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FMF 2024

Poster Presentations

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Vancouver Convention Centre

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Poster Presentations

This activity has not been formally reviewed by the CFPC; however, it is eligible for non-certified Self-Learning credits. Mainpro+® participants may also earn additional certified credits by completing a Linking Learning Exercise.

Wednesday, November 6 **Poster: 501**

Exploring the Utility of a Group-Based Advance Care Planning Workshop in the Community: A retrospective study

Daphna Grossman*, MD, CCFP (PC), FCFP; Shayne Friedman, MD; Alexa Goodbaum, MD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Enhancing ACP understanding in the community
2. Understanding the role of the substitute decision maker
3. Enhancing ACP discussions with primary care providers

Description:

Background: Advance care planning (ACP) discussions are important to ensure that people understand their illness, consider their values in health care decision making and choose their power of attorney. Despite their benefits, ACP discussions are often limited. This study examines the effectiveness of community-based group education sessions to enhance understanding of ACP's and developing individual ACP's. **Methods:** Seven ACP workshops were conducted by interprofessional health care providers (HCP) from April 9, 2019 to March 1, 2023. Pre- and post-session and 3-month follow-up surveys assessed participants' satisfaction with the workshop, understanding of ACP, likelihood of discussing ACP with their care-partners or HCP, and completion of a power of attorney (POA) document. Qualitative and quantitative analysis were done retrospectively. **Results:** 55 participants completed pre- and post-session surveys, and 30 participants completed the 3-month follow-up survey. There was significant improvement in participants' understanding of the substitute decision maker (SDM) role. In the 3-month follow-up survey, 73% of respondents had considered their values and beliefs related to healthcare, 33% had conversations with their HCPs, and 30% completed a POA document. **Discussion:** Community-based group education sessions led to improved knowledge about ACP discussions, encouraged ACP discussions with HCP's, and increased identification of POA's. There was no significant change in participants' comfort level in discussing ACP amongst friends and family. **Conclusion:** Community-based group education sessions can enhance patient and family understanding of ACP and the development of individual ACP's. Further research should explore methods of enhancing ACP discussions in the community.

Wednesday, November 6 **Poster: 502**

Trends in Focused Practice in Ontario, Canada, 1993-2021

Hina Ansari*, PhD, MSc; Richard H. Glazier, MD, MPH; Susan E. Schultz, MSc; Michael E. Green, MD, MPH; Kamila Premji MD, PhD; Eliot Frymire, MA; Maryam Daneshvarfard, MScCH; Liisa Jaakkimainen, MD, MSc; Tara Kiran, MD, MSc

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Compare the characteristics of family physicians in focused practice relative to other practice types
2. Examine time trends in focused practice relative to other practice types and population growth
3. Understand the most prevalent types of focused practice, and how this has changed over time

Description:

Context: Evidence suggests a growing trend in the proportion of family physicians choosing focused practice, with a potential to adversely impact the supply of family physicians who can provide comprehensive primary care to all those in need. **Objective:** (1) to examine trends in focused practice during 1993/94 to 2021/22, by sex, relative to other practice types and population growth; (2) to describe the types of services provided by focused practice family physicians. **Design:** A descriptive repeated cross-sectional population-based study using administrative data. **Setting:** Ontario, Canada. **Participants:** Family physicians classified into practice types, leveraging a published algorithm. **Results:** There were n=11,103 family physicians in 1993/94 (mean age 43 years, 28% female), and n=17,413 in 2021/22 (mean age 49 years, 49% female). The proportion of family physicians in focused practice increased from 7.7% (n=856) in 1993/94 to 19.2% (n=3351) in 2021/22. Between 1992/93 and 2021/22, Ontario's population increased by 38.5%, from 10.7 to 14.8 million. During this period, the total number of family physicians per capita increased by 14%, from 104 to 118 per 100,000; however, the number of comprehensive family physicians per capita decreased from 71 to 64 per 100,000. The increase in the number of family physicians per capita was largely accounted for by the growth in focused practice physicians. Moreover, a decrease in comprehensive practice was consistently observed across recent and less recent graduates. The three most prevalent focused practice types in 2021/22 were emergency medicine (37.0%), hospitalist medicine (26.5%), and addictions medicine (8.3%). **Conclusion:** Over the last 30 years, there has been a substantial increase in the proportion of family physicians doing focused practice and a corresponding decrease in the number of comprehensive family physicians per capita, with implications for workforce planning. Further research is needed to understand why family physicians are increasingly choosing focused practice.

Wednesday, November 6 **Poster: 503**

Simulations Strengthen Team Based Primary Care Dietetic Competency

Serena Beber*, RD, MScCH, CDE; Denis Tsang, MSc, MAN, RD, CDE; Jane Tyerman, RN, PhD, CCSNE; Jaclyn Adler, RD, MAN; Mary Anne Smith, PhD, RD; Wendy Madarasz, MPE, RD, CDE; Raphaëlle Laroche-Nantel, RD, MSc; Joie Shaw, RD, MSc(c); Isabelle Giroux, RD, PhD, PHEc, FDC

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the increasingly complex learning needs to practice in interprofessional comprehensive primary care settings
2. Discuss the successes and challenges of interprofessional comprehensive primary care settings that include dietitians
3. Recognize learning opportunities and strategies including virtual simulation to support enhancing interprofessional competencies

Description:

Context: "Team Primary Care (TPC)–Training for Transformation" was a national initiative to enhance the capacity of primary care practitioners through improved training, team supports and planning tools. **Objective:** To identify key practice competencies required by dietitians in Interprofessional Comprehensive Primary Care (CPC); to develop an innovative interprofessional collaboration educational tool kit featuring asynchronous virtual simulation-based learning modules; and to evaluate the toolkit. **Design:** A literature review informed survey development by an expert team of RDs in TBPC and/or Dietetic Education before online national distribution. Survey results and other key resources like the Integrated Competencies for Dietetic Education and Practice and the Canadian Interprofessional Health Collaborative Competencies guided the topics for development of three bilingual virtual simulations using the standardized CAN-sim scenario template. Simulations developed included TBPC nutrition related topics of culturally sensitive pre-diabetes care, eating disorders, diabetes with renal insufficiency. Evaluation of the simulations is continuous using a questionnaire at the end of each simulation module. **Setting:** Canadian CPC settings.Participants: Canadian CPC RDs. **Results:** Between September 2023 and February 2024, 73 RDs working in TBPC participated in the survey. Participants identified skills to improve, including cultural safety (61.6%), counseling (56.2%), navigating the primary healthcare system (46.6%) and the nutrition care process (46.6%). Dietitians felt less confident for referrals including eating disorders (58.9%), mental health disorders (43.8%), bariatric nutrition support (42.5%) and pediatrics (26.0%). Respondents desired more training in team disagreement processing (68.5%), role clarification and negotiation (38.4%), and collaborative relationship-focused care and services (34.3%). Development of simulation modules is complete, with ongoing dissemination. **Conclusion:** Many practical competency learning needs for Canadian RDs working in CPC were identified, guiding the development of education tools for RDs pre- and post-licensure. Virtual simulations can be effective tools to enhance the important contributions of RDs in broader interprofessional CPC settings.

Wednesday, November 6 Poster: 504

Experiences of Canadians Without a Primary Care Clinician

Alexander Gabinet-Equihua*, MD; Maryam Daneshvarfard, MScCH; Ri Wang, MMath; Alexander Beyer, PhD; Jasmin Kay, MA; Goldis Mitra, MD, CCFP; Mandy Buss, MD, CCFP; Amanda Condon, MD, CCFP; Alan Katz, MBChB, MSc, CCFP; Mylaine Breton, PhD, MBA; Neb Kovacina, MDCM, MHsc, CCFP; M. Ruth Lavergne, PhD, MSc; Katherine Stringer, MBChB, MCISc, CCFP; Peter MacLeod, MA; Clifton van der Linden, PhD; Tara Kiran, MD, MSc, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the challenges facing Canadians without a primary care clinician
2. Compare the preferences of Canadians with and without a primary care clinician
3. Consider how these findings may support and inform primary care reform

Description:

Objective: To characterize the healthcare-seeking behaviours and preferences for system reform of Canadians without a primary care clinician. **Design:** We conducted an anonymous, online, national cross-sectional survey that was available from September to October 2022 in English and French. **Setting:** Canada. **Participants:** Canadian residents aged 18 years and older. 14,018 surveys were submitted; 9,279 (66.2%) were complete and included for analysis. Responses were weighted on sociodemographic factors to approximate the Canadian population. After weighting, 54.6% of respondents without a primary care clinician were men, 27.0% were aged 18-29, and 32.9% were from Quebec. **Intervention:** 79 questions were displayed across 20 webpages. The estimated completion time was 15 minutes. **Main Outcome Measures:** Primary care attachment (i.e., whether respondents reported having a regular family doctor or nurse practitioner [primary care clinician]), related healthcare seeking behaviours, and preferences towards reorganizing primary care. **Results:** 22.0% of respondents reported not having a primary care clinician. This was significantly more likely for those who identified as: men, younger than 65, residents of British

Columbia, Quebec, or Atlantic Canada, French-speakers, college- or trade school- educated, making $30,000-$69,999, or having poor or fair health. 83.1% of respondents without a primary care clinician said they were looking for one. Men and those without private health benefits were significantly less likely to be looking. Significantly more respondents without a primary care clinician reported visiting a walk-in clinic in the last year (71.7% vs. 41.2%) and they were significantly less likely to be satisfied. Respondents without a primary care clinician were significantly more likely to respond favourably to system reforms that would expand team- and neighbourhood-based care. **Conclusions:** Canadians without a primary care clinician differ from their attached peers by sociodemographic characteristics, walk-in clinic utilization patterns, and preferences for system reform. Their experiences should be considered when designing primary care reforms.

Wednesday, November 6 **Poster: 505**

On-Call Experience and Scheduling for Saskatchewan FM Residents

Robert D. E. Henderson*, MD, MSc, MBA, PhD; Carolyn Augusta, MSc, PhD; Rhonda Bryce, MD, MSc; Jason Hosain, MD, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Assess the general nature of the family medicine resident primary care clinic call experience
2. Examine the relative distribution of call shifts among family medicine residents in Saskatchewan
3. Determine simple call schedule policy interventions that promote a positive resident experience

Description:

Context: All family medicine residents (FMRs) in Saskatchewan participate in on-call duties (at two urban sites, Saskatoon and Regina, and 6 rural/remote sites). Clinics are mandated in Saskatchewan to provide 24/7 call coverage. Typically, FMRs cover clinic call while on the family medicine service. At the two urban sites, call is generally by phone. **Objective:** We sought to evaluate the on-call experiences of FMRs, with a view to enhancing resident wellness and educational value. **Design:** We used two data sources: i) a survey, and ii) an analysis of call schedule data. The survey included Likert-style questions and open-ended comments. Demographics were collected to assess differences associated with family status. Schedule data were analysed over 2021-2023 for Saskatoon and Regina. This study received approval from our institution’s Research Ethics Board. **Participants:** All active FMRs (100) at the University of Saskatchewan in early 2024 were surveyed (response rate 52%). Participants were stratified into three groups: the two large urban centres, and the rural/remote sites. **Findings:** Rural/remote residents were the most satisfied with the learning experience; Regina residents were markedly more dissatisfied than satisfied. Residents in Saskatoon were more positive about the general experience (e.g., reported less stress/fatigue); however, those with children reported greater fatigue and anxiety. Half of Regina residents reported coming into clinic every shift, while Saskatoon residents very rarely attend in person while on call. Call schedules were found to be unevenly distributed among residents in the urban centres, with some FMRs scheduled for an average of one shift every two weeks, while others had more than double that. **Conclusion:** There is a large variation in the primary clinic call experience among FMRs in Saskatchewan. The discovery of the uneven distribution of call shifts has prompted a re-evaluation of the call scheduling protocol at our institution.

Wednesday, November 6 **Poster: 506**

Collaborative Primary Care Research in Resource Limited Settings of LMIC

Aishana Joshi*, MD; Regan Shakya, MPT; Pankaj Pant, MD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Assess feasibility and effectiveness of collaborative intervention research approaches in LMIC
2. Identify key challenges associated with conducting collaborative intervention research in resource limited settings of LMIC
3. Recognize collaborative research models for evidence synthesis to ensure best practices in advancing primary care

Description:

Objective: To investigate efficacy and feasibility of collaborative intervention research in resource limited primary health care setting of low and middle income country (LMIC). **Design:** A pre-post intervention research was designed at a primary care hospital in Nepal. The intervention comprised of pulmonary rehabilitation in post-COVID patients in setting of primary hospital where rehabilitation services were not available. The intervention was designed in collaboration with expert from University Teaching hospital. The research was approved by Ethical Review Board, Nepal Health Research Council. Research intervention and feasibility were tested prior to commencement engaging local health care providers and mobilizing local resources. **Setting:** This research was conducted in resource constrained setting of primary government hospital in Namobuddha municipality, Kavrepalanchowk district of Nepal. **Participants:** 80 patients were included with 40 each in intervention and control group. **Intervention:** A structured pulmonary rehabilitation intervention was designed in collaboration with expert from University teaching hospital. Intervention group received pulmonary rehabilitation for 3 weeks while control group received conventional care. Pulmonary rehabilitation was delivered by trained rehabilitation specialist from academia in out-patient setting of primary hospital. Weekly supervision of patients was done to ensure continuation of rehabilitative measures and adherence to proper techniques. **Results:** This intervention research was found to be effective as well as feasible in resource constrained primary health care setting of LMIC through collaborative support from academia. The pulmonary rehabilitation intervention showed statistically significant improvement in respiratory health and physical outcome; and health related quality of life with p-value< 0.05 in the intervention group as compared to the controlled group. **Conclusion:** Collaborative approach could be a powerful tool in fostering intervention research in resource limited primary health care settings of LMIC. Collaborative research endeavors would be beneficial in enhancing scientific rigor in primary care research to generate evidence for advancing sustainable primary health care.

Wednesday, November 6 Poster: 507

The Team is Breaking Down: Healthcare providers' lived experiences of teamwork in the rural emergency department: Work-in-progress

McTavish R*, BSN; Rymerson M, MSc; Hari K, MPH; Kim E, MPH; Bland A, MSc; Grzybowski S, MD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe teamwork in the rural emergency department
2. Examine possible barriers to team function in the rural emergency department
3. Identify the lack of data regarding team breakdown in rural emergency departments

Description:

Context: Rural Emergency Departments (EDs) across British Columbia (BC) have been closing at alarming rates due to staffing shortages. Cumulatively, rural BC EDs "were closed for [an] equivalent of around 4 months" throughout the year 20221. The team of healthcare professionals that these rural communities rely on is effectively breaking down. Throughout the literature it is largely agreed that teamwork is an important contributor to the functioning of rural healthcare centers and to overall provider job satisfaction and burnout prevention 2-6, but little research is available that discusses why the team breaks down or what can be done to fix it once this happens. **Objective:** The goal of this study is to explore BC physicians' and nurses' lived experiences with teamwork in the rural ED and to investigate what contributes to team breakdown and sustainability. **Design/Methods:** This is a qualitative study consisting of semi-structured interviews with physicians and registered nurses from four BC EDs. Approval has been obtained from the provincial research ethics board and local health authorities. **Setting:** Four rural BC EDs. **Participants:** Registered nurses and physicians currently working in one of the four rural EDs chosen for the project. **Main Outcome Measures:** Interviews will be analyzed to answer the question: What causes the rural ED team to break down and what contributes to its sustainability? **Results:** Data collection is currently ongoing. Once all interviews are completed, transcripts will be analyzed using a narrative analysis approach, with the goal of creating recommendations to improve healthcare team function and provider retention. **Conclusion:** Some of the areas this study will investigate include: Team dynamics in rural vs. urban practice; The effect of virtual care on team dynamics; How patient presentations impact team function; If team function could be improved through professional development or team building; If extreme weather/natural disasters have impacted teams.

Wednesday, November 6 Poster: 508

Virtual Primary Care for Opioid Use Disorder: Work-in-progress

Shawna Narayan*, MSc; Ellie Gooderham, MA; Sarah Muñoz-Violant, BA; Sarah Spencer, MSc, MPH; Rita K McCracken, MD, CCFP (COE), FCFP, PhD; Lindsay Hedden, PhD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Identify benefits and challenges of virtual modalities for managing opioid use disorder in primary care
2. Explore resources that facilitate the use of virtual primary care for managing opioid use disorder
3. Describe key needs of family physicians providing virtual primary care for managing opioid use disorder

Description:

Context: In 2020, British Columbia declared a dual public health emergency with the introduction of the COVID-19 pandemic to the pre-existing opioid-related overdose crisis. In response to COVID-19, family physicians rapidly introduced virtual modalities. The persistence of these modalities beyond the pandemic represents a shift in the provision of care that requires better understanding of its impacts, particularly among family physicians who play a crucial role in the care of people with opioid use disorder. **Objective:** This study aims to describe the experiences of family physicians in delivering virtual primary care to people with opioid use disorder. **Design:** Semi-structured interviews. **Setting:** British Columbia, Canada. **Participants:** Family physicians (n=12) who provide care for people with opioid use disorder. **Methods:** We used a purposeful maximum variation sampling strategy to recruit family physician with diverse personal and professional characteristics. Participants were invited to a one-hour interview via telephone or Zoom videoconferencing. We conducted interviews between March and May 2023. Informed by a qualitative descriptive approach, we inductively coded the transcripts of the interviews using NVivo 14. The study obtained approval from harmonised Research Ethics British Columbia. **Findings:** Our participants were predominantly female physicians (83%, n=10) with an average of 12.2 years of practice (range: 3-37 years) working in large urban areas (75%, n=9). Participants described positive and negative features associated with virtual primary care. Our ongoing thematic analysis explores the accessibility of providing virtual care for people of opioid use disorder, the management of opioid use disorder and other comorbidities in the primary care setting, and the impact of virtual care from the perspective of family physicians. **Conclusion:** The persistence of virtual modalities in primary care beyond the pandemic presents opportunities for family physicians to reduce barriers to care for people with opioid use disorder. Full results to be presented at the conference.

Wednesday, November 6 Poster: 509

Strengthening Primary Care in Saskatchewan: Insights from a Participatory World Café Study

Udoka Okpalauwaekwe*, MBBS, MPH; Lindsay Balezantis; Brian MacPhee; Vivian R Ramsden; Angela Baerwald

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Learn the current barriers to recruitment/retention of medical students, residents, and primary care providers to practice family medicine in Saskatchewan
2. Gain valuable insights for enhancing primary care recruitment and retention in Saskatchewan
3. Learn the strides been made in the successful recruitment/retention of medical students, residents and primary care providers to practice family medicine in Saskatchewan

Description:

Context: Saskatchewan grapples with healthcare pressures due to an aging population with chronic conditions and a shortage of primary care providers (PCPs), highlighting the critical need for systemic health reforms. **Objective:** To explore gaps and learn insights that would inform practical and sustainable strategies to strengthening primary care in Saskatchewan. **Design:** A World Café participatory approach. **Setting:** Department of Academic Family Medicine, University of Saskatchewan. **Participants:** A transdisciplinary team of policy makers, PCPs, researchers, patient partners, medical residents, and medical students. **Intervention:** World Café discussions hosted across three distinct groups. **Main Outcome Measures:** knowledge gaps, and practical steps to addressing primary care gaps as it relates to recruitment and retention of medical students, medical residents, International Medical Graduates (IMGs) and PCPs in Saskatchewan. **Findings:** Knowledge gaps identified included: insufficient data to evaluate sustainable recruitment-retention strategies, lack of recognition of family medicine compared to other specialties, community disintegration, negative media portrayal of family physicians, harsh climate conditions, physician burnout, disconnection between family physicians and other PCPs (e.g., nurse practitioners), systemic racism, inadequate mentorship for medical students/residents, and a lack of recognition or celebration of local champions. Next steps for strengthening primary care delivery included: building primary care research capacity, enhancing community engagement, coordinating primary care advocacy, providing professional support for PCPs (e.g., pensions and benefits, personal protected time), improving the primary healthcare system (e.g., implementing team-based care approaches), and enhancing medical education and training efforts for medical students and residents (e.g., tailored clerkship opportunities, prioritizing ties to SK in medical school applications, recruiting more family physician mentors). **Conclusion:** Valuable insights for enhancing primary care recruitment and retention in SK were obtained. The results of this study provide a foundation for ongoing research, active community engagement, and policy reform to bolster primary care, ensuring equitable access to healthcare for all residents.

Wednesday, November 6 Poster: 510

Primary Care Nurse Educational Program's Interprofessional Co-Creation

Marie-Eve Poitras*, PhD; Julia Lukewich, PhD; Treena Klassen, DBA; Robin Devey-Burry, PhD; Suzanne Braithwaite, PhD; Sheila Epp, MSN; Dana Ryan, MA; Mireille Guérin, M.Sc.; Anaëlle Morin, M.Sc.; Deanne

Curnew, MN; Crystal Vaughan, MN; Anne-Sophie Langlois, M ès Art; Donna Bulman, PhD; Monica McGraw, M.Sc.; Marie-Dominique Poirier; Toni Leamon

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Identify barriers and facilitators to the co-construction of a bilingual educational program in Canada
2. Apply the Knowledge-to-Action model to develop an educational innovation in primary care
3. Recognize the importance of education in optimizing Registered Nurses' roles in team-based primary care

Description:

Learning objective: Identify barriers and facilitators to the co-construction of a bilingual educational program in Canada. Background: In Canada, the role of Registered Nurses (RNs) within well-functioning primary care teams is critical to achieving accessibility, continuity, and coordination of care. The foundations of primary care-specific knowledge are not taught as part of RNs' entry-to-practice curriculum. **Objective:** To develop a strong primary care workforce focusing on post-licensure education for RNs within team-based primary care. **Study Design:** A mixed-method study based on Knowledge-to-Action to co-create an educational program for Canadian RNs in primary care (Phase 1—complete). In this presentation, we present the result for Phase 1. The research team comprises RNs in primary care, researchers, patient partners, nursing educators, mentorship experts, policymakers, and primary care administrators. In co-construction cycles, we prepared the educational program objectives and content with this established and diverse network of stakeholders. **Results:** Through co-creation cycles, we developed an online asynchronous and bilingual post-licensure-educational program tailor-made for RNs in primary care aligned with the Patient's Medical Home vision and the Canadian competencies for RNs in primary care. Engagement from our network of stakeholders ensured that the content was evidence-based and relevant to primary care across the country. Six overarching themes are presented in the learning modules, focusing on patient engagement and interprofessional collaboration. Enablers were effective communication channels and meetings, the trust relationship between the team members and the complementarity of individual expertise. The main challenge was the common understanding of scientific content respecting language differences. **Conclusion:** This project will address a considerable gap in healthcare training in Canada, particularly for primary care nurse post-licensure education and contribute to the advancement of team-based care. The national implementation and evaluation (Phase 2 – ongoing) will be a leverage for other countries to build on our training to develop similar initiatives.

Wednesday, November 6 **Poster: 511**

Recruiting Rural Dual-Physician Couples

Helen Tran*, MD; Sam Firouzli, MD; Esther Kim, MPH; Alexandra Bland, MSc; Stefan Grzybowski, MD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Explore initiatives to promote medical trainee couple recruitment to rural communities
2. Participate in initiatives to propose shared medical training for couples
3. Identify the drawing forces for dual-physicians to rural settings

Description:

Introduction: Rural communities across Canada face increasing challenges in recruiting and retaining physicians. Although spousal factors have been previously reported as a top five determinant for physicians when considering to practice rurally, no previous studies have attempted to understand the pros and cons as a dual-physician couple in rural settings. As a young couple in our final year of medical school with plans to practice rurally, we are interested in the benefits and challenges faced by dual-physician couples in rural practice ("dual-physician couples"). The aim of this review is to shed light on the experiences of dual-physician couples and promote policy and practice strategies that encourage other couples to consider rural recruitment. **Methods:** A review of articles was conducted through OVID, Medline, PubMed and JAMA. Key terms ("dual-physician", "married physician", "rural recruitment and retention") were used for selection of articles. Due to the limited availability of relevant articles, we included journals from 1995 onwards, and there were no limitations placed on inclusion criteria related to definitions of rural communities, stages of medical training, or by definition of dual-physician partnerships. **Results:** Dual-physician couples share a number of advantages including increased professional flexibility and job security. Dual-physicians can provide clinical support when working at the edge of their comfort zones. Partners also increase social support as they can more seamlessly integrate into social groups, which is associated with increased likelihood of career longevity in rural communities. However, disadvantages include child-care availability and coordinating shared time at home. **Discussion:** The lack of consideration for physician couples during medical school and residency should be addressed to improve rural recruitment and retention. We suggest changes to the rural elective selection and CaRMs application processes to further promote medical school couples to pursue a career in rural family medicine.

Wednesday, November 6 Poster: 512

Focus Groups for Informing Post-COVID-19 Condition Care: Work-in-progress

Andrea Vasquez Camargo*, MD, CFPC, MSc; Gary Groot, MD, PhD, FRCSC, FACS; Donna Goodridge, RN, PhD; James Barton, MD, FRCSC; Rejina Kamrul, MD, CFPC; Clara Rocha Michaels, MD, CFPC; Shivali Sood, MD; Jannat Ferdous, MD; Kholoud Alwan, MD; Carolyn Hoessler, PhD, CE

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the process of resident-clinician collaboration in conducting a focus group
2. Identify educational needs of clinicians, patients, and families on Post-COVID-19 Condition (PCC) in Saskatchewan
3. Describe their educational barriers and solutions to support PCC care

Description:

Context: Over 30,000 patients in Saskatchewan are affected by Post-COVID-19 Condition (PCC) for which management is not well understood. Lack of knowledge about this condition adds to the multiple barriers in caring for these patients. Building on a prior needs assessment results, new focus group interviews will be conducted to further inform educational offerings by asking about knowledge gaps and learner needs to create educational activities to support PCC care. **Objective:** To update the learning needs identified related to best practices for diagnosis and management of PCC through a clinician-resident collaborative research project. **Design:** Focus groups (in progress) utilize semi-structured interview questions to prompt discussion to identify barriers and learning needs for improved PCC care. Participants invited to the focus groups completed a PCC needs assessment survey in Fall 2022. Research Ethics Review board approval received (Beh-4371). **Setting:** Saskatchewan PCC care context. **Participants:** Family physicians, specialists, nurses, and other health care providers; patients and families who agreed to participate in the focus group interviews, after completing the Saskatchewan learning needs assessment survey in 2022. All participants will be 18 years old and older. **Results/Findings:** The focus group clinician-resident collaboration approach and results of the focus group will be described. **Conclusion:** Implications, based on the results of the focus group interviews, will assist in planning educational activities to address identified barriers to PCC care.

Wednesday, November 6 Poster: 513

Post-COVID-19 Condition Educational Needs in Saskatchewan: Work-in-progress

Andrea Vasquez Camargo*, MD, CFPC, MSc; Gary Groot, MD, PhD, FRCSC, FACS; Donna Goodridge, RN, PhD; James Barton, MD, FRCSC; Rejina Kamrul, MD, CFPC; Clara Rocha Michaels, MD, CFPC; Shivali Sood, MD; Jannat Ferdous, MD; Kholoud Alwan, MD; Carolyn Hoessler, PhD, CE

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Identify educational needs of Saskatchewan Clinicians, patients, and families on Post-COVID-19 Condition (PCC)
2. Describe educational barriers and solutions to support PCC care
3. Integrate new national CAN-PCC best practice guidelines for diagnosis and management of PCC

Description:

Context: Over 2 million Canadians are affected by Post-COVID-19 Condition (PCC) for which management is not well understood. Health care providers (HCPs), patients, and families struggle to keep pace with new evidence, and emerging guidelines for identification, diagnosis, and management of PCC. **Objective:** To identify clinicians', patients' and families' educational needs and design effective educational activities related to best practices for diagnosis and management of PCC. **Design:** This project includes: (1) learning needs assessment with surveys, representatives, and literature reviews in 2022-23 that identified the most common learning needs for PCC; (2) development of educational activities in 2023; (3) focus groups (in progress) to identify barriers and update the learning needs; and (4) knowledge mobilization activities (in progress) to disseminate information including new CAN-PCC Canadian Guidelines. The results of the project steps will be described. Approved by local Research Ethics Review board (Beh-4371). **Setting:** Saskatchewan PCC care context. **Participants:** Family physicians, specialists, nurses, and other health care providers; patients and families. **Results/Findings:** Surveys revealed 50% of six College of Medicine departments and 67% of 179 HCPs indicated that they did not have enough knowledge about PCC to provide adequate care to patients suffering from this condition. 37% of 174 patients/families indicated they did not have access to reliable information about PCC. The PCC Programming working group comprised of health care practitioners and patient representatives identified five themes based on the learning needs assessment results: Identification, symptoms, use of diagnostic resources, management, and complications. The 2023 educational webinar resulted in 83% of health care practitioner who provided feedback were considering or planning changes to practices; education on PCC remained a barrier for 40%. Focus group results and CAN-PCC knowledge mobilization implementation in progress. **Conclusion:** Continuing education and knowledge mobilization of emerging guidelines are needed to address educational barriers to PCC care.

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Wednesday, November 6 **Poster: 514**

Safety and Feasibility of Bedside Ultrasound-Guided Peripherally Inserted Central Catheter(PICC) by the Family Physician in Palliative Care for Terminal Ill Cancer Patients at a Single Center

Hak Ryeong Kim*, MD; Hwa Sun Kim, MD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the safety and feasibility of procedures performed by family physicians
2. Assess the feasibility of immediate bedside versus moving to an intervention room in patients with critical medical conditions
3. Plan the role of family physicians in providing primary care within a palliative setting

Description:

Objective: Our research aimed to evaluate the safety and efficacy of bedside ultrasound (US)-guided Peripherally Inserted Central Catheter (PICC) insertion for terminal cancer patients in palliative care, reflecting the expanded use of PICC in palliative settings. **Design/Setting:** The study was a retrospective comparative study in a palliative ward from August 2023 to March 2024 at a single center. **Participants/Intervention:** The study included 73 terminal cancer patients, which study population was divided into two groups: bedside US-guided PICC by a family physician (Group 1, n=45) and fluoroscopy-guided PICC in an intervention room by a radiologist (Group 2, n=28). **Main Outcome Measures:** Assessed outcomes included PICC success rates, catheter use duration, tip locations, and failure causes. **Results:** PICC success rates were similar (Group 1: 88.89%, Group 2: 89.29%; $p > 0.99$), favoring approach to right upper arm, and basilic vein. In Group 2, catheter tips were all adjusted in the SVC, whereas in Group 1, 4 cases in the RA and 3 cases were malpositioned. The average duration of catheter use for Groups 1 and 2 was 23.45 ± 14.06 days and 23.44 ± 19.2 days, respectively ($p > 0.99$). The most common duration of catheter use categorized was 10-20 days (32.5%) in Group 1, whereas it was less than 10 days (32%) in Group 2, also showing no significant difference ($p=0.111$). Causes of failure included puncture failure, no patient positioning, and malposition, similar across groups ($p=0.578$). The most common reason for catheter removal in all groups was death, followed by discharge, self-removal, and catheter-related bloodstream infections (CRBSI). **Conclusion:** This study underscores the role of family physicians in extending the boundaries of family medicine by successfully managing complex bedside procedures such as PICC insertions, thereby enhancing their contribution to patient care in palliative settings.

Wednesday, November 6 **Poster: 515**

Understanding Learner Mistreatment Amongst Family Medicine Residents

Michelle Lockyer*, MD; Peter Tzakas, MD, MEd, FCCFP; Abigail Ramdawar, BSc (Hons), MHSc; Sarah Wright, MBA

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe incidents where postgraduate trainees feel mistreated
2. Categorize learner experiences of mistreatment
3. Plan education for learners and faculty to help with issues of mistreatment

Description:

Context: Learner mistreatment is difficult to define and sparsely recorded or reported with any detail. An understanding of the nature of these incidents could be key in helping to address and prevent the specific issues uncovered. **Objective:** this project aims to examine the issues that postgraduate learners would identify as mistreatment. **Design & Setting:** This study is in progress and has been approved by the University of Toronto's Research Ethics Review Board. The interview guide was designed by the project team and draws upon (and seeks to build upon) work that exists in this space. Participants will be individually interviewed by a research assistant with training in trauma-informed care. They will be asked to describe their own experiences of mistreatment or those they have witnessed in the learning environment. Interviews will be conducted over zoom. The findings will be analyzed using thematic analysis. **Participants:** 8-10 postgraduate trainees from the Family Medicine Training Unit at an Academic Community Hospital. **Main Outcome Measures:** This study will result in the synthesis of a qualitative dataset that will explore, describe, and categorize learner experiences of mistreatment. With this, we expect to theorize education avenues to learners, faculty, and system considerations to help with any identified mistreatment issues. **Results/Findings:** Interviews are currently being conducted. As the analysis will be conducted concurrently with the interviews, we anticipate having some preliminary findings to share for Family Medicine Forum. **Conclusions:** None drawn yet as the work is in progress. A qualitative approach like this (compared to surveys) should uncover more details surrounding learner experiences of mistreatment. With this information, we might begin to develop more intentional steps towards addressing learner mistreatment and improving the learning environment.

Wednesday, November 6 Poster: 516

An Aspirin a Day Keeps Pre-Eclampsia Away: QI Work-in-progress

Jordan Stariha*, MD, BSc (Hons.); Janeen Kaiser, MD, BSc; Sanja Kostov, MD, CCFP, BSc (Hons)

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Identify patients who would benefit from starting ASA at 12-16 weeks gestation
2. Identify barriers to initiation of ASA in early pregnancy when indicated
3. Apply strategies to improve early identification of pregnant patients for whom ASA is indicated

Description:

Context: Pre-eclampsia is a significant cause of materno-fetal morbidity and mortality, complicating 1-2% of pregnancies in Canada and 5% worldwide. The Society of Obstetrics and Gynecology of Canada (SOGC) emphasizes the importance of early identification and initiation of daily acetylsalicylic acid (ASA) in the first trimester ± calcium supplementation to prevent pre-eclampsia, and have outlined criteria to assist practitioners. Despite proven benefit, the uptake of this practice has been slow in Canada and has been speculated to be related to inaccessibility of early pregnancy care, especially in rural areas; moreover, emphasizing an important gap that could be filled by improved access to primary care providers, specifically family medicine obstetrics (FMOB) providers. **Objective:** Identify how well our group of FMOB providers are adhering to the most recent SOGC guidelines for starting ASA in pregnancy. **Design:** Retrospective chart review to collect baseline data for quality improvement study. Charts were excluded if the patients were transferred to another obstetrical provider for delivery. Exempt by the University of Alberta Research Ethics Review Board. **Setting:** Mom Care Docs FMOB clinic in Edmonton, Alberta. **Participants:** Perinatal patients delivered by the Mom Care Group from May 1st 2023 to April 30th 2024. **Intervention:** In patients referred to our group, appropriately identified those meeting either 1 high-risk criterion or ≥2 moderate-risk criteria thus indicating daily ASA, and counseled these patients to initiate preventative treatment from 12-16 weeks up to 36 weeks gestation. **Main Outcome Measures:** Documentation of counseling discussion, criteria met, dose recommended, and whether patient took ASA. **Results:** Twenty-five percent of the 302 postpartum patient charts reviewed met criteria for ASA initiation. Of these patients, 55% were seen prior to 16 weeks, leaving 45% of patients seen too late for timely intervention. When seen prior to 16 weeks, our group appropriately counseled 60% of patients to start ASA. Interestingly, we found that all the patients who were 'missed' met criteria for ASA due to pre-pregnancy BMI > 30. Armed with this information, our practice is working on strategies to address these gaps. These quality improvement strategies will be presented. **Conclusions:** Given the established benefits of preventing pre-eclampsia with daily ASA, perinatal care providers have an obligation to identify and treat at-risk patients early on in gestation, which could be facilitated by improved access to FMOBs

Thursday, November 7 **Poster: 601**

Preparing or Deciding? Resident experiences with serious illness communication

Tavis Apramian*,MD, PhD; Jill Dombroski, PhD; Anish K. Arora, PhD; Jeff Myers, MD, MSEd

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Understand the difference between 'preparing' and 'deciding' in serious illness communication
2. Describe barriers encountered by residents attempting to address 'preparing'
3. Consider supervisory strategies for mitigating barriers to relational advance care planning

Description:

Objective: Family physicians provide most outpatient care for Canadians with serious illness. Previous research suggests family medicine (FM) residents encounter complex sociocultural barriers when communicating about serious illness. Current tools to guide serious illness communication focus on decision-making in acute care. Teaching based on these tools has failed to show sustained improvement in serious illness communication in primary care. We explored resident experiences with serious illness communication to answer the following question: how do FM residents learn to approach preparing their patients for progressing illness? Our goal was to elicit grounded empirical analysis to help future serious illness communication educational tools used in primary care leverage the uniquely relational nature of family medicine. **Setting/Participants:** We recruited interviewees from FM residency programs across the country and conducted 10 semi-structured interviews. **Intervention/Methods:** We took a constructivist grounded theory approach using interviews and constant comparative analysis. Interview transcripts were analyzed using open, focused, and theoretical coding in Nvivo. Data collection ended when the team agreed in consensus that theoretical sufficiency had been achieved. **Findings:** Participants in our study navigated marked sociocultural complexity when attempting to engage patients in preparing for progressing illness. Participants found themselves balancing autonomy as family physicians and navigating the cultural landscape of serious illness. They placed value in actively building longitudinal relationships with their seriously ill patients. Recognizing the uncertainty in treatment and prognosis complicated their conversations; and participants found themselves grappling with their own emotions while trying to remain oriented to patient needs. **Conclusion:** Exploring the workplace experiences of FM residents regarding serious illness communication offers an opportunity to ensure teaching, learning, and assessment are grounded in empiric data. The findings of this work will inform primary-care focused communication education designed to best support family physicians helping seriously ill patients prepare for progressing illness.

Thursday, November 7 Poster: 602

Enhancing Generalism and EDI in Undergraduate Reproductive Medical Education

Kayla Bailey*, BSc (Hons); Sanja Kostov, MD, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Recognize the need for generalist and EDI content in Canadian UME curricula
2. Apply a worked model to incorporate generalist and EDI content into existing CBL curriculum
3. Navigate challenges encountered during CBL curriculum revision

Description:

Introduction: Canadians continue to face challenges accessing primary care and experience health disparities related to social/structural determinants of health (SSDOH). Published evidence shows that revisions to undergraduate medical education (UME) curricula are needed to ensure that graduates can provide socially accountable care that aligns with the needs of their patients. Evidence supports the inclusion of generalist and equity, diversity and inclusion (EDI) content in curricula to foster such competency. While a process to revise EDI content in CBL curriculum exists, no studies have focused on reproductive medicine content and the unique challenges associated with this area of medicine. We aimed to enhance generalist and EDI content within the Reproductive Medicine and Urology Course (RMUC) case-based learning (CBL) curriculum. **Methods:** Five CBL cases in our UME RMUC curriculum were systematically revised for generalism and EDI using validated tools and processes. Throughout the revision process, challenges and insights gained were documented. Following curricular delivery, students (N=160) and CBL preceptors (N=20) provided formal program evaluation. Anecdotal comments were also documented. This feedback was further incorporated. **Results:** During the revision process several challenges were identified, including: (1) significant time and resources needed to accurately represent of SSDOH, (2) under representation of equity-deserving groups in media (e.g., stock photos), and (3) ensuring detection of subtly inappropriate content (e.g., paternalistic or inconsistent with a trauma-informed approach). Following curricular delivery program evaluation reflected increased student and preceptor satisfaction with the CBL curriculum. **Conclusions:** Our revision model demonstrates a systematic approach to addressing gaps in generalism and EDI within a UME RMUC CBL curriculum. In addition, other UME programs can benefit from challenges and lessons learned during the revision process.

Thursday, November 7 Poster: 603

Safer Prescribing in Elders Living With Polypharmacy

Lanting Cheng*; Shelby Elkes, MA; Sabrina Wong, PhD, MSc, BSN; Rubee Dev, PhD, MPH, BScN

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Recognize and respond to the complex care needs of elderly patients living with polypharmacy
2. Apply the science of quality improvement to facilitate changes and measure impact to optimize patient care

3. Learn about the SPIDER study concepts and the opportunity to participate in BC

Description:

Context: More than 1 in 4 Canadians 65 years or older are prescribed 10+ medications per year, contributing to the risk of poor health, reduced quality of life and high system costs. **Objective:** To assess the impact of SPIDER (Structured Process Informed by Data Evidence and Research) compared to usual care in reducing potentially inappropriate prescriptions (PIPs) among patients aged ≥65 years on ≥10 medications. **Design:** This study is a two-arm pragmatic cluster randomized controlled trial. **Setting:** Canadian Primary Care Sentinel Surveillance Network (CPCSSN) participating in primary healthcare practices across BC. **Participants:** Primary care providers (family physicians or nurse practitioners) from the practices who contribute electronic medical record (EMR) data to the CPCSSN and must consent to participate in the study. **Intervention:** In the intervention arm (SPIDER), a physician and their healthcare team participate in learning collaborative workshops with a quality improvement (QI) coach. The QI coach will help identify care gaps and develop strategies. At the same time, EMR data from the CPCSSN informs the workshops, and the QI coach will use the information to help provide methods to help practices make desired changes in a local setting. In the control arm, practices perform their usual care (with no QI coach or access to detailed EMR data). At the end of the one-year study, surveys and interviews will be conducted to understand patient and provider perspectives and experiences. **Main Outcome Measures:** Primary outcome is the number of PIPs per patient. Secondary outcome includes patients' medication-related experience with care and providers' experience with learning collaboratives and deprescribing PIPs. Results and **Conclusion:** The results of other provinces indicate that the SPIDER method empowers patients and physicians to engage in meaningful discussions about care decisions. Furthermore, the model has improved patients' quality of life and healthcare provider satisfaction. Our team hypothesizes similar findings in BC.

Thursday, November 7 **Poster: 604**

Improving Continuity of Care Within an Academic Family Health Team: Work-in-progress

Laura Cummings*, MD, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe patient and provider perspectives on continuity of care within family medicine
2. Discuss barriers to continuity of care, and identify change ideas to address these barriers
3. Appreciate how to apply quality improvement methods in your own practice to improve continuity of care

Description:

Context: Continuity of care (COC) is the cornerstone of safe, high-quality care—it leads to better health outcomes, improved patient quality of life, and greater provider satisfaction. Despite these benefits, maintaining continuity is challenging in academic family practice. **Objective:** To assess baseline continuity, patient and provider perspectives on continuity, barriers to continuity, and potential solutions to inform a quality improvement (QI) initiative (work-in-progress), **Design:** Chart audit of COC metrics, descriptive analyses of provider and patient surveys. **Setting:** The Ottawa Hospital Academic Family Health Team (TOHAFHT) in Ottawa, Ontario. **Participants:** Patients ≥18 years old; residents, staff physicians, and nurse practitioners (NPs) from one care team within TOHAFHT. **Main Outcome Measures:** Chart audit outcomes included average patient continuity of care index (COCI) and usual provider index (UPC). Patient survey measures included perceived satisfaction with continuity, access, and quality of care. Provider survey measures included perceived continuity and satisfaction with patient encounters. Both surveys included qualitative comments on perceived barriers to continuity and proposed solutions. **Results/Findings:** Randomly sampled charts from patients seen between January and December 2023 (n = 40) had an average COCI of 0.20 and UPC of 0.43. Surveyed patients (n = 25) were generally satisfied with their care, but expressed a lack of trust with unfamiliar providers, especially when discussing mental health or sensitive issues. Resident and NPs (n = 7) were less familiar and less satisfied with patient interactions relative to staff physicians (n = 4). Patients and providers agreed that COC is important, but limited by several barriers including inflexible appointment bookings, conflicting resident rotations, and access limitations. **Conclusion:** COC remains an important priority in primary care. This project provides baseline measures for a forthcoming QI initiative to improve COC and offers insights into root causes of poor continuity and solutions for change.

Thursday, November 7 **Poster: 605**

How Effective is a Virtual Osteoarthritis Education Program?

Roshani Puri, BN; Teresa DeFreitas*, MD, CCFP; Marni Wesner, MD, CCFP; Kristin Anstey, MD, CCFP; Ben Greidanus, MD, CCFP; Isabel Hedayat, MD, CCFP; Adam Keough, MD, CCFP; Olesia Markevych, MD, CCFP; Mariia Morar, BSc; James Xu, MD, CCFP; Constance Lebrun, MD, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Evaluate the efficacy of a physician led seminar in improving patient’s self-efficacy in managing their osteoarthritis
2. Evaluate the effectiveness of a virtual group seminar for knowledge translation regarding treatment options for osteoarthritis
3. Describe indications for the use of Arthritis Self Efficacy score inpatients with osteoarthritis

Description:

Context: Osteoarthritis (OA) is the third most common self-reported chronic condition in Canada. The non - surgical care of OA includes patient education and treatment decision making. A team of sport and exercise medicine physicians developed a virtual education seminar for patients with OA. **Objective:** To evaluate the efficacy of a physician led seminar in improving patient’s self-efficacy and knowledge of OA. **Design:** Prospective Program Evaluation. Participants were asked to complete baseline surveys including the Arthritis Self Efficacy Score (ASE), Hip Disability Score (HOOS), Knee Disability Score (KOOS). Participants then attended the virtual seminar. They were then asked to rate their knowledge of specific aspects of OA, and at 3 months post seminar asked to repeat the ASE, HOOS and KOOS surveys. **Setting:** A University Sport and Exercise Medicine Clinic. **Participants:** Adults ages 30 to 85 referred to the OA seminar with a diagnosis of knee and or hip osteoarthritis. (n=41). **Main Outcome Measures:** ASE, KOOS, HOOS, and patient satisfaction survey. **Results:** At baseline majority of patients responses (61%) indicated “a little” or adequate knowledge to different aspects of OA, post seminar this improved to 88% reporting adequate or significant knowledge. ASE Subsections all improved: Pain (baseline 5.36 vs at 3 months 6.54 p=0.0013). **Other Symptoms:** (baseline 6.63 vs 3 month 7.32, p =0.008. Function: 8.53 vs 3-month 8.85 p=0.0038. KOOS: Quality of Life (baseline 38.09 vs 3 month 44.7) p=0.02. HOOS: Sport and recreation (baseline 27.34 vs 3 month 42.19) p=0.0032, Pain (baseline 46.09 vs 3 month 54.69) p=0.0032. Function of Daily living (baseline 51.38vs 3 month 59.28) p=0.0032. **Conclusions:** This seminar on OA increased patients’ knowledge, and improvement in patient reported self-efficacy. This study offers quality evidence supporting the effectiveness of a virtual physician led patient education seminar on OA

Thursday, November 7 **Poster: 606**

The Family Medicine Enhanced Skills Chronic Pain Residency

Ted Findlay*, DO, CCFP, FCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the burden of chronic pain in the Canadian population
2. Describe the recommendations of the National Pain Strategy with respect to training physicians to manage this condition
3. Describe the new Family Medicine Chronic Pain Enhanced Skills R3 program at the University of Calgary

Description:

Context: An estimated 7.6 million, or one in five people live with chronic pain, many of whom report it adversely affecting some or most daily activities. Pain impacts all demographics in Canada, although not equally. It is more common as we age, with approximately one in three people over 65 experiencing chronic pain. As Canada's population ages, the prevalence of chronic pain and its impacts are expected to grow. **Intervention:** In response, the National Pain Strategy established GOAL #3: People living with pain and health professionals have the knowledge, skills, and educational supports to appropriately assess and manage pain based on population needs. The broader community understands pain as a legitimate, biopsychosocial condition and stigma is reduced. Empower leadership from University and College programs to create sub-specializations in pain management across all relevant health care professions. Expand post-graduate positions (e.g., residencies, post-doctoral fellowships) to train health professionals as pain specialists. **Conclusion:** In response to the Canadian Pain Task Force Report and its call for post-graduate training positions for pain specialists, and in keeping with physician requirements anticipated by the Alberta Pain Strategy, the Department of Family Medicine at the Cumming School of Medicine (University of Calgary) has established an Enhanced Skills program for family medicine residency graduates. This is a one year program that will be based at the Calgary Chronic Pain Centre. The first resident will begin training in July 2025.Ref: Canadian Pain Task Force Reports 2019, 2020, 2021

Thursday, November 7 **Poster: 607**

The Power of Narrative in Student Career Choice: Using a living library approach

Aaron Johnston*, MD; Grace Perez, MSc

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the importance of novel approaches to supporting medical student career choice
2. Summarize the Living Library modality
3. Discuss how Living Library might be used in their education setting

Description:

The objective of this project was to evaluate the effectiveness of the living library approach in i) fostering favourable attitudes towards rural medical practice, ii) in changing perceptions of learners about rural life and practice. The concept originated as a strategy to challenge prejudice, using volunteers as 'human books' to interact with people 'readers' and engage in meaningful dialogue. We adapted the model in a medical education context through our program "Library of Life", conducting three living libraries in 2020, 2022, 2023. We recruited physicians and other professionals in rural practice with engaging stories as Human

Books, to present and discuss life experiences with student readers. Before the Library of Life, most students (82%) were unfamiliar with rural medicine and the majority (56%) felt “rural medical practice would not be a good fit”. After the events, almost all (96%) felt that “rural physicians play a vital role in the community”, and 71% indicated that they “could see themselves in a similar rural practice”. Further, we observed statistically important improvements in: (i) perception about personality match to rural medicine (p=0.009), (ii) appreciation of rural life and work (p=0.013), (iii) recognizing need for rural physicians (p<0.001) and (iv) rural practice consideration (p=0.001). Students reported that the Library of Life allowed them to see “rural” under a fresh and newfound light, allowed self-reflection, and that the format of the event helped them to gain a sense of personal growth and consider their own individual capacities and interests. Our results suggest that the power of narrative facilitates and fosters more favourable attitudes towards rural medical practice among our students. The living library can be an effective learning tool in medical education to provide information and inspiration to learners to consider a career in rural medicine.

Thursday, November 7 Poster: 608

Using Focus Groups to Inform Geriatric Psychiatry Modules

Elliot Lass*, MD, MSc, CCFP (COE); Kirolos Milio, MD, CCFP; Vyshnave Jeyabalan, MHIS; Kristina Powles, MD, CCFP; Virginia Wesson, MD, MSc, FRCPC; Irina Nica-Graham, MD, FRCPC

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Demonstrate student preferences with respect to online learning modules
2. Identify the gaps in teaching with respect to family medicine resident learning in geriatric psychiatry
3. Describe resident preference for content in a supplemental online module in geriatric psychiatry

Description:

Context: Family doctors are often the first point of contact when older adults present with psychiatric conditions. Therefore, education during family medicine residency needs to adequately prepare residents with both clinical and supplemental psychiatric content, such as through educational modules. **Objective:** To determine the opinions of family medicine residents with respect to gaps in teaching and preferred modes of delivery of clinical and supplemental content related to a geriatric psychiatry education. **Design:** A focus group was held, and responses were coded through inductive thematic analysis. A summary of the themes derived with supporting quotes will be displayed. **Setting:** The focus group was held on March 22, 2023, to help inform the content of educational modules provided to family medicine residents during their geriatric psychiatry sessions at Mount Sinai Hospital, University of Toronto Department of Family and Community Medicine. This work has been approved by the Sinai Health System Research Ethics Board. **Participants:** A member of the research team, who was a Care of the Elderly Resident in a non-evaluative role, facilitated a focus group with 12 PGY1 and PGY2 residents at Mount Sinai. **Intervention:** A thematic analysis was completed through codifying of themes that were elicited through the focus group. **Results:** There is limited exposure to geriatric psychiatry education in residency and students are open to online learning modules. Gaps in teaching and resident preferences were derived. The type of content that residents were hoping to learn included collaborative care and dementia. **Conclusions:** A focus group for family medicine residents can help determine the content included in supplemental online geriatric psychiatry modules. Family medicine residents are interested in and would benefit from online geriatric education to supplement clinical teaching, including for practical skills.

Thursday, November 7 Poster: 609

Developing and Evaluating a Postgraduate Education CQI Program

Gurpreet Mand*,MBBS, MScCH, CCFP, FCFP; Patricia O'Brien, RN, MScCH; Paul Krueger, PhD; Chris Meaney, MSc; Stu Murdoch

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the DFCM's CQI program components
2. Identify key program evaluation results
3. Highlight proposed CQI initiatives and future directions

Description:

Context: The Postgraduate Program at the Department of Family & Community Medicine (DFCM) - University of Toronto, initiated a Continuous Quality Improvement (CQI) Program in the fall of 2021. The CQI program aims to create a culture of continuous educational improvement in the residency program. An evaluation of the program was initiated in 2023, the results of which will be discussed in this poster. **Objectives:** 1. Describe the DFCM's CQI Program components. 2. Identify key program evaluation results. 3. Highlight proposed CQI initiatives and future directions. **Design:** This was a quantitative study using a survey as the tool. The questions consisted of both Likert scale and text questions. **Participants:** This evaluation survey was distributed to all site program directors and the site administrators. **Main Outcome Measures:** To understand impact of the CQI Program in the DFCM and understand areas for improvement. **Results/Findings:** The survey was completed by 26 participants with a response rate of 72%. Some of the key findings included an increased awareness of CQI at the sites, initiation of CQI site-based projects and demonstration of good use of some support tools (CQI survey, CQI consultations). The data also showed areas where the program can be a better resource for sites. **Conclusion:** Whilst the CQI program originally was designed to meet the requirement of the College of Family Physicians of Canada (CFPC) Accreditation Standard 9.1, the Postgraduate Program has also successfully created a culture of improvement. There are many improvement initiatives underway centrally and at sites based on data collected through CQI initiatives including the development of a foundations block in year 1. The program has become a collaborative process between the Central program, the sites, and residents. The program has also been shared with other PG programs at the University of Toronto.

Thursday, November 7 Poster: 610

Resident Transcripts: Finding the signal in the noise

Kendall Noel*, MDCM, FCFP, MEd

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Demonstrate the feasibility of using historical (or contemporary) quantitative, evaluation data to assess resident performance and program expectations
2. Describe individual resident advantages to obtaining comparative data describing their performance
3. Describe the benefits for large residency programs to utilize basic statistical analysis as part of their "Program of Assessment"

Description:

Somewhere between the beginning of our pre-med undergraduate degrees and the awarding of certification in family medicine, medical learners lose some of the basic tenets of the education system: the importance of frequent formative tests, the benefits of a proper course syllabus and orientation and the beauty of a cumulative transcript. At the University of Ottawa, we have prototyped a resident transcript, using our rotation specific evaluations (ITERs) as the unit of measure. A statistical review of our historical ITER data provided the basis for expected mean scores for each ITER. These historical means, and their standard deviations, then allowed us to ‘z-score’ a resident’s performance on the ITER. In this poster we provide a theoretical basis for the feasibility and validity of tracking the data necessary to generate a resident transcript. The benefits at both the micro and macro levels of medical education will be discussed, with reference to the use of a similar approach at Harvard Medical School.

Thursday, November 7 Poster: 612

How Resident Physicians Navigate Direct Observation and Feedback

Heather Waters, MD, CCFP, CFFP; Cassandra Kuyvenhoven, PhD; Jonel Miklea, MD, MEd, CCFP, FCFP; April Kam, MD, MScPH, FRCPC; Alim Pardhan, MD, MBA, FRCPC; Elif Bilgic, PhD; Danielle O’Toole, MD, MSc, CCFP, FCFP; Bojana Babic, MD, FRCPC, FAAP; Mohammad Zubairi, MD, MEd, FRCPC; Njideka Sanya, MD, MPH; Meredith Vanstone, PhD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Compare resident physician experiences of direct observation and feedback across settings and situations
2. Explore factors impacting on resident seeking and avoidance behaviours related to direct observation and feedback
3. Idenfity aspects of the learning environment to support effective direct observation and feedback for learning

Description:

Background/Objectives: While medical education evidence clearly indicates the importance of feedback and coaching for the development of competencies, understanding learner perceptions and behaviours regarding feedback from direct observation of clinical care remains a gap in the literature. Our study explored how medical learners in three residency programs—Family Medicine, Emergency Medicine, and Pediatrics—navigate feedback opportunities through direct observation, a cornerstone of competency-based learning. Effective incorporation of direct observation for feedback is essential to support learner development while preserving their sense of independence and efficiency. **Design:** We conducted a constructivist grounded theory study with two phases of research; the first incorporated multiple non-participant etic observations paired with individual interviews, and the second was homogenous focus groups of residents and faculty within each program. Data collection and analyses were iterative and refined through progressive stages of research. **Settings/Participants:** We conducted 36 observations (>145 hrs) and 18 interviews with 18 residents working in Family Medicine, Pediatrics, and Emergency Medicine at one university; we conducted 6 homogeneous focus groups which included a total of 21 residents and educators from all three specialty areas. **Findings:** Findings emphasize an uncertainty among learners regarding what constituted feedback, as their interactions with preceptors often blended direct observation, teaching, perceived evaluation, and feedback. This uncertainty was sometimes associated with an emotional and cognitive load that made some feedback feel uncomfortable or threatening. Learners trying to avoid direct observation reported time constraints (i.e., prioritizing efficient workflows over feedback), the need for emotional self-management (i.e., avoiding negative emotions associated with being ‘wrong’), and interpersonal conflict (i.e., feeling disrespected or untrusted by their preceptor/supervisor). Educators were more likely to conceptualize feedback as formative, aimed at learner growth and development. Many learners described an ever-present summative aspect, and this provoked some of the uncertainty and negative emotions. Specialty differences emphasized the importance of a culture of direct observation and regular feedback in facilitating meaningful, formative feedback. **Discussion and Conclusion:** This study highlights complex and interwoven factors within the learner and the clinical environment that influence their decisions to seek or avoid direct observation and feedback. It underscores the need for a nuanced approach to feedback in medical education to address these complex dynamics effectively.

Thursday, November 7 **Poster: 614**

Engaging Early Medical Learners in Data-Driven Equitable Care

Karen Weyman*, MD, M.Ed, CCFP, FCFPR; Ryan Banach, MD, CCFP, FCFP; Azi Moaveni, MD, CCFP, FCFP; Melissa Nutik, MD, M.Ed; Vyshnave Jeyabalan, MHIS; Anna Loi, M.Ed, CPCD; Reza Talebi

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe a novel community-based longitudinal enrichment opportunity for early medical learners to family medicine
2. Explore the experiences of learners and community family physicians involved in the program
3. Propose modifications for future iterations of the program

Description:

Context: In response to decreasing interest of medical students in choosing family medicine and addressing the impact of the pandemic on clinical care, the University of Toronto Department of Family and Community Medicine Undergraduate Education and Office of Health System Partnerships, with support from OntarioMD, created a new pilot program to provide early medical learners with a community-based longitudinal enrichment opportunity (FM-CLLEO). **Design:** To better understand the program feasibility and experiences of the students and preceptors who participated in this novel program, a formal program evaluation of both students and preceptors through survey completion, student focus groups and preceptor interviews took place. REB exemption was received. **Setting, Participants and Intervention:** Nine 1st and 2nd year medical students were placed with a family physician working in an underserved community during their summer break following a one-week family medicine immersion week. Students were taught how to search EMR data and generate a list of patients who were missing important preventative health, such as immunizations and cervical cancer screening, which were identified as Ontario Health priorities. Learners acquired the required procedural skills through simulations in a non-clinical setting. The students then actively assisted the community physicians with catch-up in one of the physician-selected preventative health interventions over a minimum of 3 days in the clinic. **Findings:** Medical students and preceptors reported beneficial and positive experiences resulting from participation in the program. Students who had not considered family medicine residency reported at the end of the program that it was now being considered as a future career path. **Conclusion:** The findings support the feasibility of placing early learners during their summer break with community family physicians to support pandemic clinical catch-up using practice derived data. Further study is planned to assess feasibility and impact on running an expanded program during the academic year.

Thursday, November 7 **Poster: 615**

Reshaping City-Wide Migraine Treatment Access and Improving Management: Work-in-progress

James Kim*, MBBCh, PgDip, MScCH

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the limitation of the access to migraine care in Calgary, Alberta

2. Identify areas in how the primary care physicians can assist in improving the migraine care access
3. Demonstrate the effectiveness of utilizing the primary care physicians in Calgary's migraine pathway

Description:

Cross-sectional studies have demonstrated that Canada has the worst access to specialty care among the first-world nations. In Calgary, about 2000 patients are waiting to be seen by the neurologists at the University of Calgary, and another 2500 patients are waiting to be seen by the community neurologists. Surprisingly, it is estimated that about 70% of them are migraine patients. 10 primary care physicians with a special interest in migraine were identified, and put through several training modules, and the group has been incorporated into Calgary's migraine pathway where the patients who have failed in 2-3 prophylactic treatments without red flag symptoms will be seen by this primary care group. This is a work in progress, but we are expected to see an improvement in access to migraine care with patients receiving the optimal management in a more timely manner while reducing direct and indirect healthcare costs.

Thursday, November 7 **Poster: 616**

Balancing Patient Eating Habits and Planetary Health - QI

Eileen M. Wong*, MD, CCFP, FCFP; Stephanie Maclean, RD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe how to objectively evaluate patient food experience through measurements like visual estimation method, surveys
2. Apply quality improvement approach to address issues of greatest concern to patients i.e. food experience
3. Consider implementing these methods to health care setting/s to improve food experience, reduce food waste

Description:

Objective: The primary objective of this Quality Improvement project was to determine if offering vegetarian lunch entrees would decrease patient food waste as part of improving patient health and planetary health. **Design:** In-patient food consumption over one week for all three meals was measured using Visual Estimation Method (VEM). Attitudes and knowledge about vegetarian meals were assessed through voluntary patient surveys. **Setting:** Urban geriatric rehabilitation centre in Vancouver BC. **Participants:** Study population was Rehabilitation in-patients, mostly male (62.5%), average age 74.5 years, average length of stay 33 days, with 65 participants in the intervention period. **Intervention:** During the “Vegetarian Week” pilot intervention, the existing core menu was used, substituting four vegetarian (non-animal protein) entrées out of 14 lunch choices. Breakfast and dinner were unchanged. **Main Outcome Measures:** Food waste was measured using the Visual Estimation Method (VEM). Patients’ attitudes and knowledge about vegetarian meals were assessed with voluntary surveys. **Results:** Comparing pre- and post-intervention periods, overall food wastage increased at: breakfast (22% to 32%), lunch (22% to 32%), and dinner (20% to 25%) with p values 0.000. Considering lunch entrées only, wastage increased from 17% to 38%, with vegetarian entrees wasted (46%) more than non-vegetarian ones (34%). Vegetarian patients wasted (37%) as much as non-vegetarians (39%). Survey response rate pre-intervention was 45% with most patients (76%) reporting eating an omnivorous diet, prior awareness of personal and planetary health benefits of vegetarian diets (59%) and previously trying vegetarian dishes (62%). Post-intervention survey response rate was lower (22%) with only 57% willing to try vegetarian dishes again. **Conclusion:** Through evaluation of the patient food experience with Visual Estimation Method and surveys, the very complex issue of food satisfaction was explored in older adults.

Although food waste was not decreased during this “Vegetarian Week” pilot, improving patient and planetary health requires ongoing efforts.

Thursday, November 7 **Poster: 617**

A Multidisciplinary Approach to Deprescribing Potentially Inappropriate Prescriptions (PIPs) – A SPIDER protocol

Rosy Zafar*, MD, CCFP, FCFP; Yali Gao, RPh BScPhm; Faten Hassaan, M.Sc QIPS; Sima Sajedinejad, MD, MPH, PhD, PMP; Mila Ellard, RPh

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Enhance patient safety by deprescribing PIPs in the older population who are at risk of drug therapy problems due to polypharmacy by using SPIDER Protocol
2. Engage members within the multidisciplinary team who can address PIPs
3. Utilize the EMR to track patient progress and analyze data to assess efficiencies and effectiveness

Description:

Polypharmacy is common in older adults and can be associated with elevated risks of poor health, reduced quality of life, high care costs, and persistently complex care needs. This project targets medications where the potential risks may outweigh the benefits and where deprescribing should be considered. We focused on the following therapeutic classes with established evidence-based deprescribing tools: proton pump inhibitors, benzodiazepines, antipsychotics, and sulfonylureas. **Design and Setting:** 1. Engaged members within the multidisciplinary team who can address PIPs. 2. Identified patients who are taking PIPs using UTOPIAN and EMR query. 3. Implemented an appropriate strategy for safe deprescribing of PIPs. 4. Utilized the EMR to track patient progress and analyze data to assess efficiencies and effectiveness. **Participants:** Within a one-year time frame, our multidisciplinary team consisting of physicians, pharmacists, and quality improvement specialists identified eligible patients 65 years and older with ten or more medications using UTOPIAN and our EMR system. We performed chart reviews and patient interviews to assess their eligibility for deprescribing PIPs. Patients were initiated on a deprescribing protocol based on eligibility with regular follow-ups. **Results:** Our team identified 14 eligible patients rostered to one physician practice from the EMR search. The team reviewed each patient’s chart and contacted 11 of those patients to assess the appropriateness of the use of proton pump inhibitors, benzodiazepines, antipsychotics, and sulfonylureas. Five patients successfully stopped taking one of the PIPs, and five patients trialled a reduced dose. **Conclusion:** By deprescribing PIPs, we mitigate potential drug therapy problems such as drug interactions, adverse drug reactions, prescribing cascades, and increased drug utilization costs. Our project focused on the older adult population, who are often more vulnerable, have higher health care needs, and are at higher risk of polypharmacy, resulting in drug therapy problems.

Friday, November 8 **Poster: 701**

Weight-Inclusive Care in Family Medicine

Erika Crowley*, MD, MSS, MSc; Katarina Wind

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe weight-inclusive care and the harms of a weight-centric approach
2. List ways to incorporate weight-inclusive care into their practice

3. Identify resources for education and further review

Description:

Context: Weight-inclusive care prioritizes overall well-being and healthy behaviours without stigmatizing body weight. This perspective challenges traditional methods, such as medicalizing obesity and prescribing weight loss, that, although widespread, are associated with adverse outcomes. Many allied health care providers are embracing weight-inclusive care. Physicians may lag due to a lack of resources and education that addresses them specifically. **Objective:** We aimed to create a learning medium for the weight-inclusive care framework and utilization in in medical practice. **Design:** We conducted a narrative literature review and utilized knowledge translation to create an easy-to-read pamphlet for education of healthcare providers on weight-inclusive care. **Setting:** The work was completed in British Columbia, Canada and will be widely available for distribution. **Participants:** Medical students, residents, and healthcare providers across Canada will be engaged. **Findings:** Dr. Katarina Wind created a workshop series for medical students that reviews up to date medical literature about weight-inclusive care and dispels common myths. Medical students that attended this workshop went on to complete projects to further educate their colleagues. Erika Crowley (MD Class of 2024) created an easily readable pamphlet to educate physicians and medical students in weight-inclusive care. The pamphlet also contains recommendations and resources for providers who are interested in further learning. **Conclusion:** We support a weight-inclusive care approach in medicine and share educational materials as a learning medium for healthcare professionals. Future work will involve continued quality improvement of the pamphlets and widespread distribution throughout the medical community to promote a paradigm shift towards this evidence-based, patient-centered, healthcare approach.

Friday, November 8 **Poster: 702**

Optimizing Diagnosis in Canadian Cancer Care

Martin Dawes*, MD, MB.BS, DRCOG, FRCGP;Leah Stephenson, MA; Kathy Barnard, ECCE; Louise Binder, BA Hon, LLB; Alexandra Chambers, MA; Martine Elias, MSc; Fred Horne, MBA; Rachael Manion, BSc Hon, JD; Josée Pelletier, BA; Jennifer Rayner, PhD; Amy Rosvold, BA; Tina Sahay, MA; Antonella Scali, MSW; Michael Smylie, MBChB, FRCPC; Rebecca Turner, MSW; Eva Villalba, MBA, MSc; Suzanne Wait, PhD; Sophie Wertheimer, PhD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Understand the barriers, inefficiencies, and opportunities in cancer diagnoses in Canada
2. Ensure swift, accurate, and appropriately delivered diagnoses throughout the country
3. Understand the themes that are involved in the cancer diagnosis journey

Description:

Context: All.Can is an international non-profit working to improve cancer care efficiency; 2018, All.Can Canada (ACC) was established. ACC is a multi-stakeholder group working to improve cancer care efficiency in the symptom investigation stage. **Problem:** The Canadian healthcare system is burdened by delays in cancer diagnoses, delays which also increase mortality. Garaszczuk et al. projected that in 2021, \$26.2 billion dollars was spent on cancer care in Canada (2022). Further, research suggests that the removal of wasteful interventions could lead to an average gain of ~two years of life expectancy in industrialized countries, and that delays in cancer treatment are correlated with increased mortality for seven cancer types (Wait, 2017; Hanna et al., 2020). **Objectives:** Based on these problems, ACC undertook research to understand the barriers, inefficiencies, and opportunities in cancer diagnoses in Canada, with the aim to ensure swift, accurate, and appropriately delivered diagnoses throughout the country. **Design and**

Participants: A contracted independent researcher conducted a structured literature review, including 30 qualitative interviews with cancer survivors across Canada and a survey of healthcare providers, to understand the diagnosis landscape in Canada. ACC's multi-stakeholder, patient-led Steering Committee oversaw the research methodology, implementation, and interpretation of findings. **Findings:** Based on the feedback offered by participants, ACC developed the "Current State of Cancer Diagnosis in Canada" infographic, which illustrates the non-linear and often burdensome experience of being investigated for cancer. Further, ACC designated three different phases within the diagnosis process: the early phase (first interaction with a healthcare provider), middle phase (investigation of the suspicion of cancer), and the final phase (arrival at the cancer facility to a confirmed diagnosis). **Conclusion:** Three outcomes emerging from this research promise to improve the experience of cancer diagnosis for Canadian patients: (1) the need for identification of systemic issues during cancer diagnoses and inherent in equity gaps; (2) the need to determine specific solutions and opportunities practices to optimizing diagnoses; (3) the need to mobilize this information through relationships with stakeholders, including government and healthcare providers.

Friday, November 8 Poster: 703

Own Your Bones: A pilot of a novel multi-disciplinary shared medical model for osteoporosis management

Divya Garg*, MD, MClSc, CCFP, FCFP; Vishal Bhella, MD, MClSc, CCFP, FCFP; Julia Maclaren, RD; Janine Payne, RD; Candice Stapleton, PT; April Matsuno, MSc, RD; Jane Bowman, RN, MN; Emma Billington, BSc, MD, FRCPC

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Discuss outcomes from application of a shared medical model for osteoporosis management in primary care
2. Review strategies to incorporate nutrition and exercise interventions to reduce fracture risk
3. Apply a shared decision making model with patients in choosing an individualized treatment plan for managing osteoporosis

Description:

Context: Own Your Bones (OYB) is a multidisciplinary program for osteoporosis designed to support behaviour change and shared decision making around interventions for fracture risk reduction. **Objective:** To assess program acceptability and change in health behaviors as they relate to bone health. **Design:** This is a prospective pilot study and has received approval by the University of Calgary Research Ethics Board. **Setting:** OYB was piloted at Department of Family Medicine Teaching Clinics at the University of Calgary in 2023-2024. **Participants:** A total of 26 participants were enrolled in the program (median age 70.7 years). Participants over the age of 50 with a ten-year risk of osteoporosis-related fracture ≥10% or a personal history of prior low trauma fracture were eligible to participate in the study. **Intervention:** Patients participated in a 4-week (2h/week) program, facilitated by an osteoporosis specialist, family physician, dietitians, and physiotherapist including hands-on culinary medicine training and supervised exercise. **Outcomes:** Program acceptability was determined using components of the Theoretical Framework of Acceptability. Pre- to post-program planned changes in health behaviours, and confidence in making changes were compared on self reported questionnaires. **Results:** All participants agreed (60%) or strongly agreed (40%) that the program improved their ability to manage their bone health. Behavioural change was noted in both frequency and duration of exercise with participants reporting being engaged in moderate-to-vigorous activity a median of 5 days a week after attending the program. Additionally, all participants "agreed" or "strongly agreed" to better understanding their fracture risk with 55% more participants reporting having increased knowledge around risks and benefits of pharmacotherapy. **Conclusion:** Shared medical model can support behaviour change and shared decision making around interventions for bone health. Learnings from this pilot will be used to expand program delivery and create bone health resources for wider application in primary care.

Friday, November 8 Poster: 704

Supportive Experiences of Refugees and Asylum Seekers During Childbirth

Lynn Hammoud*, MD; Fanny Hersson-Edery, MD, CCFP, FCFP; Valerie Perrault, RM, MSc, OSFQ; Millie Tresiera, doula; Gabrielle Paquette, RN, MSc, OIQ; Lisa Merry, RN, PhD, OIQ

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe particular barriers to optimal care for refugees and asylum seekers in pregnancy and childbirth
2. Identify strategies to improve the quality of intra-partum care for refugee and asylum-seeking birthing persons
3. Recognize the role that doulas can play in an inter-professional team-based approach to perinatal care

Description:

This original qualitative study explores the barriers and facilitators to high quality care for refugee and asylum seekers in pregnancy and labor from multiple perspectives, including that of refugee and asylum seeker (RAS) women, a diversity of perinatal health care providers (including Obstetrics, Family Medicine, Social Work, and Midwifery), as well as community doulas practicing in a large urban setting who care for RAS patients. Snowball sampling recruited 23 participants who were divided into 8 discussion groups. An iterative thematic analysis of transcribed discussions yielded 3 overarching themes with rich subthemes. The 3 themes included access and navigation of the health care system, the experience of childbirth, and interprofessional teamwork organization. A subtheme included the challenges and emotional toll of caring for patients who present with complex social and medical needs in pregnancy and labor. Strategies for addressing identified challenges and optimizing the care for this vulnerable population of RAS were explored.

Friday, November 8 Poster: 705

Provision and Teaching of Medical Abortion

Arielle Springer, MD; Fanny Hersson-Edery*, MD, CFPC, FCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Compare the demand for medical abortion and the provision by family medicine teaching clinics
2. Identify 3 barriers to the provision of medical abortion among clinician teachers at urban teaching clinics
3. Understand how these barrier factor impact teaching of medical abortion to residents

Description:

Context: Family Medicine Residency programs are mandated to train future family physicians to provide comprehensive care. Contraception planning, pregnancy care and abortion care are integral to the health care of reproductive aged women, as more than one in four pregnancies is unplanned and roughly one in three Canadian women has had at least one abortion. Since 2015, the introduction of Mifegymiso (mifepristone and misoprostol) has added a significantly more accessible alternative to surgical abortion. **Objective:** To examine the provision of medical abortions by clinician teachers and the teaching of medical abortion to postgraduate learners in urban Family Medicine teaching clinics. **Design:** A mixed methods study included a bilingual (French/English) survey of clinician teachers. **Setting:** Nine Family Medicine teaching clinics at a Quebec University. **Participants:** Family Medicine academic physicians. **Main Outcome Measure:** Descriptive statistics on medical abortion provision and perceived barriers to the provision of medical abortion. **Main Findings:** 60.0% of participants had patients who had required or asked about medical abortion, but only 15.1% of participants had provided medical abortion. The most common barriers to providing medical abortion were lack of training or experience, the presence of abortion services nearby, and the lack of adequate resources in the participants' clinics. Only 62.8% of clinician teachers (54/86) had offered any teaching to residents about abortion. 36.0% (31/86) had provided teaching during patient encounters and 39.5% (34/86) had taught residents to refer to resources outside of the teaching clinic. Identified barriers to providing teaching about medical abortion included the personal inability to provide reliable abortion care, working in a traditional or historically religious institution, personal beliefs about abortion, lack of experience and lack of resources at the unit. **Conclusion:** There was limited provision of office-based medical abortion in the teaching clinics, despite higher patient demand. Barriers need to be addressed to increase the offer of medical abortion and, in consequence, the clinical exposure and teaching of medical abortion to Family Medicine residents

Friday, November 8 Poster: 706

Evaluating the Impact of Gross Hematuria on Patients and the Cypress Regional Hospital: Work-in-progress

Damien Spilchen*, MD; Elizabeth Hansen*, MD; Adam Clay MSc; Emmett Harrison, MD, CFPC (EM); Francisco Garcia, MD, FRCSC

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Recognize current practices in the management of gross hematuria
2. Describe the outcomes associated with different treatment options for hematuria in the ED
3. Reflect upon practice patterns in the Cypress Regional Hospital and compare to their local practices

Description:

Context: In the Emergency Department (ED) setting, gross hematuria is a common presentation. A novel treatment for gross hematuria involves the instillation of intravesicular tranexamic acid. It is unclear if this novel treatment is more effective than continuous bladder irrigation (CBI), manual bladder irrigation (MBI), or both. Few studies have been completed in Canadian centers, and more data is required on practice patterns to inform research and implementation of tranexamic acid for gross hematuria in smaller Canadian hospitals. **Objective:** We plan to gather information about current presentations of gross hematuria to the Cypress Regional Hospital (CRH), the treatments implemented, and patient outcomes. **Design:** A five-year retrospective chart review will be completed for patients presenting to the ED or admitted to hospital with the initial presentation of gross hematuria. Descriptive statistics (counts, percentage, median and interquartile range) will be calculated. This project was approved by the USask Biomedical Research Ethics Board (REB) via delegated review. **Setting:** Data will be extracted from the medical records of a rural/regional hospital in Saskatchewan. **Participants:** Patients over the age of 18 presenting with gross hematuria to an emergency room or inpatient ward in the CRH. **Main Outcome Measures:** Variables include treatment type (MBI, CBI, observation), urologist involvement, need for cystoscopy, length of hospital stay, length of remission, frequency of ED presentation, frequency of representation within 7 days and need for blood transfusion. **Results/Findings:** This study will provide information about practice variation, as well as "ED Inertia"; whether outpatient and inpatient outcomes are affected by ED management. This study also lays a foundation for future investigation into this area, such as a local RTC comparing treatment options.

Friday, November 8 **Poster: 707**

The Impact of Dexamethasone on Hospitalization and Mortality in Long-Term Care Residents With COVID-19: An interrupted time series study

Amy T. Hsu*, PhD; Kednapa Thavorn, PhD; Anna Clarke, MSc; Danielle Cruise, MSc; Danielle Sinden, MA; Benoit Robert, MD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe the prevalence of clinical use of dexamethasone for long-term care residents with COVID-19
2. Understand the impact of dexamethasone use for long-term care residents with COVID-19
3. Understand the utility and limitations of an interrupted time series study design

Description:

Objective: To examine the clinical use of dexamethasone for long-term care residents with COVID-19 respiratory illness and to explore the heterogeneity in prescribing patterns and treatment outcomes. **Design:** Retrospective study using interrupted time series analysis. **Setting:** Long-term care homes in Ontario. **Participants:** Residents in Ontario long-term care homes with an incident SARS-CoV-2 infection between March 1, 2020 and December 5, 2020. **Intervention:** Since July 2020, Health Canada has stated that clinicians should strongly consider the use of dexamethasone for patients who have COVID-19 and require oxygen or mechanical ventilation. This recommendation is largely based on the practice-changing results of the Randomized Evaluation of COVID-19 Therapy (RECOVERY) trial conducted in the UK. In the RECOVERY study, which was published in July 2020, administration of 6 mg of dexamethasone daily for up to 10 days was associated with a reduction in 28-day mortality in patients receiving oxygen only or mechanical ventilation. The effect of dexamethasone use in long-term care residents with COVID-19 has not been extensively studied. **Main Outcome Measures:** Rates of all-cause and COVID-19-related hospitalizations, all-cause and COVID-19-related emergency department visits, and mortality. **Results/Findings:** A total of 7,919 incident SARS-CoV-2 infections in long-term care residents were identified between March 1, 2020 and December 5, 2020. Prior to July 2020, there were few prescriptions (0.24 claims per 100 long-term care residents) of corticosteroids, including dexamethasone, in long-term care residents with COVID-19. Following the publication of results from the RECOVERY trial, prescription of dexamethasone (7.21 claims per 100 long-term care residents with COVID-19) and other corticosteroids (2.67 per 100 long-term care residents with COVID-19) increased significantly. In these same timeframes, rates of COVID-19-related hospitalizations (from 4.98 to 3.24 per 100 long-term care residents with COVID-19) and mortality (from 8.78 to 3.63 per 100 long-term care residents with COVID-19) decreased significantly. **Conclusion:** For long-term care residents with COVID-19, early administration of dexamethasone was associated with significantly reduced rates of hospitalization and mortality. These results suggest potential benefits to the continued use of dexamethasone in frail long-term care residents with COVID-19.

Friday, November 8 **Poster: 708**

Hyperprolactinemia and Tuberculosis: An atypical presentation

Tariq Jagnarine*, MD, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Highlight pitfalls in prolactin testing
2. Elucidate the impact of tuberculosis on the pituitary gland

3. Underscore the significance of considering tuberculosis as a cause of prolactinomas,particularly in endemic regions

Description:

Hyperprolactinemia diagnosis can be challenging due to various potential causes. Commonly, a prolactin level above 200-250 ng/mL indicates prolactinomas. However, this may not always apply, as other causes, including tuberculosis affecting the pituitary, can lead to elevated prolactin levels. Tuberculosis-induced pituitary involvement is rare and mainly detected through precise imaging, particularly in tropical tuberculosis-endemic areas. Misidentification as a pituitary adenoma can result in delayed diagnosis and treatment, causing enduring damage to both the endocrine and nervous systems. This case study, a rarity in Guyana, was identified via histopathological studies, initially escaping detection in advanced radiological assessments without signs of extrapulmonary or pulmonary tuberculosis. **Objective:** To highlight pitfalls in prolactin testing. To elucidate the impact of tuberculosis on the pituitary gland. To underscore the significance of considering tuberculosis as a cause of prolactinomas, particularly in endemic regions. **Methodology:** This case study reviews relevant research papers, emphasizing the importance of considering tuberculosis as a cause of prolactinomas, especially in endemic areas. It explores common causes of hyperprolactinemia and potential pitfalls in laboratory findings of prolactin levels. **Results:** Endocrine and metabolic manifestations due to tuberculosis are infrequent but can be severe and complex. Although the advanced treatment of Mycobacterium tuberculosis reduces endocrine gland involvement, it can affect any endocrine structure. Symptoms affecting the endocrine and metabolic systems may arise from the infection, treatment, or physiological processes. Some patients may experience immunosuppression, increasing susceptibility to tuberculosis. Symptoms often resolve with anti-tuberculosis medication, while others may require hormonal therapy. **Conclusion:** Diagnosing pituitary tuberculosis is challenging, often relying on histological or post-mortem discoveries. Clinicians should consider pituitary tuberculosis in patients with pituitary dysfunction, especially from endemic areas or with a positive TB diagnosis. Early recognition and treatment are crucial to prevent lasting endocrine and nervous system damage.

Friday, November 8 Poster: 709

Promoting Hearing Health for Adults in Primary Care

Lorienne M. Jenstad*, PhD, RAUD; Brenda T. Poon, PhD; Danielle Lafleur, MSc, RAUD; Craig Stevenson, BFA; Nardia Strydom, MBChB, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe their role as agents of change for patients seeking hearing healthcare
2. Identify barriers to promoting hearing healthcare for older adults in primary care
3. Identify practices to promote hearing healthcare access

Description:

Context: Often the first contact for adults with hearing concerns is their primary care provider (PCP). **Objective:** Determine PCPs' behaviour, attitudes, and knowledge of hearing health. Identify barriers and facilitators for PCPs to champion their patients' hearing healthcare. **Design:** (1) online survey of open and closed-ended questions about hearing healthcare; (2) virtual focus group using the nominal group technique to identify priorities for hearing health practices. **Setting:** Data collected virtually in British Columbia, Canada. **Participants:** 370 PCPs responded to the survey. Eleven PCPs participated in the focus group. Both samples included a mix of primary care physicians and nurses, and recently retired practitioners. **Main Outcome Measures:** Survey outcomes included degree of agreement with statements about hearing health and qualitative responses about practices, barriers, and facilitators. Focus group outcomes included a prioritized list of recommended PCP hearing health practices. **Results/Findings:** 71% of survey respondents agreed they play an important role in their patients' hearing healthcare. PCPs reported that their in-clinic practices regarding hearing health include advising patients on hearing protection and recommending that they seek further hearing health care with an audiologist or otolaryngologist. Barriers to providing hearing health included patient-related (e.g., finances) and PCP-related (e.g., time constraints) factors. From the focus group, the prioritized recommendations for PCP practice regarding hearing health were: 1) obtain a thorough hearing history; 2) educate the patient; 3) audiology and ENT referral; 4) consider patient's resources (financial); 5) follow up with the patient. **Conclusion:** Primary care providers hold an important role in promoting hearing healthcare for older adults; yet they encounter multiple barriers to providing optimal hearing health. Promoting hearing health access and use for patients will require coordinated approaches that recognize and address multiple intersecting barriers at knowledge, practice, and broader systemic levels.

Friday, November 8 **Poster: 710**

An Educational Toolkit for Healthcare Providers Serving the Incarcerated Who are Placed in Isolation

Claire Bodkin, MD, CCFP; Austin Lam, MD; Ruth Elwood Martin*, MD, FCFP, MPH; Michael Menconi, JD, MS, MPH, HEC-C; Baijayanta Mukhopadhyay, MD, CCFP, MA, DTM&H; Nooshin Nikoo, MD, MHSc, CCFP; Jenna Webber, MD, MPH, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Provide education about isolation and solitary confinement in the carceral setting in Canada
2. Provide tools to contribute to reducing the potential health effects of isolation and explore solitary confinement
3. Provide tools to facilitate ongoing system transformation towards reduction or abolition of isolation and solitary confinement

Description:

Context: Solitary confinement (SC) is an umbrella term that encompasses isolation, segregation, seclusion, separation, or cellular confinement in which incarcerated persons are isolated for 22 hours or more per day without meaningful human contact. The reported associated effects of SC include: onset/exacerbation of mental illness; worsened chronic medical conditions; increased risk of suicide during isolation; and increased risk of death from non-natural causes after release from custody. United Nations rules, 2016 CFPC position statement, and Canadian courts all call for the abolition or decreased use of SC. There is no current pan-Canadian educational resource for healthcare providers (HCPs) who work in carceral environments. This toolkit aims to fill these gaps by providing a resource for HCPs working with people who are detained in SC. **Design:** We collaboratively drafted this toolkit, based on a literature search and the CanMEDS framework, with ongoing incorporation of feedback from diverse external reviewers. The CFPC MIGS team copyedited, translated, graphically designed, and implemented a dissemination plan for the toolkit, supported by a CFPC MIGS grant. **Setting:** The toolkit audience is Canadian HCPs working in federal/provincial/territorial carceral settings. **Participants:** Member of the interest group of prison health at CFPC, people with incarceration experience, legal experts, external healthcare experts and an Indigenous Elder gave reviewer feedback, which was incorporated into the toolkit. Intervention: We will launch the toolkit during FMF2024, and mail copies to the clinic of every Canadian correctional facility. **Main Outcome Measures:** The number of toolkit downloads from CFPC webpage, and qualitative feedback from HCPs utilizing the toolkit. **Results/Findings:** The toolkit is a 10-page document, including a one-page clinical hand-out, and a learner's toolkit. Two journal articles are planned. **Conclusion:** This unique toolkit provides a resource for HCPs about the potential and reported associated risks of SC and promotes their participation in system redesign towards consistent replacement of SC option with clinically appropriate infrastructure units.

Friday, November 8 Poster: 711

Family Medicine-Obstetrical Care in NL: A chart audit

Victoria McClintock*, MD; Susan Avery, MD, CCFP, FCFP; Nicholas Fairbridge, PhD; Russell Dawe, MD, MDiv, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe maternal outcomes of interest in low-risk obstetrical care
2. Describe neonatal outcomes of interest in low-risk obstetrical care
3. Compare low-risk obstetrical outcomes between a Family Medicine-Obstetrical care model (i.e., Family-Centred Maternity Care) and obstetricians

Description:

Context: Family-Centred Maternity Care (FCMC), a group of family physicians affiliated with Memorial University's (MUN) Discipline of Family Medicine in St. John's, NL, provides prenatal, intrapartum, and postpartum low-risk obstetrical (LRO) care. Canadian literature asserts that family physicians provide care associated with maternal and neonatal outcomes comparable to obstetricians' (OBS). **Objective:** Compare outcomes of LRO care patients from FCMC vs. OBS providers. **Design:** Chart audit as component of a program evaluation with ethics exemption from the Health Research Ethics Authority in St. John's, NL. Eligible patients were identified and relevant data collected from their electronic medical records. **Setting:** Three academic Family Medicine clinics affiliated with MUN in St. John's, NL. **Participants:** 120 FCMC-LRO patients (estimated date of delivery [EDD] July 1, 2017 – Jan 30, 2019) from FCMC's patient database, and 130 OBS-LRO patients (EDD July 1, 2018 – Jan 3, 2020) from a practice search of three academic Family Medicine clinics, were selected by convenience sampling using exclusion criteria identified by FCMC in conjunction with the literature. **Main Outcome Measures:** 21 intrapartum interventions and maternal and neonatal outcomes, including labour and delivery modes, medication and analgesia rates, maternal postpartum complications, and neonatal outcomes in hospital, including breastfeeding. **Results:** FCMC- and OBS-LRO patients generally had similar demographics, interventions, and maternal and neonatal outcomes. Statistically significant differences included more FCMC patients exclusively breastfed in hospital postpartum (two-sided p value = 0.009) and participated in delayed cord clamping (two-sided p value = 0.011) compared to OBS patients. **Conclusion:** LRO care by FCMC demonstrates similar outcomes to those of OBS care providers. This suggests that family physicians provide high quality LRO care.

Friday, November 8 Poster: 712

Return Rate of In-Clinic FIT Distribution

Nicole Oszust*, MD; Stephanie Balko, RN, MSc; Kaili Hoffart, MD, CCFP; Roni Kraut, MD, CCFP, MSc

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Barriers of colorectal cancer screening
2. FIT to screen for colorectal cancer
3. Options for improving colorectal cancer screening rates

Description:

Context: Only half of eligible adults participate in Alberta's colorectal cancer screening program (fecal immunochemical test [FIT]). Historically patients pick up FIT kits at the lab or order online. FITs have recently become available to family medicine clinics in Alberta to distribute directly. **Objective:** To determine the return rate of in-clinic FIT distribution at a family medicine clinic. **Design:** Observational study. University of Alberta Ethics (Pro00141238). **Setting:** An Edmonton family medicine clinic. **Participants:** Average risk patients, 50-74 years old, have not had a FIT test in at least a year, and ≥30 days between receiving the FIT kit and data extraction. **Intervention:** FITs were opportunistically provided to patients between September 2023 and March 2024 by physicians and staff. Data was extracted from the clinic EMR. **Main Outcome Measure:** Return rate and days to return, aggregate and by subgroup: "regular" (last screening ≤3 years ago), "overdue" (last screening >3 years ago), and "never" (no prior screening results available). **Results:** One hundred and nineteen patients, seen by 10 different family physicians, were given FIT kits and 96 (66% female, median age 59) were eligible for analysis. The aggregate return rate was 53%, and the median days to return was 9 (IQR 2-18). Regular subgroup (43 patients, 70% female, median age 62): 65% return rate, 7 days to return (IQR 2-14). Overdue subgroup (21 patients, 61% female, median age 59): 43% return rate, 12 days to return (IQR 10-14). Never subgroup (32 patients, 63% female, median age 55): 44% return rate, 12 days to return (IQR 6-26). **Conclusion:** In-clinic distribution of FIT kits in a family medicine clinic appears effective. Follow-up is needed to determine if the return rate variation between subgroups is a true effect, if in-clinic FIT distribution improves the clinic's overall colorectal cancer screening rates, and patient and physician preference.

Friday, November 8 **Poster: 713**

Enhancing Accessibility in iOAT: A clinical prospective on the experiences of patients with disability

Liam Quinn*, BHSc; Scott MacDonald, MD; Eugenia Oviedo-Joekes, PHD

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Understand the obstacles confronted by patients undergoing Injectable Opioid Agonist Treatment (iOAT) and alternative opioid treatments
2. Analyze the positive impacts of enhanced independence with take-home iOAT
3. Recognize the intersectional relationship between disability and opioid use in the context of iOAT and alternative opioid treatments

Description:

Context: The ongoing opioid epidemic presents a significant public health crisis, necessitating a comprehensive response from healthcare providers, including family medicine doctors. As primary care providers, family doctors play a crucial role in the provision of appropriate care for substance use disorders and associated comorbidities. **Objective:** This study evaluates the impact of take-home Injectable Opioid Agonist Treatment (iOAT) and advocates for the inclusion of alternative opioid treatments within the existing continuum of care options for family medicine doctors. **Design:** A qualitative descriptive study was conducted, involving semi-structured interviews with take-home iOAT clients to capture their experiences and the benefits of this treatment approach. Data was analyzed through a critical realist approach, utilizing an abductive coding framework. **Participants:** Twenty-three (N=23) clients receiving take-home iOAT were recruited through purposive sampling from community-based clinics in Vancouver, Canada. The mean age of participants was 54.7 (± 7.3) years, the majority of clients self-identified as having a disability (n=20, 87.0%). **Results/Findings:** Interviews with take-home iOAT clients reported enhanced autonomy and substantive benefits related to their treatment. Take-home iOAT has made care more accessible for Disabled clients by recognizing the intersectional needs of Disabled experiences while supporting the agency, dignity, and freedom of Disabled people to manage their own care. **Conclusion:** Expanding access to take-home iOAT, and incorporating alternative opioid treatments into the continuum of care for family medicine doctors, aligns with harm reduction principles and person-centred care. These evidence-based approaches can facilitate engagement with marginalized populations distrustful of healthcare systems while providing comprehensive care for chronic illnesses and addressing the diverse and fluctuating needs of this population. By normalizing and integrating take-home iOAT and alternative opioid treatments, family doctors can play a vital role in mitigating the risks of the ongoing opioid epidemic and supporting individuals with substance use disorders and associated comorbidities.

Friday, November 8 Poster: 714

Family Physicians on Call for Advice

Elaine Rose*, MPH, HD, MSc; Laura Payant, RN; Brian Andrews, CHIM; Qian Yang, MSc; Gary Garber, MD, FRCPC

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Identify family physicians' medico-legal challenges resulting in calls to the CMPA for advice
2. Evaluate differences in medico-legal needs between family physicians' TOW, years of practice, and region
3. Incorporate their understanding of medico-legal challenges into their practice to help mitigate medico-legal risk

Description:

Objective: Identify medico-legal challenges faced by family physicians through analysis of calls for advice to the Canadian Medical Protective Association (CMPA). **Design:** We performed a retrospective descriptive analysis of advice calls from family physicians to the CMPA. Ethics approval was obtained from the Canadian ethics review panel of the Advarra Institutional Review Board (Pro00020829). **Setting:** Advice calls from family physicians in Canada captured by physician advisors and advice call analysts from September 1, 2023, to March 25, 2024, were included. **Participants:** During the study period, there were 5,794 calls, of which 3,221 were analyzed. Calls were received by physician advisors from consenting CMPA members practicing family medicine. Some family physicians also practiced obstetrics, anaesthesia, surgery, or emergency medicine. **Main Outcome Measures:** The study outcomes were physicians' practice region, type of work (TOW), years of practice, and their medico-legal concerns that prompted the need for advice. **Results:** The most common reasons for seeking medico-legal advice included administrative questions (n=1,518), legal and regulatory issues (n=1,501), and challenging patient interactions (n=1,029). More specifically, the most frequent sub-categorized reasons for calling concerned medical records (n=794), termination of the physician-patient relationship (n=547), and the business of medicine (n=510). Reasons for calling significantly varied by region ($p<0.001$), years of practice ($p<0.001$), and TOW ($p=0.02$). Within the study period, 9% of Canadian family physicians called the CMPA for advice, with the highest relative proportion among Ontario physicians (10%). **Conclusion:** Between September 1, 2023, and March 25, 2024, family physicians sought medico-legal advice about administrative questions, legal and regulatory matters, and concerns regarding challenging patient interactions. Increased understanding of these medico-legal challenges enables the CMPA to support members' needs by preparing learning resources tailored to family physicians and address specific medico-legal concerns for which they most frequently seek advice.

Friday, November 8 Poster: 715

Achieving Effective Patient Care: The opportunity to partner with patients in family medicine

Dana Arafeh*, MSc; Melanie Henry, MD, CCFP; Patricia Obrien, RN, MScCH

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Explore viable approaches to facilitate patient engagement in family medicine
2. Describe the contributions of patient partners to improving quality of care through a department of family medicine
3. Describe patient reflections on partnering with faculty, staff and learners at DFCM

Description:

Context: The Department of Family & Community Medicine (DFCM) at University of Toronto prioritized patient engagement, emphasizing building collaborative relationships with patients and community as a key goal in the 2022-2027 strategic plan. In 2022, the DFCM's established the inaugural Patient Family Advisory Committee (PFAC). The PFAC meets 8 times per year and is supported by the Patient & Family Engagement Specialist with faculty leadership from our Vice-Chair, Community & Partnerships. In addition to the PFAC, a database of patient partners representing our 15 academic sites has been developed to support the work of the PFAC and other patient partnership opportunities. **Objective:** This poster will showcase approaches to effective patient engagement by offering insights, experiences, and practical tools for improving quality of care in primary care. **Design:** This poster will feature patient stories illustrating how patient partners were involved in improving the patient experience, quality of care, and education of family medicine residents at DFCM teaching clinics. Patient stories will be featured along with the mechanisms of engagement, including quotes on the impact of each of the experiences from our patients and primary care providers. Tips, lessons learned, and reflections from our team members will be shared. **Setting:** DFCM academic sites. Participants: family medicine faculty, staff, learners, patient partners from 15 DFCM teaching clinics who are either members of the University of Toronto Family Medicine Patient Advisory Committee or the patient pool. **Main Outcome Measures:** Improved patient partner experience, improved faculty/staff experience, perception of impact on clinical experiences, viability of informing process improvement at the department and academic site level. **Results/Findings:** This poster will showcase patient and primary care team member's reflections, contribution to improvements, offering insights into the benefits of collaborative patient partnership, & lessons learned for future improvement of the program. **Conclusion:** This poster will highlight the ongoing efforts to effectively achieve patient centered care by authentic partnering with patients. By sharing examples and lessons learned (stories), we aim to inspire others to engage with patients in ways that improve efficiency, enhance provider satisfaction, and integrate patient perspectives seamlessly into clinical practice.

Friday, November 8 **Poster: 716**

Program Evaluation of Momma Moments Medical Services: Work-in-progress

Hiliary Hasan*, MD, CCFP; Elaine Xie*, MD, CCFP

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Describe how the Momma Moments Program provides care to at-risk mother-child dyads
2. Evaluate the current setup for delivery of medical services in the Momma Moments Program
3. Discuss and share ideas about the delivery of medical services to at-risk mother-child dyads

Description:

Context: The Momma Moments Program is a referral based, peer-to-peer community program that is part of Choices for Youth, a non-profit organization that supports at-risk youth in St. John's, NL. Since its start in 2003, the Momma Moments Program has supported and advocated for vulnerable young mothers experiencing barriers to parenthood, as well as their children. These barriers include limited or no social support, poverty, housing insecurity, complex mental health, intimate partner violence and substance use disorders. The program has grown significantly since its inception. Currently, the program offers weekly recreational activities, case management, family-oriented therapy, affordable housing units, and medical services to its participants. Dedicated medical services were added to the program in 2018. Both authors are the current family physicians working with the program. To our knowledge, since the introduction of medical services, a formal program evaluation has not been conducted on the efficacy and outcomes resulting from the addition of these medical services. The program has recently undergone a significant change in leadership, and we feel this is an ideal time to gather this information in order to continue to optimize the care provided. **Objective:** To perform a program evaluation of medical services in the Momma Moments Program in order to identify areas that can be formalized, modified and/or optimized. **Design:** Mixed-method program evaluation through qualitative and quantitative modalities. Qualitative including individual interviews and open-ended surveys. Collection of quantitative data around usage of medical services by program participants. As this is a program evaluation, local Research Ethics Review is not required. **Setting:** In-person, virtual. **Participants:** Staff working within and alongside the Momma Moments Program at Choices for Youth, who have knowledge of the medical services; previous family physicians who have worked with the program**. Intervention/Main Outcome Measures**: NA **Results/Findings, and Conclusion**: In-Progress

Friday, November 8 Poster: 717

Primary Care Setting : Pain management for IUD insertion: Work-in-progress

Annie LA Nguyen*, MD; Ariane Lamoureux*, MD, Nathalie Bettez, MD; Olivier Pothier-Piccinin, MD; Véronique Côté, MSc; Valérie Lemieux, IPSPL; Marie-Pier Groleau, MD; Marie-Dominique Poirier, Andrée-Anne Cormier; Andréa Lessard, MD, MSc

Learning objectives:

At the conclusion of this activity, participants will be able to:

1. Learn main recommendations for analgesic strategies for IUD insertion
2. Gather tools to better discuss analgesic options with patients
3. Gather tools to better document IUD procedure

Description:

Objective: To improve clinical practices at the Chicoutimi University Family Medicine Group (U-FMG) by adhering more closely with current recommendations regarding pain management during intrauterine device (IUD) insertion. Specifically, ensuring by April 2024 that: 1. Discussion about pain management during IUD insertion is documented in at least 70% patient files. 2. At least 90% of documented pain management strategies align with current recommendations. **Design:** Quality improvement project, exempt by the local Research Ethics Review board. Setting: Chicoutimi U-FMG, Quebec. **Interventions:** A literature review was conducted in August 2023 to identify key recommendations for both nonpharmacologic and pharmacologic analgesic methods during IUD insertion. A retrospective file review of 31 patients (June 2023-September 2023) assessed current clinical practice at the U-FMG. An internal survey gathered insights into obstacles to recommendation adherence. A continuous quality improvement committee, composed of family medicine residents, a family doctor, a nurse practitioner, a continuous quality improvement agent and patient partners, selected methods to implement in the clinic, including strategies to facilitate patient discussion on pain management. Implementation efforts entailed introducing the lidocaine spray and raising awareness of existing options such as the EMLA cream among clinic staff. Tools were developed to facilitate discussions on analgesia during IUD insertion, such as standardized electronic medical records templates, alongside a visual decision aid for patients. These tools and methods were disseminated to all healthcare practitioners through meetings. **Results:** An initial subsequent file review of 7 patients (February 2024-March 2024) revealed an increase in discussion of pain management during IUD insertion from 10% to 57%, and an increase in the use of effective pharmacological interventions from 50% to 88%. Data collection will continue to further analyze the trends. **Conclusion:** Effective discussion on pain management and use of recognized pharmacological methods are essential for optimal patient care during IUD insertion.