative Analysis of Opioid Agonist Therapy Policy during COVID-19

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Background and Objectives

Health promotion principles such as empowerment, inter-sectoral collaboration, and reorienting clinical services can be powerful drivers for achieving sustainable responses to public health emergencies. The provision of opioid agonist therapy (OAT) during the intersection of the COVID-19 pandemic and the drug poisoning crisis provides an opportunity to better understand whether, how, and why these principles influence policy change to address inequities in access for the marginalized and stigmatized population of people with opioid use disorder.

Approach

We are conducting a comparative policy analysis using Canadian provinces and territories as case studies to understand shifts in policy towards OAT during the COVID-19 pandemic. We have analyzed the public-facing federal and provincial policy documents related to OAT provision during and around the time of the COVID-19 pandemic. In this analysis, we aimed to establish timelines charting shifts in policy towards OAT provision. We have also analyzed the practical and rhetorical justifications in policy documents for these shifts. In our next phase we will conduct semi-structured interviews with relevant policy actors to corroborate and expand upon the document analysis.

Results

Our document analysis has showed that across provinces there was an adoption of loosened regulations on OAT including: easing restrictions on prescribing OAT; use of telehealth to access OAT; reduction in monitoring of patients; and increased access to take-home doses of buprenorphine and methadone. Most of these policy adaptations have remained in place since the pandemic. OAT policy changes were largely justified by health promotion principles such as harm reduction. The factors that led to the rapid adaptation of these policies, however, appears to have stemmed from local practicalities of accessing OAT during the pandemic. Political and historical context, however, shapes the repertoire of practical and rhetorical responses available to policymakers.

Conclusion

From our document analysis, it is apparent that otherwise slow-moving and hyper-politicized OAT policies have shifted toward harm reduction principles, spurred by COVID-19. The next phase of our study will make clear what was learned in different provinces, and which policy adaptations are likely to endure as a result.

ID: 34414

Presented by: Umair Majid

A Mining Approach for Rapid Quality Improvement Using Patient Experience Data: A Pilot Study

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Background and Objectives

Trillium Health Partners (THP) recognized limitations in its traditional patient experience (PX) data collection methods, which relied on paper-based and telephone surveys. These methods failed to capture the diversity of patient feedback essential for integrated care and rapid quality improvement. The objective was to develop a more efficient and inclusive PX data collection and analysis approach to gather timely, comprehensive feedback, enabling informed decision-making and continuous enhancement of patient care across various settings.

Approach

THP overhauled its PX data collection system by integrating multiple formats—email, QR codes, and tablets—to facilitate easier patient submission, and this has resulted in increased response rates and more diverse feedback. This presentation will discuss a pilot study to develop a data mining approach for rapid quality improvement. Advanced tools such as the Qualtrics dashboard, StatsIQ for statistical analysis, TextIQ for qualitative analysis via natural language processing, and NVivo for open-ended response analysis were leveraged to extract actionable insights from quantitative and qualitative data. Unit-specific regression models provided nuanced insights into the drivers of PX for each medicine unit.

Results

The pilot study focused on four medicine units—two with the highest and two with the lowest overall PX scores based on patient ratings. Critical enablers and barriers to PX were identified, such as emotional support and patient engagement in care decisions. Analysis of open-ended responses revealed that positive experiences were linked to effective communication and compassionate care (e.g., calling patients by their names), while negative experiences stemmed from poor communication and operational inefficiencies (e.g., extended wait times in hallways). The data mining approach provides a rapid way to generate patient-informed quality improvement ideas tailored to PX data from each unit, demonstrating the effectiveness of leveraging comprehensive PX data to enhance patient care and experience.

Conclusion

This pilot study highlights the value of a robust PX data mining approach for rapid quality improvement. THP plans to refine and extend this methodology across other programs, enabling continuous, data-driven enhancements in patient care and fostering a more inclusive, patient-centered healthcare environment.

ID: 35587

Presented by: Julie Makarski

Evaluating the Diabetes Action Canada Research to Action Fellowship Program for Patient Partners

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Background and Objectives

Patient engagement in research involves engaging patients as partners across all stages of the research process, including knowledge mobilization, to enhance the relevance and usefulness of research. The Diabetes Action Canada Research to Action Fellowship Program was developed to empower patient partners to co-lead the dissemination of diabetes-related research and included components such as training and mentoring. To ascertain successes, opportunities for improvement, and future sustainability, we evaluated the inaugural offering of this eight-month program.

Approach

We conducted a formative evaluation of the Program's pilot offering (May-December 2024) using a mixed-methods approach and informed by the RE-AIM implementation framework. Three participant types were purposively sampled and invited: Fellows and members of both the Fellowship's four Partner Organizations (PO) and development/leadership team. Fellows completed an online survey administered at four timepoints and attended two focus groups (midway and at the end). PO and development/leadership members each attended one 45-60mins virtual interview at end of the Fellowship. Survey data were analyzed using descriptive statistics and the transcribed and anonymized qualitative data were analyzed using inductive thematic analysis.

Results

Six of eight Fellows consented (living with diabetes (83.3%), White (66.7%), urban-based (66.7%), Ontario (83.3%); equally distributed by gender, age, patient partnership experience). Five of six PO members consented, representing all four POs (non-profit; size range from <10 to 50-249 employees; geographical reach spanned municipal to national to North America). Both Fellowship development/leadership team members consented. Data analysis is ongoing (completion: February 2025). Preliminary analysis showed increased knowledge and skills among Fellows in KM and patient engagement over time and high satisfaction with program. Fellows valued trainings, intensive mentorship, and collaborative opportunities with different knowledge users; suggestions include lengthening program and providing trainings earlier. PO members were very satisfied with program; suggestions include additional training topics and leveraging PO resources to support knowledge products produced.

Conclusion

The Fellowship Program was co-designed with patient partners and includes components associated with facilitating meaningful patient partner engagement in the research process, including knowledge mobilization. The findings of the program's inaugural evaluation will optimize the sustainability and impact of the program to empower future patient partners to co-lead dissemination efforts.

Trends in mental disorders among youth: a population-based administrative data study

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Background and Objectives

Globally, evidence has shown worrisome trends in the decline of mental health among youth (ages 10-24) and significant gaps in care. Ongoing monitoring of mental disorders among youth is urgently needed to inform health services and policies that can address these gaps. The objective of this study was to examine trends in the diagnostic prevalence of mental disorders among youth in British Columbia (BC), Canada.

Approach

We analyzed administrative data from January 1, 2008 to August 1, 2022 on a general population cohort of youth in BC (n=571,553). Validated case-finding definitions were used to identify youth with health service contacts for attention-deficit/hyperactivity (ADHD), mood/anxiety, conduct, substance use and/or psychotic disorders. We examined 14-year patterns of the following outcomes: any mental disorder (>1 of the five disorders), only one of each type of mental disorder, and comorbid disorders (>2 disorders in any 12-month period). We further explored pairwise correlation patterns for comorbid disorders using Kendall Tau and cross-tabulated outcomes by key variables (age, sex, income quintile, rurality).

Results

The diagnostic prevalence of any mental disorder was 54.8% (n=313,183) and comorbid disorders was 9.5% (n=54,326). Mood/anxiety disorders were most prevalent and frequently occurred as a single diagnosis (n=244,608 prevalent cases, 73% as single diagnosis). A similar pattern was observed for ADHD (n=79,444 prevalent cases, 46% as single diagnosis). Conduct, substance use, and psychotic disorders were less prevalent and frequently occurred as a comorbid diagnosis. There was a strong positive correlation between substance use and conduct disorders ($r = 0.91$) and a strong negative correlation between mood/anxiety and ADHD ($r = -0.43$) and conduct disorders ($r = -0.31$). The prevalence of any mental disorder increased with age and was higher among females compared to males and in outpatient community settings compared to hospital settings.

Conclusion

Over half of youth in BC had a health service contact for at least one mental disorder. Since most contacts occurred in outpatient community care settings, these findings can be used to inform targeted resources and strategies, such as interdisciplinary primary care teams, to augment mental health care delivery.

Actioning patient experience data to inform health system changes: Lessons learned

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Background and Objectives

Hospital organizations collect patient experience (PE) data through various methods, but it often remains unclear how this information is used beyond comparing metrics against other organizations. Acting on experiential data to inform quality improvement initiatives can be challenging when the health system is strained, and available resources cannot keep up with capacity pressures. Thus, we wanted to deepen our understanding of how to bridge the 'collection to action' gap to improve patient care and experience.

Approach

A qualitative descriptive design was used where 10 patient and caregiver partners and 13 hospital staff (leaders, managers, providers) from a multi-site, urban hospital in southern Ontario, Canada participated in either an interview or focus group. A four-part schematic outlining a potential strategy for collecting and using PE data was shown to participants followed by a semi-structured interview guide that were used to guide discussions. Interviews and focus groups were transcribed and a codebook was developed and applied to all transcripts. Thematic analysis was used to analyze the transcripts.

Results

Participants shared many insights about how hospital organizations can approach actioning PE data. The following five themes summarize what we heard from the patients, caregivers and hospital staff we interviewed: 1) Actioning PE data does not rest on one person's shoulders; 2) Actioning PE data requires systematic sense-making; 3) Tools and approaches are needed to support hospital staff in actioning PE data; 4) Quality improvement initiatives should be co-designed with patients and caregivers; and, 5) Hospital organizations need to show their work in response to PE feedback.

Conclusion

Actioning PE data is complex, but it should be an on-going priority for hospital organizations who want to deliver high quality, person centred care. This work requires intentional effort because it takes time to build relationships, interpret feedback, co-design, and to demonstrate accountability for how feedback is acted upon.

Building a National Curriculum and Community for Health Services and Policy Research Training

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Background and Objectives

Learning health systems (LHS) represent a systemic paradigm shift whereby research is integrated within operational objectives. This transition necessitates changes in health services and policy research (HSPR) education to equip graduates for roles beyond academia. Success demands embedding learners in healthcare settings and creating supportive infrastructure to support diverse career trajectories.

Approach

The Health System Impact Fellowship (HSIF) National Cohort Training Program (NCTP) brings fellows, academic mentors, and health system leaders together in an integrated learning community. This structured program complements the HSIF by fostering individual growth and collective capacity building for health system transformation. Through collaborative learning, fellows develop HSPR competencies while sharing insights across cohorts. The program advances embedded research training and identifies key elements that support successful integration of research capacity within health systems. We describe its development, implementation, and role on health system transformation.

Results

The HSIF NCTP aimed to deliver a comprehensive training program that cultivated leadership competencies for addressing complex health system challenges through evidence-based solutions. The program focused on three key objectives: (1) providing tools and learning opportunities in HSPR to advance LHS nationally; (2) creating deliberate, ongoing networking opportunities for meaningful engagement among diverse HSIF members; and (3) laying the groundwork for a sustainable Community of Practice. Participants engaged in virtual and in-person training activities, building professional networks while developing as embedded researchers.

Critical elements of the program's success included adaptive learning environments responsive to emerging needs, cross-sectoral collaboration fostered through mentorship, and instructional approaches combining theoretical knowledge with practical application.

Conclusion

The NCTP offers value for multiple partners in health system transformation. For policymakers, it illustrates the benefits of embedded training, professional development, and collaboration. Educators can adopt its framework to enhance curriculum relevance, engagement, and program sustainability. Practitioners gain from its emphasis on critical thinking, cross-sectoral perspectives, and networking opportunities.

Evaluating the HSIF National Cohort Training Program Using the Kirkpatrick Framework

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Background and Objectives

In response to challenges facing health systems and higher education training, health professionals are implementing evaluation frameworks to assess training effectiveness. The Health Systems Impact Fellowship (HSIF) National Cohort Training Program (NCTP) trains doctoral students, post-doctoral fellows, and early career researchers in health services and policy research. Using the Kirkpatrick Evaluation Framework, we assessed the program's impact on developing professional and practical skills among health systems fellows.

Approach

The NCTP features learning sessions, networking opportunities, and an annual National Cohort Retreat (NCR). Using the Kirkpatrick Evaluation Framework, prominent as an evaluation framework in the healthcare field, we assessed the program's effectiveness. NCTP fellows completed online surveys with Likert scale ratings and open-ended questions to evaluate their experiences and learning outcomes across quarterly themes over four years. Program effectiveness was analysed using Kirkpatrick's four levels: reaction, learning, behavior, and impacts. The qualitative responses from open-ended questions underwent thematic analysis to provide deeper insights into program outcomes.

Results

Four cohorts of fellows (n=152) primarily in Ontario, participated in the NCTP. Reaction: Participants strongly valued the training, with most agreeing or strongly agreeing on content relevance across themes. Participants appreciated the diverse, engaging topics. Learning: Many reported enhanced knowledge, skills, positive attitude shifts, and increased confidence. The program increased awareness of engaging with diverse populations and equity issues, while promoting thoughtful, reflective research approaches. Behaviour: Fellows offered examples of applying new insights, such as building deeper relationships and adopting reflective practices to foster inclusivity. Impact: The training demonstrated positive effects on participants' work and organizations, particularly in policy development and organizational functioning. Several fellows reported transformative experiences that significantly influenced their professional practice and perspective on health systems research.

Conclusion

The findings of this study provide insights for developing and applying future health system evaluation programs. The findings contribute to Canada's growing body of literature on health systems evaluation and demonstrate the value of embedded training in cultivating the next generation of health system and policy research leaders.

ID: 35214

Presented by: Dane Mauer-Vakil

Health system challenges faced by youth in foster care in Ontario, Canada: A qualitative study

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Background and Objectives

Youth in foster care face numerous health system challenges related to fragmented care, limited access to mental health support, and stigma/discrimination. Little research has investigated these issues in the Canadian context. Thus, the objective of this study was to examine the experiences of youth in foster care as it pertains to their interactions with the health system in Ontario, Canada.

Approach

As part of a larger mixed methods study, the data presented focus on qualitative interviews of individuals involved in the foster care system. Using a phenomenological approach, we conducted semi-structured interviews between July 2022 and December 2023. Our study participants were youth formerly in foster care (N=13), social workers (N=19), and foster parents (N=10). We undertook an inductive thematic analysis using open coding in NVivo 12.

Results

The predominant themes pertaining to the youth participants were the negative impact of transitions in care, family stress, and childhood trauma alongside a general mistrust of health professionals. Foster parents voiced concern regarding the need for better access to primary care providers and specialists. Social workers described the complexities of youth health as well as the high rates of developmental and physical disabilities as key areas of their work in supporting youth in care. Importantly, crosscutting themes across our interview participants related to the importance of enhancing mental health support via a trauma-informed approach, that a lack of communication across health system silos was the norm, and that youth need improved access to primary care services.

Conclusion

The Ontario health system is not meeting the needs of youth in foster care. Policy reforms must prioritize trauma-informed services embedded within primary care alongside improved inter-sectoral collaboration. Further research on the health service needs of this population is needed to inform programming aimed at improving quality of life.

Incidence and prevalence of peripartum mental illness in mothers with multiple sclerosis.

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Background and Objectives

Peripartum mood and anxiety disorders represent common and high-risk maternal morbidities in the general population. Few studies have examined peripartum mental illness in mothers with multiple sclerosis (MS), despite findings of higher prevalence estimates of psychiatric disorders among the overall MS population. Our objectives were to estimate the incidence and prevalence of peripartum mental illness among mothers with MS relative to mothers with epilepsy, inflammatory bowel disease (IBD), diabetes, and without any of these conditions.

Approach

This was a population-based, retrospective cohort study using Ontario linked health administrative databases. We identified mothers with MS, epilepsy, IBD, diabetes, and without these diseases (comparators) with a live birth and index dates (defined as one year before conception) between 2002-2017. We estimated the incidence and prevalence of mental illness using validated case definitions (including any, depression, anxiety, bipolar disorder, psychosis, substance use, suicide attempt) during the prenatal period and three-years post-partum. Incidence and prevalence estimates were compared between cohorts using incidence ratios (IR) and prevalence ratios (PR) with 95% confidence intervals (95%CI), and Poisson regression models, adjusting for confounders.

Results

Included were 894,852 mothers (1,745 MS; 5,954 epilepsy; 4,924 IBD; 13,002 diabetes; 869,227 comparators). Mean (SD) age at conception was 28.6 (5.7) years. Any incident mental illness affected 8.4% of mothers with MS prenatally; 14.2% during the first post-partum year; risk was higher in the first post-partum year (IR 1.27;95%CI:1.08-1.50 vs prenatal period). Mothers with MS had an increased incidence of any mental illness during the prenatal (IR 1.26; 95%CI:1.11-1.44) and first post-partum year (IR 1.33;95%CI:1.20-1.47) vs comparators. They also had an increased incidence of all mental illnesses except suicide attempt during the prenatal period (vs. comparators). Prevalence (any mental illness) for mothers with MS was 42% (prenatally) and 50.3% (first post-partum year). Some mental illness estimates were also higher for mothers with other conditions.

Conclusion

We observed a higher incidence and prevalence of peripartum mental illness among mothers with MS relative to mothers without the study conditions. Risk was higher during the first post-partum year than prenatally. Our findings demonstrate the importance of preventive interventions and early treatment of mental illness in this population.

Key informant experiences with patient-reported outcome measures in youth mental health

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Background and Objectives

Measurement-based care (MBC) is the routine use of patient-reported outcome measures to direct treatment planning in mental health care. It provides clinicians with real-time objective measures of symptoms and functioning, and organizations with outcomes data to drive decision-making. Despite its promises, few studies have investigated clinician and administrator's perspectives of MBC in child and adolescent mental health services. The objective of this study was to describe clinician and leadership experiences with MBC.

Approach

This study uses a qualitative description approach. Data were collected as part of a comprehensive implementation evaluation of the MBC at a new child and adolescent mental health centre in Calgary, Canada. Semi-structured interviews were conducted with clinicians and administrators. Questions focused on their attitudes and experiences with using MBC for individual client care and service evaluation. We used deductive, directed content analysis to analyze interview data, using benefits and drawbacks at the micro-, meso- and macro-levels as the initial coding framework.

Results

Managers (n=3), clinical supervisors (n=4) and clinicians (n=9) were interviewed. Clinicians consisted of clinical social workers, psychologists, and nurses. Four categories of results were identified: 1) Benefits at micro level – MBC is perceived to provide comprehensive data to guide care, it enhances client experiences of care, and benefits the clinicians' professional practice; 2) Benefits at the macro-level – provides data for service evaluation and to evaluate client population needs, provides outcomes to demonstrate value to funders; and 3) Drawbacks at micro level – additional burden for clients and families; 4) Drawbacks at macro level – requires additional resources to operate. Benefits were perceived to outweigh drawbacks.

Conclusion

This study provides insights into the benefits and drawbacks of MBC in child and adolescent mental health from the perspective of clinicians and leadership. It will inform future decisions to implement MBC in similar settings, and guide the selection of targeted implementation strategies.

ID: 34541

Presented by: Terrence McDonald

Cost savings associated with primary care continuity among patients with chronic disease

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Background and Objectives

Continuity of care is associated with lower costs and better patient health outcomes. Less is known about the impact of continuity with a community primary care clinic and cost savings for patients with chronic disease. We examined and compared cost savings from hospitalizations, ED visits and community primary care visit associated with continuity with a primary care physician (PCP) and primary care clinic for patients with COPD, heart failure, ischemic heart disease, asthma and diabetes.

Approach

Using a retrospective population level cross-sectional design we included all FFS PCPs from 2015-18. Patients with >3 PCP visits who met the diagnostic disease criteria for each condition were included. PCP continuity was calculated using the known provider continuity index and clinic continuity used a group care rate measure. The clinical risk grouper (CRG) was used for patient complexity, patients were categorized as low (CRG1-2), moderate (CRG3-4) or high (CRG5-9). Average and total cost savings over three years per patient were calculated. Hospitalizations and ED costs were estimated using CIHI CMG+ costing methodology for inpatient/ ED visits. Community PCP costs were the paid amounts from physician claims.

Results

Total cost savings for every 30% increase in UPC for CRG 5-9 patients was an estimated \$9883 for COPD, \$12,177 HF, \$7798 DM, \$7359 IHD, and \$4613 asthma. Cost savings were observed across CRG levels 1-4 for these 5 conditions, ranging from \$200 to \$5000 for every 30% increase in UPC. Cost savings were driven by reductions in inpatient costs. Relative to 0% clinic continuity, COPD and HF patients with high clinic continuity (100%) resulted in the greatest total cost savings per patient: \$10,000 to \$14,000 for CRG5-9, \$4000 to \$9000 for CRG 3-4, and \$2000 to \$5500 for CRG1-2. DM, Asthma, and IHD with high clinic continuity (100%) resulted in per patient savings: \$5000 to \$7800 for CRG5-9 relative to 0% clinic continuity.

Conclusion

We examined and compared cost savings associated with various levels of primary care clinic and PCP continuity for 5 major chronic diseases. The cost savings were notable for each type of continuity (clinic and PCP). These results offer valuable information for policies that impact the design of community primary care practices and remuneration models.

Working Together: Incorporating Inuit Qaujimajatuqangit principles in community-driven research

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Background and Objectives

Scientific publications predominantly focus on research outcomes. Increasingly, community partnerships and relationships are mentioned, especially in research conducted with Indigenous communities. In partnership-based research, Indigenous communities expect researchers to contribute in a multitude of ways that go beyond doing research. This article reports on a series of unforeseen, yet positive contributions realized in the Qanuinnigitsiarutiksait study, undertaken between 2015 and 2021.

Approach

The Qanuinnigitsiarutiksait study was co-created with the Manitoba Inuit Association (MIA). Members from MIA, Inuit Elders, referred to as Isumatait Sivuluiqti (decision makers), and University of Manitoba researchers worked in partnership to develop and implement the research project. The initial study used a mixed methods approach, incorporating quantitative, qualitative methods, and Indigenous methods grounded in Inuit Qaujimajatuqangit (IQ), Inuit ways of knowing. IQ-based approaches involve community engagement, collaboration, and centring Inuit knowledge and practices.

Results

Salient unforeseen benefits included the strengthening of the Manitoba Inuit community through hosting community feasts, games, and virtual events; creating opportunities to increase the visibility of Inuit Elders at University public events; supporting the growth of MIA in terms of staff, programmes, and presence at provincial policy tables; leveraging relationships towards the development of Inuit-centric primary healthcare services in Winnipeg; creating a method to identify Inuit in provincial administrative datasets which were used to track COVID-19 infection rates and ensure equity in access to testing and vaccines. As a result, the Manitoba Inuit Association's visibility has increased, and Inuit Elders have become essential contributors of Indigenous knowledge at Manitoba-based events, as First Nations and Metis have been for decades. This transformation appears to be sustainable.

Conclusion

IQ-based methods allow our research to meaningfully include the Inuit community in academic research, as well as centre Inuit knowledge and priorities. By doing so, the Qanuinnigitsiarutiksait study has achieved above and beyond its initial objectives and added meaningfully to the health and well-being of Inuit.

ID: 32603

Presented by: Tomoko McGaughey

Socio-demographics and health behaviours of high system emergency care users inclusive of rurality

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Background and Objectives

Several factors, such as age group, education level, and primary care provider attachment are associated with high system users (HSUs) of emergency services. However, these individuals are often assessed cross-sectionally and rurality is often treated as binary. This analysis aims to identify the socio-demographic and health behaviours, inclusive of those who live in rural spaces, in a longitudinal way. Through this we can further understand factors contributing to elevated use of emergency healthcare services.

Approach

This analysis presents the socio-demographic and health behaviour characteristics of emergency service HSUs, using a definition that is inclusive of those who live in rural communities (average admissions are for CTAS reason 4 or 5 (low urgency) 2 of 3 consecutive years). To identify this definition, multiple commonly used definitions were evaluated using Cox-proportional hazard modelling to determine which is most appropriate for rural inclusive analysis. This analysis was done using the 2016 Canadian Census Health and Environment Cohort and 2007-2017 CCHS linkage profile, both of which are nationally representative and linked to historical postal codes and hospitalization information.

Results

Preliminary assessment of the socio-demographic results reveals that those who are those who are female, older, who are of the lower income grouping, and rent their homes. As well, for health behaviours, those who were identified to the HSUs of emergency services were more likely to not be attached to a primary care physician, live further away from 24-hr emergency care services, have lower physical activity levels, were more likely to have an increasing number of chronic conditions, and were more likely to experience a debilitating injury. These differences were consistent Overall, and between sexes, rural typologies, and provincial regions.

Conclusion

Our study highlights key differences in rural health service use and needs and the importance of rural-centric research. By properly identifying and characterizing rural HSUs we hope this can lead to policies that allow for better health promotion practices, develop healthier communities, and advocate for health and social care resources.

ID: 35068

Presented by: Lorraine McLeod

First Nations strategies to address chronic kidney diseases in Manitoba

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Background and Objectives

Indigenous organizations play a crucial role in fostering equity, acting both as direct providers of services and as sentinels of social justice. In Canada, the First Nations and Social Secretariat of Manitoba (FNHSSM) has been collaborating with researchers from the University of Manitoba to map primary health care failures and opportunities to improve access to kidney care, especially in rural and remote communities.

Approach

This study was designed and conducted as a partnership between the First Nations Health and Social Secretariat of Manitoba and researchers from the University of Manitoba. This mixed method study used health administrative data to document characteristics of First Nations who initiate dialysis within 3 months of diagnosis to identify missed primary care opportunities. We then conducted interviews with First Nations who experience dialysis and care givers (N=30) to identify possible missed care opportunities.

Results

First Nations initiating dialysis within 3 months of diagnosis were older, disproportionately male, had a higher comorbidity score (ie, hypertension, congestive heart failure). Their first diagnostic of chronic kidney disease was on average at a similar time before the start of dialysis compared to other Manitobans, but experienced delays in nephrology referral. Interviews revealed evidence of untreated hypertension, delays in referrals, and dismissals of concerns. While clinical guidelines require primary care physicians to routinely screen all First Nations over the age of 10 for diabetes and kidney function, workforce limitation especially outside of urban centres, makes this unlikely.

Conclusion

FNHSSM is implementing a multilevel strategy to address screening needs through mobile and virtual modalities, while continuing to lead research to document missed opportunities for better care and working with providers to implement pragmatic solutions.

ID: 35606

Presented by: Carolyn Melro

Berry Harvesting: Integrating Indigenous Ways of Knowing into Learning Health System

Authors: *Melro, Carolyn, Lakehead University, MacDonald, Kathleen, McGill University, Cowan, Tovah, McGill University, Marandola, Gina, Douglas Research Centre, Restoule, Brenda, First Peoples Wellness Circle, Connors, Tecusmeh, Feather Carriers, Mushquash, Chris, Lakehead University & Iyer, Srividya, McGill University*

Background and Objectives

Learning health systems (LHS) can improve care quality, experiences, and outcomes for service users and their families while ensuring responsive, equitable, and cost-effective services. However, integrating Indigenous ways of knowing remains a gap in literature and practice. The objective of this presentation is to share early conceptualizations of a LHS in Indigenous contexts (e.g., Indigenous communities and urban settings that serve Indigenous youth) through the ACCESS Open Minds Indigenous Youth Mental Health and Wellness Network.

Approach

Our network is guided by a multi-generational and a distinctions-based approach to data collection, process, and governance rooted in Indigenous knowledge systems. By integrating the perspectives of First Nations, Métis, and Inuit Peoples we ensure our practices honour cultural teachings while applying methodologies to support culturally relevant and sustainable outcomes for Indigenous peoples. We share the story of berry harvesting as a metaphor for LHS within Indigenous contexts. Berry harvesting is a significant cultural practice contributing to holistic wellness for many Indigenous Peoples and communities across Canada; although, we recognize the beauty in the diversity of these practices.

Results

Like berry harvesting, an LHS is best founded on the values of community engagement, local knowledge and continuous learning. Both processes involve collaboration among various stakeholders, whether they are harvesters and community members or decision-makers, clinicians and researchers. Continuous learning and adaptation are key in both contexts, with berry harvesters adjusting techniques and location, while LHS incorporate new evidence and feedback to improve health services and outcomes. Sustainable berry harvesting practices ensure future availability, mirroring the LHS's goal of creating adaptable and sustainable health systems. Harvesters need to know where to harvest (knowledge-to-practice: knowing when and what data to collect) and harvest based on ripeness (practice-to-data: process of gathering data). The act of harvesting berries itself is analogous to the data-to-practice cycle.

Conclusion

Integrating Indigenous knowledge into LHS can ensure services become more inclusive and effective in addressing the health care quality, experiences, and outcomes of Indigenous Peoples. This presentation reflects on how organizations can learn from and apply Indigenous knowledge, and the evidence held within communities to support their health and wellness.

ID: 35660

Presented by: Carolyn Melro

ACCESS Open Minds Indigenous Youth Mental Health Network: building and sustaining trust

Authors: *Melro, Carolyn, Lakehead University, Gilfoyle, Meghan, Women's College Hospital, Ballantyne, Clifford, HOMEBASE, Marandola, Gina, Douglas Research Centre, Iyer, Srividya, McGill University, and Mushquash, Christopher, Lakehead University*

Background and Objectives

Health research and service delivery often fail to incorporate Indigenous worldviews and local community protocols, leaving Indigenous individuals wary of participating in research. Such a legacy of mistreatment in research and service delivery requires building meaningful and trusting relationships to ensure the equal partnership of and benefit to Indigenous Peoples. This presentation will trace the development and evolution ACCESS Open Minds (AOM) Indigenous Youth Mental Health and Wellness Network (IYMHWN), a pan-Canadian participatory research network.

Approach

Our network is guided by a multi-generational and a distinctions-based approach integrating the perspectives of First Nations, Métis, and Inuit Peoples. Through community-based partnerships we have found the upfront 'cost' of relationship-building and time can cultivate sustainable and meaningful engagement through capacity-building and trust with and between network advisors and members. We developed a conceptual framework for sustained engagement built on trust that includes the following principles and values: shared values, visions, and goals, power sharing and co-ownership, vulnerability, critical reflexivity, self-determination, and respect, responsibility, relevancy, reciprocity, and resources.

Results

Since 2014, the AOMs Indigenous Council advised on the development, implementation, and evaluation of Indigenous youth mental health service delivery transformation in demonstration sites across Canada. Building upon this work and existing relationships, the AOM IYMHWN has quickly evolved to become a gathering place for 115+ diverse stakeholders with shared values and interest in improving Indigenous youth mental health and wellness across Canada that is grounded in ceremony and cultural practices. The network facilitates connections between youth, communities and researchers to create meaningful research based on community needs and priorities, and opportunities to share successes and identify and work together to address common challenges. Over time and in response to continuous network member and community feedback, the network will house an accessible knowledge base and repository of tools.

Conclusion

This presentation uses the AOM IYMHWN as a demonstration case to explore how to build and sustain trust, enabling the meaningful involvement of Indigenous youth and communities in health service transformation. It highlights key activities and reflections that have contributed to a decade of meaningful collaboration in health system transformation.

ID: 34172

Presented by: Michaella Miller

The impact of staffing practices in LTC on the working conditions of staff: a narrative review

Authors: *Miller, Michaella; Almomani, Yasmineen; Hopwood, Pam; Haghighi, Paniz; Davis, Abbey; Littler, Emma; MacEachen, Ellen. School of Public Health Sciences, University of Waterloo*

Background and Objectives

Chronic underfunding of the long-term care (LTC) sector, coupled with increased complexity of care, has deteriorated working conditions and contributed to severe staffing shortages of healthcare workers globally. While previous reviews have examined the association between LTC staffing and care outcomes for residents, none have examined how staffing structures affect the healthcare of staff themselves. This review asked: Does staffing impact working conditions in LTC for direct care workers?

Approach

A narrative review of empirical peer reviewed literature was conducted to examine how LTC staffing practices impact working conditions and work outcomes of staff in OECD countries. PubMed, CINAHL, and Scopus databases were searched for relevant articles published within the past 10 years. Searches yielded 3935 unique articles, which were independently screened by pairs of reviewers, of which 63 articles met inclusion criteria. Data were extracted and synthesized to bring together the ways in which staffing practices impact the LTC workforce, what practices exist, and how they came to be.

Results

Deterioration of work environment occurred because of government actions and COVID-19 through a reduction of staffing levels, increasing the use of agency staff, a systematic de-skilling of care teams, chronic shortages, and a myriad of problematic cost-saving initiatives. Low staffing levels, understaffing, and shortages often resulted in staff having a higher number of residents for whom they were responsible, increased their workload, required them to work overtime/double time, and perform unpaid labour. These conditions were found to decrease job satisfaction and increased intention to leave. A sense of moral duty for vulnerable residents prompted staff to compensate for this deterioration. Studies found that negative work conditions bled into care quality and resulted in poorer care if workarounds could not be made or were unsuccessful.

Conclusion

Staffing practices shape working conditions and impacts the occupational wellbeing of care workers. Harmful work conditions were shown to destabilize the LTC workforce, perpetuating recruitment and retention problems. To create and maintain a strong LTC workforce, working conditions and occupational health need to be a priority in improvement initiatives.

ID: 34153

Presented by: Jonathan Mitchell & Nitika Rewari

Enhancing the Quality Mental Health Care Framework and Developing the Implementation Toolkit

Authors: *Marissa Persaud, Siri Chunduri, Jonathan Mitchell, Kamlesh Tello*

Background and Objectives

Since 2019, HealthCareCAN and the MHCC have co-led the Quality Mental Health Care Network, fostering national collaboration to improve mental health care. This partnership developed the Quality Mental Health Care Framework (QMHCF) to guide system improvements. In September 2024, a new project was launched to update the Framework, reflecting evolving priorities, and to develop an implementation toolkit providing healthcare providers and organizations with actionable resources to enhance mental health care delivery.

Approach

A comprehensive environmental scan of 15 provincial, territorial, national, and international frameworks was conducted, and thematic analysis was used to identify gaps and opportunities for updates. Purposive sampling was used to identify 59 key informants from diverse healthcare organizations, including hospitals, community care centers, and mental health advocacy groups. Structured interviews were conducted. Additionally, focus groups with individuals with lived and living experiences (PWLLE) including with Patients for Patient Safety Canada and MHCC's Youth Council and Hallway Groups provided in-depth insights into the Framework's dimensions, definitions, and implementation.

Results

Interview findings recommended areas for improvement, including a greater emphasis on the concepts of cultural safety, equity, and integration of mental health within healthcare systems. Insights from interviews and focus groups underscored the importance of defining the Framework dimensions of stigma-free, trauma-informed, and safe environments. In addition, interviewers provided actionable, evidence-based resources to include in the implementation toolkit. Designed to meet the needs of diverse healthcare settings, the toolkit offers practical tools such as case studies, videos, journal articles, checklists, and measures to support quality mental health care delivery.

Conclusion

The updated QMHCF and its implementation toolkit empower healthcare providers with actionable resources tailored for diverse care settings. We continue working with the Quality Mental Health Care Network across Canada to equip stakeholders and PWLLE with tools and strategies to enhance mental health care and drive measurable improvements in outcomes.

ID: 35604

Presented by: Sandra Moll

Beyond Silence: Implementing App-Based Support within the Canadian Forces Health Services

Authors: *MacLeod, Trisha; Chenette, Marilyn; Goulet, Cher (all from Canadian Forces Health Services)*

Background and Objectives

The Canadian Forces Health Services (CFHS) includes 5000 providers who support over 65,000 military members. They face unique challenges, not only related to workload pressures, but due to the complexities of providing care for themselves and their colleagues. There is an urgent need for accessible, confidential supports that are customized to their unique needs. The purpose of this study was to evaluate Beyond Silence, a bilingual mobile health platform designed by and for healthcare workers.

Approach

A mixed methods case study, informed by implementation science, was conducted. From March to August 2024, all CFHS members were invited to download and use Beyond Silence, an innovative mobile health app designed to reduce barriers to accessing mental health information and support. Aggregate data was collected on downloads, feature usage, and peer support outreach, comparing adoption patterns by gender, age, and clinical role. Baseline and follow-up interviews with four organizational leaders and focus groups with nine of the 35 peer support providers were analyzed to identify facilitators and barriers to app use.

Results

During the trial, there were 343 downloads (7% of members), and 23 peer support appointments were scheduled. Overall utilization of features was highest among women (71%), aged 40-49 (68%), and/or in non-clinical roles (76%). Peer support outreach, however, was more common among men, employees aged 18-29, and non-clinical staff. Facilitators to app use included leadership endorsement and access to private, secure, on-demand peer support. Barriers included a culture of stoicism, and concerns that reaching out would compromise career advancement. In addition, there were limitations to the technology infrastructure, and resources to support and sustain engagement across a large, multisite organization. The peer support service and app technology was new, therefore time was needed to integrate it into the day-to-day practices of the organization.

Conclusion

Beyond Silence is an innovative approach that holds promise for mitigating barriers to mental health support, but the process of implementation needs to address the unique structural and cultural context of military health services. Recommendations will be made for optimizing implementation within a stepped model of care.

A Cross-Provincial Policy Research Study on Indigenous Primary Health Care Infrastructure

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Background and Objectives

In Canada, the barriers faced by Indigenous peoples in accessing primary healthcare (PHC) stem from historical policy legacies. Jurisdictional ambiguity between federal and provincial responsibilities for Indigenous health, along with complex funding arrangements, has resulted in inadequate health service infrastructure for delivering PHC across First Nations, Métis, and urban contexts. Infrastructure within a healthcare system is understood as the combined physical, technical, and organizational components necessary for delivering healthcare services.

Approach

The research team conducted a one-year policy study on Indigenous PHC infrastructure development in Alberta (AB) and Ontario (ON). We used Bardach's eight-step policy analysis to explore the policy issue and alternative solutions. We reviewed 89 policy documents (ON = 36; AB = 39, Federal = 14) using the Policy Triangle and Indigeneity Grounded Analysis frameworks to gather information about the context, content, actors involved, and whether Indigenous peoples were meaningfully engaged in the policy development. Additionally, we conducted 14 semi-structured interviews with interest holders from AB and ON to explore policy narratives and their connections to policy events.

Results

Five themes emerged from the document review and interviews: (1) incorporating cultural infrastructure to reflect Indigenous cultural practices and values; (2) addressing geographic challenges in recruiting providers to rural areas; (3) adapting to community needs and coordinating resources for infrastructure development; (4) self-determination in PHC; and (5) funding instability affecting service delivery. Policy documents revealed ON's more extended history of Indigenous PHC infrastructure investments, including Aboriginal Health Access Centres (1995) and Indigenous Interprofessional Primary Care Teams (2018). In contrast, AB's reforms prioritized physician incentives with limited infrastructure investments. Findings informed a conceptual model of Indigenous PHC infrastructure. Interview participants identified recommendations for introducing flexible funding models and providing dedicated Indigenous PHC infrastructure funding.

Conclusion

This study is the first to explore Indigenous PHC infrastructure in Canada and develop recommendations to enhance Indigenous health outcomes through infrastructure investments. Implementing these recommendations can promote Indigenous self-determination in funding, planning, and delivering PHC services. Future research will involve Indigenous patients to ensure alignment with their experiences and needs.

ID: 35633

Presented by: Stephanie Montesanti

Effects of public health crises on emergency visits by First Nations in Wood Buffalo, Alberta

Authors: *Verstraeten, Barbara S.E.; School of Public Health, University of Alberta;*

Sjoblom, Erynne; School of Public Health, University of Alberta;

Montesanti, Stephanie; School of Public Health, University of Alberta

Background and Objectives

Indigenous Peoples in the Regional Municipality of Wood Buffalo (RMWB) in Alberta, continue to experience the compounded effects of multiple traumatic local and global events, including wildfires, floods, and the COVID-19 pandemic. Consequently, mental health is a major community priority. Moreover, Indigenous Peoples have historically faced significant disparities in accessing healthcare services. This project aims to gather knowledge on Indigenous healthcare utilization, health status, and gaps in healthcare delivery in the RMWB.

Approach

In collaboration with First Nations partners in the RMWB and health authority staff, we conducted a population-based retrospective cohort study using linked administrative health data (2014-2023) to evaluate emergency department (ED) visits in the RMWB by First Nations individuals living in the region. Visits by youth and adults were evaluated based on the primary ICD-10 diagnostic code. To understand the impact of key events, an interrupted time series analysis is being conducted to evaluate changes in the incidence and trends of ED visits, particularly for mental and behavioural disorders (MBD), among First Nations youth and adults in the region.

Results

Between 2014 and 2023, ED visits by First Nations patients with MBD as primary diagnosis increased from 4.8% to 13.2%. Of these, 65.1% was associated with psychoactive substance use. Patients were more likely to be male (54.9%) and 25-44 years old, although First Nations women use the ED more overall ($p < 0.001$). Preliminary analyses highlight notable trends in ED use by First Nations residents of the RMWB. Interruptions in utilization patterns, including those for various diagnostic categories such as MBD, appear to align with key local and global events. These include the 2016 Fort McMurray wildfire, the COVID-19 pandemic, and the introduction of initiatives aimed at improving access to primary health care and virtual care for Indigenous Peoples in Alberta.

Conclusion

Local and global events continue to profoundly impact Indigenous Peoples. Preliminary patterns in ED visits suggest connections to these events; however, further analyses—to be completed by the conference date—are underway to confirm significance, examine trends, and explore the underlying factors influencing these changes across utilization patterns.

ID: 35215

Presented by: Jennifer Murdoch

Evaluating the Nurse Transition Program for Internationally Educated Nurses in Nova Scotia

Authors: *Dr. Jennifer Murdoch (Nova Scotia Health), Dr. Caroline Chamberland-Rowe (Nova Scotia Health), Kaylee Murphy-Boyle (Nova Scotia Health), Janet Rigby (Nova Scotia Health), Kianna Benson (Nova Scotia Health), Joanne Sanford (Nova Scotia Health), Dr. Annette Elliott Rose (Nova Scotia Health)*

Background and Objectives

Nursing shortages across Canada have amplified provincial efforts to leverage the capacity of Internationally Educated Nurses (IENs) to support nursing workforce sustainability. Nova Scotia Health's Nurse Transition Program (NTP) is a transformative model designed to support IENs integrating into Nova Scotia's healthcare system. The NTP combines theoretical learning, simulation-based training, and hands-on clinical practice to address gaps in clinical readiness and familiarity with Canadian healthcare practices.

Approach

Guided by the Conceptual Framework for Workplace Integration, a mixed-methods formative evaluation of the NTP is underway. Evaluation objectives have included assessing the program's acceptability, effectiveness, and impact on IEN competency, integration, and workforce capacity. Data collection activities have included semi-structured focus groups, interviews, surveys, and competency assessment tracking. Thematic and descriptive analyses have been utilized to identify enablers and barriers to successful implementation, and describe the program's impact to date.

Results

Interim findings highlight the NTP's role in fostering IEN confidence, clinical competency, and adaptation to Nova Scotian healthcare practices. Strong leadership, mentorship, and simulation-based training have been pivotal enablers, while challenges such as resource disparities, and preceptor burnout have been noted. Participants have valued hands-on learning opportunities and mentorship, and identified the need for earlier assessments of clinical and language readiness, expanded acute care placements, and enhanced cultural competency training for staff.

Conclusion

Evaluative findings to date suggest that the NTP not only enhances IEN skills and workplace inclusion but also strengthens team dynamics and alleviates staffing shortages, demonstrating its scalability to other sites in Nova Scotia and potential for broader application across Canadian healthcare systems.

ID: 35033

Presented by: Siobhan Murphy

Home Mechanical Ventilation Care Amidst the COVID-19 Pandemic: Preliminary Scoping Review Results

Authors: *Siobhan Murphy, BA*

Kathleen Charlebois, PhD

Sandra Pelaez, PhD

David Zielinski, MD

Marta Kaminska, MD

Background and Objectives

Home mechanical ventilation (HMV) is a specialized therapy essential for managing chronic respiratory insufficiency. During the COVID-19 pandemic, patients on HMV faced increased risks of severe infection and care disruptions. However, the role of the pandemic on HMV therapies and the care provided to these patients (with a variety of diagnoses) remains unclear. This scoping review seeks to understand how the pandemic shaped home respiratory services and care experiences among patients using HMV.

Approach

The approach drew on the main steps of a scoping review: 1) Finalizing the specific research question and search strategy, 2) Identifying relevant studies, 3) Study review and selection, 4) Charting the data, and 5) Collating, summarizing and reporting results. A search strategy was developed in June 2024 and applied in July 2024 across PubMed, CINAHL, EMBASE, and Google Scholar. Eligibility criteria were established using the PICOS framework among studies published between 2020 and 2024. Identified studies were screened by two independent reviewers. Selected studies were incorporated into a charting table and then analyzed thematically.

Results

71 studies were selected. With analysis ongoing, preliminary themes include the following. Theme 1 refers to how responses to the pandemic took shape through enhanced self-care management among patients and modifications to service delivery by way of at-home strategies for diagnosis and treatment commencement. Theme 2 refers to influences on HMV adherence during the pandemic, especially telemedicine. Theme 3 relates to the implementation of telemedicine for patient education and tele-management. Theme 4 points to constraints in access to care following pandemic-related measures. Theme 5 centers on mental health, fear of infection and risk perception following guidelines over HMV use. Theme 6 focuses on the outcomes like sleep and quality of life, along with risk of infection among patients with specific diagnoses, like sleep apnea.

Conclusion

The pandemic's disruptions to HMV care highlighted telemedicine as a critical tool for continuity and self-management. However, challenges in adherence, shaped by heightened mental health concerns and uncertainty, underscore the need for improved communication, psychological support, and tailored interventions to sustain effective care during future healthcare crises.

ID: 35618

Presented by: Elizabeth Nethery

The effect of universal no-cost contraception coverage on out-of-pocket payments

Authors: Schummers, Laura (1); Cheng, Lucy (1); Stucchi, Andrea (1,2); Nethery, Elizabeth (1); Helmer-Smith, Mary (1,2); Law, Michael R

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2: UBC School of Population and Public Health

Background and Objectives

High prescription contraception costs are a key driver of inadequate, unequal contraception access in Canada. While most Canadian residents have some form of private or public insurance, high deductibles, copayments, and/or exclusion of contraception from insurance formularies results in coverage gaps for prescription contraception. In April 2023, British Columbia (BC) introduced universal, first-dollar coverage for prescription contraception. This study estimated the effect of this policy on payer-type for dispensed prescription contraception, especially out-of-pocket patient payments.

Approach

We measured the monthly percent of dispensed contraception paid out-of-pocket by patients, by private insurance, and by public insurance in each province using a national prescription database that captures all retail dispensations of pharmaceutical products in Canada for all residents (including dispensed prescriptions for individuals without provincial health insurance coverage). We used a controlled interrupted time series analysis to compare the expected percent of contraception dispensations paid by each payer type (if the policy had not been introduced) with the observed frequencies in BC. We used a synthetic control derived from Canada's nine other provinces.

Results

In April 2021, 39% of dispensations for prescription contraception were paid out-of-pocket, 49% by private insurance, and 12% by public insurance in BC. These proportions remained constant over the pre-policy period. When BC's universal contraception policy was introduced, the distribution of payers for dispensed contraception changed immediately and remained stable thereafter. At 15-months post-policy, 13% (95% CI 12%-14%) of dispensed contraception was paid out-of-pocket by patients, while 12% (11%-14%) were paid by private insurance, and 75% (74%-75%) were paid by public insurance. Just over half (55%) of post-policy dispensations with out-of-pocket payments were for contraception methods not included in the provincial coverage formulary (contraceptive patch; specific combined oral and progestin-only contraceptive pill formulations).

Conclusion

Before BC introduced universal, first-dollar contraception coverage, the mix of private and public insurance coverage resulted in a substantial fraction of dispensed prescription contraception paid out-of-pocket by patients. BC's universal, first-dollar coverage policy substantially reduced out-of-pocket payments for dispensed contraception in BC.

Strategies for Increasing Vaccine Coverage in Long-Term Care Workers: A Systematic Review

Authors: Nilormi, Adhiba, Bruyère Health Research Institute. Yung, Seles, University of British Columbia. Zha, Christina, McGill University. Luong, Anita, McGill University. Presseau, Justin, Ottawa Hospital Research Institute. Heer, Carrie, Bruyère Health Research Institute. Wilson, Kumanan, Ottawa Hospital Research Institute. Thavorn, Kednapa, Ottawa Hospital Research Institute. Manuel, Douglas, Ottawa Hospital Research Institute. McGeer, Allison, Sinai Health System. Welch, Vivian, Bruyère Health Research Institute. Little, Julian, University of Ottawa. Corace, Kim, University of Ottawa. Meyer, Samantha, University of Waterloo. Kothari, Anita, University of Western Ontario. Hsu, Amy, Bruyère Health Research Institute.

Background and Objectives

Influenza and COVID-19 are highly contagious respiratory illnesses that significantly impact the long-term care (LTC) population. LTC staff, who work closely with vulnerable residents, are essential in preventing the transmission of these illnesses. Despite the proven effectiveness of vaccines, uptake of COVID-19 and influenza vaccines among LTC staff remains low. We conducted a systematic review to identify and summarize the effectiveness of policies and strategies to promote vaccine uptake among workers in LTC settings.

Approach

The search strategy was developed iteratively and peer reviewed by a medical information specialist. Searches were conducted on July 23, 2024 across six databases, including Ovid MEDLINE®, Embase, PsycInfo, Cochrane, and CINAHL, using controlled vocabulary and keywords. No date, location, or language restrictions were applied, and animal-only studies were excluded. Screening and data extraction were performed using Covidence by three reviewers. Data were synthesized descriptively, categorizing interventions by type and their relative effectiveness. Fifty-six studies, published between 1992 and 2023 were included, comprising 41 observational, 11 experimental, 3 quality improvement, and 1 mixed-methods study.

Results

Most studies focused on influenza vaccination (n=46), with fewer addressing COVID-19 vaccination (n=10). Policy interventions increased vaccine coverage by 14.9% in pre-post studies, while organizational strategies (e.g., free on-site vaccination) and education interventions improved coverage by 40.1% and 21.9%, respectively. Social influence strategies achieved coverage rates as high as 95.6%, and communication interventions up to 40% in cross-sectional studies. Reminders increased coverage by 27.0% and incentives (e.g., T-shirts, bracelets) by 19.2% across pre-post studies. Interventions such as education, reminders, incentives and organizational supports were commonly used in settings with low baseline vaccine coverage, while policies and combined interventions were used in studies with initially high coverage (>50%). Combined interventions were the most effective, increasing coverage by 48%.

Conclusion

This review identified a range of strategies to promote vaccine uptake among LTC staff, with multifaceted interventions having the greatest impact. LTC settings provide a critical opportunity to implement multi-strategy approaches to address barriers, build vaccine confidence, and protect vulnerable populations from seasonal respiratory illnesses.

ID: 35551

Presented by: Adhiba Nilormi

Breaking barriers in COVID-19 vaccination: insights from Ontario's long-term care workers

Authors: *Nilormi, Adhiba, Bruyère Health Research Institute. Kim, Joy, Princess Margaret Cancer Centre. Hossain, Tanzima, Bruyère Health Research Institute. Presseau, Justin, Ottawa Hospital Research Institute. Heer, Carrie, Bruyère Health Research Institute. May, Kathryn, the Ottawa Hospital. Murmann, Maya, Bruyère Health Research Institute. Hsu, Amy, Bruyère Health Research Institute.*

Background and Objectives

Vaccination against COVID-19 is crucial for long-term care (LTC) workers to protect themselves and highly vulnerable LTC residents from severe illness. Despite this, vaccination rates among LTC workers have declined significantly post-pandemic, even as COVID-19 continues to pose a persistent and serious threat to public health. This study explores factors influencing LTC workers' current perception of the COVID-19 vaccines, particularly the recent formulation against the XBB.1.5 variant, and maps potential strategies to support vaccine uptake.

Approach

We conducted semi-structured interviews with LTC workers from 19 urban and rural LTC homes across Ontario to capture their perspectives on the XBB.1.5 COVID-19 vaccine and intentions for future vaccinations. Participants were recruited via flyers posted within LTC homes and onsite engagement led by the research team. The interview guide and our analysis were informed by behavioral science frameworks, the Theoretical Domains Framework (TDF) and Health Action Process Approach. Deductive coding was performed, applying these frameworks, to understand factors and motivations influencing individuals' behaviors, and explain the stages and processes individuals undergo when changing health-related behaviors.

Results

We interviewed 30 LTC workers (median age = 41 years), including 22 females (73%) and 8 individuals (27%) from visible minority groups. Eleven participants (37%) had received the XBB.1.5 vaccine. Five main barriers to vaccination were identified across four TDF domains: knowledge (misconceptions about lasting immunity and the role of the latest dose), beliefs about consequences (perceived lower risk of infection, long-term safety concerns), social influence (mixed messaging from family and colleagues) and environmental context (lack of clear, consistent, credible vaccination guidance). Six main facilitators spanned five domains: knowledge (vaccination information in plain language), beliefs about consequences (protection for family and residents, protection against current strains), environmental context (workplace vaccination programs), social/professional role (viewing vaccination as professional responsibility) and social influence (recommendations from trusted sources).

Conclusion

Our study identifies barriers and facilitators influencing LTC workers' current acceptance of the updated COVID-19 vaccine. These determinants can help to inform the design of tailored strategies and policies to address hesitancy and increase future vaccine uptake, ultimately improving protection for LTC workers and the vulnerable populations they care for.

ID: 35503

Presented by: Mildred Njoache

Red River Métis Perspectives on Medical Assistance in Dying (MAID): Creating a Dialogue

Authors: *Mildred Njoache, Debbie Olotu, Chantal Perchotte, Wajihah Mughal, A. Frances Chartrand, Garret Munch, Michelle Driedger, and Olena Kloss. Manitoba Métis Federation*

Background and Objectives

Canadian federal legislation was changed in 2016 to permit eligible adults to request medical assistance in dying (MAID). However, Red River Métis (RRM) perspectives are largely absent from federal MAID policies, with their exclusion from federal MAID monitoring reports, highlighting the need for inclusive, culturally relevant policy development that reflects their unique experiences. To address this gap, the Manitoba Métis Federation engaged Citizens to gather perspectives and drive MAID policy.

Approach

A qualitative community-based participatory research approach was used, guided by an advisory committee of RRM healthcare providers, Elders, and community leaders. Insights on MAID were gathered through focus groups with RRM Citizens from both Northern and Southern Manitoba, and semi-structured interviews were held with RRM healthcare providers. Sessions were recorded, transcribed, and analyzed using a grounded theory approach. Data was coded and analyzed through the Red-River Métis-developed Collective Consensual Data Analytical Procedure, identifying key themes and providing a deeper understanding of the Community's views on MAID.

Results

Focus groups included 170 RRM Citizens, with semi-structured interviews conducted with 11 RRM healthcare professionals. Key themes highlighted the need for improved knowledge and accessible communication about MAID. While views on MAID's ethical implications varied, it was widely regarded as a deeply personal decision influenced by cultural, spiritual, and familial considerations. Discussions also addressed the Catholic Church's role in shaping perspectives. Participants identified critical healthcare system barriers, including limited access and a lack of cultural safety. A strong emphasis emerged on the need for culturally safe and respectful end-of-life care, underscoring the importance of integrating these considerations into future MAID policy development.

Conclusion

Culturally safe, distinctions-based MAID policies must incorporate RRM perspectives. Findings from consultations with RRM Citizens and healthcare providers will provide valuable insights for developing Inclusive MAID policies that address cultural, ethical, and healthcare system considerations, ensuring equitable and respectful end-of-life care across all levels of government.

ID: 35196

Presented by: Amanda Nova

Creating comprehensive clinical profiles to understand home care population health needs

Authors: *Saari, Margaret - SE Research Centre*

Giosa, Justine - SE Research Centre

Holyoke, Paul - SE Research Centre

Heckman, George - Western University

Hirdes, John - University of Waterloo

Background and Objectives

Calls to effectively leverage routinely collected data to support evidence-informed health system reform abound. Canadians prefer to live and age at home and want care models to support that choice. However, service offerings continue to prioritize episodic “illness care”, with limited long-term integrated care options. This objective of this study was to develop clinical profiles of the health and social care needs of older adults for development of an integrated model of long-term home care.

Approach

SE Health, a not-for-profit home care provider and social enterprise, is committed to redefining how Canadians live and age at home. A core value underpinning care delivery at SE Health is taking a holistic “Life Care” approach. To build an innovative long-term home care model which incorporates “Life Care” into care delivery, leaders needed a way to define, measure and understand life care needs. This study leveraged population-level routinely collected home care assessment data to operationalize life care and create unique profiles of the clinical needs of community-dwelling older adults to support model co-design and future education and training initiatives.

Results

Assessment data from 162,523 home care clients were used to segment the population into six unique client groups. Using a holistic definition of health, called Positive Health, clinical care needs were described, and care profiles were created representing home care clients living with needs related to Social Frailty (12%), Caregiver Distress (6%), Chronic Disease Management (31%), Cognitive Impairment and Behaviours (13%), Medical Complexity (19%) and Geriatric Syndromes (19%). Over half of clients were found to have multidimensional care needs crossing four or more Positive Health domains including bodily functions, mental well-being, quality of life and participation and daily functioning. Based on the range and prevalence of identified life care needs, opportunities were identified for increased participation of nursing, rehabilitation therapies and social work in care.

Conclusion

Aging Canadians’ care needs are complex, multidimensional and aligned to a more holistic definition of health. Comprehensive profiles of the life care needs of community-dwelling older adults developed from population-level, routinely collected assessment data are foundational to the design, delivery, and evaluation of sustainable integrated long-term home care models.

Perceived Acceptability of Patients & Providers on Innovation to Improve Specialist Care Access

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Background and Objectives

Limited specialist capacity results in long wait times and specialists declining referrals leaving primary care providers (PCPs), patients and specialists frustrated. We describe the perceived acceptability, adoption, and appropriateness among providers and patients of a new referral triage option Triage Referrals to eConsult (TReC) which enables specialists to provide advice to PCPs in lieu of booking the patient an appointment (advice only).

Approach

The novel triaging workflow was implemented in November 2022 within the health information system (Epic), enabling specialists to provide patient-specific advice directly to PCPs. Guided by the Proctor Implementation Framework, this multi-method study included surveys sent to PCPs (two weeks post-TReC), patients (six weeks post-TReC), and specialists who have participated in TReC. Surveys responses were analyzed descriptively on TReC's ease of use, patient safety, overall acceptability, and potential areas for improvement along with open-ended responses analyzed through thematic analysis.

Results

Over 4300 TReCs have been completed across 14 clinical areas with a median (IQR) response time of 2 days (0-7). Analysis of surveys from PCPs (n=569, 20% response rate), patients (n=202, 7% response rate), and specialists (n=23, 19% response rate) has revealed positive impacts. Among PCPs, 84% found TReC practical, 84% reported no patient safety concerns, and 80% agreed that receiving advice on referrals is acceptable. Patients reported high satisfaction, with 70% agreeing their health concerns were addressed with the advice. 91% of specialists deemed TReC feasible for improving care access, and 83% agree it is integrable into their workload. Support for continuing TReC ranged from 80-90% across provider and patient respondents. Qualitative results highlight that TReC improves timely guidance from specialists and reduces health system pressures; however, challenges include administrative burden and communication gaps.

Conclusion

TReC shows high acceptability across the circle of care to improve capacity for timely specialist care. Further research is required to investigate post-TReC healthcare utilization to assess its broader appropriateness and safety.

ID: 33939

Presented by: Divine-Favour Chichenim Ofili

Diabetes Identification in Self-Reported Population-Based Survey Versus Health Administrative Data

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Background and Objectives

Accurate identification of diabetes is vital for effective research and interventions. In the absence of clinical diagnoses, diabetes is typically identified through self-reported surveys or algorithm-based diagnoses from health administrative data (HAD). Understanding the diagnostic agreement and uniqueness of these sources is crucial for guiding researchers in data selection. This study evaluated diabetes identification concordance across these sources in Quebec, Canada, and explored sociodemographic and health differences among individuals identified by each source.

Approach

This study used the Care Trajectories-Enriched Dataset (TorSaDE) which links the Canadian Community Health Survey (CCHS) to Quebec's HAD. Individuals aged at least 20 years during the CCHS interview and who completed at least one survey wave were included. Those with missing diabetes diagnosis survey responses or suspected gestational diabetes were excluded. Diabetes presence or absence was assessed using both self-reported CCHS data and HAD. Group characteristics were compared with ANOVA, chi-square, and post-hoc tests. Age and sex effects were adjusted for using linear and logistic regression.

Results

This study included 101,150 individuals, with 10,740 (10.6%) identified as having diabetes through self-reported and/or algorithmic diagnoses; most cases were detected in the HAD. There was a high diagnosis concordance as ~65% of individuals with diabetes were identified in both sources. In fact, ~90% of those self-reporting diabetes were also algorithmically diagnosed. Diagnosis discordance occurred in only 3.7% of the cohort. Individuals with diabetes were generally older, had lower educational attainment, poorer health perceptions, and lower household income than those without diabetes. Significant differences in age, sex, residence, health status, and healthcare use were found between individuals diagnosed exclusively in each source and those with concordant diagnoses, however, the educational and economic status of individuals across the three groups were comparable.

Conclusion

Despite a high concordance between the two data sources used, each identifies distinct subpopulations in terms of social and health characteristics. Researchers are encouraged to combine both sources for more comprehensive studies. When only one source is available, results should be interpreted based on the population it best represents.

“I might try and reach out to the long-term care home...”: A qualitative descriptive study

Authors: *Okoh, Augustine (Department of Health Research Methods, Evidence and Impact, McMaster University); Lin, Christine (Faculty of Health Sciences, McMaster University); Caswell, Caroline (Faculty of Health Sciences, McMaster University); Gupta, Paranshi (Faculty of Health Sciences, McMaster University); Dharja, Naisha (Faculty of Health Sciences, McMaster University); Siu, Henry (Department of Family Medicine, McMaster University); Howard, Michelle (Department of Family Medicine, McMaster University); Badone, Ellen (Department of Anthropology, McMaster University); Grierson, Lawrence (Department of Family Medicine, McMaster University).*

Background and Objectives

The growing elderly population significantly impacts care continuity, particularly during transitions to long-term care (LTC). Many lose contact with their family physicians as new providers take over their care. To address this, comprehensive patient handover notes are vital for ensuring continuity. In Ontario, family physicians share healthcare information during LTC transitions, but its effectiveness is under-researched. This study explores current and desired communication activities to enhance informational continuity during LTC transitions.

Approach

Using Sandelowski's qualitative descriptive design, we conducted individual interviews with community family physicians who operate a continuity-based community practice in Ontario. Participants varied in their age, gender, professional interests, and training/experience working in a LTC setting. We also sought maximum variation with respect to geographical distribution (urban, suburban, rural), funding model (for e.g., fee-for-service, capitation), and years of practice. Data was analyzed using an unconstrained deductive approach.

Results

We completed 9 in-depth interviews with community family physicians. The themes we identified were Types of transition (transition from hospital, planned and unplanned transition from home), Ideal continuity and transition, Current communication process for information transfer (agents involved, types of documents transferred, verbal and written communication), and Strategies to enhance informational continuity (streamline documentation, revising the LTC Health Assessment form, enhanced communication, education, policy and resource advocacy, empower patients and families).

Conclusion

Effective long-term care transitions rely on comprehensive documentation, efficient communication, and family involvement. Revising forms, implementing centralized electronic records, and advocating for supportive policies can streamline processes, enhance continuity of care, and improve outcomes for new LTC residents.

Optimizing health information exchange during transitions to long-term care: A multiple case study

Authors: *Okoh, Augustine (Department of Health Research Methods, Evidence and Impact, McMaster University); Lin, Christine (Faculty of Health Sciences, McMaster University); Caswell, Caroline (Faculty of Health Sciences, McMaster University); Gupta, Paranshi (Faculty of Health Sciences, McMaster University); Dharia, Naisha (Faculty of Health Sciences, McMaster University); Siu, Henry (Department of Family Medicine, McMaster University); Howard, Michelle (Department of Family Medicine, McMaster University); Badone, Ellen (Department of Anthropology, McMaster University); Grierson, Lawrence (Department of Family Medicine, McMaster University).*

Background and Objectives

Most Canadian older adults lose their family physicians when they move to long-term care (LTC) as a new set of providers assume the care responsibility. To mitigate the impact of the loss of continuity-based primary care, this study aims to describe the information care teams in LTC facilities receive and consider most important in supporting new LTC patients and the strategies they employ to seek it out to facilitate continuity of care during LTC transitions.

Approach

We employed Yin's multiple case study design. We purposefully selected LTC homes with respect to rurality (rural and urban) and home size (small [<97 beds], medium [97-160 beds] and large [160+ beds]). We conducted 1h long individual interviews. Participants across the 5 cases varied in their age, gender, years of LTC practice experience (ranging from 1-40 years). Participants included admission nurse, director of care, physiotherapist, admission coordinator, social worker, personal support worker, pharmacist, nurse practitioner, and LTC physician. Data was analyzed using an unconstrained deductive approach.

Results

We completed in-depth interviews with 20 participants from 5 cases (LTC homes). The themes we identified were Current communication processes for information transfer (agents involved, types of documents received), Activities that foster information continuity (valued information for LTC, provider-client interaction, provider-provider interaction, reaching out), Facilitators and barriers (time constraint, inadequate compensation, staffing capacity, transition route, local context), Strategies to enhance informational continuity (active patient involvement in LTC transitions, early contact and rapport, competence, bidirectional communication, increasing the LTC admission window, centralized electronic health record, education).

Conclusion

Ensuring informational continuity in long-term care transitions requires accurate documentation, proactive communication, and tailored strategies to address systemic challenges. Active patient involvement, bidirectional communication, and enhanced provider training can streamline transitions, improving care outcomes and addressing residents' medical, social, and functional needs effectively.

ID: 35509

Presented by: Debbie Olotu

Maternal Health in Red River Metis: Improving Access to Maternal and Child Healthcare

Authors: *Debbie Olotu, Oluwakemi Omole, Wajihah Mughal, A. Frances Chartrand, Garret Munch, and Olena Kloss. Manitoba Métis Federation*

Background and Objectives

Red River Métis (RRM) Citizens face disparities in prenatal and postnatal healthcare, such as lower breastfeeding rates, higher infant mortality, and a greater risk of maternal type 2 diabetes. These challenges are exacerbated by the lack of a distinctions-based approach to maternal care, overlooking their unique health needs. To address this, the Manitoba Métis Federation is investigating access to maternal care to inform policy changes that aims to improve health outcomes for RRM Citizens.

Approach

This research utilized a mixed-methods design, integrating semi-quantitative surveys with qualitative focus group discussions to explore access and gaps to maternal and child health services. Red River Métis (RRM) Citizens located in both Southern and Northern Manitoba participated in community gatherings to share their perspectives. Survey data were analyzed using descriptive statistics, while the focus group audio transcripts were coded and analyzed using the RRM-developed Collective Consensual Data Analytical Procedure. This RRM-driven methodology identified key themes and systemic barriers, providing valuable insights to inform culturally safe and equitable maternal health care for RRM Communities.

Results

Among 83 RRM Citizens engaged in the study, 55% were currently pregnant, 39% had a baby within the last 12 months, and 5% planned to get pregnant within the next 6 months. Preliminary findings revealed 46% of participants faced perinatal complications such as gestational diabetes, and 48% travelled 25-100 km for healthcare. Notably 28% reported that healthcare providers did not explain care plans in patient-friendly language, and 22% of pregnant participants had not yet been assigned an obstetrician. Additionally, 44% were dealing with pregnancy-related health issues, and 43% took medication for mental illnesses like anxiety or depression. Key themes identified included the need for prenatal/postnatal information, cultural safety, cultural midwife care, and support for young mothers and those experiencing pregnancy loss.

Conclusion

The study highlights significant challenges faced by RRM Citizens, including healthcare inadequacies, discrimination, and a need for culturally safe practices. Addressing these issues through improved prenatal and postnatal support, better access to care, and integration of traditional practices is essential for maternal and child health outcomes for RRM Citizens.

ID: 35221

Presented by: Jennifer Olson

COURAGE: An Impact Networks Model for Advancing a National Aging Strategy

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Background and Objectives

One in five Canadians will soon be over the age of 65. As Canadians live longer and manage multiple health conditions, there is still a heavy reliance on the health system as the primary gatekeeper to support.

COURAGE: Action for Better Aging mobilizes a coalition of Canadians, decision-makers and health, social, industry and other partners from across Canada for a nationwide action plan for change, harnessing the power of innovation, design thinking and technology.

Approach

COURAGE utilized impact networks through a four phased strategy. First, we completed an environmental scan of the many reports on aging over the previous decade. This informed the development of a discussion paper that analyzed the current situation and provided an evidence-informed review of trends and innovations. Next, we engaged individuals and organizations from across Canada through interviews, focus groups, conversation circles, presentations, meetings and an online survey. Phase three consisted of hosting a virtual Summit with changemakers from across Canada. During the final stage, we identified champions and sought endorsement of our Roadmap for Action.

Results

Impact networks proved a powerful tool to identify champions and inspire grassroots support for change from across fields and sectors. During the second phase of this work, we engaged over 800 individuals representing a variety of sectors and experiences who identified four key recommendations for supporting Canadians as they age. Summit participants and subsequent working groups analyzed the 4 key recommendations and identified 16 concrete, tangible actions for creating change. These are summarized in a Roadmap for Action and inform our networks' efforts to date. More than 1,300 stakeholders have informed this work, and we maintain a coalition of impact networks totaling more than 450 changemakers.

Conclusion

This initiative demonstrates the effectiveness of an impact networks approach to advancing nationwide change, particularly when success hinges on broad support from across professions, industries and levels of government.

ID: 34679

Presented by: Yemisi Onilude

Trauma-informed Organizational Practices to Support Workforce Mental Health: A Rapid Review

Authors: *Onilude, Yemisi; Butac, Michael; Yoon, Rosanra; Toronto Metropolitan University*

Background and Objectives

Emerging from the pandemic, the healthcare workforce is grappling with high rates of turnover and burnouts. The pandemic has brought issues of post-traumatic stress, psychological safety, and collective trauma to the forefront. There is a gap in implementation of trauma-informed organizational cultures within a leadership context in healthcare. This review explores trauma-informed organizational and leadership practices that can support workforce mental health.

Approach

We conducted a rapid review of peer-reviewed journal articles guided by principles outlined by Tricco et al. (2015), and Arksey and O'Malley (2005) methodological framework. The peer-reviewed journal articles that were written in English-language discussing trauma-informed approach at the organizational or leadership level from 1990 to present were included in the review. A systematic search of eleven databases that met the criteria was done. Articles were retrieved and uploaded to the Covidence platform, and the opinion of a third reviewer was sought to resolve conflicts. A second phase of title and abstract screening was conducted to narrow eligibility to healthcare settings and exclude dissertations, editorials and commentaries.

Results

Data from the 47 full-text articles that satisfied the inclusion criteria were extracted. Four areas were identified in which trauma-informed approach could be implemented: 1) leadership practices, 2) organizational culture, 3) training and education, and 4) policy. The concepts of leadership, organizational culture and training were mostly reported as an essential strategy in improving trauma-informed initiatives that can improve workforce mental health. Leadership support and involvement is significant in reducing self-reported rates of staff turnover, organizational culture and training were mostly reported as an essential strategy in improving trauma-informed initiatives that can improve workforce mental health. Training and education are key factors that can accelerate both leadership and organizational culture that support trauma-informed approach. Also, developing trauma-informed policies and procedures are important.

Conclusion

This rapid review demonstrates how trauma-informed approaches can be integrated into leadership practices, organizational culture, training, education, and policy to improve the well-being of the healthcare workforce. Implementing such changes will be of immense value in sustaining a healthy workforce and in handling future large-scale emergencies and pandemics.

ID: 35487

Presented by: Hollis Owens

Health professional Experiences with Real-Time Virtual Support - a service aimed at equitable access

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Background and Objectives

Health care providers (HCP) working in rural, remote and Indigenous (RRI) communities face unique challenges delivering longitudinal care related to geographic isolation. The Real-Time Virtual Support (RTVS) network is a virtual care initiative in British Columbia (BC) implemented to improve healthcare access in RRI communities by providing peer-to-peer HCP support, virtually. Our objective was understanding HCP's experiences with RTVS and identifying advancements for the program's objectives of improving RRI communities' access to care.

Approach

We interviewed 20 health care providers working in RRI communities who have used the RTVS service including a midwife, family physicians, and nurses and 25 RTVS dedicated virtual providers (VPs). We used semi-structured interview guides that were co-developed with the First Nations Health Authority, Ministry of Health, and Rural Coordination Centre of BC asking providers about their experience with the service and for areas of improvement. Codebooks were developed through two team members openly coding 1 HCP and 1 VP transcript. Interview transcripts were coded by 5 team members in NVivo. Themes were iteratively developed using constant comparative analysis.

Results

Interview themes for rural/remote HCP accessing RTVS clinical support centered on the benefits of timely support. This included alleviated administrative burden; increased clinical confidence; reduced anxiety; and received respectful and collegial support facilitated by VPs' communication utilizing a coaching approach and rural practice knowledge. Participants expressed RTVS contributes to outcomes of increasing access to healthcare in their RRI community by supporting recruitment/retention and embedding RTVS in practice. Challenges were discussed in the context of technological limitations like technology outages/disruptions.

VP themes as the RTVS providers supporting rural/remote HCP were: providing culturally safe care in the patient's own community and rich VP clinical experience. Recommendations for RTVS and virtual support services included providing mental health clinical support, ensuring iPad set-up, and refining triage and patient follow-up.

Conclusion

RTVS provides timely clinical support for rural/remote HCP that increased their clinical confidence, reduced anxiety, and supported recruitment/retention ultimately increasing patients' access to healthcare closer to where they live.

ID: 32144

Presented by: Dimitra Panagiotoglou

Evaluating the effects of Toronto's supervised consumption sites on neighbourhood crime

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Background and Objectives

Beginning in 2017, Toronto implemented nine overdose prevention sites and supervised consumption sites (OPS/SCS) in response to escalating opioid-related harms. Despite evidence demonstrating health benefits for people who use unregulated drugs, OPS/SCS remain controversial. We aimed to evaluate the effects of Toronto's nine OPS/SCS on local crime.

Approach

We used a multiple baseline interrupted time series study design with negative binomial regression to test for the level and trend effects of OPS/SCS on counts of crime within 100m, 200m and 500m of sites. We restricted analysis to Toronto Police Service's publicly available geocoded records of confirmed assault, auto theft, break and enter (BnE), robbery, theft over \$5000, bicycle theft, and theft from motor vehicle incidents that occurred between 1 January 2014 and 30 June 2024. We repeated the analysis using a donut hole approach to test for a potential displacement effect.

Results

Within 100m of OPS/SCS, levels of assault (61%, 95% CI: 10 – 134%), robbery (62%, 95% CI: 10 – 138%) and BnE (47%, 95% CI: 6 – 104%) incidents increased ; but monthly trends declined for robberies (2%, 95% CI: 0 – 3%) and BnE(2%, 95% CI: 1 – 3%). At 200m, BnE increased 70% (95% CI: 39 – 107%), post-implementation; but monthly trends declined 1% (95% CI: 0 – 2%). Trends for assaults (1%, 95% CI: 0 – 1%), robberies (2%, 95% CI: 1 – 3%) and thefts from motor vehicles (2%, 95% CI: 1 – 3%) also declined. Effects persisted within 500m of sites.

Sensitivity analyses revealed crime displacement may explain the level effects observed within 100m of sites for assaults and robberies.

Conclusion

The effects of Toronto's OPS/SCS on local crime are complicated. While the interventions' impacts were neutral to positive over time, initial increases in crime were observed. Continued community engagement and efforts to minimize local harm are needed to ensure the long term acceptability and utility of OPS/SCS.

The effects of a provincial opioid prescribing standard on opioid prescribing

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Background and Objectives

In June 2016, the College of Physicians and Surgeons of British Columbia released a legally enforceable opioid prescribing practice standard to minimize drug misuse and overdose deaths. We tested the effects of the practice standard on access to long term opioid treatment for patients living with chronic, non-cancer pain.

Approach

We used linked patient-level administrative data provided by Population Data BC of all opioids dispensed to non-institutionalized BC residents (≥ 18 years of age) 1 October 2012 and 31 March 2020. We used a multiple baseline interrupted time series study design with Poisson regression to model the effects of the practice standard (June 2016) and its revision (June 2018) on five measures of opioid prescribing. Autocorrelation was corrected using Newey-West standard errors.

Results

Our analyses revealed the practice standard accelerated pre-existing declining trends in the proportion of patients:

- a) prescribed an opioid with no visit with the prescribing physician within 90 days (0.3%, 95% CI: 0.0 – 0.5%);
- b) with a co-occurring benzodiazepine or other hypnotic dispensation (0.7%, 95% CI: 0.6 – 0.8%);
- c) with a supply that exceeded 90 days or 250 pills (0.4%, 95% CI: 0.1 – 0.7%);
- d) with a daily dose exceeding 90 morphine milligram equivalents (0.3%, 95% CI: 0.2 – 0.4%); and
- e) rapidly tapered (0.1%, 95% CI: 0.0 – 0.2%).

While level effects were generally in the same direction, the proportion of patients rapidly tapered immediately post-implementation increased 1.8% (95% CI: 0.5 – 3.0%). The 2018 revision slowed or reversed observed trends.

Conclusion

The 2016 practice standard had an immediate and long-lasting effect on physicians' opioid prescribing behaviours, accelerating pre-existing declines. However, the standard also inadvertently increased the proportion of patients rapidly tapered. Although effective, care should be taken when implementing similar interventions in the future to mitigate unintended consequences.

ID: 35439

Presented by: Mike Paulden

A Modern Approach for Constructing Decision Analytic Models in Microsoft Excel

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Background and Objectives

Most decision analytic models submitted to health technology assessment (HTA) agencies are developed using Microsoft Excel. The approaches used to construct these models have not been substantially updated in decades. However, Excel was recently upgraded to support dynamic array functions, which can simplify how models are developed, improving transparency and calculation speeds. The objective of this study was to review these new functions and consider how they may be used to construct decision analytic models.

Approach

A comprehensive review of all 36 new dynamic array functions was conducted to identify those that may assist in the construction of decision analytic models. An exemplar state transition model was then developed to illustrate the use of these functions. This exemplar model was also constructed using conventional Excel functions and using R. Benchmarking was then conducted to compare calculation speeds between the three approaches.

Results

The LET, SCAN, REDUCE, LAMBDA, RANDARRAY, SEQUENCE, WRAPROWS and WRAPCOLS functions were identified as assisting in the construction of decision analytic models. As illustrated by the exemplar model, these functions allow for probabilistic state transition models to be developed without the need for Visual Basic for Applications (VBA) macros, substantially improving calculation speeds over the conventional approach. Indeed, given only a set of input parameters, these functions can be used to calculate the mean discounted incremental net benefit of a treatment, across thousands of Monte Carlo simulations, using a single formula in a single cell. This, in turn, allows for value of information analysis to be conducted without using VBA macros.

Conclusion

Probabilistic state transition models can be constructed in Excel without using VBA macros, simplifying their development and improving both transparency and calculation speeds. This modern approach also reduces the burden faced by HTA agencies when validating models.

Resources to support healthcare engagement with First Nations, Inuit, and Métis communities

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Background and Objectives

Improving Indigenous health requires equitable relationships between public health and healthcare systems and First Nations, Inuit, and Métis organizations. Changes to health systems to address challenges such as waitlists provide an opportunity to work towards these goals. The Indigenous Primary Health Care Council in Ontario partnered with public health and primary care experts on this work. This project uses a two-eyed seeing approach to develop resources that enable more equitable engagement and data practices.

Approach

Using a two-eyed seeing approach, The Indigenous Primary Health Care Council and public health and primary care partners developed four resources. Additional insights and recommendations were gathered through meetings with Indigenous Primary Health Care Organizations and other leadership. Relationship building; Indigenous population health data; and emergency preparedness and response were identified as key priority areas. To support uptake in practice, our next steps focus on knowledge translation, implementation, and quality improvement.

Results

This project not only identifies the need for these changes in key priority areas but provides pragmatic examples of how they can be applied even in settings where health system resources are stretched. Two resources focus on relationship-building, First Nation, Inuit, and Métis Community Engagement Guide: For Public Health Agencies and Relationship Agreement: Guide and Template. Embedded in these resources are key wise practices, including being community-specific, spiritually grounded, trauma-informed, strength-based, and practicing cultural humility. Another resource focuses on key improvements needed in data collection, analysis, and reporting. The Indigenous Primary Health Care Evacuation Guide: Complementary Standards for more Inclusive and Culturally Safer Evacuations resource highlights priority actions in the preparedness, response, and recovery phases of emergency management.

Conclusion

Health systems are facing significant pressures and new care models are being piloted and implemented. These changes will not achieve their full goals or potential without equitable approaches. Better engagement and data practices improve public health and healthcare service design, delivery, and outcomes for First Nations, Inuit, and Métis populations.

ID: 34976

Presented by: Allie Peckham

Insights from People Living with Serious Mental Illness on the Role of Trust in Primary Care

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Background and Objectives

People with serious mental illness (SMI) have higher rates of physical disease, preventable hospitalizations, and mortality, yet receive fewer health services than the general population. In addition to facing challenges accessing primary care services, lack of knowledge and stigmatization by primary care providers (PCPs) can impact the quality and timeliness of care received.

Understanding the factors shaping primary care experiences for individuals with SMI is critical for improving access and health outcomes.

Approach

Fifty individuals with a psychiatric hospitalization (within 3-24 months) or who were clients of an Assertive Community Treatment teams (ACTs) participated in qualitative interviews exploring their primary care experiences. Participants were recruited from three hospitals and ACTs in Ontario. Participants were 19 years or older and had seen a PCP at least once in the past year. Interviews were conducted via phone or videoconference. Demographics were collected at the start, followed by open-ended questions exploring access to primary care, perceived effectiveness, and relationships with providers. Transcriptions underwent iterative reflexive thematic analysis to identify key themes.

Results

Participants were between 21-84 years old ($M=40.38$, $SD=15.05$) and predominantly White ($N=36$, 72%), with 54% self-identifying as Male, 40% Female, and 6% Other. Using reflexive thematic analysis, we identified eight trust-building factors participants associated with positive primary care experiences. These included having a PCP who: takes time and is accessible; exhibits positive traits (e.g., friendly, smiling); respects confidentiality; is relatable (e.g., shared interests or similar age); uses effective engagement strategies (e.g., honest communication, humor, probing); understands the patient's context and addresses their concerns; and ensures follow-up and continuity of care. Participants highlighted that past healthcare experiences shaped their expectations with PCPs. These trust-building factors foster more positive physical healthcare experiences and strengthen patient-provider relationships, which may lead to improved care outcomes for individuals with SMI.

Conclusion

Trust in PCPs improves health outcomes and experiences for individuals with SMI. Past healthcare experiences shape expectations, highlighting the need for person-centered care that ensures confidentiality, addresses negative experiences, and promotes relational continuity. Embedding these trust-building factors in provider training and system design can help reduce healthcare disparities.

ID: 35649

Presented by: Nell Perry

Building Better Long-Term Care for Red River Métis: Findings and Policy Recommendations

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Background and Objectives

Long-term and continuing care (LTCC) includes a range of health and personal support services for individuals with complex needs. Existing LTCC data focuses primarily on the broader Canadian or pan-Indigenous populations, without distinguishing the specific needs of the Red River Métis (RRM). This project identifies the distinct LTCC needs of the RRM and uses this information to develop a framework to improve LTCC experiences and outcomes.

Approach

Using a community-based participatory research approach, mixed-methods data was collected from RRM Citizens, Elders, and healthcare professionals in a series of consultations from 2023-2024. Two surveys were administered: one to RRM Citizens and Elders (n=252) to assess the quality of services and their overall priorities for LTCC, and another to RRM healthcare practitioners (n=10) to identify best practices for providing LTCC. Descriptive statistics were used to analyze survey data, while a thematic analysis was applied to data from 10 focus groups. The framework developed is under review by RRM Citizens with further feedback being collected through surveys and focus groups.

Results

The findings highlight the disparities relating to culturally relevant care in LTCC. Results showed 92% (n=148) of RRM Citizens agreed on the importance of RRM distinction-based care, while 50% (n=84) of Citizens expressed dissatisfaction with the adequacy of LTCC programs in their Region. The data from RRM healthcare providers echoes that from Citizens, and highlighted the importance of family involvement, cultural relevancy, and improvements to the overall LTCC system. The qualitative data shows that Citizens' key priorities are familial engagement, culturally relevant care, equitable service access in rural communities, advocacy support, and sufficient staffing. The draft framework is currently under review by Citizens for community validation prior to being finalized.

Conclusion

The findings emphasize the need for distinctions-based care plans to create inclusive and equitable long-term care for RRM Citizens. These findings inform the framework recommendations by underscoring the importance of distinctions-based initiatives to improve quality care, enhance health outcomes, and promote well-being among RRM.

ID: 35061

Presented by: Wanda Phillips-Beck

Manitoba First Nations' management of the COVID-19 pandemic

Authors: Lavoie, Josée G, University of Manitoba

Background and Objectives

Pandemic management is influenced by pandemic- and context-specific factors such as the social determinants of health. Among Manitoba First Nations (FN), the social determinants of health have not changed significantly since the pH1N1 pandemic. In this presentation, we explore the processes in Manitoba to manage the COVID-19 pandemic among FN compared to the strategies and outcomes of the pH1N1 pandemic to evaluate whether alternative management approaches could have led to improved outcomes.

Approach

This First Nations Health and Social Secretariat of Manitoba (FNHSSM)- University of Manitoba partnership designed a retrospective cohort population health study using health administrative data with housed at the Manitoba Health Centre for Health Policy. We used the Manitoba Health Insurance Registry, the First Nations Research File, COVID-19 testing data and postal codes to calculate the incidence rate of severe outcome or death from COVID-19 among those with higher Charlson Comorbidity Index to those with no CCI conditions were calculated for each group. We used policy documents and minutes of meetings to map out the pH1N1 and COVID-19 management processes.

Results

For the pH1N1 pandemic, Manitoba FNs had a 7.36 relative risk of H1N1-attributable hospitalization compared to Manitoban. Our findings show that the risk of a COVID-19 related hospitalization was 5.40. The results for this difference are multifactorial, including virulence, policies related to hospitalization and bed availability, and vaccine availability early on. In addition, FNHSSM along with First Nations and Indigenous health care leaders, took a leadership role in health data management and communication during the COVID-19 pandemic, a role FNHSSM was not equipped to take during the pH1N1 pandemic. Actions included sharing weekly bulletins through social media to First Nations communities, a strategy that boosted awareness and trust, and equipped First Nations leadership to engage in evidence-based decision-making.

Conclusion

While disproportionate compared to other Manitobans, First Nations COVID-19 mortality rates were lower than predicted. The rate of vaccination was comparable. We conclude that First Nations-led public health measures and campaigns, and sovereignty in data management, mitigated the impact of the pandemic and allowed for trusted community-specific public health responses.

ID: 35387

Presented by: Wanda Phillips-Beck

Reclaim Winter Training Institutes: Reclaiming Manitoba First Nations Data

Authors: *Leggett, Sidney and FNHSSM (co-presenter, sleggett@fnhssm.com)*

Background and Objectives

After learning circles on priorities for operationalizing data sovereignty the discussions identified the need for agile Winter Training Institutes for community members. The Winter Training Institute trains First Nations people and people working in health delivery for First Nations people on the topics of epidemiology, statistics, and knowledge translation for population health run by the Reclaim team at First Nations Health and Social Secretariat of Manitoba.

Approach

Over the course of five days, we use a hands-on approach to teach statistics, epidemiology, statistical programming, and how to use those tools to critically question data from a First Nations lens to transform research narratives and interpret data to tell your own stories. Program grounded in First Nations culture, protocol, understanding and world view. Where First Nations interpret the data to tell their own stories, where spirit and culture are the foundation. This leads to critically questioning data from an Indigenous lens that can transform research narratives and changing from deficit-based language to strengths-based analyses and framework.

Results

The first institute will be held March 3-7th, 2025 with a cohort of primarily First Nations participants, led by a team of Indigenous scholars and a Grandmother's Advisory Circle, will create a community of care and teach direct tools to work with health data in their community. On top of this we will discuss the realities of working with health related data and the harms that can come from it. Creating space to discuss epidemiology from a First Nations lens with First Nations people will lead to data being analyzed and translated directly from First Nations people, that can lead to policy change informed by data.

Conclusion

Increasing First Nations' data sovereignty and epidemiological analytical capacity will result in expanding First Nations ability and evidence to advocate for social justice in all areas where data exists and expand data holdings once gaps have been identified. Data sovereignty is key to ensure that programming is informed by evidence generated by First Nation-led, value-based research.

Experiences of Mothers with Disabilities Accessing Paediatric Primary Care for their Children

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Background and Objectives

Adequate access to paediatric primary care is critical for optimal long-term health and developmental outcomes. However, even in universal health care systems, some families experience barriers accessing paediatric primary care. This study aimed to explore barriers to and facilitators of paediatric primary care access among mothers with disabilities accompanying their children to appointments and to identify strategies and opportunities to improve paediatric primary care access and quality for these families.

Approach

We conducted a qualitative study in Ontario, Canada between April and December 2024. We recruited participants through disability advocacy organizations, social media, and the study team's networks, with purposeful sampling to identify a diverse sample in terms of socio-demographics and geography. Participants were n=26 mothers with physical, sensory, and/or developmental disabilities who had children up to 10 years of age living with them. Sixty-minute semi-structured interviews were conducted by a postdoctoral fellow and peer researcher. Following verbatim transcription of interviews, inductive thematic analysis was conducted to highlight common paediatric primary care-related experiences across disability groups.

Results

Mothers with disabilities reported significant barriers accessing primary care for their children, including physically inaccessible medical office spaces, communication barriers with providers, and a lack of flexibility in physicians' delivery of services. They also reported fear of stigmatizing provider attitudes and insufficient support related to parenting needs as they intersect with child health. Travel costs to get to appointments were also a barrier. In contrast, providers who proactively considered mothers' disability-related needs were perceived as facilitating access. Mothers' navigation of paediatric primary care solicited heightened planning skills, self-advocacy, and support systems. However, mothers reported a need for more systemic improvements to paediatric primary care access, including having enhanced disability training for providers to understand the needs of mothers with disabilities.

Conclusion

A disability lens in paediatric primary care should take a family-centred approach that considers not only the needs of the child but also those of the parent. Given one in eight mothers have a disability, equitable supports for these families could ultimately positively impact the health of Canadian children.

ID: 34953

Presented by: Neelam Punjani

Towards Equity in Care: Addressing Mental Health Needs of Racialized Youth Affected by TFSV

Authors: *Hirani, Saima (The University of British Columbia); Nandini Basuray (University of Alberta); Rishika Selvakumar (The University of British Columbia)*

Background and Objectives

Technology-facilitated sexual violence (TFSV) (online harassment, abusive messages etc.) has significant negative impacts on the mental health of youth. Racialized youth may face additional unique challenges in receiving adequate support to address TFSV due to constraints such as language barriers, lack of cultural sensitivity, and discrimination. The objective of this study is to co-design a supportive strategy with racialized youth to guide accessible and inclusive sexual and mental health service provision by healthcare providers.

Approach

We conducted two virtual workshops (each for 2 hours duration) with a diverse group of 34 young individuals (ages 15-24), who self-identified as racialized and were living in from Alberta (AB) (n=18) and British Columbia (BC) (n=15). Collaborative dialogues were used to co-design a supportive strategy including policy and practice recommendations for better support of racialized youth experiencing TFSV and its mental health consequences. Our participants also advised us on how best to disseminate this knowledge to its relevant users to achieve better support for sexual and mental well-being of young people.

Results

Our findings suggested key gaps in existing support such as limited culturally sensitive care, and insufficient trauma-informed training for healthcare providers. Victims face barriers such as stigma, judgment, high costs, and inadequate rural services. Online platforms often lack privacy controls, fail to address reports promptly, and provide limited follow-up, leaving racialized victims feeling unsupported. Recommendations include integrating trauma-informed care into primary healthcare, offering multilingual and culturally relevant services, establishing anonymous reporting systems, and expanding counseling in underserved areas. Collaboration with legal and social services and creating safe online spaces are crucial for holistic and accessible support.

Conclusion

Our findings highlight critical gaps in culturally sensitive, trauma-informed, and accessible mental health services for racialized youth. Addressing these issues promotes equity by ensuring tailored support, reducing stigma, and providing multilingual, and affordable care. Our findings inform collaborative efforts to create inclusive systems that address and prevent TFSV and related consequences and empower youth to seek support without barriers.

A scoping review of Indigenous Cultural Safety Training for Health, Social Work, and Education

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Background and Objectives

Anti-Indigenous racism is a persistent issue in health, social service, and education systems in colonized countries. Indigenous Cultural Safety (ICS) training is a key strategy to improve cultural competence among providers. However, limited research exists on how ICS training is conceptualized and evaluated within these systems. This study aims to summarize the literature on ICS training in health, social service, and education sectors to better understand its implementation and impact in addressing systemic racism.

Approach

A search was conducted in five databases (Medline, EMBASE, CINAHL, ERIC, and ASSIA) from 1996 to 2020. Eligible studies included ICS or ICS training in health, social work and education in British colonial settler nation states, including Australia, New Zealand, Canada, and the United States. Information on article characteristics, cultural safety concepts, ICS training details, and evaluation were extracted. Every article was reviewed twice, and eligible studies were extracted by two independent research staff. A narrative synthesis was performed to categorize findings.

Results

The search identified 3,600 sources, resulting in 134 articles being included. Most were published between 2011 and 2020, with nearly half (49%) based in Australia. Nursing and midwifery had the highest representation (34%), while education had the lowest (10%). Half of the studies focused on students (48%), and 46% targeted professionals or academics. Of the 134 studies, 69 described ICS training, and 61 included evaluations. Two-thirds of the training programs involved Indigenous elders, mentors, or community support, though their roles were rarely specified. High variability was observed in program objectives, modality, timeline, delivery, and evaluation methods.

Conclusion

This review highlights the significant work on ICS over the past three decades in Canada, Australia, New Zealand, and the U.S. to address anti-Indigenous racism. Future efforts should focus on meaningful engagement with Indigenous communities, recognizing their diversity and ensuring cultural safety is applied thoughtfully and respectfully.

Qualitative study on population health management between public health and healthcare providers

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Background and Objectives

Public health roots in efforts to promote and protect individual and community health. The Quadruple Aim of the healthcare system includes improving population health as a key goal. The COVID-19 pandemic highlighted the critical need for collaboration between public health and healthcare sectors in managing population health. This study aims to explore the insights of public health and healthcare leaders on system collaboration, identifying strategies and opportunities to achieve better population health outcomes through strengthened partnerships.

Approach

Five virtual deliberative dialogue sessions were conducted with fifteen leaders from public health and healthcare in Alberta and Ontario. Eligible participants, including professionals, leaders, policymakers, and academic researchers, were purposefully recruited through job title searches and professional networks. All interviews were transcribed verbatim and double-coded by two independent research staff members. A codebook thematic analysis was employed to identify key patterns and themes, while subthemes were developed through an iterative process of review and analysis.

Results

Three key themes emerged from the study. First, public health and healthcare service organizations each play a vital role in population health management but have distinct roles, responsibilities, and approaches. Second, collaboration between these sectors is often hindered by chronically inadequate public health resources and a lack of mutual awareness or understanding between public health and healthcare organizations. Third, improving access to and utilization of both individual- and population-level health data, along with a shared focus on advancing health equity, were identified as common goals that could drive joint efforts in population health management.

Conclusion

This study engaged public health and healthcare leaders, providing valuable insights for public health organizations, integrated care groups, and others with population health management mandates. Future collaboration should prioritize shared goals, focus on specific populations, and emphasize health equity, particularly in the use and sharing of health data.

ID: 35661

Presented by: Anjana Rao

Pragmatic Trial of BETTER Women: A Peer Health Coaching Program in Primary Care

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Background and Objectives

Chronic disease prevention and cancer screening are vital to reducing morbidity, yet many women face barriers to achieving health goals. The BETTER Women program integrates Peer Health Coaches (PHCs) to provide personalized, community-based support, helping participants achieve goals set in their prevention prescription. This study evaluates the impact of a six-month PHC intervention on preventive care adherence and health behaviors. An embedded process evaluation explores effectiveness, sustainability, and scalability, guiding strategies for equitable and effective primary care improvements.

Approach

This pragmatic randomized trial involves women aged 40-68 from three Ontario clinics and extends the BETTER program with six months of Peer Health Coaching (PHC) post-prevention visit. Coaches trained in motivational interviewing are matched to participants based on demographics. The study uses mixed methods, including quantitative assessments of behaviors and screening at six months and qualitative interviews on barriers and mechanisms. A hybrid implementation-effectiveness design evaluates health impacts, sustainability, and cost-effectiveness, aiming to refine PHC methods and inform community-focused preventive health strategies.

Results

Preliminary qualitative data indicate a universally positive reception of the BETTER Women program model. Improvements in patient health are primarily attributed to a holistic approach to goal setting during prevention visits and consistent accountability to PHCs. The findings underscore a reciprocal dynamic, where patients are motivated by their PHCs and feel inspired to adopt and promote healthy behaviours within their families and communities. Challenges include deviations from the anticipated frequency of PHC-patient check-ins, higher than expected, and rare instances where PHCs have independently created or modified patient goals. The NexJ app, created to help track health progress, check-ins, and resources, was used very little because it was difficult for PHCs or patients to navigate.

Conclusion

The BETTER Women program demonstrates promise in addressing preventive care gaps through Peer Health Coaching, fostering reciprocal motivation between patients and coaches. While challenges with app usability remain; preliminary results highlight significant health improvements and the program's potential to inform scalable, community-based, culturally tailored health strategies for diverse populations.

ID: 35050

Presented by: Prabasha Rasaputra

Factors contributing to changes in driving pattern among older adults in the CLSA

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Background and Objectives

Previous studies indicate that older adults value driving, due to the independence it provides. Retirement from driving can lead to depression, isolation, cognitive decline, and deterioration in function, potentially leading to admission to long-term institutional care. Having adequate social support enables and reduces an older adult's propensity to continue driving. However, few studies have examined this diverging relationship between social support and driving in older adults.

Approach

A prospective cohort of older adults from the Canadian Longitudinal Study on Aging (CLSA) who were frequent drivers at baseline. Comparison groups were divided into those who remained frequent drivers, those who became less frequent drivers, and those who had ceased driving at 3 years (Follow-up 1). There was a total of 13,337 older adults included in this study. Exclusion criteria included those below the age of 65, individuals who were not driving at baseline and individuals whose driving frequency was unknown.

Results

During the study period, the average age of those who were frequent drivers was 72.6 years, those who became less frequent drivers were 72.9 years, and those who became non-drivers were 75.2 years. Females had a much higher rate of becoming non-drivers (2.16%) than males (0.96%). Participants who are married or in a common-law relationship were less likely to become non-drivers (1.20%) than those not in a partnership (2.17%). This may be correlated with co-resident status, where those with one co-resident were less likely to be non-drivers (1.29%) than those living alone (1.90%) or those with multiple co-residents (1.98%). Non-white older adults were more likely to become non-drivers (2.38%) than older white adults (1.50%).

Conclusion

Preliminary results indicate that older adults who are in a couple were less likely to become non-drivers than those who were single, widowed and divorced or separated. However, older adults with multiple co-residents, who likely live in multigenerational households, are also more likely to become non-drivers, compared to those who live with one co-resident.

Prescription opioid use for pain in Canada: a population-based repeated cross-sectional study

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Background and Objectives

The best available evidence on prescription opioid dispensing for pain in Canada has been limited to regional analyses in only parts of the country and national estimates using pharmaceutical sales data. To address the dearth of information on population exposure to opioid analgesics and their variations by region, patient characteristics, and time, we examined the 5-year incidence and prevalence trends of prescription opioid use for pain in Canada before and during the COVID-19 pandemic.

Approach

Our population-based repeated cross-sectional analysis of pharmacy dispensing data from six provinces (i.e., British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and Québec) represented 93% of the Canadian population between January 1, 2018, and December 31, 2022. We calculated monthly population-adjusted rates per 1,000 population of new and prevalent users stratified by province and reported annual population-adjusted rates overall and stratified by age, sex, neighbourhood income quintile, and location of residence. We examined annual proportions of incident users receiving guideline-recommended maximum initial opioid doses and of prevalent users receiving the most common types of opioids (i.e., codeine, hydromorphone, oxycodone, morphine, and fentanyl).

Results

Monthly rates of incident and prevalent use of prescription opioids for pain declined across all provinces over time; however, the monthly rate of prevalent use was consistently highest in Manitoba and lowest in British Columbia. In 2022, we captured 1,818,680 incident and 2,770,268 prevalent users, with annual incidence ranging from 55.2 per 1,000 (Ontario) to 63.0 per 1,000 (Alberta) and annual prevalence ranging from 85.1 per 1,000 (Saskatchewan) and 96.3 per 1,000 (Alberta). Annual incidence and prevalence were consistently higher among females, older individuals, and people living in lower income neighbourhoods and rural regions of Canada. New opioid recipients with a daily dose >50 milligram morphine equivalents (MME) varied provincially, but declined over time, with important shifts in the types of opioids prescribed.

Conclusion

We found a short-term decrease in incident opioid use for pain corresponding to the beginning of COVID-19 pandemic and consistent declines in initiation and overall opioid dispensing across all provinces over time in line with national efforts to promote appropriate opioid prescribing for acute and chronic non-cancer pain across Canada.

ID: 33162

Presented by: Jessica Reszel

Development & user evaluation of an implementation toolkit for maternal-newborn health services

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Background and Objectives

All Ontario birthing hospitals contribute data to BORN (Better Outcomes Registry & Network), Ontario's maternal-newborn data registry. BORN is a rich source of information that can facilitate identification of practices/outcomes for improvement. Transforming this data into improvements requires knowledge and skills in implementation; however, maternal-newborn healthcare professionals and leaders have indicated a need for increased implementation capacity. We developed a “toolkit” to help healthcare providers and leaders apply implementation science to their practice-change initiatives.

Approach

This initiative is led by a PhD-trainee at BORN and uses an integrated knowledge translation approach whereby researchers and knowledge users worked together to design and execute the multi-phase, mixed-methods project. First, we interviewed implementation science experts to identify essential content to include in the toolkit. Second, we interviewed and surveyed healthcare professionals and leaders about their current approaches to implementing practice changes and their learning needs. Third, our team drafted and revised the initial toolkit draft. Fourth, we shared the toolkit with maternal-newborn healthcare professionals and leaders to assess perceptions of acceptability, helpfulness, usability, feasibility, and intent to use.

Results

The toolkit includes 13 steps for implementing practice changes. Each step includes descriptions of what to do; why it's important; considerations for equity, diversity, inclusion; tips for leveraging BORN data/reports/resources; and tools/templates to action the steps. Feedback received to date (n=15) indicates, overall, the toolkit is perceived as an acceptable and helpful resource, meeting a need for a “one-stop-shop” of implementation resources tailored to maternal-newborn health services. Feedback is informing improvements to usability (e.g., changing to web format), feasibility (e.g., identifying approaches for real-world application), and potential supports (e.g., training on toolkit process; developing community-of-practice). Users indicated the toolkit has potential to improve use of BORN data/information and increase the success/sustainability of practice changes in maternal-newborn health services.

Conclusion

This embedded research resulted in a toolkit that blends best practices in implementation science with experiential knowledge of health service leaders and practitioners. Next steps include revising the toolkit's content/format and field-testing, with the goal of widespread dissemination to BORN data partners and others in maternal-newborn health services.

ID: 35510

Presented by: Diana Ridgeway

Equity in Diabetes Care: A Focus on Lower Limb Amputations

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Background and Objectives

Lower limb amputations associated with diabetes are used internationally as a measure of quality and access related to diabetes care. These preventable complications signal an opportunity to improve diabetes care quality and reduce health system costs through timely access to primary and specialist care. The primary objective of this report is to provide national comparable data on lower limb complications associated with diabetes to inform management and prevention efforts, from an equity perspective.

Approach

Using 3 years of pooled data, we examined hospitalizations for diabetes-associated lower limb amputations and ulcers, gangrene, or infection, and presented results at both the national and provincial/territorial level. To assess inequalities in diabetes care, we analyzed hospitalization counts and rates stratified by age, recorded sex or gender, remoteness of residence, and neighbourhood-level socioeconomic factors. We also analyzed other relevant characteristics including costs of hospitalization, patients' clinical characteristics, and stories of lived experience.

Results

From 2020-2022, an average of 31,000 annual hospitalizations in Canada involved a diabetes-associated lower limb complication: 3,080 hospitalizations involved a leg amputation; 4,640 hospitalizations involved an ankle, foot, or toe amputation; and the remainder were for ulcers, gangrene, or infections. These hospitalizations alone represent approximately \$750 million in health system costs annually in Canada.

Adults aged 40-64 accounted for 43% of amputations. Leg amputation rates were several times higher for males compared with females, and for people living in neighbourhoods with the lowest income, lowest high school completion, and highest social deprivation. Rates were 7 times higher in very remote areas compared with easily accessible areas. Inequalities were similar for other lower limb complications.

Results also showed high rates of readmission and in-hospital death.

Conclusion

Higher amputation rates in certain population groups highlight the importance of equity-informed interventions to address financial, social, geographic, and other barriers to diabetes care and management. Strategies to reduce inequities include tailored health promotion initiatives (i.e., by language, literacy) and improving access to high quality primary care, specialist services, and mobility devices.

ID: 35076

Presented by: Annie Robitaille

Creating a Pan-Canadian Surveillance System for Dementia Dyads: Deepening Insight into the Journey

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Background and Objectives

Most people living with dementia (PLWD) reside in community settings, relying on care partners for support. While care partners are critical to maintaining PLWD's quality of life, caregiving demands can increase with disease progression, impacting caregivers' health. Current Canadian data lack linked insights on PLWD and care partners. This study aimed to develop a national surveillance system to collect longitudinal dyadic data using electronic medical records (EMR), exploring dementia trajectories and mutual impacts.

Approach

Using de-identified primary care electronic medical record (EMR) data from the Canadian Primary Care Sentinel Surveillance Network (CPCSSN), we linked PLWD-care partner dyads using clinic staff identification. Data on demographics (sex, age, urban/rural, social/material deprivation), dementia case definition, and health outcomes (e.g., visits, prescriptions, BMI, chronic conditions) were included in the longitudinal database. Using interrupted time series analysis, we examined care partner health trends two years before and after PLWD diagnosis, compared to age, sex and province matched controls.

Results

Data from 95 primary care providers across 22 Canadian clinics included 734 PLWD and 203 dyads, with 177 dyads analyzed. PLWD had a mean age of 82.1 years (60% male), and care partners averaged 68.3 years (62% female). Most participants lived in urban settings, with records spanning 18.5 years pre-diagnosis and 22.6 years post-diagnosis. Dyadic data highlighted trends in care partners' mental and physical health visits and prescriptions. Two years pre-diagnosis, mental health visit rates increased (care partners: slope=0.0005; controls: slope=0.0001). Two years post-diagnosis, care partners' visit rates rose 0.008/month, reaching 0.035, while controls showed no change. Similar trends in physical health visits and prescriptions were observed; detailed findings will follow.

Conclusion

This study demonstrated the feasibility of establishing a national, longitudinal surveillance system for PLWD-care partner dyads. The linked database enables deeper insights into dementia trajectories, informing policy and care delivery. Expanding dyadic

data linkage and integrating these methods nationwide will support broader applications to chronic disease management and care improvement.

Community-based supports for people living with dementia (PLWD) and their caregivers

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Background and Objectives

The rising prevalence of dementia is felt across borders, sectors and cultures. In Canada, progress has been made to promote “aging in place”, but many gaps remain. There is also limited knowledge of what features programs and services should include to sufficiently support individuals in their local communities. This rapid review aimed to identify key factors of success and best practices of innovative approaches to support community-dwelling PLWD and their caregivers, as well as promising Canadian examples.

Approach

First, we conducted a rapid literature to identify peer-reviewed community-based interventions or programs that have been evaluated. Analysis of the included identified programmatic factors that were connected to positive outcomes for PLWD and/or their caregivers, as well as considerations for the design and implementation of programs. We developed a framework building on the literature findings to outline these different factors and considerations for successful community-based interventions that are relevant to the Canadian context. We then conducted a rapid jurisdictional review to identify promising examples of innovations in Canada that met multiple programmatic elements of success.

Results

Our framework informed by the literature includes: core principles and values: stigma, accessibility, equity and intersectionality, and sustainability; programmatic factors of success: early intervention, triadic involvement in care planning, individualized and person-centred approaches, multi-component interventions, and community building and social engagement; and considerations for design and implementation: target population, delivery, co-design and engagement strategies, costs, resources and system incentives, impacts and outcomes, and geography and local context. Using this framework, we uncovered a range of Canadian initiatives that embody several of these factors and considerations with potential merit for maintenance support or opportunities for scale and spread and further evaluation. The range of initiatives uncovered from this review highlight important initiatives to support health, safety, independence, and quality of life.

Conclusion

Community-dwelling PLWD and caregivers require various supports throughout the progression of dementia. Findings provide lessons that can inform other jurisdictions or organizations seeking to implement or invest in the maintenance, scaling and spread of these approaches that achieve positive impacts on various aspects of health, wellbeing and quality of life.

A framework for meaningful collaboration with Indigenous peoples in health systems transformation

Authors: Roy, Amrita (Queen's University); Lavalley, Samantha (Queen's University); Cronin, Shawna (Queen's University); Donnelly, Catherine (Queen's University); Green, Mike (Queen's University); Galica, Jacqueline (Queen's University); Slater, Morgan (Queen's University); Grady, Colleen (Queen's University); Tranmer, Joan (Queen's University); Morrison, Kim (Frontenac, Lennox & Addington Ontario Health Team); Khrokova, Anastasiya (Frontenac, Lennox & Addington Ontario Health Team); Bell, Mike (Frontenac, Lennox & Addington Ontario Health Team); Claus-Johnson, Laurel (Indigenous Wellness Council); LaPointe, Mireille (Indigenous Wellness Council); Nolan, Dionne (Indigenous Wellness Council); Brant, Kathy (Indigenous Wellness Council); Brant, Lynn (Indigenous Wellness Council); Gerow, Lynda (Indigenous Wellness Council).

Background and Objectives

Community engagement to address inequities faced by Indigenous peoples is a stated aim of the new Ontario Health Teams. This research examines collaboration processes with Indigenous community partners in the governance and activities of the Frontenac, Lennox & Addington Ontario Health Team (FLA OHT). In addition to offering recommendations for improving collaboration within FLA OHT, this research seeks to generate a framework to more broadly operationalize meaningful collaboration between Indigenous partners and mainstream health systems.

Approach

Case study method involving community-based participatory research and using principles of Ownership, Control, Access, Possession (OCAP) in ethical Indigenous health research. Data sources included: focus groups and interviews with previous and current Indigenous members of FLA OHT working groups, tables and support structures; focus groups with FLA OHT leadership and administration; and organizational documents. Given the applied research objectives and pragmatic paradigm, a qualitative descriptive approach was adopted in the coding and thematic analysis of transcripts and documents, aided by NVivo software. Team member triangulation through group analysis, triangulation with existing literature, and member-checking sessions all enhanced analytical rigour.

Results

Indigenous members' interviews point to four major themes: relationship-building, drawing and building on previous work, creating and enhancing Indigenous spaces, increasing Indigenous representation. Barriers to meaningful collaboration included: feeling dismissed, tokenism, slow-moving work with unclear goals, burdening the Indigenous community, and lack of accountability and transparency. Enablers included: moving from continual consultation to concrete action, recognizing Indigenous peoples' time with honorariums, having open minds, and ensuring Indigenous peoples feel heard. Interviews with leadership pointed to five major themes on improving collaboration: growing Indigenous knowledge and relationships, catalyzing action, creating Indigenous spaces, increasing Indigenous representation, and obtaining additional funding and resources. Leadership proposed actions such as dedicating time for relationship-building, advocating to Ontario Health for longterm funding, and building an Indigenous lens into current programs.

Conclusion

The importance of action-oriented engagement, adequate funding and resources, and responding actively to Indigenous voices are key steps to ensure that collaboration feels meaningful to Indigenous partners. In addition to insight for FLA OHT, the framework generated may be useful for partnerships between other mainstream health institutions and Indigenous peoples.

ID: 34703

Presented by: Amanda Rush

A universal model of care for hyperemesis gravidarum? Evaluation findings of a maternity initiative

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Background and Objectives

Hyperemesis gravidarum (HG) is a severe form of nausea and vomiting during pregnancy. Access to holistic care for women with HG in Australia is inconsistent, with most hospitals lacking defined models of care. This has previously resulted in an over-reliance on acute care, including re-presentations to emergency departments. This study aimed to evaluate the implementation of a four-year statewide initiative focused on improving hospital care pathways for women with HG.

Approach

Seventeen one-hour interviews were conducted with key implementation stakeholders over a 2-month period in late 2023, with coverage of all 15 districts. Interview data were supplemented with written summaries of models of care in each district, completed by interviewees. De-identified patient data on the reach (site, date of access/discharge, provision of IV fluids, provision of other HG care) of implemented models of care were collected by district representatives over an approximately 12-month period. Content and thematic analysis of interview transcripts was undertaken using NVivo software, and descriptive statistics of reach data conducted.

Results

While uniform resources were allocated to support individual districts, there was wide variation in implementation. Two main models of care were established: 'hospital in the home' and 'early pregnancy assessment services'. Within these, provision of care differed according to geography, and HG care was not always governed by maternity units. A planned midwifery-led model of care to be delivered to women in their homes did not eventuate. Alternative models of care including virtual care were also developed to meet local needs.

Despite implementation variation, the number of women accessing care was within the expected range according to population and prevalence data, with 850 women accessing a total of 11970 days of care during data collection. Almost half of these included the provision of IV fluids.

Conclusion

This evaluation provides important insights into system-wide options for hospital care for women with HG. While a universal model of care for HG may provide efficiencies, implementation should be carried out according to local patient and staff healthcare needs, which incorporate population, geographic, rurality, and socio-economic differences.

ID: 35462

Presented by: Cayley Russell & Farihah Ali

Impact of British Columbia's decriminalization among people who use drugs: a qualitative study

Authors: *Farihah Ali (Ontario Node, Canadian Research Initiative in Substance Matters (CRISM)), Cayley Russell (Ontario Node, Canadian Research Initiative in Substance Matters (CRISM)), Savannah Torres- Salbach (Ontario Node, Canadian Research Initiative in Substance Matters (CRISM)), Margret Lo (Ontario Node, Canadian Research Initiative in Substance Matters (CRISM)), Matthew Bonn (Ontario Node, Canadian Research Initiative in Substance Matters (CRISM)), Geoff Bardwell (University of Waterloo), Juls Budau (University of British Columbia), Elaine Hyshka (University of Calgary), Jürgen Rehm (Ontario Node, Canadian Research Initiative in Substance Matters (CRISM))*

Background and Objectives

In January 2023, British Columbia (BC) decriminalized the personal possession of up to 2.5g of certain drugs. The policy aims to reduce the harms associated with drug use by addressing criminalization as a social determinant of health, improving relationships between people who use drugs (PWUD) and police, and reducing stigma and barriers to support for PWUD. Understanding PWUD's initial experiences with decriminalization is crucial for assessing the policy's impact and effectiveness.

Approach

As part of a national evaluation of the decriminalization policy, between October 2023 and February 2024, we conducted qualitative interviews with a sample of 100 PWUD across BC. Participants also partook in an interviewer-administered survey assessing socio-demographics and drug use patterns. We explored participants' initial perceptions and experiences with decriminalization, including changes in stigmatization and drug use experiences, perceived overdose risk, and police interactions since the implementation of the policy. A qualitative thematic analysis was used to synthesize the data.

Results

Preliminary results revealed persistent societal, structural, and self-stigma among PWUD post-decriminalization. Some participants reported reduced stigma due to shifting perceptions of drug use as a health issue, while others experienced increased stigma linked to the heightened visibility of public consumption. Most participants maintained their drug use patterns, though some adjusted behaviors to avoid criminalization (e.g., carried smaller amounts). Moreover, police-PWUD relationships remained largely adversarial, marked by ongoing mistrust in police due to historical mistreatment and discretionary enforcement, where some participants reported unlawful drug seizures under the policy. Despite this, many participants expressed reduced fear of police, as well as optimism for long-term stigma reduction. However, participants identified a need for improved police training and greater public awareness of the policy to support the policy's goals.

Conclusion

Preliminary findings highlight the need for enhanced education and awareness about decriminalization among police and the public to reduce stigma and support its goals. Ongoing monitoring of the policy and its impact on PWUD is critical to ensure its success in achieving broader harm reduction and public health objectives.

ID: 35314

Presented by: Angela Russolillo

Patterns of Multimorbidity among Psychiatric Inpatients: A Latent Class Analysis

Authors: *Russolillo, Angela - School of Nursing, University of British Columbia*

Guan, Daphne - Centre for Advancing Health Outcomes

Carter, Michelle - School of Nursing, University of British Columbia

Background and Objectives

Multimorbidity is increasingly common among people with psychiatric disorders, complicating treatment and increasing the risk of adverse health outcomes. Understanding patterns of multimorbidity is important for improving care quality and reducing health care costs. This study aims to identify distinct multimorbidity profiles of psychiatric inpatients.

Approach

We analyzed retrospective health administrative data for individuals (n = 5158) who experienced an acute psychiatric admission to a single urban hospital in Vancouver, British Columbia, between January 1, 2016, and December 31, 2023. Using latent class analysis (LCA) we identified 6 multimorbidity patient profiles, with the 6-class solution providing the best fit based on the Bayesian Information Criterion.

Results

All 6 classes exhibited some degree of multimorbidity (i.e. the co-occurrence of multiple chronic or acute diseases conditions within one person), though they were clinically distinct in composition. Class 6 was characterized by a high level of complexity with multiple mental, substance use and medical or social issues represented. Classes 2 to 4 were primarily defined by psychiatric diagnoses including, schizophrenia, bipolar disorder, and mixed mood or anxiety disorders with low substance use or medical issues. The remaining classes (1 and 5) were distinguished by high or moderate polysubstance substance use and mixed mental and medical diagnoses.

Conclusion

Multimorbid presentations among psychiatric inpatients are common and highly heterogenous. It is essential for clinicians and health systems to assess and address the complex, intersecting health issues faced by this population to improve outcomes and optimize care delivery.

ID: 35605

Presented by: Pushpita Samina

Role of Ethno-Religious Health Advocacy Groups during COVID-19 in Canada: A Comparative Case Study

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Background and Objectives

The COVID-19 pandemic exposed critical gaps in healthcare delivery for minority communities in Canada, prompting the emergence of culturally specific health advocacy organizations. This study compares two such initiatives: the Canadian Muslim COVID-19 Task Force (CMCTF) and the South Asian COVID-19 Task Force (SACTF). The goal is to understand the factors contributing to their formation and approach to addressing the gaps and extract insights that can inform future initiatives to achieve health equity.

Approach

We conducted an embedded case study utilizing semi-structured interviews and focus group discussions with task force members from 2023 to 2024. Our data sources included interview transcripts, organizational documents, and archival records from March 2020 to September 2021. Employing Critical Race Theory and Health Equity frameworks, we examined how pre-existing community structures influenced the organizational development, operational strategies, and key activities of the SACTF and CMCTF. Furthermore, we investigated their methods for addressing public health challenges and their accomplishments. This approach facilitated a comparative understanding of how ethno-religious organizations responded to health crises and contributed to mitigating inequities in their respective communities.

Results

CMCTF's proactive formation, facilitated by established medical and religious associations, enabled rapid mobilization and structured response. In contrast, though initially faith-based, SACTF's reactive formation evolved to serve broader South Asian communities, demonstrating adaptive capacity despite lacking pre-existing structures. Common motivations were anticipating stigma, protecting one's own communities, and addressing systemic healthcare gaps. Witnessing COVID-19's disproportionate impact firsthand, racialized physicians played pivotal roles in both organizations. Bridging gaps between health agencies and communities and translating messages into culturally accessible language and vaccination were key activities that reflected success through the high vaccination in the Peel region. However, the sustained operation of these initiatives is challenged by a lack of recognition and reward, integration with public health, funding, and limited representation in public health decision-making.

Conclusion

These findings highlight persistent systemic barriers in Canadian healthcare and underscore the need for structured integration of community-based health organizations into broader public health infrastructure. While these organizations effectively addressed immediate pandemic needs, their potential for addressing ongoing health challenges like mental health and non-communicable diseases remains untapped without systematic support and recognition.

ID: 34969

Presented by: Ambreen Sayani

Advancing Equity Through Community-Engaged Health Equity Assessments (CEn-HEAs): EMPaCT Framework

Authors: *Isra Amsdr, Fatah Awil, Victoria Garcia, Tara Jeji, Omar Khan, Bee Lee, Linda Monteith, Mursal Musawi, Jill Robinson, Stacey Sterling, Dean Wardak, Alies Maybee, Mohadessa Khawari, Emily Cordeaux, Ryan Hinds, Kelly Wu, Ambreen Sayani.*

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Background and Objectives

Traditional Health Equity Assessments (HEAs) often exclude meaningful engagement with communities impacted by inequities, limiting their ability to address systemic barriers. The Community-Engaged Health Equity Assessment (CEn-HEA) framework, developed by Equity Mobilizing Partnerships in Community (EMPaCT), centers lived experiences to generate recommendations for addressing inequities across downstream, midstream, and upstream levels. This participatory approach fosters trust, power-sharing, and accountability to inform equity-driven decisions in health policy and programs, promoting systemic change and improving health outcomes.

Approach

The CEn-HEA framework employs a participatory, five-step process: creating safe spaces, analyzing inequities, co-developing changes, making recommendations, and tracking accountability. Community members and decision-makers collaborate to identify inequities and generate recommendations addressing individual, community, and systemic determinants of health. Principles of meaningful engagement—trust-building, inclusivity, and shared accountability—guide the process. Metrics for evaluation include capacity building (e.g., skills development, partnership sustainability), knowledge advancement (e.g., co-designed tools, dissemination outputs), and decision-making impact (e.g., changes to policies, programs, and practices). This approach ensures actionable, equity-driven solutions grounded in the lived experiences of those most affected by health inequities.

Results

The EMPaCT CEn-HEA framework has demonstrated significant impact across three domains:

- Building Capacity: 25 diverse patient partners engaged, 7 academic trainees supported, 4 funding sources secured, and sustainable partnerships established to support equity initiatives.
- Advancing Knowledge: 4 publications, 30 technical reports, 20 national and 4 international presentations, 7 digital dissemination outputs, and 5 co-designed tools have been co-developed and co-disseminated to date.
- Informing Decisions: CEn-HEA sessions influenced 57 decision-makers, resulting in 8 national, 8 regional, and 14 local-level decisions addressing health inequities.

These results underscore the transformative potential of CEn-HEA in addressing health inequities by integrating lived experiences into actionable recommendations. Its participatory approach fosters systemic change across policies, programs, and institutional practices.

Conclusion

The CEn-HEA framework represents a scalable, participatory approach to advancing equity in health systems. By embedding lived experiences into equity analysis, it drives systemic change through capacity building, knowledge advancement, and inclusive decision-making. CEn-HEA offers a replicable model for fostering accountability and delivering meaningful, equity-driven health policy and program improvements.

ID: 34819

Presented by: Deborah Scharf

Alcohol-related presentations to Mississauga emergency departments during the LCBO strike

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Background and Objectives

In July 2024, a 17 day-long worker strike closed 699 Liquor Control Board of Ontario (LCBO) retail outlets, stopping most commercial alcohol sales for the first time in Ontario since 1927. Trillium Health Partners (THP) operates the only emergency departments (EDs) serving 1+ million people in the Mississauga, Ontario region. We used the natural experiment created by the LCBO strike to test how access to commercial alcohol affects alcohol-related presentations to THP's EDs.

Approach

We compared the number of alcohol-related presentations to THP EDs during the 17 days before, during, and after the LCBO strike, and one year before the strike (i.e., 17 days in July 2023) to account for seasonal trends. Data were from National Ambulatory Care Reporting System (NACRS). Alcohol-related presentations were defined as ED visits where the primary or secondary diagnosis was "F:10 Mental health and behavioral disorders due to use of alcohol". We also analyzed other ED indicators (length of stay, violent episodes) during these same periods to determine how they were impacted by the LCBO strike.

Results

Total alcohol-related ED presentations were significantly lower during the LCBO strike ($n=80$; $M = 4.7/\text{day}$) compared to the 17 days before the strike ($n=115$; $M = 6.8/\text{day}$; $F = 9.89$, $p = 0.004$), after the strike ($n=108$; $M = 6.4/\text{day}$; $F = 5.88$, $p = 0.021$), and during corresponding dates in 2023 ($n= 125$; $M = 7.4/\text{day}$; $F = 13.11$, $p = 0.001$). The relative reduction in alcohol-related ED presentations during the strike ranged from 27%-36%. In contrast, we found no differences in total (all-cause) ED presentations between the strike period and the comparison periods (strike $n=11,408$ vs. comparisons n 's = 10,273 to 11,581), nor did we find any between-period differences in ED length of stay. Analyses of violent episodes in ED are forthcoming.

Conclusion

Restrictions on commercial alcohol access created by the July 2024 LCBO strike promptly reduced the number of alcohol-related presentations to Mississauga, Ontario EDs by approximately 30%. Policies that limit commercial alcohol sales should be considered by governments and communities seeking to mitigate alcohol-related harm.

Family Physicians' Perspectives on Electronic Inbox Management: A Systematic Review

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Background and Objectives

Family physicians spend approximately half their professional time on indirect patient care activities (IPCA). Essential to patient care, inbox IPCA includes renewing prescriptions, checking lab results and reviewing messages. However, IPCA takes time away from direct patient care and has been linked to physician dissatisfaction, stress, and burnout, potentially contributing to the family medicine crisis in Canada. Our objective was to understand the range of experiences and perspectives of family physicians regarding electronic inbox management.

Approach

To understand family physician experiences of electronic inbox management, we conducted a systematic review. Eligible articles addressed the perspectives of family physicians on tasks related to the electronic inbox, were peer-reviewed, published in English between January 1, 2012 - April 22, 2024, and used any method of primary data collection and analysis. An information scientist designed the multi-database search strategy. Citation-chaining and expert consultation supplemented this search. Articles were screened independently and in duplicate. Data were extracted directly from qualitative studies. Quantitative data were transformed for integrated analysis using Sandeloski's method of "qualitizing". Data analysis used a constant comparative method.

Results

Fifty-four articles were included. The combination of fragmented and incompatible technical systems, along with an overwhelming volume of complex tasks has created a system where family physicians struggle to manage the bureaucracy of patient care. Inbox management is particularly challenging for family physicians when caring for hospitalized patients, managing prescriptions, or coordinating and following up on specialist referrals. Selected impacts include large amounts of time spent on duplicated or unnecessary tasks, inadvertently making uninformed clinical decisions, increased risk of medical errors, and perceived tension between maintaining patient accessibility and reducing workload. A variety of systemic and personal strategies for management were described, including the re-design of electronic medical record (EMR) systems, task delegation, the use of templates, and synchronizing prescription renewals with patient visits.

Conclusion

The intersection of inefficient systems and high workloads makes inbox management labour-intensive and frustrating, lowering job satisfaction and efficacy. Downloading administrative tasks to family physicians combined with the growing complexity of

patient management has generated a tremendous burden. Solutions are needed to improve the sustainability and appeal of family medicine.

Preparing for the scale up of a case management intervention: Creating tools and resources that work

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Background and Objectives

Case management (CM) is a complex intervention which seeks to improve care integration for individuals with complex care needs. The PriCARE research team developed a “toolkit” to support the implementation of a CM intervention in primary care. In the context of scaling up the intervention in primary care clinics and hospitals in Quebec and primary care clinics in New Brunswick, this presentation aims to provide insights into the adaptation and use of tools across jurisdictions.

Approach

The “toolkit” includes a variety of clinical and research tools and was shaped by active contribution from diverse groups including anglophone and francophone researchers, patient partners, clinicians, and health administrators from various provinces. The tools were adapted in each province to align with existing health systems. Key components included virtual training sessions, resources for case managers (such as screening tools, standards of care, individualized service plan forms), a patient journey map, patient recruitment tools, and videos highlighting the benefits of case management.

Results

The PriCARE research team learned valuable lessons during the preparation for a large-scale implementation of a case management intervention. These included the importance of keeping interest holders well informed throughout the implementation process, adapting tools to local contexts and integrating them into case management practice. Discussions with members of the health authority and government representatives in New Brunswick have led to adaptations to program eligibility criteria, evaluation metrics, as well as intervention forms and processes which have been amended to work within current systems and avoid duplication of work. Examples include amendments to the standard of care and the care plan. These were made by the research team in collaboration with diverse groups to adjust for differences in clinical contexts and measurement capabilities.

Conclusion

The development of tools to support a large-scale case management implementation in New Brunswick and Quebec provides insights into the value of collaboration from diverse groups, the development of partnerships for a common goal, the importance of flexibility and adaptation of resources to merge with existing systems.

ID: 33369

Presented by: Theresa Sedzro

Co-Designing Solutions: Enhancing mental health support for healthcare workers in long-term care

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Background and Objectives

Burnout poses a significant and persistent challenge in the long-term care (LTC) sector, necessitating proactive strategies for early detection and prevention to safeguard the health and well-being of the healthcare workforce. This study sought to investigate the underlying drivers of burnout and distress among LTC workers, providing a foundation for the development of a Burnout Assessment Tool (BAT) tailored to this sector.

Approach

An experience-based co-design methodology guided the study, including 11 focus groups conducted between July 2023 and October 2024 with 24 LTC workers from Ontario. Participants, representing diverse roles—including personal support workers, nurses, social workers, and administrators—were purposefully selected. Each two-hour session, consisting of 4–5 participants, aimed to: (1) explore participants' work-related experiences, and (2) evaluate the relevance and applicability of existing burnout and distress tools, such as the Maslach Burnout Inventory-Human Services Survey, within the LTC context. Audio-recorded sessions were transcribed verbatim, and an iterative coding process was employed to develop a thematic framework.

Results

The co-design team identified five key challenges and priority areas for targeted interventions: (1) the intrinsic challenges of LTC work environments, (2) the toll of workplace pressures on employee health and well-being, (3) the management of psychosocial risks in the workplace, and (4) the critical need for a context-specific burnout assessment tool for LTC settings. Participants shared deeply personal accounts of their roles, emphasizing the pervasive effects of burnout on their well-being and the systemic obstacles they navigate daily.

Conclusion

The findings underscore the urgent need for tailored interventions to address burnout and mental distress among LTC workers and leaders. This study provides valuable insights into the lived experiences of these professionals, offering a blueprint for developing a BAT that reflects the unique challenges of LTC work.

ID: 35383

Presented by: Aimun Shah

Outcomes of Grassroots-Driven Interprofessional Primary Care Teams: A Retrospective Cohort Study

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Background and Objectives

Millions of Canadians lack a family physician or experience long wait times for care. Interprofessional team-based care, a pillar of the Patient's Medical Home (PMH) vision, is a potential solution. This study examines the impact of "grassroots" teams on outcomes of access and delivery of preventative care services. These teams are developed by family physician leaders through self-initiated, community-driven approaches. The outcomes are compared with teams formed via formal government initiatives and non-team practices.

Approach

A retrospective matched cohort study was conducted using health administrative data spanning 2016-2021 from ICES. Six 'Grassroots' practices were identified through previous research. These were matched to all 'Family Health Team' (FHT) and 'Non-Team' practices within equivalent Health Region Peer Groups, defined by similar socioeconomic features and health profiles. Key metrics included: patient attachment, visit frequency, continuity of care, and the proportion receiving preventive care services. Data were linked using unique encoded identifies and analyzed securely at ICES. Descriptive (mean, standard deviation) and inferential statistics (p-value) were generated to describe the characteristics of each cohort and compare between the cohorts.

Results

Grassroots practices had significantly more attached patients per physician (1371) compared to both FHTs (1227; $p < 0.0001$) and non-team practices (586; $p < 0.0001$). Grassroots clinics also saw higher annual patient visits per physician (2792) compared to FHTs (2321; $p = 0.0002$) and non-team practices (1378; $p < 0.0001$). Continuity of care was similar across grassroots clinics (48%) and FHTs (48%; $p = 0.53$), both higher than non-team practices (41%; $p = 0.02$). Finally, grassroots clinics also outperformed non-team practices in delivering preventive care services across most metrics ($p < 0.01$), with the exception of lipid screening ($p = 0.1802$).

Conclusion

Grassroots interprofessional care models exhibited better patient attachment, visit frequency, and preventive service delivery than non-team practices. This suggests that flexible funding and support for grassroots innovations could enhance primary care access and effectiveness in Canada. Future health policies should encourage scalable, adaptable team-based models that reflect local community needs.

ID: 33929

Presented by: Anmol Shahid

Rapid Adaptation of Alberta Family Integrated Care for Broader Patient Populations

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**Dr. Shahid is a CIHR Health System Impact Fellow embedded in Alberta Health Services and has applied for a CIHR travel award to present this embedded work (application # 564792; Title: Rapid Adaptation of Alberta Family Integrated Care: Scaling A Neonatal Intensive Care Unit Care Model to Broader Patient Populations)*

Background and Objectives

Inspired by research linking family involvement in care to better outcomes, our team developed Alberta Family Integrated Care (AB FICare) to integrate parents into neonatal intensive care unit (NICU) teams. AB FICare showed shorter NICU stays, reduced parental distress, and cost savings. Partnering with Alberta's health system, we led AB FICare through research and scale phases to standard-of-care in Alberta's NICUs. We are now rapidly adapting AB FICare for inpatient pediatrics and adult ICUs.

Approach

AB FICare employs healthcare provider (HCP) educational modules and systematic implementation processes to implement and sustain the model in NICUs. In adapting AB FICare for broader acute care populations, we continue to use co-design methodology (involving patients, families, HCPs, decision-makers) and added generative artificial intelligence to (1) adapt modules for inpatient pediatrics and adult ICU populations and (2) plan feasibility and pilot studies in preparation for national randomized controlled trials. Amid Alberta's healthcare reforms, we will engage the newly created provincial improvement networks prioritizing reduced healthcare costs to lead AB FICare towards standardization of family-integrated care provincially and nationally.

Results

Inpatient Pediatrics: Using preliminary findings (interview data from 8 patients, 10 parents, and 10 HCPs), we have adapted modules to address newly-identified elements of care important these groups:

Patients: involvement in own care

Parents: Stress management, communication with and between HCPs

HCPs: resources to support, involve families in care

We have engaged local health system leaders to strategize pilot implementation for the adapted modules, which are ready for testing in Alberta Children's Hospital's units.

Adult ICUs: Through national conferences, we have identified strategic partners (researchers, HCPs, decision makers) interested in expanding AB FICare to adult ICUs. We have hosted discussions around: (1) interest, readiness for AB FICare implementation, (2) funding-acquisition, (3) baseline assessments of family-integrated care, (4) module revisions, and (5) plans for pilot implementation.

Conclusion

AB FICare spans the research-to-practice continuum: in sustainment (Alberta NICUs), in pilot exploration (local pediatric units), and in strategic partnership-development (Canada's adult ICUs). Our work highlights the potential of embedded research and strategic partnerships to rapidly evaluate and scale evidence-informed models of care, improving healthcare efficiency across populations.

ID: 35328

Presented by: Nida Shahid

Bridging Implementation and Complexity Sciences to Understand Complex Implementation Behaviour

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Background and Objectives

Chronic disease management (CDM) in Canada faces significant challenges, with eHealth interventions offering potential for improved patient outcomes. However, lagging implementation of ehealth in CDM is compounded by the complexities of Canada's multi-provider, multi-setting healthcare systems. Understanding successful implementation can improve how we effectively tailor implementation strategies based on the unique needs of ehealth users and settings within CDM. This study combines theoretical explanations with data-driven predictions to better understand ehealth implementation in CDM.

Approach

This study adopted a two-part mixed-methods design, integrating implementation science and complexity science. Study 1 used a realist review to identify critical context, mechanisms, and outcomes (CMOs) influencing eHealth implementation in CDM. Study 2 applied artificial neural network (ANN) analysis to simulate successful implementation and predict factors contributing to success. Study 1 involved qualitative data collection, with iterative sampling to capture contextual nuances, while Study 2 employed a probabilistic and stratified sampling approach. The mixed-methods design allowed for rigorous exploration of the research questions and generated complementary insights into eHealth implementation success.

Results

The study demonstrates a data-driven, predictive approach to understanding complex implementation processes. It shifts the focus from traditional process evaluations to outcome prediction in the design and evaluation of eHealth interventions.

Study 1 identified key CMOs influencing eHealth implementation in CDM, emphasizing the importance of context-specific factors such as organizational readiness and provider roles. Study 2 found successful implementation could be predicted using a machine learning model, with factors like community involvement and response mechanisms significantly contributing to success. Despite missing data, the model showed moderate predictive power, providing valuable insights into the feasibility and factors that influence eHealth implementation success.

The approach introduces methodological innovation by integrating realist reviews with machine learning techniques, providing a roadmap for future research using hybrid theoretical and data-driven approaches

Conclusion

By bridging Implementation Science with Complexity Science, it highlights the interconnectedness of these fields and demonstrates a real-world application of complexity theories. The findings provide actionable insights for improving eHealth implementation within chronic disease management.

ID: 35425

Presented by: Tetiana Shcholak

Bridging Education and Action: A Targeted Approach to Lung Cancer Prevention for the Red River Métis

Authors: *Shcholak, Tetiana; Fletcher, Alycia; Perchotte, Chantal; Mughal, Wajihah; Chartrand, A. Frances; Munch, Garret; Kloss, Olena. Primary Affiliation for all authors: Health and Wellness Department, Manitoba Métis Federation*

Background and Objectives

The Red River Métis (RRM) Citizens, one of Canada's Indigenous Peoples, face rising lung cancer rates, with cancer as the leading cause of death. Current prevention efforts follow "one size fits all" approach, overlooking the unique needs. This project led by the Manitoba Métis Federation (MMF) addressed lung cancer risks for RRM Citizens by developing a framework for targeted risk mitigation, including a pilot effort investigating radon exposure within the RRM community.

Approach

To achieve health equity for its Citizens, the MMF developed sustainable cancer prevention strategies, focusing on lung cancer. The Health and Wellness Department launched a pilot project bridging education and action for optimal cancer prevention. The team installed 109 radon test kits in 99 RRM Citizen's households for a testing period of 91 consecutive days. Certified laboratories analyzed radon levels, and households with elevated concentrations received no-cost mitigation systems. Culturally relevant informational resources were developed and distributed across MMF regions (Southeast, Winnipeg, Southwest, Northwest, Interlake, The Pas, and Thompson), and their effectiveness was assessed through pre- and post-engagement surveys.

Results

Out of 99 participating RRM Citizens' households, 30 exhibited elevated radon concentrations, 49 were below the nationally recommended threshold, and 20 had inconclusive results. The distribution of 30 households with elevated radon concentrations by MMF Region was as follows: Northwest (n=12), Winnipeg (n=7), Interlake (n=4), Southeast (n=4), Southwest (n=3). The affected households were connected to certified radon mitigation specialists to install mitigation systems at no cost. The dual approach of distributing culturally relevant informational resources alongside mitigation efforts offered tangible solutions, reducing burden of radon exposure and improving engagement with educational materials. Pre- and post-engagement surveys showed a significant increase in radon awareness scores, rising from 8.18 to 9.55 (n=66, $p \leq 0.01$, $SD \pm 3.27$, paired t-test).

Conclusion

This initiative demonstrated the effectiveness of integrating radon mitigation with culturally relevant education, addressing the unique needs of the community. It improved radon awareness and provided a sustainable model for tailored lung cancer prevention for RRM Citizens, offering valuable insight for future public health policies targeting underserved Indigenous communities.

ID: 35270

Presented by: Peter Sheffield

A Crisis of Clarity: Shared Mental Models in Primary Care Mental Health Crisis Intervention

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Background and Objectives

People experiencing a mental health crisis need support from interprofessional primary care teams. Yet, it is not clear how well these teams are working together when caring for the patients who have access to their services. Shared Mental Models (SMMs) Theory, where overlapping mental representations of task and team characteristics facilitate performance, may provide a framework for understanding and optimizing crisis interventions. This study applies SMM Theory to interprofessional primary care crisis intervention.

Approach

Four teams of interdisciplinary primary care providers (N=14 total) with mental health crisis intervention experience were recruited from Community Health Centres in Ontario. Teams included physicians, nurses, social workers, and/or system navigators. SMMs of crisis intervention were assessed for each team using: concept mapping of 22 items developed in collaboration with subject-matter experts; semi-structured interviews deductively coded for task- and team-related SMMs; and the Milward & Jeffries (2001) Team Survey, a 14-item Likert-scaled measure assessing team-related SMM.

Results

Preliminary analysis indicates that participating primary care teams did not show evidence of crisis intervention SMMs. First, we found no significant between-team differences ($p>0.05$) on any of the Team Survey subscales, demonstrating that none of the teams had higher levels of SMM than the others. Second, our preliminary deductive content analysis of interview transcripts indicates that some teams reported lacking SMMs of task objectives or team effectiveness. Third, upwards of 50% of each provider's concept map differed from their colleagues and there was a lack of agreement on when crisis intervention began and ended, as well as when and how referrals were made or documented.

Conclusion

The primary care teams we studied did not exhibit SMMs of mental health crisis intervention. We found clinically-relevant processes upon which each team lacked shared understanding. Targeting these processes and assessing if SMMs develop in future research may help improve team-based crisis intervention in primary care and further contribute to SMM Theory.

ID: 35331

Presented by: Natasha Yasmin Sheikhan

Developing a reporting framework for engagement in mental health and substance use research

Authors: *Natasha Yasmin Sheikhan*

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Background and Objectives

There has been a shift towards the engagement of people with lived experience and families (PWLE/F) as partners in mental health and substance use research. However, inconsistent reporting limits our understanding of engagement practices and their impact in this field. As there are currently no reporting guidelines or frameworks specific to engagement in mental health and substance use research, we sought to develop a reporting framework to enhance transparency, consistency, and reflection.

Approach

The present study is a qualitative descriptive study underpinned by a pragmatist epistemology. Data were collected through virtual semi-structured interviews with 13 PWLE/F partners and 12 researchers across Canada. Interviews were analyzed using template analysis. PWLE/F partners were engaged throughout the study from conception to manuscript co-authorship.

Results

The results from the template analysis identified six areas to report and reflect on: 1) How did you go about engagement? 2) What were the activities, roles, and responsibilities? 3) When did engagement occur? 4) Who was involved? 5) What was the impact? and 6) Additional reflection points. Guidance around co-authorship with PWLE/F and practical tips for reporting on engagement were also discussed. A reporting framework was developed for engagement in mental health and substance use research that balances flexibility and standardization, while incorporating reflection into reporting.

Conclusion

As engagement is inadequately reported on in mental health and substance use research, we developed a flexible reporting framework that prioritizes reflection and avoids a rigid checkbox approach. We encourage research teams that engage PWLE/F in this field to consider using the framework for transparency and reflection.

ID: 35513

Presented by: Keiko Shikako

Youth Employment through Accessible Health Communities (YEAH!) - Policy and programs review

Authors: Zeidan, Jinane, McGill University; Sinclair, Vanessa, Canadian Council on Rehabilitation and Work; Movahed Mehrnoosh, McGill University; Cardoso, Roberta, McGill University; Hagelstam-Renshaw, Amelia, McGill University; Nguyen, Linda, University of Calgary; The YEAH research project advisory

Background and Objectives

Employment is a key social determinant of health and well-being. Youth with disabilities face significant challenges in the school-to-work transition, with employment rates dropping from 55% to 39% after the pandemic. This project aims to identify best practices and barriers to inclusive school-to-work transitions, focusing on intersectionality and community factors contributing to employment. By assessing communities and incorporating youth perspectives, it seeks to inform standards tailored to the unique needs of this population.

Approach

The project adopts a participatory approach, engaging an advisory council of youth, civil society organizations, and Indigenous community partners. Key activities included: a) environmental scans of federal and international employment guidelines, programs, and services for youth with disabilities (14-30 years old); b) Community assessments (Child Community Health Inclusion Index) in successful school-to-work programs; c) Desk review of school-to-work transition programs across Canada; and d) Key informant interviews with managers, coordinators, employers, and youth with disabilities involved in these programs. Data from all sources will be triangulated to identify gaps and alignment through qualitative description.

Results

Federal environmental scan: 13 programs (n=10)/policies (n=3) were included. Programs and policies were to the individual or to organizations: skills training, career counselling, placement of first jobs, supports such as assistive technology and mentoring in jobs, and funding for programs/organizations, and subsidies for employers. International best practices: A total of 68 initiatives were included, mostly from the USA (n=29). Programs typically targeted ages 14-35, or secondary/postsecondary students and recent graduates. Key objectives included (pre-)employment services, education, skill development, accessibility support, and policy improvement and cross-stakeholder collaboration. Desk review: Six purposefully selected programs were examined at the federal level and one at the provincial level. Most programs did not specify an age or age limit and targeted a variety of disability groups (deaf, blind, autism). Programs focused on school and work-related training.

Conclusion

Programs targeted a variety of disability groups, with some programs specific for the blind, deaf, and autistic population. Most programs focused and policies were on skills training and employment-related programs in educational settings, with a scarcity of programs addressing community-related factors such as transportation, community accessibility, and inclusion awareness.

ID: 35528

Presented by: Keiko Shikako

The Canadian Health Indicators for chiLDren with Disabilities (CHILD)

Authors: *Shikako, Keiko, McGill University; Mogo, Ebele, ERIM Consulting; Arim, Rubab, Statistics Canada; Wolff, Lisa, UNICEF Canada; Movahed, Mehrnoosh, McGill University; Cardoso, Roberta, McGill University Health Center Research Institute; Yoo, Paul, The Hospital for Sick Kids; Martens, Rachel, Kids Brain Health Network/CanChild; Brenda Lenahan, parent-partner.*

Background and Objectives

Children with disabilities face disparities in accessing healthcare, education, and social services, leading to poorer outcomes. It is crucial to address this to improve their quality of life and ensure they are not left behind in national wellbeing efforts. We aimed to address the lack of comprehensive data on the wellbeing of Canadian children with disabilities, which limits the creation of targeted policies that meet their unique needs.

Approach

We employed an Integrated Knowledge Translation (IKT) approach, which involved rapid evidence synthesis, expert consultations, key informant interviews and a stakeholder-informed review of all existing Statistics Canada datasets related to the well-being of children with disabilities in Canada. This method ensured a comprehensive understanding of the wellbeing of children with disabilities, integrating both research-based evidence and lived experiences.

Stakeholders included children with disabilities, their families, healthcare providers, policymakers, and disability advocates. Engaged through interviews and consultations, these groups provided critical insights on data gaps, barriers to services, and policy priorities, ensuring the CHILD framework is both inclusive and actionable for Canadian policy development.

Results

Our research revealed critical gaps in data collection, service provision, and policy approaches for children with disabilities in Canada. We identified that children with disabilities face significant disparities in access to healthcare, education, housing, and social participation compared to their peers. These gaps result in poorer health outcomes, social isolation, and financial burdens on families. The existing national data systems lack comprehensive, disaggregated data on this population, making it difficult to track wellbeing indicators effectively.

Our findings validated existing evidence about the challenges faced by children with disabilities and highlighted the need for a more integrated, multi-sectoral approach. New insights emerged from stakeholder consultations, including the need for more accessible public spaces, better-coordinated services, and the importance of addressing intersectional issues such as income disparities, geographic location, and cultural differences in service access.

Conclusion

The CHILD framework can enhance health equity by addressing the unmet needs of children with disabilities and improving access to services. Integrating these indicators into national data collection systems will support policymakers and healthcare providers to deliver targeted interventions, improve child outcomes and reduce healthcare costs. It supports the Quadruple Aim by enhancing patient experience and population health.

ID: 35651

Presented by: Jennifer Shuldiner

Practice Facilitation to support primary care physicians with vaccine uptake

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Ivers, Noah, Women's College Hospital

Background and Objectives

A family physician recommendation is associated with the uptake of vaccines. Still, many family physicians have limited capacity to identify patients in their practice who might benefit from personalized vaccination counselling. Practice facilitation is an evidenced method of supporting changes in primary care, but its role in supporting vaccination rates is unknown.

Approach

A two-arm cluster-randomized trial was conducted with an embedded process evaluation. Family physicians with the largest number of Covid-19 unvaccinated rostered patients in the province were randomized 1:1 in November 2021. Practice facilitators contacted each intervention clinic and offered support to identify and counsel unvaccinated patients. The primary outcome was receipt of any vaccine dose during a four-month follow-up interval among rostered patients over age 12. A modified robust Poisson regression method was used to analyze intervention effects. We also collected qualitative interview data from family physicians and practice facilitators and data from facilitator field notes. Data were analyzed and triangulated using thematic analysis.

Results

There were 292 physicians randomized to the control arm and 290 to the intervention arm. Among those approached, 90 family physicians (29%) accepted facilitation. Doses of Covid-19 vaccines per 100 patients were 49.8 (95% CI 48.8-50.9) and 50.2 (95% CI 49.2-51.2) in the intervention and control arms, respectively (adjusted RR 0.99, 95% CI 0.96 to 1.02). Key factors impacting engagement with the intervention were staff shortages due to COVID-19 (structural); clinic characteristics such as technical issues and gatekeeping by the staff preventing facilitators from talking with physicians (organizational); burnout (physician); and specialized populations that required targeted resources (patient).

Conclusion

Practice facilitation in primary care clinics with high numbers of patients unvaccinated against COVID-19 was not associated with significant changes in vaccination uptake. Strategies to help under-resourced family physicians serving high-needs populations for issues of public health importance, such as vaccine promotion, must acknowledge the scarcity of physicians' time and provide new resources.

The Health Priorities of Métis Youth in Ontario: A Health Research Engagement

Authors: *Simms, Abigail (1,2), Cripps, Shelley (1), Koprich, Sebastian (1,2,3), Plaine, Jordyn (4), Tsui, Noel (1,2), Sayanthan, Jepriya (1,2,3), Sehar, Hibah (1,2,3), Edwards, Sarah (1,2,3), the Métis Nation of Ontario (1), Métis Nation of Ontario Youth Council (4)*

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Background and Objectives

Distinctions-based research and policy is important for First Nations, Métis, and Inuit health and must include youth voices. Working with the Métis Nation of Ontario (MNO) leadership, staff, and youth this work endeavored to 1) determine the health priorities of Métis youth, and 2) explore how Métis youth want to be engaged in research.

Approach

The components of this project included: 1) an engagement with Métis youth on health priorities, 2) an online survey inviting all MNO youth who had a valid email on file with the MNO Registry, 3) virtual in-depth interviews with MNO youth on their health priorities and research engagement preferences, and 4) a land-based engagement incorporating visiting and a discussion of preliminary results from the survey. The eligibility criteria included: 1) MNO citizen (or any Métis government for the land-based engagement), 2) aged 16-29. Participants for interviews were recruited via MNO social media, MNO website, youth council listserv, and word-of-mouth.

Results

A total of 583 MNO youth responded to the survey, 24 participated in virtual interviews, and 11 participated in the land-based engagement discussions. Information from all components showed considerable overlap. Métis youth require balance with all parts of their holistic health (mental, emotional, physical, spiritual, and social). Basic needs such as food, water, and housing must be met. Equitable and quick access to culturally safe healthcare and traditional practices is needed. Culture and community are fundamental. Youth view activities (i.e., cultural, recreational sports, etc.) as an opportunity to build community and social connections. Support networks that include guidance and cultural connection support holistic health. Métis youth want multiple research methods due to personal preference and accessibility. Incorporating research activities at community events is encouraged.

Conclusion

The findings from this work contribute to sparse literature on the health priorities of Indigenous youth that has been co-created with Indigenous youth and provides an often underrepresented or missing Métis perspective. This work also provides important information for program planning, policy, and advocacy regarding Métis youth health.

ID: 34759

Presented by: Abigail Simms

Exploring the experiences of Métis caregivers in Ontario before and during the COVID-19 pandemic

Authors: *Simms, Abigail (1,2), Tsui, Noel (1,2), Campbell, Madyson (1,3), Cripps, Shelley (1), Edwards, Sarah (1,2,4)*

1 Métis Nation of Ontario

2 Institute for Clinical Evaluation Sciences

3 Northern Ontario School of Medicine

4 University of Toronto

Background and Objectives

The purpose of this study was to engage with Métis caregivers and/or Métis recipients of homecare, assisted-living, or long-term care (care recipient) through keeoukaywin (the visiting way) to explore their experiences before and during the COVID-19 pandemic. Keeoukaywin is a way to exchange knowledge that honours Métis traditional ways of living and doing.

Approach

Keeoukaywin is an organic conversation-led interaction between the participants, researcher, and the land. Eligibility criteria included: 1) Métis Nation of Ontario (MNO) citizen, 2) aged 18+, 3) resident of Ontario, 4) experience as either a caregiver or care recipient. We visited with 12 MNO citizen caregivers. Each visit took its own path. Some visits were held in participants' homes, the closest MNO office, or on the land. MNO citizens from across Ontario participated in this project with the majority located in Northern Ontario. Introductory phone calls were made. A participant gathering is being planned to share back and discuss results.

Results

From our preliminary readings of these conversations, the main take-aways that have become evident include the impacts of COVID-19 on supportive care, assisted-living facilities and long-term care (e.g., isolation, death and dying in COVID-19, technology, an overwhelmed healthcare system, short staffing related to COVID-19, adapting to COVID-19), advocacy, quality of care (e.g., medication errors, hygiene, nutrition, social programming), systemic issues in supportive care, assisted-living, and long-term care (e.g., high staff turnover, short staffing, financial barriers, discrimination against Indigenous people/cultural safety), caregiving (caregiver burnout, family support, caregiving responsibilities after entering assisted-living/long-term care), aging (cognitive decline, loss of family connection), and Métis perspectives on aging and dying with dignity (Métis social determinants of health, cultural connection, Métis controlled ageing facilities/services, cultural programming).

Conclusion

The stories shared with us give important insight into the needs of Métis caregivers in Ontario and for the impacts the COVID-19 pandemic had on both caregivers and care recipients. Using these insights the MNO can find ways to better support caregivers and care recipients and for emergency preparedness.

ID: 35223

Presented by: Stephanie Simpson

Governance for Intersectoral Extreme Heat Response in British Columbia, Ontario, and Québec

Authors: *Seabrooke, Mélanie (University of Toronto).*

Allin, Sara (University of Toronto).

Joshi-Dave, Anjali (University of Toronto)

Background and Objectives

Climate change is an urgent crisis with significant negative health and equity impacts. While core public health functions such as health surveillance, promotion, and protection are critical to addressing its impacts, the inherently “wicked” nature of climate change requires intersectoral collaboration within and beyond health systems. Our study aimed to characterize and assess the governance mechanisms across three provinces, with a particular focus on extreme heat response.

Approach

We conducted a rapid scoping review of local, regional, and provincial approaches to mitigating the health impacts of extreme heat in British Columbia, Ontario, and Québec between 2005-2023. Fourteen academic and 328 grey literature sources informed preliminary descriptions of extreme heat strategies, and Vancouver, Toronto, and Montreal were selected as local cases for an in-depth examination of collaborative governance mechanisms. We then conducted 28 interviews with individuals involved in heat strategies across a range of sectors in the three cities of interest. Thematic analysis informed characterizations of existing governance mechanisms and permitted cross-case comparisons.

Results

The scoping review found there to be little focused attention on collaborative governance in the academic literature. In each city, climate response is mandated through provincial legislation and guided by protocols overseen by public health or emergency management divisions. Formal heat response evaluations are rare, and actors typically self-monitor rather than rely on formal accountability mechanisms to fulfill strategic objectives. While Montreal’s civil security coordinating structure enables an integrated response, efforts in Toronto and Vancouver are more siloed. Community organizations conduct important heat resilience activities, but collaboration with government could be strengthened. Overall, effective collaborative governance mechanisms include clearly defined roles, partner trust and goal consensus, adaptability, and shared accountability.

Conclusion

There is scant research in Canada on collaborative governance for climate action despite notable local-level efforts to mitigate the health effects of extreme weather events, including heatwaves. The governance of these heat response efforts may be strengthened through robust evaluation, cross-jurisdictional knowledge sharing, and meaningful community engagement.

ID: 34547

Presented by: Japteg Singh

Trends in Canadian Public Health Nursing: A Decade of Demographic and Workforce Change (2013–2023)

Authors: Singh, Japteg, McGill University; Anderson, Laura McMaster University; Dobbins, Maureen McMaster University; Jack, Susan McMaster University, Neil-Sztramko, Sarah McMaster University, Neudorf, Cory University of Saskatchewan; Belita, Emily McMaster University.

Background and Objectives

Public health nurses (PHNs) are the largest professional body of the public health workforce. Understanding the distribution of Canada's PHNs, and trends in this distribution over time, is critical to strategic workforce planning and optimizing resource allocation. The objective of this study was to describe PHN workforce trends in Canada.

Approach

We analyzed 2013–2023 PHN workforce data from the Canadian Institute for Health Information (CIHI) to describe workforce characteristics. Descriptive statistics, including counts and percentages, were applied to examine trends over time, focusing on age, gender, employment type, and years of experience. To assess the impact of the COVID-19 pandemic, we conducted an interrupted time series (ITS) analysis using a negative binomial model. This analysis evaluated trends in the number of PHNs in Canada during the pre-pandemic and pandemic periods. Findings offer valuable insights into the evolving demographics of the PHN workforce, providing evidence to guide future planning and policy development.

Results

The number of PHNs in Canada increased from 10,117 in 2013 to 13,328 in 2023. The largest year-over-year increase was observed in 2021 (29.7%) and 2022 (26.2%), followed by a sharp decline in 2023 (-13.3%). ITS analysis demonstrated that annual PHN hiring was stable from 2013–2019 (IRR: 0.98, 95% CI: 0.96–1.01; $p=0.14$) followed by a significant increase during the COVID-19 pandemic compared to pre-pandemic years (IRR: 1.16, 95% CI: 1.09–1.24, $p<0.001$). In 2013, PHNs <35 years old accounted for 17.9% of the workforce, increasing to 25.1% by 2023. Similarly, PHNs with <10 years of experience increased from 24.9% in 2013 to 32.4% in 2023. PHNs with 35+ years of experience declined from 26.8% in 2013 to 19.6% in 2023.

Conclusion

COVID-19 led to a surge in younger, less experienced PHNs, reversing pre-pandemic trends. These workforce changes underscore the shifting demographics of PHNs and evolving workforce to highlight the need for professional development to build a resilient public health workforce.

ID: 35659

Presented by: Steve Slade

Professional satisfaction, burnout, and solutions for family practice

Authors: *Slade, Steve, The College of Family Physicians of Canada;*

Klujic, Dragan, The College of Family Physicians of Canada

Background and Objectives

In Canada, family physicians provide most medical care and are the source of ongoing care for most people. It matters to know what makes for a healthy, professionally satisfied family physician workforce. Declining professional satisfaction could signal eventual burnout and eventual exit from the health workforce among family physicians. This study quantifies relationships between professional satisfaction and burnout; it identifies key factors that are associated with improved health among family physicians.

Approach

Online survey of all practicing family physician members of The College of Family Physicians of Canada, excluding those living outside Canada. Data were gathered in spring/summer 2024, covering all provinces and territories. Results are based on the voluntary information provided by survey respondents. Self-reported mental health and professional satisfaction were used as outcome measures. Outcome measures were cross tabulated against a broad range of independent factors, including demographic characteristics, multi-professional practice models, remuneration methods, use of technology, and professional practice contexts. Multivariate analysis shows the relative strength of various health system factors on family physicians mental health and professional satisfaction.

Results

There is a strong, statistically significant ($p < 0.001$) relationship between professional satisfaction and burnout; 75% of family physicians (FPs) who are very dissatisfied with their professional life are experiencing burnout, compared to 2% of those who are very satisfied with their professional life. FPs who work in interprofessional teams are less likely to experience burnout than those who work in solo practice (13% vs 20%). Professional satisfaction is higher among FPs who work with social workers, pharmacists, physiotherapists and other health professions (5-20% higher, based on health profession type). FPs in practices that HAVE NOT benefited from recent efforts to bolster primary care are twice as likely to experience burnout compared to those who have benefited (20% vs 10%).

Conclusion

Health system action can improve professional satisfaction and ameliorate burnout among family physicians. These actions include support for practice models that engage interprofessional teams and create new investment in primary care. Listening to and acting upon the evidence could help Canada to reverse its crisis in primary care.

ID: 35619

Presented by: Steve Slade

Changing the narrative: A more balanced, evidence-based picture of family practice in Canada

Authors: *Slade, Steve, The College of Family Physicians of Canada;*
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Oandasan, Ivy, The College of Family Physicians of Canada

Background and Objectives

Concerns about family practice in Canada are well-founded, but also negatively biased. Family doctors are burdened by administrative tasks. They are undervalued, underpaid and burning out. This narrative may fuel poor impressions among medical students, driving them away from careers in family medicine. It may also dispirit practicing family physicians, exacerbating health system problems. Using broad data, this study tells a better story of family practice in Canada, a more balanced and accurate one.

Approach

Quantitative, descriptive analysis using data from the Association of Faculties of Medicine of Canada (AFMC), Canadian Resident Matching Service (CaRMS), Canadian Institute for Health Information (CIHI), Commonwealth Fund, Canadian Medical Association (CMA), and College of Family Physicians of Canada (CFPC). Data sources are pan-Canadian and capture information from medical students, family medicine (FM) residents, and practicing physicians in all provinces and territories. Aggregate-level results are reported for all of Canada. The most recent publicly available data is used and historical trends were analyzed as possible, based on data sources.

Results

More than all other disciplines, 42% of medical students rate their family medicine (FM) experiences as being “excellent” (compared to 30% for all other disciplines). Medical students who choose FM have high rates of success in the CaRMS match; for 80% FM is their top-ranked discipline and 98% match right away. CMA data shows that 81% of general practitioners have high emotional well-being, compared to 78% of medical specialists and 75% of surgical specialists. CIHI data shows that family physicians practice in broad clinical domains, providing 52% of all medical care, 47% of psychotherapy counselling, 49% of hospital-based assessments, and 21% of anesthesia services. CFPC data shows that 90% of FM residents are proud to become family physicians and 98% feel they make valuable contributions.

Conclusion

Canada’s narrative about family practice needs to be more balanced and based on evidence. Medical students have positive experiences in family medicine. Family physicians are happy in their work and have broad professional latitude. These messages are supported by data and paint a better picture of family practice in Canada.

ID: 34698

Presented by: Julia Smith & Haaris Tiwana

GBA+ and the COVID-19 Response: gaps and bridges to equity-based pandemic preparedness

Authors: *Tiwana, Haaris, Simon Fraser University*

Background and Objectives

The Canadian federal government uniquely applied Gender-Based Analysis Plus (GBA+) to its COVID-19 pandemic response. Yet the success of these policies, in mitigating pandemic related inequities, is called into question by evidence of disproportionate secondary effects on women and priority populations. This presentation examines implementation gaps in the federal government's application of GBA+ during the COVID-19 response and offers strategic recommendations to improve the integration of equity considerations into future pandemic preparedness policies.

Approach

We employ an intersectional framework to examine structural determinants of inequities and power dynamics within pandemic policymaking processes. This mixed-methods study integrates a content analysis of federal COVID-19 policy documents with reflexive thematic analysis of 16 semi-structured interviews conducted with key informants from federal agencies and civil society organizations. By combining these methods, we uncover opportunities and gaps in the application of equity considerations and provide a nuanced understanding of how policies were designed and implemented during the pandemic.

Results

Pandemic policy documents demonstrated numerous commitments to addressing inequities, with key informants highlighting the importance of collaborative approaches to policy implementation. However, the urgent and fragmented nature of the pandemic response resulted in significant implementation gaps, particularly related to accessible information, health services, and vaccination efforts. Gaps were linked to reliance on under-resourced civil society actors and the limited capacity of priority populations to comply, constrained by the same inequities the policies aimed to mitigate.

Future equity-based pandemic preparedness should focus on social and economic insecurity, racism and discrimination, gender-based violence, healthcare workforce challenges, and barriers to accessing health services. These strategies must be implemented through a multisectoral approach in order to ensure future policies are both inclusive and effective in mitigating inequities during health emergencies.

Conclusion

GBA+ provided fertile ground from which to build equity-based pandemic preparedness, with limitations experienced during COVID-19 now providing essential learnings to guide further pandemic policy and health system innovations.

ID: 34842

Presented by: Alphonse Sowanou

General practitioners' experience about synchronous teleconsultation: a systematic review

Authors: *Authors' names*

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Background and Objectives

General practitioners (GPs) extensively used synchronous teleconsultation via video or phone (STC) during the COVID-19 pandemic. Although utilization has decreased with the end of the COVID-19 emergency status, it remains higher than pre-pandemic levels. It is still not clear why GPs decide to use STC. Thus, this review aimed to summarize the scientific evidence on the factors that influence GPs' decision to use STC over face-to-face consultation.

Approach

We conducted a systematic review and reported our results following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guideline. We searched four databases (MEDLINE, CINAHL, Web of Science, and the Cochrane Central Register of Controlled Trials) from 1990 to March 23, 2023. We used the Covidence® tool for each stage of the selection process. Two independent reviewers retained English/French articles reporting on GPs' use, attitude, satisfaction, and experience with STC, according to our defined eligibility criteria. We used the Mixed Methods Appraisal Tool to assess the quality of the studies and performed the narrative approach to synthesize the findings.

Results

The initial search yielded 9,288 articles following the deletion of duplicates. Of these, 34 articles met the inclusion criteria, and were included in this review. Almost one-third (11/34) of the included studies were conducted in the United Kingdom. Results show that GPs' decision to use STC is influenced by six categories of factors, including consultation, such as consultation purpose; information and communication technology, such as quality of equipment and bandwidth, STC' risks (e.g., data security and confidentiality issues); GP, such as convenience; patient, such as access barriers; GP-patient relationship, such as ease of diagnosis; and the institution, such as organizational and peer support. Lack of a reliable internet connection, need for physical exams, and limited visual cues were the main barriers to using STC.

Conclusion

GPs' utilization of STC depends on the interplay of six categories of factors. The results suggest the appropriate use of STC mainly depends on the purpose of consultation. Policy discussions surrounding sustained utilization of STC should prioritize equity in access, in addition to finding a fair payment model for STC.

Changes to primary care nurses' job demands and resources during the COVID-19 pandemic in Canada

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Background and Objectives

Inadequate support for primary care settings and professionals, which were an essential component of the COVID-19 pandemic response, left clinicians feeling vulnerable and overwhelmed. Existing pandemic research has focused on the health workforce broadly or those working in acute care settings. We sought to understand the experiences of primary care nurses in Canada during the pandemic to inform future pandemic responses and health workforce planning that account for primary care nurses' mental and physical needs.

Approach

We conducted semi-structured interviews with 76 licensed and registered practical nurses, registered nurses, and nurse practitioners working in primary care in four Canadian provinces: British Columbia, Newfoundland and Labrador, Nova Scotia, and Ontario. Interviews explored the varied roles of PCNs as the pandemic evolved, facilitators and barriers PCNs encountered, demographic and practice characteristics, as well as any gendered and personal experiences. Transcribed interviews were thematically analysed.

Results

Applying the National Academy of Medicine's systems model of clinician burnout and professional wellbeing to understand how the pandemic changed participants' experiences of job demands and resources, we found that the demands placed on PCNs increased during the pandemic in nearly every category. At the same time, the pandemic altered job resources that might normally protect against burnout. That is, benefits in PCNs' professional lives diminished as their workload, workplace stressors, and experiences of moral distress increased. Primary care nurses' pandemic experiences – both in the demands they faced and the resources they relied upon – provide an indication of the supports PCNs need to help mitigate against burnout and support their wellbeing during a pandemic or other times of heightened health system strain.

Conclusion

Improved pandemic preparedness, including primary care-specific supports to promote physical and psychological safety, workflow efficiency, worker rest and recovery, and preservation of primary care capacity are needed to uphold primary care nurse wellbeing during a pandemic or other extended health emergencies.

Direct-to-consumer commercial virtual care: a scoping review

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Background and Objectives

The use of direct-to-consumer ("walk-in") commercial virtual care services has expanded rapidly over the past decade. The literature examining this model of care, however, has not been synthesized. To inform health system reform, we used a scoping review methodology to determine the range and nature of research evidence examining direct-to-consumer commercial virtual care.

Approach

We created a comprehensive search strategy to identify relevant peer-reviewed and grey literature studies published between January 1st 2016 and May 17th 2024. Study eligibility was determined using the population, concept, context framework. Two researchers independently screened titles and abstracts, and full-texts manuscripts, and extracted data. Grey literature search is currently underway.

Results

We identified 6603 studies for title and abstract screening; 440 articles for full-text screening; and 88 studies meeting our inclusion criteria. Most studies were conducted in the United States (59/88), with a rapid increase in publications after 2019. About a fifth of studies (19/88 (22%)) had financial ties (funding and/or other conflicts of interest) with the virtual care industry. Most studies were cross-sectional or retrospective cohort studies (63/88 (72%)). Studies generally focused on evaluating a single health issue (69/88 (78%)) and/or on short-term quality of care measures (42/88 (48%)) rather than patient health (17/88 (19%)) or downstream health system outcomes (11/88 (16%)). No studies evaluated longer term health outcomes. Only 16 of the 88 studies (18%) compared outcomes to other models of primary care.

Conclusion

Despite many studies evaluating direct-to-consumer model of virtual care, we have little insight into how the quality of care compares to other models, nor into the implications for patient/population health and health system sustainability. The financial ties with industry indicate that there may be bias in the body of research findings.

ID: 35657

Presented by: Calista St. Hilaire

Clearing the Air: Reducing Commercial Tobacco Use Among Red River Métis

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Background and Objectives

Lung cancer is the leading cause of mortality for Red River Métis (RRM) Citizens, who report 33.3% higher commercial tobacco use compared to other Manitobans (21.7%). Rising cancer rates, especially among men, make tobacco use a critical concern. Environmental scans reveal a lack of distinctions-based smoking cessation approaches, emphasizing the need for tailored interventions. Led by the Manitoba Métis Federation (MMF), this study found MMF Citizens' needs and developed culturally tailored tobacco reduction strategies.

Approach

The MMF utilized a community-based participatory research approach to understand the unique needs of RRM Citizens and engage Manitoba-based tobacco reduction specialists. Qualitative data from focus group discussions at health consultations and semi-structured interviews were analyzed using the Red River Métis-developed Collective Consensual Data Analytic Procedure to determine consistent themes across multiple Citizens' responses. These informed the Clearing the Air (2025) strategy to promote cessation of tobacco usage. This strategy outlines recommendations and actionable items shaped to directly address RRM Citizens needs and to improve health outcomes for the Community.

Results

Thematic analysis of the qualitative data identified nine key themes, including societal drivers of commercial tobacco use, barriers to reducing recreational use, and the health impacts of smoking. Citizens and tobacco reduction specialists identified personal, community, and distal barriers to smoking cessation. Citizens proposed interventions that engage youth, integrate culture, offer education and cessation support, and promote smoke-free environments. Based on the findings, the Clearing the Air strategy was developed as a distinctions-based framework that prioritizes prevention, protection, and cessation, with actionable objectives currently being developed and implemented by the MMF's Health and Wellness Department, including culturally specific educational resources.

Conclusion

The Clearing the Air strategy reflects the importance of culturally specific interventions to address commercial tobacco use among RRM Citizens. The development of tailored resources and partnerships with national programs represent a critical step toward reducing tobacco-related health disparities and improving health outcomes for Red River Métis Citizens.

ID: 35021

Presented by: Kurtis Stewart

Predicting 8-1-1 HEiDi caller concordance with physician advice

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Background and Objectives

Canadian 811 tele-triage services collectively provide episodic advice and care to millions of callers annually, however, little is known how callers fare and whether they followed the tele-provider's recommendation. In April 2020, British Columbia's 811 service integrated virtual physicians to support nurses with high-urgency callers in a program called HEiDi. This study sought to predict HEiDi caller concordance with physician recommendations and mobilize knowledge with a "policy sandbox" dashboard within a learning health system.

Approach

All 8-1-1 calls from April 2020 through March 2023 were included and their post-call health service data linked. Concordance was defined based on each recommendation's urgency (e.g., callers advised "go to ED now" were concordant if they had an ED visit within one calendar day). First, concordance rates were disaggregated by demographic characteristics and health jurisdiction. Second, machine learning models, including logistic regression, random forest, XGBoost, and neural networks, were trained for each HEiDi recommendation category and evaluated using f1-scores. Finally, the outputs of the first two analyses were combined in a policy sandbox to visualize findings and engage study partners.

Results

113090 calls were included and concordance rates varied by HEiDi recommendation, with higher urgency callers more likely to be concordant (61% vs 44%). The largest differences in concordance rates were associated with callers' health region (Fraser=73% vs Northern=24%; odds ratio=0.12, $p<0.001$) or rural (29%) vs urban (60%) status (OR=5.07, $p<0.001$). The ML models had varied performance, with the "go to ED now" XGBoost model performing with the highest accuracy (f1-score=0.79). The policy sandbox was shared with study partners and policymakers at two committee meetings, where feedback was collected and the sandbox iteratively updated and used to inform evidence-based discussions. Together, the study team and partners highlighted the theme of caller "ecosystems of care", reflecting the regional variations and access to ED or primary care.

Conclusion

This study finds that HEiDi callers' concordance with tele-physician recommendations varies substantially, with region and rurality strongly correlated. However, only the highest-urgency recommendation was amenable to accurate ML prediction. Concordance findings can be integrated into interactive platforms to mobilize knowledge and evidence-based discussions to improve 8-1-1 tele-triage services and outcomes.

ID: 35632

Presented by: Andrea Stucchi

Bridging the gap between expanded pharmacist services and payment models: A descriptive analysis

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Background and Objectives

Expanding pharmacist services can improve access to care and patient outcomes, especially for those without a family physician. Since 2009, the province of British Columbia (BC) has been expanding pharmacists' roles to include prescription adaptations, medication reviews, and vaccination services. Despite this progress, the current pharmacist fee-for-service reimbursement model may disincentivize the provision of these services. This project analyzes BC pharmacies' service uptake and revenues to guide evidence-based reimbursement model reforms.

Approach

This study is a work in progress. We used comprehensive data between 2013 and 2022 from the BC PharmaNet system, which captures all medication dispensations, pharmacy services, and corresponding fees within the province to perform a population-based cross-sectional analysis. We characterized longitudinal trends in the rates of services and revenues generated from reimbursements for services rendered, and spatially analysed the distribution of these trends across BC's five health authorities. As a next step, we will link individual pharmacy claims with the Medical Services Payment Consolidation file to capture variation in services and revenue between pharmacy outlet, and neighbourhood income quintile/decile.

Results

Between 2013 and 2022, prescription dispensations and adaptations increased across all health authorities in BC, except Interior Health. Average annual dispensations per client increased from 17.1 in 2013 to 19.1 in 2022. The rate of adaptations nearly doubled (from 5,155.6 per 100,000 clients to 9,305.8); prescription renewals comprised the majority of these services. Medication reviews decreased, from 126,319 per 100,000 clients to 115,950, as well as witnessed ingestions (average per client: from 130 to 125). Total inflation-adjusted pharmacy revenue increased by 13.6% over the decade, from \$356.6 million to \$405.2, with dispensations and retail markup on prescription medications being the greatest revenue source. Future analysis comparing pharmacy outlets and neighbourhood income quintiles will provide insights into how these trends varied across populations within the province.

Conclusion

Pharmacy service use in BC steadily increased over the past decade, with geographic variation and shifts away from less utilized services (medication reviews and witnessed ingestion) towards higher revenue generating services, namely medication dispensations and adaptations. These findings demonstrate prescription-related services remain central to the pharmacist role despite expanding scope.

ID: 34487

Presented by: Abhimanyu Sud

Opioid Analgesics for Chronic Noncancer Pain in Patients With Opioid Use Disorder: Systematic Review

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Background and Objectives

Opioid use disorder (OUD) is a growing public health concern in North America, often coexisting with chronic noncancer pain (CNCP). Managing both conditions presents unique challenges, highlighting the need for evidence to guide decision-making. Aim: The study aimed to conduct a systematic review that summarizes evidence on the efficacy, effectiveness, and safety of opioid analgesics alone or in combination with opioid agonist

Approach

We searched MEDLINE, Embase, PsycINFO, CINAHL and AMED from inception to December 2023, for randomized or non-randomized studies that explored the effectiveness of opioids for people living with chronic pain and current or prior OUD. We assessed the risk of bias in included studies, evaluated the quality of evidence using the GRADE approach, and provided a narrative summary of treatment effects.

Results

Our search identified 14,826 unique citations, of which five observational studies were deemed eligible to inform safety outcomes for review, while no observational studies or RCTs met the eligibility criteria for efficacy or effectiveness outcomes. Compared to opioid analgesics alone, the risk of fatal opioid-related overdose may decrease in patients with CNCP and OUD who receive both opioid analgesics and OAT (absolute risk reduction: 60, 95%CI: 18 to 94 fewer deaths in 1,000 participants; Low certainty evidence).

Conclusion

There is limited evidence to guide opioid prescribing for individuals with OUD. Low-certainty evidence indicates that combining opioid analgesics with OAT may lower the risk of fatal opioid overdose in patients with CNCP and OUD. More research is needed to understand the benefits and risks of opioid analgesics in this population.

ID: 34887

Presented by: Olaoluwa Sule

Risk of ALC hospitalization among those with developmental disabilities and mental health diagnoses

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Background and Objectives

Individuals with developmental disabilities (DD) are at an increased risk of alternate level of care (ALC) hospitalizations, where a patient occupies a hospital bed but does not require the intensity of services provided in that setting, as necessary social and health supports required for discharge are not available to them in the community. We examined the impact of co-occurring mental health and addictions (MHA) diagnoses on the risk for ALC stay among those with DD.

Approach

We applied a previously established case definition to linked health administrative data from Ontario to conduct a population-based cohort study among adults aged ≥ 18 years with DD as of April 1, 2013. Patients were followed for 10 years to identify any hospitalizations with an ALC designation. Physician billing claims, emergency department records, and hospital discharge abstracts were used to ascertain the presence of three MHA diagnoses (mood or anxiety disorder, psychotic disorder, and substance use disorder) at baseline and during follow-up. Cox proportional hazard models were used to explore the association between MHA diagnosis and ALC stay.

Results

There were 56,493 individuals with DD in our cohort, of which 23,582 (41.7%) had any of the three MHA diagnoses at baseline. During our 10-year follow-up period, 10.9% of patients with any of the three MHA diagnoses experienced an ALC hospitalization compared with 6.1% of patients without an MHA diagnosis. The crude association between MHA diagnosis and ALC hospitalization was statistically significant (Hazard Ratio [HR] 1.84; 95% Confidence Interval [95%CI] 1.74-1.95) and remained significant after adjustment for demographics and comorbidities (HR 1.80; 95%CI 1.69-1.91). A diagnosis of psychotic disorder was associated with the highest risk of ALC hospitalization after adjustment (HR 2.45; 95%CI 2.29-2.61). In sensitivity analyses, using time-dependent covariates to account for MHA diagnoses occurring after baseline did not meaningfully change our risk estimates.

Conclusion

An MHA diagnosis, particularly for psychotic disorder, significantly increases the risk of hospitalizations with an ALC designation among those with DD. Additional supports and funding for individuals with DD and a co-occurring MHA diagnosis are required to alter their care trajectory and prevent unnecessarily prolonged hospital stays.

Tracking Timely Diagnostic Resolution of Abnormal Mammograms using an Electronic Quality Measure

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Background and Objectives

Complete and timely diagnostic evaluation after abnormal cancer screening tests is critical; still, many patients experience missed or delayed evaluation, placing them at risk of delayed diagnosis, more aggressive anti-cancer treatments, and lower survival. The objective was to develop and pilot an electronic clinical quality measure (eCQM) to report rates of timely diagnostic resolution after an abnormal screening mammogram for breast cancer detection using routinely collected electronic health record (EHR) data across sites and years.

Approach

An environmental scan was conducted to develop the eCQM specifications, including a review of the literature (source: PubMed 2010-2024), international guidelines for breast cancer screening in average-risk populations (source: UpToDate), and related clinical quality measures from key organizations with strong interest in quality and safety metrics. A Technical Expert Panel provided clinical and technical guidance and approved the specifications. Measure logic was applied to calculate the eCQM rate at six sites of a health system in Boston, Massachusetts using routinely collected EHR data (study period: 2018-2023). Reliability and validity of both the data and measurement approach were evaluated.

Results

The eCQM reports the percentage of patients with timely diagnostic resolution (benign diagnostic imaging or breast biopsy) within 60 days of an abnormal screening mammogram. Specifications used standard terminologies (ICD, SNOMED, and CPT codes) to facilitate interoperability. A 90% performance benchmark was selected, informed by the literature. At the pilot health system, the overall eCQM rate was 92% across all years and sites. Most eCQM rates were not statistically significantly different from 90%; however, rates varied by site (range: 87-95%) and year (range: 84-94%). Importantly, the eCQM rate for 2023 was 84% (significantly lower than 90%) resulting from significantly lower performance at three sites, indicating where efforts to improve diagnostic resolution should be focused. The data and measurement approach showed high reliability and validity.

Conclusion

These results highlight the importance of tracking performance over time even in health systems that have been consistently performing well and meeting benchmarks. This eCQM can help healthcare systems measure and report on these rates to facilitate quality improvement in near-real time and track progress over time.

ID: 35407

Presented by: Uyen Ta & Katie Seguin

Collaboratively Advancing Schizophrenia Care: Improving Patient Outcomes and Health System in Canada

Authors: *Ta, Uyen, Mental Health Commission of Canada*

Background and Objectives

Schizophrenia, a chronic mental illness with high mortality and disease burden, impacts 1 in 100 people aged 10+ in Canada with over 147,500 diagnosed individuals using health services. Despite clinical advances, it takes 14-17 years for new evidence to impact practice. To address this, the Mental Health Commission of Canada and Ontario Shores Centre for Mental Health Sciences partnered to improve evidence-based practices, drive change in mental health systems, and advance schizophrenia care in Canada.

Approach

In addition to our partnership, we are collaborating with four healthcare sites across Canada to implement Ontario Health's Schizophrenia Quality Standards to bridge the gaps in care that exist nationwide. These evidence-based standards aim to reduce care variability, improve patient outcomes, and integrate evidence-based practices. Evaluation efforts employed a mixed-methods approach, combining quantitative data on patient participation in primary treatments based on the Standards, validated assessments, and provider experience surveys, along with qualitative data on focus groups and patient/family surveys. The RE-AIM model guided the evaluation, focusing on successful implementation factors.

Results

Early implementation data shows that 634 patients have experienced improved patient outcomes. Data has shown patients benefiting from interventions like long-acting injectable antipsychotic medication (99%), clozapine (96%), cognitive behavioral therapy (82%) and family intervention therapy (67%). Early data suggests positive responses, with final results available after May 2025 with the expected impact being improved patient outcomes and enhanced quality of care offered to patients. Later in 2025, a bilingual National Implementation Toolkit will be launched to support the adoption of the Schizophrenia Quality Standards. Available in both English and French, the free toolkit will chart the course for health system transformation.

Conclusion

Through collaboration and meaningful partnerships, this initiative aims to transform schizophrenia care across Canada. Through the integration of evidence-based practices, the adoption of the Schizophrenia Quality Standards, and active patient and family engagement, we anticipate enhanced outcomes, reduced care variability, and greater national awareness, ultimately improving patient care and recovery.

ID: 35149

Presented by: Terence Tang

Supporting primary and community-based care for patients with complex needs

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Background and Objectives

In our region, demand for acute care currently exceeds and will continue to exceed capacity in the next 10 years. Projections indicate that efforts to increase acute care capacity will not meet this demand. Innovative solutions in the acute care sector are needed to support primary and community-based care for patients with complex needs. We present our experience and learning in operationalizing a technology-enabled clinical service as a model to meet these needs.

Approach

Since July 2023, we established a dedicated clinical service staffed by hospital-based General Internal Medicine physicians to support care of complex patients in the community. We extend our reach to traditionally difficult to reach people through local Community Paramedicine program. We support long term care clinicians through urgent consultations, and primary care clinicians through case discussions or rapid referrals. We leverage technology including virtual visits to provide timely and accessible services, and point-of-care testing through Community Paramedicine to expand diagnostic capabilities. We have access to hospital-based services and resources (including diagnostics or infusion clinics) to address complex needs.

Results

We have 180 to 230 visits per month, of which 60 to 80 are from the long term care sector. For long term care patients, mean time between request to consultation is 6.6 hours. For Community Paramedicine program, mean time between call to consult is 22.5 hours (50th percentile 15.5 hours). Our involvement most often results in medication changes and follow-up visits. Referral to specialists and Emergency Department are relatively uncommon for both groups. We did not specifically track outcomes for primary care. Examples of our increased reach include homebound and underhoused people. Through this service, our hospital-based clinicians have increased exposure and form relationship with primary care, long term care, and Community Paramedicine clinicians. Addressing social determinants of health remains a challenge.

Conclusion

Acute care sector can support patients with complex care needs outside of hospital walls. Creating a dedicated clinical service staffed by hospital clinicians can provide meaningful supports to primary care, long term care, and the community sector, while building capacity to address community issues in the acute care sector.

ID: 34513

Presented by: Amanda Tardif & Audrey Aw

Pan-Canadian Health Workforce Data Dashboards to Support Planning

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Background and Objectives

Current health workforce (HW) data are stranded amongst multiple data stewards and are collected through various means and data standards. This challenges policy makers, decision makers, planners and researchers in locating and using relevant data. To improve access to and connectivity of data, we developed a series of dashboards bringing together HW data in a way that is tailored to priority policy areas, improves usability, reduces burden of locating information, and meets stakeholder needs.

Approach

We undertook a user-informed development process to release an initial minimum viable product (MVP) dashboard that will be iterated over time. Development was primarily support by an advisory group comprised of key stakeholders, providing insight into data and information needs relevant to their role in Canada's health system to inform prioritization and feasibility. For the MVP, we leveraged well-established and widely used Canadian Institute for Health Information and Statistics Canada data sets. Inclusion criteria were developed, including timeliness, coverage, cost, and alignment. Publicly available data was transformed into a consistent data model that can support linkage, refresh, and expansion.

Results

The MVP included a custom JavaScript data asset catalogue and four AWS QuickSight data dashboard modules built according to the user-informed blueprint and made available for public use. Through stakeholder engagement, we gleaned deep information regarding key priorities of various health system players including specific data needs to answer questions, tangible benefits data could provide, and insight into new potential data sources. The process also revealed challenges in assembling pan-Canadian HW data dashboards, including varying standards, coverage, time series, and granularity of available data. Starting with an MVP as a baseline for feedback, developing a standard data pipeline, and incorporating advisory group guidance on data needs creates a blueprint for iterative improvement, including potential future use of AI to support analytics.

Conclusion

User feedback indicates contextual layers should be incorporated to support discussion and application of dashboard insights. The development approach highlighted areas for iteration as well as reinforced data gaps. This can provide impetus for improved data collection or standardization, forming the basis of a pan-Canadian HW data strategy.

ID: 35631

Presented by: Pearl Thompson

One Year Later: Caregivers' Experiences with Self-Navigating the Youth Mental Health System

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Background and Objectives

In Canada, youth are more likely to experience a mental health and/or addiction (MHA) concern than any other age group. For this population, the task of searching for services and navigating within the MHA system often falls on their caregiver. This study aimed to investigate the experiences of caregivers as they navigate within the MHA system and search for appropriate services for their youth during a twelve-month period.

Approach

This study was a secondary qualitative analysis of data from a randomized controlled trial in which caregivers (n=226) of youth with mental health and/or addiction concerns (ages 13-26) were assigned to receive navigation services or self-navigate through care. Semi-structured interviews were conducted over the course of one year. This analysis focuses on caregiver experiences (n=15) following twelve months of self-navigating within the MHA system in Toronto, Canada. Interviews were transcribed and analyzed using thematic analysis .

Results

The analysis uncovered six main themes (1) Systemic barriers and inefficiencies; (2) Challenges of self-navigation; (3) (Mis)Alignment between youth's needs and available services; (4) Complex role of the caregiver; (5) Impact of lived experience; and (6) Impact of MHA challenges on youth participation and functioning.

Conclusion

Findings suggest that caregivers need more information and support as they navigate the MHA system. This highlights the critical role of mental health navigation services, which have the potential to improve outcomes for families affected by youth mental illness through personalized guidance for caregivers.

ID: 34521

Presented by: Joan Tranmer

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

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Background and Objectives

Primary care nurse practitioners (NPs) have the capacity to assess, diagnose and manage patients; however, we have a poor understanding of NP contribution, and the influence of different primary care practice models, such as Family Health Teams (FHT) and Community Health Centres (CHC) on practice patterns. Assessing NP contribution to patient care is difficult, as NPs do not directly bill for their services and their functions vary within different team structures.

Approach

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

Results

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

Conclusion

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

ID: 35376

Presented by: Laura Tripp

Building Engagement-Capable Environments for Health System Transformation in Ontario

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Julia Abelson, Public and Patient Engagement Collaborative, McMaster University

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Maureen Smith, Patient Partner

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Background and Objectives

A steady stream of policies and strategies have proliferated articulating the 'why and how' of involving people with lived experience in the design of people-centred health systems. Despite this growing evidence-base and significant government investments, there has been unevenness in how organizations approach this work to meet these aims. We addressed this 'know-do' gap through the development of an actionable framework and implementation supports for high-quality engagement within the newly-established Ontario Health Teams (OHTs).

Approach

The Engagement Capable OHTs Framework was developed by a working group of engagement staff, leaders, patient partners and researchers over four phases: (1) planning; (2) evidence review and consultation; (3) framework design; and (4) implementation. As of April 2024, all 58 OHTs are required to adopt and implement the framework along with a self-assessment of their current maturity status. OHTs are supported in this work through a series of implementation and capacity-building support activities. Completed self-assessments, along with evaluations of support activities, provide insights into the effectiveness of the supports and framework for promoting engagement capable environments in OHTs.

Results

An evidence review identified more than 90 potential patient, family and caregiver engagement competencies, which were contextualized and expanded through a brainstorming survey of OHT stakeholders generating 689 knowledge and skill competencies; 462 attitudes and behaviour competencies; and 250 supports and enablers. These items were distilled and synthesized into a multi-faceted Engagement Capable OHTs Framework covering six competency and four support and enabler domains, each with sub-domains, mapped across a three-stage maturity model. OHTs began implementing this Framework in 2024/25 supported by a range of capacity-building activities including Self-Assessment, Community of Practice, Training and Coaching. Results from the self-assessments (to be completed in April 2025) and evaluation data from the first year of support activities will be shared during the presentation.

Conclusion

The Framework combines a strong conceptual foundation with actionable elements supported by a suite of implementation supports designed with and for end users. The learnings generated from this unique natural experiment will accelerate our understanding of how to build and support engagement capable environments in a rigorous and pragmatic way.

A scoping review of digital health tools that can triage musculoskeletal pain

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Background and Objectives

Despite most musculoskeletal pain being best managed in primary care, up to 1 in 4 visits to the emergency department are for musculoskeletal problems. Digital health tools could support triage of non-emergent musculoskeletal pain and help patients and clinicians identify appropriate care pathways. The objective of this scoping review was to summarise the digital health tools available for triaging adults' musculoskeletal pain across primary, urgent, or emergency care.

Approach

We followed the Johanna Briggs Institute guidance for scoping reviews. With a biomedical librarian, we conducted systematic searches of six bibliographic databases and four grey literature websites. Two reviewers independently screened abstracts, full-text articles and extracted data. To be included in this review, studies had to describe a digital health tool intended for patients or clinicians to triage musculoskeletal pain in adults (18+ years). Data synthesis is currently underway and expected to be completed by February 2025. Data will be summarized by triage tool, intended user(s), setting delivered/implemented, performance, and technological sophistication (e.g., tele-triage, mHealth, web-based, advanced computer sciences etc.)

Results

We screened 5017 abstracts and 165 full text articles in duplicate. Twenty-nine studies met the inclusion criteria and were included. In our preliminary synthesis, we've identified 11 unique digital tools across 20 studies (9 studies did not report the name of the digital tool). Most digital health tools available were patient-facing (69%, n=20), often in the format of a symptom self-checker. 83% (n=24) of digital health tools were designed specifically for triaging musculoskeletal pain, with the most common target population being inflammatory arthritis (26%, n=8). 55% (n=16) of the studies evaluated the performance of the digital tool across a variety of methods, with most tools reported to have poor performance (e.g., poor accuracy when compared to a criterion such as a physician diagnosis).

Conclusion

Few patient- and/or clinician-facing digital health tools were capable of effectively triaging musculoskeletal pain. While digital health tools hold promise for improving access and convenience, more research is needed to determine what role (if any) these tools have in early triage of musculoskeletal pain.

ID: 31716

Presented by: Lindsay Van Dam

It Takes a Village: Lessons on Interprofessional Collaboration from Recent Medical Graduates

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Background and Objectives

Interprofessional education for collaborative practice (IPECP) supports the development of collaborative healthcare teams and enhanced patient outcomes. However, there exist many challenges to enacting interprofessional collaboration within healthcare practice settings. This longitudinal study explores the professional socialization and IPECP experiences of recent medical graduates as they transition to practice during their early residency to better understand the impact of IPECP on collaborating within interprofessional teams and developing an interprofessional identity.

Approach

Interpretive, narrative methodology was used to explore the early IPECP experiences of medical graduates within residency/practice and contributions of interprofessional settings to identity development. A convenience sample of eight individuals from a longitudinal study of students from five health professions was used. All participants participated in interviews during their undergraduate medical education until 2 years into residency/practice. Narrative analysis, guided by narrative identity theory was used to explore how participants perceive and experience interprofessional collaboration and preparedness for collaborative practice. Interviews centred on the personal, social, and systemic factors that enable and challenge new medical graduates' interprofessional identity development.

Results

For new medical graduates, learning roles and developing an interprofessional identity, is evolved through exposure to interprofessional settings and collaboration in practice. Mentorship from other professionals, modelling of respectful communication and exposure to teamwork in 'real-time' were facilitators for developing collaborative attitudes and behaviours. Prevailing healthcare practice culture, settings, and other professionals were found to influence the level to which individuals can socialize and connect with others. This study identifies a need for IPECP experiences between professionals in education programs and in practice to deconstruct professional stereotyping and competition that is identified by participants to be normalized and reinforced, inter- and intra-professionally, in healthcare settings. This study also identifies gaps in IPECP for health professionals that may be unconsciously reaffirming professional tension.

Conclusion

Preparing new physicians to collaborate within interprofessional teams is contingent on the provision of IPECP experiences and exposure to interprofessional socialization in practice. Our findings support the development of IPECP programming and practice policies that address barriers to collaborative practice and promote interprofessional identity development.

ID: 31709

Presented by: Shelley Vanderhout

Co-creating an everyday language description of Learning Health Systems alongside patient partners

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Background and Objectives

Despite the emphasis that learning health systems (LHS) place on patient, community, and caregiver (PCC) needs, priorities, and perspectives, little has been done to help the public understand what a LHS is and initiate dialogue about how they can become engaged. We convened a Canadian national network of PCC partners to co-create an everyday language, arts-based resource for the general public to learn what a LHS is, and how it threads throughout patient care journeys.

Approach

PCC partners with knowledge of or experience engaging in LHS from across Canada were invited to attend two, two hour virtual workshops. In the workshops, we identified specific ways that we could better define LHS using everyday language and enable members of the public to relate their healthcare experiences to the concept of a LHS. We discussed accessible ways to share this information, and alongside a graphic designer, co-designed a comic strip that can be widely shared across diverse settings and communities, that builds on a common patient experience of waiting for care in an emergency department (ED).

Results

Our comic strip presents a crowded waiting room where patients experience confusion, frustration, and concern, but have an opportunity to share feedback. People notice that the team asking for feedback actually cares about their perspectives and intend to act on what they hear, and invite people to be part of a multi-disciplinary team to co-design solutions to long wait times. Together, this team reviews existing research and creates ideas about how to reduce ED wait times and improve experiences. In time, people see that these ideas were implemented, and the team measures their impact and makes improvements over time. The system is not perfect, but better than before, and is on a path to continuous improvement.

Conclusion

This co-created resource will be used to build capacity for LHS culture, where patients can understand how continuous learning and improvement fit within health care, and opportunities for accessible PCC engagement in LHS decision making, priority setting, continuous improvement cycles, and knowledge sharing.

ID: 34683

Presented by: Meredith Vanstone

Defining the patient partner or advisor role in health systems organizations

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Background and Objectives

As patient engagement has evolved, longitudinal collaborative partnerships between patients and health systems decision-makers have emerged. These roles are given a variety of names, and there is no consensus on the definition of “patient partner” or “patient advisor,” stymying effective research and policy development for this health human resource. We use the word “patient”, but any term specifying lived experience (e.g. caregiver, client, parent) could be substituted.

Approach

We combined four data sources to examine how the role of patient partner has been defined in the literature, by patient partners, and by organizational staff, identifying key elements and areas for variance alongside terminology considerations. Data included 506 patient partnership studies (2000-2021) identified in a systematic review, a pan-Canadian survey of 603 patient partners, and interviews with 35 Canadian patient partners and 23 organizational staff. Analysis was inductive, performed first within each data source and then across data sources, aiming to provide both a broad and deep consideration of the role and terminology for this form of patient engagement.

Results

We offer specific definitions for multiple roles that could be held simultaneously. “Patient Partner” could describe those deeply embedded in organizations, who are active participants in decision-making on multiple issues, representing both their own lived experience and the priorities of a broader community. We suggest “Patient Advisor” to describe members of networks who engage episodically on multiple projects over time, offering perspective and input when requested, drawing mainly on their own lived experience. Working within and also outside of the health system, “Patient Advocate” could define those who work independently, often striving to achieve particular outcomes, sometimes by disrupting dysfunction within the healthcare system. “Patient Mentor” expresses the role of supporting other patients in their health or engagement journeys from one’s own lived experience.

Conclusion

Multiple role definitions are needed to describe the diverse activities and approaches of longitudinal partnership. We present these definitions for clarity, without endorsement for any particular form of engagement. More precise roles may provide a starting point for dialogue between patient partners and organizations to clarify the intentions of engagement.

Relationship between pharmacotherapy for depression and healthcare utilization in British Columbia

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Background and Objectives

Major depressive disorder (MDD) impacts individual's daily activities and overall quality of life. Given the increasing prevalence of MDD, understanding this population and its potential impact on our healthcare system is of importance. We sought to describe the population with MDD in British Columbia (BC), compare patterns of healthcare utilization between those with MDD who are and are not prescribed pharmacotherapy, and assess these relationships in models that control for potential confounding variables.

Approach

We used a population-based cross-sectional study design linking billing and administrative health data to create a cohort of adult individuals with MDD in BC using a validated case definition based on International Classification of Diseases codes. We performed descriptive analysis and multivariate logistic regression modelling to examine the relationship between pharmacotherapy (dispensations of prescription antidepressant medication during the study period, based on BC PharmaNet data) and healthcare utilization (outpatient physician visits, Emergency Department (ED) visits, hospitalizations) between 2019-2020. Potential confounding variables adjusted for included age, sex, urban/rural residence, neighbourhood income quintile, and co-morbidities.

Results

The final study cohort included 549,029 participants who met the MDD case definition. We stratified our analysis based on whether study participants were classified as newly diagnosed ("recently incident") or in an active, ongoing episode ("actively prevalent"). The odds ratio for health service utilization between the pharmacotherapy group and the non-pharmacotherapy group for individuals who were recently incident was 8.14 (95% CI: 7.40, 8.95) for outpatient physician visits, 1.04 (95% CI: 1.02, 1.07) for ED visits, and 1.05 (95% CI: 1.00, 1.10) for hospitalizations (after adjusting for co-morbidities and other socio-demographic variables in our regression analyses), whereas, for the actively prevalent group, the odds ratios were 7.57 (7.27, 8.49), 0.91 (0.89, 0.92), and 1.00 (0.98, 1.02), respectively.

Conclusion

We found higher outpatient physician visits for the pharmacotherapy group and no association for inpatient visits. Recently incident individuals on pharmacotherapy have slightly higher odds of having an ED visit, whereas actively prevalent individuals have a slight decrease, suggesting a protective effect of pharmacotherapy against utilization of resource-intensive healthcare services.

Shout it from the rooftops! The MotherSafe service supports women with hyperemesis gravidarum

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Background and Objectives

Nausea and vomiting in pregnancy (NVP) and hyperemesis gravidarum (HG) can have significant impacts on quality of life for pregnant women. To address the need for improved care and support for women with these conditions, capacity within the existing Australian MotherSafe telephone service has been increased, enabling NVP/HG specific assessment and advice. With a dearth of literature on similar services, this study aimed to understand patient use, outcomes and acceptability of the enhanced service.

Approach

This convergent parallel mixed methods study included analysis of routinely collected service data since service enhancement (number of first-time calls, caller demographics, reasons for call, and number of follow-up calls). Patient data collection comprised patient-reported PUQE-24 scores (a measure of nausea and vomiting severity) at initial, follow-up and final calls. Online, semi-structured acceptability interviews were also conducted with consenting women (n=11) who had accessed the NVP/HG service during April and May 2024. MotherSafe counsellors invited women to consider participation, with informed consent and interviews conducted by independent researchers. Interview transcripts were subsequently analysed for themes and content.

Results

Over a 15-month period (April 2023 – June 2024) a total of 1088 first-time calls were made to the NVP/HG service. Most women were in their first trimester and had severe nausea and vomiting (according to their PUQE-24 score) at the time of their first call. The most common reasons for calling were to discuss medications already prescribed and/or to seek further clarifications after obtaining advice from elsewhere. PUQE-24 scores decreased over the course of contact with MotherSafe, indicating an overall improvement in nausea and vomiting symptoms. Women highlighted the positive impact that MotherSafe had had on their quality of life, and valued access to empathetic and knowledgeable counsellors. Women also reported an initial lack of understanding of the service and the types of support available.

Conclusion

This study provides the first indication of the acceptability of a specialised counselling service for women with NVP/HG, with a demonstrated reduction in the severity of NVP for those accessing support. Further promotion of the service to patients and other health professionals would likely enhance these demonstrated benefits.

ID: 35350

Presented by: Sophie Wang

Bridging the Gap: Evaluating Health Sector Involvement in Climate Adaptation Policymaking in Canada

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Background and Objectives

Climate change poses a significant threat to public health, yet the integration of health actors into climate adaptation policymaking is insufficient. The Government of Canada Adaptation Action Plan (GOCAAP) emphasizes multi-sectoral collaboration, and PHAC highlights intersectoral action on climate change and health determinants across jurisdictional levels. This research aimed to map climate adaptation policy actors, assess intersectoral collaboration, and evaluate the role of health actors in strengthening policy governance and outcomes in climate change adaptation.

Approach

This study employed Social Network Analysis (SNA) to map Canada's climate adaptation policy network, analyzing relationships among policy actors using GOCAAP as the data source. Nodes represented organizations, and links represented joint policy implementation. Degree centrality and betweenness centrality were used to measure influence and power, while network density and centralization assessed structural gaps. A scoring card evaluated health integration across six health-determining sectors, focusing on health impact context, adaptation proposals, stakeholder involvement, funding, and monitoring indicators. This mixed-methods approach identified collaboration patterns and gaps, offering insights to strengthen the role of health in climate adaptation policies.

Results

The climate adaptation policy network included 20 federal organizations, with 25% categorized under economic affairs, three from the health sector (PHAC, Health Canada, CIHR), and two from the environment sector. Despite health sector actors being the second most represented, they had a degree centrality of 0, indicating no direct connections. Environment and Climate Change Canada had the highest degree centrality (4) and betweenness centrality (3.5), highlighting its prominence and power. Network density was low (0.053), reflecting weak collaboration and information flow. Health integration scoring showed the infrastructure sector highest (8/15) and water sector lowest (5/15). Contextual health impacts were well-documented, but monitoring indicators were the weakest area of integration. Sparse collaboration and limited health actor involvement indicate critical gaps in achieving synergistic governance that could be addressed through targeted engagements.

Conclusion

Including health in climate adaptation policies strengthens cost-benefit analyses and supports shared priorities for synergistic action. Climate change is a determinant of health, and integrating health actors aligns strategies, enhances governance, and attracts funding for prioritized actions. Strengthening intersectoral partnerships can improve health outcomes and climate adaptation effectiveness.

ID: 34766

Presented by: Elizabeth Wenghofer

Evaluation of the Atlantic Physician Registry

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Background and Objectives

In May 2023, the Atlantic Registry (AR) was launched to (i) facilitate the mobility of physician services within the Atlantic region, (ii) create a coordinated and expedited licensing process across Atlantic medical regulatory authorities (MRAs), and (iii) reduce costs and administration of multi-jurisdictional physician registration (MJR) for Atlantic physicians. We conducted an evaluation to assess the AR's effectiveness, efficiency, impact, and sustainability in facilitating physician mobility and enhancing patient access to healthcare.

Approach

A mixed methods approach was employed using:

- Analysis of data from MRAs
- Online physician survey of AR-eligible physicians
- Focus groups and interviews with AR physicians
- Key informant interviews with MRA and Provincial/Territorial Medical Association leadership
- Analysis of summary provincial billing data

The quantitative analysis utilized descriptive statistics to compare AR participants to non-participants across demographic variables and survey responses. Qualitative data from focus groups/interviews underwent deductive analysis to directly address key evaluation questions, identifying implementation challenges and opportunities for improvement.

Results

The evaluation will be completed in March 2025. This evaluation will provide crucial insights into the AR's effectiveness, efficiency, impact, and sustainability. Preliminary results indicate that the AR is effective in reducing administrative burdens and costs associated with licensure. However, licensure is only one step in the process required for practice readiness, and these other processes need improvement. Sustainability needs to be considered with regard to total benefit for total cost/effort inputs. The program was effective in attracting physicians, particularly those who were already engaging in MJR and practice. Attention is needed to improve the impact on the number of physicians practising in other jurisdictions. The evaluation results support the development of a series of recommendations for enhancements to the AR and potential scale-up.

Conclusion

The findings will inform future potential implementation of MJRs across Canada and contribute to optimizing physician licensing standards and processes. This evaluation represents a critical step in understanding how regulatory innovation could address healthcare access challenges while maintaining professional standards and patient safety.

ID: 34461

Presented by: Arne Bastian Wiik

Does staff experience matter for Transfers of Nursing Home Residents to Emergency Care Facilities?

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Background and Objectives

Transferring from nursing homes (NH) to emergency care facilities (ECFs) can be harmful for NH residents. Challenging conditions for staff, such as high sick leave, few colleagues on call during shifts, and little job experience, can lead to unwarranted transfers. We investigate associations between staff characteristics, NH size, and the initial transfers to emergency care. The mortality of residents, both for those who have had a transfer and those who never transfer, is also explored.

Approach

A semi-Markov multistate survival model was used to estimate the association between the resident, staff, and institution characteristics and the resulting risk of transfer from NH to ECFs and mortality. The population was all 65+ years old NH residents receiving long-term care in Norway between 2017 and 2022. Data on resident and staff characteristics were taken from Statistics Norway (SSB), the Norwegian Registry for Primary Health Care (NRPHC), the Norwegian Control and Payment of Health Reimbursements Database (KUHR), and the Norwegian Patient Registry (NPR).

Results

In all, 76,486 long-term care NH residents were included, of which 35,060 had their first transfer to an ECF, and 51,068 died during follow-up. A significant association between the risk of ECF transfer was found for average time since graduation of staff. Significant association was not found between risk of transfer and sick leave. Size of facility was not associated with the risk of ECF transfer, but larger facilities were associated with higher mortality.

Conclusion

Nursing homes with staff with less time since graduation have a significantly higher risk of transferring residents from the nursing home to emergency care facilities. Nursing Home management should aim to retain experienced staff and have recent graduates work with colleagues with longer experience during shifts, to avoid unwarranted transfers.

ID: 35447

Presented by: James Chang-Yu Wu

Migrant People's Experiences with Healthcare Access and Policy in Newfoundland and Labrador

Authors: *Dr. Sobia Shaheen Shaikh (MUN School of Social Work)*

Background and Objectives

Migrant people across Canada face significant challenges in accessing healthcare. For many migrants in Newfoundland and Labrador (NL), navigating and accessing the public provincial Medical Care Plan (MCP) is inconsistent and difficult. The Anti-Racism Coalition NL (ARC-NL), a grassroots organization, has highlighted how migrant people are excluded from qualifying for MCP. As researchers embedded in ARC-NL, we aim to document migrants' experiences to explore how immigration and healthcare policies intersect and shape access to care.

Approach

Our study builds on four years of engagement with ARC-NL's "Healthcare for All Campaign," which has advocated for equitable healthcare access for all residents of NL, regardless of immigration or work/study status. This paper presentation focuses on an early-stage institutional ethnographic study on migrant healthcare access and MCP, conducted by community-engaged researchers with ARC-NL. It outlines the study's conceptual and methodological framework, embedded research process, preliminary findings, and next steps. Institutional ethnography—a qualitative method that examines institutions through the lived experiences of those directly impacted—will be used to uncover how immigration and healthcare policies interact to influence healthcare access.

Results

Access to provincial health coverage such as MCP has proven difficult and inconsistent for many migrants due to barriers related to residency requirements, immigration status, and work or study conditions. Through this advocacy, ARC-NL with community-engaged researchers (Shaikh et al.) identified significant gaps in understanding the diverse and complex realities of how migrants navigate healthcare systems. This research aims to fill that gap by illuminating migrants' lived experiences of navigating the intersections of immigration and healthcare systems.

Conclusion

The study offers valuable insights for policy advocates, policymakers, and other stakeholders seeking to address healthcare inequities. More critically, we anticipate that findings about challenges within MCP policy and administration will inform opportunities for systemic change, paving the way for more equitable healthcare access in NL.

ID: 35624

Presented by: Uma Yakandawala

Mind-Body Practices in Arthritis Care: A Culturally Tailored Approach for Red River Métis Citizens

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Background and Objectives

Red River Métis (RRM) Citizens face higher arthritis rates than other Manitobans. Chronic pain and disability associated with arthritis can reduce quality of life and elevate mental health risks. While conventional treatments focus on medication or therapy, complimentary mind body practices such as yoga and meditation may provide additional benefits. This study evaluated the effects of a mind-body intervention on the quality of life and well-being of RRM Citizens living with arthritis.

Approach

The 6-week mind-body intervention program was implemented for RRM Citizens aged 18 and older living with arthritis. The program delivered in-person and virtual yoga and meditation sessions for participants. Participants initially attended a half-day in-person workshop, followed by weekly online sessions, and finally a closing in-person workshop. Baseline and post-intervention assessments measured health related quality of life (EuroQol-5D-5L), mental health (DASS-21), and medication adherence (MARS-10). Eleven semi-structured interviews conducted following the final in-person workshop provided qualitative insights. Quantitative and thematic analyses were conducted to evaluate changes in physical and mental health outcomes.

Results

A total of 33 Citizens with varying severities of arthritis participated in the program, with osteoarthritis (47.2%) and rheumatoid arthritis (25.0%) being most common. Depression, anxiety, and stress scores on the DASS-21 (N=15) showed improvement. The number of participants with healthy scores increased: depression from 6 to 8, anxiety from 5 to 9, and stress from 6 to 10. Meanwhile, participants with severe and extremely severe scores decreased: depression from 1 to 0, anxiety from 5 to 3, and stress from 2 to 0. Of 11 interviewees, 9 noted improvements in physical or mental health, 1 reported no change, and 1 experienced negative effect. Citizens emphasized improvements in pain management, mobility, mental well-being, daily functioning, community connectedness, and expressed strong interest in expanding the programs.

Conclusion

This study found combining mind-body practices improved Citizens mental and physical health, highlighting the potential of yoga and meditation to complement conventional treatments in enhancing RRM well-being. These findings will inform the development of culturally relevant and accessible resources tailored to the unique needs of RRM Citizens living with arthritis.

Co-implementation and Co-evaluation of a Patient-Partnered Educational Intervention

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Background and Objectives

Structural inequities, systemic biases, and stigmatizing clinical encounters create barriers for structurally marginalized populations at-risk for lung cancer due to smoking. To address these gaps, we co-developed "Creating Safe Connections," a freely accessible, Continuing Medical Education (CME)-accredited e-learning module. The module builds primary care providers' (PCP) skills to engage in safe, equity-oriented conversations about smoking cessation and lung cancer screening. This study co-implements and co-evaluates the module to improve access to preventative care.

Approach

This equity-focused, patient-partnered study employs implementation science methods. Co-implementation involves deliberative dialogue with patient partners, healthcare providers, and decision-makers to synthesize insights for a tailored implementation plan. Co-evaluation follows an explanatory mixed-methods design over one year, using surveys and interviews to assess PCP participation, satisfaction, and knowledge. Guided by the RE-AIM framework, we evaluate the module's Reach, Effectiveness, Adoption, Implementation, and Maintenance to understand its impact on smoking cessation counseling and lung cancer screening discussions.

Results

Preliminary results are expected across RE-AIM domains: Reach—characterizing PCPs (e.g., family physicians, nurse practitioners) accessing the module; Effectiveness—measuring changes in PCPs' ability to deliver equitable smoking cessation and lung cancer screening counseling; Adoption—identifying PCP organizations prioritizing the module; Implementation—assessing feasibility for PCPs to incorporate the module into practice; and Maintenance—tracking sustained completion rates one year post-implementation. These findings will guide broader adoption of the intervention.

Conclusion

"Creating Safe Connections" equips PCPs with culturally relevant and patient-informed tools to conduct inclusive smoking cessation and lung cancer screening conversations. By fostering safer, equity-oriented interactions, this intervention enhances preventative care delivery, supporting better lung health outcomes for structurally marginalized populations across Canada's healthcare system.

Predicting mortality post-hospital transfer: the role of transfer reasons from long-term care homes

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Background and Objectives

Long-term care (LTC) residents are frequently transferred to acute care hospitals. The decision to transfer is often complex and fraught with uncertainty regarding the risks and benefits. Understanding the mortality risk associated with hospital transfer will support residents, care partners, and clinicians in making informed decisions. We aimed to develop and validate a predictive model that incorporates resident's reasons for transfer, along with other clinical and sociodemographic factors, to assess 30-day mortality risk.

Approach

We used administrative health data of LTC residents ≥ 65 years with incident admissions to LTC facilities between April 1, 2013, and March 31, 2018, in Ontario who were transferred to the emergency department. We derived a presenting complaint risk score to translate the 125 most frequent reasons for transfer into a continuous numerical summary risk index, allowing for personalized risk prediction. Predictors included 61 variables covering complaints, sociodemographic, comorbidities, instability, psychosocial, and functional status. We derived and validated our model and presented a simplified model for real-time decision-making. We used decision curve analysis (DCA) to assess clinical utility.

Results

We included 76,575 residents, of whom 17,127 (22.4%) died within 30 days of a transfer. Residents returning to LTC after a transfer exhibited greater health instability, worsened physical, and cognitive function. Our final and simplified models included eight and three predictors, with good predictive accuracy and discrimination of Brier scores of 0.15, and 0.16, and an area under the curve of 0.74, and 0.71, respectively. DCA revealed that our models provide a higher net benefit compared to both "transfer-all" and "transfer-none" strategies for threshold probabilities between 20 and 60%. We observed maximum net benefit at a threshold probability of 45%, where 10 transfers per 100 would be avoided if people with less than 45% risk of death were not transferred.

Conclusion

Our model incorporates reasons for transfer predicted 30-day mortality in LTC residents transferred to hospitals with good discrimination and calibration. LTC residents who returned to LTC exhibited worsened functional outcomes which justifies higher threshold probabilities for those who value avoiding returning to LTC home in a poor functional state.

Roadmap to Readiness: Organizational Tool for Trauma-informed Psychological Safety in Long-Term Care

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Background and Objectives

There is an urgent need to implement evidence-informed practices to bolster psychological safety of the Long-term care (LTC) workforce. Assessing organizational readiness prior to implementing practices is an essential first step, especially in under-resourced settings such as LTC. This presentation shares the development of a preliminary “Roadmap to Readiness” organizational readiness tool that can be used by LTC organizations to assess organizational capacity and readiness prior to implementation of trauma-informed psychological safety practices.

Approach

The Roadmap to Readiness organizational tool was developed by drawing on concepts of organizational readiness and informed by theoretical models from the literature by Scaccia et al. (2015) and Robertson et al. (2021). Unpacking the concepts of organizational readiness, we have focused on motivation, general organizational capacity and innovation-specific capacity. In the development of our criteria we ensured the organizations valued the principles of trauma-informed care, namely: (1) safety, (2) trust, (3) peer support, (4) collaboration, (5) empowerment and choice, and (6) cultural, historical, and gender issues. In this process, we have explicitly embedded a sex-gender-race equity perspective.

Results

Our preliminary Roadmap to Readiness tool will help organizations understand how ready they are to implement change and will be utilized in a study of five LTC organizations. Organizations can access the tool in a digestible format and ask themselves five questions to determine where they need to do work and how learning can get them on the road to improvement. The QR code on the infographic of the tool allows organizations to scan for further information on the five themes of motivation, general capacity, innovation capacity, trauma informed practices and equity. Our hope is that each LTC site will utilize the roadmap to readiness tool to guide their organizational approach and identify where their specific needs and strengths are to support implementation efforts.

Conclusion

There are multiple levels of readiness including organizational, unit, and individual readiness, and varying levels of engagement. Involving frontline staff, managers and leadership teams within LTC in assessing readiness prior to implementing change could strengthen implementation, reach and uptake of trauma-informed practices aimed to support psychological safety and well-being.

ID: 35563

Presented by: Christina Young

Building rural health research capacity: A realist review

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Background and Objectives

Health research disproportionately focuses on issues faced in urban areas, with limited high-quality research examining the needs of rural populations. However, rural residents experience unique healthcare challenges, often having poorer health outcomes and reduced access to healthcare services. This presentation describes strategies for building rural health research capacity identified through a realist review – a type of systematic review used to examine why complex interventions or programs are successful or not.

Approach

A realist review was conducted to examine “what works, for whom, and in what circumstances” related to rural health research capacity building. The review includes any English-language studies that focus on building rural health research capacity. Data extracted from included articles were analyzed by coding the data and identifying dominant concepts or themes. These data were then used to develop a program theory of the contexts and mechanisms that lead to improved health research capacity in rural areas. Our research team includes academics, clinicians, and experts in rural health research, ensuring that our findings are contextually relevant and actionable.

Results

Analysis is in progress and full results will be presented at the conference. Among 2747 articles identified, 116 are included in the synthesis. Preliminary analysis suggests that connection to highly trained researchers and university resources, meaningful engagement with the local community, and support networks among rural health researchers are key to the success of initiatives that aim to improve rural health research capacity.

Conclusion

While some studies have examined the success of individual initiatives, there are no comprehensive reviews of the most effective strategies for building rural health research capacity. The findings will address this gap in the literature and offer guidance to rural health researchers interested in developing research capacity in their communities.

ID: 35038

Presented by: Christina Young

The “invisibility” of socialization in long-term care: A qualitative analysis

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Background and Objectives

Rates of loneliness and isolation are exceptionally high among individuals living in long-term care settings. However, the structure of work in these facilities can make it difficult for staff to spend time in casual social interactions with residents. We sought to examine how resident socialization is described in provincial regulations governing long-term care in Newfoundland and Labrador (NL), and by staff working in these facilities.

Approach

We conducted interviews with 31 staff members of long-term care facilities and personal care homes in NL, including those in clinical positions (registered nurses, licensed practical nurses, and personal care attendants), and staff working in recreation, housekeeping, food preparation, clerical, and management roles. Interviews were coded and analyzed based on principles of grounded theory. We also analyzed provincial regulations governing the organization of long-term care facilities to examine how different aspects of care are described. We compared these findings to interviews with staff to consider how regulatory guidelines influence how socialization with residents is prioritized for staff in long-term care.

Results

Overall, our findings indicate a lack of acknowledgement of the social needs of long-term care residents in provincial regulations. Likewise, our interview data demonstrate that social interaction with residents is not prioritized for clinical staff; as a result, many have no time to spend with residents outside of the provision of daily care, such as bathing, feeding, and dispensing medications. Non-clinical staff appeared to have more informal time to socialize with residents while performing their regular duties. Only recreation coordinators have a mandate to plan activities that engage residents in social interaction, but this is usually a single individual responsible for dozens of residents. As well, facilities are highly dependent on families and volunteers to provide opportunities for social interaction.

Conclusion

Many staff only spend time informally with residents if there is “extra time” after finishing their primary obligations. Given the importance of socialization for residents, provincial regulations should prioritize social interaction between staff and residents in long-term care, factoring this time into the minimum required hours of care.

Shifting needs in Ontario's long-term care homes: analyzing resident characteristics from 2018-2023

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Background and Objectives

Residential long-term care (LTC) is an essential service for many seniors who cannot be safely cared for in the community. Previous research has described LTC admission trends in Ontario up to 2015, but the COVID-19 pandemic and other health system changes may have impacted the composition and care needs of the LTC population. There is a need for updated knowledge to inform health system planning to meet the needs of the future senior population.

Approach

This study describes changes in the sociodemographic, health, and functional characteristics of residents in publicly funded LTC homes in Ontario between 2018 and 2023. We conducted a population-based serial cross-sectional analysis using quarterly data from the Continuing Care Reporting System (CCRS). For each quarter between April 1, 2018 and March 31, 2023, the study population consisted of individuals with at least one CCRS assessment and a length of stay of 30+ days. Sociodemographic characteristics were captured using the Ontario Registered Persons Database, while prevalence of select health conditions and physical function were captured using the CCRS database.

Results

Overall, the LTC resident population declined from 79,104 in April-June 2018 to 74,722 in January-March 2023, with the lowest population (67,005) in January-March 2021. There was a shift towards admitting younger individuals; the proportion of admissions in those aged 65-79 rose from 25.3% in April-June 2018 to 27.3% in January-March 2023, while the proportion of admissions in those aged 80-89 decreased from 42.3% to 39.5% over the same period. The prevalence of some health conditions declined over the study period; notably, dementia (from 684 to 656 cases per 1000 residents) and coronary heart disease (from 175 to 162 cases per 1000). Other conditions, such as anxiety (from 150 to 191 cases per 1000) and schizophrenia (44 to 48 cases per 1000), rose in prevalence.

Conclusion

Our findings demonstrate notable changes in the profile of LTC residents over time, with younger ages at admission and varying healthcare needs. These shifts have implications for health system planning, including projections for LTC demand and training for LTC staff. Future research can investigate the underlying mechanisms driving these changes.

ID: 35066

Presented by: James Zacharias

Improving kidney health outcomes for First Nations in Manitoba

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Background and Objectives

In Manitoba, 250 people initiate dialysis every year. While First Nations constitute only 15 percent of the Manitoba population, 30% of those starting dialysis are First Nations. Our purpose was to document the use of protective medication known to impact progression toward dialysis.

Approach

This study was designed and conducted as a partnership between the First Nations Health and Social Secretariat of Manitoba and researchers from the University of Manitoba. We used de-identified health administrative data (Laboratory Data, Medical Claims, Hospital Discharge Abstracts, Drug Program, Public Canadian Census Files, Manitoba Health Insurance Registry, and Physician Resource File) held at the Manitoba Centre for Health Policy for the period of 2006-2017, linked to the Manitoba First Nations Research File to identify First Nations.

Results

We identified 12,613 First Nations people with chronic kidney disease (CKD) during the study period. Of those, only a minority with proteinuric kidney disease in stages 1-4 were on ACEI or ARB. Cholesterol lowering medications were in use in an even smaller proportion. Despite the risks, a significant minority of patients remained on Metformin when kidney disease reached below an eGFR of 30ml/min, and some patients remained on ACEI or ARB despite life threatening hyperkalemia ($sK > 6$). Our study therefore shows that First Nations at risk of severe kidney disease continue receive suboptimal medical care.

Conclusion

A First Nation-driven action plan is needed, including 1. Virtual Kidney Check which use provincial databases, to identify those at risk of kidney disease and advise the individual/the primary health care provider of the need for follow-up; and 2. Kidney Check bringing screening to primarily rural and remote communities.

Building capacity in health services and policy research: The role of research funding investments

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Background and Objectives

Building capacity in health services and policy research (HSPR) is important for supporting learning health systems and health system transformation. Despite the role of financial investments in supporting, retaining, and growing the HSPR workforce, available literature on this topic is limited. Our objectives were to investigate Canadian Institutes of Health Research (CIHR) financial investments into HSPR over time, provide a portrait of the HSPR workforce within this context, and highlight areas for future directions.

Approach

We applied descriptive analysis of administrative CIHR data to compare differences (e.g., t-tests with a priori significance level of $p < 0.05$) in grants/award funding, team, and investigator characteristics for HSPR versus other CIHR research pillars (biomedical or clinical or social, cultural, environmental and population health (SCEPH)). Data spanned 2001/02 to 2021/22, however, some variables were limited to more recent years. Annual funding characteristics included number of funded projects, investment dollars, duration requested and awarded, and funding type. Team characteristics included size and number of knowledge users. Investigator characteristics included number of direct trainees, unique nominated principal investigators, university setting, and gender.

Results

Over approximately two decades (2000/01 to 2021/22, HSPR projects represented 8.89% of all CIHR-funded projects. There were significant differences between HSPR versus biomedical, clinical, or SCEPH pillars across multiple funding, team, and investigator characteristics. While other pillars experienced a spike in COVID-19 investments, there was a one-year delay in increased funding towards HSPR. Investments in HSPR were significantly ($p < 0.001$) lower than clinical and biomedical research over the last two decades of data. HSPR projects generally requested and received funding for significantly ($p < 0.01$) shorter durations of time versus other pillars. HSPR projects were most frequently within priority research areas rather than investigator-initiated programs. Average HSPR teams were larger, included more knowledge users, and had a higher representation of women than biomedical, clinical, or SCEPH teams.

Conclusion

The workforce undertaking HSPR was disproportionately women who were leading larger teams of investigators and partners, with fewer financial resources, over a shorter period. These funding trends have important implications for the sustainability of the HSPR community and the ability to build needed capacity over time.

Inequalities in access to surgical care in Canada since the start of the COVID-19 pandemic

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Background and Objectives

The COVID-19 pandemic disrupted health system capacity and access to surgical care in Canada, resulting in decreased surgical volumes and longer wait times. While volumes now exceed pre-pandemic levels, disparities in recovery of surgical volumes to pre-pandemic levels continue to persist. This analysis examines Canadian trends in surgical volumes by age and income. Findings can help to identify gaps in care and inform strategies for equitable recovery.

Approach

Using clinical administrative databases, we calculated changes in surgical volumes in each year from 2020 to 2023 relative to the pre-pandemic baseline (2019). Procedures were defined as major surgeries using the National Grouping System (NGS) from the Canadian Institute for Health Information (CIHI). We examined trends by age and patient neighbourhood income quintile (using PCCF+). Older adults were defined as patients aged 65+; children and youth were defined as patients aged 0-17.

Results

In 2023, 2.33 million surgeries were performed across Canada, exceeding pre-pandemic volumes by 5%.

Among older adults, 14% more surgeries were performed in 2023 compared to 2019. Notable increases were seen in high-volume procedures: cardiac (8%), cancer (9%), cataract surgeries (12%), and hip (23%) and knee (25%) replacements. However, recovery of volumes differed by income. Older adults in higher-income neighbourhoods saw greater increases in surgical volumes than those in lower-income neighbourhoods, including for joint replacement (30% vs 13%, respectively), and urgent procedures like cardiac (18% vs -1%, respectively) and cancer surgeries (15% vs 3%, respectively).

For children and youth, volumes decreased overall, and similar disparities existed by income: surgeries decreased 8% for patients in lower-income neighbourhoods but only decreased 3% for patients in higher-income neighbourhoods.

Conclusion

These findings highlight persistent inequalities in accessing surgical care, particularly for those living in lower income neighbourhoods. As jurisdictions continue to launch various initiatives to treat patients faster, disparities in accessing care need to be considered to meet the surgical needs of Canada's growing and aging population.

ID: 34939

Presented by: Sara Zahid & Noor Al-Humuzi & Mastoora Rizai

Breaking Down Silos: Cross-Sectoral Collaboration to Support Vulnerable Youth in Regina Saskatchewan

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Background and Objectives

Canadian youth from marginalized backgrounds face barriers to accessing services, often due to service delivery fragmentation across sectors. Cross-Sectoral Collaboration (CSC) has emerged as an approach to provide coordinated support addressing the complex needs of these youth. The Regina intersectoral Partnership (TRiP) employs CSC to respond to the needs of vulnerable youth and their families. We explored the experiences of youth and families engaged with TRiP to generate insights for informing health systems policy.

Approach

Using TRiP as a case study, we employed a multi-method qualitative approach to collect qualitative data using semi-structured interviews, document reviews, observations, and World Café conversations. We interviewed 20 persons with lived experiences (youth and their families) engaged with TRiP. Purposive, convenience, and snowball sampling strategies were utilized to recruit study participants. Data was analyzed using NVivo 12 software and thematic framework analysis.

Results

Our study found that TRiP fostered personal growth in children, strengthened caregiver-child relationships, and provided families with reliable emotional and tangible support. TRiP also facilitated access to care, support systems, and material benefits, enhancing overall family well-being. Key enablers included dedicated case managers who streamlined communication and facilitated access to coordinated services across various human service organizations. However, challenges such as resource constraints, limited public awareness of TRiP, age-restricted supports, reactive service approaches, staff turnover, abrupt file closures, and insufficient transition support were highlighted.

Conclusion

Our findings highlight the effectiveness of CSC in enhancing service delivery, coordination, and outcomes for individuals in vulnerable contexts. By incorporating first-hand accounts from children, youth, and families engaged with TRiP, this research addresses a critical gap in the literature. The findings highlight the urgency for policy reforms to establish proactive, sustainable, and inclusive support systems for families.

ID: 34949

Presented by: Sandra Zelinsky

Narratives that Connect: Enhancing Health Research Through Digital Storytelling

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Background and Objectives

Digital storytelling (DST) leverages first-person patient narratives to communicate complex and nuanced health information in an engaging, accessible format. This method empowers individuals, to capture their lived experiences through a blend of voice, images, sound, and music. The objective is to enhance knowledge translation (KT) by making research findings more relatable and impactful for diverse audiences, including patients, healthcare professionals, and policymakers. DST bridges the gap between research and practice, fostering meaningful dialogue in healthcare.

Approach

Storytellers were invited through a research network to take part in a 6-week online DST workshop. Guided by trained DST facilitators, the storytellers used a seven-step methodology by the Story Center, USA to craft their digital stories. Each storyteller created a personal narrative, addressing challenges of mental health and/or diet. The group then collaboratively developed an online educational event 'GUT FEELINGS' for reflective learning and awareness as a knowledge translation output for patients, families, healthcare providers, and the public. Each storyteller presented their story with time set aside for reflective feedback and questions for individuals and the collective group.

Results

Seven individuals with lived experiences of inflammatory bowel disease (IBD) and/or irritable bowel syndrome (IBS) participated in the DST workshop. The 'GUT FEELINGS' DST Educational Webinar was co-developed by 6 patient storytellers and DST facilitators during three, 1.5 hours meetings as a knowledge translation tool for reflective learning. The webinar attracted 75 attendees from national and international locations of diverse backgrounds (ex: healthcare providers, patients/families, and public), with over 200 subsequent views on the sponsor's website. The digital stories were also featured at the sponsor's Annual General Meeting and presented at national and international conferences.

Conclusion

Digital storytelling bridges the gap between research and practice by capturing compelling patient stories for knowledge translation activities. The 'GUT FEELINGS' webinar, co-developed by patients and facilitators, demonstrated the impact of DST, reaching a wide audience of patients, clinicians, policymakers, and researchers and fostering meaningful reflective learning for awareness, behaviour change, and healthcare improvement.

ID: 35460

Presented by: Wei Zhang

Geographical access to community pharmacies in British Columbia, Canada

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Background and Objectives

The expanded scope of pharmacist-delivered clinical services in British Columbia (BC) facilitated timely access for patients to seek care in certain circumstances, such as minor ailments. However, availability of pharmacies in different regions may impact equity in accessing these services. This study aims to describe the extent of rural-urban disparity in the geographic accessibility of community pharmacies in BC.

Approach

We conducted geospatial analysis using data on community pharmacies and their locations from the College of Pharmacists of British Columbia registry and road information from the National Road Network. We used network analysis tools to construct 5-kilometre service areas around each pharmacy. The communities were defined based on Community Health Service Areas (CHSAs). The number of pharmacies that each community could access was determined by those that were either within the community or had a service area that intersected it. We reported the numbers of pharmacies by urban/rural classification. Sensitivity analyses were conducted for 15- and 25-kilometre service area definitions.

Results

We included 1,528 community pharmacies located in 231 CHSAs, comprising 137 urban and 94 rural (rural hub, rural, or remote) CHSAs across BC. Accessibility to pharmacies was significantly higher in urban compared to rural/remote communities. Nearly all urban residents (98.4%, n=4,231,580) had access to five or more pharmacies in 96% of urban CHSAs (n=132), while fewer than half of rural residents (47.3%, n=331,430) had access to the same number of pharmacies in 25.5% of rural CHSAs (n=24). In the remaining 74.5% of rural CHSAs (n=72), 10 were not within the service areas of any pharmacies, and 23 were within the service areas of only one pharmacy, representing a combined 14.5% of the rural population (n=101,655).

Conclusion

Our results suggested large rural-urban disparities in spatial access to pharmacies in BC. We identified rural communities that require urgent support to improve pharmacy access. Further research is needed to evaluate factors contributing to these disparities and identify corresponding solutions from policy and service delivery perspectives.

ID: 34216

Presented by: Yvonne Zhang

Biosimilars in Canada: policies to promote switching and what it means for payers

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Background and Objectives

Biologics sales in Canada topped \$15 billion in 2023, accounting for over one-third of total pharmaceutical sales. Given the size of this market, biosimilars offer a significant opportunity for cost savings for Canadian payers. Ongoing policy changes to promote biosimilar switching are expected to accelerate cost reductions for biologics in Canada, helping to offset the pressure from the introduction of new higher-cost medicines in coming years.

Approach

Using data from various sources, including the IQVIA MIDAS® Database, Canadian Drugstore and Hospital Purchases Audit, Private Drug Plan databases, and the NPDUIS Database at the Canadian Institute for Health Information (CIHI), this presentation compares the emerging Canadian market for biosimilars with our international counterparts. The analysis delves more deeply into the market dynamics of biosimilars in Canada from 2014 to 2023 and assesses the impact of the recent biosimilar switching initiatives and the potential for cost savings.

Results

Canada has made progress in biosimilar approvals and utilization. By the end of 2023, Health Canada had approved biosimilars for 14 distinct biologic medicines, lagging Europe (18) but ahead of the United States (12). With the ongoing implementation and potential expansion of biosimilar switching initiatives, Canada achieved biosimilar uptake levels above the OECD median for most high-selling biologics, except infliximab, realizing over 50% in savings from the use of these biosimilars. Canada's diverse approaches and timing in provincial biosimilar promotion policies were associated with important regional variations in biosimilar utilization.

Conclusion

This presentation will provide much needed information on the efforts taken to promote biosimilar use and draw on unrealized savings in Canada. It will contribute to ongoing discussion on strengthening collaboration in Canada's healthcare sector to achieve sustainable cost savings and improved accessibility to biologics.

What are the Impacts of Task Shifting and Skill Mix Interventions in Primary Care? A realist review

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Background and Objectives

Countries globally face a growing health human resource crisis in primary care. Task shifting and skill mix are two inter-related strategies that have been implemented to alleviate the health human resource crisis. Both interventions involve changing or expanding clinical roles, ultimately optimizing the current workforce. This realist synthesis of a systematic review aims to understand how and why task shifting and skill mix interventions are effective in primary care, with a focus on high-income countries.

Approach

Realist reviews are a theory-driven approach to studying complex interventions. In our review, the guiding research question was: “What are the contextual factors, mechanisms, and outcomes of task shifting and skill mix implementation in primary care settings?” Pawson outlines five steps: 1) develop initial program theory, 2) create search strategy, 3) screen and appraise documents, 4) extract and organize data, 5) analyze data into Context-Mechanism-Outcome (CMO) configurations. Following the RAMESES guidelines, we double-reviewed all titles and abstracts for articles in which task shifting or skill mix were the primary intervention and that were set in primary care and high-income countries.

Results

Our initial program theory was: “When there is a health workforce shortage (Context), Task Shifting and Skill Mix interventions can be implemented (Mechanism), to improve patient journeys and outcomes, clinician outcomes, and health system outcomes (Outcome).” Using this theory, we searched seven health sciences and nursing databases, yielding 1783 articles. 37 papers were included in the final review, spanning from Europe, North America, and Australia, with most involving changes to physician roles. In revising our initial program theory, we expanded the one to multiple in order to include the three typologies of skill mix (task shifting, adding new tasks/roles, and introducing or changing teamwork), each of which had a different mechanism. Perceptions of worker competence, patient acceptance and satisfaction, and teamwork were also important mediators.

Conclusion

Task shifting and skill mix interventions offer promising strategies for addressing the health workforce shortage in primary care. By understanding the contextual factors, mechanisms, and outcomes, our realist review highlights the importance of worker

competence perception, patient acceptance and satisfaction, and teamwork in optimizing workforce efficiency and improving care delivery.