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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.

3 Years' Experience of a New Selection Test for Family Medicine

Keith Wycliff-Jones*, MBChB, FRCGP, CCFP; Michelle Morros, MD, CCFP, FCFP; Jonathan Gerber, BSc; Mel Washbrook, BSc (Hons), MSc; Fiona Patterson, PhD, CPsychol, FRCGP (Hon), FCMI

Learning objectives:

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

1. Describe the importance of a new contextualized situational judgement test(SJT) in Family Medicine residency selection
2. Explain the process of developing a new SJT for FM residency selection
3. Understand group differences in performance in a new SJT over the previous 3 years

Objective: To determine the utility of a new situational judgement test(SJT) developed for Family Medicine (FM) residency selection. **Design**: A new, online SJT was contextualized and piloted for FM in Canada before being used in selection by 6 FM Residency Programs in 2022, 13 in 2023, and 15 programs in 2024. Candidates were invited to complete an anonymous demographic survey and a post-test evaluation. Research Ethics Boards' approvals were obtained. **Results:** In 2022, 1835 candidates completed the exam (English n=1309, French n=526). Test reliability was good (Cronbach's alpha=0.78), with a test difficulty of 73.5%. English test takers performed better than French test takers (Cohen's d =0.32, $p<0.001$). Females performed better than males (d = 0.2, $p<0.5$). In 2023, 3478 candidates completed the exam (English n=2959, French n=519). Test reliability was excellent (alpha=0.82), with a test difficulty of 77%. There was no significant difference in scores based on test language ($p>0.05$). Females scored better than males (d=0.16, $p<0.5$). In 2024, 3667 candidates completed the test (English n=3083, French n=516). Test reliability was excellent (alpha=.83), with a test difficulty of 79.5%. Test language and gender had no significant effect on total test score. In all years, Canadian Medical Graduates (CMGs) scored better than International Medical Graduates (IMGs) (2022: d=0.6, $p<0.001$), (2023: d=0.33, $p<0.001$), (2024: d=.53, $p<.001$). In 2024, there was no significant difference between IMGs and Canadians who studied abroad. Candidate evaluations of the test were generally positive. **Conclusions:** Overall, there is good evidence that this new SJT can differentiate between individuals, indicating that the methodology is an effective method for selection into FM programs in Canada. A moderate effect size was observed between CMGs and IMGs. All other group differences observed in performance were either negligible or small. Further evaluation of the observed group differences will continue in future cycles.

A PBRN Strategic Clarity Initiative: Journey, Outcomes, and Lessons Learned

Marie-Thérèse Lussier*, MD, BSc, MSc, FCMFC; Janusz Kaczorowski, PhD; Nathalie Caire Fon, MD; Marie Authier, PhD

Learning objectives:

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

1. Explain the three deliverables of an Impact and strategic clarity process

2. Discuss facilitators and barriers to conducting an impact and strategic clarity exercise
3. Share impact and strategic clarity tools useful to define an organization's mission and intended impact

Context: The Réseau de recherche en soins primaires de l'Université de Montréal (RRSPUM) is our University's Family Medicine and Emergency Medicine Department's Practice-Based Research Network (PBRN). RRSPUM includes 20 Academic Family Medicine clinics. Because of the rapidly evolving Quebec Primary PC research landscape, we embarked on a strategic planning exercise. **Objective:** To better define RRSPUM's mission, vision and 5-year action plan. **Study Design:** A rigorous social innovation approach. **Setting and Population:** The RRSPUM organization and its membership. **Intervention:** An iterative social innovation process evolved over a 18-month period guided by two experienced Innoweave strategic impact coaches. Three working committees were set up. The "core" committee composed of the department's director and research director, the RRSPUM director and a research facilitator saw to the timely unfolding of the different phases of the initiative and preparing all written documentation. Two "peripheral" committees were set up to ensure discussion of the strategic positioning of the RRSPUM both within and outside our faculty. They were consulted at predetermined moments in the process. **Results:** Three cornerstone deliverables were determined: an intended impact statement, a theory of change and a set of strategic priorities and action plan. A RRSPUM theory of change graphic representation was created as well to facilitate understanding of the process. **Conclusion:** This rigorous coach-led strategic clarity initiative increased our 20 clinics'sense of membership to RRSPUM as well as clarified their role in developing and supporting PC research in our department. We believe that sharing the documentation resulting from our strategic clarity reflection, in a user-friendly format, will encourage other PBRNs to undertake a similar approach or to draw inspiration from it to review their own action plans and clarify the relationships to develop both within and outside their internal environments.

A Virtual Reality Tool for Teaching Empathy, Collaboration, and Breaking Bad News in Undergraduate Medical Education

Miriam Lacasse*, MD, CCFP; Lina Shoppoff*, MD, CCFP; Julien Gobeil-Proulx, MEd; Sarah Dickson, MSc; Maddie Venables, PhD

Learning objectives:

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

1. Describe the development process and required resources for creating a VR-based educational module focused on empathy and communication in medical education
2. Identify key components of effective VR simulations that support the teaching of empathic listening, breaking bad news, and interprofessional collaboration
3. Discuss strategies for integrating immersive VR training into undergraduate medical curricula, including considerations for feasibility, stakeholder engagement, and cost-sharing models

Context: Virtual reality (VR) can immerse learners in realistic, emotionally charged patient scenarios that foster empathy and enhance communication skills. Although VR-based interventions are increasingly popular, few fully address the teaching of empathy, collaborative skills, and breaking bad news to medical students. This initiative leverages VR to safely and authentically engage learners with the patient's lived experience, improving patient satisfaction and quality of care. **Objective:** To describe the development process and resources required for creating a VR training module intended for integration into an undergraduate medical curriculum. **Design:** This project was developed collaboratively between the undergraduate medical program at the Faculté de médecine, Université Laval and the Department of Family Medicine at the University of Ottawa, in partnership with an industry VR developer. It was informed by the real journey of a patient with rare cancer and her healthcare team, culminating in 14 VR videos. **Setting:** Two Canadian medical faculties with a shared goal of enhancing empathy and communication training through immersive learning tools. **Participants:** Contributors included faculty advisors, a medical student, standardized patients, a patient-participant, and industry partners. A small user-testing pilot included medical students who provided formative feedback on feasibility and user experience. **Intervention:** A VR simulation was developed to emphasize empathic listening, stepwise strategies for breaking bad news, and interprofessional collaboration. Learners follow the patient journey—from diagnosis to remission—observing varied empathic communication and approaches to delivering difficult news. **Main Outcome Measures:** The presentation details the development process—from stakeholder engagement and content creation to the production workflow—for a VR educational tool intended for third-year medical students. **Results:** Development costs (~CAD $37,000) were shared evenly, offering a replicable financial model. The tool is intended for a half-day session with quizzes, discussion, and group reflection. **Conclusion:** This process demonstrates a scalable method for VR-based empathy and communication training, offering a promising blueprint for broader adoption.

Addressing the Climate Education Crisis: Development of Planetary Health Learning Modules for Family Medicine Residents and Teachers at the University of Toronto

Kit Shan Lee*, MSc, MD, CCFP; Laura Feldman, MD; Marlee Vinegar, MD; Katherine Yu, MD; Samantha Green, MD, CCFP

Learning objectives:

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

1. Identify the importance of planetary health education in family medicine residency
2. Explore possible objectives in a planetary health curriculum
3. Evaluate a planetary health e-module

Description: The World Health Organization has called climate change the biggest health threat of the 21st century, and it is already affecting the health of people in Canada. No formal climate change and health curriculum exists for family medicine residents at the University of Toronto. Family physicians and learners need adequate training on the health impacts of climate change; it is crucial for current and future family physicians to be able to recognize, treat, and prevent climate-related illnesses. **Goals and Objectives:** To fill the gap in climate change education, we are developing two educational tools with assistance of a Temerty Faculty of Medicine Education Development Fund (EDF) grant - 1. a four-part asynchronous e-learning module using Articulate Rise 360 platform; 2. a practice-based learning (PBL) module to enhance transformative learning by enabling learners to apply a planetary health lens in their clinical assessments and decision making. The 2020 Guide to Improving Family Medicine Training (GIFT) on Planetary Health will provide the framework and learning objectives for this work. The report suggests four main categories that include - 1) Environmental health literacy, 2) Planetary health advocacy, 3) Patient empowerment and 4) Sustainable practice. **Next steps - Review and evaluation:** The evaluation of these educational tools is beyond the scope of the EDF proposal. Methods being considered include analysis of metrics from Articulate Rise 360 and standardized questionnaires and interviews of testers during beta testing. Once these methods have been finalized, we will send a proposal to the University of Toronto research ethics board for review.

Advancing Health Equity Through Primary Care: Protocol for the Spread, Scale, and Developmental Evaluation of 'Deep End Canada' Network (Work in Progress)

Kerry McBrien*, MD, MPH; Joseph J O'Rourke, MSc; Mélanie Ann Smithman, PhD; Isabelle Fortuna, MPH; Ellah San Antonio, BSc; Archna Gupta, MD, PhD; Leanne Kosowan, MSc; Andrew D Pinto, MD, MSc

Learning objectives:

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

1. Identify examples of collecting demographic and social needs data within Canadian primary health care
2. Identify opportunities to address social needs within Canadian primary health care using sociodemographic data
3. Describe how Deep End Canada supports implementation of data collection and health equity initiatives

Context: Primary health care is typically the first point of contact for patients with the health care system, and represents an opportunity to address social needs. Launched June 2024, Primary Health Care at the Deep End Canada (DEC) is a network advocating to address health inequities through the collection and use of demographic and social needs data and knowledge exchange. The SPARK Tool is a validated tool to collect demographic and social needs data in primary health care. **Objective:** Spread the sustainable implementation of the SPARK Tool in 20-25 primary health care organizations through DEC. **Design:** Multi-method developmental evaluation guided by the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework. **Setting:** DEC members work in under-resourced areas with patients who may face social and/or economic disadvantages. Network activities are facilitated virtually. **Participants:** Clinicians, researchers, patient partners, and decision-makers representing 20-25 primary health care organizations engaged in demographic and social needs data collection or health equity initiatives. Intervention: DEC network meetings, implementation coaching, and implementation resources. **Main Outcome Measures:** Using surveys we will examine the reach and adoption of the SPARK Tool and changes in perceptions and actions related to data collection over 6-12 months. Through qualitative analysis of focus groups and open-ended questions we will identify factors influencing implementation, effectiveness and maintenance of the SPARK Tool or health equity initiatives, and experiences with DEC. **Anticipated Findings/Impact:** DEC is modelled after “GPs at the Deep End”. Research on Deep End Networks demonstrate peer support and advocacy benefits. This project anticipates DEC will facilitate sustainable implementation of the collection and use of demographic and social needs data and support health equity initiatives. **Conclusion:** Efforts to implement systematic and routine demographic and social needs data collection in primary health care are growing. DEC offers a collaborative, pan-Canadian approach to addressing health equity.

Barriers to Physician Recruitment in Rural Canadian Regions

Mahad Siddiqi*; Devon Ali Haseltine; Peter Joseph Mounsef; Wassim Elmasry; Akash Pattni; Maryam Wagner, PhD; Tristan Koran

Learning objectives:

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

1. List four common barriers to physician recruitment in rural Canadian regions
2. Identify strategies to mitigate barriers to recruitment for rural practice

Objective: To identify primary barriers to physician recruitment and explore mitigation strategies in a rural Canadian region. **Design:** Cross-sectional survey study. This project was reviewed and exempted by the local Research Ethics Review Board. **Setting:** A rural region in Canada with ongoing physician shortages in family medicine. **Participants:** Fifty-five family physicians currently practicing in rural areas. Inclusion criteria included active rural practice. Surveys were excluded if incomplete or if the respondent was not practicing rurally. **Intervention** (if appropriate): N/A **Main Outcome Measures:** Physicians selected five perceived barriers to rural practice from a predefined list, then rated the effectiveness of various strategies to overcome them using a five-point Likert scale. **Findings:** The leading barrier was personal/family considerations (58%), followed by professional isolation (18%), infrastructural deficits (15%), and a lack of adequate financial incentives (15%). The most effective mitigation strategies identified were financial incentivization (63%) and enhanced work-life balance (36%). **Conclusion:** Key barriers to rural physician recruitment include personal considerations, professional isolation, limited infrastructure, and inadequate compensation. Addressing these barriers through targeted financial incentives and improved work-life balance may help improve recruitment outcomes. The main limitations of this study include reliance on a predefined list of barriers as well as a lack of input from physicians in non-rural practice.

Besoins et barrières en itinérance - Travail en cours

Marie-Christine Boucher, MD, CCMF; Anne Charbonneau, MD; Jimmy Chau, MD; Rofia Dahane, MD; Catherine Makarewicz, MD; Émilie Poliquin, MD; Gabriel Savaria, MD; Catherine Beauce, MD CM, CCMF

Learning objectives:

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

1. Décrire les besoins des personnes en situation d'itinérance à St-Jean-sur-Richelieu
2. Décrire les barrières aux soins des personnes en situation d'itinérance à St-Jean-sur-Richelieu
3. Déterminer les prochains pas pour valoriser l'accès aux soins de la population en situation d'itinérance

Objectif : Comprendre l’expérience des personnes en situation d’itinérance et identifier leurs besoins dans le système de santé québécois, particulièrement dans la région de Saint-Jean-sur-Richelieu. **Type d’étude :** Étude qualitative descriptive basée sur des entrevues semi-structurées anonymes. **Lieu :** Saint-Jean-sur-Richelieu, en collaboration avec les organismes communautaires locaux. **Sujets :** Personnes en situation d’itinérance fréquentant des organismes communautaires de St-Jean-sur-Richelieu au cours de l’année 2025. **Intervention :** Aucune intervention clinique. Recueil de données par entrevues semi-structurées menées par des médecins résidents en collaboration avec des organismes locaux. Le questionnaire d'entrevue ainsi que le projet ont été approuvés en mars 2025 par le comité d'éthique du CISSSMC (Centre intégré de santé et services sociaux de la Montérégie-Centre). **Principaux paramètres d’évaluation :** Trois thématiques principales sont explorées : 1. Barrières d’accès aux soins (ex. : obstacles administratifs, discrimination, manque de ressources). 2. Besoins en soins de santé (ex. : santé physique et mentale, suivi médical). 3. Suggestions pour améliorer les services (ex. : cliniques mobiles, meilleure coordination des soins). **Résultats/constats :** Les résultats permettront d’identifier les obstacles spécifiques à l’accès aux soins locaux, de documenter les besoins médicaux et psychosociaux de cette population et de proposer des solutions adaptées. **Conclusion :** Cette étude vise à sensibiliser les professionnels de santé aux défis rencontrés par les personnes en situation d’itinérance. Les résultats pourraient inspirer la mise en place de protocoles de soins adaptés et encourager le développement de services tels que des cliniques mobiles pour améliorer l’accès aux soins.

Beyond Blame: Addressing Barriers to International Medical Graduates (IMGs) Shortages in Rural Canada

Olugbenga Adebayo*, MD, MPH, CCFP; Carla Fehr, MA; Taofiq Olusegun Oyedokun, MBChB, DTM, MMed, CCFP (EM) FCFP, PGDipAeroRT; Jon Witt, MD, MPH, CCFP (EM), FCFP

Learning objectives:

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

1. Identify the key structural, professional, and personal barriers that impact the recruitment and retention of International Medical Graduates (IMGs) in rural Canada

2. Learn stakeholder-informed strategies, including “on-ramp” and “off-ramp” pathways (e.g., PRA, CA, AP roles), that support IMG integration and long-term engagement in rural practice
3. Understand the importance of coordinated, multi-level approaches (including national licensure harmonization and community mentorship) in creating sustainable and equitable rural physician workforce solutions

Description: Context: Physician shortages in rural Canada are shaped by many factors. International Medical Graduates (IMGs), who make up 40-47% of the rural workforce, are vital to addressing this gap but are often unfairly blamed in retention debates. **Objective:** To examine barriers to IMG recruitment and retention in rural Canada and propose actionable strategies. **Design:** Descriptive and policy-oriented analysis informed by stakeholder engagement, prior scoping review, and evidence synthesis of IMG practice trends. **Setting:** Rural and remote Canada. **Participants:** IMGs, provincial health program leaders, physician advocates, and academic stakeholders involved in IMG pathways and rural healthcare planning. **Main Outcome Measures:** Barriers to licensure, practice readiness, and retention of IMGs; strategic options for creating on-ramps and off-ramps for IMG integration. **Findings:** Professional and structural barriers such as: restrictive licensure pathways, burnout, limited scope of practice, and lack of institutional support were the most cited challenges to IMG retention in rural Canada. Conversely, community integration, spousal employment opportunities, accessible education for children, and collegial work environments significantly support long-term retention. Expanding structured “on-ramps” such as Practice Ready Assessment (PRA) and rural residency positions, along with transitional Clinical Associate (CA), and Associate Physician (AP) roles, could offer sustainable entry and retention pathways. For those for whom PRA was considered too accelerated, structured “off-ramps” such as re-entry through CaRMS or supported transitional CA and AP roles could preserve engagement. Additionally, stakeholder-informed strategies should address both extrinsic (structural, professional, community) and intrinsic (family, personal) factors, recognizing their interplay in shaping retention outcomes. A coordinated multi-level strategy that includes community mentorship, competency-based licensing, national licensure harmonization, and rural bridging programs is also essential. **Conclusion:** IMGs are a vital and under-supported workforce whose optimization is critical to equitable access in rural Canada. Structural, Institutional and regulatory partnerships are required to make these solutions scalable and sustainable.

Blood-Borne Viral Screening in New Panel Patients: A Retrospective Review in an Outpatient Family Medicine Setting

Max Charalambos, MBChB, BSc (Hons), PGCert, CCFP, MRCGP, DRCOG, DFSEM (UK)

Learning objectives:

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

1. Implement BBV screening during new patient intake in a primary care setting
2. Detect undiagnosed Hepatitis B, C, and HIV infections through routine baseline laboratory investigations
3. Initiate appropriate follow-up and care for patients with positive BBV screening results

Description: Routine screening for blood-borne viruses (BBVs), including Hepatitis B, Hepatitis C, and HIV, is not consistently implemented in primary care, despite its potential to detect undiagnosed infections early and reduce transmission. Many new patients joining a family medicine panel may not have had regular access to preventative healthcare, creating a valuable opportunity for targeted screening at the point of intake. This retrospective chart review evaluated the outcomes of offering BBV screening to all new adult patients, aged 18 and over, during their initial visit to an outpatient family medicine clinic. Screening was incorporated into standard baseline laboratory investigations and included serologies for Hepatitis B, Hepatitis C, and HIV. The review assessed how many patients underwent testing, identified positive cases, and tracked follow-up care and interventions. Among 617 new patients reviewed, 3 tested positive for Hepatitis B, 1 for Hepatitis C, and 1 for HIV. All patients with positive results were referred to the infectious disease team. Subsequent care included appropriate treatment, partner testing, immunizations, and annual monitoring. The patient with Hepatitis C was started on antiviral therapy. This review illustrates that offering one-time BBV screening at intake is feasible within routine practice, and it enables the early identification and management of chronic infections that may otherwise go undetected. This approach supports a low-barrier, proactive model for infectious disease prevention in family medicine. Key practice implications include recognizing the value of intake visits for opportunistic screening, streamlining testing into existing workflows, and improving long-term patient outcomes through timely diagnosis and intervention. Family physicians are uniquely positioned to integrate public health strategies into everyday care, and one-time BBV screening for new patients represents a practical, impactful step toward early detection and disease prevention in primary care settings.

Bridging Primary Care and Expertise: Transforming Women's Health

Elise Azzi*, MD, CCFP; Jennifer Mitchell, MD, MSc, CCFP

Learning objectives:

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

1. Describe the impact of enhanced training in Women's Health (WH) on community healthcare delivery
2. Identify barriers to the implementation of focused WH practice in primary care
3. Explore strategies to enhance postgraduate WH training programs

Objective: To explore the career outcomes, practice patterns, and leadership roles of graduates from the Enhanced Skills in Women's Health (ES-WH) Program at the University of Ottawa. **Design:** A qualitative descriptive study involving semi-structured interviews. Exempt by University of Ottawa Research Ethics Board. **Setting:** University of Ottawa, Department of Family Medicine. Participants: 22 of 31 graduates (as of 2023) of the ES-WH program since its inception in 2005. **Main Outcome Measures:** Collecting graduates perspectives on the program's impact on clinical practice, leadership opportunities, and systemic challenges. **Results/Findings:** Graduates reported increased competence in WH, the ability to bridge gaps providing gynecological care in the primary care setting, and opportunities to assume leadership roles amongst colleagues and in their communities. Challenges included billing restrictions and the absence of formal certification. Recommendations include achieving Category 1 status and standardizing curricula to ensure equitable skill development. **Conclusion:** The ES-WH program has significantly contributed to WH leadership in primary care, highlighting the need for enhanced recognition and structured training to sustain its impact.

Building Together: A Case Study of the Impact of CPCRC in Co-Building a Person-Centred Primary Care Research Consortia to Strengthen Collaboration and Capacity Across Canada

Sabrina Wong*, RN, PhD; Chad Herman; David Barber, MD; Manuela Beeckmans; Onil Bhattacharyya, MD, PhD; Andrea Grunier, PhD; Paolo Marcelo; Andrew Pinto, MD, PhD; Vivian Ramsden, RN, PhD; Ayat Salman, PhD

Learning objectives:

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

1. Describe the main goals of the Canadian Primary Care Research Consortia
2. Identify early impacts of the CPCRC
3. Describe how persons with lived experience have been involved in the development of CPCRC

Description: Objective: To describe the developmental evaluation of building, supporting and sustaining research and training and early impacts of CPCRC across Canada. **Design:** A developmental evaluation approach guided by participatory and equity-oriented principles was used to assess CPCRC's structural evolution and activities. Data sources included interviews (researchers, PWLE, policymakers, and organizational leaders), network and partnership mapping and documentation of capacity-building initiatives. Special attention was paid to processes of engagement, co-leadership and strategies to support under-represented voices in primary care research. **Setting and Participants:** The Canadian Primary Care Research Consortium (CPCRC) is being established through co-building with clinicians, people with lived experience (PWLE) who have health concerns, scientists, research staff and policy makers. **Main Outcome Measures:** Engagement of participants, research and societal impacts such as funding leveraged especially towards research priorities reflecting lived experience and frontline clinical relevance. **Results:** CPCRC brings together the Canadian Primary Care: a) Research, b) Sentinel Surveillance and c) Trials Networks. CPCRC catalyzed over 30 formalized partnerships spanning academic institutions, practice-based research and learning networks, Indigenous peoples and communities, and organizations with PWLE. Through co-building, CPCRC established governance structures that centre around PWLE and community/Nation leadership; launched national initiatives focused on trainee development and mentorship that facilitates using evidence to inform policy. Key outcomes included the creation of a cross-provincial learning network, increased grant success tied to collaborative projects, and stronger infrastructure for equity-focused research. PWLE and public partners were engaged in all phases of the organizational development. **Conclusion:** CPCRC centrally supports primary care research that is locally implemented through provincial practice-based research and learning networks. CPCRC is rooted in servant leadership, meaningful engagement and attuned to equity in order to strengthen primary care research engagement, capacity and impact.

Canadian Family Physicians' Use of Artificial Intelligence, Concerns, Administrative Burden, and Wellness – A Longitudinal Perspective

Dragan Kljujic*, MA; Steve Slade, BA

Learning objectives:

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

1. Describe current patterns of AI adoption among Canadian family physicians and the clinical tasks for which AI is most commonly used
2. Identify associations between AI use and self-reported physician well-being, and explore how these patterns may shift over time
3. Recognize key concerns about AI in clinical practice and the perceived administrative burden reported by both AI users and non-users

Context: Artificial intelligence (AI) is increasingly integrated into healthcare delivery. For family physicians, AI has the potential to alleviate or intensify existing challenges, such as burnout and administrative burden. Understanding how AI use relates to well-being and what concerns physicians hold about its implementation is vital for shaping future adoption strategies. **Objective:** To compare AI usage patterns among Canadian family physicians in 2024 and 2025, and to explore associations with professional well-being, concerns about AI, and perceived administrative burden. **Design:** This is a longitudinal, repeated cross-sectional survey study using data from national surveys administered in 2024 and 2025. Descriptive statistics and chi-square tests will be used to assess relationships between AI use and self-reported well-being. The 2025 dataset will add insights on AI-related concerns and administrative pressures. **Setting:** Canada-wide survey conducted with all active members of the College of Family Physicians of Canada. **Participants:** The 2024 sample included 2,963 practicing family physicians. A comparable sample is anticipated for 2025. **Intervention** (if appropriate): Not applicable. **Main Outcome Measures:** Primary outcomes include: (1) frequency and type of AI use in practice; (2) self-reported well-being; (3) expressed concerns about AI; and (4) perceived administrative burden. **Anticipated Results/Impact:** Preliminary 2024 findings indicate that only 20.5% of family physicians reported using AI in their practice, primarily for tasks such as information gathering and documentation. These specific uses were associated with higher self-reported well-being. The upcoming 2025 data will enable longitudinal comparisons to assess changes in AI adoption and its impact, while also offering new insights into physicians' concerns and the perceived administrative burden associated with AI use. **Conclusion/Implications/Learnings to Date:** This work-in-progress highlights the evolving nature of AI adoption in primary care and its potential connection to physician wellness and system stressors. The upcoming analysis will also examine how concerns about AI differ between those who use it and those who do not, offering a more nuanced understanding of the perceived concerns, risks and barriers.

Challenges of Pediatric Consent in the Emergency Department

Francis St-Amour*, MD; Dominic Tremblay, MD, M.Sc; Gabrielle Dufresne Vallerand, B.Sc.Inf; Charles-Etienne Lemay, Ing; Claudia Vincent-Boulay, MD, CCMF (MU); Gabrielle Trépanier, MD, LL.M., CCMF (MU), FCMF

Learning objectives:

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

1. Recognize the importance of accurate identification of parental authority in pediatric medical care
2. Identify potential gaps in the consent process of pediatric medical care in the emergency department
3. Explore potential avenues for improvement of the consent process of pediatric medical care

Background: In Quebec (Canada), pediatric patients under the age of 14 require consent from a legal guardian or holder of parental authority for medical care in the emergency department (ED). This process relies on the accurate identification of the accompanying adult. No prior studies have assessed whether this identification is consistently documented in the ED. **Methods:** We conducted a retrospective chart review at two university hospitals in Quebec, covering the period from January 1 to 31, 2024. Pediatric patients under 14 years of age who presented to the ED were included. A random sample of 100 charts was reviewed from a total of 1,080 eligible visits. Additionally, all charts of patients who left without being seen (LWBS) by a physician (n = 165) were analyzed. We evaluated whether appropriate consent from a person with parental authority was documented. **Results:** Of the 100 charts reviewed, 77 patients were seen by a physician. Among them, 71 (92%) had appropriate consent documented. In 5 cases, consent was considered inappropriate: 4 lacked documentation identifying the individual providing consent, and 1 involved a person without the authority to give consent. The LWBS rate among children under 14 during the study period was 15%, corresponding to 165 patients who left without being seen. Of these, 128 (77%) had appropriate consent, 10 (6%) had inappropriate consent, and in 27 cases (16%), the accompanying person was not identified in the chart. **Conclusion:** Although consent practices are generally followed for pediatric patients in the ED, this study highlights significant documentation gaps in the identification of parental authority or gardian, particularly among patients who leave without being seen. These findings highlight a need for quality improvement initiatives to strengthen consent practices in pediatric patient in the ED.

Collaboration Between Community and Primary Care Teams (Work in Progress)

Andrea Lessard*, MD, M.Sc; Louis Gagnon, MD; Johanie Tremblay; Sarah Verreault; Sonia Tremblay; Marie-Suzanne Mathieu, MD; Isaac Chabi M.Sc.; Geraldine Layani, Md, M.Sc.; Emilie Guérin Morneau; Marie-Eve Poitras RN, PhD

Learning objectives:

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

1. Explain the benefits of the collaboration between community care organizations and primary care teams
2. Propose interventions to foster mutual knowledge between community care organizations and primary care teams
3. Measure the impact of knowledge development interventions

Context: Intersectoral collaboration between community care organizations (CCO) and primary care (PC) teams has the potential to better address health determinants and ensure integrated patient care. In Quebec, this collaboration is not yet routine. Our previous work identified three priorities to improve collaboration. The current protocol addresses the first priority. **Objective:** To develop mutual knowledge and expertise in intersectoral collaboration among CCO workers and PC professionals. **Study Design and Analysis:** We will conduct participatory research supported by the "knowledge-to-action" framework. We are an intersectoral team and we will develop multimodal intervention with four training modules: 1. Community network functioning, intended for PC professionals; 2. Healthcare system functioning, intended for CCO workers 3. Intersectoral collaboration, intended to all and 4. Teaching intersectoral collaboration, intended to family medicine (FM) teachers. The intervention will also include a socialization activity, knowledge tools for CCO and PC teams, and pedagogical innovation in FM training centers. We will run the intervention from May 2025 to July 2028. We will measure its impact using a mixed-method design. First, 1 questionnaire will be completed before, immediately after, and three months post-intervention. Second, semi-structured interviews will be conducted with participants who applied the knowledge in their practice (target n = 12-20). Ethical submission is in progress. **Setting and Population:** The study will take place in a semi-urban area of Quebec, Canada, including 2 FM residency training centers. PC professionals, CCO workers, and FM teachers and residents will be invited to participate. **Main Outcome Measures:** Knowledge improvement, intended use, perception of the other sector and knowledge application. **Results:** Both quantitative and qualitative data will be integrated into a report describing how the intervention supported intersectoral collaboration. **Expected Outcomes:** We will create a sustainable, transferable model of training interventions that foster mutual knowledge between CCO and PC teams.

Comprehensive Osteoarthritis Care: Effectiveness of Knee Injections

Trevor Hall*, MD, CCFP (CAC SEM), Dip SEM; Julian Hall

Learning objectives:

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

1. Educate patients about injections as part of comprehensive treatment for knee osteoarthritis
2. Describe patients' chance of success with viscosupplementation injections for knee OA
3. Describe patients' chance of success with Platelet-Rich Plasma injections for knee OA

Context: Comprehensive knee osteoarthritis (OA) management includes education, exercise, strengthening, weight loss, physiotherapy, medication, bracing and injections. Research on viscosupplementation and platelet-rich plasma (PRP) injections for knee OA remains insufficient. Further studies are needed to guide family physicians on patient responses to viscosupplementation and PRP injections within a comprehensive OA care approach. **Objective:** To evaluate the effectiveness of viscosupplementation and PRP injections for knee OA within a comprehensive family medicine approach. **Design:** Retrospective chart review of knee injections over a 3-year period (approval by local research ethics board). **Setting:** Community-based sports medicine clinic providing comprehensive OA care and collaborating with local family physicians. **Participants:** 270 subjects with knee OA (mean age 63; 117 males, 153 females; 55% mild-moderate OA, 45% severe OA) who received viscosupplementation or PRP injections concurrently with comprehensive OA treatment. **Exclusion Criteria:** incomplete follow-up or data. **Main Outcome Measures:** (i) pain reduction using 10-point visual analog scale for viscosupplementation and 500-point VAS for PRP; (ii) functional improvement using WOMAC score (for PRP only), and (iii) patient self-reported satisfaction ("moderate" to "high" levels of improvement). Outcomes were measured at 1 month for viscosupplementation and 3 months for PRP. **Results:** 309 viscosupplementation injections and 118 PRP injections were analyzed. Viscosupplementation injections resulted in significant (p<.0001) reductions in pain (mean 10pt-VAS decreased by 59.8%) and 79.1% of viscosupplementation injections resulted in patient satisfaction. PRP injections resulted in significant (p<.0001) reductions in pain (mean 500pt-VAS decreased by 53.7%), resulted in significant (p<.0001) improvements in function (mean WOMAC decreased by 38.7%) and 78.8% of PRP injections resulted in patient satisfaction. Patient satisfaction was higher for those with mild-moderate OA (visco:85.8%, PRP:81.9%) compared to severe OA (visco:71.6%, PRP:73.2%). **Conclusion:** Viscosupplementation and PRP injections are viable treatments for knee osteoarthritis within a comprehensive family medicine care model.

Cultural Competency Training and Refugee Health (Work in Progress)

Emma Glaser*, MD, MSc, CMFC; Assia Rarrbo, MD resident; Rachel Rodrigue, MD, CMFC; Emilie Gelinas, PhD(c); Charlotte Serrano, MSc; Lara Gautier, PhD

Learning objectives:

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

1. Describe healthcare barriers for refugee claimants
2. Compare existing cultural competency training across family medicine sites in Quebec
3. Evaluate a reflexivity intervention for family medicine residents to improve cultural competency training

Context: Refugee claimants in Canada face significant healthcare access barriers due to structural determinants of health. A recent systematic review indicated that cultural competency training for healthcare providers can improve care quality and reduce disparities. However, research on such training and its effects on professional reflexivity in Quebec remains limited. **Objective:** This study aims to evaluate the implementation and effects of cultural competency training programs for family medicine residents in Quebec and co-develop a pilot intervention to foster professional reflexivity in caring for refugee claimants. **Design:** The study uses a mixed methods design. It will include a multi-method comparative case study which will evaluate and compare different training sites using qualitative interviews and surveys. Furthermore, we will co-create, develop and evaluate a pilot reflexivity intervention with residents. **Setting:** Two family medicine training sites in Quebec: Bordeaux-Cartierville GMF-U (University of Montreal), Sacré Coeur GMF-U (University of Montreal). **Participants:** Family medicine residents (n=20) and refugee claimants (n=20) receiving care at participating sites. **Intervention:** A pilot intervention—reflexive spaces—will be implemented at Bordeaux-Cartierville GMF-U, where residents will engage in group discussions on intercultural challenges and strategies for improving refugee care. This work has been approved by the local Research Ethics Review board. **Main Outcome Measures:** Development of intercultural competencies among residents (qualitative interviews, n=20); Perceived self-efficacy of residents in managing refugee claimant patients (survey, n=20); Satisfaction levels of migrant patients regarding their healthcare experience with residents (survey, n=20) **Anticipated Results/Impact:** Findings will provide insights into effective intercultural training strategies and the role of professional reflexivity in improving healthcare access and outcomes for refugees and asylum seekers. **Conclusion/Implications/Learnings to Date:** This study will generate evidence-based recommendations for enhancing family medicine training programs in Quebec, with potential applicability across Canada to improve healthcare equity for refugees.

Defining Patient Complexity in Primary Care (Work in Progress)

Kerry McBrien*; Stephanie Garies; Divya Garg; Deidre Young; Jonathan Gerber; Aimie Lee; Emily Brockman; Halal Rashed; Michael Cummings; Tyler Williamson

Learning objectives:

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

1. Describe how patient complexity is defined in primary care settings
2. Describe the data available in primary care EMR datasets
3. Compare the requirements of complexity indicators to available data

Context: Understanding patient complexity is important– for clinicians to tailor care delivery, for practices to balance primary care team workloads, and for decision-makers for health system planning, reporting, and budgeting. However, there is no agreed-upon approach to measure patient complexity applicable to a primary care context. Most patient complexity scores are focused on multimorbidity which has only modest agreement with family physicians' assessment of complexity. A comprehensive primary care patient complexity composite index, considering several domains (medical and mental health, acute care use, and social determinants) is needed. **Objectives:** 1) To identify patient complexity indicators used in the primary care setting; 2) To assess the completeness and quality of primary care data for development and operationalization of a complexity indicator. **Design:** Scoping review following the Arksey and O'Malley Framework; Descriptive data analysis. **Setting:** Department of Family Medicine, University of Calgary (UC), Alberta. **Data Sources:** Published peer-reviewed literature; primary care electronic medical record (EMR) data – UC academic clinic data and Southern Alberta Canadian Primary Care Sentinel Surveillance Network (CPCSSN) data. Research ethics review for use of de-identified data is underway. **Anticipated Results:** We will identify studies in which patient complexity indicators have been applied in a primary care context and document the data elements used, data sources, outcomes the indicators were designed to predict, how domains of complexity were considered, and results of validation analyses (if available). We will summarize a comparison of available data elements with those used in published indicators as well as completeness of EMR variables in available data. **Conclusion/Implications:** This work will inform the development of a comprehensive, primary care-specific patient complexity indicator. A complexity index tailored to primary care will enable clinicians and decision-makers to more accurately anticipate patient care needs, assist with workforce planning, and allow for more effective resource allocation to areas of highest priority.

Delirium Quality Standard Implementation: A Multicomponent Interdisciplinary Quality Improvement Project Using the 4AT Screening Tool

Stephanie Grenier*, MD, CCFP; Thirumagal Yogaparan, MBBS, MD, FRCPC; Shelley Veinish, MD, FRCPC; Samantha Yau, RPh, BScPhm, ACPR, PharmD, BCGP, MScCH HPTE on behalf of the Delirium Working Group.

Learning objectives:

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

1. Summarize the rationale for adopting the 4AT tool in inpatient delirium screening
2. Identify key strategies that supported successful interdisciplinary implementation of the 4AT tool
3. Interpret changes in screening completion and positive delirium detection following 4AT implementation

Objective: To implement and evaluate the impact of the 4AT delirium screening tool on improving delirium detection rates among older adults in inpatient rehabilitation settings. **Design:** Multicomponent interdisciplinary quality improvement project using a longitudinal study design and iterative Plan-Do-Study-Act (PDSA) cycles. **Setting:** High Tolerance Rehabilitation and Slow Stream Rehabilitation units at a hospital serving older adults. **Participants:** Inpatient older adults aged 57–100 years (mean age 83.88). **Intervention:** In April 2024, we transitioned from the Confusion Assessment Method (CAM) to the 4AT screening tool for daily delirium screening. To support implementation, we conducted interdisciplinary education sessions, developed a microlearning module, and created a delirium education brochure for patients and families. Screening was integrated into the electronic medical record (EMR), and a coordinated care plan was established to notify physicians immediately following a positive screen. **Main Outcome Measures:** Rates of delirium screening completion within 24 hours of admission and percentage of positive delirium screenings. **Results:** Following the implementation of the 4AT tool, the screening completion rate within 24 hours of admission improved from 74% to 83% on the High Tolerance Rehabilitation unit and remained high on Slow Stream units (increasing slightly from 94.5% to 95.9%). The percentage of positive screenings rose from 0.11% with CAM to 0.98% with 4AT between April 11 and October 31, 2024. **Conclusion:** The 4AT tool, coupled with interdisciplinary education and a coordinated care plan, led to improved delirium screening completion and higher detection rates. These findings support the 4AT as a more effective tool for identifying delirium in older adult populations and highlight the importance of education and care coordination in quality improvement initiatives.

Developing Grief Resources for South Asian Families in Primary Care – A Community-Hospice Collaboration (Work in Progress)

Jastinder Bhandal*, BKin; Randeep Gill, MD; Andrea Critchley

Learning objectives:

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

1. Identify cultural barriers and needs related to grief support in South Asian communities within primary care settings
2. Describe how community-hospice collaboration can enhance culturally sensitive bereavement resources
3. Recognize how visual and language-accessible tools can be implemented in family medicine to support grieving families

Description: This ongoing project investigates a community hospice model to customize grief resources in family medicine for South Asian families. The project aims to address the gap in bereavement support for South Asian patients, who often face stigma and language barriers, by adapting existing Punjabi materials created by the Abbotsford Hospice Society. A set of culturally tailored bereavement support materials derived from accessible hospice resources like bilingual brochures and visual supports, is being prepared for use in primary care clinics. This project might include revising accessible materials and developing new materials. Subsequent steps are to gather informal input from family doctors and South Asian community members to guide further development and establish clinical and cultural acceptability.

Dying Behind Bars: Palliative Care in Canadian Prisons

Katie Oldford*, MPH; Françoise Guigné, MD, CCFP, MA; Susan MacDonald, MD, CCFP, PC, FCFP

Learning objectives:

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

1. Define palliative care

2. List the options for palliative care in Canadian prisons
3. Explore barriers to accessing palliative care faced by incarcerated individuals in Canada

Context: Like the general Canadian population, the imprisoned population is aging. A quarter of inmates in federal custody are over 50. Incarcerated people are also considered medically "older" than the general population by about 10 years. This aging prison population means that the need for palliative care for incarcerated Canadians is increasing. **Objective:** This research aims to describe palliative care options currently available to Canadian prisoners, as well as attitudes towards those options. **Design:** A comprehensive rapid review of the existing literature, including quantitative, qualitative, and grey literature was carried out. **Setting:** Reviewed literature involved prisons, halfway houses, and other institutions involved in the incarceration of people convicted of crimes, who are receiving palliative care or may receive it in the future. **Participants:** To be included, papers or articles had to discuss palliative care in prisons in Canada and had to be available in English. Twenty-four sources were included. **Findings:** Three main categories of palliative care are available to inmates - care while incarcerated, compassionate release or parole for care in the community, and medical assistance in dying. Literature highlighted barriers to accessing programs, differing goals of palliative care and incarceration, ethical considerations around consenting to medical assistance in dying while incarcerated, and a decarceration approach as inmates age in prison. Information on specific programs was very difficult to find, and statistics provided by Correctional Services Canada were often contradictory or confusing. **Conclusions:** This review highlighted a gap in palliative care services needed for aging incarcerated populations. More research is needed to understand the barriers to accessing palliative care resources along with a more in-depth review of the unique ethical considerations of processes like MAiD compared to the free population. To effectively address these issues more accurate and updated statistics and publicly available information is also needed.

Eight Legs of Success for Primary Care Project Teams

Alexander Singer*, MB BCh BAO, CCFP, FCFP; Michelle Greiver; Celine Jean-Xavier; Simone Dahrouge; Donna Manca; Leanne Kosowan

Learning objectives:

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

1. Understand practical elements needed for a successful project in primary care practices
2. Choose which element(s) can best fit their project
3. Consider how to incorporate these elements in ways that fit the scope of their project

Objective: To present lessons learned from managing a large national primary care practice-based randomized controlled trial, SPIDER (Structured Process Informed by Data, Evidence and Research), and outline essential recommendations for successful projects in primary care practices and teams. **Design:** The SPIDER framework was developed based on experiences from a large national primary care practice-based study. It includes eight essential recommendations for project teams. SPIDER has received REB approval from every jurisdiction where the study was implemented. **Setting:** Primary care practices, ranging from small-scale quality improvement projects to large international research studies. **Participants:** Project teams in primary care practices, including administrative personnel, research coordinators, team members, leadership, patient partners, researchers, and clinicians. **Results:** The SPIDER framework outlines eight essential recommendations for successful project teams: 1. Administrative Excellence: Implement robust administrative and management processes with skilled personnel to ensure project success. 2. Central Coordination: Embed a central research coordinator/project manager responsible for the project; ideally, the coordinator should be linked with an academic program that provides necessary support and professional development. 3. Teaming: Foster a culture of 'teaming' where team members are flexible, collaborative, and ready to act in moments of potential collaboration. 4. Continuity and Documentation: Maintain continuity in coordination and management through detailed documentation and clear processes. 5. Engaged Leadership: Establish a clear governance structure and engage leadership to guide the project. 6. Diverse Perspectives: Include diverse perspectives from patient partners, researchers, and clinicians to enrich the project. 7. Protocol Fidelity: Ensure consistent and reliable data management, collection, and quality assurance throughout the study. 8. Ethical and Privacy Compliance: Adhere to applicable rules, including Research Ethics Board (REB) rules and provincial privacy legislation. **Conclusion:** Applying the SPIDER framework in primary care projects enhances the likelihood of project success by providing a structured approach to project organization and management.

Evaluating Policy Change and Staff Perspectives on the Eat, Sleep, and Console Guidelines

Baithat Adeyinka*, MSc, BSc; Laura Lyons, MD, FCFP

Learning objectives:

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

1. Compare differences between Finnegan Neonatal Abstinence Scoring System and Eat Sleep and Console (ESC) guidelines
2. Describe the potential impact of ESC guidelines on neonatal outcomes
3. Evaluate frontline healthcare staff perspectives on ESC policy

Objective: To determine whether the Eat, Sleep, and Console (ESC) guideline improves neonatal outcomes compared to the traditional Finnegan Neonatal Abstinence Scoring System (FNASS); and to evaluate frontline healthcare staff perspectives on the ESC policy. **Design:** Retrospective chart review and cross-sectional electronic questionnaire. Approved by Western University's Research Ethics Board. **Setting:** Antenatal, obstetric, and postpartum units at Victoria Hospital in London, Ontario. **Participants:** Chart review of patients admitted between June 20, 2021, and May 30, 2023, with opioid use disorder. Patients admitted before June 20, 2022, were managed using FNASS (n=46), those admitted from June 20, 2022 were in ESC protocol (n=17). Inclusion criteria required infants born at ≥36 weeks gestation. Exclusion criteria included stillbirths, neonatal deaths, maternal hospital stays <24 hours, and infant length of stay (LOS) <72 hours. The electronic questionnaire was collected from obstetrical care staff (n=17). **Intervention:** Implementation of the ESC guideline for managing Neonatal Opioid Withdrawal Syndrome compared to FNASS. **Main Outcome Measures:** LOS, NICU admissions, morphine administration, and staff ratings on ESC effectiveness and practicality. **Results:** There were no significant differences between the ESC and FNASS policies in baby's LOS (p=0.14), NICU admissions (p=0.25), and morphine administration (p=0.67). 93% of staff agreed or strongly agreed that the ESC model supports the mother-baby dyad. However, majority (60%) disagreed or were neutral about the ESC being more effective and practical, and 53% were neutral on whether the ESC guideline reduces NICU admissions compared to the FNASS. **Conclusion:** The transition to ESC did not significantly impact neonatal outcomes, and staff perspectives on its effectiveness varied. However, frontline staff generally viewed the ESC guidelines as patient-centred and family-friendly. Continuous evaluation and adaptation of ESC training are crucial for successful implementation. Future research with a larger sample size is needed to assess the clinical significance of the ESC policy.

Exploring the Challenges Facing IMG Family Physicians: A Mixed Methods Research Study

Samir Migally, MD, CCFP; Cathy Zhang, MSc; Qian Yang, MSc; Fernanda Claudio, MSc, PhD, FRAI MAAA; Jacqueline Fortier, MSc; Gary Garber, MD, FRCPC, FACP, FIDSA, CCPE

Learning objectives:

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

1. Identify the challenges facing IMG Family Physicians in Canada
2. Describe a convergent mixed methods research study design
3. Compare the difference in medicolegal issues facing IMGs and Canadian medical graduates

Objective: In 2023, 31% of family physicians in Canada were IMGs, and 46% of licensed IMGs were family physicians. Challenges facing IMGs globally include discrimination and increased disciplinary action by their professional Colleges. Our study explored the challenges faced by family physician IMGs in Canada. **Design/Setting:** We conducted a convergent mixed methods research study. In a quantitative retrospective study, we extracted data from the CMPA national repository of medico-legal data and, using multi-level models, calculated family physicians' medicolegal (civil legal and College) case rates and case outcomes. In a qualitative descriptive study, we used purposive sampling to recruit and interview 15 IMG family physicians across Canada. We used a pilot-tested semi-structured interview guide to explore pathways to licensure, as well as challenges and facilitators throughout their careers. Transcribed interviews were analyzed using hybrid deductive-inductive thematic analysis. Integration occurred at interpretation and reporting through a narrative weaving approach. Ethics approval was obtained from the Advarra Research Ethics Review board. **Results/Findings**: IMGs followed multiple pathways to licensure. Before licensure, challenges described include financial issues, discrimination, and less choice in location or specialty. Once in practice, like all physicians, IMG challenges were related to the healthcare system e.g. lack of resources. Some racialized physicians described incidents of discrimination. Compared to Canadian and American medical school graduates, IMGs were more likely to be named in a College complaint ($p < 0.0001$) and their cases were less likely to be dismissed without concern ($p < 0.0001$). There was no difference between both groups in civil legal case rates and case outcomes ($p=0.05$). All IMGs described social support as a facilitator throughout their career, from personal or professional networks and through belonging within their community. **Conclusion:** Challenges faced by IMGs impact job satisfaction and stress levels; dismantling these barriers is essential for optimizing the contributions of IMG physicians within the health workforce.

Family Medicine Specialty Selection in Medical Students

T. R. Campbell*; M. E. Pedersen, MD; L. R. LeClair

Learning objectives:

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

1. Understand the paucity of research regarding family medicine specialty selection in medical students
2. Describe which medical school experiences have a positive influence on family medicine specialty selection in medical students
3. Understand the importance of further research regarding family medicine specialty selection in medical students

Objective: To determine the effect of medical student experiences on family medicine specialty selection. **Design:** Comprehensive scoping review. **Setting:** Medical schools across Canada and the United States. **Participants:** Medical students in all years of study. N=36875. **Intervention:** Database search using MEDLINE, Embase, Web of Science, Scopus, and PsycINFO found 3029 articles looking at factors that influence North American medical students' specialty choice. 1002 articles were identified as duplicates and removed. 2027 article titles and abstracts were screened, with 445 of those undergoing full text review. Data was extracted from

143 articles and categorized into demographics, sex and gender, race and ethnicity, medical education experiences, career expectations, and psychosocial factors. A more focused review narrowed down articles that explored family medicine and primary care specialty choice. **Results:** A total of eight articles (0.06%) were identified that examined family medicine and primary care as a specialty choice in medical students. Only five articles (0.03%) were identified that examined solely family medicine. Of the articles identified, three (37.5%) examined specific programming, one (12.5%) examined location influences, one (12.5%) examined the influence of research and debt, one (12.5%) examined lifestyle factors, one (12.5%) examined experiential factors and one (12.5%) was a broad qualitative study. The most identified medical experience themes amongst the articles were exposure to rural environments (50%) and family medicine specific programming (37.5%) which both had a positive influence on family medicine specialty selection. **Conclusion:** Exposure to rural environments and family medicine specific programming, particularly longitudinal programs, has a positive influence on family medicine specialty selection in medical students. As research in this area is lacking, and the family medicine specialty continues to have unfilled positions despite growing demands, further research would be beneficial.

Family Physician in Community Pharmacist Networks of Collaborative Care

Irene Kuo; Ruishen Yu, PharmD; Bryanna Basra, PharmD; Laura Nimmon, PhD; Anique Atherlley, MD, PhD

Learning objectives:

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

1. Recognize the family physician’s position in community pharmacist network of collaborative patient care
2. Identify collaboration between family physicians and community pharmacists
3. Consider facilitators and challenges to the collaborative relationships

Context: Community pharmacists are often the first point of contact for patients in primary care. Understanding how community pharmacists collaborate with others, especially family physicians, is necessary to ensure continuity of patient care. **Objective:** To characterize community pharmacist networks for collaborative patient care, including relationships with family physicians. **Design:** We conducted a qualitative egocentric social network analysis **Setting:** British Columbia, Canada. This work was approved by the University of British Columbia Behavioural Research Ethics Board. **Participants:** Pharmacists who have worked in a community pharmacy for at least one year. **Intervention:** We collected ego network data using a two-stage participant -aided concentric circle technique for network visualization. Participants named and created labels for collaborators in their network of care. Participants then physically positioned these labels in a four-ring concentric circle according to the relative strength of their relationship with the collaborator. During semi-structured interviews, participants described dimensions of relationships with collaborators and what relationship facilitators and challenges they experienced when collaborating for patient care. **Results:** Thirty participants were recruited and interviewed. Participants had been practising in community pharmacy between 1 and 28 years (mean 10.6). Family physicians appeared in 19 (63%) community pharmacist networks with strong collaborative relationships (concentric ring position 1 and 2) for patient medication management. Participants revealed how easily reaching family physicians in their office or in person for conversations, especially in smaller communities, enhanced collaboration. Positive patient outcomes also promoted mutual trust. Some participants described how relationship-building has become more difficult as reliance on fax for communication has steadily increased since the pandemic. **Conclusions:** Family physicians are essential members of community pharmacist networks of patient care. Relationship formation and maintenance is threatened by demands of the contemporary healthcare environment. Individual strategies and system changes are necessary to support their communication and collaboration.

Healing the Healers: Cultivating Well-Being Using Narrative Medicine (Work in Progress)

Aisha Husain*, MD, CCFP, FCFP, MScCH; Melanie Hing, MBBCh BAO; Sarah Kim, MD; CCFP; Nasreen Ramji, MD; Diana Toubassi, MD, CCFP, FCFP; Nick Pimlott, MD, PhD, CCFP, FCFP

Learning objectives:

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

1. Evaluate faculty development to shift perspectives on NBM tools for cultivating well-being
2. Analyze results to establish common themes among family physician clinical teachers
3. Generate an understanding and plan to foster sustainable faculty development for cultivating well-being

Description: Over half of family physicians report burnout and plan to leave the specialty. Solutions for occupational distress are more acceptable when they centre on cultivating well-being rather than reducing burnout. One call to action from the WHO includes rediscovering meaning and purpose, rooted in Narrative-Based Medicine (NBM) principles. The FD on NBM tools was designed and piloted as a three-hour workshop. In our pilot study, 33% of registrants responded “unsure” whether NBM tools can cultivate well-being, and only 37% had confidence in their knowledge of NBM influencing well-being pre-workshop (n=10). Post-workshop (n=6), 100% responded that NBM could cultivate well-being, and all responded with “full” confidence in their NBM knowledge. Three weeks post-workshop (n=3), two continued employing NBM. To improve accessibility, the workshop has been trimmed to one hour. A convergent parallel mixed methods design will be used. Surveys will capture baseline and post-intervention perspective shifts using a 5-point Likert scale. Paired statistical tests to assess sustained changes from baseline to each follow-up interval. Participants will be invited to a focus group to understand further facilitators and barriers shifting perspectives on NBM. Our target sample size is up to ten participants. We will employ thematic analysis using constructivist grounded theory to explore themes including sustained behavioural changes. This curriculum bolsters all four principles central to FM and addresses numerous CanMEDS-FM roles. It contributes to the CFPC’s FD vision of “leading family physician well-being”. This study's implications include enhancing the culture of reflective practice and bolstering resilience. We aim this program evaluation to provide insight into future FD development in cultivating well-being. We hope to glean outcome perspectives, such as factors that influence and impede the long-term usability of NBM.

Healthcare's Digital Future: Training for Lifelong Learning (Work in Progress)

Victoria Meeker*, BSc; Tetiana Polishchuk, PhD; Oksana Babenko, PhD

Learning objectives:

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

1. Articulate the evolving landscape of lifelong learning in health professions education in the digital era
2. Describe how digital technology shapes trainees’ self-initiated learning activities and support their psychological needs
3. Discuss social and psychological factors influencing digital technology adoption for lifelong learning and practice

Context/ Importance: Lifelong learning in professional fields, and particularly healthcare, is being transformed by rapidly advancing digital technology, yet research and theory lag behind these changes. **Objectives:** This study aims to: (I) explore lifelong learning practices among learners in health professions; and (II) guide the development of a new measure of lifelong learning relevant to 21st-century learning. **Design:** A qualitative methodology was employed to address key empirical questions that will guide the development of a new quantitative measure: Q1. How does digital technology shape students' self-initiated learning? Q2. What are students' perceptions of digital technologies in supporting their basic psychological needs of autonomy, competence, and relatedness? Q3. How do students envision ongoing learning throughout their careers? **Setting/Participants:** Five focus groups were conducted with undergraduate students, including students in dentistry, medicine, nursing, and pharmacy, at a large Canadian university. Ethics approval was obtained (REB Pro00102091). **Anticipated Results/Impact:** This research addresses the challenges of integrating digital technology into healthcare education and practice. It emphasizes the crucial human dimension—the social and psychological factors that influence how future healthcare professionals accept and utilize digital tools for lifelong learning and improved patient care. **Implications:** By investigating how healthcare trainees adapt to digitally enhanced and globally connected learning and work environments, this research will inform the development of educational approaches that better prepare healthcare professionals to leverage technology throughout their careers, ultimately enhancing patient outcomes and healthcare delivery.

Identification and Management of REDs by Family Physicians

Emma Wardhaugh*, BHSc; Emma M. McGinnis, BSc; Jenna M. Schulz; PT, PhD; Jane S. Thornton, MD, PhD

Learning objectives:

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

1. Understand how well Canadian family physicians understand REDs risk factors, investigations, and management strategies
2. Understand the prevalence of REDs investigation and management strategies, and how these align with recommendations
3. Understand how physicians prescribe contraceptives for patients with REDs, associated risks, and best practice strategies

Context: Relative Energy Deficiency in Sport (REDs) is a syndrome of impaired physiological function and athletic performance in male and female athletes secondary to low energy availability. Family physicians are first line providers who can identify and treat REDs, but research suggests that they have low knowledge and confidence in treating it. **Objectives:** To assess Canadian family physicians' knowledge of REDs, and how they identify and treat the condition. Secondly, to assess how family physicians prescribe and monitor contraception for patients with REDs. **Design:** Cross-sectional survey. **Setting:** Across Canada, December 2023 to May 2024. **Participants:** Fifty-six family physicians practicing in Canada. **Intervention:** A novel online survey of 24 questions was sent to 10 national/provincial Family Medicine Colleges and 17 Family Medicine academic institutions. **Main Outcome Measures:** Knowledge of REDs, investigation and management practices, and advice on future directions to take in family medicine REDs education. Descriptive statistics were analyzed using Excel and SPSS. **Results:** While 76.5% of participants correctly identified signs and symptoms of REDs, 60.4% had experience managing the condition. The most common investigations were laboratory investigations/bloodwork (54.3%) and eating disorder screening (52%). The most common management strategies included mental health counseling (54.4%) and vitamin D supplementation (51.2%). Eighty-four percent reported they would prescribe contraception to patients with REDs, with 26% prescribing oral contraceptives (OCPs) specifically to treat amenorrhea. OCPs are not considered best practice, as they can mask the return of menses and allow continued bone loss until energy deficits are corrected. Most participants (96%) agreed that more REDs education would be beneficial. **Conclusions:** Although Canadian family physicians exhibit knowledge of REDs, there is variation in how they assess and manage the condition. OCPs are being prescribed to patients with REDs without addressing underlying energy deficits. Further resources and training on REDs for family physicians may be beneficial.

I'm Ready Doctor, Now You Can Ask

Marie-Thérèse Lussier, MD, BSc, MSc, FCMFC; Claude Richard,PhD; Marie-Hélène Goulet, inf, PhD; Clara Dallaire, MÉd, PhD(c), Patiente partenaire; Viviane Tran*, PhD; Marie-Eve Lavoie, PhD; Caroline St-Denis, MSc; Marie-Pier Lehoux, Inf Clin, MSc; Anne Dubé

Learning objectives:

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

1. Evaluate the impact of preparatory tools on patient confidence and consultation efficiency
2. Describe how digital tools improve patient-provider communication in primary care settings
3. Identify strategies for integrating digital innovations into clinical workflows to enhance patient outcomes

Introduction: In Québec, the Primary Care Access Point (Guichet d'accès à la première ligne, GAP) provides access to medical consultations for non-urgent or semi-urgent health needs to patients without a family doctor. Despite the obvious benefits of this service, there are challenges, including the unfamiliarity between healthcare providers (HCPs) and patients with complex needs, and short consultation times, which can complicate patient-provider interactions. To help patients better characterize their reason for consultation, describe their experience with the problem (FIFE: feelings, ideas, function and expectations), and prepare questions before their appointment, our research team adapted "Getting Ready", a consultation preparation sheet (CPS) that was previously developed for use in other care contexts. **Objective:** Evaluate Getting Ready's perceived impact on patient preparation and participation in GAP consultations, both from patient and HCP perspectives. **Design:** Prospective observational study. **Setting:** One regional health authority GAP service and two primary care clinics offering GAP appointments. **Participants:** HCP (n=10) and adult patients (n=200). **Intervention:** Patients referred to these two clinics through GAP are invited to complete Getting Ready online prior to their appointments. Outcome measures include patient-reported preparation levels, perceived pre-consultation stress and post-consultation adherence to medical recommendations as well as HCP feedback on perceived consultation duration and impact of preparation on the unfolding of the encounter. **Measures:** patient questionnaires, both immediately post consultation and 7 to 10 days later, HCP questionnaires at the end of patient recruitment, patient and HCP focus groups, and metrics on 'Getting ready" usage. **Results:** Data collection is underway at this time, but will be available at the time of the conference. **Discussion/Implications:**Based on our prior findings suggesting that CPS improved patient-provider interactions across diverse healthcare contexts, we expect similar benefits to be reported by patients without a family doctor accessing episodic care in this specific care context.

Impact de la relation superviseur-supervisé sur la progression du médecin résident: et si c'était au-delà de la position d'apprentissage. Perspectives du résident et du superviseur en médecine de famille. (Travail en cours)

Louise Champagne*, MD, FCMFC; Marie-Ève Boulais, MD, CMFC; Andrée-Anne Paré-Plante, MD, CMFC; Claudie Forest; Olivia Parker; Camille Boileau

Learning objectives:

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

1. Réfléchir à l'impact de la relation superviseur-supervisé sur la progression du médecin résident en médecine de famille
2. Identifier les éléments de la relation superviseur-supervisé permettant aux résidents de devenir des médecins compétents

3. Développer de nouvelles stratégies de supervision auprès des résidents en médecine de famille

Contexte: La supervision clinique en médecine famille est un élément central dans la formation des médecins résidents. Dans ce contexte, l'adoption d'une « position d'apprentissage » des apprenants est essentielle. Quels sont les autres éléments de la relation superviseur-supervisé qui permettent aux résidents de devenir des médecins compétents et autonomes ? **Objectif:** Décrire les facteurs dans la relation superviseur-supervisé qui favorisent la progression des résidents en médecine de famille. **Type d'étude:** Devis de recherche qualitative descriptive. Cette étude a été approuvée par le Comité d'éthique du Centre de recherche Hôpital Charles-LeMoyne. **Lieu:** GMF-U Charles-LeMoyne, Montérégie, Québec, Canada (milieu de formation de l'Université de Sherbrooke). **Sujets:** 10 à 12 résidents en médecine de famille et 10 à 12 médecins superviseurs du GMF-U Charles-LeMoyne seront recrutés. **Intervention:** Des groupes de discussion focalisée (4) seront menés par l'équipe de recherche à l'aide d'un guide d'entrevue élaboré à partir d'une revue de littérature préalable sur le sujet. **Principaux paramètres d'évaluation:** Les données (verbatims) seront enregistrées et transcrites. Une analyse thématique inductive est prévue afin d'identifier les thèmes principaux des groupes de discussion. **Résultats/impacts anticipés:** Les résultats attendus contribueront à une meilleure compréhension des éléments facilitateurs à l'acquisition des compétences en médecine de famille, en lien avec l'interaction entre le superviseur et le supervisé durant la formation des résidents. **Conclusion/implications/apprentissages:** En identifiant les facteurs qui favorisent la progression de l'apprentissage des résidents en GMF-U, y compris ceux qui sont moins tangibles et parfois imperceptibles dans la relation résident-superviseur, il serait possible d'adapter les stratégies de supervision pour renforcer les approches existantes et potentiellement en développer de nouvelles.

Implementation of a Hospital Medicine Pharmacist

Liberty Liu*, MD, CCFP; Calli Safnuk, BSP, ACPR; Nikita Baker, RN, BN, MScHq

Learning objectives:

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

1. Build a consult referral form
2. Identify physician and patient impact from a service-based model
3. Have the knowledge on how to implement a similar model within their practice area

Context: Clinical pharmacist involvement positively impacts patient safety, quality of care, decreases mortality, cost, length of stay, and readmission rates. At an acute care center, a hospitalist physician group provides care to ~230 patients across 26 units. The dedicated hospitalist pharmacists provide care on 2 designated units, thus limiting access of service by geographical location. **Objective**: To design, implement, and evaluate a service-based pharmacist care model which identified patients by physician-led consultation, or by self-directed pharmacist screening process. **Design:** Designated one full-time pharmacist to pilot model from Nov 22, 2023 to March 30,2024. **Setting:** A large, tertiary, teaching hospital (Foothills Medical Centre, Calgary, AB). **Participants:** Patients admitted under hospitalist physicians were eligible. **Intervention:** A referral and contact form to guide workflow were disseminated to a physician group. Physical space was secured within a centralized hospitalist office for pharmacist workspace. The clinical pharmacist responded to consults and self-identified patients that would benefit from involvement. Clinical activities were performed at the pharmacist's discretion. **Main Outcome Measures:** The utilization was captured through number of consults and trended over time. The number of pharmacist-led recommendations, acceptance, and type of activity were captured. Feedback from patients and physicians were measured through qualitative surveys. An ethics exemption was obtained. **Results/ Findings:** 106 physician-led consults were placed; the number of consults increased from Dec (n = 14) to March (n=28). 751/837 recommendations were accepted and identified, respectively. Several cost-saving events, up to $450/event and 46 pharmacist-led teaching events occurred. Stakeholder surveys illustrated positive outcomes. **Conclusion:** A service-based pharmacist model was utilized by a hospitalist physician group. The model shifted pharmacist involvement from geographical location to physician and pharmacist identified need. The pilot catalyzed change of 3 full-time unit pharmacist positions to service-based. At the time of writing, the model was adapted for 2 additional acute care sites.

Implementing Food Rx Into Primary Care Teams in Hamilton, Ontario

Russel de Souza, RD, ScD; Myles Sergeant, MD, PEng, CCFP, FCFP; Brain Mckenna, MD, MSc, CCFP; Samuel Ramos Acevedo, RD, DSc; Sujane Kandasamy*, MSc, PhD

Learning objectives:

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

1. Learn about the barriers and facilitators for implementing Food Rx programs in primary care teams
2. Understand what barriers and facilitators are most relevant to Hamilton, Ontario
3. Learn about the recommendations for the co-design of a Food Rx program to fit the primary care contexts in urban cities with high proportions of systemically underrepresented groups

Background: Daily plant-rich eating can: 1) help people with type 2 diabetes mellitus (T2DM) achieve remission and 2) reduce an individual's environmental impact. Hamilton, Ontario is an urban city in Canada that experiences a higher burden from structural determinants of health and is home to numerous vulnerable groups including newcomers, unhoused people, and people living in poverty. In Hamilton 23% of households experience food insecurity, and over 13% of the population live with diabetes. Hamiltonians with T2DM are two times more likely to live in food insecurity, resulting in limited access to daily plant-rich foods. Primary care providers (PCPs) can support their patients through plant-rich food prescriptions (Food Rx), however there exists a gap in understanding optimal delivery of Food Rx to fit clinician workflow and patient needs. **Method:** First, we conducted a systematic review and qualitative meta-synthesis to investigate the challenges and strategies to implementing Food Rx into clinics in Canada and similar contexts. A structured search strategy was used to identify relevant studies, and a thematic analysis was used to integrate findings. Second, to contextualize key themes, we conducted a series of community engagement workshops with PCPs, community leaders, food subsidy program staff, and eligible patient representatives. The first workshop was used to contextualize the barriers and facilitators identified in the review to the Hamilton context. A second workshop was used to co-design the Food Rx program. The second project has received provisional approval from the Hamilton Integrated Research Ethics Board and is pending full acceptance. **Results:** In this abstract we present barriers and facilitators to implementing Food Rx in the context of an urban city in Ontario. Results will equip PCPs with practical recommendations to provide optimal care that meets the needs of vulnerable communities.

Improving Nurse to Physician Communication

Shirlee Ren*, MD, CCFP; Nikita Baker, RN, BN, MScHq; Nancy Egbogah, RN, BN, MN

Learning objectives:

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

1. Develop an appropriate paging algorithm
2. Identify gaps in communication
3. Explore rollout of algorithms and teaching sessions

Context: Unnecessary pages lead to disruptions in patient care and increased medical and surgical errors. Prior studies indicate approximately 25% of pages are not clinically relevant. There has been increasing feedback from South Health Campus (SHC) colleagues that quality of pages has decreased since the COVID-19 pandemic with increased non-urgent pages, while not being paged for critical issues. **Objective:** To reduce unnecessary paging and streamline nursing to physician communication for hospitalist inpatients via implementation of a paging algorithm. **Design:** A quality improvement project spanning September 2023 – March 2024. **Setting:** An acute care hospital in Calgary, AB. **Participants:** Hospitalist ward nurses, nursing educators, and hospitalists. **Intervention:** Pre-implementation paging data was obtained from March – April 2023 and categorized. Recurring issues were identified, and a paging algorithm was subsequently developed to help nurses differentiate between urgent vs non-urgent clinical issues. The algorithm was taught via in-person education sessions that ran from September 2023 – March 2024 and further disseminated by nursing educators. Nursing and physician feedback were obtained to continuously update the algorithm. **Main Outcome Measures:** The primary measure was a reduction in number of clinically unnecessary pages. The balancing measure was no adverse impact on hospitalist inpatient mortality. **Results/ Findings:** There was a decrease in overall paging volume by 7.7%, a reduction of pages not required by 56.1%, a reduction of inconclusive pages by 45.4%, and a decrease of non-urgent pages by 38.7%. Hospitalist inpatient mortality remained unchanged throughout the course of this project. **Conclusion:** The paging algorithm is effective in reducing unnecessary pages to hospitalists. This algorithm has since been adopted by hospitalists at Calgary acute care hospitals.

Managing Patient Expectations: A Photovoice Project (Work in Progress)

David Pinkerton*, MD, CCFP, FCFP; Colleen Grady, DBA; Han Han, PhD; Mary Martin, MSc

Learning objectives:

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

1. Identify some of the examples of patient expectations leading to burnout among family physicians
2. Understand how photo voice has informed dialogue among family physicians to address management of patient expectations
3. Learn about current and proposed strategies, including what patient education is needed to mitigate burnout caused by unreasonable patient expectations

Context: One of the identified stressors for family physicians is managing patient expectations, many of which has become increasingly unreasonable and seen as contributing to high burnout. There has been limited focus on interventions to mitigate this, likely since it is challenging to address. **Objective:** This study seeks to identify strategies and steps which can be used to increase support for family physicians in the management of patient expectations. **Design:** Participatory Action Research (PAR) approach, using photovoice, a qualitative methodology which captures images in response to a research question, followed by focus groups and interviews to allow participants to share images, the stories behind them, and recommended actions for change. This study has been approved by the local Ethics Review Board. **Setting:** Primary Care, Ontario **Participants:** Family physicians practicing comprehensive primary care. **Anticipated Results/Impact:** 17 family physicians are participating in this study. They are using photography and engaging in dialogue to address three specific research questions. Firstly, their data collection will focus on the ways in which patient expectations contribute to burnout. Secondly, this exploration will identify effective, and proposed strategies that can be used in patient education to frame reasonable expectations. Lastly, a broader public engagement strategy will be informed by these findings which can enhance physician-patient relationships in the future. This research will have immediate impact on participants by sharing existing strategies being used, and broader impact on clinics and the patients within those clinics, plus it has the potential to affect change at the association and regulatory level.

Conclusions/Learnings to date: The response and support for this study has been overwhelmingly positive, indicating that this is an area of study previously not addressed. Participants have indicated their appreciation for the opportunity to 'get creative' and to contribute to much-needed change which has the potential to improve family medicine practice.

Medical Learner Experiences in a Community Health Centre

Allyson Merbaum, MD, CCFP, FCFP; Andrea Pozo-Barruel, BSc, MEd; Catherine Yu, MD, MSc, CFPC (EM), FCFP; Melanie Henry*, MD, CCFP; Nick Petten, MA; Kulamakan Kulasegaram BHSc, Ph.D

Learning objectives:

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

1. Recognize the unique learning opportunities in a community health centre environment
2. Identify community health center based learning as a valuable component of family medicine teaching
3. Describe the supports that could support and expand the community health centre learning opportunities

Background: Meeting patients in the community is an ideal context in which to learn about social determinants of health, population health outcomes, and advocacy. One venue for learning can be Community Health Centres (CHCs): primary care interdisciplinary clinics that provide healthcare and health promotion to equity deserving populations. CHCs are not routine training settings in most disciplines including family medicine (FM). This study explored the experiences of FM learners in one CHC to better understand the unique learning experiences and challenges in this context. The findings contribute to development of improved social accountability and health equity curricula utilizing CHCs across the continuum of learning. **Methods:** Learners from University of Toronto's Department of Family & Community Medicine who trained at an urban CHC were recruited between October 2023 and March 2024. Five medical students and five residents were interviewed; transcripts were analyzed abductively for benefits and challenges for learning and emergent themes. **Results:** All participants expressed that this was a meaningful experience and that they are better equipped to care for equity-deserving populations. Learners identified that the context required more intentional preparation and orientation, and that providing clinical care to this population was more complex. Unique learning outcomes included exposure to a broad interdisciplinary collaborative approach and immersive training with a focus on cultural humility. **Discussion**: Understanding the unique learning opportunities and challenges in a CHC environment is instrumental in expanding learner placements to other community-based settings that serve vulnerable populations. Our results show additional supports may be needed to expand CHC learning opportunities.

Mitigating Stress in the Workplace for Family Physicians: Developing Peer Support

Robyn Brown, MD, CCFP; Laura DiQuinzio, MD, CCFP; Mary Martin, MSc; Amber Holmes, BSc; Colleen Grady, DBA; David Pinkerton*, MD, CCFP, FCFP

Learning objectives:

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

1. Implementation of peer support training within a family health organization led to a community-based pilot and potential network development.
2. Implementation factors of peer support within a family health organization
3. Understand the benefits of peer support for family physicians and potential for development within a community

Objective: The study purpose was to investigate the value and impact of local peer-support for family physicians and explore sustainability beyond the pilot phase. **Design:** Participatory Action Research (PAR) approach to development, delivery, and evaluation of peer support training with mixed methods. Approval obtained from local Research Ethics Review Board. **Setting:** A Family Health Organization (FHO) (Phase 1) followed by a regional implementation (Phase 2). **Participants:** Family physicians in comprehensive practice in Kingston (Ontario). **Intervention:** Four virtual training and practice sessions were provided within the FHO, followed by one full-day session one year later in the community. A peer-support trained family physician facilitated both virtual and in-person training. **Main Outcome Measures:** Increased knowledge of peer support, change in capacity of trainees as facilitators, perception of value of peer support, perception of capacity to sustain program in FHO or the broader community. **Results/Findings:** Seventeen physicians participated in the study. Participants described three primary benefits of peer support: 1) feeling heard and validated, 2) feeling less alone, 3) improved problem solving through sharing workplace challenges. Benefits achieved through training included 1) learning a new skill/way of listening, 2) promotion of learning through a combination of didactic and experiential training, 3) enhancing confidence in supporting a peer through learning new ‘language’ or concepts related to peer support. Considerations for sustained peer support program include 1) a low-cost intervention, 2) an experienced facilitator for successful training, 3) availability of trained peers to enable easier access, 4) a community-based approach to reduce barriers to reaching out for support. **Conclusion:** Peer support is a viable, low-cost intervention which can decrease stress among family physicians. Expert training that includes a mix of didactic and practice sessions enables expansion of peer support, with increased knowledge and confidence among those trained which could lead to a train-the-trainer approach for expansion and sustainability.

Nurturing the Future Rural Generalist Physician: A Qualitative Study of Learners’ Insights From a Longitudinal Integrated Clerkship

Aaron Johnston, MD; Martina Kelly, MD; Grace Perez, MSc

Learning objectives:

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

1. Describe the factors that influence student experience the complex longitudinal integrated clerkship (LIC) environment
2. Understand the central role of continuity in the LIC
3. Broad understandion of the complexity of the LIC environment

Study Objectives: This study explores the complexity of the Longitudinal Integrated Clerkship (LIC) environment, through the lens of the current generation of LIC learners. **Study Design:** Qualitative study, semi-structured interviews. **Participants:** Medical students from the University of Calgary who were placed in the longitudinal integrated clerkship (LIC) program. **Main Outcome Measures:** Qualitative themes from the interview transcripts. **Results/Findings:** Of the LIC cohort of 22, 18 consented to be interviewed. The participants were mature, many had previous careers and most had families with them. The LIC learning environment uncovered was highly complex. We used Brofenbrenner's ecological systems model to explore this complexity. Beyond the continuity of relationships with preceptors and patients, the study uncovered other factors that influenced the learning of the LIC students. Apart from students’ interactions in the clinical settings (patients, preceptors and other multi-disciplinary teams), factors such the personal relationships, community connections, learning in a resource-strained environment, the geographical isolation, and other socio-political dynamics, impacted the LIC learner experiences of continuity and community integration. The results showed that LIC students were self-directed in their learning and the LIC experience shaped their professional development and facilitated their readiness for future residency. **Conclusion:** The relationship between learner and primary preceptor is central but the overall experience of the learning environment is much broader and more complex. Much of the richness of the LIC experience is embedded in the complexity of the learning environment and it's embedded continuity. The findings will help guide policy and programs to optimize the rural education experience and to find novel solutions to address challenges around the issue of connection between medical education and healthcare delivery. This will also provide supports for the ongoing active advocacy work regarding achieving a sustainable rural health workforce now and into the future.

Patient Experience of Live Discharges From Palliative Care

Armaan Babaei; Lily Zeng; Ingryd Ventura, PhD; Jordan Pelc*, MD, MSC, CCFP

Learning objectives:

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

1. Describe the prevalence of live discharges from palliative care units
2. Describe the care gaps that patients experience in live discharges from palliative care units
3. Describe areas of need for patients who have been discharged live from palliative care units

Context: Live discharges from hospices and palliative care units (PCUs) represent a growing health care phenomenon. While most patients who are admitted to these settings expect to die there, the literature shows that approximately 20% of patients admitted to palliative care units will be discharged live. This can lead to challenging emotional reactions, goals of care discussions, and resource management. **Objective:** To understand the current literature on patient experience of live discharge from PCU. **Design:** Given our focus on patient experience, we performed a scoping literature review of the qualitative literature on live discharges from PCU following the methodology of Arksey and O'Malley. To screen for appropriateness for inclusion in our study, we screened each citation abstract again three inclusion questions: 1. Does the article focus on hospice palliative care? 2. Does the article discuss live discharges from hospice palliative care? 3. Does the article report results from a qualitative study and/or mixed methods study? An answer of 'yes' for all questions was required for an abstract to be included. Each abstract was screened manually, with 20% of abstracts screened by two reviewers to ensure validity. Any discrepancies were resolved by a third reviewer. After article identification, we then performed a qualitative thematic analysis on the resulting articles using grounded theory. **Main Outcome:** Our initial literature search revealed 4482 citations. After manual review, only 9 of these articles were appropriate for our thematic analysis. Thematic analysis revealed themes of loss of autonomy, financial concerns, and reduction in access to healthcare upon discharge from PCU. **Conclusion:** The literature on patient experience of live discharge from PCU demonstrates significant distress associated with this experience, especially related to loss of autonomy, financial concerns, and reduction in access to healthcare. Family physicians should consider these themes when caring for patients discharged live from PCU.

Penicillin Allergy Delabeling in a Family Medicine Clinic (Work in Progress)

Pooja Venkata*, MD; Kaili Harvie, MD, CCFP; Krystal Morton, BScN, RN; Karanpreet Bath, MD; Stephanie Liu, MD, CCFP, MSc; Uzma Khan, MD, CCFP; Fabiola Diaz, MD, CCFP; Ying Yao, MD, CCFP; Jennifer Khil, MSc; Eric Lui, MEd; Roni Kraut, MD, CCFP, MSc

Learning objectives:

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

1. Undestand the improtance of penicillin allergy delabeling
2. Determine which individuals have a low risk penicillin allergy

3. Describe the process of delabeling individuals with a low-risk penicillin allergy

Context: A large proportion of family practice patients are labeled with a penicillin allergy, yet over 95% do not have a true allergy. This label is associated with poorer health outcomes and increased healthcare costs. Low-risk patients (as determined by PEN-FAST) can be delabeled through a simple oral rechallenge in the clinic, avoiding the need for an allergist referral. To our knowledge, delabeling low-risk patients with an oral rechallenge has not been previously reported in family medicine. **Objective:** To determine the effectiveness of penicillin allergy delabeling for low-risk patients in a family medicine clinic using an oral rechallenge. **Design:** Observational study, March 2024-present. **Setting:** Community family medicine clinic. **Participants:** Adult patients (≥18 years) with a penicillin allergy listed in their electronic medical record (EMR). Exclusion criteria: PEN-FAST >2, psychological/neurological comorbidities, pregnancy, regular antihistamine use, and blistering skin conditions. **Intervention:** Six physicians (~3,500 total patient panel) reviewed their list of patients with a penicillin allergy. Suitable patients were contacted via EMR portal messaging system or phone call and invited to participate. Interested patients underwent a phone screening to confirm eligibility. Eligible patients were scheduled for an in-clinic oral rechallenge (amoxicillin 250 mg x 1, observed for one hour). **Outcome:** Patients with a penicillin allergy delabeled. **Results:** A total of 170 patients had a penicillin allergy listed, 161 qualifying after physician review, 52 expressed interest and to date 41 have been screened. Among these screened patients, 19 were eligible, 14 successfully completed the rechallenge, and 5 have a rechallenge scheduled. **Conclusion:** It appears that ~40% of patients with a penicillin allergy label who are interested in being delabeled can be delabeled safely in the clinic using PEN-FAST coupled with oral rechallenge. Future studies should explore how best to integrate this process into the busy family medicine environment.

Primary Care Integration to Optimize Comprehensive High-Quality Multi-Disciplinary Care for Patients With Heart Failure

Fatemeh Zevari*; Qin Yuan 'Alis' Xu, MD, CCFP, MSc (SLI)

Learning objectives:

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

1. Describe methods for improving EMR data quality in primary care, including accurate coding of patients with heart failure
2. Learn how retrospective chart reviews can help uncover care gaps and improve data quality
3. Apply quality improvement strategies, including multidisciplinary team-based approaches, to close gaps in diagnosis and treatment

Context: Heart failure with reduced ejection fraction (HFrEF) is associated with high morbidity and mortality. Guideline-recommended quadruple therapy (ARNI/ACEi, beta-blocker, MRA, SGLT2i) for NYHA Class II–IV patients is underused due to multiple barriers. Non-pharmacological care—education, lifestyle change, symptom management—is often neglected due to resource constraints. Managing non-cardiac comorbidities and care transitions requires system-level solutions. **Objective:** To improve HFrEF care at Southlake Academic Family Health Team via pharmacological and non-pharmacological interventions: 1. Implement a point-of-contact care manager to improve access; 2. Increase HFrEF patients with NYHA class II-IV on quadruple therapy; 3. Reduce ED return visits and hospital readmissions. **Design:** Quality improvement initiative based on Ontario Health's Quality Improvement Guide and Model for Improvement. A multipronged approach targeting clinical outcomes, patient/provider experience, and health equity (Quintuple Aim). **Setting:** Southlake Family Health Team, Ontario. **Participants:** Chart review of 161 patients identified 16 with HFrEF and NYHA Class II–IV; 25% were on quadruple therapy. Most were managed by cardiologists; two solely by primary care. **Intervention:**

Implementing a “point-of-contact” care manager (e.g., nurse, social worker) to support system navigation, medication review, symptom management, and prompt access. Collaboration with a nurse practitioner-led Heart Function Clinic is underway to establish a shared-care model. **Main Outcome Measures:** Primary: Access Response Index (wait time); Patient survey (% able to access timely care); Provider survey (including workload balance). Secondary: % on quadruple therapy; % meeting Ontario HF care standards; Socioeconomic barriers (via patient survey); 30-day ED return rate; 30,90, 120-day hospital readmission rates. Anticipated Impact: Improved therapy adherence, sustainable team-based care, and high-quality cardiac care integration. **Conclusion:** Findings show collaboration across care teams enhances heart failure management. Our chart review revealed gaps in both therapy and diagnostic documentation. A point-of-contact model may enable safer, more efficient care without overburdening primary care.

Reducing Administrative Burden in Primary Care: A Digital Solution to Optimize the Use of PROMs and PREMs (Work in Progress)

Marie-Eve Poitras*, RN, PhD; Mireille Guérin, M.Sc.; Anne-Sophie Langlois, M.Sc.; Vanessa T. Vaillancourt, M. Sc.; Marie-Dominique Poirier, M.Sc.; Amélie Fournier; Pierre-Henri Roux-Lévy, MD, PhD; Marie-Eve Perron, RN, M.Sc.; Géraldine Layani, MD, M.Sc

Learning objectives:

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

1. Describe how PROMs and PREMs support clinical improvement and organizational decision-making in primary care
2. Identify key features of the digital training and application for PROMs and PREMs integration
3. Recognize evaluation frameworks used to assess PROMs and PREMs implementation and long-term impact

Background: Family physicians perform numerous tasks related to service organization, which significantly contributes to their workload. They often lack access to adequate data sources to support evidence-informed organizational decision-making. Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) have strong potential to optimize clinical processes and improve professional practices. **Objectives:** To enhance the integration of PROMs and PREMs data into primary care by: 1. Providing a digital infrastructure; 2. Supporting clinical settings in the regular collection and use of PROMs and PREMs. Study **Design:** Multiphase study. The project has received approval from the local research ethics board. **Setting:** Primary care clinics in Québec, Canada. **Participants:** Family physicians and interprofessional team members. **Intervention:** Phase 1: Development of an asynchronous training module and a digital application to support the collection, analysis, and visualization of PROMs and PREMs data. Phase 2: Twenty primary care clinics will receive training and ongoing support to implement the routine use of PROMs and PREMs. **Main Outcome Measures:** A developmental evaluation will be conducted using mixed data sources, guided by the RE-AIM, Normalization Process Theory (NPT), Knowledge-to-Action, and Kirkpatrick frameworks. Using questionnaires, we will assess knowledge and intention to apply the acquired knowledge before and after the training. Focus group interviews will allow us to gain an in-depth understanding of the implementation process. The evaluation will assess the impact of the initiative and identify conditions that promote sustained and longitudinal use of PROMs and PREMs to support practice and process efficiency. **Anticipated Impact:** Participating clinics will be better equipped to guide organizational decision-making, team composition, and service delivery based on patient-reported data. **Conclusion:** This capacity-building initiative is a key step toward the routine integration of PROMs and PREMs in primary care. The study will contribute to developing an implementation framework to support their long-term and effective use.

Retrospective Analysis of Cardiovascular Risk and Statin Prescribing

Adam Merlo*, MD, CCFP; Tania Rubaiyyat, MD, CCFP, FCFP

Learning objectives:

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

1. Review cardiovascular risk estimation tools and web-based resources
2. Review the indications for initiation of statin therapy for dyslipidemia
3. Appraise widely available cardiovascular risk estimation tools

Objective: Statin prescribing for primary prevention remains a topic of debate, especially in individuals at a low to moderate risk of cardiovascular disease. This study aimed to determine if there is a difference in risk estimation between different risk calculators and describe the proportion of patients that may fall under a different risk category if an alternative calculator was utilized. **Design:** Retrospective chart review. **Setting:** London, Canada. **Participants:** This work was approved by the local research ethics board. 50 randomly selected adults, aged 40 and older, without a statin-indicated condition or prior cardiovascular event, who underwent a lipid assessment at a single family medicine clinic between 2010 and 2023, were included. **Main Outcome Measures:** Baseline demographics and cardiovascular risk factors were extracted. Validated online calculators were utilized to re-estimate cardiovascular risk and compare with values documented in the patient chart. **Results:** Out of 50 patients, 20% did not have a documented cardiovascular risk value at the time of lipid assessment. However, the mean difference in Framingham risk values from the electronic medical record and PEER Lipid online calculator was statistically significant (3.44%, 95% CI 0.11 to 6.76, $p<0.05$). Additionally, 23 (46%) patients would have fallen into a different risk category as per Canadian clinical practice guidelines if the ASCVD calculator was utilized instead of Framingham for cardiovascular risk estimation. **Conclusions:** Cardiovascular risk percentages differ between those calculated using an electronic medical record tool versus online calculators. Depending on the calculator used, a proportion of patients may fall into a different cardiovascular risk category, possibly changing management decisions. Further research is required to inform consistency among point-of-care risk tools. With the emergence of novel risk calculators, updated clinical practice guidelines should reflect their appropriate clinical applications. Statin prescribing should involve shared decision making after a comprehensive assessment of individual risk factors.

Revalidation of the Priority Topics for the Assessment of Competence in Emergency Medicine (Work in Progress)

Andrew Organek*, CCFP (EM), FCFP; Tatjana Lozanovska, MEd; Brian Hess, PhD; Roy Wyman, CCFP, FCFP; Brent Kvern, CCFP, FCFP

Learning objectives:

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

1. Describe the purpose of the Priority Topics for the Assessment of Competence in Emergency Medicine
2. Explain the revalidation process for the existing Priority Topics
3. Summarize the results of the revalidation survey

Context: The current 35 current priority topics for emergency medicine (EM) and their key features were originally published in 1999. The current list of 35 priority topics and their key features. They are used for in-training assessment of residents during in the enhanced skills training and to guide the development of the CFPC’s Examination of Added Competence in Emergency Medicine. **Objective:** Revalidate the existing EM priority topics and their key features and identify potential new topics. **Design:** The survey consisted of two questions: one three-point Likert scale to validate the existing and one open text to suggest new priority topics. Using established methodology, the frequency-importance combinations for each topic were aggregated to give high, medium, and low relevance ratings. Open text responses were coded by two independent reviewers. **Participants:** The survey was sent to all currently active CFPC members who hold a Certificate of Added Competence (CAC) in EM (4,063 recipients). The response rate was 11%, with an acceptable balance in gender, geographical distribution, years in practice, location of practice, and teaching experience. **Results:** According to the composite score, 27 of 35 priority topics were ranked as highly relevant, 8 as medium, and 0 as low. Open text responses were coded to 135 different topics (26 existing topics or skill dimensions and 109 new), with frequencies of responses for each topic ranging from 54 to 1. **Next Steps:** Coded open text responses will be analyzed by the Working Group on the Priority Topics in Emergency Medicine, which will recommend potential additions, changes and updates to the existing topics. The group will then develop key features for the new priority topics, as well as review and revise the key features for the existing topics.

Section of Researcher's Blueprint 3: Development and Evaluation

Lee Green, MD, MPH, CCFP; Dima Omar, MPS; Steve Slade*, BA

Learning objectives:

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

1. Describe the development process of Blueprint 3, including stakeholder engagement approach and priority setting
2. Demonstrate the impact that Blueprint 3 can have on capacity and advocacy for family medicine research
3. Discuss the emerging evaluation framework for the Blueprint's implementation, impact, and future refinement

Description: Founded in 1995, the College of Family Physicians of Canada's (CFPC) Section of Researchers (SOR) includes over 3,000 family physicians and Associate Members engaged in family medicine and primary care research. Led by a diverse Council, the SOR unites clinician and non-clinician scientists, learners, and university-based researchers to advance research that strengthens family medicine and improves the health of Canadians. The Section of Researchers' Blueprint 3 (2024-2029) provides a roadmap to guide research efforts over the next five years. It focuses on two key priorities: building research capacity and advocating for the value and application of family medicine research. By integrating stakeholder perspectives and environmental scanning, the Blueprint seeks to strengthen primary care research, inform policy, and enhance collaboration across the research community. The Blueprint was shaped by Advancing Family Medicine Research in Canada: A Guidance Report for the CFPC's Future Role and Action, which served as a key developmental input. Building on this guidance, the Blueprint establishes priorities to strengthen research impact through advocacy and supportive family medicine research funding and infrastructures. This poster outlines the Blueprint's development, including literature reviews, stakeholder consultations, and priority-setting exercises. The process ensured that the Blueprint reflects the evolving needs of family medicine researchers, while aligning with national and international research agendas. To measure its long-term impact, a structured evaluation framework is in development. This framework will combine quantitative and qualitative measures to assess engagement, research outputs, and policy influence. It aims to gauge progress and provide insight into research priorities set out in the Blueprint. As the evaluation progresses, findings will guide refinements, ensuring the Blueprint remains relevant and adaptable for the family medicine research community. This presentation will highlight key lessons on developing and evaluating a national research strategy, emphasizing collaboration, policy influence, and capacity building in family medicine research.

Strengthening Relationships in Primary Care: Reflections on the Evaluation of the OECD PaRIS Dashboards

Udoka Okpalauwaekwe*, MBBS, MPH, PhD; Brenda Andreas, BSW, MSW; Mark Lees, MD, FCFP, BASc (Eng); Vivian Ramsden, RN, PhD, MCFP (Hon.), FCAHS

Learning objectives:

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

1. Learn how fostering trust, transparency, and mutual respect among primary care providers, and patients enhances care quality and patient outcomes
2. Learn insights into how relationship-driven strategies improve engagement and healthcare delivery
3. Learn how PaRIS Dashboards empowered PCPs to evaluate clinic performance, make informed decisions, and implement practice improvements

Objective: As part of a commitment to enhance relational equity in primary care in Saskatchewan, we engaged primary care providers (PCPs), medical and health administrators and patients in reflecting upon and evaluating the OECD PaRIS Dashboard Reports shared with them at their respective clinic. **Design:** Participatory evaluation. **Setting:** Saskatchewan **Participants:** Primary care providers, medical and health administrators, and patients within seven primary care clinics. **Intervention:** Transformative learning environments (these are relationship-driven environments that enhance mutual learning, reflection and action). **Findings:** PCPs from across all clinics expressed strong appreciation for the dashboards, emphasizing their value in facilitating data-informed interventions and supporting strategic decision-making within the clinics. The clinics also appreciated the opportunity to engage in the interpretation of the findings, underscoring the importance of the participatory process in making the results meaningful and applicable within their unique contexts. They also noted that this process contributed to the high response rates from both provider and patient PaRIS surveys in 2023. Feedback from participants highlighted the need for clearer, more intuitive dashboards that align with clinic strengths and values (e.g. presenting data in a consistent, actionable, and context-sensitive way while simplifying visual presentations). Participants further emphasized leveraging successful patient engagement strategies for future surveys and strengthening relationships across primary care clinics to enhance coordinated advocacy efforts and tailored policies that addressed both rural and urban health disparities. **Conclusions:** This participatory evaluation demonstrated that the clinics valued their involvement in all phases of the OECD PaRIS Project, while also identifying opportunities for improvement. These findings further underscored the importance of accountability in building unique, equitable and sustainable relationships within primary care systems.

Technology and Primary Care Clinician Burden (Work in Progress)

Marwa Ilali*, MD, MSc, PhD ; Elise Boulanger, MDCM, CCFP, BEng, MSc; Nebojsa Kovacina, MDCM, CCFP, MHSc; Frantz Daniel Lafortune, MDCM, CCFP; Claire Grillet; Stefanie Viens

Learning objectives:

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

1. Identify key technological factors contributing to administrative and other burdens in primary care
2. Evaluate human-centered design strategies that reduce clinician burden
3. Apply a modified integrated framework to analyze the impact of health IT on clinician work

Objective: As part of the Care for Tech initiative, this rapid review aims to identify the factors contributing to the administrative burden experienced by primary care providers when using information technologies (IT), and to explore promising human-centered design strategies that may reduce this burden and inform the co-development of digital health guidelines for primary care in Quebec. **Design:** Rapid review of empirical studies (2014–2024) conducted following PRISMA guidelines. Studies were selected from Ovid MEDLINE, Embase, PubMed, Scopus, CINAHL, Web of Science, Cochrane, and Google Scholar. For data extraction and analysis, we developed a unified framework by adapting three models: HOT-fit model (Human, Organization, Technology); Four Cs of Primary Care (First Contact, Continuity, Comprehensiveness, Coordination); and Quintuple Aim (patient experience, health outcomes, cost reduction, clinician well-being, health equity). **Setting:** Primary care settings in high-income countries. **Participants:** primary care providers, including family physicians and clinical nurses. Intervention: The review examined IT applications included electronic health records, e-prescribing, telemedicine platforms, patient portals, automated/AI documentation systems, and clinical decision support tools. **Main Outcome Measures:** Outcomes of interest included reduction in administrative, cognitive, and emotional burden; improved design, usability and workflow integration. **Anticipated Results:** Across 53 included studies, our analysis revealed a paradox. While IT solutions aim to improve care, they often introduced or exacerbated administrative burden, time pressure, and workflow disruptions. Common issues included high documentation burden, low clinical value, poor usability, and fragmented systems. Many systems prioritized administrative compliance over clinical value, with limited training and poor alignment to primary care workflows. However, tools developed using human-centered design principles, such as iterative co-design with clinicians, team-based documentation, adaptive AI, and user-centered design demonstrated greater potential to improve usability, reduce cognitive burden, and improve care coordination. As a support, supporting primary care workflows improves the overall performance of the health system.

The AFFIRM Clinic: A Bi-Monthly Clinic Within an Academic Family Health Team Supporting Transgender and Gender Diverse Patients and Enhancing Medical Learners' Educational Competencies (Work in Progress)

Thea Weisdorf*, MD, CCFP, FCFP; Suza Hranilovic MN, NP-PHC, ACRN; Sarah Nestico, MPH, RN

Learning objectives:

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

1. Create educational opportunities for resident family physicians in the provision of transgender and gender diverse (TGD) primary care
2. Enhance gender-affirming clinical care and support for TGD patients by medical and interdisciplinary health professional (IHP) learners and providers
3. Upscale departmental knowledge and capacity through faculty development to support new and existing TGD patients in gender affirming care

Context: St. Michael's Hospital Academic Family Health Team has over 1700 patients "tagged" who identify as transgender and gender diverse (TGD). Many family physicians do not feel comfortable providing gender affirming care (i.e. social, medical and surgical transitioning). The AFFIRM clinic is staffed by clinicians with expertise and provide consultation until issues are stabilized and then these patients return to their family physician. Family medicine residents gain increased exposure to the provision of gender affirming primary care where they may not ideally have this experience. **Objective:** To provide an educational opportunity for family medicine residents to learn the provision of primary care for TGD patients, while decreasing barriers to patients who identify as TGD. **Design:** This is a program evaluation of the AFFIRM clinic from its inception in July 2023 to December 2024 involving. **Setting:** St. Michael's Hospital Academic Family Health Team (SMHAFHT): The AFFIRM clinic is a bi-

monthly half day clinic offered as part of the Inner City Health component for resident teaching during PGY1 with additional opportunity if requested. **Participants:** Physician or NP supervisor, Family Medicine resident, RN and social work available during the clinic if requested. **Intervention:** Patients are seen in the AFFIRM clinic. Formal teaching is provided to the family medicine resident (use of the Gender-Affirming Tool Bar, taking a gender-focused history, how to do surgical assessments, etc). TGD patients from within the FHT who have been referred to the AFFIRM clinic are seen for assessment, follow ups and e-consults as appropriate. **Main Outcome Measures:** Number of patients seen in AFFIRM clinic between July 2023 and Dec 2024 (81). Number of residents participating in AFFIRM clinic (24). General experience of resident with AFFIRM clinic (to be presented on the Poster) **Anticipated results/Impact:** FM residents find the AFFIRM clinic useful and helpful in the provision of gender-affirming care. They feel better prepared to provide hormone therapy and surgical assessments for their patients. Family physicians appreciate the availability of colleagues with expertise in gender-affirming care to assist with their patient's care without having to send them outside of the FHT.
Conclusion/implications/learnings to date: The creation and implementation of the AFFIRM clinic confirmed the value of increasing TGD patient care access and providing medical learners with dedicated learning opportunities, as well as increasing the capacity for family physicians to care for their TGD patients.

The Art of Healing: An Innovative Communication and Arts & Humanities Curriculum

Emma Glaser*, MD, MSc; Clara Dallaire, Phd (c); Aspasia Karalis, MD; Emilie Laurier, MD; Stephen Legari, MA, MSc(A); Benoit Pierre Stock, BAA; Mathieu Moreau, MD, CMFC, MSc

Learning objectives:

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

1. Describe the Communication + Arts & Humanities UGME curriculum at University of Montreal
2. Explore the impact of co-constructing curricula with multiple partners
3. Describe the innovation of integrating modalities and using coaching early on in medical training

Context: The faculty of medicine at University of Montreal underwent a curriculum renewal of the entire undergraduate program. Recognizing chosen values (excellence, humanism, collaboration, creativity, courage) it became imperative to create a new communication skills curriculum. **Methods:** Using a quality improvement (QI) lens, we performed curricular reform. We surveyed existing curricula in other faculties, participated in curriculum development workshops, reviewed faculty and Medical Council of Canada objectives. We engaged with Arts & Humanities, surveying different pedagogical modalities and retained museum-based education, specifically Visual Thinking Strategies (VTS). Each communication objective was paired with a teaching modality. We collaborated with the Patient Partner Office, medical students, and the Montreal Museum of Fine Arts to co-create our curriculum. **Results:** Communication skills are taught everywhere where clinical reasoning is taught. Using Calgary-Cambridge Guide to the Medical Interview and ALOBA (Agenda Led Outcome Based Analysis), we focus sequentially and iteratively on: relationship building, information gathering, emotions, plans. Students explore and experiment skills in small groups supported by a coaching dyad throughout the year: patient partner and MD. Each session has a thematic discussion and then experiential learning. At a future date, the same small groups attend the museum to engage in VTS, now in a dyad with MD and museum educator. **Discussion:** Using QI, we engaged in a major innovative curricular reform that was co-created in collaboration with patient partners. We teach the art of healing with a longitudinal, spiral approach. We will continue to engage in QI and evaluate the impact of our curriculum.

The Role of Primary Care Networks in Addressing Workforce Challenges in Ontario Health East

Collenn Grady*, DBA; Alison Eyre, MD; Kate Hurst MScN; Sophy Chan-Nguyen, PhD

Learning objectives:

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

1. Increase understanding of the potential role for Primary Care Networks in Ontario related to workforce challenges
2. Increase knowledge about types of workplace challenges from the perspective of 4 different stakeholder groups
3. Increase knowledge about how Primary Care Networks can further efforts to address workplace challenges through collective action

Objective: This study sought to identify the ways in which Primary Care Networks (PCNs), in conjunction with Ontario Health Teams, can address workforce challenges in primary care. **Design:** A phenomenological study, using semi-structured interviews. Approval obtained from local Research Ethics Review Board. **Setting:** Eastern Ontario Health region, specifically non-accelerated Ontario Health Teams catchment area. **Participants:** Physicians, Nurse Practitioners, Administrators, Inter-professional healthcare providers working in primary care. **Findings:** Twenty-four participants were interviewed. Across all stakeholders' groups, PCNs were seen to have capacity to address the top two workforce issues: Financial challenges, and Recruitment/Retention. Advocacy by PCNs to address financial concerns would include staff wages, high overhead costs for physicians, potential for sharing program resources and increasing efficiencies through group purchasing. Recruitment and retention efforts led by the PCN could address rural limitations, cultivate a regional retention strategy (for physicians and staff) and foster shared recruitment efforts to alleviate shortages within primary care. Additionally, PCNs were seen to have a valuable role in addressing current high burnout and low morale within the primary care sector. **Conclusion:** Primary Care Networks can be instrumental in strengthening the primary care sector, specifically by advocating for much-needed change to address workforce challenges that are widely shared. By doing so, PCNs can act as the voice for primary care, fostering collaboration within a region and will foster change that would immediately add value.

To Describe the Experience, Preliminary Results, and Lessons Learned From the Government of Québec's Integration of Clinical Decision Support (CDS) in Family Practice Clinics

Mélanie Lacasse*, MD, FCFP, CCFP; Caroline Samson, MD, FRCP(c); Luigi Lepanto, MD, MSc, FRCPC; Roberto Boudreault, MD; Amelie Tremblay; Nathalie Bazlewicz

Learning objectives:

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

1. Describe the CDS implementation process in two Québec family practice pilot regions
2. Explain the impact of CDS on referral reduction, conformity of referrals, and healthcare cost savings
3. List the lessons learned throughout CDS implementation

Objective: To describe the experience, preliminary results, and lessons learned from the Government of Québec's integration of clinical decision support (CDS) in family practice clinics. **Design:** A prospective study Setting: This study took place in family practices in two pilot regions in Québec, the Centre intégré de santé et de services sociaux (CISSS) des Laurentides and de l'Outaouais. The potential referral volume to hospitals from the family practices is 41,000 annually, per hospital. **Intervention:** CDS was integrated into the existing computerized provider order entry and was deployed in Laurentides in April 2024 and in Outaouais in November 2024. In total, 149 clinical indications and 1874 scenarios have been integrated using recommendations from the Canadian Association of Radiologists (CAR) Diagnostic Imaging Referral guidelines, l'Institut National d'Excellence en Santé et Services Sociaux (INESSS), as well as custom entries. **Main Outcome Measures:** As of February 24th, 2025, over 44,000 referrals have been processed through CDS. As additional recommendations were shared from the CAR and INESSS, the clinical content coverage increased from 90 to 95%. Six percent of the orders have been cancelled, as they were determined to be 'non-relevant' based on the recommendations from the CDS, resulting in a potential savings of $750,000 per year, per site. Conformity of the referrals has improved over time, as referring clinicians interact and learn from the system. Lessons learned include the importance of ongoing communication (e.g., presentations, webinars, user guides), the continuous improvement of the CDS tool, and the unceasing involvement of relevant stakeholders and consultation with medical champions. **Conclusion:** There has been an impactful reduction in non-relevant orders in these two regions, which helps to manage the average of 8-10% annual increase in referrals. Integration of CDS into five additional pilot sites are planned in 2025, in preparation for a provincial deployment.

Use of ICD-9 Diagnosis Codes by Family Physicians (Work in Progress)

Stephanie Garies*, PhD; Michael Cummings, PhD; Kerry McBrien, MD, MPH; Keith Denny, PhD; Himasara Pathiraja, MScPH; Cathy A. Eastwood, RN, PhD; Terrence McDonald, MD, MSc; Tyler Williamson, PhD

Learning objectives:

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

1. Describe variations in how ICD-9 is used to code diagnoses for family physician billing across Canada
2. Recognize patterns in use of codes according to diagnosis categories
3. Determine what non-specific ICD-9 codes might represent

Context: Family physicians in many provinces use the International Classification of Diseases, 9th revision (ICD-9) to code diagnoses for billing submissions. ICD-9 was adopted in Canada in 1979, initially for use in hospitals. ICD-9-coded billing data are used extensively for secondary purposes, such as research, quality improvement, surveillance, and policy. However, this 45-year-old coding system may not adequately capture newer diagnoses or represent the full range of conditions seen in primary care. **Objective:** To describe how ICD-9 diagnosis codes are used in Canadian primary care. **Design:** Descriptive quantitative analysis. **Data Source:** Electronic medical record (EMR) data from the Canadian Primary Care Sentinel Surveillance Network (CPCSSN). This study was approved by the University of Calgary Conjoint Research Ethics Board (REB22-0440). **Participants:** Primary care patients with at least one billing code in their records between 2017 and 2022. **Outcome Measures:** From the billing records: 1) distribution of unique ICD-9 codes within ICD categories by year, stratified by EMR system and province; 2) frequency and type of ICD-9 code used for physician billing compared to text for the corresponding patient visit in the EMR; 3) for non-specific ICD-9 billing codes (e.g., 780, 799), a description of the most common conditions documented in the visit text. **Anticipated Results:** Approximately 1.2 million patients were eligible for inclusion (54.2% female, mean age 39.4 years). Non-specific ICD-9 codes are among the top 6 most frequently used in all study years. We anticipate seeing shifts in the distribution of ICD-9 codes by diagnosis category before/during the COVID-19 pandemic and noting variations by EMR system and province. **Conclusion:** This analysis will indicate how ICD-9 codes are used in primary care and where variations occur. This will also highlight gaps in the current ICD-9 system and complements our parallel work to test newer classification systems that may better represent primary care.

Voice Biomarkers for Depression Screening Using Machine Learning

Wesley Chorney, PhD

Learning objectives:

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

1. Explain how voice biomarkers aid depression screening using artificial intelligence
2. Compare AI-driven voice analysis with traditional depression screening tools
3. Identify the benefits, challenges, and ethical considerations of AI-based screening

Context: Depression affects approximately 280 million people worldwide, with a rising prevalence. It presents as low mood, cognitive decline, and psychomotor disturbances, severely impacting daily life. Linked to negative health outcomes, depression increases mortality and worsens prognosis in individuals with comorbidities such as diabetes and cardiovascular diseases. Despite its significance, many cases remain undiagnosed due to patient unawareness and diagnostic challenges. Untreated depression can lead to poor quality of life and increased suicide risk. **Objective:** While existing tools like the PHQ-8 are useful, novel methods leveraging speech biomarkers and machine learning offer promise for early detection. This study aims to develop a machine learning model for automated depression screening using voice features, enabling timely intervention and improving mental health outcomes. **Design, Setting, and Participants:** We validated a novel machine learning approach using the Distress Analysis Interview Corpus-Wizard of Oz (DAIC-WOZ) dataset, which includes 189 participants (300–492 sessions) categorized as depressed or non-depressed based on the PHQ-8 (cutoff ≥10). Since this is a secondary analysis, ethics approval was not required. **Main Outcome Measures:** The proposed model utilizes a separable convolutional neural network with multi-headed attention to analyze speech patterns. Unlike traditional methods, this model captures temporal dependencies in speech without needing a transcript, enabling efficient deployment in a primary care settings. **Results:** Trained and validated on DAIC-WOZ, the model achieved 70.21% accuracy in distinguishing depressed from non-depressed individuals. This enables automated distress screening in recorded consultations, flagging high-risk cases for clinical follow-up. **Conclusion:** This study presents a novel machine learning model for depression screening in a primary care setting. The proposed model offers background depression monitoring even when the focus of consultation is not on mental health. This can ensure that at-risk populations receive timely interventions and treatment for depression. Future studies can test this model on a larger scale.