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Book of Abstracts – Poster Presentations

Organized by last name of Primary Presenter

Addressing Health Inequities to Prevent Diabetes-Related Amputations - Quantitative Mapping

Presented by: Anwar Abdi

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Background and Objectives

Peel region has a 15.5% diabetes prevalence among adults, exceeding the 9.4% national average. The overall rate of diabetic amputations in the region is low; however, poor social determinants of health (SDOH), including socioeconomic status, are critical barriers to effective diabetic foot care, increasing lower extremity amputation risks. This study investigates geographic variations in diabetic foot amputation and infection rates in Mississauga, exploring their relationship with SDOH.

Approach

This retrospective cohort study analyzed anonymized hospital data from Trillium Health Partners (THP) between January 2021 and March 2024. Diabetic foot amputations and infection hospitalizations were identified using CCI and ICD-10-CA codes. Amputation and diabetic foot infection rates per 10,000 individuals were calculated for forward sortation areas (FSAs), adjusted for diabetes prevalence in each area. Rates were mapped via QGIS to visualize geographic disparities. The Ontario Marginalization Index (ON-Marg), a validated measure of socioeconomic deprivation, will be used to explore SDOH associations with outcomes through correlation, regression, and stratification by quintiles.

Results

Preliminary analysis using amputation records pulled directly from THP electronic health records identified a total of 504 amputations, with 324 cases among Mississauga residents. Geographic disparities were evident: FSA L5K recorded the highest amputation rate (13.47/10,000), while L5H had the lowest (0.57/10,000). Absolute numbers of amputations also varied, with L5B accounting for the highest count (38 cases). Further analysis of both diabetic amputation and foot infections using the complete admissions data linked with diagnoses will be conducted. Additionally, correlating socioeconomic data using the ON-Marg Index will be performed.

Conclusion

To our knowledge, this will be the first study exploring geographic variations in diabetic foot complications, specifically amputation and infections, within Mississauga and their association with SDOH. The findings will provide valuable insights, guiding targeted interventions to address disparities and improve equitable access to care in Mississauga.

Policy learning in the time of COVID-19: Decentralized epistemic and reflexive learning

Presented by: Saeed Ahmadiani

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Background and Objectives

The COVID-19 pandemic, marked by prolonged uncertainty, demanded unprecedented policy learning to manage its complex challenges. This study explores policy learning in Quebec and Ontario, focusing on the determinants influencing the process. Grounded in Dunlop and Radaelli's framework, the research evaluates four forms of learning—epistemic, reflexive, bargaining, and hierarchic—based on the levels of uncertainty and actors' certification. The objective is to identify mechanisms and barriers to effective policy learning during a crisis.

Approach

A qualitative comparative case study was conducted, using data from over 30 interviews with policymakers and advisors, complemented by secondary sources. The analysis examines key factors, including policy capacity, decision-making centralization, and the role of non-governmental advisory bodies. Attention was given to political dynamics and regional differences, highlighting how contextual factors shaped learning outcomes across provinces. Dunlop and Radaelli's framework guided the categorization and interpretation of learning types.

Results

External epistemic learning requires urgency (super crisis) and institutionalized external expert groups that are diverse, self-formed, and equipped with consensus-building mechanisms.

Reflexive Learning occurs more at the regional level, where public health organizations adapt health measures to local needs through community engagement. Local communities, NGOs, and media act as "collective memory" (as per Cyert and March's theory), helping policymakers identify challenges and anomalies.

Centralization's Impact: Contrary to some literature, over-centralized systems hinder learning by reducing diversity, delaying communication, and silencing dissenting voices.

Political Dynamics: Quebec's hypercautious measures (e.g., curfews) reflected political rivalry and election considerations, while Ontario's conservative government resisted stricter measures, prioritizing ideological values.

Policy Capacity: Overlooking lessons from past pandemics highlights the need for institutional memory. Crises reveal latent capacities, which can be developed through structured learning pathways.

Conclusion

In this study, we contribute to existing theories of policy learning by elaborating on its processes and key active elements. Our findings highlights the importance of decentralized, inclusive structures to increase use of available knowledge outside the traditional sources of information. We emphasize recognizing latent capacities, fostering diversity, and institutionalizing independent memory to enhance responsiveness in public health systems.

A critical analysis of Ontario's Bill 124: The utility of the 3I + E framework

Presented by: Eberechukwu Akadinma

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Background and Objectives

Two years after its adoption, in 2022, Ontario's lower court declared Bill 124 unconstitutional, ordering it to be struck down. The bill, capping public sector wage increases at 1% annually and violating workers' collective bargaining rights, exacerbated tensions during COVID-19, particularly for frontline workers. In 2024, Ontario's Top Court upheld its unconstitutionality, ordering repeal and $7 billion in retroactive wages. In a post-COVID-19 landscape emphasizing public participation, what insights emerge from its adoption and repeal?

Approach

This paper situates its analysis in the policy adoption, while oscillating between this stage and repeal phase as needed to buttress findings. A document review method was adopted to analyze and synthesize relevant materials. Accordingly, the overarching question that guides this work is: What role did institutions, interests, and ideas and external factors play in the adoption of Bill 124?

Results

Three key lessons emerge: 1) The need for interest groups to recognize how governments leverage policy feedback to minimize repercussions; 2) While institutions are resistant to change, they are not impervious to external factors. Interest groups are best served by noting the fluctuations in the dominance of the 3i constructs and leveraging them well to advance their cause; 3) The power of emotive framing. The success and subsequent failure of Bill 124 illustrate the power of problem framing in policymaking. The adoption of the bill was successful in part due to the government's emotionally resonant claims. Conversely, public sector workers, aided by the pandemic, reframed the narrative such that it aligned with public values. Interests groups are best served by paying attention to these intricacies.

Conclusion

This paper finds that the adoption of Bill 124 was not simply a response to fiscal constraints but was shaped by the confluence of institutional structures, ideological beliefs, and external factors, with institutional structures emerging as the decisive factor. Interests groups are best served by paying attention to these intricacies.

Measuring the quality of integrated care for older adults with multi-morbidity: A scoping review

Presented by: Ifeyinwa Akamike

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Background and Objectives

Despite its benefits, the provision of integrated care continues to be a challenge. The lack of clarity around integration makes it difficult to identify important outcomes of care and how they should be measured. To design and implement a successful integrated healthcare system, it is important to measure integrated care in a consistent and systematic way. This study reviewed existing literature on measuring the quality of integrated care for older adults with multi-morbidity.

Approach

This study is a scoping review. The databases that were searched include MEDLINE, EMBASE, and PsycInfo. Primary studies were included that reported on quality measurement of integrated care for people with multi-morbidities and were published in English language between 2007 and 2022 (last 15 years). All narrative studies were excluded. Data was extracted for each paper using a data extraction form with the following domains: name of first author and year of publication, study location, study design, study subjects and sample size, quality indicators, disease conditions, and framework or theory used.

Results

The search yielded 1078 papers (EMBASE: 550, MEDLINE:458, PsychInfo:70). A total of nine papers were included in the final review. Structure, process, and outcome measures of quality of integrated care were reported in the studies. The outcome measures most frequently reported include number of emergency room visits, number of hospitalizations, quality of life, and satisfaction with health care. The structure measures reported include insurance and service access such as residential area, transportation needs, and service use barriers. Process measures included physical examinations and laboratory investigations carried out, continuity of care, person centredness, feasibility of integrated care pathway, and timing and quality of medical discharge summaries. Continuity of care, a crucial aspect of management of people with multi-morbidities, was assessed in only one study.

Conclusion

Most of the measures were outcome measures and most focused on the effectiveness dimension of quality. It is therefore recommended that future studies should consider a more holistic approach that reflects the three components of Donabedian's framework while also considering the various dimensions of quality of integrated care.

Longitudinal Financial Worry in a Cohort of Patients With Advanced Cancer

Presented by: Philip Akude

INTRODUCTION:

This paper describes the proportion of patients experiencing financial worry longitudinally in a cohort with advanced colorectal cancer in Canada.

METHODS

Secondary analysis of a prospective cohort study 'Palliative Care Early and Systematic (PaCES)' project which recruited patients with advanced colorectal cancer from Alberta's tertiary cancer centres January 2018 - December 2020. Rates of self-reported financial worry were obtained from the Canadian Problem Checklist, completed monthly for ten months and three-monthly thereafter.

RESULTS

Demographics: Of 131 participants completing enrolment, 57 were female (43%), 105 (80.2%) were white, median age was 62.3 years [56.5-69.5], most were married (76.3%). Self-reported household income is shown in Table 1. During the study period, 95 participants (72.5%) died with median survival of 274 days (23 months) from enrolment.

Financial concern: Fifty-seven patients (43.5%) affirmed at least once that they had worried about their finances in the preceding month. Of those, 47 patients (82.4%) endorsed this question on at least two encounters and 18 (31.6%) on more than five (see graph 1). Of those who reported no financial concerns at enrolment, 41 (35.7%) subsequently answered 'yes'. Conversely, of those who answered 'yes', 14/16 (87.5%) affirmed further episodes of worry.

The proportion of patients experiencing financial concerns at any given time point fluctuated (see graph 2); however, mean proportion was 18.8%. A significant increase in the proportion of patients reporting worry late in the study period may be overstated by small numbers surviving.

Bivariable analysis confirmed younger age (<65), non-white ethnicity and male gender were associated with more financial worry (p-value 0.004, 0.038 and 0.039 respectively). Only age remained significant on multivariable analysis.

Cost Effectiveness and Time Toxicity of an Early Palliative Care Intervention in Patients with Advanced Colorectal Cancer

Presented by: Philip Akude

Background: A pragmatic trial of early palliative care (PC) in outpatient cancer clinics for advanced colorectal cancer (CRC) increased early referrals (>3 months before death) by 17%. Timely PC improves quality of life, symptom control, and time spent at home, addressing the issue of time toxicity in advanced cancer care. This study evaluates the cost effectiveness of this trial.

Methods: This pragmatic controlled before-and-after study included 18 outpatient cancer clinics across two tertiary cancer centres. Baseline phase was from April 2017 to December 2018 with intervention phase only occurring in 1 of the cities, from April 2019 to December 2020. Intervention included systematically screening patients for unmet PC needs, adding a community-based PC nurse specialist and templated 'shared care' letters sent from oncologists to primary care providers. Effectiveness was defined by days at home in the last 90 days of life, subtracting hospital, residential hospice, emergency department and clinic visits. A healthcare system perspective was used to calculate costs in all sectors. Healthcare outcomes and costs were analysed using a difference-in-differences (DID) method, accounting for geographic variations and other covariates.

Results: Among 695 decedents, the intervention reduced hospital stays by 15% and chemotherapy use by 18% in the last 90 days of life. The intervention was cost dominant with an overall DID increase of 2.3 community days with an average cost reduction of C$1,953.02 per community day gained. Adjusted analysis showed no statistically significant differences, but bootstrapping (1,000 iterations) indicated a 66% likelihood of cost dominance. The biggest cost contributors were inpatient care (53.8%) and residential hospice (33.4%).

Conclusion: Early integration of PC for advanced CRC may reduce costs and increase community days in the final 3 months of life. Time toxicity is a valuable metric for evaluating early PC interventions and their cost implications.

What services do people seek when they visit a community pharmacy primary care clinic?

Presented by: Yazid Al Hamarneh

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Background and Objectives

Community pharmacy primary care clinics were established to improve access to pharmacy services for assessment and management of common ailments and chronic diseases, point-of-care testing, and administration of medications by injection. As part of an ongoing assessment program, we report the characteristics of people who accessed the first clinic to open in Alberta and services they sought during the first seven months of operation.

Approach

This cross-sectional study examined information collected from self-reported intake forms submitted when individuals visited the clinic in Lethbridge, AB. Individuals seeking services between June 24, 2022 and January 31, 2023 were eligible for inclusion.

Results

3305 people visited the clinic 4962 times and submitted 3831 forms with 4611 reasons for seeking care. Mean age was 32 years and 62% were female. 32% reported not having a family physician and 5% reported usually seeking medical care in urgent/emergency care. Reasons for seeking care were: 79% Common Ailments (e.g., upper respiratory symptoms, urinary tract infections); 16% Chronic Disease Management (CDM, e.g., diabetes, hypertension); 4% Point-of-Care Testing or Immunization; or <2% Other. Reasons for seeking care differed whether an individual had a family physician or not ($p<0.01$). CDM was more frequently reported as a reason for the visit for people without a family physician (29%), while common ailments were more frequently reported as reason in those who had a family physician (86%).

Conclusion

The community pharmacy primary care clinic has improved access for people who do not have a family physician and supported those with a family physician. It is also likely that these clinics reduced some ER visits for primary care issues.

Implementation of a PT-led primary care model for musculoskeletal pain: A process evaluation

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Background and Objectives

Musculoskeletal conditions are leading contributors to disability and among the most common reasons for primary care visits. A physiotherapist-led primary care model for musculoskeletal pain may be an effective strategy to improve patient and health system outcomes. This process evaluation aims to understand how a PT-led primary care model was implemented, how the context influenced implementation, potential mechanisms of the model, and the experiences and perspectives of patients and primary care team members toward the PT-led primary care model.

Approach

This study in progress is a mixed methods process evaluation embedded within two cluster randomized controlled trials aimed at evaluating the impact of integrating a PT as the first point of contact for people with back pain (trial 1) and hip/knee pain (trial 2). The process evaluation includes health record extraction to assess how the model was implemented (e.g what care was provided), self-report measures to assess intervention fidelity and participant adherence, mediation analysis to assess potential mechanisms, and semi-structured interviews with patient and health professional participants to understand experiences with implementation and how the context influenced implementation.

Results

We have analyzed fidelity data from 761 patient participants from the back pain trial and 677 participants in the hip/knee pain trial and are currently extracting health record data to compare the care provided between the physiotherapist-led primary care model and usual physician-led care. We have conducted qualitative interviews with 24 patients, 10 physiotherapists, 24 other primary care health professionals, 9 medical office assistants, 4 primary care organizational leaders or administrators to understand experiences and perspectives with the team-based model of care. Analysis is ongoing and we will present this work in progress.

Conclusion

This process evaluation seeks to answer questions related to how a PT-led primary care model was implemented, what the active components were, potential pathways that led to an intervention effect (or no effect), and the experience of those involved. Results are expected to help interpret the results of the trials and provide direction for future implementation.

When there is a need for healthcare policy reform why complete a narrative review?

Presented by: Arman Ali

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Background and Objectives

Understanding neurotrauma (brain and spinal cord injury) in older adults is essential for addressing the complexities of diagnosis, management, and rehabilitation in this population in order to enhance quality of life and reduce the impact of these injuries on healthcare systems. Our objectives were to synthesize knowledge on neurotrauma care in older adults, focusing on traumatic brain and spinal cord injury (TBI and SCI), and identify gaps in care among older neurotrauma patients.

Approach

This narrative review was conducted following PRISMA guidelines. A comprehensive search was performed across Medline, CINAHL, Embase, PubMed, PsycINFO, and Web of Science using terms related to TBI, SCI and older adults (e.g. 'geriatric', 'senior'). Only English-language studies were included, and the review considered studies without publication year or location restrictions. Two reviewers independently screened title and abstract, resolving disagreements through consultation and a consensus process with a third reviewer. Reviews focused on studies assessing incidence, clinical outcomes and survival in those 65 years or older. Policy implications were discussed by committee, including persons with lived experience.

Results

245 peer reviewed articles were identified and abstracted (194 TBI and 51 SCI). Most studies were retrospective (79%), followed by prospective cohort studies (13.9%). The average age of TBI patients across studies was 72.5 years. Falls were the leading cause of injury (73.5% for TBI, 64.5% for SCI). Incidence of both TBI and SCI is increasing among older adults. Older adults had worse outcomes, including longer hospital stays (e.g., SCI patients aged 80+ stayed 57 days vs. 32 for younger patients). Inpatient rehabilitation was received by up to 15.3% of people after TBI and up to 32.5% after SCI. Cognitive decline (61.3%) and dementia (16.8%) were common long-term complications after TBI, while complications after SCI were pain, urinary tract infections and pressure ulcers.

Conclusion

This review emphasizes the rising incidence of TBI and SCI in older adults, primarily caused by falls. Older adults with neurotrauma face worse outcomes, longer hospital stays, and higher mortality. This public health concern requires policy leadership to ensure health outcomes are optimized for older persons after injury.

Financing public health systems in Canada: A multiple methods research program

Presented by: Sara Allin

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Background and Objectives

There are noticeable differences in the levels and trends in public health expenditures across Canada. Though sufficient and stable financing is critical to the effectiveness of public health systems, the existing literature on the determinants and processes of public health financing is limited. This presentation will summarize a program of research that aimed to address the questions of how much do Canada's provinces and territories spend on public health, and what explains the variations?

Approach

We used CIHI national health expenditure data to compare the trends over time in public health expenditures across Canada's provinces and territories. Then we conducted qualitative comparative case studies using document reviews and semi-structured interviews with decision-makers and key stakeholders in three provinces with different expenditure trends (British Columbia, Ontario and Nova Scotia) to describe the budget setting process for the public health sector, and uncover the factors influencing this process. Our cross-province thematic analysis informed by political economy theory helped uncover the political and system factors influencing expenditure trends.

Results

We found increasing rates of growth of public health expenditures across most provinces over the past 40 years, except in Quebec and Nova Scotia where growth rates declined slightly. Through our comparative case studies, we found that system-level factors such as including public health system leaders in budget-setting and maintaining independent public health budgets were seen to protect funds from reallocation. Interviews also highlighted that strong relationships between public health actors and senior decision-makers promote stable investment. Unique case findings included the influential role of public health advocacy in British Columbia, the benefit of health as central to Nova Scotia's political agenda, and the power leveraged by Ontario municipalities in protecting public health budgets.

Conclusion

The analysis of documentary and interview data sheds some light on the divergent trends in expenditure growth rates over time. More detailed reporting of public health expenditures at the provincial level would facilitate future analyses and aid in government decision-making.

Sociodemographic Characteristics of IENs Associated with their Successful Integration in Canada

Presented by: Nasrin Alostaz

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Background and Objectives

The global demand for healthcare professionals, amplified by the COVID-19 pandemic, has led to a surge in internationally educated nurses (IENs) relocating to Canada, resulting in an increased reliance on this workforce (Walton-Roberts, 2023). This article describes the sociodemographic characteristics of internationally educated nurses since the change in the registration examination in 2015. It aims to investigate the association between internationally educated nurses' sociodemographic characteristics and their successful integration into the nursing workforce in Canada.

Approach

This study adopts a cross-sectional and secondary data analysis, utilizing data from IENs who engaged with internationally educated nurse initiatives such as the Creating Access to Regulated Employment Centre for Internationally Educated Nurses (CARE) or initiated the registration process with the College of Nurses of Ontario (CNO) in 2015 and after.

Results

There were 259 participants, with 155 participants from primary data collection and 104 participants from secondary data sources. Quantitative analysis reveals that most participants are females, under 40 years old, educated in English, and hold at least a bachelor's degree in nursing, with 47.3% of internationally educated nurses migrated from India and the Philippines. Significant associations were identified between internationally educated nurses having CARE membership and the currency of nursing practice and their successful outcomes.

Conclusion

Recognizing and addressing the unique needs of IENs is essential for their successful integration into the Canadian healthcare workforce, thereby ensuring resilience and cultural competence in nursing for the future. The findings have substantial implications for nursing policy, practice, professional development, and research.

Factors associated with community treatment order initiation in Alberta

Presented by: Jennifer Anderson

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Background and Objectives

Community Treatment Orders (CTO) are legal tools used to support recovery for people with a serious mental illness in the community at-risk of experiencing repeated relapse and hospitalization by formalizing treatment plans, including pharmacotherapy and psychosocial interventions. No studies have described CTO application at the population-level, so their use in Canada remains unknown. This study describes the application of CTOs and identifies predictors for CTO incidence in people experiencing a psychotic disorder in Alberta.

Approach

This cohort study used administrative data to identify predictors of CTO incidence. A cohort was assembled using diagnoses in the Discharge Abstract Database (DAD) and billing claims from Physician Claims (PC), 5 years preceding index date (April 1, 2021). We used CTO initiation billing codes from PC to identify new CTOs between 2021-2024, with a 2-year washout. Index demographic, clinical, and health service utilization characteristics were obtained from the Population Registry, census, PC, DAD, and the National Ambulatory Care Reporting System. Logistic regression with backward selection was used to estimate odds ratios for factors associated with new CTOs.

Results

5.6% (n=2391) of participants had a prevalent CTO between 2019-2021, qualifying their exclusion. Of the remaining 35537 Albertans at-risk for CTO initiation, 1.9% (n=683) experienced an incident CTO between 2021 - 2024. Eight variables were found to be associated with CTO incidence. Individual-level variables found to increase odds of CTO incidence included homelessness, substance use disorder, alcohol use disorder, greater frequencies of previous hospitalizations and psychiatrist visits. Conversely, variables associated with a decreased odds of CTO incidence included older age, more frequent emergency department visits, and rural residence.

Conclusion

CTOs are used in a minority of individuals with a psychotic disorder in Alberta. They are appropriately targeting individuals with characteristics associated with higher risk of relapse and hospitalization. However, without provider- and treatment-level predictors of CTO use, appropriateness of their utilization in relation to other treatments remains unknown.

Strengthening Relationships Using Transformative learning Environments: A Participatory Evaluation of the PaRIS Dashboards in Saskatchewan

Presented by: Brenda Andreas

Identifying How to Improve Communication for Ductal Carcinoma In Situ

Presented by: Suzanna Apostolovski

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Background and Objectives

Ductal carcinoma in situ (DCIS) accounts for 15–25% of screen-detected breast lesions. Some “low-risk” forms of DCIS (low/medium grade) may never progress to invasive cancer. Because standard management includes surgery and/or adjuvant therapy, communicating about low-risk DCIS is challenging for both women and clinicians, often leaving women confused and anxious. This study explored ideal labels, language, and other strategies to improve communication about low-risk DCIS (henceforth, DCIS).

Approach

We adopted a multi-methods approach, combining data from a theoretical review and qualitative interviews. For the review, we searched multiple databases, screened titles/abstracts, then full text, and extracted data in duplicate. For telephone interviews, we recruited women aged 18+ who had DCIS within 5 years via clinicians, advocacy groups and community agencies, and clinicians of differing specialty via professional societies and academic web sites, and used content analysis to analyze transcripts in duplicate. In integrated data, we identified labels, language, and other strategies preferred by women and clinicians, then mapped data to Communication Accommodation Theory (CAT) for higher-level interpretation.

Results

CAT analysis of data from 21 studies, and interviews with 12 women and 16 clinicians revealed that women and clinicians differed in Initial Orientation and Psychological Accommodation. Women preferred “abnormal cells” because it reduced anxiety, while clinicians preferred precursor-to-cancer (e.g. pre-cancer) or cancer (e.g. stage 0 cancer) out of habit, to match labels women saw elsewhere (e.g. medical records) and to convince women of the need for treatment. CAT analysis revealed that women and clinicians agreed on Accommodating Tactics to improve communication including language: use plain language, state that DCIS is not the same as cancer, and discuss the risk of spread and recurrence; and other strategies: use visual aids, provide take-home information, connect women to support groups/services, and take time to address questions/concerns.

Conclusion

Prior research has focused on changing the DCIS label without fully exploring the rationale behind such changes. Our findings suggest that label changes alone are insufficient. Improved communication about DCIS, supported by advocacy and professional groups, may help reduce confusion and anxiety for women with DCIS.

Estimating the Proportion of Emergency Department Visits for Low Urgency Musculoskeletal Pain

Presented by: Clare Arden

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Background and Objectives

A common reason people visit emergency departments (ED) is for musculoskeletal pain. Solutions that re-direct people with low-acuity musculoskeletal pain to primary care are being developed. Current proportion estimates for musculoskeletal pain in ED vary from 3-25%, presenting a challenge for effective primary care health service planning. Our aim was to show how the methods used to identify people with musculoskeletal pain impact estimates.

Approach

We analyzed the MIMIC-IV and the HCAI electronic health record datasets using previously published ICD-10CM code lists: i) All codes in the Diseases of the Musculoskeletal System & Connective Tissue ICD-10CM chapter (M_Codes). ii) Codes previously used to identify visits to primary care physicians for musculoskeletal pain (MSK_Prim). iii) Codes previously used to identify low-urgency visits to ED for musculoskeletal pain (MSK_Low). In MIMIC-IV ED, low-urgency cases were identified using the patients' discharge disposition.

Results

The primary outcome was the proportion of ED visits for low-urgency musculoskeletal pain (%) identified with each code list, averaged across the two datasets. The secondary outcome was the most common low-urgency diagnosis. The mean proportion of visits by patients with musculoskeletal pain in the ED was: M_Codes = 7.0%, MSK_Prim = 2.3%, and MSK_Low = 15.6%. The most common low-urgency diagnoses were M_Codes = Low back pain, MSK_Prim = Low back pain, and MSK_Low = Headache.

Conclusion

Method choice impacted estimates. An average of ~8% of ED visits were for low-urgency musculoskeletal pain, which could have been re-directed to primary care. Low back pain was the most common diagnosis. Redirecting patients with low-urgency musculoskeletal pain from ED to primary care may help alleviate demands on ED capacity.

The Impact of Using Measurement-Based Care in Youth Mental Health Program: A Systematic Review

Presented by: Bishnu Bajgain

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Background and Objectives

Measurement-Based Care (MBC) is a routine systematic assessment of patient outcomes in treatment using standardized, validated measures (patient-reported symptom rating scales before, during, after clinical encounters) to allow patients and clinicians to make informed treatment decisions. Evidence shows that MBC improves patient outcomes and care satisfaction, however, the adaptation of MBC is lower in youth care. This review aims to map the impacts of MBC in youth mental health services to inform its broader adaptation.

Approach

A comprehensive search was performed on MEDLINE, EMBASE, CINAHL, and PsycINFO, using subject headings, keywords, and synonyms for ‘youth/caregivers’, ‘mental health’ and ‘measurement-based care’. The search included studies published up May 2024, along with a manual search of reference lists. Studies that presented impact of using MBC in youth mental health program were eligible. Two independent reviewers screened title, abstract, and full text, and resolving disagreement through discussion or third reviewer. Abstracted data includes bibliometric information, study design, population, and outcomes. Outcome variables will be synthesized thematically and summarized descriptively. Validated tool will be used to assess included studies quality.

Results

The database search returned 11,850 citations; after removing 4,038 duplicates, 7,812 articles underwent title and abstract review, from which 190 articles were selected for full text review. After full text review, ten articles were included in this review. Data extraction is currently in progress and findings will be shared at this conference. The finding from this study will be summarized into four major categories of outcomes: 1) youth health status (i.e., symptoms, quality of life), 2) youth and caregiver perspectives of the benefits and drawbacks of MBC, 3) healthcare provider perceptions of the impacts of MBC on clinical care, and 4) organizational-level impacts of MBC.

Conclusion

MBC offers an objective, systematic approach to monitoring clinical progress, evaluating treatment efficacy, and informing clinical decisions. This study provides an understanding of the impacts of using MBC in youth mental health programs, which will be helpful to care providers, health administrators, and policymakers for successful adoption of MBC.

Disparities in Surgical Care for ACB Communities in western countries: A scoping Review

Presented by: Linda Bakunda

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Background and Objectives

African, Caribbean, and Black (ACB) populations in Western countries experience health disparities, including higher rates of chronic diseases, worse outcomes, and access to high-quality healthcare. These inequities extend to surgical care. However, the existing evidence on surgical disparities among ACB patients in Western countries is fragmented. This scoping review aims to systematically map and characterize research on disparities in surgical access and quality for ACB patients in Western countries.

Approach

The scoping review, following the Joanna Briggs Institute methodology and reported using the PRISMA-ScR checklist, will apply a comprehensive search strategy across MEDLINE, Embase, CINAHL, APA PsycINFO, and Cochrane Library (and grey literature sources) using terms related to ACB and surgery, without restrictions on publication date or language. All study designs will be eligible. Two reviewers will independently screen titles/abstracts, and full-texts for eligibility, with data charting performed by one reviewer and validated by another. Findings will be synthesized through descriptive statistics and thematic analysis to provide a comprehensive overview of the evidence.

Results

The review is currently underway, with preliminary findings expected to provide key insights into disparities, if any, in access to and quality of surgical care for ACB populations in Western countries. The results will summarize the extent of disparities, if any, in surgical access, quality of care, and outcomes for ACB patients compared to other populations. Additionally, the review will identify gaps in the existing literature, such as under-researched areas. The synthesis will include both quantitative data (e.g., prevalence rates) and qualitative themes (e.g., systemic barriers). These findings aim to highlight critical areas requiring further research and inform strategies to address inequities in surgical care for ACB communities.

Conclusion

This scoping review will provide a map and synthesis of evidence on surgical care disparities affecting ACB populations in Western countries. By identifying research gaps and summarizing existing knowledge, the findings aim to guide future studies and inform interventions to improve equitable access to high-quality surgical care for ACB patients.

Convictions or Discrimination: The Illegitimacy of Conscientious Objection to Gender-Affirming Care

Presented by: Jess Baptista

Author(s): *Baptista, Jess McGill University*

Background and Objectives

Transgender and gender-diverse individuals in Canada are entitled to gender-affirming care (GAC). However, many physicians refuse care and defer patients to specialized clinics with long wait-times, creating barriers to access. Conscientious objection (CO) allows medical professionals to refuse services based on moral convictions. The objective of this research is to delimit the permissibility of CO to GAC, focusing on whether such refusals conflict with anti-discrimination laws and undermine liberal principles of autonomy and equality.

Approach

This study identifies significant gaps in existing CO and GAC policies. It draws on Nehushtan and Coyle's legal framework for identifying illegitimate conscientious objection, which emphasizes conflicts with anti-discrimination laws, and Neal's concept of proper medical treatments, which considers the moral relevance of a treatment's liminal status for CO. To determine the liminal status of GAC, a systematic risk-benefit analysis was conducted using published data. This analysis evaluates patient satisfaction, mental health outcomes, and detransition experiences. Additionally, arguments supporting physician integrity were considered to balance the ethical debate.

Results

The risk-benefit analysis demonstrates the overwhelming therapeutic value of GAC, with 97% of patients reporting satisfaction and only 3% detransitioned. Among those who detransition, emotions are mixed, including grief and regret alongside gratitude, personal growth, and satisfaction with residual changes. Access to GAC strongly correlates with improved mental health outcomes, including reductions in suicidal ideation, severe depression, and self-harm among transgender and gender-diverse individuals. Evidence further shows that CO to GAC exacerbates healthcare disparities, particularly for rural populations and those who do not conform to the gender binary, restricting equitable access to essential services. These results demonstrate the therapeutic value of GAC and the anti-liberal imposition of CO to GAC.

Conclusion

CO to GAC is illegitimate as it violates anti-discrimination laws and liberal values. Restricting CO to GAC would foster education and awareness about the healthcare needs of transgender and gender-diverse patients. These measures have the potential to improve health outcomes and shape policies that support inclusive and patient-centered healthcare systems.

Transforming mental health, addictions, and supported housing services through voluntary integration

Presented by: Mary Bartram

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Ottawa Salus

Background and Objectives

Fragmentation in mental health, addictions, substance use health, and supported housing services is a long-standing challenge that undermines the quintuple aims of equity, client experience, health outcomes, efficiency, and staff wellness. Person-centred care is a core priority for the Ontario government, and yet structural integration rarely happens. We will describe lessons learned from efforts to implement voluntary integration of two community-based organizations in Ottawa, including key factors that have shaped the outcomes along the way.

Approach

This program innovation seeks to explore, on a voluntary basis, the integration of two community-based organizations: Ottawa Salus, a supported housing provider, and Rideauwood Addiction and Family Services, a counselling services provider. After a broader exploration across four community agencies that started 2021, Salus extended a preliminary offer of integration that was accepted by Rideauwood in 2024. A due diligence review and comprehensive stakeholder engagement are underway in 2025, to inform final Board decisions. Should the Boards approve, a formal proposal to integrate will be made to the Ontario government, and a fulsome change management process will be implemented.

Results

Key success factors for this voluntary integration initiative have included: provincial policy alignment and supports, access to external expertise, buy-in from staff and partners, and deeply committed leadership. Key challenges have included: leadership transition, one-time resource requirements, and managing complex organizational change. Should this integration move forward, the anticipated impacts include: improved client experience and outcomes arising from more holistic services; improved recruitment, retention, opportunities for career growth, and staff wellbeing in a larger organization; stronger capacity for quality assurance and data-informed decision-making; increased system efficiency, as a stronger community organization will reduce reliance on hospitalization; and increased opportunities for growth as a larger organization is better positioned to secure additional funding, and to expand through further integrations.

Conclusion

This voluntary integration has the potential to lead the way for Ontario's next generation of mental health, addictions, substance use health, and supported housing services. By integrating two missions and mandates, one plus one could potentially equal three, as opportunities for further growth create capacity to better meet emerging needs.

Post-pandemic Recovery in South Asian Women Care Partners of Older Adults: A mixed methods study

Presented by: Pamela Baxter

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Background and Objectives

In Canada, South Asian care partners of older adults living with chronic conditions face significant barriers to accessing social and healthcare services. This lack of access may have contributed to disproportionately high COVID-19 infection and mortality rates in the Greater Toronto Area (GTA) during the pandemic. Our objective is to promote post-pandemic recovery and prepare for future public health emergencies by understanding and responding to the high-priority caregiving needs of unpaid South Asian care partners.

Approach

This mixed methods study involves semi- interviews with service providers (Phase #1) to center the voices of the South Asian community and South Asian women care partners (Phase #2) in generating knowledge, followed by the collection of quantitative data (survey) (Phase #3) from a larger, demographically diverse sample to corroborate and expand upon the qualitative findings. Both strands of data will then be jointly interpreted to achieve our goals of identifying the needs of South Asian women care partners, current gaps in social and healthcare services, and informing the co-creation of interventions to address these needs.

Results

Data were generated from 60–90-minute semi-structured telephone interviews with 16 service providers from across the GTA who provided services to the South Asian community during the COVID-19 pandemic. Using Braun and Clarke’s reflexive thematic analysis, several high-priority needs were identified:, access to food and nutrition, housing, and healthcare (basic human needs and rights); culturally relevant social, mental, and emotional support; and knowledge and training related to chronic conditions and care provision. Participants also described the need to pivot to meet basic needs and Eurocentric social and healthcare systems. Such systems being inadequate for meeting the unique South Asian care partners’ needs resulting in unnecessary stress and anxiety for care partners of those older adults living with chronic conditions.

Conclusion

The South Asian community in the GTA needs more accessible, culturally relevant, linguistically appropriate social and healthcare services. Such gaps mean care partners are less able to receive much-needed support. Understanding service gaps is the first step in understanding how to better serve the South Asian community of care partners.

Visits to the emergency department for conditions that could be managed in primary and virtual care

Presented by: Kris Beking

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Background and Objectives

Survey data show gaps in access in primary care across data, but little granular, pan-Canadian data exist. The Canadian Institute for Health Information (CIHI) has reported for the first time indicators of access to primary and virtual care using data on visits to the emergency department (ED) for conditions that could potentially be managed in primary and virtual primary care. These data can measure unmet needs by comparing results across population groups.

Approach

The indicators are calculated using data from the National Ambulatory Care Reporting System. The denominator is all ED visits in patients age 2+; the numerator is the subset that:

- Have a main diagnosis on a list of primary care sensitive conditions (PCSC) or virtual primary care sensitive conditions (VPCSC)
- Were discharged home
- Were triaged with a Canadian Triage Acuity Scale of 3, 4, or 5

To develop the conditions lists, CIHI validated a previously developed PCSC list and created a new VPCSC list in iterative consultation with clinical experts.

Results were adjusted for age and sex.

Results

In fiscal year 2023-2024, 15% of visits to the ED was for a condition that could be managed in primary care and over half of these (9%) were for a condition that could be managed virtually. These results varied substantially across the country at the provincial/territorial and regional levels. Longitudinal analysis showed that while rates have come back to pre-pandemic, the number of people visiting the ED for PCSCs is higher compared to 2019-2020. Further stratification of the results found variability across populations, with the following population groups having higher percentages:

- Children under the age of 10
- People living in rural and remote areas
- People who report not having access to primary care or a walk-in clinic – which also differs by time of day

Conclusion

These indicators can be used at the regional level and over time to monitor impacts of Canadians' access to primary care and virtual care and determine unmet needs for this kind of care, to drive initiatives in health system improvement.

Evaluation in Learning Health Systems: A Jurisdictional Scan

Presented by: Marissa Bird

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Background and Objectives

The Learning Health System (LHS) aims to improve healthcare by using data, patient experiences, culture and incentives to create equitable, patient-centered, and cost-effective care. Evaluating LHS success is challenging due to real-world variability, system context, and absence of clear metrics. We conducted an international jurisdictional scan to highlight common evaluation approaches, frameworks, indicators, outcomes, challenges, and assumptions related to establishing counterfactuals in LHS evaluation, with the goal of improving evaluation methods for continuous healthcare improvement.

Approach

The MRC Framework for Complex Interventions and the LHS Action Framework provided theoretical guidance for the scan. Papers that referenced at least four of eleven pre-specified LHS characteristics, described an evaluation of LHS implementation, and were published in English after 2007 were included. Evaluation outputs were categorized into four types: description, lessons learned, efficacy, and effectiveness. Frequencies and thematic analysis were used to describe LHS, their evaluations, indicators of change, and lessons learned.

Results

45 papers were included. 30 papers shared lessons on LHS progress, 14 reported on efficacy during scaling, and none reported on effectiveness of sustained systems. Ingredients perceived to contribute to a successful LHS included engagement of key individuals, establishment of a LHS culture, data considerations, and contextual factors. Indicators of change commonly focused on population health and quality care outcomes, but rarely included equity. Few papers discussed counterfactuals or contextualized measures of success. To map real-world LHS improvement outlined in the included reports, a framework was created depicting LHS progression through phases of development, implementation, scaling, and sustainment. We integrated these phases of development with corresponding evaluation approaches – ranging from feasibility assessments and lessons learned, to findings on efficacy, and ultimately, sustainability of LHS.

Conclusion

Future evaluations should consider LHS maturity, utilize counterfactuals, and prioritize equity. The shift toward structured and standardized evaluation efforts recommended within this jurisdictional scan could contribute to a culture of continuous learning and improvement, enabling health systems to better enhance population health outcomes and deliver high-quality, equitable care.

Rethinking the way we measure access to health services for minority language populations

Presented by: Lise Bjerre

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Background and Objectives

Providing care in a patient's preferred language improves outcomes and satisfaction. Many studies quantify the demand for French-speaking physicians (FSPs) using FSP-to-francophone ratios as proxies for access, comparing these to general physicians-to-population ratios. This approach overlooks that FSPs also serve non-francophone patients, forcing Francophones to compete with the entire population to access FSPs. We propose a novel approach to address this issue, enabling unbiased comparisons of access to language-concordant care across linguistic groups.

Approach

Using publicly available data containing linguistic variables for the Ontario population (Statistics Canada, 2021 Census) and for Ontario family physicians (College of Physicians and Surgeons of Ontario; January 2024), we calculated crude, unadjusted ratios for different linguistic groups (i.e. general physician-per-1000 population; and FSPs-per-1000 francophones). Next, ratios were adjusted to reflect competition by considering the proportion of FSPs-to-general population. Finally, the probability of receiving language-concordant care was calculated by estimating physician panel sizes, the number of patients receiving non-concordant care and the number of patients receiving no care at all.

Results

We obtained the following results at the provincial level; regional comparisons were also made and will be reported at the conference. The unadjusted ratio of FSPs-per-1000 francophones was 2.42; for general physicians it was 0.67 per 1000 population. After adjusting for the competition effect, the ratio of FSP per 1000 population was 0.09, reflecting actual francophone access to FSPs. Assuming 84% of Ontarians are attached to a family physician (based in INSPIRE PHC estimates), there is a 100% probability of receiving language concordant care for a non-francophone seeking physician services in English compared to an 11.4% probability for a francophone to receive care in French. Expressed otherwise, non-francophones are 8.8 times more likely to receive language concordant care (i.e. care in English) than francophones.

Conclusion

Crude physician-to-population ratios overestimate francophones' access to FSPs. Francophones, competing with the broader population, are much less likely to access language concordant care than non-francophones (11.4% vs 100%). This novel approach has equity implications for health human resources planning and can be applied to other linguistic minority groups and healthcare providers.

Assessing the Influence of BC's Opioid Prescribing Guidelines on Cancer and Palliative Care Patients

Presented by: Xander Bjornsson

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Background and Objectives

The opioid crisis has had profound implications for public health in British Columbia (BC). In 2016, the College of Physicians and Surgeons of BC implemented opioid prescribing practice standards to limit the management of chronic, non-cancer pain with long-term opioid treatment. Clinicians, patients and stakeholders worried the practice standards would have spillover effects on exempt patients. This study assesses the impact of these policies on opioid prescriptions for cancer-care and palliative care patients in BC.

Approach

This study uses an interrupted time series study design and administrative health data (i.e., PharmaNet, BC Cancer Registry, patient registry, and Vital Statistics Mortality) from January 2012 to March 2020. I employ Poisson segmented regression, adjusting for autocorrelation to evaluate the effects of the 2016 practice standard and its 2018 revision on three outcomes: opioid dosage (measured in morphine milligram equivalents), prescription duration, and the proportion of patients being prescribed opioids.

Results

Data analysis is ongoing; with no results are available at this time. Outputs will include changes in opioid prescribing level and trends following the implementation of the practice standard (June 2016) and its revision (June 2018). Based on literature from the United States and discussions with clinician experts, we anticipate the prescribing standard negatively impacted access to opioid analgesics for patients living with cancer or receiving palliative care.

Conclusion

This research aims to inform opioid prescribing practices. The findings will support evidence-based policy adjustments to ensure exempt populations receive adequate pain management. These insights are critical for balancing patient care needs with public health priorities, contributing to national and international efforts to address opioid-related challenges.

Impact of Pharmacist Prescribing for Lyme Disease Chemoprophylaxis on Emergency Department Visits

Presented by: Emily Black

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Background and Objectives

All areas of Nova Scotia are considered at high risk for Lyme disease. Pharmacists in Nova Scotia (NS) gained authority to prescribe chemoprophylaxis for the prevention of Lyme disease after a tick bite in August 2021. The objective of this study was to describe and compare the frequency of emergency department (ED) visits for prevention of Lyme disease after a tick bite before and after implementation of community pharmacist prescribing for this indication.

Approach

A retrospective cohort study using a pre-post design compared prescribing for Lyme disease chemoprophylaxis in the ED 1.5 years before to 1.5 years after implementation of community pharmacist prescribing for this indication. Patients who were assessed for a tick bite in accordance with ICD-10 codes in three EDs across NS during the study period were eligible for inclusion. Patients diagnosed with, or prescribed treatment for, any active infection were excluded. Medical record data were reviewed by trained research assistants. Data were reported descriptively and the proportion of ED visits for tick bites was compared using Chi-square.

Results

A total of 1026 patient encounters for tick bites (619 pre-intervention vs. 407 post-intervention) that met inclusion criteria across 3 EDs were identified. Of these ED visits for tick bites, 66.4% (681/1026) resulted in a prescription for a single dose of doxycycline to prevent Lyme disease. After implementation of pharmacist prescribing for Lyme chemoprophylaxis, the overall frequency of patient encounters for tick bites at the three EDs significantly declined (619 encounters in 88512 ED visits pre-intervention vs. 407 encounters in 115847 ED visits post-intervention ($p<0.0005$)). The frequency of patient encounters for tick bites also significantly declined at each individual ED post-intervention.

Conclusion

After implementation of pharmacist prescribing for Lyme disease chemoprophylaxis, there was an overall decrease in frequency of patients visiting the ED for tick bites in NS. Enabling pharmacist scope to include management of tick bites may alleviate some burden on local EDs in communities with high risk of Lyme disease.

Examining Health System Needs & Organizational Priorities: An Analysis of Embedded Research Projects

Presented by: Rhonda Boateng

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Background and Objectives

Embedded research integrates research professionals into Health System Organizations (HSOs) to address complex real-world challenges, ensuring relevant and applicable research. The Canadian Institutes of Health Research's Health System Impact Program (HSIP) supports this by developing the embedded research workforce and enhancing HSOs' capacity to address their priorities with innovative, evidence-based solutions. This study examines HSIP-funded embedded research projects to highlight the challenges, priorities and project approaches that HSOs are prioritizing for embedded research.

Approach

We conducted a qualitative document analysis of 336 embedded research projects funded by the HSIP from 2017 to 2024. The analysis examined themes (health system priorities), types of HSOs (e.g., not-for-profit, health authority, public, delivery organization, Pan-Canadian Health Organization), geographical scope (provincial, rural, northern, national, international), year, and fellowship type (PhD, postdoctoral, Early Career Researchers [ECR]). Data were thematically coded and summarized descriptively to identify trends and shifts in research priorities over time, providing insights into the alignment of embedded research with health system needs.

Results

Our analysis revealed that 158 organizations hosted Health System fellows and/or early career researchers (ECRs). Delivery organizations (n=50), not-for-profit organizations (n=46), public institutions (n=34), and health authorities (n=20) were the primary hosts. Organizations in eight provinces, two territories and two countries engaged as hosts over the study period. Fifty-six HSOs hosted fellows/ECRs in more than one year. Integrated Care, Public & Population Health, and Mental Health & Substance Use were the top themes across the projects. Regional and organizational variations in thematic priorities were observed, reflecting tailored approaches to local needs. Integrated Care was the predominant theme across multiple years, with shifts towards Chronic Disease Prevention, Mental Health, and Equity in recent years.

Conclusion

The study underscores the value HSOs place on embedded research for addressing system challenges. Aligning research with system needs and fostering a capable workforce are crucial for innovation and improved outcomes. Understanding HSOs' evolving priorities inform program planning and capacity development to strengthen embedded research and advance learning health systems.

Determinants of competency frameworks for youth mental health service providers: A Scoping Review

Presented by: Rhonda Boateng

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Background and Objectives

Despite high prevalence, less than 20% of Canadian youth receive adequate mental health care. Marginalized youth face challenges like cultural misunderstandings, long wait times and negative care experiences. A competency framework for mental health clinicians can enhance the health workforce's capacity to deliver culturally responsive care. This scoping review summarizes existing literature on competency frameworks for mental health and youth service providers, assessing their alignment with culturally responsive care, development, equity considerations, and implementation determinants.

Approach

We follow the Joanna Briggs Institute guidelines. The search strategy, developed with a librarian, covered Medline, CINAHL, EMBASE, PsycInfo, and CENTRAL databases. Included were empirical studies on competency frameworks for mental health and youth service providers (ages 12-29). Excluded were systematic reviews, meta-analyses and commentaries. Covidence and EndNote managed search results. Two reviewers independently conducted title, abstract and full-text screening. Data extraction was done independently. NVivo was used for thematic coding based on frameworks such as Consolidated Framework for Implementation Research 2.0 and the WHO Conceptual Social Determinants of Health Framework, and R for quantitative analysis.

Results

The scoping review included 57 studies on competency frameworks for mental health and youth service providers. Competency frameworks across various fields, including child neurology, educational psychology, and pediatric endocrinology were identified. Key themes were the development of competencies through literature reviews, group techniques, stakeholder deliberation, and consensus methods. Equity considerations such as income, social status, and access to health services of their patients and interest holders were frequently addressed. Studies emphasized culturally responsive care and end-user engagement in co-design approaches. Effective implementation strategies included harmonizing standards, comprehensive training programs, educational activities, and intersectoral actions. Common barriers were insufficient training, lack of clinical workflows, and limited access to mental health experts, hindering the adoption of competency frameworks.

Conclusion

This scoping review highlights the importance of competency frameworks in enhancing culturally responsive mental health care for youth. Effective implementation strategies and addressing barriers such as insufficient training and limited access to experts are crucial for improving service delivery and outcomes. Further research is needed to standardize methodologies and frameworks.

Factors influencing the implementation of the Quebec Program for Mental Disorders: Views of managers

Presented by: Chani Bonventre

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Background and Objectives

The Quebec Program for Mental Disorders (QPMD) is a provincial program that aims to improve access to evidence-based care for common mental disorders, notably in primary care. It is a multifaceted program that has major potential to transform and improve care. However, it has also been challenging to implement, especially in settings like family medicine groups (FMGs). The aim of our study is to describe the factors influencing the QPMD's implementation generally and in FMGs.

Approach

We are conducting a multiple case study in three regions of Quebec (Capitale-Nationale, Chaudière-Appalaches, Mauricie). We have partnered with the regional integrated health and social service centres from these regions and have recruited health managers from these centres that are involved in the QPMD's implementation in primary care. These managers were invited to participate in 1-hour semi-structured interviews to explore their views on their strategies for implementing the QPMD and the barriers/facilitators they have encountered during this process. Our data collection and deductive-inductive thematic analysis (conducted in NVivo) has been informed by the Consolidated Framework for Implementation Research.

Results

This study is in progress and recruitment is ongoing. Currently 7 managers have participated out of the 15 that have been targeted (data collection and analysis will be completed by conference time). Preliminary results highlight the challenges of the QPMD's implementation. Participants emphasized the program's complexity as a major barrier: only as implementation progressed did managers begin to appreciate the program's vast, multifaceted nature and the extent of practice change involved. Resistance to some program components, tensions between actors, and a lack of access to resources were also viewed as important barriers. Some factors were described as both barriers and facilitators, such as participants' attitudes towards the program, the collaborative cultures within clinical teams, and the relationships between the health centres and FMGs.

Conclusion

This study is shedding valuable light on the implementation process and barriers/facilitators related to a province-wide mental health program in Quebec. Future interviews will be conducted with FMG clinicians and the insights gleaned from interviews will be used to co-design support strategies to facilitate QPMD implementation and improve care.

Rural-urban disparities in healthcare utilization and cost at the end-of-life, a retrospective study

Presented by: Jean-Frédéric Boulianne

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Background and Objectives

The aging population raises concerns about health and care organization, as it is associated to increased health problems, potentially disrupting the allocation of healthcare resources. Knowing that regional resource availability may contribute to some variations, we aimed to describe rural and urban disparities in healthcare utilization and costs during the last year of life among Quebec residents aged 66 years or older who died between 2014 and 2018.

Approach

A retrospective cohort study of 21,255 individuals aged 66 or older, who died between April 1, 2014 and March 31, 2018, was used to describe utilization and cost of healthcare services during the last year of life. Data on healthcare and social service use during the last year of life were extracted from administrative health databases, including medical visits, emergency visits, hospitalizations, community care, long-term care, and social services. Costs were extracted from administrative health databases and financial reports, and then attributed to services using correspondence tables tailored to each type of service, depending on the year and location.

Results

Among the cohort, 40% were aged 80+ at death, and 53% were women. The highest mortality rates occurred in the Montreal (urban), Abitibi-Temiscamingue (mid-urban), and Gaspesie-Iles-de-la-Madeleine (rural) regions. There was no specific trend in healthcare or social service use across regions, except for long-term and community care, which showed greater variation. While the proportion of individuals using emergency services (80%), hospitalization (70-75%), and medical visits (90-95%) was relatively consistent across regions, the use of long-term care (20-30%) and community care (60-80%) varied more substantially, with higher utilization observed in urban areas. The average cost per individual, estimated using a generalized linear model, ranged from $25,050 in Bas-Saint-Laurent to $32,934 in Montreal. Montreal, Capitale-Nationale, and Cote-Nord had costs consistently higher than the provincial average.

Conclusion

The study revealed regional differences, with some urban and rural regions systematically showing higher individual costs than provincial average. Given the variations in service offering generally between rural and urban regions, this highlighted the disparities in utilization and costs accross regions of different demographic concentration.

Co-designing the Emergency Department Patient-Activated Transition from Care to Home (ED-PATCH) tool

Presented by: Leah Boulos

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Background and Objectives

The Emergency Department Patient-Activated Transition from Care to Home (ED-PATCH) tool will empower patients and caregivers to use their mobile device to track important information shared throughout their ED visit. A prototype of the tool has undergone usability and feasibility testing. There remains a need to further refine the prototype to make it accessible and appropriate for users with varying health literacy, for those whose first language is not English, and for busy ED clinicians.

Approach

We adopted a co-design process and assembled a working group that included patient/public partners with lived experience as immigrants working with other newcomers to Canada, urban and rural ED nurses and doctors, computer science professionals, and project staff. For the first prototype refinement phase, members met biweekly for three months. Members collaborated to identify the essential components and technical specifications of ED-PATCH and edit text to enhance clarity for a range of end users. The refinement period will be followed by further usability testing, after which the tool will be subject to an effectiveness-implementation trial with sites in four provinces.

Results

The list of 15 core components developed by the working group includes features such as speech-to-text capability, built-in language translation functions, and the option for ED clinicians to check patient summaries remotely on their own devices in order to minimize impact on ED workflows. The tool content has been shortened from over 20 questions in the prototype to 13 questions with optional branching. Questions have been re-worded to improve clarity for users of all literacy levels and have also been refined to limit free-text data entry where possible, making it more accessible to those with limited ability to type on a mobile device during their ED visit.

Conclusion

Our co-design process to refine the tool with this diverse knowledge user group has led to rich discussions about user preferences, key core components, and critical content for inclusion in ED-PATCH. We anticipate our co-design process will enhance uptake and sustainability of ED-PATCH in emergency practice settings.

Generating data-driven policy solutions for Ontario's primary care crisis

Presented by: Saredo Bouraleh

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Background and Objectives

Medical schools in Canada are committed to social accountability, which involves advancing health equity by aligning their activities with the health needs of the communities they serve. However, limited evidence exists regarding the effectiveness of these initiatives. This project examines how Ontario medical schools contribute to the primary care workforce in terms of graduating family physicians who pursue additional competence training and provide care in rural and remote areas.

Approach

We are conducting a population-level cross-sectional study using the physician registration data collected by the College of Physicians and Surgeons of Ontario (CPSO). We will create a cohort of family physicians who obtained their independent license in Ontario between July 1st, 2000, and July 1st, 2020. We will describe the current sociodemographic characteristics (e.g. gender and language) and training contexts (international vs. Canadian graduates, medical school of graduation) among our cohort. We will use multivariable modelling to examine the associations between these characteristics and the pursuit of additional competence training and the provision of care in rural and remote areas.

Results

This study is part of an emerging program of interdisciplinary research at the interface of health systems, medical education and health equity. Our results will provide valuable insights and offer evidence to guide targeted interventions for stakeholders in medical education and the health workforce.

Conclusion

Multi-pronged strategies are essential to overcome Ontario's primary care crisis and advance health equity. This study will highlight the role of medical schools in shaping the workforce distribution. Ultimately, our research aims to support the development of a more equitable and resilient primary care system in Ontario.

Re-thinking Responsibilities to Population Data: Evolving Practices for Equity in Health Research

Presented by: Laura Bowler

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Background and Objectives

Big data, particularly health administration data, is often heralded for its ability to reduce bias, allow whole-population inclusion, and reduce participant attrition. The often uncriticized assumption that administrative data is neutral, has strengthened and perpetuated systemic inequities and barriers, overlooking underlying causes of health inequities resulting in missed opportunities for impactful policies. Responsibility towards system change takes many forms, including within data research organizations and data research projects.

Approach

Three tools that health researchers use to conduct population data studies were the target of our analysis: (1) common data models, (2) concept dictionaries, and (3) phenotype libraries. A literature search was conducted focusing on the development of these tools in Canada, EU, UK, and USA. We then analyzed whether and how principles of inclusion, diversity, equity, and accessibility (IDEA) were considered within the development of these tools. From there, recommendations were made targeting organizations implementing these tools in Canada and researchers who use them to conduct population data research.

Results

Significantly, we found that that the academic literature about the development of common data models, concept dictionaries, and phenotype libraries lacked helpful information about how issues related to population inclusion vis-à-vis disaggregated data (sex/gender, race/ethnicity, ability, income), equity in development, and accessibility of data were incorporated into the development of these tools. While some grey literature demonstrates consideration of diversity (ie: common data models and race/ethnicity), no systematic review considering IDEA has been conducted. From these results, we developed preliminary recommendations for embedding IDEA in common data models, concept dictionaries, and phenotype libraries tailored to both specialists developing these research tools and researchers who ultimately use them for population health research.

Conclusion

Through this research, we have examined the development of three health research tools and provided preliminary recommendations for researchers and infrastructure developers. This work shifts our responsibility for using large population-based data for health research, embedding IDEA within tools and research systems, and ultimately complimenting equity models focusing on individual responsibility.

Examining Drivers of Obstetric Program Closures in Rural Northern Ontario

Presented by: Navishka Brahmbhatt

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Background and Objectives

Northern Ontario continues to experience closures of rural obstetric programs, forcing pregnant persons to travel further for care. This reduced access is associated with poorer maternal and newborn health outcomes and creates logistical and financial barriers to care. Despite closures, factors underlying this trend are not well understood. Senior hospital administrators, nurses, and physicians involved in rural obstetrics at the time of program closure are well-positioned to identify factors contributing to service attrition.

Approach

Semi-structured interviews were conducted with senior administrators (n=12), nurses (n=6), and physicians (n=10) who were directly involved in the operation of rural obstetric programs in Northern Ontario at the time of their closure. Interview guides, designed to identify and understand the factors influencing rural obstetrical program closure, were developed following a comprehensive literature scan. They were refined with input from an experienced rural obstetric practitioner to ensure relevance and depth. Thematic analysis of the interview data was used to reveal key themes perceived as contributing to the closure of rural obstetric programs in Northern Ontario.

Results

Qualitative analysis revealed several interconnected factors perceived to contribute to the closure of rural obstetric programs. First, a decline in obstetric competence and confidence among healthcare providers was highlighted. This decline was attributed to insufficient exposure to obstetrics during education, low birth volumes in rural settings that limit hands-on experience, and inadequate opportunities for ongoing training and skills development. Second, a significant shortage of health human resources was noted, driven by challenges in recruitment, retention, and a reluctance among new providers to practice obstetrics in rural areas. Third, participants identified insufficient support from the provincial government and tertiary referral centers, including inadequate funding, lack of policy prioritization, and limited collaboration, as critical barriers to sustaining rural obstetric care.

Conclusion

The closure of rural obstetric programs in Northern Ontario reflects systemic failures and policy gaps. Targeted policy interventions are needed to address workforce shortages, enhance training, and ensure government support for rural healthcare infrastructure. These measures are integral to maintaining obstetric care services in rural communities.

Impact of Technology-Enabled Prehabilitation on Quality of Life in Cardiac Surgery Patients

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Background and Objectives

In cardiac surgery, poorer health-related quality of life (HRQOL) after surgery has been associated with worse survival outcomes. However, it is unclear how HRQOL is impacted by a combination of a cardiac surgical procedure and a patient health optimizing process prior to surgery known as "prehabilitation". This study addresses this area by investigating changes in HRQOL among cardiac surgery patients undergoing prehabilitation.

Approach

Prehabilitation program patients (n=460) awaiting coronary artery bypass graft (CABG) surgery over a 31-month period were included in the study. All patients completed the 12-item short-form (SF-12, comprised of physical component scale, PCS-12, and mental component scale, MCS-12) health survey HRQOL questionnaire at 1-day post-program enrolment (pre-surgery) and at 3-months post-CABG surgery discharge via automated interactive voice response (IVR) system call. Patients were stratified by whether they raised a flag in the pre-surgery IVR call, indicating need for prehabilitation intervention, and compared within groups (flagged or non-flagged) pre-post surgery and between groups (flagged vs. non-flagged) pre- and post-surgery.

Results

Before surgery, non-flagged patients (i.e., no intervention needed pre-surgery) (n=129) had a statistically significant higher median MCS-12 score than flagged patients (n=331); PCS-12 score difference pre-surgery was statistically insignificant. After discharge, flagged patients' median MCS-12 score improved by 1.15 points (1.18 % change) and median PCS-12 score increased by 7.46 points (17.50% change). For non-flagged patients, median MCS-12 score improved by 0.84 points (1.45% change) and median PCS-12 score increased by 9.74 points (25.08% change). As such, median PCS-12 and MCS-12 scores were higher for non-flagged patients than flagged patients, but only the PCS-12 score difference was statistically significant. However, no significant differences in change scores for MCS-12 and PCS-12 were noted, indicating comparable effects post-surgery for flagged and non-flagged patients.

Conclusion

HRQOL for patients needing prehabilitation intervention improved and was comparable to non-flagged patients' HRQOL post-discharge; this may not have occurred without IVR screening. Since flagged patients had lower mental HRQOL than non-flagged patients' pre-surgery, IVR-enabled prehabilitation improved mental wellbeing by providing a feeling of security and involvement in their health.

Virtual care utilization differs by rurality among persons living with Parkinson Disease in Ontario

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Background and Objectives

Virtual care increased substantially during the COVID-19 pandemic, enabling access to care during challenging times. To date, most published studies in Parkinson Disease (PD) have examined the uptake of virtual care in tertiary centres with limited generalizability to broader populations and longitudinally. We sought to describe trends in virtual care use over time in persons living with PD in Ontario, Canada by rural versus urban region of residence.

Approach

Using a repeated cross-sectional design and population-based administrative data, we identified all community-dwelling individuals living with PD aged 66 years and older at the start of each week from March 2020 through August 2023. Main outcomes were rates of virtual and in-person physician visits (neurologists, family physicians, geriatricians/psychiatrists) analyzed in 6-month intervals (0 to <6 months through 36-42 months). Poisson regression models with generalized estimating equations were used to calculate adjusted rate ratios (RR) with 95% confidence intervals (95% CI) to compare rates of virtual care visits between rural and urban populations within physician specialties over time.

Results

Rural persons living with PD (n=2,487) were modestly younger than urban individuals (n=22,249) and less likely to have 5 or more chronic conditions, however sex distribution, PD duration and neighbourhood income quintiles were comparable. Compared to those living in urban areas, individuals living rurally had a significantly lower rate of virtual visits to neurologists (adjusted RR=0.93, 95% CI (0.90,0.96)), family physicians (adjusted RR=0.73, 95% CI (0.75,0.77)) and geriatricians/psychiatrists (adjusted RR=0.67, 95% CI (0.65,0.77)) throughout the study period. Compared to the first six months of the pandemic, rates of virtual visits decreased over time for all specialties, including for neurologists (adjusted RR_3.5 years=0.23(0.22,0.25)), family physicians (adjusted RR_3.5 years=0.39(0.38,0.41)), and geriatric/psychiatrists (adjusted RR_3.5 years=0.45(0.40,0.51)).

Conclusion

Individuals living with PD in urban regions accessed virtual care more frequently compared to those living in rural regions and virtual care utilization overall decreased substantially following the start of the pandemic. Future studies should explore preferences and barriers for virtual care among persons living with PD in rural regions.

2023 Digital Health Equity Analysis: Variation in Electronic Access to Personal Health Information

Presented by: Terece Brown

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Background and Objectives

As uptake and availability of digital health technologies continues to increase, it is important to consider these solutions through an equity lens. We sought to explore the concept of digital health equity and discuss its importance in improving health outcomes and experiences through increased access to electronic personal health information across the health system. Therefore, we examined the current landscape of access to electronic personal health information across several sociodemographic and socioeconomic subpopulations across Canada.

Approach

We used data from the 2023 Canadian Digital Health Survey, a cross-sectional survey of 10,130 Canadians aged 16 and older. The survey collected information on the adoption of digital health services, including access to electronic personal health information (PHI), along with sociodemographic, socioeconomic, geographic, health-related, and digital factors. These characteristics were used to define equity stratifiers. A comparative descriptive analysis was conducted, calculating summary statistics (proportions and odds ratios) for PHI access across the defined strata. Post-survey demographic weights from the 2021 Census were applied to ensure representativeness of the Canadian population. Statistical significance was tested at the 5% level.

Results

Access to electronic PHI varied across health-related factors: (1) respondents with a regular healthcare provider (HCP) were more likely to access electronic PHI than those without one (42% vs 25%); (2) access was more common among those with a chronic illness (45%). For sociodemographic determinants: (1) those aged 65 years and older reported highest access to their electronic PHI (48%); (2) urban Canadians had higher access relative to rural/remote populations; (3) Female identifying respondents had increased access (43%). Regarding socioeconomic factors: Canadians accessing electronic PHI increased with household income and education level. Finally, for digital factors, accessing PHI increased with digital health literacy (40%) and doubled with virtual care experience (52% vs. 24%). All stratifiers were found statistically significant at the 5% level.

Conclusion

The prioritization of equity in digital health solution design, deployment and use is required to support electronic access to personal health information. Improved access to electronic personal health information is key to fostering patient engagement which, in turn, enables better health outcomes through active patient partnership with their healthcare providers.

An international comparison of community attitudes towards health data use

Presented by: Julia Burt

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Background and Objectives

Social licence refers to ongoing community acceptance and support for an activity or enterprise. Studies in Canada and internationally show public support for health data use that delivers public benefit under certain conditions. Social licence can evolve with shifting public expectations. Here, we aim to explore approaches to monitoring community attitudes towards health data use, and how social licence may differ, across different populations.

Approach

In Canada, diverse members of the public participated in facilitated dialogues to explore whether they could come to consensus on i) supported uses of health data and i) essential requirements for health data social licence.

In Australia, national surveys and citizens' juries were conducted to understand i) attitudes towards private sector data use and ii) ethical, legal and social implications of using general practice data in research.

Follow-up workshops were held with Canadian, Australian and international participants to build on this work, exploring factors that may impact community acceptance of health data use and innovative methods for monitoring social licence.

Results

Despite the different approaches taken, many conditions for community acceptance of health data use were similar across Canadian and Australian participants. Both groups agreed on conditions for health data social licence related to equity, governance, privacy, and transparency. However, there was a stark contrast between levels of support for private sector data use, personal control and consent.

Factors likely to impact community acceptance of the use of health data in research as identified by workshop participants included data breaches and security, the role of government and policy, artificial intelligence and social media. Select recommended methods for monitoring social licence included the establishment of a national, citizen-designed Public Advisory Group, and the implementation of ongoing "pulse check" surveys at different points of health care.

Conclusion

This exercise contributes valuable insights into the dialogue surrounding community attitudes towards health data use globally. Continued research on community acceptance of health data use across populations, as well as effective monitoring methods, is imperative for public trust while gaining full benefits from health data use in research.

Career Outcomes of Graduate Programs in Health Services and Policy Research: A Scoping Review

Presented by: Karli Chalmers

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Background and Objectives

There is an increasing number of graduates from master's and doctoral programs globally, including those in health services and policy research. This highlights the need to understand career trajectories to improve program design and enhance career readiness. This scoping review will synthesize existing literature to identify the sectors, career paths, roles, and overall satisfaction of graduate students within health services and policy research to identify knowledge gaps and offer recommendations to improve graduate programs.

Approach

A comprehensive database search on Ovid MEDLINE, Scopus, and Web of Science, as well as grey literature will be conducted. No restrictions will be placed on the study design, geographic location, or publication date. Inclusion criteria include articles identifying the career outcomes of research-based graduate programs (master's and/or doctoral) in the health services and policy research field. Professional degrees, including nursing, medicine, dentistry, and allied health will be excluded. Data extraction will include employment industry, roles, and information about career path (e.g., satisfaction, change in field). Results will be disaggregated based on master's and doctoral degree, where possible.

Results

Our findings will identify career endpoints of research-based graduate programs in the health services and policy research and levels of career satisfaction. These results will provide current graduate students with insight into potential career paths. Preliminary results suggest that graduates are employed in sectors such as academia, public health, and healthcare delivery within the public and private sector. Common positions include professorships, policy analysts, program evaluators, researchers, and leadership roles. Notably, existing literature focuses more on master's degrees in public health and doctoral degrees than on master's degrees in health services and policy research. By highlighting these gaps, we aim to guide future research on career outcomes and provide recommendations on how graduate programs can better support students as they transition into the workforce.

Conclusion

This scoping review will provide an in-depth understanding of the diverse career outcomes of graduates of research-based graduate degrees in health services and policy. The results will provide insights into graduate program development, employment opportunities and career satisfaction, and will highlight areas to guide future research.

Critical Review of the Sensory Processing and Occupational Therapy Literature

Presented by: Corrine Clyne

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Background and Objectives

Occupational therapy assessment and interventions for children with sensory processing differences are vital in occupational therapy. These occupational therapy assessment and interventions are founded from a Western worldview which often lack cultural relevance for First Nations families. Utilizing a Cree worldview, this review will critically examine sensory processing literature specific to pediatric occupational therapy, theory and practice to determine the current approaches used in this area.

Approach

This review will use a critical interpretive synthesis to examine professional occupational therapy guideline documents, pediatric occupational therapy practice websites and peer-reviewed literature from the American Journal of Occupational Therapy (AJOT) and the Canadian Journal of Occupational Therapy (CJOT). Inclusion criteria will focus on literature specific to pediatric occupational therapy practice for sensory processing in North America, and in English. After screening, five articles will be randomly chosen from each category of assessment, intervention, or theory for in-depth review. A research team will meet once chosen articles have been read to discuss what theories have emerged.

Results

A modified PRISMA diagram of the screening will show the breadth and depth of information on occupational therapy and sensory processing currently available and descriptive information about the documents selected for review. The results will be a thematic synthesis developed from the critical review questions and ensuing discussions by the research team. It is anticipated that this analysis will reinforce that theory and practice on sensory processing is based on and developed from Western thought and theory, without considering Cree perspectives. This knowledge will be used to help develop more culturally relevant approaches for occupational therapy sensory processing practice to better serve First Nation Peoples and communities.

Conclusion

This critical review will determine the current theoretical underpinnings of sensory processing in pediatric occupational therapy in North America. It will be a catalyst for moving towards culturally safer occupational therapy practices for First Nation communities and people.

Eating Disorders in Gender Minoritised Youth: Clinician Bias and Other Barriers to Equitable Care

Presented by: Jennifer Coelho

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Background and Objectives

Amid a growing body of literature highlighting disparities in eating disorder care for 2SLGBT+ youth, this project is the first to quantitatively assess how a young person's gender biases the diagnostic and treatment decision clinicians make when working with youth with ED symptoms. It further explores to what extent these decisions may be influenced by implicit associations between eating disorders and feminine gender identity, a stereotype perpetuated throughout ED literature, clinical practice, and society.

Approach

120 Clinicians working with young people with eating disorder symptoms will complete the study. To examine potential biases in ED assessment and treatment approaches, an Implicit Association Test is used, measuring clinicians' implicit and explicit associations between different genders and aspects of eating disorder symptomology. Additionally, the study involves a quantitative vignette design, with youth gender as key variable. It further incorporates a demographic assessment, including questions on clinical practice (specialist vs generalist), and location (urban vs remote/rural). We are engaging with Youth Patient Partners (young people of all genders with lived experience of disordered eating) in the development of the protocol and stimuli.

Results

Results from this study will improve eating disorder care for young people from marginalised genders by measuring implicit and explicit biases in clinicians who assess and treat ED.

Specifically, it assesses the diagnostic and treatment decisions clinicians make when presented with clinical information for TGD individuals, and whether these differ from the assessments of their cisgender peers. Additionally, the study will examine clinicians' implicit associations between youth gender presentation and eating disorder diagnoses and how these relate to the diagnostic and treatment process. Research findings will be used to develop a clinician training module which will be implemented across BC and the Yukon via the CIHR-funded Provincial Eating Disorder Training Hub.

Conclusion

Findings from this study will advance our understanding of treatment barriers faced by 2SLGBT+ youth, providing tangible targets for further research and system change. Subsequent development of a clinician training module will improve ED care for young people across BC and the Yukon, with further transferability and applicability to the mental health workforce throughout Canada.

Aging, healthcare utilization and residential mobility in Canada

Presented by: Ana Collares

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Background and Objectives

A small portion of health care users utilize a high proportion of the system's resources. Older age and rural living are identified risk factors for using more health resources. Despite inequities in availability of health services in rural areas, older adults tend to migrate to these areas. This research investigates the impact of increased use of health resources by older adults in rural areas on their probability of migrating/relocating towards less remote areas.

Approach

Data comes from Statistics Canada's 2016 Canadian Community Health and Environment Cohort (CanCHEC). Respondents from the 2016 Population Census who were 65+ years old, living in non-metropolitan areas, were linked to their reported inpatient healthcare experiences through the Discharge Abstract Database to measure frequency of hospitalizations, and to a historical postal code file providing annual residency from 2013-2019, to measure migration/relocation experiences. The change in rurality upon move was measured by a remoteness index (Statistics Canada). A survival analysis was employed to assess the impact of frequency of hospitalizations on the probability of relocating to less remote areas of Canada.

Results

Preliminary results show around 15% of community dwelling older adults migrated both across census subdivisions and interprovincially between 2011 and 2016. Controlling for home ownership, family arrangements, and sex, older adults with a higher number of hospitalizations were more likely to relocate across census subdivisions, and more likely to migrate from more remote to less remote areas of Canada. The rate in which older adults relocated to less remote areas over time given the average number of urgent hospitalizations was positive and significant. Urgent hospitalizations have a higher impact than routine hospitalizations, and although those 75+ years of age relocate less, they are more likely to migrate to less remote areas given more frequent hospitalizations than those between 65-74 years of age.

Conclusion

Preliminary outcomes indicate that health-related issues have a measurable impact on older adult's migration towards urban areas, contrary to their known trend of rural migration. Results suggest that some of the most vulnerable among this group, those without home ownership and nearby family support, are the most likely to move.

Clinical and Economic Evaluation of a Hybrid Virtual Primary Care Program in Rural Ontario

Presented by: Shawna Cronin

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Background and Objectives

Canada currently has a worsening shortage of family physicians that disproportionately affects rural areas. Integrated Virtual Care (IVC) aims to attach unattached individuals and offers comprehensive, physician led, team-based primary care, available either in-person or virtually. The objective of this study is to describe the characteristics and health utilization of individuals in the IVC program and compare them with attached and unattached individuals in the same region of IVC and in Ontario.

Approach

This study is set in Renfrew County, Ontario. We will conduct a retrospective cohort study using data collected from IVC electronic medical records linked to other health administrative databases. We will use frequencies and chi-square tests to describe and compare the demographic and health utilization variables of IVC participants and other unattached individuals during fiscal year 2018/19. Emergency department use, hospital use, and costs for participants during the first year of IVC program enrollment (between 2021-2023) will also be compared to individuals in the same region and in Ontario.

Results

Descriptions of IVC participants and their health use prior to joining IVC will be reported and compared to others within the same geographic area, and Ontario. Hospital, ED use, and costs for the first year of the program will be shared.

Conclusion

Understanding the profile of IVC participants can inform program adaptations to better meet the unique needs of participants and the region. Quantifying how the health use of IVC participants compares to other models can help to inform program spread and support the use of the IVC program in other regions.

Implementation of Indigenous- Focused Research in an Integrating Health System (Work in Progress)

Presented by: Shawna Cronin

Author(s): *Roy, Amrita Queen's University*

Background and Objectives

Integrated care systems, including Ontario Health Teams (OHTs), are working to incorporate more equity focused approaches into their systems and program planning. Research and knowledge exists regarding how to improve health services accessibility and approaches for Indigenous individuals and communities; however, OHTs have seen little implementation of these practices. The objective of this study is to describe the implementation process of Indigenous-related research projects in an OHT in southeastern Ontario.

Approach

Using a single, descriptive case study approach and guided by the EPIS (Exploration, Preparation, Implementation, and Sustainment) framework, we will undertake a collaborative process to advance evidence from three separate research projects conducted in collaboration with the OHT and local Indigenous partners This work focused on improving access, collaboration, approaches, and evaluation for Indigenous peoples' health. We will first describe and contextualize the evidence to be implemented, and then collaboratively prepare a plan for implementation. Guided by an advisory group of Indigenous individuals both involved with the OHT, and with lived experiences, approaches to implementing new practices will be co-designed.

Results

Promising practices, improvements to collaboration with Indigenous partners, and approaches to governance, programs for aging, palliative care, in addition to evaluation indicators will be incorporated into the implementation plan, and consultation will be pursued. Narrative descriptions of each stage of the EPIS framework will be reported, in addition to descriptions of the number of new practices considered at each stage of the process, and of decision making. Brief quantitative and qualitative survey feedback from meetings with OHT leadership, OHT partners, and Indigenous partners will be compiled and shared. A brief plan to evaluate the implementation of these approaches to care will also be completed.

Conclusion

Describing the process of implementation of Indigenous-focused research in integrated care is relevant for models of integrated care that emphasize the incorporation of equity-focused and Indigenous-focused advances. This work also has implications for integrated care systems leveraging a learning health system approach.

Mirou Jaana Navigating Complexity in Long-Term Care: Challenges and Opportunities for Transformative Change

Presented by: Danielle Cruise & Mirou Jaana

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Background and Objectives

Long-standing challenges exist within the long-term care (LTC) system (e.g., physical/emotional residents' suffering, staff burnout, long wait times) that were further exacerbated by the COVID-19 pandemic. These present stressors on the healthcare system leading to high costs (e.g., $949 per resident/day for unnecessary hospitalizations (Canadian Medical Association, 2017)). This research presents the results of a descriptive review on the Ontario LTC system and analyzes its state to inform future initiatives/policy changes.

Approach

A literature review (OVID Medline and Google Scholar) was conducted to inform a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. A total of 51 articles were reviewed. Strengths (i.e., assets and competitive advantages), weaknesses (i.e., areas of improvement or underperformance), opportunities (i.e., external factors that can be exploited), and threats (i.e., external challenges and risks that may negatively impact performance) were extracted from the articles to provide key insights into the current state of Ontario's LTC system. Each of the identified dimensions in the SWOT matrix were evaluated and prioritized to develop actionable insights and recommendations.

Results

In Ontario, 627 LTC homes with 76,000 beds (16% publicly owned; 57% private for-profit; 27% private not-for-profit), employ 100,000 staff, and account for 7% of the health care budget ($6.8 billion). Strengths relate to the skilled/diverse healthcare professionals providing 24-hour nursing care for residents. Weaknesses include staffing shortages/burnout, placement wait times (average 201 days, over 45,000 people on the waitlist), and adequacy/quality of care (limited information available on residents). Virtual care, innovations, and person-centered programs present opportunities to provide timely access to medical care meeting the residents/caregivers' needs/preferences. Disease outbreaks (e.g., COVID-19 outbreaks), labour shortages (e.g., additional $1.8 billion needed for staffing), increasing residents' care needs (e.g., chronic conditions/dementia), and regulation changes (e.g., increasing LTC homes operating costs without receiving additional funding) are threats that must be proactively addressed.

Conclusion

The Ontario LTC system demonstrates an established infrastructure that can be leveraged for expansion to meet the increasing aging population needs. Benchmarking against successes in non-health care sectors that leveraged innovations/technologies to support scaling up may be beneficial. Policies should be informed by internal/external factors/changes in this environment.

Supporting the Evaluation of Patient Engagement in Ontario Health System Organizations

Presented by: Andrea Dafel

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Background and Objectives

Patient engagement has become a common practice across health system organizations, yet there is limited evidence of health system organizations bringing robust evaluation to their engagement work. Evaluation is essential to identify effective engagement practices, understand how methods can be adapted to different contexts, explore patient partner experiences, and address barriers to engagement. We explored challenges health system organizations face in evaluating their patient engagement initiatives and enablers that foster effective evaluation practices.

Approach

32 semi-structured interviews were completed with individuals working in diverse roles across various health system organizations in Ontario such as Ontario Health Teams, hospitals, mental health, senior health, and home and community care organizations. Participants were recruited via email, and purposive sampling ensured maximum variation in participants. Interviews lasted 30–60 minutes and explored topics such as approaches to and methods for evaluating patient engagement initiatives, challenges associated with evaluation, supports required to foster evaluation, and organizational culture related to continuous learning and improvement. Interviews were recorded, transcribed verbatim, and inductively coded.

Results

Preliminary findings identified several key themes. The first theme was challenges in evaluating patient engagement, including hesitancy, limited patient partner capacity, and resource constraints like time, funding, and personnel. A second theme was the lack of formal planning for evaluation. Few organizations had formal evaluation plans, often relying on informal methods like casual check-ins for feedback. A third theme was the need for organizational supports to foster evaluation efforts. Participants highlighted the value of evaluation training, staff with evaluation expertise, and senior leadership support. Lastly, organizational culture was identified as a significant influence on evaluation. Participants highlighted the importance of a culture that values openness to change, continuous improvement, and collaboration with quality improvement staff to enable more effective evaluation efforts within health system organizations.

Conclusion

Health system organizations face significant challenges in evaluating patient engagement, with few having robust evaluation frameworks. Addressing these gaps requires training, dedicated resources, leadership support, and formalization of evaluation methods. Strengthening evaluation capacity is crucial for fostering meaningful patient partnerships and advancing continuous learning and improvement in health system organizations.

Voices Beyond the Margins: Indigenous Patients' Experiences with Accessing Mainstream Healthcare

Presented by: Suha Damag

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Background and Objectives

Indigenous Peoples in Canada face ongoing inequities in accessing healthcare services, often marked by systemic barriers and cultural insensitivity. These disparities are not merely statistical; they are deeply personal and reflect the lived experiences of patients. Understanding patient access experiences, including emotional and physical interactions within the healthcare system, is crucial for addressing these inequities and fostering culturally safe, patient-centred care. This study aimed to synthesize evidence on patients' experiences and their recommendations for improvement.

Approach

This systematic review used meta-aggregation to synthesize qualitative studies on Indigenous patients' experiences accessing mainstream healthcare services in Canada. Eligible studies explored firsthand or second-hand experiences and were identified through comprehensive database searches. The project was guided by an Indigenous advisory committee and experts in systematic reviews and Indigenous health and forms part of a multi-methods PhD project on Indigenous patients' experiences of accessing healthcare services. Findings were categorized into themes and synthesized to provide actionable insights. Screening, data extraction, and quality appraisal were independently conducted by two reviewers, with disagreements resolved through discussion or consultation with a third reviewer.

Results

Preliminary findings revealed a complex narrative of resilience and frustration in Indigenous patients' access to mainstream healthcare in Canada. Emotional and physical interactions with healthcare providers were pivotal, with stories of warmth and culturally safe practices contrasting sharply with accounts of discrimination, cultural insensitivity, and systemic neglect. Trust, empathy, and cultural understanding were identified as transformative, while their absence caused significant harm. Patients emphasized the need to integrate Indigenous perspectives and cultural practices, enhance cultural safety training for providers, and build trust-based relationships. Recommendations called for prioritizing cultural competency and inclusivity, addressing systemic barriers to foster equitable care, and creating a healthcare system that centers and respects Indigenous voices.

Conclusion

Transforming healthcare systems to prioritize cultural competency and inclusivity is vital for improving Indigenous patients' experiences and fostering equitable care. Centering Indigenous voices and creating inclusive healthcare environments are key steps. Our goal is to inspire healthcare organizations to create environments that build trust, respect, and truly patient-centered care for all.

Fostering Frontline Resilience: Insights on Supports for Nurses' Health and Well-Being

Presented by: Suha Damag

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Background and Objectives

Frontline nurses are the backbone of healthcare systems, yet their health and well-being are often overlooked. Collegial, supervisory, and organizational supports are essential for fostering resilience, mitigating stress, and creating environments that promote self-care and individual agency. This study explores how these supports, from peer interactions to organizational structures, nurture nurses' health, promote self-care and cultivate a culture of well-being, ensuring that nurses not only survive but thrive in their vital roles.

Approach

This mixed-methods study includes a qualitative phase with 20 semi-structured interviews with frontline nurses in Southern Alberta. Participants shared experiences related to peer, supervisory, and organizational supports, revealing key factors influencing their health and well-being. Thematic analysis was conducted to identify key themes and actionable insights. The quantitative phase is currently being developed, using a survey to validate and quantify findings across a larger population of nurses. This comprehensive approach integrates rich qualitative insights with measurable data to provide a nuanced understanding of workplace supports and their impact on nurse health and well-being.

Results

Results from the qualitative phase of our study underscore the important role that co-workers play in supporting nurses' health and well-being through task-sharing, emotional check-ins, and caring gestures, such as assisting with workloads or providing encouragement during stressful times. Nurses highlighted how these interactions foster shared values that promote healthy self-care habits and behaviours. Supervisory support was highly valued, particularly when supervisors encouraged self-care participation, maintained open communication, and actively addressed workload challenges. At the organizational level, timely responses to health-related concerns, improved communication, and resources such as ergonomic tools and wellness programs were seen as critical in creating environments that encourage self-care and individual agency. Ongoing quantitative analysis will expand on these findings, providing a broader context for developing actionable strategies to foster nurses' well-being.

Conclusion

Nurturing frontline nurses with tailored support systems is essential for addressing workforce challenges and improving health system performance. By fostering shared values of self-care and resilience through collegial, supervisory, and organizational support, healthcare organizations can create environments that empower nurses, enhance their well-being, and ultimately improve patient care outcomes.

The Development of the NExT Network: Who We Are, What We Do, and Why It Matters

Presented by: Megan Davies

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Background and Objectives

The Network for Early Career x Trainee Researchers (ECRs) in youth mental health (NExT; established 2024), offers an innovative solution to dismantle the barriers to collaboration that ECRs face. Through its peer-led structure that emphasizes collaboration, shared leadership, mentorship, and capacity building, NExT supports ECRs in addressing system challenges in youth mental health. This presentation describes the development, goals, and accomplishments of NExT to demonstrate the value of peer-led ECR networks in health system improvement.

Approach

NExT's peer-led model represents a shift from conventional research networks that emphasize individual achievement. By prioritizing relationships and collective impact, this network creates opportunities for ECRs to co-lead projects, develop grant applications, and author publications collaboratively. NExT creates an inclusive, respectful, and supportive environment where diverse perspectives foster innovation and dismantle silos across research areas, institutions, and settings. Our collaborative approach builds ECRs' capacity to address complex challenges in youth mental health and shifts the focus toward valuing co-creation and shared successes alongside traditional research metrics.

Results

NExT's growth to 49 members across 8 Canadian provinces/territories, from over 35 institutions, highlights the necessity and success of our model. To date, NExT has co-developed a CIHR grant application, commentaries, presentations and events. Through monthly meetings and asynchronous online collaboration platforms, members have built capacity leading and co-developing projects across institutions, supported by peers and senior research mentors. During NExT's 2024 kick-off event enabled by a CIHR Catalyst Grant and the Canadian Collaborative Mental Health Care Conference, key system gaps were identified and shape the network's research priorities for improving youth mental health. NExT is now focused on operationalizing these priorities, strengthening collaborative relationships and processes, and increasing the sustainability and impact of the network on ECRs and the health system.

Conclusion

NExT embodies a transformative peer-led approach to empower ECR collaboration. The network breaks down traditional barriers while building capacity, leadership and mentorship support for interdisciplinary research and collective impact in youth mental health. NExT's early successes demonstrate the potential for peer-led networks to drive meaningful change and address complex system-level challenges.

Data communication methods to inform clinical decision-making: A scoping review

Presented by: Alannah Delahunty-Pike

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Background and Objectives

Strategies to leverage data for point-of-care decision-making vary for hospital frontline healthcare workers (HCWs) and administrators. Data communication strategies such as data dashboards and other real-time or near real-time tools have become prominent over the past five years. This scoping review explored strategies and tools used by HCWs and administrators to communicate and/or access data in real or near-real time to inform decision-making at the point-of-care in acute care hospital settings

Approach

This scoping review used JBI methodology and included studies and program descriptions. A library scientist designed and executed the search using MEDLINE with keywords: real-time data prompts, alerts, feedback, dashboards, other visualizations, combined with keywords related to acute care hospital setting. The search included MEDLINE, Embase, CINAHL, and APA PsycInfo databases. A grey literature search was not conducted due to the low likelihood of finding published studies. Titles, abstracts, and full texts of included studies and program descriptions were screened by two independent reviewers. Data extraction was conducted by one reviewer and verified by a second.

Results

Title and abstract screening was conducted for 2,503 sources, with 163 eligible for full-text screening. A total of 32 studies and program descriptions underwent data extraction. Dashboards were the dominant strategy used for data communication across most of the studies and program descriptions and the dominant target population was clinicians. Primary outcomes extracted included clinical (e.g. patient); process (e.g. rates of screening); safety (e.g. medication errors); healthcare worker (e.g. experience providing care with tool); and system level (e.g. improved workflow). While administrators were included in a few studies and program descriptions, patients were not included. The rationale for tool choice and design were rarely reported.

Conclusion

The use of real or near real-time data in acute care hospital settings can support system improvement for HCWs and administrators and has the potential to provide more equitable care for patients. More standardization in how acute care settings use their data to inform decision-making at the point-of-care is required.

Effectiveness Results from the CanCEASE Pilot Randomized Controlled Trial

Presented by: Émile Diamant

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Background and Objectives

Fifteen percent of Canadian children are exposed to household secondhand smoke. Clinical Effort Against Secondhand Smoke (CEASE) is a clinic-based intervention that systematically screens parents for tobacco use and facilitates access to evidence-based cessation services. In the United States, CEASE has been shown to be effective and cost-efficient when targeting parents that smoke. We tested CanCEASE, a version of CEASE expanded to included adolescents and e-cigarette users, adapted for the Canadian healthcare setting.

Approach

This study was a single-blind pilot randomized controlled trial (RCT), comparing CanCEASE to usual care. Parents of children 0-17 years old and adolescents aged 14-17 years were eligible if they reported smoking or using e-cigarettes during the past 7 days. Consumption behaviors were evaluated at baseline and at a 1-, 3- and 6-month follow-up through a web-based survey. Our primary outcome was self-reported smoking or vaping cessation, defined as declaring having quit smoking or vaping for at least 7 days at any of the follow-up timepoints. Secondary outcomes included quit attempts and decrease in consumption at 6-month vs baseline.

Results

We recruited 53 adolescents and 74 parents and obtained follow-up data on 45 adolescents and 67 parents, who were included in final analysis. Observed clinic-level vaping and smoking prevalence were 20% [95%CI 15.6-25.3] and 7.9% [95%CI 5.1-11.8] among adolescents and 8.1% [95%CI 6.1-10.7] and 14.6% [95%CI 11.9-17.9] among parents, respectively. Parents in the intervention group were 7.6 [95%CI 1.3-46.5] times more likely to report cessation at least once over the study period and 2.4 [95%CI 1.1-5.8] times more likely to have decreased their consumption at 6-month follow-up than those in the control group. Adolescents in the intervention group were not significantly more likely to report cessation or to decrease their consumption.

Conclusion

In this study, parents who received the intervention reported significantly better use-related outcomes than those who did not, suggesting that CanCEASE could be effective at helping parents quit smoking or vaping. Future phases will include refining CanCEASE for adolescents, and a multicentric RCT assessing its effectiveness through biologically confirmed cessation.

Simplifying the hepatitis C treatment pathway improves SVR achievement among people who inject drugs

Presented by: Katerina Dolguikh

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Background and Objectives

In October 2020, Alberta expanded access to hepatitis C virus (HCV) treatment by allowing family physicians, in addition to specialists, to supervise treatment with direct-acting antivirals. This simplifies the treatment pathway, which is particularly impactful for populations facing stigma and social barriers to care, including people who inject drugs (PWID). This study aimed to evaluate the impact of this change on successful treatment completion among people who do and do not inject drugs.

Approach

This study used linked hospitalization, emergency department, pharmacy, and laboratory data from Alberta Health Services. A cohort of adults treated for HCV with direct-acting antivirals between 2017 and 2021 were identified and followed for ≥ 1 year until March 31, 2023. The cohort was characterized in terms of demographics, acute care utilization, and substance use. PWID were identified using a validated case definition. Successful treatment completion was defined as achievement of sustained virologic response (SVR). To assess the effect of the policy change on treatment completion , an interrupted time series analysis was conducted using a quasi-Poisson model.

Results

We identified 5,545 adults treated for HCV in Alberta during the study period (36% female, 20% rural). Of these, 1,169 (21%) were identified as PWID. Among those eligible, 66% of PWID and 85% of non-PWID successfully completed treatment. The number of those initiating treatment increased through 2017 and began declining through 2021. While most completed treatment, this proportion also steadily declined over time. In the interrupted time series analysis, there was a 39% (95% CI 16-66%) immediate increase in treatment completion among PWID following the October 2020 policy change, but no lasting effect was observed (IRR 0.97; 95% CI 0.89-1.04). No immediate (IRR 0.97; 95% CI 0.84-1.12) nor lasting (1.01; 95% CI 0.98-1.05) change was observed for people with no indication of injection drug use.

Conclusion

The main benefit of allowing family physicians to supervise HCV treatment was for PWID, despite the change not being targeted at them directly. Simplifying the treatment pathway for all patients may be an important step toward health equity through removing barriers to care that most affect underserved patients.

Medicolegal collaboration on advance care planning: aligning practice to reality

Presented by: Maureen Douglas

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Background and Objectives

Although Canadians believe advance care planning (ACP) is important, it often fails to influence decision-making in healthcare settings, lawyers lack understanding of healthcare realities, and healthcare providers struggle with advance directive validity and decontextualized instructions. Researchers and practitioners advocate for multi-sectoral collaborations to improve understanding and uptake.

To maximize the potential of ACP to improve quality of care, we implemented our medical-legal collaborative framework to overcome professional siloes, identify gaps, and jointly develop best practices.

Approach

In 2013, as part of an Alberta ACP research program, we launched a collaboration of health, law, government, academia, and patient advocates to clarify legal and health care roles in ACP, and guide activities.

Data and feedback from surveys of lawyers and Albertans, joint workshops, stakeholder interviews, and literature reviews provided an understanding of attitudes, barriers, needs, complaint trends, and practices.

In our second phase, with input from focus group participants and subject-matter experts, we jointly developed practice principles, a legal practice guide, and a course for lawyers ("Aligning Practice to Reality"), delivered in partnership with the provincial legal education provider.

Results

Rates of engagement were substantial: 53 lawyers registered for the course and 26 participants from health (policy, practice), law (public, private), the Public Guardian, social work, and ethics, co-drafted practice principles. Strategic advice, endorsement, and content expertise from multi-sectoral leaders established credibility and attracted participants.

Evaluation results confirmed the course's quality (e.g. "extremely informative and educational") and impact ("I can seriously improve my service to my clients," "I will revise my precedent Personal Directive and my instructions to my clients"). The course and guide remain accessible to 10,000 lawyers.

In March, we will host a province-wide Medical-Legal Symposium on ACP to share perspective and map concrete approaches, including co-developing guidelines for advance directives to improve their usefulness in health care settings.

Conclusion

A multi-sectoral collaboration between researchers, medical practitioners and lawyers co-designed a new course and valuable resources to improve understanding and engagement in ACP. This novel collaboration fostered understanding and motivated practice change by lawyers, who support clients and substitute decision makers with ACP, better aligning practices to clinical reality.

Evaluating Compassionate Communities public awareness initiatives: a comprehensive framework

Presented by: Maureen Douglas

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Background and Objectives

Raising awareness of palliative care and advance care planning is essential to better prepare people for living with serious illness, dying, caregiving and grieving. A multi-year, multi-sectoral Compassionate Communities initiative was undertaken to increase public awareness and understanding of palliative care and advance care planning in Alberta, Canada. An evaluation framework was developed with the objectives of determining program effectiveness and contributing to best practice and knowledge on evaluating Compassionate Communities public awareness initiatives.

Approach

The initiative (branded Compassionate Alberta) ran from 2020 to 2025. We began by reviewing the literature to identify relevant framework(s) to guide our evaluation. Key informant interviews were held with stakeholders to solicit feedback on the selected evaluation framework(s) and proposed measures. A logic model was developed to synthesize the goals, inputs, audience, activities, and anticipated outputs of the public awareness initiative. Data collection is ongoing until September 2025.

Results

We adapted the Healthy End of Life Program (HELP) Evaluation Framework to guide our process evaluation, based on its public health palliative care approach to evaluation, health promotion principles, and focus on community development. We adapted the Australia Palliative Care Evaluation framework to guide our outcome evaluation, to capture impacts on ‘consumers’, ‘providers’, and the ‘broader care delivery system’. Outcome measures were adopted or adapted from validated tools where available and appropriate; new measures were developed to assess domains lacking validated tools. Our process measures indicate we have created change in six of the eight HELP domains (People, Programs, Participation, Practice & Practitioners, Place, Partnerships); outcome data collection suggests our tools are improving knowledge of and attitudes toward palliative care and advance care planning.

Conclusion

The evaluation of Compassionate Communities initiatives is a relatively new area of study. We have successfully adapted evaluation frameworks for comprehensive evaluation of a Compassionate Communities initiative, and this approach may prove useful for similar public awareness programs.

Evaluating How Readiness for Change Influences Quality Improvement Innovations

Presented by: Malcolm Doupe

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Background and Objectives

Implementation science (IS) seeks to enact sustainable innovations in complex settings. While experts define readiness for change (R4C) as core IS step more knowledge is needed to operationalize this construct, to properly assess team members' preparedness to commence IS initiatives, and to evaluate if time-consuming R4C activities promote greater implementation success. This presentation will describe the processes used to incorporate key R4C activities into an IS initiative and will evaluate the effectiveness of this process.

Approach

This Manitoba-based research was co-designed by researchers/planners to help nursing homes (NHs) improve resident care. The literature identifies that, before implementation, R4C activities should assess/promote care context plus change efficacy and valence at macro, meso, and micro-levels. R4C activities were thus created to (i) ensure that NH care directors could convey project benefits and use evidence-based criteria to select participating units, (ii) help unit managers create/support effective front-line teams, and (iii) foster ownership amongst these teams. Following feasibility tests, refined R4C activities were integrated into a larger innovation where teams, with support, used PDSA cycles to enact their change ideas.

Results

Nine NHs participated in the full innovation that lasted 8 months equally divided into R4C and implementation activities. Guided by the Holt et al (2007) and Shea et al (2014) scales, front-line team members assessed their personal readiness, and that of their managers and organization, at the beginning, middle and end of the implementation phase. While 80+% of each front-line team agreed that their managers and organizations were ready for the innovation at baseline, person-level readiness varied considerably at this time (90+% of two teams felt they were ready for the innovation versus 70% of two teams). R4C scores did not change considerably during implementation, and teams with the highest baseline R4C scores had greater implementation success. End-of-study team-specific focus groups further explain these findings.

Conclusion

While time consuming, R4C activities can lead to more rapid implementation success, and conversely, teams that feel less R4C are generally less successful. Findings highlight the importance of selecting and preparing team members to engage in complex change innovations, and potentially for creating targeted support strategies based on R4C scores.

Factors that Promote Effective Clinical-Administrative Co-Management Practices in Primary Care

Presented by: Savannah Dubé

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Background and Objectives

In recent decades, healthcare organizations in Canada have increasingly adopted governance models of co-management in which clinicians and health administrators work together to manage the clinical and administrative functions of their organizations. Yet, little is known about the conditions necessary for optimal co-management practices in primary care settings. This study aimed to identify factors that promote effective co-management practices in the context of Quebec's Family Medicine Groups (FMGs), where various co-management models co-exist.

Approach

We conducted a multiple case study involving 7 Family Medicine Groups from 3 health regions in Quebec. Family Medicine Groups were purposefully selected to be diverse in terms of funding models, academic affiliation and size. A total of 37 individual or group semi-structured interviews were conducted with 41 key actors (e.g., medical directors, administrative managers, clinical team members) involved in the management of these clinics. Participants were asked to share their perspectives on the factors that contributed to effective and sustainable co-management practices. The data was analyzed using a deductive-inductive thematic analysis approach, supported by NVivo.

Results

A total of 27 factors were identified across four levels: individual, relational, organizational, and systemic. At the individual level, 9 factors were identified, including knowledge of the primary care system, integrity, transparency, and a collaborative leadership style. The relational level also encompassed 9 factors, namely adaptability, clearly defined roles, and effective communication. At the organizational level, 3 factors were noted, i.e. a culture of collaboration, physical spaces for collaboration, and projects requiring collaboration (e.g., strategic planning processes). Finally, at the systemic level, 6 factors emerged, including remuneration and incentive systems aligned with collaborative practices, policies fostering co-management, and inter-organizational coherence and partnerships.

Conclusion

These findings provide novel insights into the factors and conditions for promoting effective clinical-administrative co-management practices in primary care settings that can, in turn, potentially enhance the performance of primary care teams.

Spatial variations of healthcare offer and use of over 65 aged people in Quebec from the CLSA cohort

Presented by: Juliette Duc

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Background and Objectives

Health needs of aging individuals are increasing and becoming more complex, requiring appropriate healthcare services to maintain their life quality. In Quebec, the availability of healthcare services and population needs vary by region, influencing access to care and service utilization. This study explores the relationship between the healthcare offer and utilization among aging populations.

Approach

Data from the Canadian Longitudinal Study on Aging (CLSA) were analyzed for 2,506 Quebecers aged 65 and over living in Montreal and Sherbrooke, using R and QGIS software. An ascending hierarchical clustering algorithm, a machine learning (ML) technique, identified and characterized typical healthcare utilization profiles based on similarities in individuals' use of healthcare services. Spatial analyses (GIS) were used to map these profiles according to the healthcare services availability in individuals' environments, their health conditions, and levels of urbanization and deprivation.

Results

Four distinct healthcare utilization profiles were identified. Profile 1, representing most participants (n = 2,172), included individuals who received formal home care and had interactions with the healthcare system. Profiles 2 and 3 represented varying degrees of healthcare system interaction, with Profile 2 specifically associated with a history of falls. Profile 4 was distinguished by exclusive use of formal home care services. Results are presented using maps, showing the geographical distribution of individuals by utilization profile and healthcare facilities in their surroundings.

Conclusion

This exploratory study highlights the potential of combining AA and GIS tools to examine variations in healthcare utilization. These methods are adaptable to other Canadian provinces using CLSA data. This project aims to improve the understanding of factors influencing healthcare utilization, ultimately contributing to improved care for older adults.

Oral health of humanitarian migrant children: A discourse analysis of Canadian health policy

Presented by: Olawale Dudubo

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Background and Objectives

Humanitarian migrant children (child refugees and asylum seekers) arrive in Canada with oral health problems. In Canada, the Interim Federal Health Program (IFHP) includes dental services for a maximum of $1,000 per person. The dental coverage provides emergency dental services and restorative treatments for humanitarian migrant children. However, there are no child-focused provisions for children's oral health, despite the fact that children's mouths and oral health needs are different than those of adults.

Approach

For this project, we will conduct a qualitative policy analysis that aims to uncover how humanitarian migrant children are discursively framed and thus constructed in federal and provincial (Quebec) policy documents. We will use discourse analysis methodology and engage Bacchi's "(WPR) What's the Problem Represented to Be" analytical framework to critically examine the way humanitarian migrant children's oral health is represented. This framework builds on a body of post-structural scholarship highlighting how policies are not merely tools of governance but also key sites to produce meanings around social problems.

Results

This study critically examine how humanitarian migrant children are constructed by, and then attended to, via Canadian policy. Our overall goal is to build a foundation from which to better understand current empirical data regarding humanitarian migrant children's oral health and oral healthcare experiences, as well as directions for future research and policy creation. This project will advance the Migrant Oral Health Program (MOHP) research on humanitarian migrant children's oral health, building on the UN's Sustainable Development Goals.

Conclusion

This study is underpinned by childhood ethics, a theoretical frame that recognizes children as simultaneously vulnerable and as rights-holders, with capacity to participate in matters that affect them. Further, it is informed by theories of policy, which see policy as discourse, within which social issues and their solutions are constructed.

Post-COVID-19 Symptoms, Psychological Distress, & Cognitive Dysfunction in Healthcare Workers

Presented by: Elsie Duff

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Background and Objectives

The COVID-19 pandemic has profoundly affected Canada's healthcare system, especially frontline healthcare workers (HCWs). HCWs endured substantial challenges due to the increased risk of infection and extended work hours, including mental and physical strain. Little is known regarding the patterns of post-COVID-19 condition (PCC) symptoms, psychological distress, and cognitive dysfunction among HCWs. We aimed to measure self-reported metrics of PCC physical, psychological, and cognitive impacts among HCWs in Manitoba, Canada.

Approach

This cross-sectional survey explored the impact of PCC symptoms (occurred 12 weeks post-infection) among the Manitoba Health Professional Associations Coalition (MHPAC) member groups, spanning 11 diverse healthcare professions with over 20,000 potential participants. After obtaining ethical approval, healthcare and frontline workers who agreed to participate were invited to complete an online questionnaire developed using Qualtrics software. The questionnaire was then distributed through the respective professional health organizations using members-only communication, i.e., through MHPAC groups from May through July 2024. Data analysis was performed using the IBM SPSS statistics software version 29.

Results

A total of 550 frontline HCWs participated in the survey, where over one-fifth (21.6%) of the participants reported that they experienced COVID-19 symptoms lasting ≥3 months (PCC symptoms). Among those who reported PCC symptoms, fatigue (64.2%), insomnia (29.2%), headache (24.7%), arthralgia (24.3%), cough (23.8%), general weakness (23.0%), and loss of hearing (20.6%) were most prevalent PCC symptoms, respectively. Using the Kessler Psychological Distress Scale (K6), 17.2%, 10.7%, 19.1%, 8.8%, 22.9%, and 7.2% of the HCWs reported feeling nervous, hopeless, restless, depressed, effort and worthless (often & always- combined), respectively. Whereas, with cognitive dysfunction, 17.2%, 13.8%, 11.6% and 11.0% of the HCWs reported difficulty concentrating/maintaining attention, organizing oneself, forgetting things and losing items (often & very often-combined), respectively.

Conclusion

This study is the first Manitoba-based examination of PCC symptom patterns, psychological distress, and cognitive dysfunction across a wide array of geographically distributed frontline HCWs. These results will contribute significantly to understanding PCC, potentially guiding future cross-jurisdictional and national surveillance initiatives focused on workforce health and disability planning.

Standardizing Approaches to Transitions in Care Following Early Psychosis Intervention

Presented by: Janet Durbin

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Background and Objectives

Early Psychosis Intervention (EPI) is a time-limited program to help clients stabilize and continue their recovery. However, program practices to support transition are inconsistent and disengagement is a serious risk at the point of transition. While Canadian provincial and other international EPI standards highlight the importance of transition, detailed implementation guidance and tools are lacking. The present study developed a protocol and client assessment measure to increase standardization and consistency in transitioning clients from EPI.

Approach

A structured systematic process was used to develop the protocol and assessment measure. An environmental scan of relevant health transition guidelines and tools was conducted to guide the development of an initial draft protocol and assessment measure. Then stakeholder feedback was collected on relevance, clarity, feasibility and completeness of each product through focus groups with providers, families and former EPI clients (n=23), and a provider survey (n=23). An EDI team at CAMH suggested strategies to support health equity. Feedback was used to revise and finalize the products. A Canadian advisory with multi-province representation guided the work at all stages.

Results

The final protocol proposes eight strategies to guide transition. These include early transparent discussions about the time-limited nature of EPI; use of a structured client assessment to inform the plan; shared decision-making with clients and families throughout; appointment of a designated lead to manage the process; and a warm handover that includes providing overlapping care and adjusting as needed. Each strategy includes actions to implement and a checklist was developed to enable providers to monitor adherence. The final assessment measure includes 30 items that address client treatment progress, illness management, health stability and risk, and community functioning. Items are rated on a 5-point Likert scale based on the last 6 months. Completion is collaborative with providers and clients.

Conclusion

Improving transition processes may increase client, family and clinician satisfaction, and create a more equitable and successful experience. A standardized transition protocol can provide a foundation for improving discharge practices, enhancing continuity of care after discharge, and identifying gaps in follow-up care for EPI clients.

Implementation of an Indigenous Support Hub for Culturally Safe Primary Care for Indigenous Patients

Presented by: Dionne Edgecombe

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Background and Objectives

Workforce constraints hinder primary care providers' capacity to address social and cultural factors essential for culturally safe care of Indigenous patients. Evidence shows Indigenous support workers (ISWs) can effectively bridge this gap. This work aims to co-design, implement, and test the "Indigenous Support Hub" model for Alberta Primary Care Networks (PCNs). This model seeks to enhance patient care and workforce capacity by connecting providers with ISWs for guidance on the unique needs of Indigenous patients.

Approach

Health system, academic, and community partners will be meaningfully engaged throughout this multi-method study guided by the Exploration, Preparation, Implementation, and Sustainment Framework. During Exploration, data on design considerations and implementation context will be collected through interviews, focus groups, and document reviews to co-design the Hub and its implementation. During Preparation, the Hub will be established, and implementation plans will be co-developed with PCNs. Implementation will be monitored over 12 months through observation and feedback. Pre-post-intervention surveys will assess changes in patient experience and providers' care competencies. Co-operative inquiry groups will explore provider and Hub members' experiences, informing sustainment strategies.

Results

Integrating ISWs' unique traditional and local knowledge into primary care through a Hub-and-Spoke model is anticipated to address health inequities and unmet social needs facing Indigenous patients. Using collaborative, case-based learning, the Hub is expected to strengthen providers' social and cultural care competencies while improving patient experience, measured through pre-post-implementation surveys and focus groups. Leveraging implementation science frameworks to guide and evaluate the implementation of the Hub will provide critical insights into context-informed processes and strategies for integrating innovative models of social and cultural support for providers. Examining this approach to expand the scope of the local Indigenous health workforce, enhance collaborations between health and social care professionals, and strengthen health workforce capacity will advance the development of equitable and effective culturally-informed workforce models.

Conclusion

The Indigenous Support Hub model expands the critical role of ISWs in addressing service gaps in culturally-safe care from providing direct patient support to developing primary care providers' competencies. This model strengthens primary care teams' capacity to provide high-quality, culturally appropriate care for Indigenous patients and ultimately reduce health inequities.

Exploring the Experiences of International Medical Graduates: A Qualitative Study

Presented by: Reem El Sherif

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Background and Objectives

International medical graduates (IMGs) play an important role in the health care system and constitute over a quarter of the physician workforce in Canada. A recent literature review has identified challenges facing IMGs including discrimination and increased risk of disciplinary action by professional colleges. The aim of this study was to explore the experiences of IMGs: their pathway to licensure in Canada, barriers they have faced, and supports they have received.

Approach

We conducted a qualitative descriptive study, recruiting Canadian physicians who had completed medical school outside of Canada/US. Using purposive and maximum variation sampling, and a pilot-tested semi-structured interview guide, 40 IMGs were interviewed. They were asked about their pathway to licensure, current practice, and challenges they faced and supports they received throughout their career. Interviews were transcribed verbatim and analyzed using a hybrid deductive-inductive thematic analysis. The interviews and coding were conducted 5 at a time, and continued until saturation was reached. This study was approved by the Advarra Research Ethics Review board.

Results

IMGs are a heterogenous group of physicians with only one thing in common: they completed medical school outside of Canada or the US. There are multiple pathways to licensure from a direct-to-practice pathway to years of examinations and residency applications. Before licensure, the challenges faced by IMGs are specific and include financial challenges, adjustment to a new system, discrimination, and less choice in location or specialty. During practice, however, their challenges are more general and related to interpersonal tensions or issues with the healthcare system such as lack of resources. Some racialized IMGs described microaggressions and discrimination even later in their career. All IMGs described social support as a facilitator throughout their career, from personal contacts, professional networks or through belonging within their community or work environment.

Conclusion

Barriers faced by IMGs may impact job satisfaction, stress levels, and medicolegal risk. Dismantling these barriers is essential for fostering inclusive environments that optimize the contributions of IMGs and provide support in diverse healthcare settings. Future research should explore how discrimination against racialized physicians influences their career.

Healthcare Accessibility and Navigation in Alberta: An 18 Month Thematic Case Analysis

Presented by: Emma Elder

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All authors are affiliated with Open Arms Patient Advocacy Society

Background and Objectives

Our patient advocacy organization offers support to patients in navigating the complex healthcare system. Client data provides a first-hand perspective of the challenges faced by community members in obtaining quality healthcare. Yet, the accessibility and navigation of the health system remains an underrepresented area of study. Our advocacy team conducted this research as a part of a longitudinal project to: 1) understand trends in healthcare challenges faced by Albertans and 2) influence provincial health policy.

Approach

Prospective clients complete an intake form via an online webform or over the phone with our advocacy consultant to receive services. Completed intake forms (n = 388) from July 2023 to December 2024 were retrospectively analyzed. Intake forms, rather than cases passed to volunteer advocates, were used for this study to assess the scope of support that patients are seeking. Cases were categorized into short-term (resolved within one week) or long-term (supported by a volunteer advocate) and sorted using thematic analysis. Demographics of long-term cases including sex and geographic location were also collected at the time of intake.

Results

Of the 338 Albertans who completed intake forms within this timeframe, 144 cases were considered short-term. Notably, 20.1% of these patients were seeking support with finding a family physician or specialist and 17.4% of patients had concerns related to hospital care. 15.3% of short-term inquiries were regarding senior and long-term care facilities, and 12.5% were related to mental health. 71 long-term cases were supported by an advocate, with 70.4% of these patients being female. 47.9% of long-term clients resided in the Calgary area, 32.4% in the Edmonton area, and 19.7% lived in rural communities. Patients seeking support in navigating the healthcare system comprised 46.5% of long-term cases. Other key themes included mistreatment and/or misdiagnosis (29.5%), senior care (14.1%), and complex conditions (9.9%).

Conclusion

The increase in demand for our services since the start of this project demonstrates the necessity of health support outside of clinical settings. Similarly, the high rate of cases related to healthcare system navigation suggests the need for increased collaboration between health agencies and policy makers.

Family physicians’ perspectives on implementing and managing fees for uninsured services in Ontario

Presented by: Asiana Elma

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Background and Objectives

Minor uninsured services, e.g., prescription renewals and form completion, add administrative burden to family medicine practices. Some family physicians charge fees for these services to offset costs, generate revenue, and improve practice efficiency. There are two common approaches: annual “Block Fees” to cover a suite of services, or payment on a fee-per-service basis. This study explores how family physicians in Ontario implement and manage fees for uninsured services to address patient and practice needs.

Approach

A secondary analysis was conducted using qualitative data from an exploratory sequential mixed-methods study investigating before-tax income differences (“pay gaps”) among Ontario family physicians. The qualitative arm included interviews with 55 purposively-sampled family physicians. Interviews explored professional decisions related to income, billing, practice management, and identity. An inductive reflexive thematic analysis approach was used, with data familiarization and iterative coding capturing perspectives on block fees, including their operationalization, decision-making, and income implications. A preliminary codebook was developed, and analytic memos documented key patterns. These findings were iteratively refined through team consultations to ensure depth and rigour in developing themes.

Results

Participants described various approaches to managing uninsured services. Some implemented annual block fees, while others opted only for a fee-per-service model to ensure fairness. Others avoided charging fees altogether due to ethical concerns or administrative challenges. Many adjusted or waived fees based on perceptions of patients’ ability to pay, the context of the service request, or whether the fee was seen as proportionate to the benefit received by the patient. When communicating options, some provided clear explanations of available options, allowing patients the autonomy to choose. Others never charged for uninsured services, citing discomfort with fee discussions or concerns about patient finances. Some participants reported significant revenue and improved practice efficiency from charging these fees, which reduced unnecessary patient visits and streamlined administrative workflows.

Conclusion

Managing uninsured services requires balancing ethical concerns, patient affordability, and administrative efficiency. Clear communication and thoughtful implementation are essential to align fees with patient circumstances, manage physician workload, and ensure fees do not negatively impact patients' access to or perception of care.

Promoting the Engagement of Indigenous Boys and Men in Mental Health Services: A Scoping Review

Presented by: Naomi Epp

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Background and Objectives

Indigenous boys' and men's engagement with mental health services is underrepresented in the literature, despite evidence suggesting they are less likely to seek mental health support compared to Indigenous girls and women. This scoping review synthesizes existing literature on interventions designed to enhance engagement with mental health supports among Indigenous boys and young men, addressing this critical gap in both the literature and practice to foster culturally responsive and effective support.

Approach

A scoping review was conducted to map and synthesize key findings regarding engagement of Indigenous boys and young men with mental health services. Eligible literature includes studies focused on boys and men aged 11–25 in Canada who are at risk or in need of mental health support. Peer-reviewed articles exploring, testing, or describing interventions, such as peer support programs, digital tools, school-based initiatives, and community-based services, were included. This comprehensive review seeks to map the existing evidence base and inform the design of culturally responsive and effective mental health interventions.

Results

This review identifies barriers and facilitators to mental health service engagement among Indigenous boys and young men, highlighting gaps in research and offering recommendations for designing and implementing culturally responsive and effective support. Historically, programming that has been tailored for Indigenous boys and men maintains a colonial framework, emboldening a legacy of assimilation within mental health services. By synthesizing literature on interventions, the study serves as a vital resource for practitioners in various settings, including educational institutions, community spaces, justice systems, healthcare facilities, remote and rural mental health sites, and private practices. The findings will provide actionable insights to guide the development of culturally relevant mental health interventions tailored to the needs of Indigenous boys and men, contributing to effective and decolonized mental health services.

Conclusion

This review underscores the importance of decolonizing mental health services by addressing barriers and fostering culturally relevant interventions. Our research aims to inspire culturally relevant and effective mental health support to promote the well-being of Indigenous boys and men, as well as Indigenous communities more broadly.

Addressing Care Transition Gaps for Older Adults with Multimorbidity using a Digital Bridge Solution

Presented by: Obinna Ezeani

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Background and Objectives

Transition from hospital to home is a vulnerable time for patients with multimorbidity (the occurrence of 2+ chronic conditions) due to the complexity of care and risk of complication. One way to improve care transitions is through technologies that enable effective communication between hospital/primary care providers and with patients. This research aims to ensure that technology design is fit to address care transition challenges through usability testing.

Approach

The study is guided by the Fit between Individuals, Tasks, and Technology (FITT) framework and the Heuristics Evaluation framework. The FITT framework ensures that the technology fits into provider workflows and patients' daily routines. An interpretive descriptive multi-method design will be employed. The quantitative data was derived from a target of 40 participants using Post-Study System Usability Questionnaire (PSSUQ) analyzed via descriptive statistics. The qualitative component was derived from 20 participants through a think-aloud exercise and cognitive walkthrough session to gather contextual insights, which will be analyzed through rapid qualitative analysis. Data is collected across two timepoints (T0, T1).

Results

Data from the first timepoint (T0) suggests that overall users had a positive usability experience with the technology. 19 participants completed the PSSUQ (mean score: 2.97) with the benchmark for mean scores at 2.82 (99% CI 2.62–3.02). From qualitative data, both providers and patients have similar communication needs around care transitions, such as access to up-to-date discharge information to facilitate smooth transitions for patients. However, providers emphasized the need for the technology to integrate into clinical workflows to prevent burnouts, especially among primary care providers. For patients, they are interested in the technology's ability to manage their care in their daily routines. The difference in how these groups experience the technology poses an interesting technology and implementation challenge.

Conclusion

There is a need to consider the challenge and requirement for adaptability and agility in the way we design solutions meant for multiple user groups. Attending to different tasks and workflows that each seek to meet the same aim requires iterative design and adaptation along with continuous usability testing.

Emergency Department and Primary Care Visits for Non-Traumatic Dental Problems Among Métis Citizens

Presented by: Bahja Farah

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Background and Objectives

Dental care access is a significant issue in Canada, particularly among Indigenous populations. Studies show that Métis individuals face disproportionate challenges regarding oral health, including poverty and limited access to dental care, leading to untreated dental issues. This can lead individuals to seek care in emergency departments or primary care settings. This study is the first to assess the prevalence of non-traumatic dental problem visits to non-dental care settings among Métis populations.

Approach

A retrospective population-based cohort study was conducted using ICES data. Data for emergency department and primary care visits related to Dental Problems not Associated with Trauma (DPNAT) in Ontario between 2012 and 2021 for registered Métis Nation of Ontario (MNO) citizens were obtained from the National Ambulatory Care Reporting System (NACRS) and the Ontario Health Insurance (OHIP) database. Descriptive statistics were used to analyze the Métis sample, the frequency of ICD-10 CA codes and OHIP diagnosis codes were calculated, and unadjusted and adjusted rate ratios were calculated to describe DPNAT trends from 2012 to 2021.

Results

This study analyzed DPNAT visits among 27,128 Métis citizens from 2012 to 2021. There were 1,676 visits to emergency departments (ED) and 1,655 visits to primary care. DPNAT visits in both settings were more common among lower-income citizens and those residing in urban areas, with an even distribution by sex. From 2012 to 2021, MNO citizens experienced an average of 167.6 ED visits for DPNAT per year, an average of 183.9 physician visits per year and an overall upward trend in visits. Within one year, there were 179 return visits to the ED and 146 to primary care for dental-related issues. Diseases of pulp and periapical tissues (45.5%) were the most common ED diagnosis, while dental caries (36.9%) was the most common primary care diagnosis.

Conclusion

Dental-related visits to emergency departments and primary care settings are increasing in Métis citizens and disproportionately impacting low-income quintile citizens. These findings underscore the necessity for publicly funded dental care and the implementation of oral health interventions in Métis communities to decrease DPNAT visits in non-dental care settings.

Evaluating Adherence to Enhanced Prenatal Syphilis Screening Recommendations in Ontario, Canada

Presented by: Amanda Featherstone

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Background and Objectives

Congenital syphilis is a significant public health threat. Canadian guidelines for prenatal syphilis screening recommend one universal screen for all pregnant people during the first trimester or initial prenatal visit. In response to rising congenital syphilis rates, certain Ontario public health units (PHUs) issued recommendations to increase prenatal syphilis screening at mid-gestation and/or at delivery. This study aims to evaluate adherence to these enhanced recommendations and assess whether they were applied equitably into practice.

Approach

We conducted a quasi-experimental study using provincial laboratory data from five Ontario PHUs. Eligible pregnant women were included based on receipt of prenatal syphilis serology screening (chemiluminescent microparticle immunoassay [CMIA]) between January 2019 and December 2023. Based on a provincial-wide web-based survey, we determined which PHUs enhanced prenatal syphilis screening recommendations (exposed; n=2) and which maintained screening practices (control; n=3). A difference-in-differences analysis, using a linear regression model, was used to determine increases in screening rates while controlling for secular trends.

Results

The five PHUs included in this study represent three of Ontario's six health regions. The exposed and control PHUs had similar population-level age distributions and proportions of people living in materially deprived neighbourhoods. Between January 2019 and December 2023, 36,523 CMIA tests were ordered for 26,122 pregnant women, aged 15 to 49 years old. There were no significant differences in the number of tests performed between exposed (mean=1,319) and control (mean=1,349) PHUs before the recommendations were issued (p-value=0.9). After controlling for secular trends (from control PHUs), there were 1,015 (95% CI: -249, 2,278) more tests performed in the PHUs that issued enhanced screening recommendations. We confirmed parallel trends in the pre-intervention period. Stratified results by neighbourhood-level socio-economic status (ON-MARG) will be reported at the conference.

Conclusion

Ontario PHUs are taking decisive local action in response to a rise in congenital syphilis. Following enhanced screening recommendations, there was an increase in the number of prenatal syphilis screening tests performed. Future research should examine the effectiveness of enhancing prenatal syphilis screening recommendations on congenital syphilis prevention.

Treatment of Minor Ailments among Pharmacists and Family Physicians in Canada: Preliminary Analyses

Presented by: Gregory Feng

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Background and Objectives

Pharmacists' scopes of practice are expanding in Canada to include prescribing authority for various minor ailments. These initiatives are proposed to improve access to primary care and reduce family physician workloads. Nevertheless, evidence on the uptake of these programs among patients and the impact on family physicians' caseloads is still emerging. This analysis describes the uptake of pharmacist prescribing programs in Canada and compares patient volumes among pharmacists and family physicians using preliminary data.

Approach

Pharmacist prescribing data submitted by Saskatchewan, Ontario, and British Columbia was extracted from CIHI's National Prescription Drug Utilization Information System (NPDUIS). Family physician payment data was extracted from CIHI's Patient Level Physician Billing (PLPB) repository across the same jurisdictions. Minor ailments were identified using pseudo/drug identification numbers (PDINs/DINs) in pharmacist claims data, or ICD-9 codes in physician billing data. The top five ailments treated by pharmacists in each jurisdiction in 2023 were identified using descriptive statistics. Numbers of patients treated by pharmacists were subsequently compared to numbers treated by family physicians. When possible, patient counts were examined over time.

Results

In 2023, over 481,000 patients in Ontario, 151,000 in British Columbia, and 30,000 in Saskatchewan were treated by a pharmacist for a minor ailment. The top five minor ailments were uncomplicated UTIs, herpes labialis (cold sores), conjunctivitis (pink eye), contraceptive management, and allergic rhinitis (hay fever) in Saskatchewan and British Columbia. In Ontario, dermatitis was among the top five ailments rather than contraceptive management. Across ailments, more patients were treated by family physicians compared to pharmacists. Nevertheless, early data from Ontario suggests that the number of patients treated for cold sores (n=42,815) and conjunctivitis (n=137,023) by a pharmacist in 2023 was approaching the number treated by a family physician in the previous year (n=42,619 and n=204,722, respectively).

Conclusion

Pharmacist prescribing programs are utilized by a high volume of patients, although family physicians continue to be a larger provider of treatment for minor ailments. Further exploration of the trajectories of patients seen by a pharmacist (e.g., health outcomes, additional visits with providers, etc.) and in other jurisdictions is warranted.

From Data to Solutions - Actions for Workforce Retention

Presented by: Colleen Ferris

Author(s): *Colleen Ferris, Healthcare Excellence Canada; Kyle Kemp, Health Standards Organization; Lynn McNeely, Health Workforce Canada*

Background and Objectives

Workforce retention remains a challenge for many organizations across Canada. A culture of collaboration and engagement, measurement, supported by timely data and indicators, with the ability to learn from and action findings is crucial for success. It also calls on organizations to work together. This session will address this issue and demonstrate how three pan-Canadian organizations are working together to support workforce retention

Approach

Health Workforce Canada (HWC) has introduced its “Workforce in View” and “Policy Tracker” dashboards, which are powered by data from multiple sources to better understand current supply and distribution patterns and the policy issues driving them. Additional data that examines the workforce is Health Standards Organization’s (HSO) Global Workforce Survey (GWS) that has findings on safety culture and employee work-life, as captured from over 100,000 respondents across Canada. Then using that data to drive improvements in the system, Healthcare Excellence Canada (HEC) led a Health Workforce Innovation Challenge that supported healthcare teams across Canada to strengthen their workforces.

Results

Together these three organizations have demonstrated how their work enables and supports each other in moving towards collective action. Data from the 2024 GWS, in conjunction with HSO’s Workforce Index and Benchmarking Report, provides an overview of areas that are working well and those that need improvement. To support actions towards system improvements, HEC’s Innovation Challenge supported teams to address their goals with nearly three-quarters of teams progressing on their goals from improving turnover rates, work-life balance and patient care. Finally, HWC can showcase how that and other information can be collated through a couple of public facing tools: dashboards and digital front door to help with scale, spread and use of the information by workforce planners to further address retention issues.

Conclusion

Retaining the health workforce not only supports the workforce but also is connected to patient safety and quality. Many organizations are using evidence and working on actions to make improvements. As national organizations we are committed to using our respective levers to share data and actions to support the workforce.

Developing a Patient Reported Experience Measure for care transitions from acute to primary care

Presented by: Sarah Filiatreault

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Background and Objectives

Care transitions (CTs) from acute to primary care are an important focus for health-system improvement. Primary care plays a significant role in supporting successful CTs. An ongoing project in Alberta called A DiseAse-Inclusive Pathway for Transitions in Care (ADAPT) focuses on enhancing primary care CT practices, which includes evaluating how patients experience CTs. The objective of this study was to develop and test a PREM to capture patients' CT experiences from acute to primary care.

Approach

Currently, there are no validated patient-reported experience measures (PREMs) that address all transition timepoints and key concepts for this type of CT. Therefore, we developed a preliminary PREM through a literature review and concept mapping, followed by content validity testing with content experts (n = 6) through calculating item content validity index (I-CVI) scores and with patients (n = 6) through cognitive interviews. The instrument was modified based on triangulation of results, followed by a participant validation exercise (patients, n = 6) and health literacy review. The PREM is now being piloted with eligible patients at one participating ADAPT site.

Results

Three of 13 potentially relevant PREM instruments identified from the literature review addressed both CTs and primary care. Concept mapping confirmed none of the 3 instruments captured all concepts or time points of interest. The preliminary PREM contained 18 core items. All core items had I-CVI scores >0.78 (i.e., high relevance) . Four broad themes were identified from these interviews: 'Health Literacy' (n = 10), 'Clarity of Terms' (n = 7), 'Concept Measurement' (n = 2), and 'Ability to Comment' (n = 4). Minor wording changes and clarification of definitions and instructions addressed most themes. All 18 core items met the criterion for agreement (> 67%) during the participant validation exercise. Therefore, the final PREM instrument contains 18 core items plus 4 open-text options.

Conclusion

This PREM will provide robust evidence on patient experiences during transitions between acute and primary care to support quality improvement efforts. Psychometric testing of the PREM will be done as part of the ADAPT project aimed at improving CTs and integrating healthcare for adult patients with diverse chronic conditions.

Political economy, popular discourses and the climate crisis

Presented by: Erin Flanagan

Author(s): *Dennis Raphael, York University*

Background and Objectives

The study critiques neoliberal climate strategies for ignoring systemic health inequities, such as those driven by fossil fuel reliance and energy poverty. It aims to explore solutions that prioritize public energy control and eco-socialist governance, aligning with health policy goals to improve social determinants of health. By addressing environmental inequities and fostering equitable, sustainable practices, the study highlights pathways to mitigate climate impacts while promoting health and equity for marginalized populations.

Approach

The study uses a critical political economy lens to explore how neoliberal policies and individualistic climate discourses undermine systemic action needed to address health inequities. It emphasizes that fossil fuel dependence and energy poverty disproportionately harm marginalized populations, worsening social determinants of health such as clean air, stable housing, and access to affordable energy. By advocating for public control of energy systems and eco-socialist governance, the study links environmental sustainability with equitable health outcomes. This approach highlights the need for climate strategies that prioritize community well-being, fairness, and the inclusion of marginalized voices in policy decisions.

Results

The study found that mitigating the climate crisis requires systemic change, moving beyond neoliberal approaches that prioritize individual responsibility and technocratic fixes. Results emphasize the necessity of public control over energy policies, equitable renewable energy access, and the dismantling of fossil fuel industry dominance. This transition aligns with health policy by addressing social determinants of health—like energy poverty and environmental inequities—that disproportionately affect marginalized communities. Policies fostering democratic energy governance and eco-socialist systems can improve health equity by reducing pollution, ensuring fair access to energy, and creating sustainable, health-promoting environments.

Conclusion

We conclude that systemic changes, such as eco-socialist governance and public energy policy, are critical for addressing climate change and advancing health equity. These measures reduce environmental health risks, tackle energy poverty, and ensure equitable access to resources, aligning with health policy's goal of addressing social determinants to promote wellbeing.

Evaluation of the Pharmacist Care Clinic Pilot in New Brunswick

Presented by: Chris Folkins

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Background and Objectives

Launched in August 2023, the Pharmacist Care Clinic pilot provides clinical pharmacy services during dedicated clinic hours at six New Brunswick community pharmacies. In addition to providing existing services such as minor ailments assessment, pilot pharmacists also have expanded authority to assess and prescribe for Group A Strep (GAS) and prescribe for chronic disease management (CDM). The pilot provided the opportunity to assess the patient- and system-level impacts of this clinic model.

Approach

Clinic operational details and services rendered were tracked by staff at the six clinic sites from August 2023 through March 2024. Patients visiting the clinics during this period were invited by staff to complete patient experience surveys. Clinic operations, service records, and survey responses were summarized and described.

Results

Among 10,365 appointments (7,800 patients), the most common reasons for visits were prescription renewal/adaptation (38%), CDM (18.4%), minor ailments (15.9%), and GAS (15.2%). CDM services were more prevalent than GAS services among patients unattached to a primary care provider (PCP) (40.7% CDM, 5.8% GAS), while the opposite was true among attached patients (4.0% CDM, 21.4% GAS). Pharmacists referred 8.9% of patients to another provider, and 43.7% of referrals were for ordering lab tests (NB pharmacists do not have authority to order labs). Survey respondents (n = 409) reported high satisfaction. Most indicated that visiting the clinic prevented the need to seek care from another provider (92%), and that it was unlikely they would have been able to access timely care elsewhere (60.4%).

Conclusion

Distribution of reasons for clinic visit differed depending on attachment to PCP. Findings suggest that authorization of pharmacists to order laboratory tests may reduce burden on other providers. Survey results indicated high patient satisfaction and suggested that clinics improved timely access to care and relieved burden on the healthcare system.

pan-Canadian Health Data Stewardship: A framework to transform health data management & drive change

Presented by: Jesse Fracassi

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Background and Objectives

Researchers and stakeholders across Canada's health systems are challenged with obtaining data they need to provide quality, timely care and facilitate research advancements. Sharing data securely and ethically is limited due to lack of technological, organizational and human interoperability.

To support data sharing with trusted partners and realize the potential of using data for public benefit, CIHI is developing a pan-Canadian health data stewardship framework to transform management and decision-making related to health data.

Approach

CIHI reviewed existing frameworks, principles, policies and conducted targeted scanning and engagements with health system stakeholders, federal/provincial/territorial jurisdictions, researchers and clinicians, and national/international experts to build understanding of current data-sharing and stewardship landscapes across the country.

The framework will build on this knowledge, developing a set of data sharing principles to drive necessary changes in jurisdictions' policy, practice and legislation. It will provide users with tools required to adopt a data stewardship approach to managing and sharing data, including: Common structures and vocabulary; Guidelines for adoption at jurisdictional, sector and organization levels; Mechanisms to advance data stewardship capabilities within jurisdictions.

Results

Ultimately, through the implementation of the pan-Canadian health data stewardship framework, several key benefits will be realized, including:
1) Health system data stewards will have the tools and community they need to adopt a data stewardship approach to managing and sharing health data, grounded in the pan-Canadian Health Data Charter.
2)Canadians will benefit from health information being shared securely and efficiently across care settings and with trusted partners for their individual and common good.
3)Health system leaders will have timely and secure access to quality data to efficiently manage the health system.
4)Researchers will have timely and secure access to quality evidence-based data to generate actionable insights and address health inequities.

Conclusion

The framework will provide the foundation for provinces, territories, Indigenous Peoples, the public, researchers, health care providers and other key stakeholders to transform Canada's health system into one that enables high-quality, timely, integrated health data management to enable better health outcomes, research, innovation, and policy planning.

Technology enabled care for hospital at home: Adapting HTA for digital health technologies

Presented by: Nora Fripp

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Background and Objectives

Hospital at home (HaH), a program that provides acute care to eligible patients in the comfort of their homes, exists across all seven health authorities in BC. Remote patient monitoring (RPM) technologies, such as two-way communication tools, vital signs monitors, and medication dispensers, can provide crucial support for HaH programs. Our aim was to develop a sound and sustainable strategy to assess RPM technologies for HaH by building on current health technology assessment (HTA) methodologies.

Approach

In June 2024 we formed an interdisciplinary team of experienced HTA evaluators, HaH practitioners, health services and digital health researchers, and patient partners from across BC. To inform the evaluation strategy we consulted the published literature and existing HTA frameworks. Subsequently, we sought input from our interdisciplinary team of experts.

Results

We developed an HTA framework for the assessment of RPM technologies for use in HaH. The framework is comprised of 8 domains, seven of which are maintained from traditional HTA methodologies used in British Columbia. We add one new domain for assessment items related to digital safety and integrate digital-specific items across the seven traditional HTA domains.

Conclusion

While we maintain the traditional structure of HTA frameworks, there are specific considerations that shouldn’t be overlooked when assessing RPM technologies for HaH. Going forward we will be able to inform health care decision-makers around specific assessment needs for HaH and RPM while ensuring rigorous HTA methods are applied.

Policy in Action: How Late Effects Clinics Integrate Primary Care Providers into Survivor Care

Presented by: Nicole Fu

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Background and Objectives

Access to centralized care for survivors of childhood cancer is limited by patient and system-level barriers. In response, an Ontario-based oncology group championed a policy reform to integrate community-based primary care providers (PCP) into survivor care. Support was provided to late effects "AfterCare" clinics to engage local PCPs. However, the operationalization of this policy is unknown. This research explores strategies undertaken by AfterCare clinics and features to promote uptake, sustainability, and care continuity for survivors.

Approach

The works is approached as an environmental scan and leverages theoretical foundations of implementation research. In the first phase, survey data was generated through engagement with Ontario AfterCare clinics to identify strategies used and describe uptake by clinics for PCP integration into survivor care. In the next phase we will be undertaking focus group discussions with key informants from the AfterCare clinics to explore features that promote initiation and continuation of these strategies. Transcripts from the discussions will be considered within the tradition of qualitative case study, and analysed using qualitative description analytic techniques.

Results

Survey responses from five (out of seven eligible) AfterCare clinics identified several strategies to integrate PCPs into survivor care. These included adapting care delivery for individual patients, such as transferring the late effects care of clinically stable survivors with low risk of late effects to their current PCP and matching survivors without a PCP to a family physician or nurse practitioner, as well as general outreach activities, such as prospectively identifying PCPs interested and able to accept survivors into their practice and/or providing late effects education. There was variability observed in the uptake and continuation of activities, as well as the staffing and resource requirements to support activities. It is anticipated that analysis of the focus group discussions will provide insights into this variability.

Conclusion

These findings confirm uptake of the policy across participating clinics. Further, the variability observed suggests consideration be given for adaptability and latitude for individualization by clinics when developing evidence-based practices to support this provincial reform.

Advancing Equity in Mental Health Care Access from a Policy Perspective: a Critical Narrative Review

Presented by: Morgane Gabet

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Background and Objectives

Despite increasing recognition of the need for upstream interventions, policies targeting access inequities remain limited and poorly evaluated. Notably, the involvement of equity-deserving groups in designing these policies is minimal. Involving equity-deserving groups in the planning and designing of healthcare services based on their unique needs, capacities, and preferences is essential for optimizing resources and improving health outcomes.

Approach

Policy design is a particularly understudied structural determinant of health, despite its significant influence on equitable access to services. While very little information is available as to how mental health policies are designed, the outcomes of these policies have been linked to significant inequities related to access to quality mental health care. A critical narrative review was chosen, allowing for an interpretive analysis that compares health services research and public policy understandings of the topic. Our research question was: "What do we know about policy processes, with regards to design, implementation, evaluation and/or governance, related to access to mental health?"

Results

There is growing recognition of the need to study upstream factors and their contributions to (in)equities. However, research on mental health policy design remains limited, with only nine studies identified, primarily in high-income countries. Methodological shortcomings are common, with reliance on social science concepts but poorly described and justified methods. Research addressing access and (in)equity is notably scarce, and when (in)equity is discussed, it is often poorly defined and conflated with terms like disparity and inequality. While some studies examine service user involvement in policymaking, they lack alignment with the comprehensive evaluative approaches typical of health services research.

Conclusion

This project comes at a critical time in mental health care policy and planning, especially in the aftermath of the COVID-19 pandemic. This study aims to foster health equity capacity building, integrating principles of social justice and human rights while promoting stakeholder dialogue in mental health policy design.

The impact of coaching as a change management intervention in practice change

Presented by: Isabelle Gaboury

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Background and Objectives

Telerehabilitation can improves access to rehabilitation services. Despite its drastic increase in use during the pandemic and emerging effectiveness evidence, its sustainability has varied among rehabilitation professionals. To be successful, its implementation requires a significant practice change, yet a dearth of evidence exists as to what constitutes the best change management strategy. Our objective is to explore the use of coaching as a change management intervention and its impact on telerehabilitation adoption.

Approach

A multiple case study design was employed, encompassing eight sites where telerehabilitation services were provided alongside coaching (the intervention) to optimize telerehabilitation delivery. Telerehabilitation services focused on either children with a developmental delay or adults having sustained a stroke. Data collection included qualitative individual interviews with professionals and managers, and non-participant observations of team interactions. Interviews were transcribed verbatim, and a descriptive thematic analysis was conducted to identify key patterns and themes among and across cases. This approach allowed for a comprehensive understanding of telerehabilitation practices and the impact of coaching, integrating insights from both narratives and observed behaviors.

Results

Themes identified aligned with organizational and individual factors. Telerehabilitation practice change was viewed as a gradual, reflective process requiring conscious investment and engagement. The coaching intervention promoted reflection on practice and service delivery, triggering thoughts and tension for change. It was perceived to enhance knowledge, skills, confidence, and ease in using telerehabilitation, increasing reflections on its effectiveness. However, professionals' physical and cognitive capacity, along with performance pressures, impacted their willingness and ability to change, even with coaching. The intervention also highlighted additional previously unidentified needs related to organization (e.g., workflow), professional (e.g., technological literacy), and client (e.g., understanding of service). Overall, many sites perceived improved quality, flexibility, and reach in service delivery model.

Conclusion

Coaching interventions provided to the professional over time can led to the gradual reflective change in practice. Moreover, its impacts may be broader reaching, affecting the quality and flexibility of reach of services provision. However, some organisational factors and professional characteristics may need to be addressed to maximize their impact.

Evaluation of frailty domains and 6-month changes in HRQoL, living status, and decisional regret

Presented by: Ryan Gainer

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Background and Objectives

It is critical to understand the ultimate fate of recovery in frail patients at 6 months post-operatively, when there has been a sufficient chance for recovery from the surgical insult. As such, the goal of this study was to determine whether, among patients 65 and older who undergo elective cardiac surgery, frailty, as measured by the Frailty Assessment in Care Planning Tool (FACT) is associated with quality of life outcomes at 6 months post-surgery

Approach

The current study used a prospective cohort pre-post design, with cross-sectional data at 6 months. Self-reported questionnaires were used to measure change in HRQoL, dependent living status, and treatment decisional regret. The target population included all individuals, 65 years of age or older, set to receive an Isolated Coronary Artery Bypass Graft (CABG), Isolated Valve (Aortic Valve Replacement or Mitral Valve Replacement), or a CABG & Valve Surgery at the Halifax Infirmary

Results

Results indicate worse mobility and ADL FACT scores were positively associated with higher levels of impairment in the mobility ($\beta = 0.13$, $p < 0.05$) and usual activity ($\beta = 0.08$, $p = 0.04$) HRQoL domains from baseline to 6 months. Cognition FACT scores were positively associated with higher levels of impairment in the Usual Activities ($\beta = 0.07$, $p = .037$) and Pain and Discomfort HRQoL domains. Lastly, those with worse final FACT scores had higher odds of reporting a dependent living status (aOR (95% CI) = 1.41 (1.01-1.58), $p = 0.04$).

Conclusion

While the reasons for poor patient-reported post-operative HRQoL among elective surgical patients are likely multiplicitous and interacting, the current study indicates that the inclusion of a domain-specific frailty assessment at the pre-operative stage for patients referred for cardiac surgery may better identify those individuals at risk of experiencing prolonged HRQoL impairment and dependent living status.

Adapting Adult Cognitive Behavioural Therapy with Mindfulness Program for Adolescents in Manitoba

Presented by: Jori Ganetsky

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Background and Objectives

Adolescence is a critical period for mental health intervention, yet existing programs often fail to meet youths' unique needs. Cognitive Behavioral Therapy with Mindfulness (CBTm) has shown effectiveness in adults, but its adaptation for adolescents remains underexplored. This study proposes to investigate youth perspectives on modifying an adult CBTm program to enhance accessibility, engagement, and relevance for adolescents aged 12–17. The objective is to inform tailored adaptations that address youth mental health challenges effectively.

Approach

This study will use a qualitative, participant-led approach to explore adolescent perspectives on adapting a CBTm program. Focus groups will be conducted with youth aged 12–17 to gather insights on program content, delivery, and engagement strategies. Transcripts will be analyzed using grounded theory and thematic analysis to identify key themes related to barriers, facilitators, and preferences for mental health interventions. Ethical considerations, including informed consent and confidentiality, will be prioritized. Findings from this study will generate practical recommendations for adapting CBTm programs to better meet the needs of adolescents while improving accessibility and program effectiveness.

Results

This proposed study aims to identify key themes related to youth perspectives on adapting a CBT with mindfulness (CBTm) program for adolescents aged 12–17. Expected results include insights into how program content, delivery methods, and engagement strategies can be modified to better suit adolescent needs. Thematic analysis may reveal preferences for interactive activities, relatable examples, and strategies to address barriers such as stigma and accessibility. Findings are anticipated to highlight youth recommendations for incorporating mindfulness techniques, addressing stress, and improving program flexibility. Results will provide practical guidance for tailoring CBTm programs to enhance relevance, accessibility, and engagement for adolescents, ultimately supporting the development of effective mental health interventions that reflect youth priorities and lived experiences.

Conclusion

This proposal seeks to address gaps in youth mental health interventions by exploring adolescent perspectives on adapting CBTm programs. Findings will guide the development of tailored interventions that improve accessibility, cultural relevance, and engagement, ensuring CBTm programs better meet adolescents' needs and promote long-term mental health and well-being.

Why Know Information if You Don't Share It? Enhancing Traumatic Brain Injury (TBI) Recovery.

Presented by: Judy Gargaro

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Background and Objectives

Many patients with TBI receive care from non-specialized or community healthcare providers who do not have experience to manage this complex condition. The communication gap between specialized clinicians and (1) TBI patients and (2) non-TBI specializing clinicians further exacerbates this problem and can result in poor quality information communicated during the discharge/transfer process. Our objective is to develop clear guides that improve care coordination and communication for TBI patients, thereby enhancing healthcare delivery and outcome.

Approach

Two guides were developed to facilitate communication from specialized clinicians to patients and non-TBI specializing clinicians. The development process involved: (1) reviewing the Canadian Clinical Practice Guideline for the Rehabilitation of Adults with Moderate to Severe TBI and the Neurotrauma Care Pathway (NCP) to ensure alignment with evidenced-based practices, (2) leveraging the NCP's pilot implementation projects as key resources, and (3) consulting with end-users. To ensure broad access to the guides, a wide-reaching knowledge mobilization (KM) strategy was used (i.e., collaborating with the Neurosurgery Education & Outreach Network and Acquired Brain Injury Navigators, presenting at conferences, leveraging social media platforms).

Results

Written in lay language, the patient guide includes a primary care checklist, information on what to do without a primary care provider and in an emergency, and Ontario-wide and regional (Greater Toronto Area) TBI resources. The guide for non-TBI specializing clinicians uses the I-PASS patient handoff framework (Illness severity, Patient summary, Action list, Situation awareness and contingency planning, Synthesis by reviewer) and focuses on key clinical practices (e.g., addressing responsive behaviors, co-morbid conditions, disorders of consciousness), rehabilitation assessment, potential complications, and resources. While the patient guide is generalizable to all TBI patients, the guide for non-TBI specializing clinicians must be tailored to each patient by specialized clinicians. Both guides can be scaled and incorporated into standardized healthcare delivery models. KM metrics will be presented.

Conclusion

The two guides for TBI patients and non-TBI specializing clinicians offer a scalable solution to enhance the facilitation of patient transition from specialized acute care into the community. The guides enhance clinician-patient communication and ensure standardized evidence-based TBI practices are used, supporting systemic improvements in TBI management nationwide.

A pan-Canadian study to explore modernizing the disease classification system used in primary care

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Background and Objectives

Canada adopted the International Classification of Diseases version 9 (ICD-9) in 1979, which is still used by many physicians to submit diagnostic codes for outpatient billing, as well as for clinical documentation within electronic medical records (EMRs). However, ICD-9 is outdated and does not reflect today's healthcare system or patients. The objective of this study was to examine alternative systems to ICD-9 and explore perspectives of family physicians and key organizations on replacing ICD-9.

Approach

This was a mixed methods study comprised of a patient vignette coding exercise, post-coding survey, focus groups and interviews. Family physicians from across Canada were recruited to complete an online coding exercise, where they assigned diagnostic codes to a series of mock patient visits using ICD-9 and two newer systems (ICD-11, International Classification of Primary Care [ICPC-3]), as well as participate in a virtual focus group. Additionally, virtual interviews were held with individuals from relevant organizations who may be impacted by a change to the ICD-9 system, including EMR vendors, health ministries, healthcare delivery organizations and national organizations.

Results

161 family physicians from 6 provinces completed the coding exercise/survey (56% women, mean age 41). Participants preferred ICD-11 and ICPC-3 over ICD-9 for billing and documentation, reporting better capture of medical and social complexities. Vignettes were coded the fastest using ICPC-3. Participants rated both ICD-11 and ICPC-3 as more comprehensive, precise, easy to use and able to capture necessary information compared to ICD-9.

29 family physicians participated in 5 focus groups and interviews were conducted with 24 participants. Many barriers to replacing ICD-9 were shared across various participants, such as time, cost, difficulty adjusting, integration concerns, unclear value proposition. Facilitators for a successful transition included identifying compelling reasons for change, benefits of a new system, collaboration/buy in, implementation/ change management support, user friendly EMR integration.

Conclusion

ICD9 is over 45 years old. Our research found that most physicians support replacing ICD-9 and this work starts the process of engaging physicians and relevant organizations to outline strategies to ensure successful adoption of a newer classification system in the future.

Evaluating Digital Tools to Reduce Administrative Burden in Primary Care Workflows in Ontario

Presented by: Meghan Gilfoyle

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Background and Objectives

Patients Before Paperwork, an Ontario initiative, aims to reduce clinicians' administrative burden by digitizing manual tasks like fax-based referrals to combat burnout. Women's College Hospital Institute for Health System Solutions and Virtual Care (WIHV), commissioned by Ontario Health, evaluated the impact of digital tools, particularly eReferrals, on workflows and administrative tasks. The evaluation compared time and steps for tasks, including lab requisitions and prescription refills, across two EMR systems: Telus PS Suites; OSCAR Pro.

Approach

A mixed-methods evaluation was conducted, involving semi-structured interviews providing qualitative insights into primary care providers (PCPs') experiences and simulated clinical encounters with 10 PCPs at the Women's College Hospital Virtual Care Lab which included time-motion studies. Each PCP completed four patient cases—two "simple" and two "complex"—across three workflows: eReferral, eFax, and paper-based. "Simple" cases involved routine follow-ups with minimal documentation, while "complex" cases had higher medical complexity, requiring more time and decision-making. Simulations were recorded and live-coded to capture time and process steps. Workflows for lab requisitions and prescriptions were examined for both paper-based and eFax systems.

Results

In 40 simulated encounters, PCPs spent on average 2 minutes and 53 seconds completing referrals using Ocean eReferral. For simple cases, trends indicated that eReferral was 8.88% faster than paper-based workflows, while for complex cases, it was 17.65% faster than eFax referrals. Paper workflows excluded steps like printing and handoff to staff. Usability challenges, like system errors and incomplete forms, caused delays despite eReferral's time-saving potential. Generating and completing lab requisitions required 7 steps for TELUS PS Suites and 8 for OSCAR Pro, averaging 29 seconds. Prescription workflows involved 10 steps for TELUS PS Suites and 9 for OSCAR Pro, averaging 39 seconds. Ultimately, findings underscore the potential areas for digital tools like eReferral to streamline workflows and reduce administrative burden.

Conclusion

Expanding eReferral and digital tools could improve workflows if issues like system stability and form completion errors are resolved. Future research should expand the study sample, incorporate clinical observations, refine interfaces, standardize processes, and address broader tasks like inbox management to reduce administrative burden and enhance efficiency for PCPs.

Addressing Changing Healthcare Needs: A Realist Review of Innovative Rehabilitation Care Models

Presented by: Catherine Giroux

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Background and Objectives

Canada's healthcare system faces an aging population, an increasing prevalence of chronic disease and disability, and escalating costs. Integrating innovative rehabilitation service delivery models may contribute to more sustainable and resilient health systems that promote long-term health and wellbeing. This study examined the contexts, mechanisms, and outcomes (i.e., CMOCs) associated with implementing and sustaining these models, emphasizing how they operate in different circumstances to achieve the Quintuple Aim objectives.

Approach

A realist-inspired narrative review was conducted to explore how, when, and in what circumstances innovative rehabilitation models of care have been implemented and sustained. Realist reviews iteratively refine theories to explain the causal processes that produce a given intervention's effects. The peer-reviewed and grey literature was searched and screened by title, abstract, and full text. Extracted data identified country of origin, publication year, intervention purpose, and any contexts, mechanisms, and outcomes. A numerical analysis of quantitative data and a conventional content analysis of qualitative abstractions was conducted. Mixed methods research techniques were applied to integrate the quantitative and qualitative findings.

Results

Twenty-six documents published between 2014 and 2021 were uncovered primarily from Australia and Canada. Studies aimed to describe (n=10), develop (n=4), evaluate (n=8), or compare (n=4) models of care. Contexts included the political impetus for change, care models' implementation settings, and the capacities and relationships necessary for adoption. Mechanisms purposefully addressed inequities in healthcare, leveraged human resources, and considered barriers, facilitators, and strategies related to adoption. Outcomes included increased access to quality care, successful and cost-effective implementation, and improved health, confidence, and satisfaction. New care models should: 1) articulate clear goals, 2) secure short- and long-term funding, 3) align with key legislative changes to optimize buy-in, 4) use a multidisciplinary approach, and 5) incorporate implementable educational and outreach strategies.

Conclusion

While integrating innovative rehabilitation models of care may help improve Canadians' access to timely care, the heterogeneity of included studies and reporting gaps precluded the identification of context-mechanism-outcome configurations. Future implementation research should adhere to relevant reporting guidelines to enhance clarity and applicability of their findings.

Influence of social determinants on primary care access for Quebec's older adults with dementia

Presented by: Claire Godard-Sebillote

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Background and Objectives

Primary care is vital in dementia care management and diagnosis, yet people living with dementia (PLWD) face many challenges in accessing care. Social determinants of health (SDH) factors such as material deprivation and being part of a visible minority group may contribute in differences in access. The study aims to describe primary care use in community-dwelling older adults with dementia in Quebec using health administrative databases and explore potential inequalities across social determinants.

Approach

A retrospective study using health administrative data accessed at the Institut de la Statistique du Québec (ISQ). These databases record most services provided via the public health insurance system, including primary care visits. The descrpitive analysis was conducted to examines material deprivation (MDI), racialization (RI) on primary care utilization among PLWD in Quebec. Health administrative data were linked with census-based neighborhood data to analyze these associations.

Results

Preliminary findings indicate that individuals in less deprived, more racialized neighborhoods had higher primary care visit rates. The fewest PLWD were found in the least deprived and most racialized neighborhoods, where the mean number of visits was highest. In contrast, those in highly deprived neighborhoods with more PLWD had fewer visits on average.

Conclusion

The findings suggest potential barriers to accessing primary care in more deprived areas, including limited healthcare resources and socioeconomic challenges. These results underscore the complex relationship between material deprivation and racialization in determining healthcare access.

Improving Practices of Information Transfer between Hospitals and Primary Care for Older Adults

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Background and Objectives

Geriatricians play a crucial role in caring for older adults, often making new diagnoses or medication changes during a hospital stay. However, there is no systematic process for transferring geriatrician notes to primary care physicians (PCPs), causing a loss of information.

This study aims to describe the transfer of geriatrician plans to outpatient providers, identify barriers and facilitators to implementing best practices, and generate evidence-based recommendations to improve this transmission.

Approach

First, we developed a survey about information transfer practice that we sent to geriatricians and performed a descriptive analysis.

Second, we conducted 20-minute semi-structured interviews with geriatricians and performed a thematic content analysis.

Third, we are conducting a scoping review of the literature to identify existing and suggested practices of information transfer.

Results

Key survey results indicated that although geriatricians believe that consult notes should be sent to PCPs and that lacking a systematic procedure negatively impacts the quality of care, only 2% say that such a procedure exists.

Thematic content analysis of our interviews revealed that no systematic way of transmitting geriatrician recommendations to PCPs exists, disrupting communication of medical information; a unified EMR can help; and confidentiality considerations are vital.

Preliminary scoping review results show that various information transfer methods exist across different healthcare systems, from mailing to fax to electronic medical systems. However, there is a gap in the literature addressing improving information transfer between hospital geriatricians and PCPs, despite it being a widespread problem.

Conclusion

Lacking a systematic process for information transfer to PCPs decreases the healthcare quality for frail older adults. We hope to generate and disseminate actionable recommendations on effective strategies to improve this information transfer.

Assessing Factors Influencing Physician Turnover in the Integrated Virtual Care (IVC) Program

Presented by: Leanda Godfrey

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Background and Objectives

The Integrated Virtual Care (IVC) program in Renfrew County, Ontario, was created to increase access to comprehensive primary care and attachment to family physicians. IVC faces some of the challenges of recruitment and retention of family physicians faced by many jurisdictions across Canada. This study aims to understand the experiences of IVC physicians who have decided to leave and those who continue in their role in IVC, specifically exploring the factors influencing their decisions.

Approach

This qualitative study was set in Renfrew County and used one-on-one semi-structured interviews with physicians who are part of, or recently left the IVC program. Using an internally developed interview guide, we captured information about their experiences and factors that drew them to the IVC program and factors influencing their decision to leave or to continue to provide care in IVC. Interviews were transcribed verbatim, and coded using an inductive approach to identify themes in the entire group of physicians, as well as within the two subgroups of those leaving IVC and those continuing in the program. Conventional content analysis was employed to describe the phenomena extracted from the interviews.

Results

Eighteen hour-long semi-structured interviews were conducted with IVC physicians, six of whom were leaving or left the IVC program during the past six months. The remaining twelve participants chose to stay. Further analysis is ongoing, and we expect to present and discuss themes related to the flexibility of providing care in IVC, challenges associated with virtual care delivery, and the challenges of working in family medicine in the current healthcare climate and in a rural area. We expect factors such as the program's compensation model and administrative burden of caring for a roster of patients were identified as influences on the decisions to stay or leave the program.

Conclusion

This study provides a greater understanding of the determinants and factors influencing the retention and turnover of virtual care physicians. The key insights gain can be used to inform similar models of primary care delivery in other regions and enhance the recruitment and retention of family physicians in underserved areas.

SUCCEED reporting checklist: enhancing transparency and quality in reporting scaling studies

Presented by: Amédé Gogovor

Author(s): *for the SUCCEED Group*

Background and Objectives

Accurate reporting of studies on the scaling of health intervention scaling can facilitate their replication and translation into practice and policy. In response to the absence of a dedicated reporting guideline for scaling studies, we registered the development of the standards for reporting studies of scaling evidence-informed interventions (SUCCEED) with EQUATOR Network. We outlined the development process of the SUCCEED reporting guideline and introduced the finalized checklist.

Approach

We followed the EQUATOR Network framework for developing health research reporting guidelines. An international executive committee was established to guide the process. We performed a systematic review to identify existing relevant guidelines and to generate a list of potential items. We conducted a consensus process, which included a two-round e-Delphi survey with an 80% consensus threshold and three virtual consensus meetings involving various interested parties: researchers, clinicians, patients, funders, policymakers, and journal editors. The final list of items for the SUCCEED reporting guideline was validated by the international executive committee.

Results

The international executive committee comprises 11 members, including 2 patient partners, 4 women, and 3 members from the Global South. We generated 829 potential items from 42 guidelines which were refined through three iterations for the consensus phase. In the first round of the e-Delphi, 24 participants from six countries contributed, comprising 14 women and 7 men. The participants included 19 researchers, 6 program implementers, 5 clinicians, 5 funders, 3 patients, 3 journal editors, and 1 policymaker. Twenty-six out of 35 items reached the consensus threshold. In the second round, 17 participants were involved, and 8 out of 10 items reached the consensus threshold. The final checklist consists of 34 items, organized into 6 sections: title and abstract, introduction, methods, results, discussion, and other information.

Conclusion

The SUCCEED reporting guideline will contribute to quality reporting in the science and practice of implementation and scaling. Researchers, practitioners, and policymakers will benefit from the improved clarity and completeness of reported information, enabling better evaluation, comparison, and utilization of findings in the field of implementation and scaling.

Health information technology in pharmaceutical marketing: an explication and analysis

Presented by: Brigid Goulem

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Background and Objectives

Prior research indicates that pharmaceutical companies, in conjunction with Health Information Technology (IT) companies, are using patient data and electronic medical record systems to promote pharmaceutical products to clinicians. Our objective in this ongoing project is to examine the use of health IT in pharmaceutical marketing in Canada and its implications for patients, communities and society.

Approach

We are conducting a qualitative research study informed by situational analysis, a critical grounded theory methodology. To date we have 1) interviewed ten individuals affiliated with the Health IT industry in Canada; 2) conducted 24 hours of participant observation at pharmaceutical marketing conferences; 3) collected 98 publicly available documents on websites of relevant companies. We are undertaking a continuous and iterative process of data collection and analysis; theoretical sampling; line by line and selective coding; analytical map creation; memo writing; and generation of theoretical concepts to explain findings.

Results

We identified three Canadian Health IT companies that produce pharmaceutical marketing tools. According to companies' claims, these tools are used by more than 30,000 health care providers in Canada. Participants described how Health IT companies receive payments from pharmaceutical companies to create patient handouts, decision support tools and patient identification algorithms with the objective of increasing clinician prescribing of the pharmaceutical companies' products. The Health IT companies sell, or give, these tools to clinics and hospitals, where they are imbedded in electronic patient care systems. The Health IT companies provide the pharmaceutical companies with feedback on tool use, and in some cases, clinician prescribing. Company documents rarely mention pharmaceutical industry involvement in the tool creation and position the tools as important clinical aids.

Conclusion

As intermediaries, the Health IT companies act to obfuscate the role of the pharmaceutical company in the production of clinical tools. This lack of transparency may impede oversight of the promotional activities and increase pharmaceutical industry influence over patient care.

Tailoring Pediatric Patient Acuity Tools: Strategies for Successful Implementation

Presented by: Megan Gray

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Background and Objectives

Patient acuity tools are designed to ensure safe nurse-patient assignments. These tools often fail to meet pediatric needs, as they are largely based on adult care models. Despite the availability of pediatric-specific tools, research on their implementation remains limited. This study aimed to identify approaches for implementing a pediatric patient acuity tool across inpatient units at a tertiary pediatric health centre to improve consistency through an evidence-based approach to staffing decisions and patient care.

Approach

This sub-study, part of a larger project, utilized qualitative methods to explore implementation strategies for a pediatric acuity tool. Interviews and focus groups with 29 staff nurses, clinical leaders, and clinical managers from four pediatric inpatient units were conducted to identify perceived barriers and facilitators. Content analysis, guided by the Consolidated Framework for Implementation Research (CFIR), mapped barriers and facilitators onto the five CFIR domains. Using these mapped barriers and facilitators, effective implementation strategies were identified through the CFIR-Expert Recommendations for Implementing Change (ERIC) Matching Tool (Version 1.0).

Results

Perceived barriers and facilitators were mapped to CFIR constructs, including adaptability, patient needs and resources, compatibility, knowledge and beliefs about the intervention, and self-efficacy. These factors differed by nursing role (staff nurse, clinical leader, clinical manager), and pediatric in-patient unit. Based on identified CFIR barriers in the first phase of this study, recommended implementation strategies included: 1) identify and prepare champions, 2) promote adaptability, 3) conduct local consensus discussions, 4) provide facilitation, 5) identify early adopters, 6) inform local opinion leaders, and 7) develop educational materials to support implementation efforts.

Conclusion

Using the CFIR-ERIC Matching Tool, we identified targeted strategies to support implementation of a pediatric patient acuity tool. These findings provide actionable guidance for adapting and integrating evidence-based tools into practice and will inform the implementation process at a tertiary pediatric health centre, ensuring alignment with local needs and resources.

Examining the use of patient-reported experience measures for medications: A survey study

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Background and Objectives

Prescription medications are commonly used in Canada and globally; however, patient-reported experience measures (PREM) for medications are not routinely used in clinical practice. Understanding and measuring patient-reported experiences is of key importance for providing safe, effective, and high-quality patient-centered care. The objective of this study was to examine the barriers and facilitators to the use of a PREM for medications in routine practice in Ontario, Canada.

Approach

We report quantitative findings from a theory-based, mixed-methods study. Guided by the 14 behavioural domains outlined in the Theoretical Domains Framework (TDF), a cross-sectional survey was developed based on a literature search, interviews, and consultation with an advisory committee comprised of five persons with lived experience of taking medication (PWLE). A 5-point Likert-type scale was used for most responses. Participants included PWLE, medication prescribers (physicians, pharmacists, nurses), and decision-makers. The electronic survey was self-administered, collecting data on demographics, factors impacting the use and implementation of PREMs for medications, and the ideal delivery of a measure. Data were analyzed descriptively.

Results

To date, 299 individuals have completed the survey, including 152 medication prescribers (97% pharmacists), 138 PWLE, and 8 decision-makers. The TDF domains that participants identified as barriers to using and/or implementing a PREM for medications were Knowledge, Reinforcement, and Environmental Context and Resources. The TDF domains that participants identified as facilitators to using and/or implementing a PREM for medications were Skills, Beliefs about Capabilities, Optimism, Goals, and Social Influences. In terms of delivery of a PREM for medications, all participant groups agreed that the PREM should take less than 10 minutes to complete and there should be both open and close-ended questions. Most PWLE preferred the measure to be implemented in primary care, while most prescribers preferred community pharmacy as the setting of implementation.

Conclusion

We identified the TDF domains that act as barriers and facilitators to the implementation and use of a PREM for medications in routine healthcare in Ontario, Canada. This understanding will support the development of a PREM for medications, along with coinciding program and policy interventions to enhance implementation and sustainability.

Decomposing wage imbalances by gender and sexual minority status in the Canadian nursing workforce

Presented by: Neeru Gupta

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Background and Objectives

Studies reveal a persistent gender wage gap among physicians, a traditionally male-dominated workforce. Some have also found earnings disparities in female-dominated nursing, associated with devaluation of women's labour alongside accelerated promotions and other workplace rewards favouring men. The research is less robust on wage differences for gender and sexual minorities (GSMs). This work aims to systematically decompose how GSM status may interact with gender as predictors of earning differentials in the Canadian nursing workforce.

Approach

This national observational study leverages the 2021 Population Census, the first large-scale data source to collect information on both sex at birth and gender identity, plus same-gender couples, enabling to distinguish GSM individuals. Nurses are identified by the National Occupational Classification, and professional earnings are captured through integrated administrative income tax records. Following a descriptive analysis, we will conduct Oaxaca-Blinder decompositions for explaining earnings differentials (logged) by gender and GSM status, adjusting for various human capital confounders (e.g., place of work, hours worked) and intersecting social identity characteristics (e.g., racial/ethnic origin, childcare status), and estimating any "unexplained" residual.

Results

Approximately 0.3% of the adult population were enumerated as transgender or non-binary, and 1.5% of census families represented same-gender or transgender/non-binary couples. At the time of writing, analyses of the de-identified 2021 census microdata were underway in the secure computing environment of the Canadian Research Data Centre Network, in compliance with Statistics Canada's stringent privacy and confidentiality protocols. Preliminary findings indicated that women nurses earned significantly less on average than men. By the CAHSPR Conference, results of the decomposition analyses will enhance understanding of whether the gender wage gap is exacerbated or attenuated by GSM identity, which human capital and intersectional factors explain the gaps, and what proportions of the gaps remain unexplained (i.e., often attributed in the literature to statistical evidence of discrimination).

Conclusion

This research will build knowledge on gender and sexual diversity-related wage gaps to help inform policy and practice for optimizing equity in health human resources and reducing barriers to full economic inclusion associated with social discrimination.

Co-designing research tools and methods for persons with dementia from underserved communities

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Background and Objectives

Patient engagement integrates lived experiences into health research, thereby improving its relevance and outcomes. People with lived and living experience of dementia (PWLLED), particularly those from underserved communities, face significant barriers to accessing specialist care and are underrepresented in research. This study documents how co-design can be used to develop an inclusive interview guide and recruitment strategy to gather PWLLED's perspectives on the use of electronic consultations (eConsult) as a means of accessing specialist care.

Approach

As part of a large CIHR-funded initiative to improve access to specialist advice via eConsult in Ontario and Quebec, we assembled a multidisciplinary team of patient/care partners, researchers, clinicians, and knowledge user organizations. Using a participatory approach, we established two advisory groups: one comprising geographically diverse PWLLED from underserved communities, and another of primary care providers (PCPs) and specialists. Through collaborative meetings, we co-created an interview guide and recruitment strategy to capture perspectives on eConsult's impact in improving care access for PWLLED.

Results

To date, one co-design session has been conducted with seven patient/care partners. Participants contributed to the interview guide development by providing feedback during the meeting and via email. Revisions enhanced the tool's relevance for PWLLED and included rewording questions for accessibility, removing one redundant question, and adding three questions (addressing patient preferences for eConsult; comfort discussing eConsult with their PCP; and challenges faced by underserved communities). Recruitment strategies are under development, focusing on ensuring representation across diverse populations. We expect completing the interview guide, finalizing the recruitment strategy, and compiling lessons learned by the conference date. We anticipate these lessons showcase effective strategies for co-designing research tools, addressing challenges, and providing valuable guidance for researchers aiming to engage underserved communities in health services research.

Conclusion

Co-designing research tools and methods with PWLLED from underserved communities ensures inclusivity and fosters shared ownership of research processes and outcomes. It also enhances the relevance of findings for informing equitable health policy and decision-making. By sharing our strategies, we aim to inspire wider adoption of patient engagement in research.

Community Factors Related to Employment Pathways for Youth with Disabilities: A Realist Review

Presented by: Amelia Hagelstam Renshaw

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Background and Objectives

Youth with disabilities face significant challenges in accessing employment, and transitioning from school to a work settings. Youth with intersectional challenges such as women or girls with disabilities, or youth with multiple disabilities face additional barriers. Through a project with Accessibility Standard Canada, the objectives were to identify the community-based factors that contribute to the employment of youth ages 15 to 25 with all types of functional disabilities in Canada.

Approach

We conducted a realist review following RAMESES standards on Medline, PsycINFO, ERIC, Policy Commons, Sociological Index, Google Scholar, REHABData and Canadian Research Index. Search terms included: employment, disabilities, youth, and community factors. We used the Child Community Health Inclusion Index macro level factors as a framework for data extraction and analysis including: transportation, staff training, community design, awareness initiatives, healthcare access, general programs/services, volunteer/work, education, technology, web-mapping, accessibility policies, and social factors. Data was analyzed by context, mechanisms, and outcomes and using the LGBT+intersectional lens.

Results

From 13167 studies identified, 57 articles met the inclusion criteria and were retained . The most prominent Contexts of youth-related employment included: education (n=35) such as skills training (social, practical job interviews, CV writing, etc) and information about post high school education options and general programs/services in the community (n=18) such as job search and job readiness training, and mentorship programs. Mechanisms that seem to contribute to successful transition from school to employment outcomes include: equipping students with employment skills such as job-search and job-retention abilities, and providing social supports (friendly attitudes towards youth and accessibility), and increasing collaboration and communication between school and work spaces. No specific considerations of intersectionality were addressed in these studies.

Conclusion

Skills training, job preparedness and individual/employer-targeted strategies, including workplace social support, should inform the development of youth employment standards. Increased intersectoral collaborations are necessary to improve transition outcomes, including creating early work/volunteering opportunities. There is a critical need to address disabled youth's intersectional backgrounds in transitioning to employment spaces.

Unlocking Variation in Physician Home Visits: Patient Receipt, Physician Delivery & Fee Code Costing

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Background and Objectives

Though end-of-life physician home visits have been shown to align patient preferences with desirable outcomes, including community deaths, only 59.5% of Ontarians receive end-of-life home visits. Variation in receipt, rising forecasted costs, and growth of non-goal concordant care all comprise a research imperative to inform improved access. To date, research has not explored the relationships between fee code composition, cost, timing and variation across patients and physician providers.

Approach

Using retrospective health administrative data from ICES in Ontario, we applied novel approaches to fee code stratification and costing along with frequentist statistics to analyze home visit receipt and provision to patients in their last year of life. Eligibility criteria included: enrollment in Ontario Health Insurance Plan, residence in community, and death between January 1, 2021-December 31, 2022. We used frequentist statistics to assess receipt and delivery of home visits. Fee code level analysis enabled differentiation between home visit fee codes and adjacent codes billed during home visits. Multiple costing methodologies allowed an examination of variation and outliers using imputed and non-imputed costs.

Results

While home visit receipt has historically been treated dichotomously in health services and health economic research, our results suggest significant variation in receipt during the last year of life with between 1 to 246 visits per patient and a mean of 4.3. Total cost of home visits per patient in the last year of life also ranged significantly between $14.98 and $46,289.89 with a difference of 16% between costing methodologies (imputed vs. non-imputed). Adjacent fee codes billed by physicians during home visits were documented over 200,000 times during the study period. From a physician perspective, volume of delivery and cost of home visits varied significantly with 20% of physicians providing only one home visit and compensation ranging between $14.98 to $805,758.64 for total home visits delivered over the study period.

Conclusion

The health system challenges of caring for patients at home in their last year of life are growing. Our findings offer methodological considerations for future home visits research including treatment of this intervention as non-dichotomous. Significant variations in cost also suggest that additional exploration of this heterogeneity is warranted.

In-the-moment assessments of substance use in clinical samples of youth: a systematic review

Presented by: Jillian Halladay

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Background and Objectives

Understanding daily patterns youth substance use is critical to optimizing substance use treatment. A novel micro-longitudinal method, ecological momentary assessment (EMA), now offers more accurate insight of substance use patterns and related antecedents and consequences of this use than previous designs. EMA enables repeated, brief data collection in near-real time. This systematic review aims to summarize the methods and findings of EMA studies conducted on clinical samples of youth.

Approach

We conducted a systematic review of studies published up to May 2024 using EMA to explore substance use and related behaviours, antecedents, and consequences among youth (mean/median age <=26 years of age) in clinical samples (e.g., emergency department, outpatient medical, outpatient mental health). 8,335 titles and abstracts were screened and 939 full-texts were reviewed, of which 29 studies (published between 2009 and 2023) met eligibility criteria. Data extraction is underway, including study and sample characteristics, measurement, EMA procedures, outcomes, and quality appraisal.

Results

Current results are preliminary. Of the 29 papers, samples were from the emergency department (10%) or mental health (24%), substance use (24%), or medical (12%) outpatient clinics. Most were conducted in the US (93%), with 2 in Australia. Sample sizes ranged from 8 to 248 with an average age of 20. Assessments periods were on average 31 days with approximately 4 assessments per day which typically included time (79% of studies), event (44%), and signal (62%) contingent prompts. The most commonly explored substances included alcohol (76%), cannabis (55%), and tobacco/nicotine (31%). Correlates of substance use were grouped into: how they were feeling (captured by 69% of studies), who they were with (45%), and what (38%), when (52%), where (41%), and why (28%) they were using.

Conclusion

This review will summarize current insights related to the: (1) who, what, when, where, and why youth use substances who are accessing care, which can help determine whether current treatment approaches appear to target relevant triggers; and (2) methods used in clinical EMA studies to guide future larger EMA studies.

Co-designing a Francophone Autism Engagement Framework with Community Members

Presented by: Michèle L. Hébert

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Background and Objectives

Despite Canada's commitment to French-English bilingualism and federal Autism Strategy, francophone autistics often face barriers to employment and services, worsened by linguistic and cultural gaps. With autism-first language generally preferred, disconnection deepens. Further, non-official language speakers face heightened risk of healthcare harm than official language speakers. Thus, this project aims to co-design an engagement and support framework with and for French-speaking autism organizations, facilitating inclusion and advocating for policies that strengthen pan-Canadian community-wide equity.

Approach

With inclusive equity-policies as goals, three groups will participate : francophone self-advocates/persons with lived experience and French-speaking service providers and decision-makers. First, we are completing a scoping review to identify frameworks that engage francophone autism communities. Second, a pan-Canadian environmental scan will describe provincial/territorial language-use by organisations serving autistics and by governments with autism-strategies. Next, e-surveys, audio-recorded interviews/ focus groups will concurrently (i) describe degree and type of engagement by francophones, (ii) validate optimal frameworks. Triangulation of descriptive statistics and thematic analyses will describe francophone engagement and inform framework co-design, fostering in-depth understanding of autistic francophone engagement in Canada.

Results

Jointly with participants, we expect to discover autism engagement patterns related to French-speaking. Also, themes will emerge from conversations with francophone self-advocates, service providers and decision-makers, at organisational or policy-making levels. Namely, we will improve our understanding of similarities and differences in degree of engagement by francophone autistic youth and persons in services and autism-strategies within distinct Canadian provinces and territories or governments. These findings will help inform the francophone autism engagement framework co-creation.

Conclusion

The first ever Autism Alliance Canada francophone engagement framework will be developed and validated with and for francophone autism community members across the country.

Informing family physician payment reform: protocol for a cross-provincial, multi-method study

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Background and Objectives

Amid growing concerns about access to primary care and the need to bolster community-based longitudinal practice, provinces in Canada have implemented major reforms to how family physicians are paid. These models aim to make community-based longitudinal family practice more attractive and, to some degree, address long standing disparities in pay between family medicine and other specialties. These new remuneration models require rigorous and transparent evaluation to guide improvements, future investments, and planning.

Approach

We will conduct a multi-method study to explore physician perceptions and outcomes of these new models. First, we will complete semi-structured interviews with family physicians (FPs) in British Columbia (BC), Manitoba (MB), and Nova Scotia (NS) (provinces where a new blended compensation model, or BCM, has been introduced). Interviews will explore FPs' motivations for moving onto the BCM; how the BCM has impacted their practice, administrative burden, visit length, capacity, and changes to care coordination. Second, using provincial and national administrative datasets, we will assess the impact of BCM reforms on service volume, attachment/enrolment, continuity of care, and costs.

Results

BC implemented its new BCM – Longitudinal Family Physician – payment model in February 2023; NS followed with its Longitudinal Family Medicine model in October 2023; and MB implemented its Family Medicine Plus model in April 2024. All three models blend the same components – physician time, services delivered, and a panel payment – but differ in the weighting and amounts of each component. In BC and NS, physician time is the dominant mode of payment while in MB this is based on services delivered. Through physician interviews and analyses of administrative data, we will work toward an understanding of whether these models meet their provinces' objectives to improve clinician experiences and improve recruitment and retention of family physicians.

Conclusion

We will summarize province-specific and cross-provincial study findings to share with policy makers. Our recommendations will address potential refinements to the BCMs, as well as broader changes to processes for workforce planning, to be developed and refined by a cross-provincial advisory.

Understanding the implementability of a novel surgical scheduling system: A qualitative study

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Background and Objectives

Inefficiencies in surgical services contribute to rising costs and increasing wait times in the Canadian healthcare system. Surgical delays, worsened by COVID-19 backlogs, have negatively impacted patients. A reliable, data-driven approach integrating Machine Learning with automated scheduling is needed. A team at Sunnybrook's Holland Orthopedic Centre and the University of Toronto have developed a new automated surgical scheduling system (HOPE). Understanding the behavioural and organizational factors influencing its implementation is essential before scaling widely.

Approach

We conducted a qualitative descriptive study to identify the determinants (barriers/facilitators) of implementing HOPE at the Orthopedic Centre. We used a purposive sampling strategy to invite individuals involved in implementing or using the new automated system: surgeons, nurses, decision support and administrative personnel, and surgical unit program directors. Data were collected through 60-minute semi-structured virtual interviews, informed by the Theoretical Domains Framework. Interviews were audio-recorded, transcribed verbatim, and analyzed using content analysis. Data was organized using the Consolidated Framework for Implementation Research (CFIR). Quantitative data from the demographic survey was analyzed using descriptive statistics.

Results

17 knowledge users of HOPE were interviewed (53% women, 70% aged 41-60 years). We identified implementation challenges in the context of the existing and new (HOPE) scheduling systems. For the existing system, three categories of challenges were identified: 1) System functioning (access to information, data quality, predicted surgery algorithm, surgical codes, user-friendliness), 2) process-related factors (adherence, capability, changes, complexities, expectations, timing), and resource factors. Participants viewed HOPE as a potential solution to challenges. CFIR domains captured HOPE's determinants, comprising barriers (n=53), enablers (n=46), and recommendations (n=186). Most challenges (56%) were represented by HOPE's adaptability, relative advantage, complexity, and evidence base (Innovation domain of CFIR) with recommendations provided by participants to address them. Enablers (n=33) highlighted HOPE's advantages over the old system and machine learning evidence.

Conclusion

This qualitative study identified key barriers and enablers of the existing and new surgical scheduling systems with recommendations for optimizing the implementation of HOPE. Findings will be used to refine HOPE to support improved surgical scheduling efficiency and outcomes. A future implementation/scale-up guide will help spread HOPE more widely.

“Palliative care” beds across 3 provinces: presence, profiles and types

Presented by: Leonie Herx

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Background and Objectives

Patients with advanced illnesses may experience complications and needs that require inpatient care in specialized palliative care units (PCUs) or hospices. Studies show benefits of these services to patients, families and healthcare systems alike. To address different needs, PCU and hospice beds are needed in the right proportions, based on population sizes (“Catalonia” formula). This study examined the numbers, types and profiles of PCU and hospice beds across regions in three Canadian provinces.

Approach

As part of a larger study to develop a Canadian Atlas of Palliative Care that maps the status and vitality of palliative care across several domains and indicators, we used a mixed-methods approach to identify the presence of PCU and hospice beds across three provinces (Ontario, Alberta and British Columbia). Data collection included online surveys and interviews of palliative care leaders, website searches, and focus groups of frontline palliative care providers. The following data was compared across regions and provinces: location of PCUs and hospices (geographic and care setting), number of beds in each, and patient profiles.

Results

Considerable variation was found in numbers and profiles of PCU and hospice beds across regions. PCUs, while usually hosted in acute or continuing care hospitals, vary in profiles; some care for persons with complex needs notwithstanding prognosis while others admit only at end-of-life (last days) notwithstanding complexity. Some beds are in dedicated PCUs with trained staff, while other PCU beds are “floating” (not in a dedicated unit) and/or only designated (not for the exclusive care of palliative patients), resulting in lack of access at times to these beds and staff without palliative care training. Some regions have enough PCU and hospice beds, while others lack one or the other, or have disproportionate numbers and profiles.

Conclusion

Determining an accurate number of palliative care beds is elusive given different profiles and definitions. Overall, some regions have enough beds while others lack PCU and/or hospice beds. In some cases, although PCU beds are present, their profile may be misaligned with population needs. Health care planners should address gaps.

Digital platforms, workers, and hospital and LTC interests in triangular employment arrangements

Presented by: Pamela Hopwood

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Background and Objectives

Chronic health worker shortages have pushed organizations to engage 'gig' platforms as a technology 'solution'. Platforms take different forms from apps to websites to software integrated with staffing scheduling programs. Hiring temporary gig care workers exacerbate poor work conditions and may jeopardize patient safety. We describe positions of parties involved in the hiring of gig care workers via digital platforms and identify policy gaps related to this employment context.

Approach

This qualitative research study involved interviews with 20 gig care workers, seven industry experts with knowledge of digital platforms, and five informants who used temporary staff (n=32). Interview questions addressed experiences of platform use, frequency, functions of platforms and implications of hiring gig workers. We used thematic analysis to code data, with consideration of the perspectives of the three parties involved in the triangular employment arrangements. Through comparing these interests, we discerned potential policy gaps related to workers' occupational health conditions and policy issues relevant for patient care.

Results

Hiring workers from digital platforms provided easy-to-access, on-demand staff for hospitals and LTC homes. However, there were problematic aspects of using platform staff not accounted for by all organisations, such as workers compensation coverage, and familiarity with facilities. Platform workers spoke about enjoying flexibility and higher on-demand wages, but analysis revealed limitations in opportunity and additional unpaid labour of job seeking and self-employment (i.e., remitting own income taxes). Platform companies reported being focused on 'service' for customers; however, tensions arose between the stated service orientation and digital platforms' lack of responsibility for independent contractors, which further conflicted with healthcare organisations' objectives and workers' interests. This painted a picture of a triangular employment relationship that left gaps in policy for protecting workers and patients.

Conclusion

Considering the interests of workers, gig platforms and client-employers such as hospitals and LTC revealed tensions between parties in a triangular employment relationship. Gig platform technology seen only as an easy solution to workforce shortages may mask policy gaps related to work conditions and patient safety.

Karen Okrainec Paving a Road Map for Integrated Care Evaluation

Presented by: Jennifer Hyc & Karen Okrainec

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Background and Objectives

Integrated care (IC) models can shift care from the hospital to the community and support patients while improving patient and provider experience, outcomes, and equity while reducing unnecessary care and costs. A feasible yet meaningful way to evaluate IC models is not well known. The objective of our study was to evaluate the feasibility of a minimum data set which addresses Quality Standards, Quintuple Aims, and allows for continuous evaluation of Canadian IC models.

Approach

Patient and caregiver partners, senior hospital and community leadership and policy leaders helped inform the selection and refinement of our minimum required metrics for implementation in Ontario. A mixed methods retrospective evaluation of University Health Network's (UHN) IC program was conducted using a minimum data set which included: 1) program-specific and hospital-level chart data for 2868 patients enrolled and 4064 controls between June 1 2019 and May 30 2023, 2) Semi-structured interviews and surveys with enrolled patients, staff, and homecare providers and 3) provincial survey and administrative health services data.

Results

Detailed and interdisciplinary linkage of homecare, hospital-relevant program and patient-level data allowed for a feasible way to create a minimum data set except for equity-relevant data where the use of natural language processing was harnessed to improve capture rates. Low response rates to national survey data within our study cohort (~2%) led to a much higher response rate through hospital-specific patient experience surveys. However, accessibility to comparable patient experience data outside our institution will impact our ability to assess the program's impact beyond our institution.

Conclusion

Our minimal data set was found to be feasible, sustainable and scalable with minor refinements within our institution. The biggest limitation for province wide scalability remains the paucity of equity-relevant data, the need for shared records between hospital and community. Greater information sharing between sites and use of machine learning methods are needed.

Motivational Interviewing to Promote Healthy Behaviors in Young Adults (MOTIVATE): A Pilot RCT

Presented by: Taylor Incze

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Background and Objectives

Healthy behaviors, including physical activity and balanced nutrition often decline during young adulthood, contributing to long-term health risks. Motivational interviewing (MI) is a person-centred counselling approach designed to enhance intrinsic motivation. We evaluated the feasibility of a 6-month MI-based intervention, compared to educational materials, to promote health behaviors in young adults aged 18-29 at a Canadian university.

Approach

We conducted a pilot RCT with 101 participants (intervention = 52; control = 49). The intervention group received monthly online MI sessions and educational materials based on Canadian guidelines, while the control group received educational materials only. Feasibility outcomes included recruitment (≥50%), retention (≥80%), data completeness (≥80%), and satisfaction (mean score ≥3). Secondary outcomes, including changes in BMI, physical activity, nutrition, quality of life (QOL), and mental health, were measured using activity trackers, self-reported weight, and online questionnaires at baseline and every two months. Data were analyzed according to CONSORT guidelines for pilot studies using descriptive and comparative methods.

Results

A total of 81 participants completed the 6-month questionnaire (intervention = 43; control = 38), with only four withdrawals (intervention = 1; control = 3). Feasibility outcomes exceeded pre-specified targets, with high eligibility (98%), recruitment (86%), retention (80%), and data completion (93%). Overall, participant satisfaction was high, with a mean score of 3.9 (SD = 0.99) on a 5-point Likert scale. Modest BMI reductions were observed in both the intervention group (-0.3 kg/m2, 95% CI: -0.56, -0.04) and the control group (-0.5 kg/m2, 95% CI: -0.97, -0.03). Improvements in physical activity, dietary behaviors, and QOL domains (particularly self-care and anxiety reduction) were not statistically significant. No changes were observed in depressive symptoms or anxiety.

Conclusion

This pilot RCT supports the feasibility of an online MI-based intervention for promoting healthy behaviors in young adults. Findings suggest a larger-scale trial to evaluate the effectiveness of MI to improve health behaviors is feasible and may be warranted to address adverse population health trends.

RN-RPN Collaboration in Acute Care: Generating Evidence to Inform Nursing Workforce Optimization

Presented by: Alyssa Indar

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Background and Objectives

Critical health human resource shortages, particularly related to the nursing workforce, continue to compromise care delivery in post-pandemic healthcare systems. In Canada, there has been a 25% increase in vacancies for RN (Registered Nurse) positions and a 20% increase for RPN/LPN (Registered Practical Nurse/Licensed Practical Nurse) positions (Statistics Canada, 2023). Recent strategies to maximize the RPN scopes of practice have addressed workforce shortages but pose challenges in complex clinical situations (Lankshear et al., 2016).

Approach

We conducted a multiphase study to (1) explore RN-RPN collaboration in acute care settings, and (2) develop an RN-RPN collaboration tool. This study took place at an academic hospital network in Ontario, Canada. Our team includes academics, knowledge users and an advisory team (RPNs, patient advisor). In Phase 1 we conducted an interpretive descriptive study (Thorne, 2016) to explore RN-RPN collaboration in complex clinical situations. We interviewed 24 participants, with representation from RNs, RPNs, PSWs (personal support workers) and nurse leaders. We collected macro- and meso-level documents pertaining to RN-RPN scopes of practice and collaboration. We analyzed the data to generate a thematic summary.

Results

The findings highlight: (1) differences in participant perceptions of practice 'complexity', and (2) how this informs adaptive RN-RPN collaboration strategies. The role of leadership in cultivating psychologically safe environments was a key ingredient to supporting RN-RPN collaboration, particularly in settings where RPN roles were recently introduced. When considering the macro- and meso-level contextual factors framing RN-RPN collaboration (from the document analysis), there is limited formal guidance; although a gap, participants identified opportunities for RNs and RPNs to implement context-specific and adaptive strategies to address the uniquely complex features of their individual settings. These findings informed Phase 2 planning, in which we held interprofessional focus groups to support the development of an RN-RPN collaboration tool (in progress).

Conclusion

The Phase 1 findings on RN-RPN collaboration have informed practical, organizational-level leadership and policy recommendations to improve nurse retention and work environments. This work may be relevant for macro- and meso-level leaders and decision-makers seeking strategies to support of collaborative work environments and safe patient care

Recurrence risk for spontaneous preterm birth: a population-based cohort study examining variation by spontaneous preterm birth cause

Presented by: Catalina Ionescu

Background: Spontaneous preterm births (SPTB) account for 70% of preterm births, resulting from either spontaneous preterm labor (SPTL) or preterm premature rupture of membranes (PPROM). Previous literature estimates SPTB recurrence at 27-34%, with recurrence risks of 6-9% for PPROM and 13-33% for SPTL. Uncertainty remains regarding how recurrence risk varies by initial SPTB cause (SPTL vs. PPROM), gestational age (early vs. moderate-late preterm), and applicability of existing estimates to a Canadian population.

Methods: We analyzed a population-based cohort of pregnancies in British Columbia (BC) from 2004 to 2020 using a comprehensive birth registry (BC Perinatal Data Registry) linked with administrative health records. We estimated recurrence risks with 95% confidence intervals for SPTB overall, cause-specific SPTB (due to SPTL vs. PPROM), and gestational age (early: <32 gestational weeks and moderate-late: 32–36 gestational weeks).

Results: Among 719,171 births, 7.8% resulted in SPTB, (4.4% SPTL, 3.4% PPROM), 12.6% were <32 weeks, and 87.4% were moderate-late. Among 33,666 individuals with an initial SPTB, 21.8% (21.4-22.3) experienced a recurrent SPTB in their next pregnancy (13.4% SPTL, 8.4% PPROM). For individuals with an index SPTL, 22.0% (21.43-22.56) experienced recurrent SPTB, (18.2% recurrent SPTL, 3.8% PPROM). Among those with an index PPROM, 21.6% (20.9-22.3) had a recurrent SPTB (15.5% recurrent PPROM, 6.1% SPTL). Among those with an index SPTB <32 weeks, 24.8% (23.5-26.1) had recurrent SPTB, compared to 21.4% (20.9-21.9) for index SPTB at 32–36 weeks.

Significance: We found similar overall SPTB recurrence risks but higher PPROM recurrence than previously reported. SPTB recurrence also varied by gestational age at initial SPTB. These findings may inform clinical counseling on recurrence risks after a first SPTB.

Ontario’s healthcare system utilization: A time-trend analysis

Presented by: Liisa Jaakkimainen

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Background and Objectives

While all Ontario residents receive universal healthcare, which includes physician care, emergency department (ED) visits and hospitalizations, these resources are increasingly strained. To guide decisions and policies which support healthcare, information is needed on whether these services are meeting the needs of population growth. Our objective was to examine 20-year trends in the annual average number and type of healthcare services utilized by Ontarians in an average 24-hour period and per 10,000 population.

Approach

All Ontario residents with provincial healthcare coverage were included in the analysis. A time-trend analysis (2002/03 to 2023/24) was conducted using linked health administrative data in Ontario, Canada. For each fiscal year, standard measures of healthcare utilization were explored: family physician visits, specialist visits, hospitalizations, ED visits, total hip or knee replacements and diagnostic imaging scans. Average number (per 24-hour period) of select weekday/weekend healthcare visits per fiscal year for Ontario residents from April 1, 2002 to March 31, 2024 were created. The average number of visits per 10,000 population were also calculated.

Results

The average number of FP visits per day was stable from 2002/03 to 2023/24, but the average number of FP visits per 10,000 persons in Ontario has declined. While the average number of FP visits per day increased for persons over 65 years of age, people living with diabetes, hypertension, cancer and dementia, the average number of FP visits per 10,000 persons decreased for these groups. The gap between FP visits per day and specialist visits per day is narrowing. The average number of specialist physician visits per day increased from 2002/03 to 2023/24, as did the average number of specialist physician visits per 10,000 persons. The specialist physician visits per population slightly increased for persons over 65 years of age and for persons having hypertension, congestive heart failure, chronic obstructive pulmonary disease and dementia.

Conclusion

Family physician visits remain the most frequently accessed service in Ontario’s healthcare system. While the trends in the average number of family physician visits per day is stable or for some groups increasing, the average number of visits is not keeping up with the population growth.

Engaging Black Communities in Research: Learnings from a Community-based Cross-Sectional Study

Presented by: Ambili Kariaparambil Rajan

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Background and Objectives

Lack of research among the Blacks in Canada has led to a limited understanding of their health and social experiences and a lack of interventions to improve their well-being. Conducting research in the Black community is essential to fill this knowledge gap and inform evidence-based policies and interventions. Using a community-based research (CBR) approach, we want to assess the extent of chronic diseases in the Black community and understand how COVID-19 policies impacted their needs.

Approach

The study was designed with the support of Black community members. Community-based advisory committee co-developed research materials and engagement strategies. Different recruitment channels and forms were implemented to ensure a representative sample in a cross-sectional survey conducted over four months in the Greater Toronto Area. Data were collected on sociodemographics, health needs, and perceptions of health services of Black/African/Caribbean self-identified participants during and before the pandemic.

Results

Although there were challenges in communicating with the advisory committee and eliciting feedback on the study tools, contacting them directly by phone obtained better responses compared to sending emails. Overall, direct engagement through community events guided by the advisory committee, interacting with people in person at the events, and having a trusted organization or a familiar person approaching people and advocating about the study resulted in the greatest number of respondents in a shorter period. Indirect recruitment strategies like online advertising fared lower results where <30% of participants expressed interest. The representation of both francophones and anglophones in the recruitment strategies was essential. 74% of interested individuals completed the survey

Conclusion

This study underscores the importance of adaptability, community engagement and in-person interactions in CBR. It emphasizes how the involvement of trusted organizations can enhance participant recruitment and study outcomes. The findings are valuable for bridging the gap between researchers and communities. CBR can address health disparities and social inequalities experienced by Black communities and empower them through increased engagement.

Health Status Among Community-Dwelling Afro-Caribbean Black Canadians Before and During the Pandemic

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Background and Objectives

Racial inequities can lead to marginalization, discrimination in health services, lack of access to care, and poor quality of care. The COVID-19 pandemic has exacerbated pre-existing health, social, and economic disparities within marginalized communities. This study aims to identify how the COVID-19 pandemic impacted the health of Black communities in Canada and to identify associated factors, both prior to and during the pandemic, to inform areas for action and service planning.

Approach

This community-based cross-sectional study included English- or French-speaking Canadians self-identifying as African, Caribbean, or Black, living in the Greater Toronto Area. A survey was conducted to collect data on sociodemographic and clinical factors, as well as perceived health status. Perceived general and mental health status, overall and by characteristics, both prior to and during the pandemic was described. Key factors associated with perceived health before and during the pandemic were explored using multivariable logistic regression.

Results

The study included 388 individuals, mostly English-speaking and non-Canadian-born. Before the pandemic, 81.4% reported good/excellent general health and 76% reported good/excellent mental health, compared to 48.7% and 44.6%, respectively, during the pandemic. Before the pandemic, physical activity (OR= 2.87) and multimorbidity (OR= 0.15) were significantly associated with self-reported general health. Immigration status, age, education, employment status, multimorbidity, and insurance coverage influenced self-reported mental health before the pandemic. Multimorbidity and being female lowered the odds of good/excellent general health while being French-speaker (OR=0.35) and being female lowered the odds of good/excellent mental health during the pandemic. Having private insurance (OR=2.76) and being physically active increased the odds of good/excellent mental health by three times during the pandemic.

Conclusion

This study provides information on health status in a community-based sample of Black Canadians before and during the COVID-19 pandemic and explores how social determinants of health vary in different contexts and situations. The study may support decision making through a better understanding of the factors affecting health status in this community.

Can eConsult enable palliative care in the community? A cross-sectional analysis

Presented by: Sathya Karunananthan

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Background and Objectives

Most Canadians prefer to die at home. While primary care providers (PCPs) play a pivotal role in providing palliative care in the community, only 40% have reported being prepared to manage palliative care needs. eConsult allows PCPs to submit clinical questions to specialists. To understand its role in enabling access to palliative care advice, we examined eConsult questions submitted by PCPs to palliative care specialists, specialists' responses, and the impact of eConsult on patient care.

Approach

This was a cross-sectional observational study where descriptive analyses were conducted to present service utilization data, PCPs' responses to a close-out survey, and results from categorizing eConsult content according to two validated taxonomies: The Taxonomy of Generic Clinical Questions and the International Classification for Primary Care, version 3. Data were obtained from the Champlain eConsult BASE™ service of Eastern Ontario. Four clinicians adapted the taxonomies and iteratively coded cases, meeting to resolve discrepancies until agreement was achieved. The remaining cases were coded independently by one clinician, with a random sample (10 cases) sent to a second clinician for independent review.

Results

We included 78 cases submitted between Jan 2018 – Dec 2022 to palliative care specialists. Mean patient age was 76 and most were female (59%). The top three clinical content areas were general (e.g., pain, fatigue, sleep) (23.7%), digestive (22.4%), and social circumstances (13.5%). The patient's goals of care were referred to in 34.6% of the PCPs' questions (n=27), the Palliative Performance Scale was documented in 5.2% of PCPs' questions (n=4), and the PCP's question and/or specialist's response discussed involvement of the family caregiver(s) in 38.5% of cases (n=30). The top five primary life-limiting diagnoses were metastatic cancer (28.6%), localized cancer (23.4%), other (11.7%), no life limiting diagnosis (9.1%), and dementia (6.5%). Pharmacological management was the most frequent PCP question (n=61) and specialist response type (n=65).

Conclusion

There is room for expansion in the use of this resource as evidenced by the relatively low number of eConsult cases identified. Our findings will have important implications for how and to what extent eConsult can be used to facilitate receiving palliative care in the community.

Long-Acting Injectable Antipsychotics for Bipolar Disorder: A Systematic Review

Presented by: Saguna Katyal

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Background and Objectives

Background- Long-acting injectable (LAI) antipsychotics have been shown to improve medication adherence in individuals with bipolar disorder (BD). Although there is growing support for LAIs in managing BD symptoms, real-world evidence is lacking. Objective- In this systematic review, we aimed to assess the effectiveness of LAI antipsychotics using naturalistic evidence.

Approach

Methods- Ovid MEDLINE, Ovid Embase, and APA PsycINFO databases were searched on February 4, 2024. Naturalistic studies investigating efficacy of LAI compared to oral medication for BD I/II patients in various clinical settings were included. Title and abstract screening, full text review, and data extraction were performed in duplicate. The Newcastle Ottawa tool (NOS) was used to assess the risk of bias. A random-effects meta-analysis for each outcome (all-cause hospitalization, emergency department visits and mortality) was planned

Results

3237 records were identified, and 2147 records were screened for their titles and abstracts. 13 studies were included after the full text review for a total of 5,889 participants with BD. The pooled estimate for time-to-hospitalization, from 2 studies, indicated a 30% reduced risk of hospitalization among LAI users (HR=0.70, 95% CI=0.64-0.77) compared to oral antipsychotic users. The mean difference of hospitalization days from 8 mirror-image studies reported an overall reduction in hospitalization after LAI use. However, the significant heterogeneity precluded further pooling and meta-analysis. Hence, subgroup analyses were performed showing all studies favoring the intervention groups. The community vs. hospital subgroup analysis indicated that hospital-based studies had larger reduction (SMD= -1.92, 95% CI= -2.49, -1.36).

Conclusion

The findings of this review must be interpreted with caution considering the significant clinical and methodological heterogeneity, as well as the limitations posed by the NOS tool. Future research from longitudinal studies and pragmatic trials is required to make healthcare decisions regarding treatment options for individuals with BD.

A Human Factors Approach to Understanding Medication Administration Processes: An Observation Study

Presented by: Sarah Keeping

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Background and Objectives

Medication administration is a frequent activity for nurses in acute care settings. A considerable portion of adverse events in hospitalized patients also results from preventable medication errors. Education, training, and policies governing medication management generally describe the associated tasks linearly, failing to capture the complexities of medication management. The overall aim of this study is to explore nursing medication management and practice variability in acute care through observation using a Safety II approach.

Approach

An observation checklist and coding manual were co-developed with knowledge users (researchers and nurses) following a literature review, identifying the core components of medication administration. This checklist was imported into the Work Observation Method By Activity Timing (WOMBAT) software. This tool was piloted by observers through six observations and was refined and assessed for interrater reliability. Formal observations of nurses' medication administration practices will be conducted by trained observers in four care areas. Observations will be conducted at various times to capture different real-life situations influencing medication administration. Data analysis will be conducted through descriptive statistics and deductive content analysis.

Results

Preliminary results from one patient care area are available. Observations lasted between 44 and 144 minutes. Nurses managed up to 3 patients, up to 16 different medications, and spent up to 79 minutes engaging in multitasking or interruptions in a single observation session. These preliminary results provide insights on how patient assessment, family involvement, medication preparation, human resources, multitasking, interruptions, and unit navigation impact medication administration by prolonging or obstructing the process. These results reveal that the tasks of medication management (transcription, translation, preparation, verification, administration, and documentation) are complex and nonlinear, challenging the way medication management is traditionally understood. Results from at least two patient care areas will be available at the time of presentation.

Conclusion

This observation study fills a pertinent gap in literature regarding the complexity of medication administration by nurses. The results from this study will highlight how the everyday complexities of nursing practice impact the processes of medication management by nurses.

Exploring how health equity is understood and applied in Ontario hospitals: A qualitative case study

Presented by: Alyssa Kelly

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Background and Objectives

The convergence of the COVID-19 pandemic alongside heightened awareness of systemic racism has put a spotlight on health equity in recent years. While pursuing health equity has been a longstanding goal of those working in the health field, limited guidance exists regarding how organizations should address this concept and measure their progress toward achieving health equity. Therefore, this work explores how health equity is understood and applied in three Ontario hospitals.

Approach

A scoping review of academic and grey literature was completed to first identify how health equity is conceptualized, operationalized, implemented, and measured in Canadian hospitals. Then, using a descriptive multiple-case study approach, we conducted individual interviews and analyzed policy documents to explore how health equity is conceptualized, operationalized, implemented, and evaluated in a sample of hospitals across three regions of the province. Additionally, we used the Consolidated Framework for Implementation Research to identify the determinant factors that help and hinder participating hospitals in their pursuit of health equity. Case hospital selection was informed by the concept of positive deviance.

Results

The results of this research will include examples of relevant approaches, metrics, and tools used within specific Ontario hospital contexts. We will also describe promising practices used by leading healthcare organizations in the pursuit of health equity and barriers to conducting such work. Findings will help advance action regarding how health equity is conceptualized, operationalized, implemented, and evaluated. After learning about these promising practices and lessons learned, other researchers and health practitioners can consider these strategies as a starting point and adapt them to best fit similar or different hospital environments.

Conclusion

Evidence regarding how health equity is understood and applied – particularly in Canadian hospital settings – is remarkably absent, despite recent shifts to prioritize health equity. To address this dearth of information, this exploratory, descriptive research is laying the foundation for future health equity and implementation science efforts to build from.

Patient-Centered Quality Indicators among Patients who Leave Hospital Against Medical Advice

Presented by: Kyle Kemp

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Background and Objectives

Historically, when patients have left hospital against medical advice (LAMA), the focus has often been on non-compliance or other patient-level factors, rather than on how services may be designed to better support these patients. Efforts to better understand why patients LAMA could strengthen the provision of patient-centered care; care that is responsive to individual needs and values. The present study examined the experiences of Albertan adults who LAMA.

Approach

We analyzed seven years of survey data, encompassing hospital discharges from April 2016 to March 2023. A random sample of respondents completed the Canadian Patient Experiences – Inpatient Care (CPES-IC) instrument by telephone within six weeks of hospital discharge. From the data, we assessed ten patient-centred quality indicators (PC-QI) which were previously co-created with patient advisors, researchers, and health system administrators. Survey responses/PCQIs were reported as percent in "top box", as represented by the most positive answer choice. Differences between patients who LAMA and other medical/surgical discharges were assessed.

Results

A total of 144,480 surveys were successfully linked with inpatient records and included for analysis. This included 1,177 (0.9%) respondents who LAMA. In our sample, those who LAMA were predominantly male, younger, had a lower level of educational attainment, and were living with a greater number of comorbid health conditions. They also had lower self-reported levels of physical and mental health and had a longer average length of stay. The LAMA group had significantly lower top-box percentages on all ten of the PCQIs which we examined. This difference ranged from 20.7% (communicating test results; 51.6% LAMA group vs. 71.3% others) to 29.2% (patient involvement in decisions about their care and treatment; 39.8% vs. 69.0% respectively).

Conclusion

Patients who LAMA reported lower ratings of patient experience across all PCQIs studied. Our findings may provide actionable, service-related insights into the reasons why patients LAMA. This is important as those who do so may place themselves at increased risk for future unplanned healthcare events, mortality, and morbidity.

Patient-reported experience of adults leaving inpatient care against medical advice in Alberta

Presented by: Kyle Kemp

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Background and Objectives

Research suggests that patients who leave hospital against medical advice (AMA) have increased odds of future morbidity, mortality, and unplanned readmission. The clinical and demographic profile of AMA cases has been previously described, but limited work has reported on AMA patient-reported experiences with care. The objective of the present study was to describe the experiences of patients who left inpatient care AMA relative to patients who did not leave AMA.

Approach

The analytic sample included Albertan adults discharged from hospital between April 2018 and March 2023. Patient experience surveys were collected by Alberta Health Services and linked to the Discharge Abstract Database. Descriptive statistics were calculated for demographic and clinical characteristics. Using natural language processing (NLP), comment sentiment (positive/negative valence) was calculated from a free-text response survey item. Patient-reported experience scores and sentiments were compared between AMA and non-AMA survey respondents.

Results

The sample included 118,040 surveys (mean age: 55.01; 61.5% female), with 912 surveys (0.5%) identified as AMA. Patients who left AMA provided free-text comments more frequently than patients who did not (51.9% vs. 48.3%). Ratings of overall experience were lower among AMA cases (45.3% top-box responses) than non-AMA cases (72.5%). This finding was consistent across other reported aspects of care, including communication with clinicians. Average comment sentiment was less positive among AMA respondents (median: -0.01) than non-AMA respondents (median: 0.14).

Conclusion

Patients who leave AMA report negative experiences with inpatient care. While the sample may be subject to selection bias, ongoing work seeks to classify topics within free-text patient-reported experience data using NLP. This project demonstrates that patient-reported experience measures can provide actionable insights to improve experience and overall care.

Talking About Suicide: Empowering Healthcare Providers, Instilling Hope in Clients

Presented by: Michaela Keogh

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Background and Objectives

How prepared are Canadian healthcare providers to assess suicide risk and openly discuss thoughts of suicide with their patients? Almost half of people who die by suicide have seen their primary care provider in the month before their death (45%), a figure that rises to 70% for older adults. This online self-directed training module has been updated to better equip healthcare providers with the skills and confidence to engage in life-saving conversations.

Approach

Suicidal thoughts and behaviours affect people of all ages, races, ethnicities, sexual orientations, and occupations yet suicide attempts are often preventable. Healthcare providers are ideally positioned to identify patients experiencing thoughts of suicide and to provide (or link them to) the care they so desperately need.

This knowledge exchange initiative was a collaboration between physicians, nurses, patients, and suicide prevention experts to launch Talking About Suicide: Empowering Healthcare Providers, Instilling Hope in Clients. The updated training module emphasizes the importance of asking directly about suicide, providing tangible strategies for building trust and hope through conversation and connection.

Results

Healthcare providers play a pivotal role in preventing suicide, particularly by recognizing and addressing suicide risk during routine patient interactions. The Talking About Suicide training engages providers in developing skills and confidence to have open and caring conversations about suicide. They learn how to build trust, foster empathy, and adopt a person-centered approach that honours the patient's lived experience.

Through this training, healthcare providers will engage in meaningfully collaborative risk assessments that move beyond risk categorization. They will gain practical insights on how to ask directly about suicide, respond appropriately in crisis situations, and co-create an individualized safety plan.

Talking About Suicide empowers healthcare providers to help at-risk patients regain confidence in themselves and see hope in a possible future.

Conclusion

Approximately 4,500 Canadians die by suicide each year. The Talking About Suicide training enables healthcare providers to effectively and confidently engage with patients experiencing thoughts of suicide. By fostering meaningful collaboration with at-risk patients, this training helps chart the course for health system transformation in the area of suicide prevention.

State of the Evidence on Social Robots in Older Adults' Care Organizations: An Umbrella Review

Presented by: Tarek Khalil

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Background and Objectives

Social assistive robots (SARs) integration in older adult care organizations marks a paradigm shift in healthcare services delivery with potential noted benefits (e.g., decreasing workload, improving productivity, enhancing quality of life) in published reviews in this area. We present an "umbrella review" that synthesizes findings across published systematic reviews/meta-analyses (SR/MAs), providing a comprehensive assessment of the magnitude and significance of the evidence on SARs impacts and the facilitators/barriers to their implementation.

Approach

Following the Preferred Reporting Items for Overviews of Reviews (PRIOR), we searched 5 databases (MEDLINE, CINAHL, EMBASE, Scopus, and Cochrane), from inception to August 2024, using predefined search terms covering the domains of older adult care organizations and SARs. Two independent reviewers screened the studies based on predefined inclusion/exclusion criteria; disagreements were resolved by a tiebreaker. A coding scheme was developed for data extraction of relevant information (e.g., impacts, facilitators/barriers etc.). The methodological quality of the SR/MA was assessed using the AMSTAR2 tool. The number of reviews reporting significant impacts are included in parentheses under the results section

Results

Of 775 reviews, 29 SR/MA met the inclusion criteria (years 2012-2024) across 19 countries (mostly Europe). The majority assessed the empirical studies quality using the Cochrane Risk of Bias tool; 26 types of SARs were reported (PARO robotic pet seal most common). SARs have statistically significant positive impacts on older adults' agitation (7), engagement (6), depression (6), loneliness (4), quality of life (4), mood enhancement (3), pleasure and interest (2). The qualitative nature of empirical studies, non-standardized results across reviews and setting differences, precluded quantitative estimation of impacts. Facilitators included ease of use, robot features (i.e. human-like characteristics, voice commands responses, pet robots' appearance and engaging interactive functions-touch/movement). Barriers included usability (i.e. operational difficulties, technical failures), high costs, and healthcare professionals' negative perceptions.

Conclusion

SARs improve older adults' wellbeing and access to timely services, albeit variability in SR/MAs rigor and empirical studies' quality. Findings should inform future policies and funding of assistive technologies like SARs in long-term care. Health services/management journals should ensure sufficient information be presented in publications during peer-review process.

Polypharmacy Among Manitoba Adults with and without Intellectual and Developmental Disabilities

Presented by: Nafiseh Kiamanesh

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Background and Objectives

Polypharmacy, commonly defined as the regular use of five or more medications, is prevalent among individuals with intellectual and developmental disabilities (IDD). Polypharmacy is defined as an important public health problem as it is linked to adverse health outcomes, including medication-related hospitalizations. Despite its significance, research on polypharmacy in IDD population is limited. The objective of this study is to examine and compare the prevalence of polypharmacy between Manitoba adults with and without IDD.

Approach

We will adopt a retrospective cohort design using administrative data from the Manitoba Centre for Health Policy (MCHP) repository. Polypharmacy prevalence will be classified into three categories: no polypharmacy (<5 medications), polypharmacy (5–9 medications), and severe polypharmacy (≥10 medications). Adults with IDD will be identified using an algorithm previously developed by MCHP researchers. Each adult with IDD will be matched with an adult without IDD based on age, sex, and region of residence. The prevalence of polypharmacy will be calculated and compared between those with and without IDD using Generalized Equation Modelling.

Results

This study provides Manitoba-specific prevalence rates of polypharmacy among adults with IDD, and examines the association between IDD diagnosis and polypharmacy. Based on previous literature, we anticipate that polypharmacy is highly prevalent among adults with IDD, and that IDD diagnosis is associated with a higher polypharmacy burden. Using unique data housed at MCHP allows us to identify the individual drugs that comprise polypharmacy in this population, and to analyze polypharmacy rates by key patient characteristics including age, sex, income quintile, and health region.

Conclusion

Findings of this study will (1) highlight the need for health interventions or healthcare policies to improve medication management in individuals with IDD, (2) inform clinical practices potentially contributing to more tailored and effective medication prescribing strategies, and (3) underscore the need for future health provider education and training programs.

Lived experience in substance use policy: The case of boundary organizations in Quebec's Action Plan

Presented by: Alexie Kim

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Background and Objectives

Boundary organizations play a key role in knowledge translation and mobilization and provide institutional spaces for collaborative and intersectoral work. This work often includes the engagement of equity-deserving groups, and the synthesis of various kinds of evidence, including lived and living experience (LLE). Though the meaningful engagement of people with LLE is widely encouraged in the field of mental health and substance use, little is known about the inclusion of lived expertise in policy development.

Approach

This project seeks to document the integration of LLE in Quebec's Interministerial Action Plan on Addiction (2018–2028), with an emphasis on the supportive role of boundary organizations (i.e., steering, consultative, and advisory committees). Using a comprehensive literature review and 20 semi-structured interviews with members of the boundary organizations surrounding the plan's development and implementation, this study will document the involvement and experiences of individuals with lived experience within these organizations and examine the engagement frameworks and consultation processes utilized in the development of this policy.

Results

It is recognized that the integration of scientific, lived and practical knowledge is essential to create evidence-based policies and programs that are responsive to the needs of communities. Nevertheless, there is still little knowledge about the forms, processes, and structures that frame practices related to the integration of LLE in substance use policy. Additionally, the challenges and opportunities associated with boundary organizations supporting such policy initiatives remain underexplored. As many actors are mobilizing for greater coherence between substance use interventions in Quebec, a better understanding of the dynamics and mechanisms through which lived experience is integrated or negotiated to inform public policy is essential.

Conclusion

Despite its importance, the engagement of people with lived experience in the co-construction of health policies remains under-studied. This research contributes to filling this gap by documenting the role and potential of boundary organizations as spaces for the integration of lived experience to optimize the relevance and coherence of substance use policy.

Developing a Conception Cohort for Reproductive Population Health using Health Administrative Data from British Columbia.

Presented by: Saloni Koshti

Reproductive health applications of Canada's administrative databases have been largely restricted to births (pregnancies with gestational age (GA) ≥20 weeks). Miscarriages (pregnancies ending spontaneously at GA <20 weeks) and abortions (pregnancy terminations, most GA <20 weeks) are generally excluded from population research. Identifying these outcomes requires extensive algorithm development and programming to determine case definitions, index date, and episode characteristics (typical or atypical care trajectories). No gold standard algorithm exists to define these outcomes or differentiate between miscarriages and abortions. This underestimates pregnancy rates and impedes research to identify associations between pre-or early pregnancy exposures and birth outcomes.

Objective: Develop a valid algorithm to create a Conception Cohort of all pregnancies correctly classified as births, miscarriages, abortions, using linked health administrative data from British Columbia (BC), Canada.
Methods: We linked 5 administrative databases to produce a cohort of reproductive aged (15-49) females,2004-2020. We identified births by the BC Perinatal Data Registry (captures >99% of births and late terminations at ≥20 weeks in BC). Working with clinicians, we used practitioner billing records, medication dispensations, hospital admissions, and emergency department data to identify abortions and miscarriages. We determined event date using an episodic approach, with events within 6-weeks before or after the event date considered the same pregnancy.

Results: We identified 957 743 pregnancies-728 299 (76%) ending in birth, 102 673 (11%) in miscarriage and 123 890 (13%) in abortions. 3% of births had codes for abortion, miscarriage or both during gestation, highlighting the need for an episode-based approach.

Significance: Refinements of this episode-based algorithm to create the BC Conception Cohort will facilitate applied research for pregnancies ending with GA <20 weeks.

Evaluation of a provincial approach to promote quality standards using clinician decision support

Presented by: Miria Koshy

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Background and Objectives

This study evaluates a provincial clinical decision support (CDS) program across different use cases including heart failure (HF) and anxiety and depression (A&D) in primary care and acute care. Our objectives are to a) describe clinician experience with the HF and A&D CDS tools, b) evaluate changes in clinician behavior as a result of using the tools in acute care, and c) examine effectiveness of program engagement mechanisms for increased tool utilization.

Approach

This program evaluation uses mixed methods including user experience surveys and semi-structured interviews with key informants (n=17), as well as HF and A&D tool users and non-users in primary care (n=24) and acute care (n=17). Program analytics data is leveraged to assess the impact of engagement mechanisms (e.g., change management sessions and academic detailing sessions) on tool uptake at selected sites. Changes in clinician behavior (in acute care) are assessed through aggregate hospital data from the GEMINI network (for HF) and directly from hospital information systems (HIS) (for A&D), based on metrics shortlisted from the Ontario provincial quality standards.

Results

Program value and ease of implementation varied with use case as well as care setting. Acute care HF data demonstrated improvement in four process metrics (brain natriuretic peptide testing, daily weight measurement, and prescription of two drugs for quadruple therapy), but there was limited impact in primary care. Despite a statistically significant (p-value=0.035) increasing trend in Personal Health Questionnaire-9 (PHQ-9) utilization for the acute care A&D setting, these forms had limited perceived value by most specialists given the unstable and complex condition of inpatients. Overall low tool uptake in primary care highlighted the need for improved tool design and differential engagement strategies. Our analysis indicated that change management (CM) sessions may have greater impact on tool utilization (number of uses) than uptake (number of users).

Conclusion

This evaluation will inform provincial decisions on the future direction of the program, and existing efforts to support quality standards that may need to be revisited. Recommendations consider the effort and cost involved in program design, engagement, and implementation, with more concerted CM efforts involving clinic-level leadership as well.

The impacts of Epic Hospital Information System on Patient Quality of Care:A Physicians' Perspective

Presented by: Amanda Kutenski

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Background and Objectives

Despite the increasing adoption of hospital information systems in Canadian hospitals (e.g., Epic in Ontario, Quebec, Alberta), there is limited evidence on their impacts in acute-care institutions. Notably, little knowledge is available on the use of the electronic medical records (EMR) component of these systems to direct improvements in quality of care. This study investigates the perspectives of key users, physicians, on the effects of Epic on medical work practices and quality of care.

Approach

This study applies an explanatory mixed-methods approach, employing a survey and follow-up interviews, at the University of Ottawa Heart Institute (UOHI). The survey, which includes mostly close-ended (Likert scales) and three open-ended questions assessing the impacts of Epic on medical practices/care processes/quality of care, was sent to all full-time physicians at the UOHI (N=72). 10 physicians, with expertise in quality assurance/improvement, were invited to participate in semi-structured interviews to be scheduled in January-February 2025. These will examine how Epic use affects various dimensions of quality of care, thus providing additional contextual information that complement the survey results.

Results

The survey currently underway has obtained so far a 43% response rate. 68% of respondents were male, 23% female and 10% preferred not to say. Respondents had a median age of 50 years [32-63]; 8 years working at the UOHI [1-30]. They reported that Epic improved care coordination/communication between physicians, was well integrated with their workflows although necessitating workarounds to perform certain tasks and decreased efficiency. They also expressed dissatisfaction with time spent on documentation in Epic with Epic use after-hours negatively affecting their wellbeing. Physicians neither agreed nor disagreed with Epic improving the quality of care (median=3), although specific quality questions were mostly on the positive end of the scale. The anticipated interviews will enable a better understanding and interpretation of these findings.

Conclusion

This research will point to internal processes gaps at UOHI, and uncover physicians' experiences with Epic, which serve as benchmark for hospitals in provinces like Quebec planning wide Epic deployments. They also contribute to the limited literature on EMR impacts and guide implementers/decision-makers in improving the use of these systems.

The Impacts of Perinatal Loss on Work: Adapting a Work Productivity Loss Instrument

Presented by: Jacynthe L'Heureux

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Background and Objectives

Perinatal loss encompasses loss prior to pregnancy (infertility), during pregnancy (miscarriage, abortion and stillbirth), and after pregnancy (infant death). This loss is often multi-faceted, highly consequential on quality of life and employment. Testimonies point to lasting impacts on work, however there is a lack of measurement methods in the health economic analysis literature. Our research's overarching objective is to adapt a work productivity loss instrument to encompass the experiences of perinatal loss.

Approach

Our approach is to conduct 30 in-depth semi-structured interviews to adapt the Valuation of Lost Productivity (VOLP) instrument to encompass the experiences of perinatal loss; and perform a scoping literature review about the impacts of perinatal loss on work to contextualize the set of outcomes contained in the VOLP. An interactive process will be used to test and finalize the VOLP adaptation applying cognitive interviewing methods until data saturation is reached. Our scoping review was performed on MEDLINE, CINAHL, EconLit, Psycinfo, and EMBASE with a time span of 10 years using keywords related to perinatal loss and work.

Results

Measuring work productivity loss is an important component of economic evaluations for interventions from a broader societal perspective. Adapting the VOLP is critical to the intersection of maternal (paternal) and child health to that of health economics. Our research will equip health and labour policymakers to measure empirically the impacts of services, and policies on the work productivity of Canadians experiencing perinatal loss. Our research design will triangulate our findings to contextualize the work productivity loss outcomes contained in the VOLP with the impacts on work reported in literature to evaluate the breadth of its measurement. Quantifying the economic impacts of perinatal loss on work and workforce participation ultimately will help health systems, employers, insurers and policymakers support employees and fight workforce disenfranchisement.

Conclusion

We will address a critical measurement gap by adapting a work productivity loss instrument to encompass perinatal loss experiences. Aligned with CAHSPR's focus on advancing measurement and patient-oriented outcomes, our findings will support Canadians in an out of their workplaces, improving health system performance and societal outcomes.

Améliorer la qualité en partenariat avec des usagers : Mise à l'essai en oncologie pédiatrique

Presented by: Maude Laberge

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Background and Objectives

L'implication des usagers dans les décisions d'amélioration de la qualité suscite un intérêt grandissant, mais rares sont les initiatives spécifiques aux pratiques infirmières en hémato-oncologie pédiatrique (HOP). L'innovation HOPtimise a permis la création d'un comité formé à parité de cliniciens/gestionnaires (n = ±10) et de parents/jeunes survivants (n = ±10). But : Évaluer la première année de mise à l'essai d'un comité d'amélioration de la qualité des soins infirmiers en HOP.

Approach

Étude de cas avec intégration de données quantitatives et qualitatives issues de questionnaires auprès des membres du comité au début (T1; N = 18) et après la cinquième rencontre (T2; N = 22), ainsi que d'artéfacts relevant de sa mise en œuvre (ex. : documents de recrutement, formation, matériel des rencontres). Analyses descriptives quantitatives et analyses qualitatives rapides indépendantes des données issues des questionnaires. Intégration thématique des constats en s'appuyant sur une analyse temporelle et objective des artéfacts. Vérification de vraisemblance et partage progressif des constats avec les acteurs responsables de la mise en œuvre de l'innovation.

Results

Taux de réponse de 66% (T1) et 59% (T2) avec participation plus forte des usagers. Les principales raisons d'implication aux T1 et T2 sont : « contribuer à l'amélioration de l'expérience des soins » et « aider au développement des expertises infirmières ». Aux principales raisons de poursuite s'ajoute « aider les établissements de santé ». Le niveau de confiance en la capacité à effectuer des suivis est plus bas que celui consistant à identifier des pratiques à améliorer. Au T2, 77% exprime un niveau de satisfaction globale élevé. La satisfaction moyenne des acteurs organisationnels est plus basse. L'analyse qualitative indique que la disponibilité des membres est un obstacle à la pérennisation. L'influence prépondérante des usagers sur les décisions s'est traduite par la priorisation d'une pratique proposée par un parent.

Conclusion

S’appuyant sur les principes de système de santé apprenant, l’innovation HOPtimise vise la consolidation des expertises infirmières avec les usagers. En étant partagés avec les acteurs responsables, ces constats alimentent les processus de mise en œuvre de cette innovation et la volonté organisationnelle d’améliorer les soins en partenariat avec les usagers.

BeFrIENDS-PC: A Conceptual Framework for Implementing Youth Suicide Prevention in Primary Care

Presented by: Maryam Pyar & Ali Lakhdir

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Background and Objectives

The implementation of youth suicide prevention interventions within primary care settings demands a comprehensive guiding framework, considering the complexity of factors influencing successful implementation. This study aims to develop a conceptual framework, "BeFrIEND-PC (Barriers and Facilitators in Implementing measures to END Suicide in Youth in Primary Care Setting), synthesizing key elements from established models in implementation science, tailored to support the implementation of youth suicide prevention interventions in primary care settings

Approach

The development of BeFrIEND-PC involved a thorough exploration of existing implementation theories, frameworks, and models within the context of youth suicide prevention interventions. A scoping review extracted relevant concepts, with a focus on those addressing implementation in healthcare contexts. Constructs from the Consolidated Framework for Implementation Research (CFIR), Theoretical Domains Framework (TDF), Implementation Outcome Taxonomy (IOT), and Zero Suicide Framework (ZSF) were selectively integrated and refined to construct the BeFrIEND-PC framework.

Results

BeFrIEND-PC framework consists of micro, meso, and macro levels, encompassing eight interconnected domains: 1. individual, 2. provider, 3. family, community, 4. organizational, 5. societal, and 6. health system factors 7. intervention and 8. outcome classifications. These domains collectively measure multifaceted factors influencing implementation, presenting a comprehensive lens to understand and guide the implementation of youth suicide prevention measures within primary care settings.

Conclusion

BeFrIEND-PC provides a holistic framework tailored to guide the implementation of youth suicide prevention interventions in primary care contexts. It may serve as a foundational tool for future research and practical initiatives, fostering a cohesive understanding and application of strategies aimed at preventing youth suicides in primary care settings.

The Cancer Health Equity Collaborative: Advancing Equity-Oriented Care via Nurse-Led Research in BC

Presented by: Leah K Lambert

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Background and Objectives

People with lived/living experience of health and social inequities (PWLE-HSI) face alarming disparities across the continuum of cancer care. Yet, little transformative action has been taken to date to redress inequities in cancer care access, outcomes, and experiences among PWLE-HSI in British Columbia (BC). We sought to establish an agenda to use research, integrated knowledge translation, and implementation science to advance equity-oriented healthcare at BC Cancer, a provincial cancer control program.

Approach

Starting in 2019, we assembled a nursing-led interdisciplinary team of health system leaders, advanced practice nurses, and nursing scholars. A rapid scoping review explored how health and healthcare equity are conceptualized and addressed in Canadian cancer care. Engagement sessions with policymakers, health and social service providers, and community organizations identified priority areas. We then secured peer-reviewed funding to build authentic partnerships with PWLE-HSI and community organizations in Vancouver's densely-populated Downtown Eastside (Canadian Cancer Society), as well as to innovate new approaches to team-based cancer care (Canadian Partnership Against Cancer), and mobilize knowledge about equity-oriented cancer care (University of British Columbia).

Results

Five priority areas for action emerged through our engagement sessions: (1) sustaining commitment and buy-in from leadership; (2) data and measurement of equity-sensitive indicators; (3) intersectoral collaboration, policies, and practices; (4) recognition of the social and structural determinants of health in cancer care; and (5) knowledge mobilization and staff training. The process of collaboration culminated in the creation of the Cancer Health Equity Collaborative (CHEC). Through our collective efforts, which has included >75 hours of community engagement and clinical shadowing at a community health centre in Vancouver's Downtown Eastside neighbourhood, we have engaged with >100 PWLE-HSI and community-based health and social service providers; most of these individuals have expressed their interest to engage with work related to advancing equity-oriented cancer care among PWLE-HSI.

Conclusion

Nurses are well-positioned to advance health and healthcare equity in the cancer care sector; however, doing so requires (1) sustainable and authentic partnerships with people and communities with lived/living experience of health and social inequities, and (2) broadening the deployment of applied health research and implementation science methodologies in oncology.

Collectif première ligne : Pour réussir les transformations des services de première ligne au Québec

Presented by: Catherine Lamoureux-Lamarche

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Background and Objectives

Le Québec vit actuellement une crise de première ligne (PL). La mise en place d'une nouvelle entité gouvernementale et la négociation de nouvelles ententes avec la profession médicale ont créé une opportunité d'échanger sur la place de la PL au Québec. Le but de ce collectif est d'identifier les conditions à succès et les incontournables pour réussir les transformations de PL au Québec.

Approach

La collecte de données s'est effectuée lors d'une journée de réflexion (novembre 2024) où 29 experts en PL se sont rencontrés (cliniciens, chercheurs, gestionnaires, patients). Des activités de type World café ont été effectuées selon trois thèmes: 1) Continuité relationnelle en contexte de transformations vers une inscription à une équipe, 2) Collaboration interprofessionnelle et gouvernance d'une clinique PL et 3) Gouvernance territoriale et collaboration intersectorielle. Les thèmes avaient préalablement été déterminés avec un groupe d'experts. Un animateur et deux preneurs de notes étaient présents. Une synthèse a été effectuée et révisée.

Results

Neuf incontournables ont été identifiés. Une des conditions à succès pour le thème 1 est l'affiliation de chaque citoyen à un médecin de famille ou IPS responsable au sein de l'équipe interprofessionnelle. Pour le thème 2, les éléments identifiés incluent la mobilisation de la collaboration interprofessionnelle pour repenser l'organisation du travail d'équipe en fonction des besoins de la population inscrite et la négociation de modèles de rémunération pour encourager la collaboration. Sur le plan de la gouvernance territoriale (thème 3), une condition de succès est l'importance de la décentralisation de la gestion au niveau local (RLS/CLSC) selon la taille de la population et du territoire.

Conclusion

Ces recommandations sont basées sur les réflexions d'un groupe d'experts et émergent d'une approche volontaire et indépendante pour démocratiser les conversations sur la réorganisation des services de PL. Il est indispensable de réfléchir collectivement aux solutions à mettre en place pour répondre à la crise en PL au Québec.

Perspectives on group-based treatments: a systematic review

Presented by: Mélanie Le Berre

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Background and Objectives

Physiotherapy is widely recognized as an effective intervention for managing various health conditions. Group-based physiotherapy treatments could be a promising solution to reduce waitlists and improve access to care while maintaining clinical effectiveness. However, despite this potential, adoption remains limited. This systematic review aims to identify the determinants of the use, intention to use, satisfaction, attitudes, and experiences of patients and physiotherapy professionals with group-based treatments, and determinants of preferences for group-based over individual treatments.

Approach

This systematic review involved searches of Medline, Embase, Web of Science, CINAHL, and Cochrane databases for quantitative, qualitative, or mixed-method studies in French or English. Two reviewers independently screened 7,105 articles for inclusion using Covidence, and will extract data from the 75 included studies, and assess them using the Mixed Methods Appraisal Tool. For quantitative findings, the direction, magnitude, and significance of relationships between use, intention to use, satisfaction, attitudes, or experiences of patients and physiotherapy professionals with group-based treatments and their determinants will be reported. For qualitative findings, quotes will illustrate how these outcomes are influenced by their determinants.

Results

Use and intention to use will capture current and future utilization patterns. Satisfaction could influence both use and intention to use. Attitudes, reflecting a positive perception of group-based physiotherapy, could shape the likelihood of selecting this option and are thus closely linked to use and intention to use. Experiences of care could influence satisfaction and, in turn, use and intention to use. Preferences for group-based physiotherapy will reflect the values and factors guiding decisions, directly impacting use and intention to use. This systematic review will identify key determinants of these outcomes for both patients and physiotherapists, providing insights into the adoption of group-based physiotherapy. Additionally, the findings will inform the development of a discrete choice experiment, enabling a deeper exploration of preferences for group-based physiotherapy.

Conclusion

The findings from this systematic review, combined with the conclusions derived from the subsequent discrete choice experiment, will inform strategies and policies aiming to support the access to physiotherapy care, while considering the treatment format preferences of both patients and physiotherapists.

What are patients' perspectives on group-based physiotherapy treatments?

Presented by: Mélanie Le Berre

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Background and Objectives

In 2017, over 18,000 individuals in Québec were on waitlists for physiotherapy, with 16% waiting over a year. Persistent delays can exacerbate physical and mental health deterioration and increase healthcare costs. Group-based physiotherapy, shown to be as clinically effective as individual care for various conditions, could offer a strategy to help address these challenges. Despite its potential, this approach is underutilized. This study will examine the determinants influencing patient preferences for group-based and individual physiotherapy.

Approach

This descriptive qualitative study will use semi-structured interviews with 30 patients who recently received physiotherapy. The interviews will be guided by the Theoretical Domains Framework (TDF), a conceptual framework on behavior change widely used in the literature to assess challenges in implementing health innovations The interview guide will be developed in collaboration with a patient partner, integrated to the research team, to ensure that the study captures relevant perspectives. A hybrid thematic analysis, combining both deductive and inductive methods, will be performed iteratively to identify key themes. Member checking will be conducted to validate findings and ensure methodological rigor.

Results

Although group-based physiotherapy presents a promising approach, no studies have yet examined the perceptions of Québec patients regarding this format. This study will provide foundational insights into the factors influencing patient preferences of different treatment formats. The findings will inform the design of discrete choice experiment scenarios (DCE) for patients. Through thematic analysis, descriptive codes will be developed and refined to identify attributes emerging from the data. Attributes will be further defined with levels. While the specific attributes and levels are unknown at this stage, potential examples could include group size or treatment modality, with levels such as small, moderate, or large group sizes, and in-person, telephone, or videoconference modalities. A subsequent phase will explore physiotherapists' perspectives and inform DCE scenarios specific to this group.

Conclusion

This study will enhance understanding of the factors shaping patient preferences for group-based and individual physiotherapy. Its findings will contribute to the development of strategies and policies aiming to support access to physiotherapy care while addressing the treatment format preferences of both patients and physiotherapists.

Reimagining Collaboration: Co-Design as a Catalyst for Building Early Career Networks in Research

Presented by: Michelle Leach

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Background and Objectives

The Network of Early Career X Trainee Researchers (ECRs) in Youth Mental Health (NExT) revolutionizes youth mental health research through co-design and collaboration. Our peer-led network has 49 members in over 35 institutions. NExT focuses on co-designing initiatives to foster equitable research practices and develop a new generation of researchers equipped to tackle emerging system and resource challenges. Founded on trust and a common purpose, NExT leverages complementary expertise to reimagine collaboration in research.

Approach

NExT operates as a decentralised network spanning institutions and regions across North America, prioritizing relationship-building over project-specific outcomes. Through peer-to-peer learning and shared decision-making, our meetings foster open dialogue to co-design research priorities. Building on our transdisciplinary experiences, including health services research, epidemiology, psychology and psychiatry across organizations, we aim to redefine traditional power dynamics in healthcare research, particularly those rooted in funding and leadership models, while challenging conventional system-level metrics. By embracing diverse forms of knowledge and centering belonging and reciprocal relationships, we demonstrate how co-design can advance systems-level change in youth mental health.

Results

In its first year, NeXT demonstrated the effectiveness of its co-design framework through successful initiatives including ongoing monthly meetings, grant application submissions and development of manuscripts-in-progress. The network's success is rooted in trust, shared goals, and mutual accountability. Key facilitators supporting a co-design framework include:
Development of a shared vision and collective ownership of deliverables.
Cross-pollination of ideas by incorporating diverse perspectives from across disciplines, institutions, and geographies.
Implementation of flexible leadership and rotating responsibilities to promote equity and representation.
Despite training gaps, funding constraints and institutional pressures, this approach illustrates how a co-design framework can transform traditional research collaboration by fostering equity, sustained relationships, and shared purpose. These principles provide a framework for co-producing research that prioritizes youth mental health and supports ECRs in advancing systemic change.

Conclusion

NeXT demonstrates how co-design grounded in mutual trust, shared goals, and equitable partnerships transforms research practices while nurturing ECRs. This peer-led network provides a framework for conducting inclusive, impactful research, building research capacity, and leveraging skills and resources, where investment in relationships enables ongoing responsiveness to healthcare challenges.

Adherence to late-effects surveillance among survivors of childhood cancer in Ontario, Canada

Presented by: Felicia Leung

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Background and Objectives

Most survivors of childhood cancer develop chronic or severe morbidities because of their cancer therapies. As such, surveillance for these late effects among survivors is essential for early detection, treatment and better long-term outcomes. We estimated adherence to guideline-recommended surveillance among a cohort of childhood cancer survivors at increased risk for three late effects (breast cancer, colorectal cancer and cardiomyopathy) and examined survivor characteristics associated with adherence.

Approach

This population-based study utilized linked cancer registries and health administrative databases from Ontario, Canada. We used the Children's Oncology Group Long-Term Follow-Up Guidelines' (v5.0) criteria to define survivors, aged ≥18 years, at increased risk for breast cancer, colorectal cancer or cardiomyopathy and eligible for surveillance. We calculated the percentage of survivors who adhered to late-effects surveillance as of June 30, 2021. We estimated odds ratio to analyze the relationship between survivor characteristics and surveillance adherence, including long-term follow-up clinic attendance.

Results

In 2021, there were 175, 187 and 2,518 adult childhood cancer survivors at increased risk for breast cancer, colorectal cancer and cardiomyopathy, respectively, and eligible for surveillance. Among these survivors, 32.6% (95% CI: 26.0–39.9%), 19.8% (14.7–26.1%), and 48.1% (46.1–50.0%) had the respective surveillance. Long-term follow-up clinic attendance was highest among survivors at risk of cardiomyopathy (54.6%), followed by breast cancer (45.1%) and colorectal cancer (28.3%). Long-term follow-up clinic attendees at increased risk for breast cancer, colorectal cancer or cardiomyopathy were 7.0 (3.4–14.4), 12.9 (5.6–29.8) and 17.0 (13.9–20.8) times more likely to be adherent to the respective surveillance than non-attendees. Younger age at diagnosis and fewer years since diagnosis, were significantly associated with increased likelihood of cardiomyopathy surveillance.

Conclusion

Although a large proportion of childhood cancer survivors were non-adherent to recommended late-effects surveillance, long-term follow-up clinic attendees had significantly greater adherence. Future work will focus on identifying reasons for survivors not engaging in surveillance and development of programs to improve adherence.

Examining the Utilization of Pediatric Oncology Satellite Clinics in Ontario through an Equity Lens

Presented by: Felicia Leung

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Background and Objectives

Background: Pediatric cancer care is primarily centralized at tertiary hospitals leading to transportation and financial challenges, especially for families in rural and remote areas. To address these challenges, the Pediatric Oncology Group of Ontario introduced satellite clinics offering care closer to home. However, it is unclear whether sociodemographic disparities exist in this decentralized model. The study's objective was to examine whether satellite clinic utilization differs by sociodemographic factors, namely age, sex, income, and rurality.

Approach

Methods: We included cancer patients aged 0-17 years newly diagnosed between 2017 and 2022 and living in a satellite clinic catchment area. We examined two access indicators: 1) the percentage of patients visiting a satellite clinic within a year of diagnosis; and 2) the median number of days from systemic therapy start to first satellite visit. We linked cancer registry and PCCF+ databases to ascertain age, sex, neighborhood-based income, urban/rural dwelling, diagnosis, and year of diagnosis. Driving-time saved between tertiary hospital and satellite clinic was derived from OpenStreetMap. These variables were included in multivariate logistic regression and Cox-proportional hazards models.

Results

Results: Among the 1280 eligible patients, 844 (65.9%) visited a satellite clinic within one year of diagnosis, with a median time to first visit of 39 days (IQR:14–67). Driving time saved (>=60 minutes) was the most strongly associated with satellite use followed by cancer type (with CNS patients least likely to visit). Patients living in rural (vs. urban) areas were significantly less likely to visit within 1 year (OR=0.48 (95% CI: 0.31–0.74)) and took longer to make their first visit (HR=0.65 (0.53–0.81)); similar to patients in the lowest income quintile compared to middle-income neighbourhoods (OR=0.53 (0.35–0.80), HR=0.73 (0.60–0.89)).

Conclusion

Conclusion: Disparities in satellite clinic use among rural-dwelling and lower-income childhood cancer patients warrant attention. These results are already informing future satellite site planning and targeted patient outreach. Monitoring social determinants of health at the community level can inform efforts to improve timely and equitable access to childhood cancer care.

Accessibility and use of sexual health services on adolescent sexual behavior in Côte d'Ivoire

Presented by: Lignon Lignon

Author(s): *Lignon Lignon, PhD Candidate in Public Health, École de Santé Publique de l'Université de Montréal; Roxane Borgès Da Silva, Professor, École de Santé Publique de l'Université de Montréal*

Background and Objectives

In Côte d'Ivoire, new HIV infections largely affect adolescents, particularly girls compared to boys. Also, nearly one in four girls aged 15 to 19 has already experienced pregnancy. This risky sexual behavior adopted par many Ivorian adolescents may reflect limited accessibility and use of sexual and reproductive health (SRH) services. This research aims to understand the extent to which the accessibility of SRH services and their use influence sexual behaviour of adolescents in Côte d'Ivoire.

Approach

Explanatory sequential mixed method will be use. Data from Côte d'Ivoire Demographic and Health Survey 2021 will be used for quantitative part. Bivariate and multivariate analyses will be conducted to measure the associations between, firstly, accessibility to SRH services and their use, and, secondly, the use of these services and adolescents sexual behaviour. For the qualitative part, semi-structured interviews will be conducted with young people and professionals working with them to understand the process by which the accessibility and use of SRH services influence the sexual behaviour of adolescents. Qualitative data will be examined through thematic analysis.

Results

This research will contribute to providing evidence on the dimensions of accessibility to SRH services that influence their use by adolescents and young in Côte d'Ivoire. It will also contribute to knowledge of the effects of the use of these services on the sexual behaviour of adolescents in Côte d'Ivoire. Finally, it will deepen the understanding of the factors that explain the relationships between the accessibility of SRH services, their use and the sexual behavior of adolescents in Côte d'Ivoire.

Conclusion

The results of this research can be used to inform evidence-based SRH policymaking. They will also optimize SRH services organisation among adolescents in Côte d'Ivoire, which should lead to improved SRH outcomes for them.

The Patients’ Den: A novel event for patient and public involvement in healthcare reform

Presented by: Alison Luke

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Background and Objectives

While patient-oriented research is widely recognized as fundamental to evidence-based healthcare, opportunities for patient involvement in research funding allocation and setting research priorities receive little attention. The Patients’ Den, a novel twist on the television series Dragons’ Den, addresses these gaps and contributes to patient partner engagement in healthcare reform. This presentation will share successes and challenges from Patients’ Den 2024, with a goal to receive feedback as we plan for Patients’ Den 2026.

Approach

Patients’ Den is a co-designed initiative that was hosted by the Centre for Research in Integrated Care (CRIC) in partnership with the Maritime SPOR SUPPORT Unit (MSSU). The organizing committee, formed in January 2024, included two patient partners, the director and a research associate from CRIC, and three research coordinators. The committee sought financial support from diverse sources, developed and distributed calls for patient panelists and for research proposals in health services, and advertised the event. Advertising highlighted the cash awards for the winning proposals and the event being free and open to the public.

Results

Patients’ Den 2024 took place on October 8th, 2024, in Saint John, New Brunswick. Four trainees and four early-career researchers presented their research proposals to five patient partner judges and an audience of approximately 150 people. The CEO of Horizon Health (one of two health authorities in NB), emceed the event. Each presenter took questions from the judges, who awarded two trainees with $2,500 each to support their projects; these focused respectively on supporting the dietetic care of food-insecure individuals, and the advantages of team-based primary care. The judges also awarded two early-career researchers $5,000 each, for their projects respectively examining the experiences of youths seeking referral for Fetal Alcohol Spectrum Disorder (FASD), and the advantages of more nurse practitioners in long-term care.

Conclusion

Patients’ Den 2024 achieved its aims of providing patient partners with a leading role in setting research priorities by making funding allocation decisions. However, peer feedback could help enhance several aspects of the event, including recruiting a diverse patient panel, facilitating deliberations, distributing awards, and increasing community attendance.

Factors associated with nurse outcomes in Atlantic Canadian Long-Term Care Facilities

Presented by: Adrian MacKenzie

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Background and Objectives

The Atlantic Research Collaboration on Long-Term Care (ARC LTC) is comprised of researchers, trainees, and sector collaborators interested in improving outcomes for Atlantic LTC staff and residents while building capacity for LTC research in the region. Within this broader program of research, the objective of the present study is to estimate the effects of individual and organizational factors on indicators of quality of work-life for nurses employed in the long-term care sector in Atlantic Canada.

Approach

Collaborating with members of the Translating Research into Elder Care (TREC) program, minor adjustments were made to their suite of survey instruments to reflect the Atlantic context. Data were gathered from 724 Registered Nurses and Licensed Practical Nurses at 53 care homes across the four provinces selected through a stratified random sampling process. Regression and structural equation modeling techniques are being used to examine the effects of individual (demographics, employment status, professional designation) and organizational (culture, leadership, resources, ownership model) on indicators of quality of work-life (work engagement, professional quality of life, intention to leave).

Results

Study results will help illuminate and unravel the complex interrelationships which exist, as well as those that do not, between the individual (nursing staff), the work environment, and the larger provincial and regional LTC policy context. The direct, indirect, and total effects of individual and organization factors on nurses' quality of work-life will be reported as well as the amount of variance explained by the model.

Conclusion

Findings from this study and others currently being undertaken by members of the Atlantic Research Collaboration on Long-Term Care (ARC LTC) will enhance understanding of the work environment in LTC facilities and the implementation of interventions to improve quality of work-life for staff and ultimately the quality of care for residents.

Defining, Locating and Characterizing Child Psychiatrists and their Practices in Ontario

Presented by: Madison MacKinnon

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Background and Objectives

The current supply and distribution of child psychiatrists in Ontario is unknown, making it difficult to effectively conduct mental healthcare planning. We aimed to create a data-driven definition of a child psychiatrist, then summarize the characteristics and location of child psychiatrists and their practices in Ontario in 2023 compared to non-child psychiatrists.

Approach

A cross-sectional study was employed using administrative data from ICES. All practicing Ontario-based psychiatrists, defined as those submitting at least one billing claim to OHIP in the years 2013-2023, were included. Child psychiatrists were defined as those with 50% or more of their patients <19 years of age. Characteristics (age, sex, rurality, and outpatient practice characteristics) of child (compared with non-child) psychiatrists were summarized descriptively.

Results

In 2023, there was a total of 259 child psychiatrists and 2099 non-child psychiatrists in Ontario. Child psychiatrists were younger (55.8 ± 9.3 (mean ± SD) vs. 60.1 ± 11.5), more likely to be female (52.1% vs. 41.9%) and less likely to work in rural regions than non-child psychiatrists. Both subspecialties, on average, saw a similar number of patients overall (276.7 ± 265.9 vs. 329.3 ±403.1), but child psychiatrists saw more outpatients (132.5 ± 160.8 vs. 91.0 ± 163.5). Just over 20% of child psychiatrists saw <40 outpatients compared to 53% of non-child psychiatrists. Average outpatient visit frequency per patient per physician was one visit per year for both subspecialties, but a greater proportion of patients seen by child psychiatrists had ≥4 visits per year.

Conclusion

There are relatively few child psychiatrists in Ontario, particularly in rural regions. While child and non-child psychiatrists have similar outpatient practice characteristics, child psychiatrists are less likely to have small practices, and their patients are slightly more likely to have longitudinal care.

Assessing the Effects of Social Prescribing on Caregivers of Older Adults: A Systematic Review

Presented by: Aaya Mahdi

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Background and Objectives

This systematic review examines the impact of social prescribing on the well-being and mental health of caregivers for older adults. Caregivers often face high stress, isolation, and burnout due to their caregiving responsibilities. Social prescribing connects individuals to non-clinical resources such as support groups, counseling, and mindfulness activities. This review aims to assess the effectiveness of these interventions and identify gaps in evidence to inform policies that improve caregiver well-being and caregiving sustainability.

Approach

Using the Campbell Evidence and Gap Map titled "The effects of social prescribing for older adults" as the foundational resource, the review will systematically analyze randomized and non-randomized studies addressing social prescribing for caregivers of older adults. Data extraction followed Cochrane methods, and quality appraisal used RoB 2 and ROBINS-I tools. Interventions, such as support groups, fitness classes, and counseling, were compared against standard care controls. Currently conducting meta-analyses, we will synthesize standardized mean differences for continuous outcomes and relative risks for dichotomous outcomes.

Results

The review includes 18 studies encompassing perspectives of over 1500 caregivers on a global scale. Caregiver relationships to care recipients include spouses, parents, siblings, children, and friends. Interventions are classified as either Psycosocial or Lifestyle. Outcomes for caregivers include improved mental health, reduced stress, decreased loneliness, and enhanced social connections, as well as increased resilience and quality of life. For recipients of care, outcomes focus on improved well-being, better physical and mental health, and reduced reliance on healthcare services such as emergency room visits. Variability in the study populations and intervention designs highlight the need for more inclusive approaches. Ongoing meta-analysis aims to provide precise estimates of intervention effectiveness and to further identify key factors contributing to these outcomes.

Conclusion

Social prescribing may offer promising benefits for caregivers of older adults, improving mental health, reducing stress, and enhancing social connections. Findings have the potential to underscore the need for recommendations to policy development to support caregivers holistically. Future research should address evidence gaps and prioritize caregiver inclusion in program design.

From Military to Civilian Life: Chronic Pain and Military Identity

Presented by: Umair Majid

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David Pedlar, School of Rehabilitation Therapy, Queen's University
Kerry Kuluski, Institute of Health Policy, Management and Evaluation, University of Toronto

Background and Objectives

The transition from military to civilian life is a complex process involving significant adjustments, especially for Veterans enduring chronic pain from military service. Chronic pain and mental health challenges profoundly affect Veterans' identities and their ability to adapt to civilian roles. This study aims to explore the identity changes experienced by Canadian Veterans living with chronic pain and mental health issues during their transition.

Approach

We employed a narrative inquiry methodology to deeply examine the lived experiences of Canadian Veterans with chronic pain. Twenty-five Veterans participated in in-depth, semi-structured interviews focusing on three critical stages: their time during military service, transition to civilian life, and experiences within civilian society. This approach allowed participants to share personal stories in their own words, providing rich, first-person accounts of their identity transformations. The interviews were analyzed thematically to identify common patterns and unique experiences related to identity change, chronic pain, and mental health challenges throughout the transition period.

Results

Analysis revealed profound identity challenges during Veterans' transition to civilian life, including feelings of loss, disorientation, and uncertainty intensified by chronic pain and mental health issues like depression and anxiety. Chronic pain emerged as both a persistent physical burden and a factor diminishing self-worth and adaptability to civilian roles. Veterans grappled with redefining their identities outside the military, facing changes in social support systems and a sense of purpose while often feeling isolated or misunderstood by civilian society. Positive coping mechanisms, such as seeking social support and engaging in meaningful activities, were identified but frequently hindered by chronic pain limitations. This study illuminates these challenges through Veterans' narratives, providing real examples of their experiences.

Conclusion

This research offers valuable insights into the identity transformations of Veterans with chronic pain and mental health challenges, informing effective policies and support services. The findings contribute to developing targeted programs that enhance healthcare access, pain management, and mental health support, improving Veterans' quality of life during their transition.

Cost Valuation and Cost-Effectiveness of Mobile Crisis Response Team in a Rural Ontario Community

Presented by: Madeline Mantler

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Background and Objectives

Crisis calls for people with mental illness (PMIs) have been drastically increasing over the last 10 years, becoming a big policy issue for mental health and addiction services and public health. In response, South Coast Wellness (SCW) in Haldimand-Norfolk, Ontario launched a Mobile Crisis Response Team (MCRT) to respond to mental health crises alongside police. This study aims to conduct a comprehensive economic evaluation to assess the costs and cost-effectiveness of this program in Haldimand-Norfolk.

Approach

This study utilizes a mixed methods approach. The comprehensive economic evaluation uses microcosting of the SCW MCRT program to sum up total program costs with a decision analysis tree model to estimate the incremental cost-effectiveness ratio (ICER) favoring MCRT over standard response. One-way deterministic sensitivity analysis is used to assess uncertainty within the costing along with regression modeling for variable factors. Additionally, qualitative interviews with program staff were used to explore the perceived benefits and drawbacks of the program from both police officers and mental health professionals. Thematic analysis of interview responses was applied to identify themes and program feedback.

Results

This study reports on preliminary results of research in progress. It is anticipated that the estimated ICER will be favorable to the MCRT relative to length of ER visits avoided for PMIs following a 911 call. This is consistent with previous literature showing similar MCRT programs have high rates of successfully diverting PMIs away from the hospital. However, previous literature did not compare the effectiveness or cost-effectiveness of crisis teams compared to standard police response. This analysis has the potential to positively impact individual experiences during mental health crisis and support the allocation of healthcare resources more effectively. A comprehensive economic evaluation is crucial to support the expansion of the SCW MCRT program as well as the development of other MCRT programs in other communities.

Conclusion

This study has identified that the SCW MCRT program is likely cost-effective for responding to crisis calls by avoiding unnecessary ER visits and providing care to PMIs safely in the community. Future research can influence policy decisions to allocate resources for scaling up or starting other MCRTs in other regions.

‘For youth by youth’: Distributive leadership in action with a youth co-design team

Presented by: Reid Martin

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Background and Objectives

Integrated youth services are an emerging delivery model in Canada to address siloed and fragmented youth mental health and other services. Youth engagement is a viable approach to developing integrated youth services when purposefully built. However, it is not always clear how youth are involved within service transformation as decision-makers. This presentation reflects on the development of HOMEBASE and documents the process of actively and authentically engaging with a Provincial Youth Co-Design Team through distributive leadership in the co-design process.

Approach

We worked with a sub-group of youth co-design members, who are co-authors on this abstract, who deconstructed the decision-making process between the co-design team and the backbone team. Within the presentation we will provide examples of how members of the co-design team are represented throughout the organizational structure and the fluidity of their participation in organizational and program level decisions.

Results

Youth are actively and eagerly willing to participate in the co-design process of developing integrated services when there is a shared responsibility, and they are authentically involved and informed within the decision-making process. This requires time to form trust, build relationships and provide youth with low pressure environments to foster healthy debates.

Conclusion

Through utilizing a distributive leadership approach, the Youth Co-Design Team have engaged in various levels of decision-making. By following these guiding principles, policy makers, youth development workers, and researchers can engage youth in meaningful ways to improve the design and development of integrated care.

Examining Family Physician Roles in COVID-19 Surge Capacity: Challenges and Practice Implications

Presented by: Maria Mathews

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Background and Objectives

Surge capacity planning is a critical component of public health emergency preparedness, enabling the healthcare system to meet increasing demands while delivering essential clinical care. During the COVID-19 pandemic, family physicians (FPs) contributed to surge capacity efforts while also maintaining the continuity of primary care operations. We examined FPs' firsthand experiences in supporting surge capacity during the pandemic and identified strategies to enhance primary care providers' contributions during pandemics and health emergencies.

Approach

As part of a larger, multiple case study, we conducted semi-structured qualitative interviews with FPs between October 2020 and June 2021 across four Canadian provinces: British Columbia, Ontario, Nova Scotia, and Newfoundland and Labrador. During the interviews, FPs were asked about the roles they assumed during different stages of the pandemic and the factors that impeded or facilitated their ability to fulfil these roles. Interviews were transcribed verbatim and a thematic analysis approach was employed to identify recurring themes in the data.

Results

We interviewed a total of 68 FPs across the four provinces and identified two overarching themes: 1) mechanisms used to create surge capacity by FPs, and 2) key considerations for an organized surge capacity program. During the pandemic, strategies for surge capacity included extending FP working hours, expanding the FP workforce, and redeploying FPs to new roles and settings. Effective implementation relied on organized communication and coordination mechanisms, FPs working within their scope of practice, training and mentorship related to new redeployment roles, the presence of credentialing and hospital privileges, and policies that helped to preserve primary care capacity.

Conclusion

FPs play a vital role in surge capacity but require structured support to balance their redeployment roles with ongoing primary care responsibilities. Ensuring adequate practice coverage and employing strong communication and coordination mechanisms are essential for sustaining high-quality care and reducing strain on FPs and the broader healthcare system.

Collaborative primary mental health care implementation: A scoping review of system-level factors

Presented by: Dane Mauer-Vakil

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Background and Objectives

Collaborative care models offer an evidence-based approach to address mental health needs in primary care. However, in Canadian contexts, its implementation seldom conforms to evidence-based practice and has not been rigorously evaluated. The key aspects of the most studied collaborative care models have been inconsistently and infrequently implemented. This scoping review addressed the research question: What are the system-level barriers and enablers to implementing collaborative care models to integrate mental health services in primary care?

Approach

We conducted a scoping review in accordance with the Arksey and O'Malley methodological framework and guidelines developed by the PRISMA extension for scoping reviews. We searched the MEDLINE, EMBASE, and PsycINFO databases. Inclusion criteria comprised peer-reviewed studies investigating barriers and enablers to primary mental health care implementation published from January 1990 to May 2020. We utilized the Consolidated Framework for Implementation Research to code and analyze implementation factors across its domains and constructs.

Results

Reviewers screened 3,239 unique citations and 64 articles met the inclusion criteria. A range of barriers and enablers influenced system-level implementation of collaborative care models to integrate mental health services in primary care. The main themes that emerged from the findings included: funding; health practitioner workforce and training; and relationships with organizations and communities. Barriers included a lack of funding for non-physician services, fee-for-service payment mechanisms, and workforce shortages, while enablers were strong partnerships across organizations and health practitioner training/educational opportunities.

Conclusion

This review informs the evaluation of collaborative care initiatives and educates policymakers on the key system-level barriers and enablers to program implementation. By addressing the barriers and leveraging the enablers, policymakers can facilitate the integration of mental health services into primary care, ultimately improving access at a population level.

Comparing psychoeducation groups for persons with bipolar disorder: Life Goals versus Changeways

Presented by: Dane Mauer-Vakil

Author(s): *Heer, Kathy - Queen's University; David, Michela - Queen's University; Jokic, Ruzica - Queen's University; Radloff-Gabriel, Debbie - Queen's University*

Background and Objectives

Group psychoeducation is effective for individuals with bipolar disorder given that medication alone is oftentimes inadequate for symptom management. For several years leading up to 2016, Providence Care Hospital in Kingston, Ontario offered two programs for the outpatient treatment of bipolar disorder, Changeways and Life Goals. These programs followed an educational framework emphasizing individualized application of illness management and goal-setting. This study compared the programs as a quality improvement initiative to inform future clinical practice.

Approach

Participants aged 18+ (N=79) completed measures at baseline and follow-up pertaining to anxiety, depression, mania, social adjustment, satisfaction with daily occupation, hope, and quality of life. Paired sample t-tests were conducted to examine the data longitudinally, chi-square tests of associations to examine sex differences, and Spearman’s correlations to assess associations between measures within groups.

Results

Participants who completed both psychoeducation programs observed either maintenance or improvement in overall psychosocial and occupational functioning. Further, there existed a complex relationship involving measures of depression, anxiety, and hope. For non-completers of both programs, strong negative correlations existed between anxiety and depression with hope scores.

Conclusion

These findings suggest that higher levels of anxiety and depression along with low hope could be related to a higher likelihood of program dropout. Further, measures of hope may be clinically useful as a screening tool for bipolar disorders populations.

Risk factors for incident peripartum mental illness in multiple sclerosis.

Presented by: Colleen Maxwell

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Background and Objectives

Persons with multiple sclerosis (MS) have an increased risk of psychiatric disorders relative to those without MS; this heightened risk is also evident during the peripartum period. Given the adverse consequences of peripartum mental illness for mother and child, it is important to identify those at particular risk, to better inform intervention strategies. Our objective was to identify sociodemographic and clinical factors associated with the risk of incident peripartum mental illness among mothers with MS.

Approach

This population-based retrospective cohort study used linked health administrative data from Ontario to identify mothers with MS (validated case algorithm) with live births between 2002 - 2019. Using validated definitions, we estimated the incidence of depression, anxiety, and bipolar disorder from conception through the first post-partum year (peripartum period) for the first pregnancy. Incident cases were those without any relevant mental illness diagnosis codes for two years prior to conception date. We used multivariable Poisson regression to estimate associations between age, delivery year, area-level deprivation (Ontario Marginalization Index), disease duration, disability, and obstetric comorbidity and incidence of peripartum mental illness.

Results

Included were 1,745 mothers with MS, with a mean (SD) age at conception of 31.2 (4.8) years. Most had singleton births and resided in urban areas, and about 15% had high disability scores. Adjusting for covariates, mothers living in communities that lacked cohesion (i.e., higher deprivation in relation to family/neighbourhood stability and cohesiveness, continuous measure) had increased rates of peripartum depression (incidence rate ratio [IRR] 1.25; 95% CI 1.11-1.42) and anxiety (IRR 1.20; 95% CI 1.07-1.33). A higher MS disability score was associated with elevated peripartum depression rates (IRR 1.51; 95% CI 1.12-2.04) and longer disease duration was associated with elevated rates of depression (IRR 1.03; 95% CI 1.00-1.07 per year) and anxiety (IRR 1.04; 95% CI 1.01,1.07 per year).

Conclusion

Mothers with MS residing in areas with higher deprivation in households/dwellings, with higher disability levels and longer disease duration experience an increased incidence of peripartum mental illness. These findings may assist clinicians in identifying women with MS who may benefit from peripartum mental health screening and relevant care interventions.

Improving Influenza Vaccine Uptake Amongst Adult Kidney Transplant Recipients: A Mixed-Methods Study

Presented by: Erin McConnell

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Background and Objectives

Kidney transplant recipients (KTRs) are immunocompromised and more susceptible to infections like influenza. Despite their increased risk of severe illness and mortality with influenza infection, uptake of the influenza vaccine is sub-optimal amongst KTRs, warranting further investigation. The main objectives of the proposed, mixed-methods design include: (Obj. 1) Examine barriers and facilitators to influenza vaccine uptake amongst KTRs in Nova Scotia; (Obj. 2) Co-design tailored implementation strategies to support influenza vaccine uptake in KTRs.

Approach

A scoping review will be utilized to map existing evidence on vaccine hesitancy and KTRs. Review findings will then be used to inform a qualitative study guided by the Behaviour Change Wheel (BCW) and Theoretical Domains Framework. Semi-structured interviews on the barriers and facilitators to influenza vaccine uptake in KTRs will be conducted with KTRs and clinicians (Obj. 1). We will use the BCW to map implementation strategies onto the identified barriers and facilitators. Nominal group technique will be conducted to assess the implementation strategies on their affordability, practicability, effectiveness and cost-effectiveness, acceptability, side-effects/safety and equity (Obj. 2).

Results

This project will explore knowledge and gaps in influenza vaccine uptake with a unique population with complex health needs and considerations. Understanding the barriers and facilitators to vaccine uptake amongst KTRs is integral to addressing vaccine hesitancy systematically, and meaningfully in this vulnerable population. Using an integrated knowledge translation approach, which meaningfully engages patient partners and other knowledge users, will ensure the relevancy and responsiveness of the project to end-user needs and priorities. The findings will be used to tailor appropriate implementation strategies to enhance influenza vaccine uptake. The insight gained from selecting, tailoring and evaluating implementation strategies in this context can also help inform vaccine uptake in other priority populations.

Conclusion

The proposed research will explore vaccine hesitancy and factors impacting vaccine uptake in KTRs. Based on the findings, evidence-informed implementation strategies will be tailored to improve influenza vaccine uptake and ultimately, health outcomes amongst KTRs.

Building system capacity for home visits for patients near end of life: A mixed methods study

Presented by: Madeline McCoy

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Background and Objectives

Despite known benefits, many Canadians do not receive adequate physician and nurse practitioner (NP) home visits in their last year of life. Contributing to this gap is the small number of palliative specialists, and the small proportion of family physicians providing home visits. We need to better understand factors that facilitate and prevent willingness to provide home visits. Our objective was to understand how physician and NP perceptions of system-level characteristics influence home visit provision.

Approach

We conducted a sequential explanatory mixed methods study, starting with a survey followed by interviews designed to explain and provide deeper insights into the survey findings. The research team identified clinicians, researchers, and policymakers across Canada who circulated emails about the study to their networks. Physicians and NPs from across Canada who do and do not provide home visits to adult patients in their last year of life completed an online survey (April-November 2024). Survey respondents indicated their interest in participating in an optional, virtual interview. These semi-structured interviews (July-October 2024) investigated deeper meanings of survey findings using thematic analysis.

Results

There were 77 survey participants (47 physicians, 30 NPs) and 16 interview participants (10 physicians, 6 NPs). Top enablers for physicians/NPs who provide home visits were enhanced provider-patient relationship, providing an alternative option for homebound patients, and sense of purpose. Providers who do not deliver home visits prioritised providing an alternative option for homebound patients, alongside collaboration between healthcare professionals and short travel distances. Top barriers for those who provide home visits included: heavy workload, long travel distances, and staff shortages. Providers who do not deliver home visits prioritised heavy workload, alongside increased time spent at the home visit and concerns for safety. To scale up home visit delivery, interview participants suggested provincial/territorial governments should address workforce shortages, prioritize education/training, and promote community care models.

Conclusion

While unsatisfactory remuneration is commonly cited as a major barrier, our findings highlight other key factors. Thus, multi-pronged interventions are required. Combined with findings from our ongoing health economics analysis, we will provide evidence to provincial/territorial governments outlining how home visits at the end of life can be scaled up.

Loneliness as a predictor of patient experience

Presented by: Kaileah McKellar

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Background and Objectives

Loneliness has emerged as a significant global public health issue, linked to increased risks of mortality, cardiovascular disease, dementia, depression, and functional decline. While these health outcomes are well-documented, there remains a paucity of information on how loneliness shapes patients' experience of care. This study investigates loneliness as a predictor of patient experience within Ontario's integrated care model, addressing critical gaps in understanding its impact on healthcare access and quality of care.

Approach

As part of an Ontario Health Teams (OHT) evaluation, this study analyzed survey data from 2,673 respondents (from December 2023–March 2024), focusing on Patient Reported Experience Measures (PREMs). Loneliness (the exposure variable) was measured using the UCLA 3-item loneliness scale, dichotomized into "lonely" (scores 6–9) and "not lonely" (scores 3–5). Descriptive statistics summarized socio-demographic characteristics, with t-tests and chi-square tests comparing lonely vs. not lonely groups. Multivariable logistic regression examined associations between loneliness and patient experience outcomes, adjusting for covariates.

Results

Demographic characteristics of the study sample (n=2,673) revealed 80% were "not lonely," while 20% reported loneliness. The lonely group had higher proportions of women (67.1% vs. 59.1%), younger individuals (17.7% vs. 9.3%), and higher PHQ-2 (depression) scores (4.25 ± 1.79 vs. 2.62 ± 1.11). They reported more financial difficulties, food insecurity, and housing instability. Associations showed lonely patients were less likely to feel healthcare providers understood their needs (OR=0.615, p=0.015) or to feel confident managing their health (OR=0.529, p=0.005). Sensitivity analyses, in which the outcome was measured as a stricter threshold for positive patient experiences, revealed loneliness was associated with lower care coordination (OR=0.665, p=0.002) and confidence in care management (OR=0.714, p=0.008).

Conclusion

Patients experiencing loneliness report poorer healthcare experiences, highlighting its impact on perceived quality of care. Addressing loneliness through screening, patient-centered care, and integrated behavioral health services could strengthen patient-provider relationships and improve outcomes, emphasizing the need for targeted interventions. More research on the temporal relationship between loneliness and PREMs is warranted.

Enriched Core Competency Framework for Health Services and Policy Research - An Update

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Background and Objectives

Doctoral and postdoctoral training in health services and policy research (HSPR) needs to evolve to address changing career trajectories, emerging health system challenges, and the advancement of learning health systems. This changing landscape necessitates examination of the core competencies that underpin training. This study presents a refreshed set of core competencies for HSPR to guide the modernization of training, implementation options, and an update on implementation progress.

Approach

Qualitative methods and an iterative development process with extensive community engagement throughout was used. Data were obtained from multiple sources, including literature reviews, a survey of the HSPR community, key informant interviews with a purposeful group of health system and research leaders, focus groups (with trainees, health system leaders, and deans and directors of university-based doctoral training programs), Task Force meetings, a consensus workshop, and a validation process (Fall 2022 - May 2024). An 11-member Training Modernization Task Force led this refresh process.

Results

The refreshed core competencies include nine essential domains that maintain an emphasis on rigorous scholarly preparation and prioritize leadership and other professional skills deemed essential to contribute to evidence-informed system improvement and learning health systems. Additionally, the framework features two new transversal domains: Equity, Diversity, Inclusion, Accessibility and Anti-Oppression; and Indigenous Cultural Safety and Humility. These domains are considered fundamental principles to be embedded into all aspects of HSPR competencies and training, fostering more inclusive and equitable leaders and health systems. Implementation of the framework has commenced within the Canadian Institutes of Health Research and progress is underway engaging with universities and health system organizations.

Conclusion

The refreshed core competencies maintain continuity with the inaugural competency framework while also including important additions. The framework can be used to guide the enhancement of individual-level skill development, organization-level training program modernization, and the growth and development of a future-fit HSPR workforce with skills to advance health system improvements.

The Impacts of Adverse Childhood Experiences on Autonomic and Psychological Stress Reactivity

Presented by: Carissa Melnyk

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Background and Objectives

Adverse childhood experiences (ACEs) affect 50-60% of the population and are linked with the development of many physical and mental illnesses, making them a pervasive threat to public health. A potential mechanism contributing to these outcomes may be long-term stress response alterations. However, it is unclear whether ACEs differentially impact the sympathetic and parasympathetic nervous systems. Additionally, their influence on psychological stress responses remains unclear. This study's objective is to address these research gaps.

Approach

Participants will first complete an online survey to assess the number of ACE categories they have been exposed to. Subsequently, stress responses will be measured experimentally through the Trier Social Stress Test (TSST) and a Control-TSST. This study will utilize a series of simple linear regressions to test whether the number of ACEs experienced will predict cardiovascular, sympathetic, parasympathetic, and state anxiety reactivity, as well as the utilization of maladaptive appraisals during acute stress. Additionally, four mediation analyses will assess whether stress appraisals mediate the relationship between ACEs and cardiovascular, sympathetic, parasympathetic, and anxiety reactivity.

Results

It is anticipated that cardiovascular reactivity will be negatively predicted by ACE score and that the number of ACEs experienced will negatively predict sympathetic reactivity. We further expect to find a negative predictive relationship between ACEs and parasympathetic reactivity during the acute stress task. It is also hypothesized that ACE scores will positively predict the utilization of threat appraisals and that ACE scores will predict higher state anxiety reactivity. Lastly, it is anticipated that threat appraisals will mediate the relationships between ACEs and physiological and anxiety reactivity.

Conclusion

This study will address several gaps in the existing research, most notably by clarifying the impacts of ACEs on sympathetic, parasympathetic, anxiety, and appraisal responses to acute stress. Findings may inform health policy development to better support individuals who have been exposed to ACEs.

Building a data catalogue to advance the study of language and health in Quebec populations

Presented by: Alixe Ménard

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Background and Objectives

Language concordant care is a determinant of health often overlooked in health services research, despite its significant impact on outcomes. English-speaking communities in Quebec face healthcare language barriers that exacerbate disparities. While other social determinants like income are well-studied, language remains underexplored. This study develops a data catalogue documenting language-related variables across national, provincial, and local datasets, addressing gaps to advance research on language and health in Quebec.

Approach

We are cataloguing datasets including the Canadian Community Health Survey, MED-ECHO, TorSaDE, the Canadian Longitudinal Study on Aging, and the ICLSC database. This catalogue captures language, healthcare utilization, health outcomes, and socioeconomic variables at various geographic scales, addressing the absence of Quebec data in some federal health datasets. Variables like patient-provider language concordance, immigration, and racialization enable intersectional analyses. The data is extracted by one team member, with spot checking by a second extractor and regular team meetings to review the content and extraction process. A data dictionary will be validated by database users and key informants.

Results

We have documented multiple sources of language-related variables in Quebec's health data infrastructure. For instance, the Canadian Community Health Survey captures language concordance between patients and providers, and the MED-ECHO database tracks hospital admissions with language-specific demographic variables. Initial linkage of datasets, such as TorSaDE and administrative records, provide the potential to evaluate associations between language discordance and health outcomes, including mortality, morbidity, and quality-adjusted life years. The catalogue also provides data on gender, immigrant status, and socioeconomic factors, facilitating research on intersectional health inequities. This infrastructure will serve as a critical resource for addressing language-related health disparities in Quebec.

Conclusion

The development of a comprehensive data catalogue will enable population-level studies on the impact of language barriers in healthcare for Quebec's English-speaking communities. By supporting targeted research and interventions, this initiative aims to reduce health disparities, inform policy, and enhance healthcare delivery for linguistic minority populations in Quebec.

Regional Disparities and Operational Insights: An Overview of Safer Opioid Supply in Ontario, Canada

Presented by: Jordan Mende-Gibson

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Background and Objectives

Canada is navigating an opioid epidemic, seeing increases in opioid-related harms that are largely attributable to increased toxicity of the unregulated opioid supply. In response, Safer Opioid Supply programs have been established across Canada, providing pharmaceutical-grade alternatives to people who use drugs. The objective of this study is to provide insights into program operations, highlighting geographic and operational differences that exist, and helping to develop a more thorough understanding of this vital harm reduction pathway.

Approach

A list of 16 safer opioid supply programs was obtained from Health Canada's Substance Use and Addictions Program website. Two additional programs were identified through email correspondence, for a total of 18 publically-funded programs operational as of September 2024. Data was collected from program websites, and when information was not publically available or was unclear, a member of the research team independently contacted a program representative to validate and inquire about missing information. Program data includes: program location and infrastructure, eligibility criteria, priority populations, capacity and enrollment, procedures and requirements, referral pathways, prescribed medications, and wraparound services.

Results

All safer opioid supply programs in the province were integrated within an existing health organization, whereby other wraparound services were offered. Programs were found to have specific eligibility requirements, such as residency requirements or health coverage, whereby clients were required to reside within the locality of the program, or have an Ontario Health card to access services. Information on program capacity and current enrollment was obtained from 15 programs, with capacity limits ranging from 30 to 150, the highest enrollment at a single program being 148 clients, and the lowest at 24. Data on medications offered were obtained for the majority of programs, presenting significant variability among the medications available.

Conclusion

Overall, this analysis revealed a shortage of programs across several health regions in Ontario, demonstrating gaps in program availability. Furthermore, strict requirements for program enrollment created access barriers, while disparities in the medications offered and precarity in program funding contributed to challenges with client retention and program sustainability.

Bridging the Divide: Exploring the Compatibility of MAiD and Palliative Care in Canada

Presented by: Matthew Midori

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Background and Objectives

The compatibility of medical assistance in dying (MAiD) with palliative care in Canada is contentious. While palliative care aims to relieve suffering without ending life, some argue that MAiD acts as an essential bridge for addressing suffering which cannot be relieved. This study explores the perspectives of palliative care physicians to gain insight into this debate. The objective of this research is to inform end-of-life health policy that addresses patient needs and fosters ethical dialogue.

Approach

This study applies a qualitative descriptive approach, utilizing semi-structured interviews with 20 to 25 palliative care physicians practicing across Canada. Participants will include both physicians who provide MAiD and those who abstain for moral reasons to allow for balanced perspectives. Interview questions will focus on their professional experiences that inform their views on the compatibility of palliative care and MAiD, patient and family encounters, and perceived gaps (and what causes them) in current palliative care services. Thematic analysis will be conducted to identify key insights to allow for the identification of moral, professional, and practical considerations that influence participant beliefs.

Results

The anticipated results of this study will reveal a spectrum of perspectives regarding the compatibility of MAiD and palliative care, reflecting the moral divide among palliative care practitioners. Physicians who participate in the provision of MAiD will likely emphasize its role in alleviating irremediable suffering, while those who abstain may focus on MAiD's ethical incongruence with palliative care's foundational principles. A common theme expected to emerge regardless of opinion on practice compatibility is the importance of bridging gaps in health service access. Participants are likely to underscore the necessity of fostering communication among practitioners and families to ensure patient-centered care despite personal beliefs. These findings aim to illuminate the ethical challenges and opportunities posed by the integration of end-of-life care practices.

Conclusion

This study will provide valuable insights into the compatibility of MAiD and palliative care through the perspective of palliative care specialists. By bridging the schism in this debate, these findings aim to inform end-of-life health policy that addresses service gaps and meets the diverse needs of patients and families.

Mental health service utilization measures among youth: a scoping review

Presented by: Yukiko Mihashi

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Background and Objectives

Despite high prevalence, fewer than 25% of youth with mental health problems receive the care they require. While service use data is invaluable to addressing this gap, there is currently a lack of a gold standard measure to assess service utilization in this population. The present study is a scoping review that aims to identify standalone, patient- or caregiver-reported mental health service utilization measures that have been used in youth, with established psychometric properties.

Approach

Three online databases were searched using keywords related to youth mental health, self-reported instruments, and measurement properties. Identified abstracts were reviewed by two independent reviewers, and full-text review and data extraction were undertaken by three independent reviewers.

Results

N=8 instruments were identified that met eligibility criteria with established measurement properties. The most commonly tested measurement properties were test-retest reliability and concordance with medical/administrative records. Of the eight identified measures, the Service Assessment for Children and Adolescents (SACA) had both the most number of established measurement properties and instances of use within studies identified through our search. Most of the instruments were developed in western settings and none of them had been developed for a young adult population. None of the instruments included more recent developments in the field, such as patient engagement during development or the ability to differentiate between virtual vs. in-person visits.

Conclusion

The results of this review indicate a need for re-evaluation and update of the existing instruments or the development of a new measure targeting a youth and young adult population that borrows from the strengths of the existing measures while augmenting some of their weaknesses.

The Primary Care Problem Framings of Key Professional Interest Groups in Ontario: A Policy Analysis

Presented by: Shraddha Mishra

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Background and Objectives

Ontario pharmacists were recently granted the authority to diagnose and treat 13 ailments as a means for addressing primary care access gaps across the province. Key interest groups have since engaged in public discourse surrounding this scope of practice change, each group uniquely framing Ontario's primary care access problem. We sought to critically examine these different problem framings, given the potential for their influence in shaping chosen policy solutions.

Approach

Interpretive policy analysis methods were used to identify and analyze different framings of the primary care access problem by professional colleges and associations representing Ontario nurses, pharmacists and physicians. Data were collected from digital news articles and organizational websites. Analysis was guided by Deborah Stone's 'problem definition' framework including: (1) Symbolic devices, which are literary devices often leveraged by actors to define problems in particular ways and advocate corresponding policy solutions, and (2) Causal theories, which are invoked when a policy problem is attributed to specific factors, implying that these factors must be targeted by policy.

Results

252 news articles and 32 documents from the websites of the identified organized interests were included. Nurse groups highlighted a 'story of decline', emphasizing a growing primary care crisis rooted primarily in the province's potentially-deliberate neglect of nurse practitioners. Physician groups, too, told a story of decline, though focused instead on the growing family medicine crisis rooted in poor family practice conditions and continuously denied by the Ford administration. They also commonly used metaphors characterizing family medicine as essential and existing policies as futile or potentially dangerous. In contrast, pharmacist groups told a 'story of rising', anticipating improved primary care access with recent scope of practice expansion. Moreover, they appeared to counter physician groups' assertion that pharmacists' ability to diagnose and treat ailments is risk-laden.

Conclusion

Our results demonstrate the role of 'problem framing' in serving the interests of key professional groups and their potential influence on primary care reform policy outcomes. How problems are defined cannot be divorced from organizations' longstanding, systems-level struggles over clinical, economic, and political autonomy.

Charting New Frontiers in Peer Support for Healthcare Workers: Lessons from App Implementation

Presented by: Sandra Moll

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Background and Objectives

Healthcare workers (HCWs) face significant stressors, yet stigma and limited access to timely support often prevents them from seeking help. Peer support can improve mental health outcomes, but traditional models are not always scalable or accessible. Beyond Silence is a new mobile health platform designed to provide HCWs with confidential, easy-to-access mental health information and peer support. The purpose of this project was to explore forces affecting adoption of app-based peer support for healthcare workers.

Approach

A mixed methods implementation study was conducted over a four to eight month period in eight diverse case study healthcare organizations. Employees could access trained peer support providers either within or outside their organization via the Beyond Silence app. Data was collected on app usage (e.g., downloads, usage patterns, peer support bookings). Interviews were conducted with 27 organizational champions, and focus groups were conducted with 69 peer supporters to explore individual and organizational forces that shaped uptake. Trends in app use were summarized and analysis of the interview transcripts was informed by the Consolidated Framework for Implementation Research (CFIR).

Results

Over 33,000 HCW's across eight diverse healthcare organizations had access to the app, with 1155 downloads and 3672 app opens over the four to eight month trial. Downloads and peer support outreach rates varied by organization. A total of 64 peer support calls and 48 chats were booked with trained peer support providers. Most appointments (75%) were booked with peer supporters external to the organization. Individual forces shaping uptake of the app-based peer support included: awareness of its availability, mental health literacy, digital literacy, stigma, perceived value or relative advantage of app-based peer support, time to reach out, and trust. At the organizational level, uptake was reportedly shaped by mission alignment, leadership support, organizational culture, the implementation process, resources, and the technology/peer support infrastructure.

Conclusion

Beyond Silence is a promising tool to reduce barriers to mental health support for HCWs through scalable, app-based peer support. Optimal implementation requires consideration of the organizational context and integration of peer support into broader health and wellness policies and programs.

Toward a Sustainable Nursing Workforce: Perspectives from Canadian Nurses

Presented by: Sahar Momin

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Background and Objectives

In summer 2024, the Canadian Nurses Association (CNA) conducted a nationwide survey capturing the perspectives of 1,796 nurses on the future of nursing and health care in Canada. This initiative aimed to address pressing workforce challenges, amplify nurses' voices in policy-making, and enhance health-care outcomes. Key objectives included understanding workforce demographics, identifying systemic issues such as staffing shortages, and highlighting nurses' views on licensure models, workplace excellence programs, and public versus private health-care delivery.

Approach

CNA's survey employed a mixed-methods approach, combining quantitative and qualitative data collection to assess the state of the nursing workforce. The survey was distributed nationwide and included representation from various age groups, geographic regions, and nursing roles. Data analysis focused on identifying patterns related to workforce demographics, systemic challenges, and areas of opportunity. Respondents shared insights on staffing shortages, mental health, workplace conditions, and their perspectives on professional development and licensure. Key thematic areas were analyzed to inform actionable recommendations for policy-makers, employers, unions, and regulatory bodies, ensuring alignment with the evolving needs of Canadian nurses and the healthcare system.

Results

The survey revealed critical findings. Most notably, 95% of nurses value retention-focused workplaces, yet 86% lack access to workplace excellence programs. Specialty certification support by employers was a key retention factor for 75% of respondents. Recruitment and retention strategies remain the most important policy measure to address the nursing shortages. Notably, 93% supported a multijurisdictional licensure model to improve labour mobility. A majority of respondents, 73%, preferred either maintaining the current public-private mix in the public health system or reducing the extent of privately delivered health services. Recommendations included expanded educational funding, supportive workplace policies, and enhanced mental health resources. These findings underscore the urgency for coordinated efforts to address workforce sustainability and improve healthcare outcomes through targeted investments and policy reforms.

Conclusion

The CNA survey highlights nurses' priorities for systemic change: addressing workforce shortages, supporting mental health, and enhancing professional development. These insights guide actionable strategies for sustainable health-care improvements. CNA remains committed to advocating for nurses' needs, ensuring their voices drive equitable, effective, and resilient health-care policies in Canada.

Scaling Up eConsult for Chronic Pain Specialists in Primary Healthcare Across 4 Canadian Provinces

Presented by: Isabella Moroz

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Background and Objectives

Wait times at Canadian multidisciplinary pain clinics often exceed benchmarks, leaving patients struggling to access timely specialist advice for chronic pain and causing delays in treatment. Electronic consultation (eConsult) offers a solution by enabling primary care providers (PCPs) to securely communicate with specialists, improving timely and equitable access to care. In this study, we examine the implementation of eConsult for chronic pain and evaluate its impact across four provinces: Manitoba, Ontario, Quebec, Newfoundland and Labrador.

Approach

We conducted a cross-sectional descriptive study of all eConsult cases submitted in the participating provinces to chronic pain specialists between January 1, 2019, and December 31, 2024. System utilization data and mandatory close-out surveys collected routinely by the service were analyzed using the RE-AIM framework, assessing reach, effectiveness, adoption, implementation, and maintenance. This approach was used to gain insights into service growth and usage patterns in each province, including the impact on access to chronic pain specialists, and to identify best practices for scaling eConsult services for chronic pain ensuring long-term sustainability.

Results

Implementation timelines varied by province based on system maturity. Early results show that Ontario, with the most established system, completed 2,564 chronic pain eConsults, followed by Newfoundland (n=122), Quebec (n=56), and Manitoba (n=37). In Ontario, the median specialist response time was 1.4 days, an originally contemplated referral was avoided in 38% of cases, and primary care providers reported receiving new advice 66% of the time. In Quebec, the average specialist response time was 4.4 days and referral was avoided in 36% of cases. We anticipate that complete results will further clarify utilization patterns and outcomes in each province and confirm some consistency across provinces in key metrics despite differences in implementation scope.

Conclusion

This study evaluates eConsult's impact on chronic pain care, focusing on reach, effectiveness (including anticipated and unanticipated outcomes), adoption, consistency of implementation, and planning for sustainability. Findings will inform strategies to expand access to eConsult, thereby driving transformative changes in healthcare delivery for Canadians living with chronic pain.

Centring equity in addressing the healthcare workforce crisis: Lessons from Black workers

Presented by: Alice Murage

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Background and Objectives

The healthcare workforce crisis in British Columbia is characterized by workers' intention to leave the profession and high turnover. The Government is mediating by implementing policies to increase the number of healthcare workers. Through an intersectional analysis of lived experiences of Black workers, we interrogate underlying systemic issues. As most workers in the sector are women, racialized, and/or immigrant workers, addressing challenges affecting this demographic is essential, with positive implications to other workers.

Approach

Data was collected through semi-structured interviews with 30 Black workers in the healthcare sector across British Columbia. Research design, data collection and analysis were guided by intersectionality as a conceptual framework to examine nuanced experiences based on race, gender and immigration status, and to interrogate systemic drivers. A precarious work—health outcome framework (developed by co-authors) was used to analyse nuanced ways in which employment relationships and work conditions affect the health and wellbeing of workers and consequently, their intention to leave their professions. Reflexive thematic analysis was utilized in interpreting data.

Results

Preliminary analysis of interview data indicates that workers' limited control i.e., over work hours, schedule and workflow, and limited support are important dimension of precarious work that impact workers' health and wellbeing. Workers further experience dissonance between their values to care for patients and their inability to do so. Black workers face additional strain due to systemic and inter-personal racism. Workers also face gendered power dynamics also associated with their occupation. Women navigate unique work effects on family responsibilities. Immigrant workers further experience barriers associated with limited social support and difficulty navigating institutional bureaucracies for credentials and certification. Moral distress, emotional exhaustion, negative physical and mental health outcomes, and limited career progression were important contributors to intention to leave.

Conclusion

Addressing the current healthcare workforce crisis requires systemic solutions and an equity lens. For instance, increasing workers' control over their work, enhancing practical and moral support, creating clear pathways for career advancement, ensuring job security and adequate compensation for frontline workers, and explicitly addressing racism.

Curating a Compendium of Roles for the Primary Care Health Workforce to Foster Collaboration

Presented by: Sophia Myles

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Background and Objectives

Foundational to comprehensive team-based primary care is a mutual understanding of the roles that team members from a range of occupations play. Evidence suggests that many involved in primary care provision are not fully aware of the training and regulated scopes of practice of other provider groups, which poses a significant barrier to optimal interprofessional collaboration. We curated a compendium outlining the roles of various primary care team members to support team-based models of care.

Approach

Over 20 practitioner training partners joined the Team Primary Care Interprofessional Collaborative Table which met quarterly between December 2022 and June 2024. As part of the 'curriculum' designed by three co-chairs and personnel with expertise in interprofessional primary care, participants were tasked with conveying their roles to each other in three selected primary care domains to begin to enhance foundational knowledge to learn to practice together more collaboratively. Over the course of several meetings, these conversations led to the development of a template for the compendium of roles shared amongst partners, with extensive expertise in their respective roles.

Results

The process of sharing information about the training and potential roles of 24 unique professional partners in primary care at the Interprofessional Collaborative Table revealed a notable level of ignorance of each others' roles making the case for the use value of this compendium. Entries from 24 partners ultimately consisted of: (1) a case study narrative of the practitioner's potential role within a team-based model of primary care; (2) details about the training, regulation and scope of practice of each practitioner, and (3) specific contributions of their practitioner group to three illustrative primary care domains that were applied across all entries. Draft entries were shared and revised to ensure consistency across the entries in collaboration with partners.

Conclusion

The curating of the information in this compendium for the first time is a necessary foundational step but is insufficient if it is not integrated into the training and knowledge base of all primary care practitioners moving forward. Sustained change requires embedding this knowledge into curricula and accreditation standards.

Assessing Impact: An evaluation of CIHR’s eHealth Innovations Partnership Program

Presented by: Jessica Nadigel

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Background and Objectives

Research funders make substantial investments in health research to support the implementation, evaluation, and adoption of evidence-based solutions in the health system. However, there is limited understanding of the impacts of these investments and their influence on policy and practice. The Canadian Institutes of Health Research (CIHR) undertook a research impact assessment on its largest digital health program, the eHealth Innovations Partnership Program (eHIPP), to understand the program’s impacts and outputs.

Approach

A mixed methods approach was taken to collect and analyze data from eHIPP grant recipients and their partners. This involved a review of CIHR’s program documents and online surveys sent to the lead researchers and their project partners. Semi-structured interviews with research teams were used to further explore survey findings, followed by thematic analysis, triangulation, and synthesis of data from the various sources. Two complementary impact frameworks, the Canadian Academy of Heath Science’s Making an Impact Framework and the Canadian Health Services and Policy Research Alliance’s Informing Decision-Making an Impact Framework, served as the foundation for the impact assessment.

Results

The eHIPP program invested $42M in 22 research teams located in 19 institutions across 6 provinces. eHIPP positively impacted the research programs, research teams and careers of lead investigators, with most respondents agreeing that eHIPP funding was essential for their research and advancements in digital health. Additionally, the program helped to support 127 trainees and 100 research personnel.

The teams reported 35 co-designed solutions aimed at enhancing care coordination across the health system. Strong partnerships with healthcare providers, patients, and policymakers were considered critical to the success of these solutions. Respondents reported their solutions improved equitable access to care, enhanced patient experience, improved health outcomes, and enhanced health equity. Respondents also indicated that their solutions contributed to influencing health system practices and informing health policy.

Conclusion

This impact assessment underscores the importance of strong partnerships and co-design in implementing patient-centred digital health solutions that address population needs, enhance equity, and shape policy. It advances the science of funding for impact, demonstrating how funders can leverage impact assessments to understand program impacts and the value of research investments.

Values and preferences of people accessing safer supply in Canada: A qualitative evidence synthesis

Presented by: Frishta Nafeh

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Background and Objectives

Canada's response to the overdose crisis includes an innovative harm reduction approach called safer supply, which provides prescribed pharmaceutical alternatives to toxic unregulated drug for people at a high risk for overdose. This qualitative evidence synthesis examines safer supply users' experiences to inform respective clinical practices and harm reduction policy developments.

Approach

Following Cochrane guidelines, we systematically reviewed qualitative studies of safer supply user experiences published between January 2016 and August 2024. Seven databases (MEDLINE, Embase, PsycINFO, CINAHL, EBM Reviews, Web of Science, and Scopus) were searched, complemented by gray literature sources. We employed Thomas and Harden's thematic synthesis approach, assessed study quality using CASP, and evaluated confidence in findings using GRADE-CERQual.

Results

Our synthesis included 19 papers involving 395 safer supply users in British Columbia and Ontario, of whom 60% were men and 36% were women. We developed five analytic themes: (1) safer supply as a pathway to improved quality of life, (2) the need for appropriate opioid medications and dosing, (3) the importance of continuous access and availability, (4) supportive and person-centred care environments, and (5) the necessity of flexible, non-punitive clinical protocols. Safer supply users emphasized the importance of the program's role in facilitating stability, daily functioning, and autonomy in managing substance use.

Conclusion

Safer supply programs' successful implementation requires balancing program accessibility with appropriate medication options and flexible protocols that accommodate complex needs and lived experiences. While safer supply shows promise as a harm reduction strategy, its effectiveness depends on maintaining adaptability to individual needs while operating alongside existing opioid prescribing models.

Two thirds of community pharmacies can dispense mifepristone within 3 days: a mystery caller survey

Presented by: Elizabeth Nethery

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Background and Objectives

Access to abortion in Canada has historically been inadequate and inequitable, with geographic disparities. The mifepristone-misoprostol medication abortion regimen became available in Canada in 2017, offering the potential to expand access and reduce geographic disparities. Despite rapid uptake, patients and providers report difficulty finding pharmacies that dispense mifepristone. This study quantified the proportion and geographic distribution of community pharmacies that dispense mifepristone within 3 days and the resulting geographic access to mifepristone in British Columbia (BC).

Approach

In this cross-sectional mystery caller telephone survey, we called all community pharmacies in BC (July – August 2024) posing as patients looking to fill a mifepristone prescription. If a pharmacy could not dispense mifepristone within 3 days, callers requested a referral to one that could. We cross-referenced mifepristone practice among referral pharmacies. Using road network analysis, we estimated: the 1) proportion of reproductive-aged (15-49 years) females who reside in a census dissemination area within 15- and 60-minute driving times of a mifepristone-dispensing pharmacy and 2) proportion of pharmacies within these driving times that dispensed mifepristone.

Results

Of the 1,511 pharmacies in BC, we excluded specialty or central fill pharmacies (n=34) and successfully contacted 98.8% of community pharmacies (n=1,460). Two thirds (66%) of pharmacies could dispense mifepristone within 3 days. Among non-dispensing pharmacies (n=498), two thirds (66%) did not provide a valid referral to a dispensing pharmacy. Nearly all (99.7%) reproductive-aged females lived within a 60-minute drive from a community pharmacy, 98.4% were within a 15-min drive of a mifepristone-dispensing pharmacy and less than 0.1% were further than a 60-min drive. While urban areas generally have more pharmacies, the proportion of pharmacies that dispensed mifepristone was lower than in rural areas.

Conclusion

While most reproductive-aged females in BC live close to a mifepristone dispensing pharmacy, 1 in 3 urban pharmacies could not dispense within 3 days; putting the onus on the patient to find a dispensing pharmacy. Despite widespread local availability, policies to enhance pharmacist referral networks could improve mifepristone access.

Policy Research for Health System Improvement: Promising Approaches and Top Tips from Policymakers

Presented by: Jennifer Newell

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Background and Objectives

The strategic planning process for CIHR's-Institute of Health Services & Policy Research identified policy research as a domain for greater investment to enable high-performing healthcare systems. In response, $9M was invested in the Policy Research for Health System Transformation program with the goal of producing timely, evidence-informed policy options aligned with policymakers' needs. This study examines the program's outcomes, including policy priorities addressed, research approaches used, and policy leaders' tips for mobilizing research into action.

Approach

This descriptive study draws on evidence from the three-year period from program conception to completion.

Literature reviews, key informant interviews, and historical analysis of CIHR grants informed the program's development. Document analysis of funded projects (n=60) and their end-of-grant policy briefs identified the policy priorities studied, partners involved, and policy research approaches used. A Policy Roundtable convening funded teams, policy leaders, and people with living/lived experience (PWLE) (n=250+) informed a "top 12" list of strategies to maximize the impact of research on policy. The top 12 list was validated post-roundtable with panelists (n=6, including policy, clinical, research, lived experience expertise).

Results

Several program design elements were identified to enhance the research and its potential value: integrated knowledge translation, cross-jurisdictional and interdisciplinary collaborations, co-design with policymakers and PWLE, tailored communications (e.g., policy briefs), and a mechanism for cross-project learning.

Sixty policy research teams were funded across Canada, including 10 cross-jurisdictional projects. Analysis of policy briefs revealed diverse priorities (e.g., primary care, health workforce) research approaches (e.g., mixed methods, patient-oriented research), and policymaker partners (e.g., health authorities, regulatory authorities). Several projects have already influenced policy or seen their policy options implemented. The end-of-grant Policy Roundtable generated twelve strategies to advance research impact, which can inform future health policy research. Additional insight from the Knowledge Mobilization Synthesis Project (KMSP), the mechanism designed to generate cross-project learning, is forthcoming.

Conclusion

The program successfully united researchers, policymakers, and PWLE to co-develop timely, relevant policy options. Program outcomes highlight strategies for researchers and funding organizations to advance the impact of research on policy. As KMSP findings emerge, ongoing efforts to strengthen the research-policy connection remain critical to advancing high-performing health care systems.

Promoting Equity in Cancer Diagnosis at a Systems Level: Knowledge User Perspective

Presented by: Emma Newman

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Background and Objectives

Ontario Health-Cancer Care Ontario has partnered with the Institute for Better Health to address sub-optimal experiences and wait times in the diagnostic phase, focusing on health equity. The project aim is two-fold: i) establish a replicable process and structure for engaging people with lived experience from high priority populations to inform design of a responsive cancer diagnosis model. ii) to enable knowledge users to initiate and manage these engagement tables for sustainable partnership with communities.

Approach

This initiative brings together system decision makers, academic researchers, and 45 individuals with lived experience of the cancer diagnostic phase from three high priority communities in Ontario- Black, Francophone and Newcomers. This research utilized a mixed methods approach including community-based participatory research and system-design methodologies. A rapid literature review was conducted to identify strategies for engaging individuals from structurally marginalized communities in research. We conducted 16 semi-structured interviews with key informants to understand the opportunities and challenges with replicating and sustaining an equity oriented PFA model that can inform future consultations on health system improvement, measurement, and evaluation needs.

Results

This 'Engaging Diverse Voices' initiative is focused on engaging equity-deserving communities in healthcare improvements or design. Strategies include targeted recruitment, intentional outreach initiatives and brokering of community relationships through engagement and equity leads. Establishing and sustaining engagement and PFA diversity require these initiatives to adopt protocols and provide resources that address not only the 'why' of low engagement (i.e., skepticism, low degrees of trust, failed past initiatives), but the 'how' of meaningful engagement (i.e., language accessibility, scheduling flexibility, transparent communication, recognition, etc.). Furthermore, the relational distance between a provincial institution and high priority communities poses a considerable barrier for program sustainability within a dynamic health system. The equity-oriented engagement resource package developed by this initiative includes recommendations for approaches to overcoming these barriers.

Conclusion

Changes in policies and approaches at a systems level are necessary to create equitable, inclusive, and responsive cancer services. Strategies and lessons from this initiative will inform the design and delivery of equitable and integrated cancer diagnosis services, at a systems level and advance the 2024–2028 Ontario Cancer Plan.

Canada's Emerging Support for Young Caregivers: Identifying Barriers and the Need for Policy Reform

Presented by: Kristine Newman

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Background and Objectives

Over 8 million Canadians provide unpaid care, including 1.25 million young caregivers (YCs) under 25. Despite their critical role, YCs' needs are often overlooked in policy and services. Without proper support, YCs face significant health and developmental challenges, worsening health inequities. This study examines caregiving organizations' role in supporting YCs in Alberta, British Columbia, and Nova Scotia, identifying barriers and policy gaps that impact their well-being.

Approach

Focus groups with 18 service providers from caregiving organizations in Alberta, BC, and NS were conducted using a semi-structured interview guide. The development of the guide was informed by intersectionality and the social determinants of health alongside feedback from community partners who provided provincially specific information on policies/context related to young caregivers. Intersectionality and the social determinants of health were also used to identify key findings and interpret data. Thematic analysis was used to group and refine our findings for reporting.

Results

Participants reported encountering young caregivers (YCs) less frequently than adult caregivers with no specific services for young caregivers, but rather based on needs regardless of age. However, the lack of recognition of YCs as a distinct group limited the effectiveness of services, such as peer support groups. Service providers noted that YCs faced unique challenges, which were not adequately addressed in mixed-age groups. Additionally, limited staffing and insufficient funding from agencies, which did not target YCs, hindered support. In BC, participants highlighted gaps in provincial policies compared to Ontario and international models like the UK and Australia. Despite these barriers, service providers emphasized the value of peer support and networking with established YC-focused organizations, such as Ontario's Young Caregivers Association.

Conclusion

Service providers are committed to supporting YCs but face barriers due to funding and resource limitations. Recognizing YCs as a critical part of the healthcare system, policymakers and funding agencies must prioritize tailored policies and funding. A national strategy is essential to strengthen support and address the needs of YCs.

Addressing Health Inequities to Reduce Diabetes Related Amputations

Presented by: Jason Nie

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Background and Objectives

Diabetic foot ulcers are a common complication of diabetes, and can often result in lower-limb amputations without timely and coordinated care. Many patients in the Peel region face significant barriers to accessing evidence-based interventions, which can exacerbate health inequities and worsen outcomes for patients. This study aims to understand access barriers to care faced by patients with diabetic foot ulcers in Peel in order to co-design interventions that would alleviate barriers to improve health equity.

Approach

Semi-structured interviews with patients and clinicians/staff (including infectious disease specialist, vascular surgeon, primary care physician, wound care physician, endocrinologist, and other members of the wound care team) were conducted using a prepared interview guide. The interviews were then transcribed and analyzed using NVivo software. Inductive and deductive analysis techniques were used to identify themes and then conceptually map with a theoretical framework. The coded data will be used to understand facilitators, barriers and potential solutions.

Results

While this study is still in progress, preliminary findings from interviews have highlighted significant barriers, including financial constraints, transportation challenges, delays in care, and mismatches in cultural and language competencies. Inconsistent referral processes and limited collaboration between healthcare providers were also identified as key contributors to poor outcomes. The data suggests that patients often experience repeated hospital admissions due to inadequate continuity of care and delayed interventions.

Conclusion

The results from this study highlight that addressing these gaps requires coordinated efforts among hospitals, primary care, home care, and community services to effectively implement evidence-based interventions. These findings will guide the co-design phase of this study and help ensure that barriers experienced by patients with diabetic foot ulcers are addressed.

Co-Designing Research for Inclusive Engagement of Continuing Care Clients and Staff

Presented by: Kelly O'Neil

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Background and Objectives

This qualitative research, embedded within a provincial continuing care program, focuses on enhancing case management for older adults requiring complex care. The well-being of older adults involves an interplay of health and socioeconomic circumstances, identities, and histories. Client complexity is inseparable from equity and the barriers people face in accessing care. An equity lens also considers the insights of continuing care staff who support older adults to ensure diverse perspectives are accounted for in research.

Approach

Equity is an overarching principle within a learning health systems approach, which guides this research and compels the direct engagement of those impacted by research results. This presentation will share findings from an ongoing series of research co-design sessions held with continuing care staff and patient family advisors. The sessions will influence development of a formal research plan for submission to ethics review in the spring of 2025. Following ethics approval, the research will engage older adults accessing continuing care services, family care providers, staff, and subject matter experts identified as important contacts in the co-design sessions.

Results

The co-design work will inform a model for future engagements, highlighting the benefits and challenges of the process. Initial sessions suggest a diverse range of perspectives should be engaged, including older adults experiencing mental health and housing challenges, and clients falling through the cracks of service provision due to unclear or misdiagnoses, lack of informal supports, or behaviors the care system is not equipped to address. Flexible engagement of clients and families is key: "What works for you?" is a suggested opening question in terms of how, where, and when they are engaged in research. Co-designers emphasize the need to include rural and urban staff perspectives, where resources may differ significantly. A staff preference for in-person, informal conversations to report back on research results is noted.

Conclusion

This research contributes to knowledge about enhancing case management services for older clients. A better understanding of older people with complex circumstances and the implications of equity-informed practice arising from this research will provide new insights which will be translated to enhance staff competencies in supporting client outcomes.

Factors delaying the public listing of new drugs in Canada

Presented by: Brian O'Shea

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Background and Objectives

Canada's decentralized public payer structure has been criticized for contributing to long delays in the public listing of new drugs. This research aimed to identify the main factors contributing to delays during the listing process.

Approach

A cohort study approach was used to examine the prescription drugs with a first Canadian public listing between 2018 and 2023. Time-to-listing components, timeline exceptions, reimbursement recommendations, and negotiation results were documented using the Canadian Institute for Health Information's Formulary Coverage tool, Health Canada's Notice of Compliance (NOC) database, the Canadian Drug Agency (CDA) Reimbursement Review reports, and the pan-Canadian Pharmaceutical Alliance's Brand Name Drug Negotiation Status website. We compiled summary measures of time-to-listing and used linear regression models to identify factors contributing to delays.

Results

From 2018 to 2023, N=160 new drugs were added to Canadian public. The average time from Health Canada approval to public listing was 906 days (2.5 years), with a standard deviation of 640 days (1.8 years). Factors associated with the longest delays were drugs without a CDA submission (average delay of 629 days, N=10 drugs), with unsuccessful price negotiations (587 days, N=19), with CDA submissions made after the approval (467 days, N=71), and with "do not list" recommendations from the CDA (278 days, N=19). The N=92 drugs impacted by one or more of these factors had an average time-to-listing of 1,194 days (3.3 years, SD 1.9 years) compared to 517 days (1.4 years, SD 0.6 years) for the N=68 drugs not affected by these factors.

Conclusion

Adding new drugs to public formularies takes over 2 years on average in Canada. Important factors delaying time-to-listing include manufacturer decisions about CDA submissions, unsuccessful price negotiations, and drugs with unproven cost-effectiveness that receive a negative recommendation from the CDA.

Trends in the global drug development pipeline 2024

Presented by: Brian O'Shea

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Background and Objectives

Analyzing the international drug pipeline is a horizon-scanning exercise to identify trends in current development. The goal is to provide intelligence on the future pharmaceutical landscape to aid the optimal adoption of novel medicines.

Approach

The primary source for this study is GlobalData's Healthcare database, which contains information on medicines in the development pipeline. The snapshot of the global pipeline current to 2024 is obtained by filtering for medicinal ingredients with a highest development stage of Phase I, II, and III clinical trials, or pre-registration. Therapeutic area, indication, and orphan drug designation for each medicine are also extracted for analysis and comparison with past extracts dating back to 2019.

Results

There were 12,203 new medicines at different stages of development in the global development pipeline in 2024, more than double the number observed in 2019 (5,584). The pre-registration development stage showed the most growth, increasing 244% from 68 to 234 over the same period. Oncology medicines constitute a plurality of each phase of the 2024 development pipeline, accounting for 33% of the total pipeline, followed by infectious disease medicines at 13%. Orphan designated medicines represent 22% of the pre-registration stage of the pipeline, pointing to a focus on bringing new therapies for rare diseases to market.

Conclusion

The rapid growth in the international drug research pipeline observed since 2019 has continued in 2024, with a higher number of medicines in later development stages. This research overviews general trends in international drug development and highlights therapeutic areas, such as oncology, which could affect the launch of novel treatments.

The drivers and barriers to corruption in Kebbi State's drug revolving fund

Presented by: Tolulope Ojo

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Background and Objectives

Access to medicines is critical to providing quality healthcare, yet studies indicate poor availability of medicines in Nigerian public health facilities.,, Drug Revolving Funds (DRFs) are financing mechanisms used to ensure the supply of quality, affordable medicines. DRFs are however vulnerable to corruption, defined as the abuse of entrusted power for private gain. This study explores stakeholder perceptions about the drivers and barriers to corruption in the implementation of the DRF in Kebbi State, Nigeria.

Approach

We conducted semi-structured key informant interviews between November 2023 - October 2024 with public officials and health care workers involved with administering the DRF in Kebbi state Nigeria. Our interviews focused on learning about corruption drivers and anti-corruption, transparency and accountability (ACTA) mechanisms in place to mitigate corruption risks. Purposive sampling was used to recruit stakeholders (n=12) involved in the design, implementation and evaluation of the DRF at the national, state and health facility level. Analysis include descriptive statistics and inductive coding and deductive coding based on Vians Framework of Corruption in the Health Sector.

Results

Key informants included health officials at the national level (n=3, 25%), state level (n=4, 33%) and health care workers in charge of the daily administration of the DRF (n=5, 42%). Key factors key informants described as facilitating corruption within the DRF structures include: financial pressures (e.g. pilfering of funds for political gain), opportunities to abuse (e.g. lack of adequate oversight) and rationalization (e.g. perception of funds as discretionary, justification of funds to supplement revenue). ACTA mechanisms identified include anti-corruption activities (e.g. implementation of standardized guidelines), transparency mechanisms (e.g. increasing community awareness), accountability practices (e.g.legislative authority to hold individuals/ organizations to account; empowering citizens' voices). Political buy-in and managers' attitude are also necessary for mitigating corruption.

Conclusion

DRFs are vulnerable to corruption risks, especially in low-resources settings with more opportunities, pressures and rationalization to abuse power for private gain. Understanding corruption drivers and risks, can allow policymakers to implement structures and processes to mitigate corruption, and improve DRF succeeding in ensuring affordable, high-quality medicines for the public.

Incorporating Perspectives of Health Actors in the Development of a Chronic Disease Predictive Model

Presented by: Jo-Ann Osei-Twum

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Background and Objectives

Population health and health services research that uses administrative data often does not integrate the perspectives of multiple and diverse actors. However, these actors have extensive knowledge of the health sector, which could shape secondary data analysis and health care systems transformation. This study aimed to incorporate actors' perspectives into the development of a predictive model by identifying and addressing research considerations before conducting the study. This will improve the relevance and impact of findings.

Approach

This study is part of a mixed methods project that explored the adoption of artificial intelligence solutions in the context of population health management in Ontario. Semi-structured interviews were conducted with public health and health systems actors and were inductively coded using NVivo software. Using reflexive thematic analysis, excerpts coded as a research consideration were further analyzed and a descriptive summary added. Considerations were then categorized into high-level domains and mitigation strategies were proposed. The feasibility of implementing each mitigation strategy was determined, using the development of a predictive model for kidney care management in Ontario as a use case.

Results

Fifteen interviews were conducted between April and October 2024 with public health and health systems professionals working within Ontario's health sector. Twenty-three research considerations were identified from interviews and these included items such as parameters delineating the scope of inquiry, the historical development of data holdings and data stability. Research considerations were grouped into seven high-level domains related to the research process. It was deemed feasible to address eight considerations; the proposed mitigation strategies will be presented. The remaining 15 considerations were not applicable or could not be addressed in the secondary data analysis study. These considerations were related to institutional or legislative concerns, such as policies regulating the access, sharing and use of personal health data by entities and researchers in Ontario.

Conclusion

This study presents a novel approach to developing a chronic disease management predictive model, which incorporates qualitative input from multiple actors. The sequential nature of this study highlights actionable steps, that when taken, can strengthen health services research. This will ensure that findings maximize health and health care system outcomes.

Direct-to-consumer teleconsultation services in Quebec: a descriptive study

Presented by: Luciano Otero

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Background and Objectives

The COVID-19 pandemic significantly accelerated the adoption of teleconsultation globally, including in Quebec. While government-sponsored teleconsultation services struggled in Quebec, private teleconsultation providers thrived, offering innovative virtual care models. This study aimed to track the evolution of private direct-to-consumer teleconsultation services in Quebec from 2021 to 2025, examining their characteristics and accessibility.

Approach

A descriptive environmental scan was conducted through a systematic search online in 2021, 2023, 2024 and 2025 to identify private direct-to-consulter teleconsultation services available in Quebec. Keywords emphasized virtual primary care and remote consultations in both English and French. Inclusion criteria required services to provide consultations with healthcare professionals for Quebec residents through synchronous communication (phone, video, text). Data collected included funding type, consultation methods, service availability, types and characteristics of services offered. Duplicate services were removed, and classification was based on funding type and service delivery (online-only or hybrid).

Results

From 2021 to 2025, private teleconsultation services in Quebec grew significantly, with a notable shift toward online-only platforms and video consultations becoming more common. Three main funding types were identified: business-to-business (B2B, mostly through private insurance companies), business-to-consumer (B2C), and mixed models. Some services were offered by physical clinics, while others were not clearly attached to physical sites. Service availability improved, with more providers offering 24/7 access. Targeted services increased over time, focusing on specific groups (e.g. masculine health, mental health). Most B2C services require out-of-pocket payment from patients. Hence, concerns remain regarding equitable access to teleconsultation services, and alignment with the principles of universal healthcare.

Conclusion

Private teleconsultation services in Quebec have expanded, enhancing accessibility and convenience but raising equity concerns. To optimize their integration into the healthcare system, Quebec must establish clear standards to ensure quality, continuity of care, and equitable access while addressing potential conflicts with universal healthcare principles.

Improving Timely Healthcare in BC through Virtual Care: Patient and Family Caregiver Experiences

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Background and Objectives

As part of the provincial COVID-19 pandemic response, partnering organizations in British Columbia (BC) established a network of virtual care (VC) pathways called Real-Time Virtual Support (RTVS) to support patients with urgent issues and health professionals in rural and remote communities. HealthLink BC, as part of the RTVS network, aims to better understand patients/caregivers' experiences with its services to improve the delivery of care. The knowledge gained can be applied to the broader RTVS network.

Approach

Patients and their family caregivers who used BC's 8-1-1 service to speak with a HealthLink BC Emergency iDoctor-in-assistance (HEiDi) or COVID Anti-viral Treatment eTeam (CATe) physician via phone or video were recruited through an online patient engagement portal, REACH BC. Participants completed 30-minute video or phone interviews that were audio-recorded and transcribed. A codebook was developed through independent open coding of one transcript by 2 researchers. The study team then used NVivo to code the remaining transcripts, continued discussions on new codes, and met to develop themes based on consensus. Constant comparative analysis was used to develop interview themes.

Results

We interviewed 11 patients, 3 caregivers and 4 patient-caregiver dyads, from the greater Vancouver area, Vancouver Island, and Interior regions. Their reasons for calling HEiDi/CATe included obtaining advice on managing their illnesses appropriately and whether to seek in-person care at an emergency department. Several key themes highlight participants' VC experiences. First, participants described the benefits of receiving timely access to a physician as increasing their confidence in self-management, reducing stress and anxiety, and avoiding unnecessary emergency department visits. Second, receiving telephone advice was helpful in reducing visual bias, enhancing cultural safety for relevant participants. Finally, participants suggested improvements in communication about the anticipated wait times, internet connectivity, personal connection and rapport building, and limitations of not being able to provide a physical examination virtually.

Conclusion

Overcoming barriers, such as the technological limitations and providing thoughtful emotionally responsive services throughout could improve patient experience while leveraging facilitators such as the advantages of meeting patients' informational needs and reducing unnecessary Emergency Department visits.

Bridging the Gap in Plasma Donation: Intersectional Insights to Enhance Equity and Participation

Presented by: Amelia Palumbo

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Background and Objectives

Growing global demand for plasma underscores the need for equitable donation access to support a sustainable supply, ensure health justice, and deliver diverse therapeutic benefits. An intersectional lens highlights how social categories and power structures can create systemic barriers, affecting engagement in donation. Our objective was to synthesize evidence on barriers, enablers, and interventions, emphasizing how social and structural factors shape participation in plasma donation and offering strategies to foster inclusive practices and outcomes.

Approach

Three systematic reviews were conducted examining qualitative literature, survey research, and intervention studies. Initial synthesis used the Theoretical Domains Framework and Behaviour Change Intervention Ontologies. We then explored how intersecting social identities (e.g., gender, socioeconomic status) and structural factors (e.g., discrimination, healthcare access) shaped donation intention, behaviour, and intervention outcomes. Specifically, we extracted demographic and contextual information for each study, then assessed how social categories and power dynamics were addressed, identifying patterns and gaps in intersectional consideration. Our final synthesis integrated these intersectional insights to illuminate overlooked barriers, enablers, and pathways for more inclusive plasma donation strategies moving forward.

Results

Across the literature, explicit recognition of how multiple social categories and systemic factors might intersect to shape donation behaviors was limited. While many studies emphasized individual drivers (e.g., attitudes, motivations, perceived risks), broader social, cultural, historical, and economic contexts were less consistently examined. When contextual factors were acknowledged, they often lacked depth, hindering insight into the influence of structural forces on donation decisions. Incomplete demographic reporting further constrained efforts to systematically explore variations in donation participation and intervention effectiveness across different groups. Though behavioral frameworks captured important individual determinants, they offered little perspective on broader macro level influences. Notably, a recurring theme was the gap between donation intentions and actual behavior, suggesting unexamined barriers may be at play.

Conclusion

Shifting from an individual-level focus to also consider systemic and social factors could enhance our understanding of plasma donation barriers and enablers, guiding more equitable interventions, and potentially boosting effectiveness. Such an approach could also contribute to fostering inclusive health systems and ultimately promoting health equity, even beyond plasma donation.

Evaluation of a service-provider toolkit on intellectual disability and perinatal mental health

Presented by: Rachel Peiris

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Background and Objectives

Birthing parents with intellectual disabilities (ID) are at elevated risk of postpartum depression and anxiety. However, service-providers report a lack of knowledge and confidence in delivering postpartum mental health care to this group. To address this gap, we developed an evidence-based postpartum mental health toolkit for providers to help support birthing parents with ID. This study's objective is to evaluate the toolkit's acceptability, feasibility, and impact on service-provider knowledge and confidence.

Approach

In this pre-post, single group study, approximately 30 Canadian health- and social-service-providers who work with new parents during the postpartum period are being recruited via adaptive snowball sampling. Participants will be administered a survey on knowledge and confidence about topics related to ID, postpartum depression and anxiety, and treatment options relevant to this group. Participants will then review the toolkit. Finally, they will be administered the survey again, with additional questions regarding the toolkit's feasibility and acceptability. Pre- and post-intervention knowledge and confidence scores will be calculated using paired t-tests, and feasibility and acceptability responses will be reported descriptively.

Results

Data collection will be complete by May 2025. The toolkit includes detailed information on ID and postpartum mental illness (including signs and symptoms; diagnostic overshadowing; and behavioural, medical, and treatment considerations specific to people with ID), and techniques for supporting birthing parents with ID with postpartum mental illness. We anticipate that participants' post-intervention scores in their knowledge and confidence related to ID and postpartum depression and anxiety will be higher than their pre-intervention scores. We expect that the toolkit will also be reported as acceptable overall and feasible in practice, and that participants would be likely to use it themselves.

Conclusion

This study offers an evidence-based, tangible solution for equipping health- and social-service-providers as they support the postpartum mental health of birthing parents with ID. Ultimately, better disability-related training for health- and social-service-providers will lead to improved mental health outcomes for their patients.

Enhancing CBTm Facilitator Workshops using the RE-AIM Framework

Presented by: Essence Perera

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Background and Objectives

The prevalence of mental disorders is increasing worldwide. Manitoba leaders launched the Cognitive Behaviour Therapy with mindfulness (CBTm) program to improve access to care for individuals to promote mental health and wellbeing. While 1,000+ providers to date have completed the CBTm training curriculum, many have yet to implement this program with patients/clients. This project will address provider-perceived training needs and enhance the CBTm workshop curriculum to support effective delivery in healthcare and community settings.

Approach

This multi-stage quality improvement initiative is guided by the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework. In Phase I, voluntary pre- and post-workshop surveys with a new cohort of workshop participants will identify provider knowledge gaps and areas for skill-based improvements. The findings will guide revisions to the curriculum, with an emphasis on ensuring equitable access, sustainability, and practicality for diverse healthcare and community settings. The CBTm Hub Team will incorporate interactive, context-specific methods and refine the content accordingly. In Phase II, the updated curriculum will launch with a new cohort, and follow-up data will inform further refinements.

Results

Phase I, scheduled for spring 2025, will identify gaps in provider capacity and training content. The CBTm Hub Team will analyze the findings, reach consensus on priority areas, and revise the CBTm curriculum to address these challenges while promoting equitable access and sustainability. In fall 2025, Phase II, will implement the revised training with a new cohort, evaluating immediate post-training competency and longer-term impacts at 6 months and 1-year post-training. Results are expected to demonstrate improved competency, and later follow-ups will demonstrate fidelity to CBTm principles, and feasibility of implementation. Actionable insights from follow-ups will guide recommendations for sustaining and scaling the CBTm program to maximize its effectiveness and adoption across diverse healthcare and community settings.

Conclusion

This project will enhance the CBTm training workshop, creating an equitable, sustainable, and effective program. By addressing provider-perceived gaps and refining the curriculum, the project will empower trainees to confidently deliver CBTm techniques, support broader adoption, and improve access to evidence-based mental health care, promoting better outcomes in diverse settings.

HealthCareCAN's National Vision to Transform Health Research in Canada

Presented by: Marissa Persaud

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Background and Objectives

Canada's health research ecosystem is poised for transformation. HealthCareCAN envisions a future where Canada emerges as a global leader in health research by 2030. This requires addressing systemic underfunding, supporting diversity, and fostering innovation. Key objectives include enhancing research investments, empowering a sustainable workforce, and translating discoveries into improved health outcomes. This vision emphasizes equitable, people-centered care, leveraging advanced technologies, and integrating Indigenous knowledge to address current and future health challenges.

Approach

HealthCareCAN's national vision to transform health research in Canada is built on four strategic objectives: (1) positioning Canada as a global research and innovation hub; (2) accelerating knowledge generation; (3) empowering a diverse, sustainable research workforce; and (4) transforming health outcomes through innovative adoption and implementation. This vision emerged from guidance from HealthCareCAN's Vice Presidents of Research (VPRs) committee, highlighting Canada's needs and opportunities in the critical field of health research. . Cross-sector partnerships will address Canada's global health challenges with a comprehensive and inclusive approach as technologies including AI and genomics accelerate progress.

Results

The vision lays the groundwork for implementation of policy measures to position Canada as a global leader in health research and innovation. Canada should align its health research ecosystem with top Organization for Economic Co-operation and Development (OECD) nations, driving immediate progress and measurable improvements. This vision recommends fostering interdisciplinary collaboration, and prioritizing equity and accessibility. Early outcomes include heightened awareness of Canada's health research ecosystem potential and strengthened partnerships across sectors. By 2030, HealthCareCAN envisions a strong Canadian research ecosystem to drive economic growth, foster technological advancements, and deliver measurable improvements in population health, solidifying its position as a global leader in health research. Next steps actively mobilize stakeholders including HealthCareCAN members stakeholder organizations and governments to operationalize these recommendations and ensure measurable impacts.

Conclusion

Achieving this vision requires sustained investment, interdisciplinary collaboration, and inclusive practices. By fostering innovation and translating research into impactful solutions, Canada will improve health outcomes, address systemic inequities, and lead globally in health research and innovation, ensuring a healthier future for all.

Access To Primary Care Pre, During and Post-COVID-19 Among Older Canadians: A National Survey

Presented by: Anh Pham

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Background and Objectives

The COVID-19 pandemic exposed and worsened weaknesses in Canada's healthcare system, particularly for older adults, who faced higher risks of severe illness, death, and care disruptions. Social inequities, such as race, gender, and socioeconomic status, compounded access challenges, with significant impacts on health and well-being. We aims to provide a description on our cohort of Canadian older adults, their health care needs, and difficulties accessing to primary care before, during and after the pandemic.

Approach

We surveyed community-dwelling patients aged 65+ across all Canadian provinces who had at least one primary care contact between 2015 and 2024. The survey focuses on two key areas: wait times for primary care appointments and difficulties accessing necessary services. Data collected includes demographics, language use, years in Canada, income, occupation, living arrangements, health conditions, primary care encounters, type of care (in-person or virtual), transportation, accompaniment, delays, canceled appointments, and social/economic impacts. Responses were gathered at three time points: pre-pandemic (2010-2019), during the pandemic (2020–Spring 2022), and post-pandemic (since Spring 2022) for each participant.

Results

As of January 3, 3025, we received 423 responses in English and 120 in French. Our sample represents the Canadian population, with 18% aged 80+, 49% female, 1% Indigenous, and 5% visible minorities. Most participants (80%) were Canadian-born, and 93% were Canadian citizens. While 72% live with a spouse/partner, 30% live alone, and 4% live with offspring. Regarding health, 41% reported good health, 9% excellent, and 3% poor health, with most having at least one chronic condition, often diagnosed pre-COVID. During COVID, in-person visits to family care clinics dropped from 86% to 32%, rebounding to 65% post-COVID. Wait times of 1-4 weeks rose from 30% pre-COVID to 38% during and post-COVID. Challenges, including canceled appointments, delayed referrals, and unavailable services, significantly impacted participants' health, finances, emotions, and overall well-being.

Conclusion

Our findings reveal persistent challenges in primary care access for older adults post-COVID, including longer wait times, delayed referrals, and unavailable services. These disruptions have impacted health, finances, and well-being. Targeted policies and improved virtual care integration are essential to address these gaps and support vulnerable populations effectively.

Insights from Linking Primary Care and Administrative Data for Rheumatoid Arthritis-Alberta, Canada

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Background and Objectives

Primary care electronic medical records contain valuable clinical data, but understanding their limitations is crucial for health policy makers and researchers. Using rheumatoid arthritis (RA) as an exemplar, we demonstrate how linking Canadian Primary Care Sentinel Surveillance Network (CPCSSN) data with provincial administrative health records enhances epidemiological research capabilities while highlighting both data source limitations and linkage challenges that affect result interpretation.

Approach

We conducted deterministic linkage between CPCSSN data from Southern Alberta family medicine clinics and Alberta Health Services (AHS) administrative data (hospital records, pharmaceutical dispensations, and vital statistics) using unique personal health numbers. Following confidentiality protocols, CPCSSN data was sent to AHS for linkage. We evaluated linkage success rates and assessed two types of limitations: data source issues (completeness, coding practices) and linkage process constraints that could affect epidemiological research findings

Results

Of 678 eligible RA patients, 597 (88%) were successfully linked to their administrative records. While the linked cohort was representative by age and sex, it showed disproportionate representation of urban and academic clinic patients due to rural CPCSSN providers declining data linkage participation. The linkage enhanced tracking of medication use, hospitalizations, and health outcomes. Two key limitation categories emerged: 1) data source issues - incomplete laboratory and diagnostic testing data in primary care records and underrepresentation of rural practices, and 2) linkage process constraints - inability to access physician billing claims due to provincial policies (specific to Alberta), limiting our ability to track diagnostic timing and specialist referrals/consultations.

Conclusion

Using RA as an exemplar demonstrated that while dataset linkage enriches epidemiological research capabilities, both data source limitations and linkage challenges must be carefully considered in study design. These findings inform future research approaches using linked primary care and administrative data in Alberta.

Indigenous perspectives to eating disorders: a exploratory qualitative study

Presented by: Maureen Plante

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Background and Objectives

Eating disorders (EDs) persistent disturbances in eating behaviour that negatively impacts a person's psychological, physical, mental, and psychosocial health. The vast majority of research has focused on understanding EDs through Western theories, which informs treatment and the factors that contribute to the development of EDs. Research on EDs is lacking regarding understanding, treatment and Indigenous perspectives, although prospective research is emerging. This research aimed to understand how Indigenous therapists understand eating disorders.

Approach

Using Indigenous methodology and thematic analysis, this research explores how Indigenous therapists understand eating disorders. Utilizing a sharing circle and one individual conversation, three women who are of Cree, Métis, and Stl'atl'imx ancestry were asked to discuss eating disorders through an Indigenous lens. Transcripts were analyzed and themes grouped together based on patterns that emerged from the conversations.

Results

Indigenous therapists who practice Indigenous based therapy discussed the importance of Indigenous worldviews, the impact of historical trauma and colonization, and the land-based techniques used in therapy. The results revealed salient themes including the Indigenous world view of Interconnectedness, survivance/ intergenerational wisdom and land-based care. Results revealed a close connection to the impact of colonization and the way eating disorders are viewed among Indigenous therapists. The results revealed that colonization breaks up interconnectedness and disconnection to culture.

Conclusion

This research has important implications for culturally relevant and supportive care when working with Indigenous peoples struggling with eating disorders. Additionally, this research is in response to the Truth and Reconciliation Calls to Action and Canadian Eating Disorder Strategy to improve outcomes for people affected by eating disorders.

Physician Perception of LLMs: A Qualitative Protocol Leveraging Technology Adoption Behaviour Model

Presented by: Binit Pokharel

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Background and Objectives

Healthcare systems have historically adopted many tools, but Large Language Models' (LLMs') rapid evolution, intersection with a diverse range of stakeholders and institutions make preparations for their attendant risks particularly challenging. Since physicians face the dual mandate in embracing innovations and safeguarding patient welfare, understanding physicians' views on LLMs provides an opportune moment to examine the complex interplay of technical, ethical, and professional considerations influencing LLM adoption and inform policies that optimize healthcare system performance.

Approach

This qualitative study employs a descriptive qualitative design to explore how primary care physicians perceive the adoption of LLMs in the context of their clinical practice. We will use semi-structured interviews with purposively sampled primary care physicians from British Columbia, stratified by their level of LLM use. The Technology Adoption Behaviour (TAB) framework, which integrates perceptions of ease of use and usefulness with actual usefulness considerations, will guide data collection and analysis. We will use thematic analysis drawing on both deductive and inductive approaches to help describe physicians' perceptions. Reflexive memos and discussions among a multidisciplinary research team will ensure nuanced interpretations.

Results

We anticipate that physicians' perceptions of LLMs will vary based on various criteria within the Technological Adoption Behavior Model developed by our team. The study is likely to reveal a complex interplay between technical, ethical, and professional considerations influencing LLM adoption. We expect to identify facilitators and barriers to LLM integration in clinical practice in key areas including perceived impact on patient care, professional identity, and workflow efficiency. The results may highlight the need for tailored training programs, clear guidelines and robust governance structures to support responsible LLM adoption. Furthermore, we anticipate additional insights into how physicians balance their social mission of optimizing patient health with the need to protect against potential harms associated with LLM use.

Conclusion

This study will provide timely insights into physicians' perceptions of LLMs, informing evidence-based strategies for their integration into healthcare. Findings will support policymakers, health professionals, and patients in developing relevant policies, practices, and behaviors to optimize LLM use while mitigating potential risks in healthcare services.

Pistes d'action pour l'organisation des services de soutien professionnel en milieux de garde

Presented by: Gabrielle Pratte

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Background and Objectives

Plusieurs besoins de services de soutien professionnel (ex. : orthophonie, ergothérapie) ont été identifiés pour favoriser le développement et l'inclusion des enfants en milieu de garde au Québec. Ces dernières années, la conjoncture politique a été favorable à la mise en place de nouveaux services de soutien professionnel en milieux de garde. Le projet Soutien visait à élaborer des pistes d'action pour l'organisation de ces services.

Approach

Un devis mixte séquentiel explicatif suivi d'un processus de consensus Delphi a été utilisé. Des pistes d'actions préliminaires ont été identifiées lors de l'intégration des données mixtes issues d'une enquête en ligne et d'entrevues auprès de gestionnaires de milieux de garde (n = 344 / 18) et de professionnels (n = 48 / 12). Ces pistes d'action ont servi de base au processus Delphi à trois tours. Pour chacun des tours, les parties prenantes du gouvernement, d'associations et du milieu universitaire (n = 13) ont évalué leur niveau d'accord (/10) et suggéré des améliorations.

Results

Au terme du Delphi, 94 pistes d'action consensuelles ont été identifiées. Elles visent toutes les parties prenantes: notamment les professionnels (n = 29), les gestionnaires (n = 21) et les ministères impliqués (n = 40). Nos résultats soulignent la nécessité de différents modèles d'organisation de services pour répondre à l'ensemble des besoins. Ceux-ci devraient inclure, pour chaque milieu de garde : 1) un poste en éducation spécialisée, 2) l'accès à un trio de professionnel du réseau de la santé et des services sociaux (orthophonie, psychoéducation, ergothérapie), et 3) un contact dans le réseau de la santé, afin de combler à la fois les besoins individuels des enfants et les besoins des milieux de garde.

Conclusion

Les pistes d'action obtenues au terme du projet Soutien ont permis de dégager une vision de l'organisation des services souhaités pour les prochaines années au Québec. Cette vision mise sur une collaboration accrue entre le réseau de la santé et les milieux de garde.

Substance Use Trends Among Street-Involved Youth: The People With Lived and Living Experience Survey

Presented by: Rebecca Prowse

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Background and Objectives

Street-involved youth are at elevated risk of substance-related harms, yet are under-represented in population-based surveys. To address this important data gap, the People with Lived and Living Experience Survey (PWLLES) was developed by Health Canada as a targeted survey of street-involved youth. This analysis explores quantitative and qualitative data related to substance use trends and behaviours among street-involved youth and provides a description of the targeted recruitment methods used.

Approach

Community organizations that provided services for street-involved youth were recruited as sentinel sites from urban city centres across Canada. Financial incentives were provided to both sites and participants to support recruitment. Staff at each site recruited street-involved youth aged 14-24 years who used alcohol, tobacco, cannabis, or other drugs in the past year. Staff from sentinel sites conducted semi-structured interviews to collect both quantitative and qualitative data, such as demographics, substance use prevalence, and harms. Recruitment strategies and compensation were adapted as necessary throughout the survey to account for limited site resources as a result of the COVID-19 pandemic.

Results

442 participants from 16 sites across 9 cities completed the survey between September 2021 and February 2023. 34.2% identified as 2SLGBTQI+, 26.0% as Indigenous, and 33.9% as visible minority. Among those who had ever used illegal drugs, 57.0% had used in the past 30 days. Most found it very easy to obtain (i.e., within 90 minutes) (69.3%). 33.0% of participants reported ever experiencing an overdose. Participants reported several reasons for substance use including for mental health, pain reduction, and recreation/experimentation. 197 participants provided at least one useable qualitative response. Youth discussed the toxic and unpredictable drug supply, and the ease of access and affordability of various substances. In addition, youth described concerns and fear surrounding overdoses and unsafe substance use environments in their community.

Conclusion

Youth reported high prevalence of substance use and harms; several reasons for use including for mental health, pain reduction, and recreation/experimentation; ease of access to substances; and concerns surrounding substance use in their communities including the toxic drug supply and frequent overdoses. Findings may inform policymakers and service providers.

Participant feedback on community-based bereavement interventions: An umbrella review.

Presented by: Laura Quintero Silva

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Background and Objectives

The efficacy of community-based bereavement interventions on participants' health outcomes has been investigated widely. To complement this quantitative data, participants' feedback on the applied intervention has also been explored, resulting in a large and heterogeneous body of data. A synthesis of these findings is needed to understand participants' acceptability of and perceived benefits from community-based bereavement interventions, which will support future program design and implementation.

Approach

Following the guidelines from the Joanna Briggs Institute, we conducted an umbrella review (i.e., a review of reviews; PROSPERO #CRD42023397005) of participants' feedback on community-based interventions (i.e., non-hospital setting) designed to support adults who have lost a life partner (any co-habiting relationship). In July 2024, a comprehensive literature search was performed across ten databases: AgeLine, CDSR, CINAHL, Embase, Epistemonikos, MEDLINE, ProQuest Dissertations & Theses, PsycINFO, Scopus, and Web of Science. Two reviewers independently screened titles, abstracts, and full texts for eligibility. Data from selected reviews and subsuming studies were abstracted for synthesis. The review quality was assessed using AMSTAR 2.0

Results

We identified five reviews (1 systematic; 4 unsystematic) encompassing 16 unique interventions. Interventions mostly involved the use of support groups (50%) and online-based interventions (25%), delivered in group formats (62.5%) by peers/volunteers (37.5%) or healthcare professionals (25%), in high-income countries. Most interventions (87.5%) were viewed positively. Participants appreciated online-based interventions for improved accessibility and participants' anonymity, and those led by facilitators with expertise to conduct the intervention. Several personal gains were noted, particularly improved grief and emotional management, better social support, and increased feelings of comfort. Issues such as inadequate facilitator training, lack of tailored content, and imbalanced participant engagement were also noted. Some participants experienced increased distress and/or felt a sense of unmet needs after the intervention.

Conclusion

Community-based bereavement interventions are generally appreciated by bereaved life partners, resulting in important benefits. Additional distress and a sense of unmet needs may persist in some individuals, however. Implementing community-based bereavement interventions requires careful consideration of facilitator competence, content adaptation, and group dynamics to enhance overall acceptance and perceived benefits.

Barriers to Primary Healthcare Access for Immigrants in Canada: An Umbrella Review

Presented by: Mohammad Raihan

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Background and Objectives

Access to primary healthcare (PHC) is a persistent challenge for immigrants in Canada due to structural, cultural, and systemic barriers. This umbrella review applies the Candidacy Framework to systematically identify and categorize these barriers, providing a comprehensive analysis of critical gaps in healthcare access. The framework offers a structured approach to understanding how individuals navigate healthcare systems and are legitimized as service users, helping to identify priority areas for targeted interventions to improve equitable access.

Approach

A systematic literature search was conducted across six major databases—MEDLINE, Embase, PsycINFO, Web of Science, CINAHL, and ProQuest—yielding 7959 records. Following the removal of duplicates, 6508 studies underwent title and abstract screening, with 387 studies reviewed in full-text. Ultimately, 29 studies met the inclusion criteria. Data extraction and synthesis were conducted following the seven stages of the Candidacy Framework, focusing on dimensions such as identification of need, navigation of services, and interactions with healthcare systems. A Community-Based Participatory Research (CBPR) Approach was employed, involving a community advisory group of Bangladeshi immigrants who co-designed the study and contributed to its analysis.

Results

Preliminary findings reveal recurring barriers to PHC access, including language limitations, cultural stigma, financial constraints, and geographic inaccessibility. Structural issues, such as long wait times and inefficient referral systems, were particularly pronounced. Women often faced gender-specific challenges, such as the need for culturally sensitive care and access to female providers. These barriers highlight the systemic inequities that hinder equitable healthcare access for immigrant populations.

Conclusion

This review categorizes the barriers immigrants face when accessing PHC in Canada, setting the stage for future research to explore their root causes. The findings will inform policymakers and healthcare providers, guiding the development of inclusive strategies to enhance equity and accessibility in primary healthcare for immigrants across Canada.

Exploring Menopause: Beliefs, Perceptions, and Experiences of Immigrant Punjabi Women in Peel

Presented by: Tanveer Randhawa

Author(s): *Tanveer Randhawa, School of Public Health Sciences - University of Waterloo*

Background and Objectives

Punjabi immigrant women in Canada face unique challenges during menopause, shaped by sociocultural norms, stigma, and healthcare barriers. Despite these complexities, their experiences remain underexplored, resulting in limited culturally responsive care. This study aims to understand how cultural beliefs, immigration, and social structures influence menopausal experiences among Punjabi women. By addressing these gaps, the research seeks to inform cultural humility in healthcare practices, improve health equity, and reduce stigma around reproductive health within marginalized communities.

Approach

This study employs a qualitative research design, using Constructivist Grounded Theory to explore the thoughts, perceptions, and experiences of menopause among immigrant Punjabi women aged 35+ in the Region of Peel. Using semi-structured interviews, conducted in English or Punjabi, the study will capture culturally nuanced insights and diverse narratives on the intersection of culture, migration, and healthcare. Data collection and analysis will proceed inductively, guided by reflexivity to address potential biases. Collaborations with trusted community organizations will establish rapport, build trust, and foster open dialogue. This approach ensures a comprehensive understanding of menopause within the sociocultural context of Punjabi women.

Results

The study is expected to reveal how sociocultural beliefs, norms, and immigration experiences shape the menopausal journeys of Punjabi women. Anticipated findings include diverse perceptions of menopause, influenced by cultural stigma, family dynamics, and access to healthcare resources. Barriers to care, such as language challenges and limited culturally responsive services, are likely to emerge as significant themes. The study may also highlight the role of community support and traditional practices in navigating menopausal symptoms. These insights will provide a deeper understanding of how cultural identity intersects with health behaviours and outcomes. Findings are anticipated to guide the development of culturally attuned healthcare practices, reduce stigma surrounding reproductive health, and empower women to seek support, ultimately contributing to improved health equity for immigrant and minority populations.

Conclusion

This study will contribute to the understanding of menopause within the Punjabi community, shedding light on the cultural, social, and healthcare barriers faced by women. It aims to inform healthcare practices and policies, promoting cultural humility, reducing stigma, and enhancing access to support, ultimately improving health outcomes for marginalized populations.

Exploring Menopause Across South Asian Immigrant Communities in Canada: A Multicultural Perspective

Presented by: Tanveer Randhawa

Author(s): *Tanveer Randhawa, School of Public Health Sciences - University of Waterloo*

Background and Objectives

Building on work exploring the menopausal experiences of Punjabi immigrant women in the Region of Peel, this study expands the focus to encompass South Asian immigrant communities in Canada. South Asian women's menopausal experiences are influenced by diverse cultural, religious, and social factors. This study aims to examine how beliefs, practices, and immigration experiences shape menopausal perceptions among women from Indian, Pakistani, Bangladeshi, Nepali, and Sri Lankan backgrounds, informing culturally inclusive healthcare, promoting equity.

Approach

This qualitative study uses Constructivist Grounded Theory to explore the menopause-related experiences of South Asian immigrant women aged 35+ in Canada. Semi-structured interviews, conducted in English or participants' preferred languages, will explore themes such as cultural beliefs, religious practices, stigma, family dynamics, and access to healthcare. Community collaborations will foster trust and inclusivity. Building on findings from Punjabi women, this research will analyze cross-cultural similarities and differences among South Asian groups, emphasizing reflexivity throughout the process. The study will generate a deeper understanding of how cultural diversity within South Asian immigrant communities influences menopausal experiences and healthcare needs.

Results

This study anticipates uncovering both shared and distinct menopausal experiences among South Asian immigrant women in Canada. Common themes may include the influence of family dynamics, cultural stigma, and reliance on traditional remedies, while unique variations are expected to emerge based on religious practices, migration histories, and sociocultural norms. Barriers such as language limitations, stigma around reproductive health, and lack of culturally tailored healthcare services are likely to surface. Findings from Punjabi immigrant women will be compared to other South Asian groups, highlighting how cultural diversity within the broader South Asian community shapes menopausal experiences. These insights will provide a foundation for developing culturally attuned healthcare interventions, reducing stigma, and fostering equitable healthcare access for South Asian immigrant women across Canada.

Conclusion

Expanding on prior research with Punjabi women, this study illuminates the multifaceted menopausal experiences of South Asian immigrant women in Canada. By addressing cultural and healthcare barriers, it aims to guide culturally attuned practices, reduce stigma, and improve equitable health outcomes for diverse immigrant populations.

The unintended harms of virtual care

Presented by: Shakeel Rashid

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Background and Objectives

Virtual care (VC), that is "any interaction between patients and/or their circle of care occurring virtually . . . with the aim of facilitating or maximizing the quality and effectiveness of patient care" was rapidly implemented during the COVID-19 pandemic. While VC has been applauded for its established benefits, concerns are being raised regarding potential unintended harms of VC. We aimed to comprehensively review and establish a framework that outlines the dimensions of VC harm.

Approach

A search conducted in Medline, Embase and Cumulative Index to Nursing and Allied Health literature (CINAHL) from 2020 to July 2024 resulted in 8,452 papers. Search terms reflected the goal of identifying any type of harm or negative outcome from VC encounters intended to supplement or replace in-person care. There were no regional or study-type restrictions placed on the search. After abstract and full-text screening, 52 papers were included for this study.

Results

Included papers revealed a common theme of clinicians using VC in situations that could be deemed to be clinically inappropriate. Patient safety concerns arose due to delayed diagnosis from inadequate physical exams and in some instances poorer patient-physician relationships especially when dealing with sensitive news. Most of these instances, however, did not have a substantial effect on patient outcomes or were confined to case studies. There was some evidence that VC may be partially responsible for increasing workload in some physicians, although it is unclear if this will continue to persist as systems become more adjusted to this modality of care. Lastly, we did not find evidence VC creating systemic barriers of care that led to poorer health outcomes or complete inaccessibility.

Conclusion

These instances of harm likely represent the minority of encounters and when taken into context with the benefits of VC, these concerns should be conceptualized as areas where we should guide quality improvement initiatives or more rigorous studies comparing VC to in-person care, rather than be raising alarm bells.

Patient-Physician Language Concordance and Cancer Outcomes: A Retrospective Cohort Study

Presented by: Michael Reaume

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Background and Objectives

Social determinants of health contribute to major disparities in cancer outcomes. While linguistic diversity is growing rapidly, few studies have considered the impact of language barriers on cancer outcomes. We sought to determine whether patient-physician language concordance/discordance was associated with cancer outcomes.

Approach

We performed a retrospective cohort study of adult respondents included in one of the annual cycles of the Canadian Community Health Survey (CCHS) who were living in a minority language community at the time of survey completion (January 1, 2003 to December 31, 2014). Respondents' preferred language was defined using language spoken most often at home. Respondents who spoke to their regular medical doctor in their preferred language were classified as having received language-concordant care, while all other respondents were classified as having received language-discordant care. Respondents were linked to administrative databases (CCR and CVSD). The co-primary outcomes were cancer diagnosis and cancer death within 10 years of survey completion.

Results

The cohort consisted of 46,820 adult respondents, including 6,535 English-speaking patients in Quebec (14.0%), 14,525 French-speaking patients outside of Quebec (31.0%), 1,900 Indigenous-speaking patients (4.1%), and 23,860 Allophone-speaking patients (51.0%). When restricting the cohort to patients who had a regular medical doctor, we found that the proportion of patients who received language-concordant care was highest for English-speaking patients (82.9%) and French-speaking patients (67.8%), while Indigenous-speaking patients (6.9%) and Allophone-speaking patients (33.1%) were much less likely to receive language-concordant care. There were no statistically significant differences in the risk of cancer diagnosis or cancer death when respondents who received language-concordant care were compared to respondents who received language-discordant care.

Conclusion

Patient-physician language concordance/discordance was not independently associated with diagnosis of cancer or cancer death. Future studies should consider specific types of cancers for which evidence-based screening strategies exist at the population-level; outcomes for these cancers may be associated with the quality of care delivered to minority language communities.

Embedding a Culture of Research in Canadian Community Hospitals: A Qualitative Study

Presented by: Kian Rego

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Background and Objectives

In Canada, academic hospitals are the principal drivers of research and medical education while community hospitals provide patient care to a majority of the population. Increasing community hospital research can improve patient outcomes and equitable access to research, enhance staff satisfaction and retention, and increase research efficiency and generalizability. This study aimed to understand how research culture is experienced and shaped in Canadian community hospitals to provide strategies for strengthening community hospital research culture.

Approach

This qualitative descriptive study was part of a larger study focused on understanding the factors that influence community ICU research participation. Participants were purposefully sampled who were healthcare providers, research staff or hospital administrators from community hospitals across Canada, with non-existent, emerging or established research programs. Data were collected via a demographic questionnaire and virtual semi-structured interviews. Demographic data were analyzed using descriptive statistics. Interview transcripts were analyzed using Braun and Clarke's six steps to reflexive thematic analysis. An inductive-deductive approach was employed, guided by Schein's Model of Organizational Culture as a sensitizing framework.

Results

A total of 38 participants from 20 Canadian community hospitals described their experiences of research culture illustrating three key themes: 1) From limited awareness to broad and active engagement, 2) Combining research and clinical practice: from siloed perceptions to integrated professional responsibility and 3) From leadership indifference to organizational commitment. As community hospital research programs matured, participants described a shift in research culture whereby research became more embedded in 'the way things are done' within the community hospital. Recommended strategies to achieve an embedded culture of research involve: communications; relationship building; mentorship, training and education opportunities; selecting locally relevant studies; and systems-level support. A'top-down' approach to embedding research culture was contrasted with a 'bottom-up' approach.

Conclusion

This study described the underlying dimensions of community hospital research culture and targeted strategies for strengthening research culture at different levels of research program maturity. Although challenging, fostering a culture of research from the bottom-up may be necessary to initiate the process to build research capacity within a community hospital.

The Research Activities of Canadian Community Hospitals: A Bibliometric Analysis

Presented by: Kian Rego

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Background and Objectives

Most of the hospitals in Canada are community hospitals, yet many lack the necessary resources required to participate in health research. Including more Canadian hospitals in research studies is important to increase patient access to health research, improve research efficiency and ensure results are generalizable to local community hospital patient populations. This study aimed to describe the research activities, including the number and type of publications, of the 544 community hospitals in Canada.

Approach

A bibliometric analysis was conducted using Clarivate's Web of Science (WoS). The WoS database was searched for publications that included at least one author affiliated with one of the 544 Canadian community hospitals from 2018-2023. All publication types were included. Screening and extraction occurred concurrently by two members of the research team. Data was exported to Microsoft Excel and analyzed by a third member of the research team using descriptive statistics. Included records were analyzed at the national, provincial/territorial and hospital levels.

Results

13,689 publications were included of which 12,472 (91.1%) were identified as unique publications. The number of unique publications increased annually from 2018-2022, with an 8.4% mean annual increase, and decreased from 2022-2023 by 1.7%. Most publications were indexed as articles (n = 8,389, 67.3%), followed by meeting abstracts (n = 1,512, 12.1%) and reviews (n = 1,316, 10.6%). Neurosciences & Neurology (n = 1,865, 15.0%), Oncology (n = 1,486, 11.9%), and General & Internal Medicine (n = 1,127, 9.0%) were the most frequently indexed research areas. Ontario had the highest number of unique community hospital affiliated publications (n = 7,925), followed by Alberta (n = 2,086) and Quebec (n = 1,480). 228 (42%) Canadian community hospitals contributed to at least one publication from 2018-2023.

Conclusion

Overall, Canadian community hospital research participation has increased. However, the proportion of total community hospitals participating in research remains low. Systems level strategies focused on strengthening research capacity across Canadian community hospitals are required to improve overall health research capacity and achieve a true learning health system in Canada.

Measuring Learning Health Systems: Co-Design and Testing of a Capability Self-Assessment Instrument

Presented by: Rob Reid

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Background and Objectives

The Learning Health System (LHS) has emerged as an operational framework for higher value delivery to patients, providers, and the community at large. By harnessing real-world data analytics, the LHS facilitates embedded research and data-driven decision-making at the clinical, operational, and strategic levels. To guide leaders engaged in LHS adoption, we co-developed a prototype self-assessment tool that measures socio-technical LHS capabilities required for enacting LHS initiatives at scale.

Approach

The survey tool is based on the LHS Action Framework developed at the Institute for Better Heath (IBH), Trillium Health Partners (THP). To design the tool, we used a four-step process: 1) item bank development and prioritization by core research team, 2) expert panel review with LHS researchers (n-=8), 3) cognitive testing with health system leaders (n=5), and 4) pilot testing with a purposive sample of leaders in two different contexts (n=7; n=98). The resulting generalizable tool is intended to be completed by interprofessional collaborators/leaders across any given health system (i.e., executives, managers, clinicians, operational supports, patient representatives, and researchers).

Results

Content review and cognitive and pilot testing were undertaken at THP including participants from THP and other Ontario health system providers. Preliminary user feedback validated the tool's content, structure, and assessment outputs (i.e., actionability of survey data analysis and visualizations). By completing the tool, respondents provided valuable insights regarding the current state of perceived LHS capabilities at THP. Survey data visualizations depicting the current state of LHS capabilities were produced and used during discussions with senior leadership teams to prioritize opportunities for organizational improvement. Early insights from pretesting the tool will be discussed as part of the presentation in order to help users and proponents of the LHS framework understand how to connect principles and priorities to actions and practices within their systems.

Conclusion

By assessing the current-state of LHS capabilities, the tool is intended to facilitate strategic planning. Next steps include the application of the tool with a wider sample of leaders across Canadian hospital programs to measure LHS capabilities in other contexts and collect additional data for tool validation/tailoring where necessary.

Implementation processes and capacity-building needs in Ontario maternal-newborn health services

Presented by: Jessica Reszel

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Background and Objectives

Pregnant/birthing people and infants do not always receive care that aligns with the best available evidence. Implementation science can inform how to close these evidence-practice gaps. However, it remains unknown to what extent current implementation practices align with recommendations from implementation science, and how confident health service leaders and providers are completing steps in the implementation process. We aimed to understand current approaches to implementing practice changes and perceived confidence completing various implementation activities.

Approach

We conducted a cross-sectional survey. Using purposive sampling, we invited health service leaders and providers working in Ontario maternal-newborn hospitals to complete an online questionnaire. Participants were required to have experience participating in or leading implementation projects. The questionnaire was informed by Harrison and Graham's Implementation Roadmap, which includes three core phases (identify issue; build solutions; implement, evaluate, sustain). The questions probed participants' perceptions of completion, importance, and confidence for each of the 28 Implementation Roadmap activities. We used descriptive statistics for the close-ended questions and grouped the written responses into categories.

Results

Between September and November 2023, we received responses from 73 individuals (26% response rate), representing nearly two-thirds of Ontario maternal-newborn hospitals. Nearly all respondents (>90%) agreed that each of the 28 activities in the implementation process were "very" or "somewhat" important. Respondents reported "always" completing a median of 8 out of 28 activities (29% of activities, range=0-28), with the number of activities completed declining from phase 1 though to 3. The majority of respondents indicated they were "somewhat" confident across the activities and "strongly agreed" or "agreed" that their teams would benefit from increasing their knowledge (88.4%) and skills (92.8%) to using an evidence-informed approach to implementing clinical practice changes.

Conclusion

Despite viewing implementation activities as important, many teams are not consistently doing them and lack confidence, particularly in later phases of the implementation process. These findings inform where further capacity-building and supports may be needed to enable maternal-newborn healthcare services to apply implementation science to their change initiatives.

How are pharmacists being integrated in primary care in Canada? Examples from two provinces

Presented by: Monika Roerig

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Background and Objectives

Over the years, pharmacists in Canada have experienced expanded scopes of practice, new governance and funding models for providing patient care, and different collaboration models with other health providers. These changes position them well to strengthen their involvement in the primary care system especially highlighted through their vital services during the COVID-19 pandemic. This work aimed to explore recent efforts of integrating pharmacists into primary care and draw out emerging lessons to inform ongoing reforms.

Approach

We performed an environmental scan of policies and programs since 2020 on interdisciplinary primary care with pharmacists and their expanded scopes of practice in Ontario and Quebec. We then conducted semi-structured interviews with community pharmacists across both provinces (n=11). Using thematic analysis we identified themes regarding how pharmacists are working with other primary care providers and providing direct patient care, both in the community at pharmacies and interdisciplinary primary care teams. Finally, we held a virtual stakeholder dialogue to further learn and enhance lessons and co-develop policy recommendations.

Results

Although Ontario and Quebec have legislated different aspects of pharmacist's practice, both have reached similar changes in the past decade including authorizing pharmacists to diagnose and prescribe for minor ailments. Pharmacists working in the community reported differences in how they enact changes to their expanded scopes of practice, influenced by their level of independence, organizational structures, and resources. Pharmacists spoke about their varied levels of engagement and collaboration with other health providers, leading us to question whether their integration was at the level of the system (where patients were centred and drove choices) or other primary care providers (to support their practices), the latter reinforcing medical hierarchy. Legislation was viewed as a first step that requires additional focus on implementation and operationalization.

Conclusion

Results provide insight about emerging lessons and challenges to pharmacists' expanded scopes of practice and integration into primary care. Stakeholders propose actionable recommendations to improve implementation in order to optimize of the role of pharmacists in primary care in Canada and improve access to quality patient care.

Cost Analysis of Psychiatric Care and Supportive Housing for Severe Mental Illness: A Review

Presented by: Maryann Rogers

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Background and Objectives

Canada's mental health crisis affects 1 in 5 annually, costing over $50 billion. Supportive housing for individuals with serious mental illness (SMI) improves quality of life and reduces hospitalizations and justice system interactions. This review examines the cost-effectiveness of psychiatric care with and without supportive housing for individuals with SMI, aiming to inform Canadian mental health policy.

Approach

A scoping literature review (inception–2024) was conducted to assess the existing economic evidence on supportive housing. A narrative synthesis was then performed to identify consensus in the literature regarding the cost-effectiveness of supportive housing.

Results

660 references were found in peer-reviewed literature of which five were selected for inclusion. Our narrative synthesis generally indicated supportive housing to be cost-saving. The narrative synthesis suggested that, despite high initial costs, supportive housing is generally cost-saving with reduced resource utilization and the benefits for participants in community support programs potentially justifying these initial expenses

Conclusion

This review indicates that supportive housing may lead to significant cost savings compared to inpatient psychiatric care alone. Policymakers should prioritize expanding access to supportive housing as a cost-effective solution for individuals who need a "middle ground" between inpatient care and full community reintegration.

Impact of income-based cost sharing on drug usage in lower-income adults: a quasi-experimental study

Presented by: Maryann Rogers

Author(s): *Maryann Rogers (1), Andrea Stucchi (1), Christopher Holiday (2), Martin Odendaal (2), Lucy Cheng (1), Michael Law (1)*

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Background and Objectives

Income-based cost-sharing is present in several provincial public drug plans in Canada and have been the subject of extensive debate. We will study the impact of a 2019 change in deductible and co-insurance structure in British Columbia's Fair PharmaCare plan on pharmaceutical utilization among lower-income adults.

Approach

We will employ a quasi-experimental regression discontinuity design to evaluate the impact of updated BC regulations. These rules eliminated deductibles and co-insurance for households with an annual income below $13,750, imposed a 30% co-insurance rate on drug costs for households earning more than $13,750, and introduced a deductible starting at $650 for households with an income of $30,000, which increases incrementally across higher income bands. We studied the impact of these thresholds on public and total drug expenditures between 2019 and 2023.

Results

Data analysis is ongoing. This study aims to measure the proportion of enrollees in each income band per person-year to assess the impact of co-insurance and deductibles on the proportion of BC residents receiving public drug plan benefits. Additionally, we will estimate the impact of co-insurance and deductibles on public plan spending by calculating the average amount paid by the Fair PharmaCare program per person-year. Other analyses will include the average total prescription drug expenditure, the average number of prescriptions dispensed, and the number of unique medicines per person-year within the cohort.

Conclusion

Income-based cost-sharing has the potential to significantly influence the extent of public subsidies for prescription drugs. While cost-sharing can be an effective tool to manage public expenditures, this ongoing work aims to provide insights that will help policymakers evaluate the implications of these measures, particularly for vulnerable populations.

Family physician views on payment: A qualitative study using theories in health economics

Presented by: David Rudoler

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Background and Objectives

Payment models influence practice behaviour through the alignment of incentives with policy objectives. Understanding how to use financial incentives effectively can impact the supply of physician services, access to care, the quality of care, and provider recruitment and retention. This study analyzes family physician interview data using rational choice and agency theories to understand how physicians think about payment.

Approach

We recruited 63 participants from British Columbia (n = 23), Ontario (n = 18), and Nova Scotia (n = 22). Participants were family physicians in their first 10 years of practice. Transcribed audio recordings were analyzed using deductive and inductive thematic analysis, applying a model of physician behaviour inspired by the health economics literature. At least two researchers independently coded the data using a deductive codebook, adding inductive themes as needed. A finalized codebook was applied to subsequent transcripts. Three researchers then met to review the coded data, organize the codes into themes, and select illustrative quotes.

Results

Our deductive codebook assumed physicians maximize personal utility, subject to constraints, by trading off income, leisure, and patient benefit. Sub-themes emerged under the broader theme of income, including that physicians selected payment models based on earning potential and established earning expectations based on comparison with physicians working in other provinces and specialties. Preferences for leisure were rarely discussed as a priority. Physicians reported achieving greater well-being for themselves and their patients through alternatives to traditional fee-for-service and in focused practice settings. Physicians often sacrificed income to prioritize patient well-being under traditional fee-for-service and in office-based practices, which, for some, was a reason to avoid practicing in these settings. Some physicians also sacrificed income to work in environments that provided greater intellectual satisfaction.

Conclusion

Earnings drove the selection of payment models, but were often secondary to patient benefit. Some physicians sacrificed income to enhance patient well-being in traditional fee-for-service, office-based practice, while others were deterred from these models. Payment reforms could ameliorate disincentives for office-based practice, but may not increase access to care overall.

Stigma, Comfort, and Care: The Attitudes of Clinicians Toward Substance Use in an Acute Care Setting

Presented by: Angela Russolillo

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Background and Objectives

Stigma is a major driver of the harms associated with substance use and can interfere with the provision of high-quality, effective healthcare for people who use drugs. Our study aimed to explore the relationship between mental health clinicians' comfort in providing substance use care and their attitudes towards substance use.

Approach

In this cross-sectional study, the Brief Substance Abuse Attitudes Survey was administered among a convenience sample of mental health clinicians [N=71] working in an acute care setting in Vancouver, Canada. One-way ANOVA and the Kruskal–Wallis test were used to examine the association between three levels of comfort and five predefined attitude subgroups among respondents.

Results

Level of comfort was significantly associated with attitudes towards substance use across three subscales: permissiveness, non-stereotyping, and treatment optimism. In pairwise comparisons, the neutral group held significantly less permissive attitudes when compared to the comfortable group. However, the neutral group held more stereotypical views, and less optimism about treatment outcomes, when compared to the comfortable and uncomfortable groups, respectively.

Conclusion

Findings demonstrate that clinicians who are undecided or neutral about their comfort in providing substance use care are more likely to have negative views towards people who use substances. Future research should evaluate stigma-reduction interventions. This study is expanding to sites in British Columbia and Quebec to inform evidence-based interventions.

Annual prevalence of mental illness among younger home care clients in Ontario

Presented by: Emily Rutter

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Background and Objectives

Little is known about mental illness among younger home care (HC) clients or appropriate surveillance strategies for this population. This group has unique experiences compared to their older counterparts, particularly during transition into care, an event associated with loss of independence and social connections. Our objective was to estimate the crude and age- and sex-specific annual prevalence of mental illness among Ontario HC clients (aged <65), using different validated case definitions for administrative data.

Approach

This population-based, repeated cross-sectional study used linked Ontario clinical and health administrative databases to estimate the annual prevalence of mental illness during fiscal 2012-2022 among HC clients aged 18-64, overall and by sex. The sample comprised those with a first Resident Assessment Instrument for Home Care (RAI-HC) during this period (n=130,812), where assessment date = the index date. Prevalence estimates (95% CI) were derived for each index year (6 months pre/post index date) using validated case definitions based on healthcare use, including any mental illness, mood/anxiety disorder, schizophrenia, depression and anxiety (with and without drug claims), and bipolar disorder.

Results

Younger clients represented 16% of the total HC population, with mean age 53 (SD 11) and 53.2% female. In fiscal 2022, the prevalence of healthcare use for any mental illness was 51.8% (52.8% female, 50.8% male), with estimates ranging from 38.2% for mood/anxiety to 6.4% for schizophrenia. The inclusion of medications in case definitions showed a small impact on depression estimates but resulted in a higher anxiety prevalence (43.0% with vs 33.8% without drug claims). Many conditions were more prevalent in females (e.g., anxiety, 38.2% vs 29% in males). In 2020 and 2021, there was an increase in prevalence of all conditions (e.g., mood/anxiety rose 8.5% from fiscal 2019 to 2020), suggesting unique healthcare use patterns and/or characteristics of clients receiving HC in this period.

Conclusion

While there is a high prevalence of mental illnesses amongst younger adults receiving HC in Ontario, some estimates vary depending on the definition used. A better understanding of how well current surveillance approaches perform in HC settings is needed to support preventive and treatment strategies in this age group.

Laurie Proulx Rediscovering Patient Support Programs: A Patient-led Evaluation

Presented by: Anna Samson & Laurie Proulx

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Background and Objectives

The Canadian Arthritis Patient Alliance (CAPA) is a patient-led organization and we launched a survey to understand patient experiences with Patient Support Programs (PSPs), introduced in the early 2000s when biologic medications were introduced. PSPs provide direct patient services (e.g., infusions) though they do not have any formal independent evaluation. Our aim was to directly evaluate patients' experiences with PSPs and develop patient-centred recommendations to improve these programs.

Approach

A survey was co-developed with individuals living with inflammatory arthritis to explore domains such as first interactions with PSPs, healthcare experiences, and transitioning to biosimilar medications. The survey findings informed patient-centred recommendations. To disseminate the results, a webinar was conducted in October 2024, attended by over 50 participants, primarily from the pharmaceutical industry. The webinar highlighted key survey findings and patient-centered recommendations for improving PSPs. All aspects of the project—survey design, analysis, recommendation development, and dissemination—were conducted with a patient lens.

Results

The survey was completed by 375 respondents who self-identified as living with various forms of inflammatory arthritis; over 90% were under the age of 50. Respondents reported accessing a wide range of PSP services with the most valued being information about the prescribed medication (28%) and guidance on storing or accessing the medication (31%). Satisfaction rates ranged from 50% to 60% across all domains with notable gaps informing the development of patient-centered recommendations. Recommendations emphasized the need to simplify processes related to informed consent, patient communications, and insurance systems. Additional recommendations included enhancing the role of patient organizations in delivering education about PSPs and establishing independent monitoring systems. A cross-cutting recommendation involved improving patient engagement, including the creation of a national patient advisory council for PSPs, co-chaired by patient and industry leaders.

Conclusion

This the first patient-led evaluation of PSPs despite their use by patients with arthritis since the early 2000s. Survey results suggest the need to improve patient satisfaction rates and our patient-centred and identified recommendations can inform program improvements and the role of PSPs in Canada’s publicly funded healthcare system

Older Adults' Views of Foodborne Illness and Food Safety

Presented by: Kanika Sarwal

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Background and Objectives

Foodborne illness is a significant global public health issue, especially for older adults, who are more vulnerable due to age-related physiological changes. Canada's aging population is growing, yet there is limited research on how older adults who live independently perceive and manage food safety risks at home. This study aims to explore how and why persons aged 65 and older perceive and mitigate these risks and whether they follow recommended food safety guidelines.

Approach

We will conduct 10-30 semi-structured interviews with adults aged 65 and older, living independently in Kitchener-Waterloo (Ontario), who speak English, can provide consent, and are primary food preparers. Participants will be recruited using flyers, and at community centers, the Schlegel-UW Research Institute for Aging, libraries, religious institutions, and senior housing buildings. The interviews, guided by the World Health Organization's Five Keys to Safer Food, will be: 45-60 minutes long; conducted in person, by phone, or virtually; and audio recorded and transcribed. We will analyze the data using reflexive thematic analysis guided by the COM-B framework. Ethics is currently underway.

Results

The findings will provide valuable insights into older adults' food safety behaviours and investigate how and why they perceive foodborne illness risks. We anticipate respondents will perceive their demographic as high risk for developing foodborne illness but view themselves as low risk due to optimism bias and confidence in their practices. We anticipate respondents will follow long-standing habits that may not align with current best practices, like relying on visual cues to judge whether food is safe to eat in lieu of thermometers. We also anticipate respondents may place low priority on food safety behaviours compared to other needs. For example, while they may be aware of best-before dates, respondents might overlook them because they prioritize reducing food waste over reducing their foodborne illness risk.

Conclusion

Findings about older adults' food safety knowledge and behaviour gaps will identify specific food handling practices that can be improved. These insights can inform public health, policymakers, and senior care experts to develop tailored resources to better support the needs of older adults and support their ability to live independently.

Vers une gestion décentralisée des services à domicile : Facteurs essentiels à considérer

Presented by: Virginie Savaria

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Background and Objectives

Les deux dernières réformes du système de santé québécois ont mené à une centralisation accrue de la gestion, limitant l'efficacité des professionnels dans les services à domicile (SAD) pour les aînés. La décentralisation, en offrant plus d'autonomie aux acteurs de terrain, pourrait améliorer la réactivité et la qualité des soins. Toutefois, cette approche demeure peu explorée dans le contexte québécois.

Approach

Notre recherche-action participative vise à co-construire des stratégies de gestion décentralisée dans les SAD afin d'explorer les pratiques pouvant être intégrées au quotidien des professionnels et des gestionnaires. La recherche s'est déroulée en deux cycles comportant des phases d'observation, de réflexion et d'action impliquant les principales parties prenantes des SAD. Les résultats présentés portent sur les entrevues menées avec des gestionnaires.

Results

Nos résultats préliminaires révèlent que plusieurs facteurs influencent l'intégration de la gestion décentralisée dans les SAD. Concernant l'autorité, la volonté des cadres supérieurs à déléguer facilite cette intégration. Toutefois, l'absence de personnes à qui déléguer constitue un obstacle. En ce qui concerne les capacités, les compétences des gestionnaires et des travailleurs ainsi que la présence de porteurs de changement favorisent l'adoption de pratiques décentralisées. Cependant, la disponibilité limitée des gestionnaires et la rigidité de la structure du système de santé représentent des freins importants. Pour les responsabilités, la consultation préalable des équipes contribue positivement à la mise en place de la gestion décentralisée, tandis que la centralisation des ressources humaines constitue un obstacle.

Conclusion

L'identification de ces facteurs offre des pistes de réflexion pour repenser la gestion des SAD et favorise une meilleure intégration de pratiques décentralisées au niveau local, contribuant ainsi à l'amélioration de la qualité des services offerts aux aînés.

Describing perinatal factors of Métis Nation of Ontario citizens: A retrospective cohort study

Presented by: Hibah Sehar

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Background and Objectives

Despite perinatal factors being important indicators of population health they are under reported among Métis people. Current research suggests that Métis people have more adverse outcomes compared to non-Métis individuals, including higher rates of hypertension and substance use during pregnancy and birth outcomes such as infants born large for gestational age. The objective of this study is to describe perinatal factors for Métis Nation of Ontario (MNO) citizens between 2012 and 2021.

Approach

This was a retrospective, population-based cohort study which utilized health administrative data held at ICES, including the Better Outcomes Registry Network (BORN) tracking all births in Ontario, linked to the MNO Citizenship Registry. The MNO holds the only recognized registry of Métis citizens across Ontario, and citizens consent to the collective use of their information for research and evaluation purposes by the MNO. Métis citizens are linked to their administrative health data using personal identifiers (first name, last name, date of birth). Descriptive statistics were compared between MNO and non-MNO citizens in Ontario for maternal characteristics, antenatal and postnatal factors.

Results

There were a total of 1,362,434 singleton births between 2012 and 2021, of these, 2,751 (0.20%) were births by an MNO citizen and the remaining were non-MNO citizen births. There were some significant perinatal differences between MNO and non-MNO citizens. MNO citizens were, on average, younger at delivery than non-MNO and had higher weight gain. Non-MNO citizens more often had an obstetrician present whereas more MNO citizens had a family physician present. MNO had higher rates of morbidities, hypertension, pre-existing health conditions and substance use during pregnancy. MNO citizens were more likely to use folic acid and exclusively use breastmilk. MNO citizens were also more likely to have their newborns transferred to the neonatal intensive care unit.

Conclusion

This is the first population-based study to explore perinatal differences between MNO and non-MNO citizens giving birth in Ontario. The results from this study can be used to inform programs designed to support healthy and safe pregnancies for Métis mothers. Future research should also incorporate Indigenous voices and qualitative methodology.

Community implementation of a peer-led mental health intervention for family caregivers

Presented by: Avra Selick

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Background and Objectives

Family caregivers of people with neurodevelopmental disabilities (NDD) experience high levels of stress, anxiety, and depression. The Caring for the Caregiver Acceptance and Commitment Training (CC-ACT) program is a group-based psychological intervention for families of people with NDD co-delivered by clinician and family facilitators. Previous studies found CC-ACT significantly reduced participant depression and stress. The aim of this study was to evaluate the feasibility of implementing CC-ACT in diverse community settings.

Approach

Between 2022-2024, CC-ACT was implemented in 12 organizations in four provinces. The CC-ACT model aims to increase psychological flexibility through six manualized sessions delivered virtually or in person. A central team provided training for all facilitators, ongoing coaching and a community of practice. The multi-method evaluation was guided by the RE-AIM framework. This presentation focuses on four domains: Reach, Adoption, Implementation and Maintenance. Data were collected through focus groups with program facilitators and organization leadership, participant surveys, and fidelity checklists completed after each session. Data were analyzed across programs to identify barriers and facilitators to implementation.

Results

Adoption: In total, 12 organizations delivered at least one CC-ACT program; five organizations delivered the program twice. Facilitators and organizations reported high acceptance of CC-ACT; in particular, they valued the co-delivery model. Reach: Across programs, 166 caregivers participated. Participants were typically more likely to be white, female, and higher income. It was suggested the program may benefit from adaptations to improve accessibility for underserved caregivers populations. Implementation: Overall fidelity was high with a mean fidelity score of 93% across programs, though there was some variation at the activity level. Maintenance: Teams expressed concern about capacity to continue delivering the program, in particular funding to pay caregivers who are not employees. They stressed the need for commitment from leadership and dedicated funding for sustainability.

Conclusion

CC-ACT can improve caregiver wellbeing. However, two key challenges were identified to the spread and scale of this model: sustainability and accessibility. Next steps include working with local communities to adapt the model to meet their needs, as well as regional and national efforts to develop infrastructure to support sustainability.

A closer look at long-stay psychiatric inpatients with intellectual and developmental disabilities

Presented by: Avra Selick

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Background and Objectives

Ontario is in the midst of a hospital crisis. One contributing factor is difficulty discharging patients who no longer require hospital care leading to extended hospital stays. Patients with intellectual and developmental disabilities (IDD) and a mental illness are at higher risk for unnecessarily long hospitalizations. This project examined the prevalence of IDD among long-stay patients in Ontario psychiatric beds, and compared the demographic and clinical profiles of long-stay inpatients with and without IDD.

Approach

This cross-sectional study used administrative health data held at ICES to identify people with IDD using health records. All patients over 18 years of age occupying a psychiatric inpatient bed in Ontario on September 30th, 2023 were included in the analysis. We focused on patients with a length of stay of at least 365 days ("long-stay"). Forensic and non-forensic patients were examined separately. Prevalence of patients with IDD was assessed and patients with and without IDD were compared on their demographics, clinical characteristics, cognitive/functional status prior to admission and support needs using standardized differences (SD >10% represented meaningful difference).

Results

On September 30th 2023, 22% of all long-stay patients in non-forensic psychiatric beds had an IDD (n=322) and 42% of all long-stay patients in forensic beds had an IDD (n=233). In the non-forensic group, patients with IDD were more likely to be younger (mean age 44 vs 48; SD=0.195) and male (64.3% vs 50.1%; SD=0.29), while the forensic patients were demographically similar. In the 2 years prior to admission, patients with IDD in the non-forensic group were more likely to be diagnosed with a psychotic disorder (73.3% vs 54.0%; SD=0.409), but less likely in the forensic group (80.3% vs 92.1%; SD=0.348). In both groups, patients with IDD were more likely to have cognitive impairment and difficulty with activities of daily living.

Conclusion

Adults with IDD comprise less than 1% of the population but account for more than 1 in 5 long-stay patients in non-forensic beds and almost half of long-stay forensic patients. This group has different needs than other long-stay patients. Successful transitions out of hospital require specialized resources and inter-sectoral collaboration.

Emotion Regulation Under Pressure: Cognitive Reappraisal and Expressive Suppression Impact on Stress

Presented by: Ayesha Shafiq

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Background and Objectives

Stress is an inevitable aspect of modern life with significant health impacts. Emotion regulation strategies, such as cognitive reappraisal (CR) and expressive suppression (ES), influence individual stress responses. CR involves reframing stressors to reduce their emotional impact and is linked to improved stress responses. Conversely, ES suppresses outward emotional expressions and is associated with mental health issues. This study investigates how CR and ES influence acute stress response, exploring both psychological and physiological stress outcomes.

Approach

This two-part study includes a cross-sectional survey (Study 1) and an experimental design (Study 2). Participants meeting the inclusion criteria for Study 2 will complete stress assessments as they participate in the TSST and C-TSST. The TSST stimulates stress through public speaking and arithmetic tasks, while the C-TSST induces minimal stress. Physiological responses, including heart rate (HR), heart rate variability (HRV), and skin conductance response (SCR) will be recorded using BIOPAC MP160 systems. Psychological measures of stress will also be collected through completion of the State-Trait Anxiety Inventory (STAI-S) and Stress Appraisal of Acute Stress (SAAS).

Results

Our hypotheses predict that employment of CR will result in adaptive stress responses, including higher HRV, lower SCR, and faster HR recovery. In contrast, ES is expected to lead to heightened sympathetic nervous system activation, prolonged recovery, and increased subjective stress ratings. Statistical methods, including ANOVA and regression models, will analyze the effects of emotion regulation strategies. Data analysis will focus on validating these predictions by comparing physiological and psychological stress markers between CR and ES. Differences in baseline stress levels and recovery trajectories will be examined to determine the effects of these strategies. These results will provide a detailed understanding of how specific emotion regulation strategies impact acute stress response.

Conclusion

This study seeks to validate CR as an adaptive strategy for stress management, emphasizing its role in preventing stress-related conditions. The findings can inform intervention plans for high-stress environments. By exploring the detrimental effects of ES, the research aims to guide mental health prevention strategies and foster better stress management.

Evidence-informed policymaking: Unpacking the black box

Presented by: Nida Shahid

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Canadian Institutes Health Research - Institute of Health Services and Policy Research

Background and Objectives

Evidence-informed policymaking to improve health and health system performance by maximizing research's relevance and impact on policy, is a shared goal among many stakeholders. However, policymaking is complex, with many factors influencing decisions, making the role for research evidence unclear. This study, led by the Canadian Institutes of Health Research-Institute of Health Services and Policy Research (CIHR-IHSPR), aims to better understand the policymaking process and ways to advance the research impact on health policy.

Approach

A qualitative study utilized key-informant interviews (KII) and an environmental scan, assessing peer-reviewed (n=25) and grey (n=24) literature (2005-2024) through Google Scholar and Elicit to understand policymaking processes, stakeholders, and enablers and barriers to evidence-informed policymaking, including receptor capacity for evidence use. Purposefully selected informants (n=8) identified by the Institute team and Advisory Board were interviewed virtually to assess evidence use, gaps and opportunities for CIHR's support in evidence-informed policymaking. Data were collected using Excel and analysis thematically. Kumu.io facilitated network mapping and role exploration, with degree centrality identifying key influencers in the policymaking process.

Results

Preliminary findings reveal that policymaking relies on multiple forms of evidence, including research. Additional forms include public opinion, cross-jurisdictional scans, contracted evaluations, and more. The policymaking process is highly contextual and shaped by a multitude of factors, actors, and evidence.

Findings indicate that it is critical for researchers to understand the policy process, the organizational structure of government, and the roles of political officials and civil servants. Additionally, developing trusting relationships between researchers and policymakers is essential.

Advancing evidence-informed policymaking requires more than just robust research. Researchers may benefit from training in strategic communication and relationship-building with policymakers. Policymakers may benefit from organizational support, a culture of evidence use (e.g., dedicated knowledge brokering roles), and training in research use to enable meaningful collaboration with researchers.

Conclusion

Advancing research impact in evidence-informed policymaking requires enhancing capacity through training and strengthening relationships between researchers and policymakers. Key enablers include trust, strategic communication, and institutionalized processes. Addressing barriers like competing priorities and resource constraints is essential to improving evidence-informed policymaking and ensuring research influences policy effectively.

Determining hospitalized psychiatric patients eligible for assertive community treatment in Ontario

Presented by: Isobel Sharpe

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Background and Objectives

Assertive community treatment (ACT) is an intensive, interdisciplinary care delivery model for individuals diagnosed with severe and persistent mental illness. Those requiring ACT have a history of frequent psychiatric hospitalization and serious functional difficulties in several areas, including work, social relationships, and residential independence. Our objective was to identify hospitalized psychiatric patients in administrative data who may benefit from ACT services and to examine the subsequent health care use of these individuals.

Approach

We included all individuals upon their initial psychosis- or bipolar-related psychiatric hospital discharge in Ontario between April 1, 2022 and March 31, 2023. Those eligible for ACT had at least one other psychosis- or bipolar-related hospitalization, while spending 30+ days combined in-hospital, during the previous two years; and were assessed as having either an inability to maintain a stable living situation, inadequate social contacts to support discharge, or indicators of severe psychosis. We used relative rates to compare the occurrence of mental health (MH)-related hospitalizations and emergency department visits in the year following discharge between ACT eligible and ineligible patients.

Results

There was a total of 16,356 individuals with a psychosis- or bipolar-related psychiatric hospital discharge during the study period. Using our study definition, we identified 1,769 (10.8%) discharged patients as eligible for ACT services. In the year following discharge, 57.5% of ACT eligible patients had an MH-related hospitalization compared with 40.9% of ineligible patients (Relative Rate [RR] 1.41; 95% Confidence Interval [95%CI] 1.35-1.47, p-value <0.001). Similar results were observed for MH-related emergency department visits in the year following discharge where the event rate was significantly higher (RR 1.35; 95%CI 1.30-1.41, p-value <0.001) for ACT eligible patients (62.6%) compared with ineligible patients (46.4%). These RR estimates did not meaningfully change after adjustment for demographics, medical comorbidity, and concurrent substance use disorder.

Conclusion

Among those discharged with psychosis- or bipolar-related disorder, we identified a specific group of ACT eligible patients who were at significant risk for returning to the hospital setting. This estimate of ACT eligible patients using administrative data may be useful to provincially and regionally plan for ACT service availability.

Developing Guidance to Facilitate Retention in Canadian Team-Based Primary Care

Presented by: Peter Sheffield

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Background and Objectives

Canada has a healthcare provider shortage, exacerbated by increasing turnover of primary healthcare (PHC) providers and interdisciplinary healthcare providers (IHPs). While improving IHP retention is known to improve the retention rate of a healthcare team, explicit guidance for doing so in the PHC setting is limited. Developing this guidance will require synthesis of (i) current applicable recommendations, (ii) consensus amongst Canadian primary healthcare experts, and (iii) best practices developed by existing high-retention PHC teams.

Approach

i) Qualitative content analysis of Government of Canada-supported Psychological Health And Safety Toolkit For Primary Care to identify existing guidance, coding for a) facilitators of overall provider well-being, b) protective factors for provider retention, c) diversity/equity/inclusion support; ii) Delphi study with primary healthcare experts (including clinicians, researchers, policy-makers, and patient partners) for consensus on “What should a) PHC organizations, b) provincial governments, c) the federal government do to retain team-based primary healthcare providers?”, iii) individual interviews with IHPs at higher-retention (≥5 years median IHP time-in-role) and lower-retention (<5 years) primary healthcare teams in Ontario about organizational facilitators of retention.

Results

1) N = 87 English-language resources (including, but not limited to, the entire Canadian Medical Association’s online Wellness Hub) extracted into N =921 documents, of which N=168 explicitly mention family medicine, general practice, primary care, and/or primary healthcare. Preliminary deductive content analysis indicates limited prescriptive retention guidance; examples include securing a primary care physician for oneself and constructing opportunities for close relationships in practice (e.g., Balint groups); 2) Ongoing pan-Canadian Delphi study recruiting clinicians, researchers, policy-makers, and/or patient partners, explicitly recruiting underrepresented minorities (e.g., racialized persons, LGBTQ+) in medicine amongst sample to address retention challenges therein; 3) Ongoing recruitment of IHPs in Ontario Family Health Teams with atypically high or low retention relative to median IHP retention rates based on administrative data.

Conclusion

Preliminary results indicate existing guidance for facilitating PHC provider retention offer limited explicit instructions for how to ameliorate this challenge. Ongoing Delphi- and interview-based approaches may be superior to literature-based toolkits for improving PHC provider retention in the specifically Canadian context.

Understanding Sepsis Policies, Guidelines, and Standards in Canada to Inform a National Action Plan

Presented by: Fatima Sheikh

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Background and Objectives

Sepsis, the body's life-threatening response to an infection, impacts 50 million people each year and accounts for 20% of all deaths worldwide. In 2017, the World Health Assembly (WHA) passed a resolution calling on member states to recognize sepsis as a priority. To address the WHA resolution, we conducted a scoping review to identify and describe existing sepsis policies, clinical practice guidelines, and health professional training standards in Canada to inform evidence-based policy development.

Approach

To analyze the landscape of Canadian sepsis policies, guidelines, and standards, we performed a scoping review with the following stages: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, (5) collating, summarizing, and reporting the results, and (6) consultation. Non-traditional sources of evidence were identified using environmental scanning methodology. Policies, guidelines, or standards related to the identification, management, and/or reporting of sepsis, published since 2010 and available in English or French, were included.

Results

We identified 32 sources of evidence, including nine sepsis guidelines, three sepsis policies, 16 health professional training standards that included sepsis, three accreditation standards, and one sepsis reporting standard. Most (19/32; 60%) were national in scope, with 10 (31%) and 3 (9%) being provincial and international in scope, respectively. We identified sepsis policies or guidelines for 38% of the provinces and territories (8/13), the inclusion of sepsis as a training competency in 16% (11/67) of the Royal College of Canada medical specialties/subspecialties competency standards, and in only two Canadian Hospital Accreditation Standards. Only 6.25% (2/32) of identified sources considered the role of social determinants of health, and only 13% (4/32) engaged people with lived sepsis experience or members of the public.

Conclusion

Our review demonstrates that Canada lacks a Sepsis National Action Plan and a paucity of Canadian sepsis policies, guidelines, and training standards. Given the significant preventable sepsis-related morbidity, mortality, and health system costs, these policy gaps should be addressed to reduce the burden of sepsis on the Canadian health system.

Enhancing the Role of Medical Office Assistants in Primary Care: Co-Developing Solutions

Presented by: Jennifer Shuldiner

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Background and Objectives

Medical Office Assistants (MOAs) are staff who carry out a range of of administrative and often clinical tasks, playing a crucial role in primary care, but are not always supported or recognized for their work. This study aims to: (1) understand MOAs' current role and experiences; (2) find barriers and drivers that affect their work in primary care; and (3) co-create scalable, innovative ways to support MOAs in their role in primary care.

Approach

Four workshops were conducted with MOAs in Ontario to map their work experiences and challenges, envision ideal MOA experiences, and co-create solutions to address challenges. Data were collected using an online collaborative whiteboard platform - Miro - and workshops were recorded. Solutions were then presented to a diverse panel of MOAs, primary care clinicians, and health system executives. They rated the solutions through a two-part Delphi survey using a Likert-scale on acceptability, practicality, effectiveness, affordability, safety, and equity (APEASE). Open-ended text boxes captured feedback and insights. Next, panelists discussed survey results and the implementation of prioritized solutions in an online workshop.

Results

Eight MOAs, 6 health system executives, 5 researchers, and 8 primary care providers in the workshops and Delphi. MOAs face challenges with patient expectations, difficult interactions, and limited time to build relationships. In clinics, they feel undervalued, overworked, and excluded from decisions, with little support for learning. System inefficiencies like complex referrals and outdated EMRs further complicate their tasks, affecting their ability to work efficiently. Eight solutions were co-developed, including: centralized referral system, and "best practice" resource for primary care clinics. The top-rated solutions supported MOAs by networking and education. They also aimed to improve the system with better EMR and referral processes. In the final workshop participants discussed implementation plans involving system partners, stakeholder engagement, ensuring MOA engagement in solution development, and funding opportunities.

Conclusion

We can help MOAs overcome key work challenges. As the first point of contact for patients and as vital nodes between different parts of the system, MOAs have the potential to play a pivotal role in improving the quality and delivery of primary care.

Leading practices to safeguard the mental health of investigators and trainees in research teams

Presented by: Sarah Simkin

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Background and Objectives

Although the stresses associated with academia and graduate studies are well recognized, little is known about how to best support the mental health of investigators and trainees in research teams. Through the Healthy Professional Worker Partnership, a large pan-Canadian mental health research project, we explicitly examined the mental health issues affecting researchers and trainees, and possible interventions. Our goal was to identify issues and leading practices for safeguarding the mental health of research team members.

Approach

Near the end of the Healthy Professional Worker Partnership, we collected insights from trainees, co-investigators, the project director and the leaders of the project trainee support network. We undertook inductive thematic analysis of exit interview transcripts and written feedback, identifying common mental health challenges along with interventions, promising practices, and lessons learned. We developed guidance tailored to research teams using a theoretical framework anchored in public health, consisting of general principles with respect to team organization and operation and specific suggestions with respect to promotion of mental health and prevention and remediation of mental illness.

Results

Across the Partnership, there were clear mental health implications of doing research on the mental health of professional workers. Typical mental health challenges such as stress, anxiety and burnout were compounded by the COVID-19 pandemic context, the dynamics of a large and distributed team, and the sensitive subject matter. Responsive interventions included regular training and check-ins, adjusting the interviewing approach, and managing workload. Promising practices included a trainee support network, built-in debrief time following interviews, and clear communication and flexibility around expectations and timelines. Lessons learned included the need for optimized responsiveness, flexibility and support, more formalized onboarding throughout the project, access to a consortium of resources, and a systematic approach to promotion of mental health and prevention and remediation of mental health issues arising.

Conclusion

A multi-layered a priori strategy for safeguarding the mental health of research team members, particularly when focused on mental health topics, is recommended that includes general principles for team organization and operation, as well as specific strategies focused on promotion of mental health and prevention and remediation of mental illness.

An innovative approach to modeling physician retirement

Presented by: Sarah Simkin

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Background and Objectives

Given an aging physician workforce, planning for retirement-related attrition is essential. And yet, many planning methodologies use simplified assumptions to model retirement, such as universal retirement after age 65. The complexity of retirement decisions and a paucity of high-quality health workforce data contribute to underdeveloped approaches to modeling and planning for retirement. The goal of this study was to develop a fit-for-purpose physician retirement modeling methodology to support local and regional workforce planning.

Approach

In the context of ongoing primary care workforce planning in Toronto, we developed a methodology to assess the neighbourhood-level impact of physician retirement. Using physician workforce profiles, physician service capacity, age-related changes in physician workload, age-related physician retirement probabilities, and the Poisson distribution, we were able to quantify the impact of physician retirement on the health system. For each neighbourhood, we estimated the probability of a given number of retirements in the base year and into the future, and calculated the number of at-risk primary care visits under a series of retirement probability thresholds.

Results

This approach quantifies both the risk of retirement as well as the potential impact of retirement-related attrition from the primary care physician workforce at a neighbourhood level in Toronto. We generated outputs for 158 neighbourhoods in Toronto for 2019 (the base year) through to 2025. Results are available through an interactive dashboard, allowing decision-makers to explore up to 14 scenarios to identify neighbourhoods with high volumes of visits at risk, either through the combined impact of multiple retirements or through the retirement of a small number of physicians who provide a high volume of care. Once neighbourhoods at risk of being underserved due to physician retirement have been identified, planning can take place to mitigate their impact.

Conclusion

Effective modeling of physician retirement is an important part of planning. This methodology, which considers both the probability and impact of physician retirement, has the potential for application to other professions and settings and can be leveraged to support proactive responses, including mobilization of other providers, for neighbourhoods at risk.

Nurses' Transition to Practice Experience and Contributions Within Family Care Teams in NL

Presented by: Myuri Sivanthan

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Background and Objectives

An effective, high-quality primary healthcare system has the potential to offer many benefits to Canadians. In Newfoundland and Labrador (NL), the widespread implementation of team-based primary care is still in its early stages. Strategies to optimize the nursing workforce within Family Care Teams (FCTs) are required to ensure success. An understanding of nurses' transition to practice experiences and their contributions within FCTs in NL is necessary and is the purpose of this study.

Approach

We used a qualitative descriptive approach. We conducted semi-structured interviews with nurses who work in FCTs in NL. We employed purposive snowball sampling to identify nurses working within established FCTs across NL. Virtual interviews were conducted with Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners (NP). We recorded the interviews and transcribed them verbatim. The researchers performed thematic analysis of the transcribed interviews to identify themes inductively and NVIVO software was used to organize the data. We analyzed demographic information using SPSS and presented these as a narrative and in a table.

Results

Twenty-five interviews were conducted with nurses, representing the five health care zones in NL. Emerging themes from the data include: on-the-job learning, lack of role clarity, and the need to orient to a new normal. Participants indicated they needed to "learn on the go" and lacked opportunities for mentorship. RNs and LPNs noted a lack of role clarity, both among clinic team members and the nurses themselves, whereas the role of NPs was described as being more defined. Participants also expressed that patients receiving care within their FCT lacked understanding of nursing roles within the team, suggesting the need for education to orient community members to the concept that primary care providers can include professionals other than a family physician.

Conclusion

Understanding nurses' transition experience within FCTs is critical to inform the development of supportive practices and maximize the efficacy of these teams. Having an understanding of the scope of practices of nurses to map the role of the RN or LPN may decrease underutilization and increase the efficacy of FCTs.

Tests of Change for Enhancing Collaboration between Primary Care Providers and Homecare Coordinators

Presented by: Sameena Somani

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Background and Objectives

Primary care providers (PCPs) and homecare coordinators are essential care providers for homecare patients living in the community. However, communication barriers hinder care provision and increase the likelihood of adverse outcomes. This quality improvement (QI) project was an initiative of the North York Toronto Health Partners Ontario Health Team (OHT) and aimed to improve primary care-homecare integration by implementing tests of change.

Approach

Project team members had the influence and skills to implement tests of change and consisted of a PCP, Director with Ontario Health atHome, evaluation scientist, and a research assistant. A phone survey of PCPs and coordinators was conducted to explore two change ideas: improving information sharing on shared clients via the Ontario Health atHome Quarterly Report (QR) and improving PCP-coordinator communication. Survey responses were analyzed using content analysis to identify prominent categories that were then incorporated into a small-scale test of change, which was the modification of the QR.

Results

Respondents emphasized the need for a common communication platform, but this was not a feasible small-scale change. While phone calls were effective for urgent matters, they were considered inefficient for re-establishing contact; many PCPs were unaware of coordinator contact details. Respondents preferred that QRs be actionable and suggested the addition of patient status alerts and education on the need for health assessment reports for long-term care applications. The QR was modified (i.e., QR 2.0) to include: (1) coordinator contact information per patient, (2) a score indicating risk of emergency department visit, Detection of Indicators and Vulnerabilities for Emergency Room Trips (DIVERT) score, and (3) a reminder of the most recent long-term care application. The QR 2.0 is currently being piloted with an online feedback survey.

Conclusion

Early feedback suggests that integrating coordinator contact details and actionable elements, such as the DIVERT score and long-term care reminders, are useful and can reduce collaboration barriers but which require further testing. The QR 2.0 shows potential to enhance primary care-homecare communication and care provision.

Cervical cancer screening among immigrants, interprovincial migrants, and all other Manitobans.

Presented by: Tracey-Ann Spence-Golaub

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Background and Objectives

Across Canada, cervical cancer screening remains suboptimal in certain populations such as international immigrants. Additionally, persons who have relocated within Canada may also have lower screening uptake. This study will determine the incidence of screening via Pap testing in Manitoba among international immigrants, interprovincial migrants, and all other Manitobans and, determine if refugee status, region of birth or province of origin, and time since migration are associated with screening rates.

Approach

This retrospective cohort study will use data from the Manitoba Centre for Health Policy to determine screening rates among individuals assigned females at birth, aged 21 to 69 years, across two periods: pre-COVID (2017-2019) and COVID (2020-2022). Screening incidence will be calculated for international immigrants, interprovincial migrants, and all other Manitobans. Modified Poisson regression will estimate the relative risks for the association with migration status, refugee status, region of birth or province of origin, and time since immigration, adjusting for confounders. Interaction terms will assess changes in screening rates over the time periods, and sensitivity analyses will evaluate these findings.

Results

Ethics, privacy and data access approvals are ongoing, with analysis projected to begin in March 2025. Screening incidence is expected to be lowest among international immigrants, highest among all other Manitobans, and interprovincial migrants with an incidence in between. Screening incidences are anticipated to be lower in all groups in the 2020-2022 period compared to 2017-2019, with the largest reduction among international immigrants. Within the immigrant group, screening incidence is expected to vary by refugee status and region of birth, while among interprovincial migrants, variation by province of origin is expected. Additionally, screening rates are expected to increase as time since migration increases for both international immigrants and interprovincial migrants.

Conclusion

This study will identify cervical cancer screening gaps among immigrant and migrant populations in Manitoba. It will highlight the need for improved care strategies, supportive policies, and targeted programs to raise awareness, educate patients, and promote regular screening in collaboration with primary care providers and organizations serving immigrant communities.

The Impact of Unattachment Duration: Costs, Healthcare Utilization, and Patient Outcomes.

Presented by: Antoine St-Amant

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Background and Objectives

In the NAPCRG 2024 opening plenary, renowned GP and researcher Iona Heath emphasized the vital role of the patient-provider relationship, referencing a Scandinavian study showing a 25% reduction in mortality with longer attachment. In Canada, rising unattachment rates threaten this relationship, and more patients now face prolonged periods of unattachment. This project quantifies the impact of unattachment duration on healthcare utilization, costs and patient outcomes.

Approach

This project includes two phases that use Ontario's population level health administrative databases. New findings from Phase II of the study will be available for presentation at the CAHSPR 2025 conference. Phase 1, a retrospective cohort study, examined the relationship between attachment status, unattachment duration, and patient demographic and health characteristics with healthcare utilization (ED visits, hospitalizations), and healthcare costs. Phase 2 builds on these findings by refining definitions and new outcomes (granular hospitalization patterns, all-cause and premature mortality).

Results

Phase 1 underscored the significant influence of comorbidities on outcomes related to attachment status and unattachment duration. In terms of costs, highly comorbid attached patients incurred 13-fold higher one-year costs ($3,731 vs. $287) compared to low-comorbidity attached patients. Unattachment further amplified these costs in high-comorbidity groups by 90% ($7,106), with longer unattachment durations adding an additional 15% ($8,177). However, inconsistencies in findings on unattachment duration suggest potential healthy non-user bias. Phase 2 addresses these limitations by using refined attachment definitions, stratifying patients by prior healthcare utilization and adjusted comorbidity categories and conducting sub-analyses for individuals over 65. Time-to-event models will also be used to account for potential survivor bias.

Conclusion

Limited evidence exists on the consequences of unattachment duration for healthcare utilization, costs, and patient outcomes. The Unattachment Duration Project aims to address this gap, providing insights to guide strategies that prioritize unattached individuals and support resource allocation to enhance access to primary care, improve outcomes, and optimize healthcare efficiency.

Impact of billing policy changes on telehealth use in Ontario: a population-based study.

Presented by: Vess Stamenova

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Background and Objectives

Healthcare policy makers have been integrating telehealth into a regularly functioning system, while also adding some restrictions to access related to the modalities (e.g. telephone visits could be reimbursed at lower rates than video) and the requirement of a patient-provider pre-existing in-person relationship. The purpose of this study is to explore how the new policies impacted the levels of use across telehealth modalities and if distinct sociodemographic and chronic condition groups were impacted differently.

Approach

This is a population-based repeated cross-sectional study examining all outpatient visits in Ontario, Canada on a weekly basis from the week of January 1st, 2018 until the week of December 25th, 2023. We used linked health administrative databases of health services provided to all Ontario residents who are insured through the Ontario Health Insurance Plan (OHIP). We examined the total number of visits and the rates of in-person and telehealth visits per 1000 persons per week. We also compared patients with no to low telehealth use (0 to 1 telehealth visits) vs high (2 or more telehealth visits).

Results

Across Ontario, there were 115 046 536 telehealth visits during the study time period (26.4% of all ambulatory care). There was a 6.7% reduction in telehealth use when the new policies were introduced and a 10% reduction in the number of physicians who provided telehealth services. The proportion of video visits was 24.5% in 2023. The impact of the telehealth policy restrictions varied across medical specialties, patient age groups, rurality and chronic conditions, but seemingly not across sex or income quintiles. Patients with higher proportions of telehealth before the new policies were impacted more by the new rules. Patients in the high telehealth user group had higher rates of outpatient visits and ED visits compared to the low user group.

Conclusion

Telehealth reimbursement policies had a significant and immediate impact on the level of telehealth use in Ontario. Future studies should focus on exploring whether there are clear benefits of using video over telephone as the reductions in reimbursements for telephone may be placing certain sociodemographic groups at a disadvantage.

Return on investment (ROI) of Retinopathy Screening and Treatment among uninsured patients

Presented by: Aleksandra Stanimirovic

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Background and Objectives

Compared with Standard screening, Tele-retina program is cost-effective in diagnosing Diabetic Retinopathy among vulnerable populations. Yet, Canadian screening practice falls behind recommended guidelines. Individuals who seek services at Ontario Community Health Centres do not require health insurance to receive care. Objective was to determine ROI associated with implementation of Retinopathy program Screening and Therapy in comparison with no Screening/No Therapy option for Retinopathy for uninsured patient populations in an Ontario Community Centre.

Approach

Undertaken using a payer perspective, this was an extension of previous study-based cost-effectiveness analysis expanded to go beyond just DR screening and include cost of treatment, and aversion of severe vision loss (SVL) and ROI. Data sources for costs were estimated using a cohort of patients that sought DR screening at SRCHC between April 1, 2023, to March 31, 2024, meanwhile consulting published literature and expert opinion. ROI was calculated by subtracting the initial cost of the investment from its final value (gain), then dividing this new number by the cost of the investment.

Results

In a cohort of N=827 patients that sought DR screening at SRCHC between April 1, 2023, to March 31, 2024, by providing screening and treatment we may prevent DR progression to SVL in N=108 individuals (13%). Total annual cost of screening and treatment would be $183,531.90 (low-cost therapy); and $592,011.76 (high-cost therapy). The cost per SVL averted would be: $1,699.37 (low-cost therapy) and $5,481.59 (high-cost therapy). Annual cost with sight loss including loss of well-being would be $5,129,794.8 (per person $47,498.1). By providing screening and treatment, we would gain $4,946,262.9 (low-cost therapy) or $4,537,783.04 (high-cost therapy). We calculated ROI for Screening + low-cost therapy as $26.95 for $1 invested and for Screening + high-cost therapy as $7.66 for $1 invested.

Conclusion

We found that the costs to implement the DR Screening Program at SRCHC alongside (provincial) coverage of subsequent therapy between 2023 and 2024 are outweighed by monetised value associated with benefits of screening and treatment, making a powerful case for the investment in DESP and therapy for uninsured patient populations

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

Presented by: Leah Stephenson

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Background and Objectives

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

Approach

All.Can Canada undertook mixed methods research, including structured literature review, qualitative interviews with cancer survivors, healthcare provider survey, and roundtables with 25 structurally underserved community members, including First Nations and Métis, and their primary healthcare providers.

The objectives were to:

Assess Canada’s current state of cancer diagnoses
Identify outcomes that matter most to patients, including performance indicators
Identify practices in cancer diagnosis that could be adapted, spread and scaled
Understand what works well, enablers, issues, barriers and gaps against identified outcomes
Identify inefficiencies that represent improvement opportunities towards achieving identified outcomes.

Results

ACC developed the “Current State of Cancer Diagnosis in Canada” patient experience map, which illustrates the messy and burdensome experience of cancer diagnosis from the point of symptom presentation, the barriers and harms posed by poor determinants of health, invalidated identities, plus generational, cultural, and geographic factors. Further, ACC detected three different phases within the diagnosis process: suspicion (first interaction with a healthcare provider due to symptoms until first referral for investigation), investigation (visits and testing to rule out/diagnose a possible cancer), and diagnosis (arrival at a cancer facility/team to a clinical diagnosis, staging, and therapeutic options). ACC also learned the seven outcomes patients are trying to achieve during diagnosis, and what an optimized, equitable “Future State of Cancer Diagnosis in Canada” should be.

Conclusion

ACC will share the challenges to equitable and swift cancer diagnoses; outcomes patients want to achieve; what an equitable future state comprises; evaluated practices; and metrics to assess progress. Through guided dialogue, participants will explore how the findings relate to their work and opportunities to contribute towards improvement.

A Proof of Concept Evaluation of CRAFT: an Interview Study

Presented by: Stephen Sundquist

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Background and Objectives

In 2021-23, the Canadian Remote Access Framework for clinical Trials (CRAFT) was implemented in oncology as a proof of concept to reduce geographic inequities by bringing trial opportunities closer to where patients live. The CRAFT hybrid decentralized clinical trial (DCT) model involves delegation of designated activities by a "primary" site to regional "satellite" centres to form a "trial cluster". This study evaluates proof of concept implementation in British Columbia, Ontario, and Newfoundland and Labrador

Approach

Participants were clinicians and healthcare professionals participating in the proof of concept at primary and satellites locations. Potential participants (n=26) were identified by the Canadian Cancer Clinical Trials Network and shared with the evaluation team. Interviews were digitally recorded, transcribed, and organized in NVivo. A coding framework was developed incorporating both a priori categories from the interview script and new trends detected in the data. The principles of constant comparison were applied to test the reliability of the coding framework. CB coded all transcripts; HMC independently coded one-third of the transcripts. Discrepancies between coders were resolved through discussion and consensus.

Results

Thirteen one-on-one telephone interviews were conducted with participants from British Columbia (n=4), Ontario (n=6), and Newfoundland (n=3). Participants were from primary sites in all three provinces; however, not all satellites were represented in the study. Participants endorsed CRAFT as means to increase equitable access to experimental therapies for underserved populations; upskill regional healthcare teams and integrate smaller hospitals with primary sites; and re-envision the future of trial delivery as decentralized. Challenges to CRAFT implementation centred around linkage between sites, including i) identifying the steps and personnel responsible for contract review and approvals at smaller centres not oriented to clinical research; ii) coordinating research services and senior management across sites and health authorities; and iii) research ethics boards' unfamiliarity with trial cluster organization.

Conclusion

Participants endorsed CRAFT as a feasible means to reduce geographical disparities in access to clinical trials for Canadians and grow research capacity. A planned stakeholder workshop will address the need for improved intra- and inter-provincial research infrastructure to support scaling CRAFT to additional centres across Canada.

Health System Documentation of Transportation Barriers for Children Living with Sickle Cell Disease

Presented by: Jennylee Swallow

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Background and Objectives

Barriers to incorporating social needs into electronic health records (EHR) have limited the ability to identify patients who could benefit from social needs assistance. Marginalized populations often experience higher rates of unmet social needs and are disproportionately impacted by sickle cell disease (SCD), a complex genetic disorder requiring frequent healthcare encounters, which is challenging for patients experiencing transportation barriers to manage symptoms. This study examines transportation-related EHR documentation by providers for patients living with SCD.

Approach

We conducted a retrospective chart review of EHR data from 2022-2023 at a large academic medical center in Michigan. Pre-existing lists of pediatric patients (<25 years) with SCD were used to establish the study population. We searched the study populations' EHR for Transportation Insecurity ICD-10 Z-code (Z59.82). Next, we developed a 62-item list of terms related to transportation based on previous literature and utilized an EHR search engine (Electronic Medical Records Search Engine (EMERSE)) to find terms within medical notes. We extracted and analyzed transportation-related documentation and the provider type who made the documentation (e.g., hematologist, nurse practitioner, social worker).

Results

The study included 123 pediatric patients living with SCD receiving care at a large academic medical center in Michigan. The population had a mean age of 11.9 (std=6.8), 46% were female, and 89% were Black. We hypothesized that a significant proportion of patients have transportation barriers; however, using only z-codes, we discovered only 5% of patients showed a need. By expanding our search using EMERSE, 52% (64/123) of the study population had at least one transportation-related documentation (facilitator or barrier) within their medical notes, representing a much more powerful and comprehensive tool for detecting social barriers than Z-codes alone. Documentation most commonly reported a transportation barrier (e.g., lack of personal transportation, gas card request, scheduling Medicaid transportation) and was most frequently documented by social workers.

Conclusion

Our findings illustrate that location and documentation style differences for transportation-related data create a systematic barrier to patients' needs being visible to providers. Promoting accessible transportation data in the EHR would help connect patients living with SCD to reliable transportation for medical appointments and reduce complications resulting from delayed care.

Cannabis Use in a National Sample of Canadian Correctional Service Workers

Presented by: Tamara Taillieu

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Background and Objectives

Correctional workers (CWs) experience high levels of traumatic event exposures, occupational stress, and mental health difficulties; factors that have been associated with cannabis use in extant research. However, research on cannabis use among CWs remains virtually unexplored to date. The primary objectives of the current national study were to examine the association of sociodemographic characteristics, mental health comorbidities, and other risk factors with past 6-month cannabis use among provincial and territorial CWs in Canada.

Approach

Data stem from the Canadian Provincial and Territorial Correctional Worker Mental Health and Well-Being Study (CWMH). The CWMH is a multi-year study using an online survey that collected data from correctional service organizations across Canada's 13 provinces and territories. Data from CWs (n = 2,733) responding to the cannabis use section were analyzed. Descriptive statistics were used to examine the prevalence and characteristics of self-reported past 6-month use, including provincial and territorial differences. Logistic regression modelling was used to examine associations between sociodemographic covariates, mental health comorbidities, and risk factors related to self-reported past 6-month cannabis use among CWs.

Results

In this sample, 26.0% of CWs reported using cannabis in the past 6 months. Among cannabis users, 27.9% reported using cannabis 4 or more times per week. The prevalence of past 6-month cannabis use ranged from 16.1% (Quebec) to 50.0% (Northwest Territories), with significant differences noted across Canadian provinces/territories. Screening positive for different mental health disorders was strongly associated with past 6-month cannabis use (odds ratios [OR] ranged from 1.55 to 3.53, all p < .001). Total number of adverse childhood experiences, total number of different lifetime trauma exposures, and mean level of organizational and operational stress were associated with significantly increased the odds of past 6-month cannabis use (OR ranged from 1.05 to 1,19, all p < .01).

Conclusion

The strong association between mental disorders, traumatic exposures, and occupational stress and cannabis use suggests that CWs may represent a population that would benefit from additional treatment services and supports. These findings will help inform prevention and intervention strategies aimed at improving CW health and well-being.

Effectiveness of interventions and policies that enable home visits delivery: a systematic review

Presented by: Sabah Tasnim

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Background and Objectives

Though a historically common practice, the provision of home visits have declined in recent years as fewer physicians and nurse practitioners (NPs) now deliver this service. Certain interventions and policies have been tested to facilitate home visits delivery, though their effectiveness remains unclear. We conducted a systematic review to assess the effectiveness of interventions and policies on the increased provision of home visits delivered by physicians and NPs when compared to usual practice.

Approach

We searched seven electronic databases (Medline, Embase, APA PsycINFO, CINAHL, AgeLine, CENTRAL, and Scopus) in June 2024. We included randomized controlled trials (RCTs) and quasi-experimental studies that recruited family physicians, palliative care physicians, geriatricians, NPs, medical students, and NP students. We completed screening and data extraction in duplicate. We used the Cochrane Risk of Bias 2 tool and the Newcastle Ottawa Scale to assess risk of bias in RCTs and quasi-experimental studies, respectively. We used the Behavior Change Wheel (BCW) and its broad intervention and policy functions as the underlying framework to categorize interventions described in included studies.

Results

We screened 5725 titles and abstracts and assessed 140 full texts. We identified 16 relevant studies. Most studies were conducted in Europe (n=14) and utilized quasi-experimental designs (n=13). All studies focused on interventions and policies designed for physicians. All study interventions contained more than one intervention or policy function outlined in the BCW including: environmental restructuring, fiscal, regulation, training, education, incentivization, and legislation. Education and training programs that enhanced physicians' knowledge and capability significantly increased the provision of home visits. However, interventions that either entailed role substitution and task delegation to NPs to address high workload or fee incentives did not exhibit significant effect on physician home visits delivery. Policy reforms, including physician teams, reduced home visit delivery but increased telephone consultations.

Conclusion

Some interventions were unable to increase home visit delivery but preserved existing levels despite an overall decline. Our findings suggest that there is no standalone solution; rather multiple targeted strategies are required to address various barriers. Prioritizing providers' education and training and supporting independent practice models for NPs is key.

Interpretation and Use of Quality Indicators by Health System Decision Makers: A Scoping Review

Presented by: Kaitlyn Tate

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Background and Objectives

While the identification and prioritization of quality indicators (QIs) are discussed in the literature, there is a lack of clarity around how these indicators are interpreted and applied to healthcare delivery systems beyond public reporting measures. This is important to ensure that the information obtained is valid, relevant, feasible, and clinically meaningful. Our study aimed to explore how health system decision-makers interpret and utilize quality indicators to inform decisions regarding healthcare delivery.

Approach

We conducted a scoping review, searching 5 databases and including academic literature focusing on the interpretation, use, application, or implementation of QIs in decision-making in healthcare settings where direct-patient care is provided, at the macro or meso levels. Articles in English, Portuguese, or Spanish were included. Two reviewers independently screened titles/abstracts and full texts. One reviewer extracted the data and the other validated the extraction. We collated findings based on a) types of quality indicators, b) quality indicator method of development, and c) strategies or approaches decision-makers implemented to utilize & interpret quality indicators.

Results

Out of 10,542 articles retrieved, we screened 7,968 based on their titles and abstracts, reviewed 89 full texts, & included 19 for data extraction. Our analysis is ongoing. Preliminary results follow next. The main types of QIs identified were quality of care assessment activities, performance monitoring, patient-reported outcomes, and employment satisfaction. Most QIs were developed using existing health service statistics, standard guidelines, or stakeholder input. Approaches to interpreting and utilizing QIs included use of satisfaction surveys, performance frameworks, automated reporting/feedback systems, visualizations (e.g., charts, booklets, color-coded target system, online access, linking quality indicators to incentives), disseminating findings to the public and stakeholders, routine data monitoring, and systematic use for identifying best practices, setting priorities, funding allocations, as well as organizing organizing training courses.

Conclusion

There is a critical need for theory-driven research that develops and evaluates strategies to guide how quality indicators can and should be interpreted and applied to inform changes in practice and policy.

Patient Engagement in Economic Evaluations of Cancer Care: Advancing Practices Beyond Tokenism

Presented by: Kednapa Thavorn

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Background and Objectives

Patient and public involvement in health technology assessment (HTA) has grown significantly over the past two decades. Despite its importance, there is limited practical guidance on when and how to meaningfully engage patients in all aspects of economic evaluations, from project design to implementation. This study examines the extent and methods of patient engagement in economic evaluations of cancer care and offers recommendations for improvement in line with Canada's Strategy for Patient-Oriented Research (SPOR).

Approach

We define patients as individuals with personal health experiences or informal caregivers as per the SPOR’s patient engagement framework. A scoping review of peer-reviewed and grey literature was conducted to assess the extent of patient engagement in economic evaluations involving people affected by cancer. We distributed an online survey to corresponding authors of studies included for full-text review to supplement the findings and gather additional insights into patient engagement practices. For studies reporting patient engagement, we will invite study authors and patient partners to participate in semi-structured interviews to explore processes, barriers, and facilitators to engagement.

Results

Targeted literature searches across 32 top-tier international journals in health economics, oncology, and patient engagement identified 4,981 records, with 452 eligible for full-text review. Among these, 15 studies reported engaging patients in economic evaluations and were included in a narrative synthesis. Authors of these studies will be invited to interviews. Results of the online survey will also be used to identify further interview participants. Full findings will be presented at the conference.

Conclusion

This study highlights gaps in engaging people affected by cancer in economic evaluations and provides actionable recommendations to address barriers and foster meaningful patient involvement in future economic evaluations.

Opportunities to reduce administrative and technology burden and support administrative staff

Presented by: Rachel Thelen

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Background and Objectives

While administrative burden in primary care is receiving widespread attention, solutions (e.g., technologies, shifting team members responsible) may not be getting at root problems faced by administrative staff and could be unintentionally creating more work. As part of a mixed-methods research project, we brought together experts in technology in practice and primary care administration to confirm issues identified in research and hear practical response strategies to make administrative work more efficient.

Approach

We held four 60-minute expert dialogues on Zoom in October 2024, each with 4-9 clinical, administrative, policy, and service planning leaders in Nova Scotia (21 participants total). Sessions surrounded one of two topics (technology in practice, or training, resources, and support for administrative staff) guided by topic-specific discussion questions about opportunities and requirements for action. Discussion topics and questions were informed by prior qualitative interviews with family physicians, nurse practitioners, and administrative staff in the overarching study. We synthesized notes from all dialogues to identify common themes and shared summaries and outstanding questions with participants.

Results

To improve technology in practice, participants emphasized including primary care end users in technology development and implementation, addressing double work created by the co-existing use of paper and electronic administrative processes, resolving lack of technology integration, attention to unique clinical contexts, needs, and relationships, addressing data access differences among team and patients, and increasing accessible technology training and support informed by primary care expertise. Supporting administrative staff requires expanding content and time for administrative staff training (in post-secondary education or on the job) and improving administrative role clarity and experience compared to clinician counterparts (e.g., salary, classification, education days, inclusion in team meetings, performance assessments).

Conclusion

Primary care experts with varied perspectives confirmed priority issues with technology in practice and training, resources, and support for administrative staff and shared practical responses. Solutions are complex and require coordinated action for government, educational institutions, technology companies, and individual clinics to reduce administrative burden and support administrative staff.

What characteristics are needed for effective interdisciplinary teams in rheumatology care?

Presented by: Daphne To

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on behalf of the Canadian Rheumatology Implementation Science Team (CAN-RIST)

Background and Objectives

Rheumatologists manage complex chronic, disabling conditions involving bones, muscles, and joints. The rising prevalence of these conditions exceeds the rheumatology workforce supply, limiting access to care, resulting in significant patient and health system impacts. Interdisciplinary teams hold promise to improve care capacity and quality, but there is low adoption in community-based rheumatology practices. To inform implementation efforts, our objective was to explore rheumatology health professionals' perspectives of characteristics required for effective interdisciplinary care.

Approach

This qualitative descriptive study involved a secondary analysis of semi-structured interviews with 11 health professionals (HPs), including rheumatologists and interdisciplinary health professionals (IHPs) such as physical therapists, occupational therapists, and pharmacists with experience working within an interdisciplinary rheumatology care team in Newmarket, Ontario (Centre of Arthritis Excellence). Participants were asked about the factors necessary for optimal team function and for implementing this model of care in new sites. We used thematic analysis to generate codes and develop themes from the transcripts, with input from our multidisciplinary research team.

Results

We constructed three themes: (1) Importance of program infrastructure; (2) Key HP qualities (subthemes: rheumatology preparedness and the team player); and (3) Synergy of complementary skillsets. Participants emphasised the importance of sufficient infrastructure to support team functioning, through shared workspaces, integrated electronic medical records, and competitive compensation. Rheumatology-specific training was viewed as a critical enabler for IHPs participating in interdisciplinary care. Attitudes and attributes for effective teamwork such as trust, adaptability, and openness to feedback were seen as important characteristics of HPs. Participants saw the value of using their complementary skillsets to enhance patient care (perceived improved clinical outcomes and patient experience) and their own professional well-being. This synergy, in turn, enables ongoing motivation for team members to develop the key HP qualities identified.

Conclusion

Interdisciplinary care may be optimised when teams have appropriate program infrastructure, IHPs are supported with rheumatology-specific training, and HPs share personal attributes that support effective teamwork. Our findings inform the structuring of community-based interdisciplinary rheumatology care teams, which have potential to improve care access and quality.

Accelerating Integrated Care Through Collective Impact: The THINC-NICE Knowledge Mobilization Hub

Presented by: Sylvia Urbanik

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Background and Objectives

The Network for Integrated Care Excellence (NICE) is a first-of-its-kind collective impact knowledge mobilization hub within CIHR's Transforming Health with Integrated Care (THINC) initiative. The THINC-NICE hub connects research teams, healthcare providers, decision-makers, and community partners across Canada to amplify evidence, foster shared learning, and accelerate integrated care implementation. This presentation will describe how the hub is building a pan-Canadian approach to knowledge mobilization for integrated care transformation.

Approach

THINC-NICE's approach centers on accelerating the implementation of evidence-informed integrated care by building connections across Canada's healthcare landscape through six interconnected elements: (1) cultivating a pan-Canadian learning community, (2) engaging diverse stakeholders, (3) developing practical skills and capacity, (4) supporting evidence-informed decision making through knowledge mobilization, (5) measuring collective impact, and (6) ensuring effective governance. These elements create structured pathways for knowledge-to-action by engaging integrated care stakeholders through virtual and in-person events, online collaborative spaces, and targeted resources to accelerate the uptake of evidence into practice.

Results

This presentation will demonstrate how NICE is implementing a pan-Canadian approach to knowledge mobilization for integrated care transformation. The hub connects 13 Implementation Science Teams through structured knowledge exchange activities, including virtual and in-person meetings, learning series, and communities of practice, while drawing on international expertise through its partnership with the International Foundation for Integrated Care. We will describe how NICE creates pathways for meaningful collaboration between researchers, practitioners, decision makers, and people with lived experience. The session will illustrate how these coordinated approaches to knowledge mobilization are building system capacity and accelerating implementation of evidence-informed integrated care across Canada.

Conclusion

NICE demonstrates how structured approaches to knowledge mobilization can drive systems-level transformation in healthcare delivery. This examination of early implementation provides insights into building effective pathways between research, policy, and practice to advance integrated care across Canada.

Defining the Black population in Canadian health research: A scoping review

Presented by: Marie Claire Uwamahoro

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Background and Objectives

The lack of consistent definitions, labels, and classifications of the Black population in Canadian health research raises an important question: Who is considered Black? This inconsistency can unintentionally hinder the comparability and effectiveness of studies. This scoping review examines how the Black population is defined and represented in Canadian health research.

Approach

A scoping review was conducted based on the methodology of Arksey and O'Malley. Academic databases and grey literature, including MEDLINE (Ovid), PsycINFO, EMBASE, PubMed, CINAHL, Scopus, ProQuest, OAISter and others, were searched until November 2023. Studies were included if they were conducted in Canada, reported race or ethnicity-specific outcomes, and focused on health. Two reviewers independently screened titles, abstracts and full texts for inclusion and extracted data using Covidence software. An inductive approach to data analysis was taken by conducting the reflective thematic analysis.

Results

A total of 11,935 records were retrieved and 517 were included. Most records are from Ontario and are focused on clinical. We grouped terminologies in core terms while also listing their connected labels. The core terms are broader categories like Black (e.g., Black/black, Black Canadian/American); African (e.g., African American); Caribbean, African, Caribbean and Black (ACB), BIPOC-Black, West Indian, Negroe, Nova Scotian and references to Africa regions (e.g., East-African). In addition, descriptors such as individual, population, people, community were used alongside these terminologies. Only nine records explicitly defined the terms used, yet these terms varied in meaning across studies. 46% allowed participants to self-identify, and the majority (53%) did not define the terminology. It was observed that terminologies were defined based on the flawed foundation rooted in colonial ideologies of race, slavery trajectory and immigration.

Conclusion

Inconsistencies of the terminology used to describe the Black population in health research can create several problems: ambiguity, where similar terms can refer to different concepts; reliance on assumptions that may introduce selection and systemic bias; a lack of community involvement; the potential for intentional discrimination; confusion between ethnicity and race; and inaccurate policy recommendations.

Collaborating During Crisis: Experiences of Interprofessional Practice During the COVID-19 Pandemic

Presented by: Lindsay Van Dam

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Background and Objectives

Ensuring effective collaboration between professionals is essential to meet population health needs during pandemic crises. Interprofessional education for collaborative practice (IPECP) during students' pre-licensure education is an important primer for collaborative practice and supports interprofessional identity development. However few studies have followed students longitudinally into practice to understand how IPECP supports readiness for collaborative practice. This study sought to understand how interprofessional socialization was experienced by new healthcare professionals during the COVID-19 pandemic.

Approach

A narrative approach guided by philosophical and theoretical tenets of interpretivism and hermeneutics was used to understand the influence and contributions of pandemic events, contexts and practice settings on interprofessional collaboration and identity development.

Semi-structured interviews guided by narrative identity theory were conducted with a sample of 24 healthcare professionals from five health professions (dentistry, medicine, nursing, pharmacy and physiotherapy) who were educated together within IPECP, and who participated in a longitudinal study on professional socialization during their pre-licensure education. Interview coincided with the timing of the global outbreak of the COVID-19 pandemic.

Results

The pandemic was identified as a key 'critical incident' that set a unique stage for collaboration and teamwork. The COVID crisis was a catalyst for team formation, and enhanced new professionals' understanding and value of collaboration. Exposure to teams within the context of constrained resources/settings enabled meaningful socialization between professionals. Complex and urgent patient care scenarios were found to repress professional hierarches. Routinely working alongside others and experiencing collaborative behaviours during challenging events enhanced team commitment. Practicing professionals found solutions to overcome barriers to interprofessional collaboration and pandemic contexts facilitated the creation of innovative interprofessional practice spaces and teams. Interprofessional collaboration was facilitated in this study by exposure to crisis scenarios and settings of the pandemic.

Conclusion

Repeated exposure to interprofessional teamwork across diverse settings/scenarios is needed for practitioners to develop skills, attitudes and behaviours for collaboration and an interprofessional identity. Engaging healthcare students early in their education in IPECP and as professionals in practice can support developing resilient, collaborative healthcare teams/systems in future crises.

The Use of Surgical Wait Time Information by Physicians

Presented by: Olivia Varkul

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Background and Objectives

The Ontario Wait Time Information System (WTIS) is a publicly accessible database that provides wait time data for most surgical procedures in Ontario. The goal of the WTIS is to promote the transparency of surgical wait time data. Despite its availability, the utilization of wait time data remains unclear. This study aims to assess how primary care physicians in Ontario use the WTIS, to understand how wait time information is understood and disseminated.

Approach

We invited 1306 primary care physicians affiliated with the Seamless Care Optimizing the Patient Experience (SCOPE) program to complete a short online survey about factors influencing surgical referrals, family physicians' awareness of WTIS, and their willingness to participate in single-entry referral models. Descriptive statistics and frequencies were collected from the preliminary data.

Results

151 family physicians completed the survey. Participants reported that hospital or office location (96.0%, n=109) and prior experience with a hospital or specialist (95.0%, n=108) were key factors in referral decisions. Yet, when presented with specific referral scenarios—such as gynecological, general surgery, and orthopedic cases—the approximate wait time for appointments was the most critical consideration. 90.9% (95% CI, 84.1% to 95.0%) of participants reported that they have never accessed the WTIS. However, 87.5% (95% CI, 79.4% to 92.7%) of participants specified that WTIS information on hospital wait times would impact their referral decisions. In instances of long wait times, 97.2% of physicians indicated that they would be willing to refer their patients to a single-entry program for surgery (95% CI, 92.1% to 99.0%).

Conclusion

Further efforts are necessary to raise awareness of the WTIS among family physicians in Ontario. Providing data on surgeon-specific wait times could enhance the usefulness of this publicly accessible resource, better aligning it with existing referral practices.

Equity-focused evaluation of expanded blood donation eligibility among 2SLGBTQIA+ communities

Presented by: Elisabeth Vesnaver

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Background and Objectives

Canada introduced new policies that expanded blood donation eligibility among 2SLGBTQIA+ communities. To understand impact of inclusion efforts, there is a need to consider implementation outcomes with an equity lens. Guided by the conceptual framework of Equity-focused Implementation Research (EquIR), this study aimed to explore the acceptability and appropriateness of the policy's implementation among impacted communities.

Approach

This project is supported by partnerships with people with lived experience of blood donation after exclusion and with the blood operator. N=12 newly eligible blood donors were interviewed about their experience of blood donation and opportunities to improve inclusion. Thematic inductively generated themes were mapped to the Theoretical Framework of Acceptability. Themes related to fit among 2SLGBTQIA+ communities were used to understand appropriateness. N=3 non-donors, who were excluded by prior criteria, participated in a focus group to discuss how opportunities to improve inclusion prioritized by donors would be received by broader impacted communities who remain ineligible.

Results

Acceptability: Dissemination of the new policy was viewed as insufficient, negatively impacting the effectiveness of the policy. Donors largely reported positive donation experiences. Appropriateness: Lack of community outreach about the implementation led some donors to question the organization’s commitment to inclusion. Some did not feel sufficiently psychologically safe to disclose their previous exclusion and aspects of their identity. Others initiated conversations about the change with staff which led to expressions of acceptance, creating safety. The onus was borne by impacted communities to learn about the change, create opportunities for authentic exchange with staff, and initiate efforts to feel safer in a space long closed to them. Increased dissemination of the new policy should clearly explain eligibility and targeted messaging for community members who remain ineligible.

Conclusion

Equity-focused evaluation of implementation can surface opportunities to enhance policy impact. Improved communication of the policy may increase awareness among newly eligible prospective donors while improving the donor experience by increasing the perception of institutional welcome. Highly interested members of impacted communities who remain ineligible need separate consideration.

Evaluating Primary Care Opioid Agonist Therapy Programs in Winnipeg, Manitoba: A Mixed Methods Study

Presented by: Jenna Villarba

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Background and Objectives

The opioid crisis is a significant public health concern in Canada. While Opioid Agonist Therapy (OAT) is a first-line treatment for Opioid Use Disorder (OUD), many barriers to accessing this therapy exist. To address this, OAT programs have extended into primary care settings in Manitoba. This project will evaluate OAT programs in primary care settings across Winnipeg, identifying barriers, facilitators, and ideal models of care from the perspectives of providers, administrators, and patients.

Approach

This study will use a sequential mixed methods evaluation design. In Phase 1, we will survey administrators and physician/nurse practitioner prescribers to assess and quantify barriers to providing OAT. In Phase 2, follow-up interviews will be conducted to understand survey findings more richly. In Phase 3, we will collaborate with People with Lived/Living Experience of OUD (PWLE) to co-design a study interviewing individuals who have accessed OAT in Winnipeg. Interviews will explore components of OAT programs that support holistic, person-centred care. Results for all phases will be integrated within an implementation mapping approach to develop a structured implementation plan.

Results

Phase 1 and co-design sessions with PWLE have been completed. Preliminary findings suggest limited resources, support, and training hinder OAT provision in primary care settings. While stigma was not perceived as a barrier to providing care, co-design sessions with PWLE emphasized stigma as a critical priority for improving experiences for people with OUD. PWLE also highlighted the need for patient-centred, trauma-informed care, where current practices may benefit from the consideration of individual challenges and lived experiences. Evaluating both provider and PWLE perspectives will reveal opportunities to bridge gaps and improve alignment between OAT practices and community needs. These insights will guide the development of recommendations for OAT programs in Winnipeg, where implementation strategies may be adapted and contextualized for specific practice sites.

Conclusion

Findings across study phases will be integrated to inform interventions that support improved access and quality of care for people with OUD. This transformative approach will lay the foundation for implementing effective, meaningful strategies to drive change, address inequities, and support community empowerment for people with OUD.

Healthcare navigation experiences: A scoping review

Presented by: Anh Thu (Theresa) Vo

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Background and Objectives

USA and countries with the universal healthcare system have suffered from 'siloes syndrome'. Delivery of care is managed in uncoordinated settings with ineffective interprofessional communication. Patients and their caregivers often struggle to navigate the system themselves. They need to enhance skillsets in navigating a such health system, but a knowledge synthesis of patients' experiences in the navigation process is limited. This scoping review aims to explore navigational health system experiences among patients in these countries.

Approach

This scoping review examined patient experiences navigating healthcare system in the USA and countries with universal healthcare. Guided by Arksey and O'Malley framework and the PRISMA checklist, the search process was performed using electronic databases using terms like "healthcare navigation" and "literacy". English language articles from January 2013 to September 2024 that focused on adult patients and caregivers were included. Title and abstract screening were supported by the ASREVIEW LAB, followed by full-text screening and data extraction by two independent reviewers. The framework by Griese et al. (2020) was used to analyse patients' experiences in navigating the healthcare system.

Results

Eligible studies (n=164) were included. Experiences in navigating healthcare system were examined at system (n=90), organizational (n=113), and interactional (n=78) level. Most system-level challenges related to understanding the healthcare system and its operation (n=69) and issues on healthcare cost and coverage (n=29). Patients experienced a broad range of organizational-level challenges from unawareness of regulations (n=35), scheduling (n=22) to locating their way within the setting (n=51), navigating healthcare services (n=14) and administrative process (n=6), and accessing support programs (n=34). Interaction-level experiences were mixed, with many studies identified competent abilities to negotiate with healthcare providers or self-advocate (n=30) while others found struggles in communication and interactions with the providers (n=49). The review revealed a recognized need for improving communication and self-advocate skills (n=11).

Conclusion

Patients and their caregivers in the USA and countries with universal healthcare struggles to understand the system, navigate process and services, as well as negotiate and self-advocate. This highlights a need for user-friendly policies, education programs, and navigation services to support patients.

Exploring Hong Kong newcomer post-secondary students’ mental health and supports in Ottawa-Gatineau

Presented by: Abraham King Kwok Wan

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Background and Objectives

Research shows that newcomers to Canada tend to find the immigration experience difficult and often experience mental health challenges. Yet they are reluctant to seek mental health support and services due to various reasons. Following an influx to Canada of Hong Kong newcomers facing unique challenges, this study aims to explore perceptions of Hong Kong newcomer post-secondary students of their mental health, of services and supports in Ottawa-Gatineau, and their recommendations for improvement.

Approach

This qualitative research is being conducted through semi-structured interviews with Hong Kong newcomer post-secondary students. The transcripts are analyzed using NVivo and Braun and Clarke's (2006) six-step thematic analysis process. This involves transcribing data, generating codes, and searching, reviewing and defining relevant themes. 'Factors influencing the service encounter' from Luiking et al.’s Immigrant Health Service Utilization framework (2019) and 'General and Immigrant-specific factors' from Yang & Hwang’s Migrant Patients’ Health Care Experience framework (2016) are used to inform the analysis. To enhance credibility, the following steps are adopted: generating rich descriptions, clarifying researcher bias and seeking member checks on analysis.

Results

Analysis is currently ongoing. Findings so far show political turmoil, better work-life balance and existing Canadian social connections as common immigration reasons. When unexpected challenges such as loneliness, study fatigue and language barriers appeared, participants’ mental wellness declined. Participants cite language differences, cultural barriers, lack of awareness of available services, personal privacy, excessive wait times and fear of stigma as reasons for their reluctance in seeking formal mental healthcare. Participants used several strategies to substitute formal help and reduce mental unwellness, including exploring their new surroundings, selectively talking to family members and friends in their social network, and exercising. Participants suggested Ottawa-Gatineau’s mental healthcare system could advertise mental services on syllabuses and social media, provide urgent services and hire ethically diverse staff to encourage help-seekers.

Conclusion

This study identified declining mental health of Hong Kong newcomer post-secondary students and reluctance in seeking mental help. Some alternatives were also named by participants. We hope these results can stimulate further research and discussions to improve the mental healthcare experiences for Hong Kong and other newcomer post-secondary students.

Localized Physician Retirement Risk in Ontario: An Exploratory Cross-Sectional Geospatial Study

Presented by: Abraham Wan

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Background and Objectives

More than 2.5 million Ontarians do not have a family physician, which reduces their ability to receive due medical care and referrals. As Ontario's physician workforce ages, this situation could worsen. To better understand these risks, this exploratory study examined the distribution and demographics of Ontario's family physicians, with the goal of identifying and locating family physicians who are at risk of retirement, and communities at risk of losing access to family medicine services.

Approach

Using public data from the Government of Ontario, Statistics Canada and the College of Physicians and Surgeons of Ontario, we conducted a descriptive cross-sectional geospatial analysis to determine family physician counts, demographics, and estimated retirement risks across Ontario. After reviewing physician career lengths, we deemed physicians who obtained their medical licenses 30 years ago or more as having higher risks of retirement. We separately grouped the English-speaking family physicians and the French-speaking family physicians by their geographical census subdivisions (CSDs, corresponding roughly to municipalities), and investigated the regional distribution and percentage of family physicians who are at risk of retiring.

Results

Our data set included 14,754 family physicians, of whom 1,678 of whom spoke French. Overall, we found that 33.54% of family physicians and 34.27% of French-speaking family physicians were at a higher risk of retirement. Most family physicians were concentrated around urban areas. However, when results were examined by geographic distribution, we found many rural areas (especially Northern Ontario) with high risks for physician retirement, such as Algoma (North) and Sioux Narrows-Nestor Falls. The French-speaking family physician patterns were found to be similar to the general family physician patterns. We also found some extremely high-risk regions where all family physicians were at high risk of retiring, including regions where all French-speaking family physicians were at high risk of retiring.

Conclusion

We found regions of Ontario where many English-speaking and French-speaking family physicians are nearing retirement. Without adequate numbers of new physicians entering these regions, patients may lose access to primary care and to language-concordant care. With both a repeatable methodology and results, this will serve as a stepping stone towards future research.

Building capacity across Canada to support data access for multi-regional research

Presented by: Carrie-Anne Whyte

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Background and Objectives

Health Data Research Network Canada (HDRN Canada) is a network of member organizations that work to develop and improve services and supports for multi-regional data access. Among these services is the Data Access Support Hub (DASH) which facilitates data access for multi-regional research. Several successes and opportunities have emerged around data access from the collaboration of members across the network. As the network's learnings continue to grow, the greater potential for influence and problem-solving.

Approach

HDRN Canada's network of provincial/territorial and pan-Canadian member organizations have collaborated over the past five years to facilitate access to multi-regional administrative health data in Canada. The network facilitates knowledge sharing and collaboration that have helped improve understanding of the unique variations in data access across Canada. This includes variations in data access policies and procedures, forms and resources, methodologies and available services. The exchange of information, resources and connections between individuals and provincial/territorial data systems has led to increased harmonization and efficiency and supported capacity building across the network.

Results

The network has experienced numerous successes and opportunities over its lifecycle and has streamlined and harmonized processes for data access for multi-regional research. Some critical achievements include understanding and mapping local processes through data centre consultations and meetings, implementing service level agreements to improve timelines and efficiency, and more recently, developing and piloting new analytical methods (i.e. distributed analytics) to support researchers with multi-regional research (and in some scenarios, where limitations around moving data across provincial/territorial boundaries occur). As the network evolves, improvements in data access processes and capacity will continue to be observed across the country. The network is currently working on enhancing its centralized forms with the user experience in mind and developing new tools and technologies to support multi-regional research.

Conclusion

HDRN Canada is integral in streamlining the process for requesting data from multiple provinces/territories across the country. Through its pan-Canadian members and partnerships, the network facilitates collaboration, resource sharing, information access, and transformative multi-regional health data use for researchers, with opportunities to advance data access within the health ecosystem.

Equity of financial protection for health in high-income countries: a scoping review

Presented by: Edward Xie

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Background and Objectives

Despite being an ultimate goal of health systems, and abundant research in low and middle-income countries, little is known about the equity of financial protection in high-income settings. Financial protection is the mechanism for enhancing equitable access to healthcare without financial hardship underlying recent expansions of pharmaceutical and dental care coverage in Canada. We aim to synthesize evidence on the distribution of financial protection in high-income countries and how equity is characterized.

Approach

We are conducting a scoping review following Colquhoun et al (2014) and the PRISMA-ScR checklist. Our search strategy was iteratively developed and validated with the assistance of research librarians. We searched academic databases (Embase, MEDLINE, IBSS, EconLit) and grey literature sources (WHO, OECD, World Bank) for four main outcomes: variables used to characterize equity, financial protection indicators, measured distribution of financial protection, and value judgements regarding equity. Selection criteria included original research published in any language since 2010. Two reviewers independently assessed records for eligibility. Our protocol has been published: 10.1136/bmjopen-2023-081029. We anticipate completing data tabulation and thematic analysis by March 2025.

Results

We included 77 records selected from 4162 search results. Preliminary findings from 30 completed extractions include evidence from 46 countries. The variables most commonly used to disaggregate financial protection were income or consumption (23/30), age (9/30), sex or gender (8/30), and health status (7/30). Education and employment were more often used as controls than distributional dimensions. Financial protection indicators included diverse variants of out-of-pocket spending and measures of unmet needs. Inequality favouring advantaged groups was found for most variables in nearly all settings (59/70 analyses). Fewer than half of studies explicitly invoked a framework, set of principles, or value judgements to conceptualize equity (14/30). No theories of social justice were mentioned. Emergent themes include challenges with delineating health needs and necessary services as well as inconsistent, implicit or absent accounts of equity.

Conclusion

Our review advances knowledge about health system equity and financial protection. Conclusions will be formulated after data extraction is complete. Our findings can inform health coverage policies and the elimination of inequitable barriers to services, with relevance for program design and evaluation in Canada and other high-income contexts.

Bridging Perspectives: Key Stakeholder Insights into AI Adoption in Canadian Healthcare

Presented by: Barry Xu

Author(s): *Barry Xu, Manager, Data Science & Analytics, Performance, Canada Health Infoway*

Background and Objectives

Artificial intelligence (AI) has the potential to transform healthcare, but successful adoption hinges on addressing the underexplored perspectives and priorities of key stakeholders across Canada. This study analyzes survey data from Canada Health Infoway (Infoway) to examine clinicians' (physicians and nurses) AI adoption rates, knowledge level, and perceived priorities for supporting AI use in clinical practice. The findings aim to inform policy and regulatory efforts to support effective AI integration in Canadian healthcare.

Approach

This study used descriptive analysis of data from two national web-based surveys conducted through non-probability sampling, with weighting applied to enhance representativeness. The 2024 National Survey of Canadian Physicians included 1,145 respondents: 559 general practitioners/family physicians, 531 specialists, and 55 residents; and the 2023 Canadian Survey of Nurses collected responses from 1,907 nurses including nurse practitioners, registered nurses and nurses from other designations. Structured questionnaires were used in these cross-sectional surveys, and AI-related questions were analyzed to explore adoption rates, knowledge, and perceived priorities for integrating AI into healthcare practice.

Results

There is growing AI adoption among Canadian clinicians, with 7% of physicians using AI in 2024 compared to 2% in 2021; 6% of nurses reported AI use, primarily for clinical decision support, medication management and predictive analytics. Younger nurses (age <30 years) are more likely to use AI (18%) than their older counterparts (4.3%). Regional disparities are observed, with rural nurses reporting lower AI use (2.3%) than nurses in non-rural areas (6.2%). Among AI users, 79% of physicians and 77% of nurses highlight regulatory systems, while 77% and 74%, respectively, emphasize workforce education as priorities to support AI use in their practice. Only 30% of nurses feel knowledgeable about AI and 37% are comfortable using it.

Conclusion

These findings highlight the need for targeted efforts to support AI adoption in healthcare, including workforce education, regulatory systems, and addressing age and regional disparities. Furthermore, increasing clinicians' knowledge and comfort with AI is essential to realizing its potential to improve healthcare delivery across Canada.

A Methodological Framework for Constructing Opioid Agonist Therapy Episodes in Administrative Data

Presented by: Kiana Yazdani

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Background and Objectives

As Canada, particularly British Columbia (BC), faces a worsening drug toxicity crisis, administrative data has become a key resource for analyzing opioid agonist therapy (OAT) outcomes. To optimize its application in OAT-related policy-making and to capture the complex and rapidly evolving nature of the OAT programs, a robust methodology is needed to define stable OAT episodes accounting for single-OAT, transitions, and multitherapy events.

Approach

Data were sampled from people with HIV in BC from 2010-2020. We applied a medication episode construction framework based on Allen's interval algebra, a temporal logic that defines possible relations between time intervals, including seven base temporal relations (meets, overlaps, before, starts, finishes, contains, and equals). The "before" relation was combined with the maximum allowable gap to establish discontinuation windows. A time error margin (Ɛ) was used to relax Allen's "overlaps" relation: a) to differentiate short and long overlaps in single-OAT episodes and b) to differentiate transitions from multitherapy in multi-OAT episodes. Extensive analysis was conducted to determine Ɛ values.

Results

The "before" relation predominated across all OATs, particularly for methadone (99.41%). The "equals" relation was most notable for iOAT (36.45%), followed by buprenorphine (20.99%) and SROM (19.98%). We identified 2,184 dispensation sequences with multiple OAT types, the most common being OAT1→(OAT1+OAT2)→OAT1 (82.64%) and OAT1→(OAT1+OAT2)→OAT2 (14.78%). The iOAT→(iOAT+SROM)→iOAT sequence was most frequent (53%) in the first, while SROM→(SROM+Methadone)→Methadone was the most common in the second sequence (27.86%). A 7-day time error margin was used to build continuous single-OAT episodes, whereas a 14-day margin was applied for multi-OAT episodes. We identified 9,235 continuous episodes, with 93.82% as single-OAT, 3.14% as transition therapy, and 2.48% as multitherapy. Less than 1% involved transition and multitherapy. All episodes' median (Q1, Q3) duration was 1 month (0, 6).

Conclusion

We propose a framework for defining single-OAT, transition, and multitherapy episodes by integrating Allen's relations, the maximum allowable gap, and data-driven time error margins. This methodology improves the usability of administrative data and allows for the assessment of transitions and multitherapy, which are becoming increasingly prevalent in clinical practice.

Medication-Based Care for Older Adults Experiencing Homelessness: Healthcare Providers' Perspectives

Presented by: Amanda Yee

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Background and Objectives

Older adults experiencing homelessness face worse health outcomes and higher rates of healthcare use than housed older adults. Consequently, they require medication-based care, often experiencing inappropriate drug therapies and high prescription rates. The aim of this study is to explore healthcare providers' perspectives when providing medication-based care to older adults experiencing homelessness, including medication-based care during the transition into a purpose-built long-term care home.

Approach

A qualitative descriptive approach employing one-on-one online interviews will be used. Using maximum variation sampling, we will recruit 20-25 Ontario healthcare professionals, specifically, physicians, nurses, and pharmacists. The semi-structured interview guide is informed by medication-based care and transitions of care frameworks. The audio-recorded interviews will be transcribed verbatim and anonymized. On NVivo12, deductive and inductive thematic analysis will be performed.

Results

The study is in progress; however, there are three anticipated impacts. First, the study expects to provide an overview of how medication-based care is being provided to older adults experiencing homelessness, including potential gaps in current services. Second, the study expects to highlight potential facilitators and barriers when providing medication-based care to older adults experiencing homelessness. This can help inform the improvement or development of targeted medication-based services. Third, the study expects to offer potential recommendations to improve current medication-based services, including considerations when transitioning such services from hospital or community/shelter to a long-term care home that is tailored for older adults experiencing homelessness. Ultimately, the study aims to contribute to advancing medication-based services, policy, and resource allocation when caring for older adults experiencing homelessness.

Conclusion

This study will provide insights into medication-based care practices/processes when caring for older adults experiencing homelessness. The study expects the findings to have clinical and policy implications, which will contribute to strengthening Canada's healthcare system towards one that is adaptable and equitable to the needs of an aging homeless population.

Mobility Matters: Exploring the Impact of Mobility Challenges on Diabetes Care and Management

Presented by: Gillian Young

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Department of Family Medicine, Western University

Background and Objectives

We won the 2024 CAHSPR Dragon's Den to conduct a mixed-methods study examining the impact of mobility impairment on diabetes patients. Mobility challenges can exacerbate barriers in diabetes management, worsening disease progression and mobility. We examine patients from the Primary Care Diabetes Support Program (PCDSP), a primary care-led program in London, Ontario that targets three groups of patients (medically complex, without a regular primary care provider, and socially complex) at high risk for diabetes complications.

Approach

Using data from the PCDSP electronic medical record, we followed 3062 PCDSP patients for 5 years to examine the association between having a mobility impairment (i.e. use of mobility aid, amputation, diabetic foot and/or wound) and developing an additional mobility impairment and another diabetic complication. We are conducting qualitative interviews with PCDSP patients with mobility impairments to understand how mobility impairments affect their diabetes care.

Results

After controlling for other demographic, clinical and social factors, PCDSP patients with a mobility impairment were more likely to develop an additional mobility impairment (OR=14.49; 95% CI: 9.93-21.14) than patients without a pre-existing mobility impairment, but no more likely to develop other diabetic complications. Notably, there was no difference in glucose control between the two groups, both saw similar reduction in HbA1C over follow-up period. Preliminary data from interviews illustrate how mobility issues hamper the ability to engage in preventative behaviours and access health services.

Conclusion

Mobility impairments pose significant risk for diabetes patients. Good diabetes management for at-risk patients can prevent the development of other diabetes complications. Findings highlight the need for a multi-pronged approach to prevent the development of new and additional mobility impairments among high-risk diabetes patients.

Understanding the Economic Causal Factors Underlying Canadian Drug Shortages

Presented by: Ronald Zahoruk

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Background and Objectives

Drug shortages adversely impact Canadians and others around the world. Solutions require an understanding of the root causes. A growing literature has identified potential causes; however, there is little convincing empirical evidence on root causes of drug shortages in Canada. We thus obtained the perspectives of senior Canadian generic pharmaceutical industry executives – individuals who manage our generic drug supply – for their perspectives.

Approach

This study was of an exploratory qualitative design using semi-structured interviews to investigate the opinions of pharmaceutical executives regarding their beliefs on why generic drug shortages arise. The qualitative methodology was based on Straussian grounded theory, which is in line with the growing trend of applying Straussian grounded theory when conducting similar qualitative research within the business and economics literature (Kosti, 2024). Targeted and criterion sampling along with snowball sampling was employed to recruit pharmaceutical executives (n = 8) for interviews. Progressive, multi-stage data analysis via open, axial and selective coding generated a theory based on overall themes established.

Results

The literature identified low generic reimbursement prices as an important factor. The executives we interviewed concurred it is a factor, although they noted that much of the reimbursement amount, whatever its level, must be paid to pharmacies in the form of rebates to sell the product. This has forced generic firms to use low-cost manufacturing. Thus, manufacturers rely on imported active pharmaceutical ingredients (APIs) along with offshored final dosage production and packaging. The interviews have also revealed other factors not previously addressed in the literature. Chief among these is regulatory agency inflexibility and risk aversion, preventing manufacturers from changing APIs even if they are approved by peer agencies, such as the case with Health Canada and the US Food and Drug Administration (FDA).

Conclusion

The generic pharmaceutical executives interviewed affirmed that some of the causes of Canadian generic drug shortages identified in the literature (such as reduced generic reimbursement) were indeed relevant. However, other factors, like regulatory scrutiny, were indicated as being much more significant than previously thought.

Pressures behind the rising costs in Canadian private drug plans: 2018-2023

Presented by: Yvonne Zhang

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Background and Objectives

Private drug plans are key stakeholders in the Canadian healthcare system and reimburse an important share of drug spending, with costs being a major concern for plan sponsors. This study explores the key cost pressures for private drug plans, differentiating between short-term effects and those with longer-lasting impacts, and highlighting the impact of the COVID-19 pandemic since March 2020.

Approach

Using data from the IQVIA Private Pay Direct Drug Plan Database, an expanded Laspeyres cost driver model isolates the key factors contributing to the growth in drug expenditures: demographic, volume, price, substitution (generic and biosimilar), and drug-mix (i.e., shifts in utilization). The study focuses on 2023, with a retrospective look at recent trends since 2018 and an integration of age and gender considerations.

Results

Prescription drug expenditures for private plans rose by 12.9% in 2023, returning to the pre-pandemic trend, with a compound annual growth rate of 7.1% between 2018 and 2023. Increased use of higher-cost medicines—drug mix effect—was the primary driver, pushing costs up by 5%–9% annually. Medicines costing over $10,000 and $25,000 annually represented one-third and one-sixth, respectively, of total drug costs. Even pronounced savings from generic and biosimilar substitution—enhanced by biosimilar switching initiatives and price reductions—did not fully mitigate the increasing drug-mix effect. The pandemic reshaped drug plan claims, initially causing a downward demographic effect due to fewer reimbursed beneficiaries in 2020, followed by a rebound surpassing pre-pandemic levels after 2021.

Conclusion

Greater adoption of high-cost drugs is a significant driver of expenditure growth in Canadian private drug plans. Understanding the forces driving expenditures in private drug plans will help benefit plan advisors and sponsors to benchmark their individual claims experience to the rest of the market.

Project ECHO Rheumatology – Rationale and Results from a Multi-Method Study to Capture Impact

Presented by: Jane Zhao

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Background and Objectives

Project ECHO (Extension for Community Healthcare Outcomes) is a virtual health education model aimed at improving patient care by enhancing primary care capacity in specialty areas. Launched in 2017, Project ECHO Rheumatology ('ECHO') has engaged 500+ primary care clinicians in learning about rheumatic disease management. Data on clinician self-efficacy, satisfaction, knowledge, and practice change have been collected. However, due to the diverse clinical presentations and diagnoses discussed, measuring clinical outcomes has proven challenging.

Approach

We adopted a multi-method study design to evaluate the impact of ECHO on clinicians by 1) exploring experiences in ECHO and its impact on rheumatic disease management and 2) assessing the impact of ECHO on clinicians' self-efficacy and knowledge. In this study, both a qualitative component through focus group discussions and a quantitative component through online pre-post questionnaire were conducted. Descriptive statistics were calculated from pre-post questionnaire responses and after testing for normality, paired samples t-tests and effect sizes were also calculated. Thematic analysis was used to analyze focus group discussions.

Results

Through analysis of both qualitative and quantitative components, ECHO impacted clinicians in multiple ways: clinicians increased in self-efficacy in managing rheumatic conditions ($p<.001$) and benefited from ongoing mentorship and a supportive community of practice. Clinicians from rural and Northern Ontario particularly benefited from ECHO participation as access to specialists in their areas was sparse to none. While qualitative results demonstrated various ways in which clinicians increased their knowledge, such as increasing their awareness of interprofessional rheumatic management and understanding when and how to refer to a rheumatologist, quantitative results did not demonstrate significant changes in knowledge ($p=.13$). Further, primary care clinicians were able to better manage rheumatic conditions within primary care through ECHO, using resources and the larger health care system more wisely.

Conclusion

The burden of rheumatic disease is rising. ECHO is a promising education model that builds capacity within primary care to manage rheumatic conditions more adeptly and wisely. Our multi-method research demonstrated positive changes in participants and future research includes conducting a mixed methods study for further analysis of our data.

How do We Teach Concussion Best Practice? Results from a multi-method evaluation of ECHO Concussion

Presented by: Jane Zhao

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Background and Objectives

Concussion management is a growing public health concern, with our understanding of its prevalence – 150,000 Ontarians annually – cutting across the lifespan, and its acute and chronic clinical and economic consequences disrupting work, school, and sport. The ECHO (Extension for Community Healthcare Outcomes) model disseminates best practice guidelines and standards of care in common, complex, acute and chronic conditions. Launched in 2019, ECHO Concussion has been improving diagnosis and management of concussion across Ontario and beyond.

Approach

OBJECTIVE: 1) To examine the impact of ECHO Concussion on clinical practice by subgroup, profession and case presenter (Yes/No); 2) To explore clinician experience and impact on concussion management. DESIGN: Multi-method study of ECHO Concussion clinicians employing questionnaires measuring self-efficacy and knowledge (quantitative) and focus group discussions (FGD) exploring experiences, self-efficacy, knowledge, and clinical practice (qualitative). ANALYSES: Tests for normality were performed and the Kruskal-Wallis and Mann-Whitney U Tests were chosen to analyze change scores between profession group and case presenters. Thematic analysis was used to inductively code FGD transcripts; discrepancies in qualitative codes were discussed until consensus was reached.

Results

From 2019 to 2024, 636 clinicians attended ECHO Concussion. Of these, 115 (18.1%) completed both pre-post questionnaires; 11 (1.7%) participated in FGDs. In terms of quantitative results, significant differences were detected by subgroup for some self-efficacy items but no differences in knowledge scores. Physicians and nurse practitioners gained more confidence in managing prolonged symptoms (30+ days), using provincial guidelines, and being a concussion resource within their team compared to allied health or mental health professionals ($p<.05$); furthermore, clinicians who presented patient cases gained more confidence than compared to those who did not ($p<.05$). In terms of qualitative findings, clinicians were highly satisfied with ECHO Concussion, sharing that the program helped them increase confidence and knowledge, become up-to-date with current evidence, and better utilize concussion guidelines.

Conclusion

Concussion management is common and complex and ECHO Concussion is beneficial for clinician learning. ECHO Concussion significantly improved clinician confidence, particularly for physicians and nurse practitioners, who reported greater gains in managing prolonged symptoms and using provincial guidelines. Further research needs to be conducted to understand changes in clinicians' knowledge.