FMF
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Forum en médecine familiale

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

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Poster Program

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Présentations d'affiches

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Family Medicine Matters • La médecine de famille est essentielle

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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.

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604 A Validated Survey to Assess Climate Change Preparedness

605 Factors Associated With Family Physicians Leaving Clinical Practice

606 Redesigning Team-Based Care in Primary Care: Evaluation of a nested team model

607 Strengthening Primary Care Through Systemwide Transformation

608 From Principles to Practice: A systems evaluation of palliative care integration in a family health team

609 Population Level Trends in ADHD Incidence and Stimulant Medication Dispensation in Alberta, Canada (2010 to 2024)

610 Identifying Priority Research Questions to Strengthen Primary Care Globally: Findings from a deliberative dialogue study

611 Has Specialists' Perceptions of Family Physicians Changed Post-COVID?

612 Pilot Adaptation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home Survey for Use in Patient Medical Homes in Prince Edward Island, Canada

613 Family Physicians' Acceptance of AI Tools for Cardiovascular Assessment

614 Addressing Community Health Priorities: ECRC-WISH Initiative (Work-in-Progress)

615 Studying Practice Settings: An analytical approach to understand family physicians and family practice

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617 Implementing a Blended Capitation Funding Model: Creating sustainable primary care and family practices in Newfoundland and Labrador (Work-in-Progress)

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620 KidneyWise: Advancing chronic kidney disease management in primary care

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701 Ultrasound-Guided IUD Placement During Family Medicine Residency Training

702 Sexual Health Experiences Among Patients with Gynecologic Malignancies

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705 Decision-Making Capacity Assessment Education Using Online Modules

706 Assessing the Use of Potentially Inappropriate Medications in Older Patients in a Primary Care Clinic

707 The Association Between Patient-Perceived Empathy and Patient-perceived Ageism in Patients ≥60 Years age at the Dalhousie Family Medicine Mumford Clinic (Work-in-Progress)

709 Impact of Time Constraints on Preventive Care Delivery

710 Patient Preferences for Research Collaboration in Family Medicine Groups (FMGs)

711 Family Physicians' Attitudes on a Pilot Acute Care Uniprofessional Theatre-Based Simulation Experience

712 Culturally Sensitive Grief Resources in Primary Care (Work-in-Progress)

713 Evaluation of the Sustainability of Healthy Lifestyle Habits Following a Personalized Primary Care Obesity Management Program (Work-in-Progress)

714 Effectiveness of Teach-Back Methods in Primary Care

715 Conversation Cards for Pregnancy: A feasibility study

717 Evaluation of the "Mini-BASICS" Faculty Development Program for Rural Family Medicine Clinical Faculty Using the CIPP Model

718 Improving Primary Care Access for Unattached Patients: Insights from clinicians and system leaders in Canada

719 Imagerie médicale urgente: de la requête au résultat

720 Dose-Sparing Obesity Pharmacotherapy: Real-world combination success

Revalidation of the Priority Topics for Assessment of Competence for Certification in Family Medicine (Work-in-Progress)

Kathrine J. Lawrence*, MD, CCFP, FCFP; Tatjana Lozanovska; MEd, Brian Hess, PhD; Brent Kvern, CCFP, FCFP

Poster # 501

Learning objectives:

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

1. Explain the revalidation process for the existing priority topics
2. Summarize the results of the revalidation process
3. List potential new priority topics

Context: The CFPC's Priority Topics for Assessment were determined from a survey conducted in 1998 (1). The topics were validated in 2004 and 2014. Following the 2014 revalidation survey, six new topics were added to the list. The CFPC committed to validation every 10 years. **Objective:** Revalidate existing and identify potential new priority topics for assessment. **Design:** The survey consisted of two questions: one three-point Likert scale to validate the existing priority topics and one open text to suggest new topics. Frequency-importance combinations for each topic were aggregated to give high, medium, and low relevance ratings. Open text responses were coded by one reviewer and checked by three others. Institutional ethics screening classified this work as quality improvement and exempt from REB review. **Participants:** A stratified random sample of CFPC members and a target group of CFPC Section and Committee members, SOO examiners, SAMP markers, and FM Residency Programs leadership were invited to participate. A total of 11,696 English and 901 French invitations were sent. 740 responses were received, with an acceptable balance in gender, geographical distribution, years in practice, location of practice, and teaching experience. **Results:** 55 of 105 priority topics were ranked as highly relevant, 49 as medium, and 1 as low. There were 438 open text responses. 228 were coded to the existing list of priority topics. 134 unmatched responses were sorted into 50 additional topics, and 76 were coded under 11 professionalism themes. Of the 50 topics, five were selected for further consideration: Attention Deficit Disorder, Sport and Exercise Injuries, Concussion, Planetary Health and Stewardship, and Abuse. **Next steps:** Key features will be developed for the five potential new topics and submitted to Board of Examinations and Certification for approval. 1 - Allen, T., Brailovsky, C., Rainsberry, P., Lawrence, K., Crichton, T., Carpentier, M. P., & Visser, S. (2011). Defining competency-based evaluation objectives in family medicine: dimensions of competence and priority topics for assessment. Canadian family physician Medecin de famille canadien, 57(9), e331–e340.

Who Teaches Family Medicine in Canada?

Ivy Oandasan*, MD, MHSc, EMBA, CCFP, FCFP; Mahsa Haghighi, MSc; Lorelei Nardi, MSc; Steve Slade, BA

Poster # 502

Learning objectives:

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

1. Describe national family medicine teaching capacity using available Canadian data sources
2. Describe differences in teaching participation and intent between international and Canadian medical graduates
3. Identify data gaps limiting effective family medicine education and workforce planning

Context: Family medicine (FM) training in Canada faces increasing pressure on teaching capacity. International medical graduates (IMGs) may represent an important source of teaching capacity; however, their participation in teaching roles is poorly documented. More broadly, existing national data sources provide a fragmented understanding of who teaches FM,

where teaching occurs, and whether current faculty supply aligns with learner needs. **Objective:** To synthesize available national data sources to inform evaluation of teaching capacity in Canada, describe teaching participation and interest- including among IMGs- and identify key data gaps limiting education and workforce planning. **Design:** This descriptive study analyzed secondary data from three national sources: the College of Family Physicians of Canada (2026) membership database, the FM Longitudinal Survey (2024/2025), and the Association of Faculties of Medicine of Canada (2023/2024) Faculty Members Study. Data sources received ethics approval at the time of original collection. **Setting:** Canada. **Participants:** FM residents and practising family physicians. **Main Outcome Measures:** Indicators of FM teaching capacity, including teaching participation, faculty appointment status, and intended involvement in teaching health profession learners. **Results:** Across data sources, FM teaching roles were inconsistently defined and incompletely captured. Only a small proportion of CFPC members self-identified as supervisors of training (n=6,539). AFMC data reported 1,426 full-time and 18,528 part-time FM faculty members, the majority unpaid volunteers (n=13,573). Among early-career physicians approximately three-years into practice, just over 40% of both IMGs and Canadian medical graduates (CMGs) reported including teaching in their practice. Resident-reported data at entry to and exit from residency indicated high teaching intent, with 80–85% of IMGs and CMGs planning to teach health profession learners. **Conclusions:** Teaching contributions are under-captured and inconsistently defined across sources. Coordinated national data collection integrating faculty, membership, and learner perspectives is needed to support ongoing FM education planning and address emerging teaching capacity challenges.

Navigating Practice, Identity, and Place: Transition to practice for internationally trained physicians in rural and underserved settings

Udoka Okpalauwaekwe*, MD, MPH, PhD; Olukayode Olutunfese, MD, MHPE, CCFP; Stephanie Ascence, MD, MPH, CCFP; Eleanor Francis, MD, CCF; Carla Fehr, MA, PMP; Joseph Akinjobi, MD, CCFP; Taofiq Olusegun Oyedokun, MD, MSc, CCFP, FCFP; Jon Witt, MD, MPH, CCFP, FCFP

Poster # 503

Learning objectives:

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

1. Describe how transition to practice for internationally trained physicians is experienced across clinical, organizational, and community contexts in rural settings
2. Identify key barriers and facilitators that influence successful transition and retention of internationally trained physicians in rural family medicine
3. Apply insights from transition to practice research to inform practical strategies for supporting integration and retention of internationally trained physicians in rural practice

Context: Internationally trained physicians (ITPs) are essential to sustaining family medicine in rural and underserved communities in Canada. While practice-ready assessment (PRA) programs facilitate entry into independent practice, less is known about how ITPs experience transition to practice and how this influences retention. **Objective:** To map how transition to practice among ITPs in rural and underserved settings is conceptualized, experienced, and supported, and to identify factors influencing workforce sustainability. **Design:** Scoping review guided by Joanna Briggs Institute methodology and reported using PRISMA-ScR guidelines. **Setting:** Studies conducted in rural, remote, and underserved settings across countries including Canada, Australia, the United Kingdom, and the United States. **Participants: I**nternationally trained physicians (or international medical graduates) entering early independent practice through pathways such as PRA or comparable programs. **Main Outcome Measures:** Conceptualizations of transition to practice; reported transition experiences; barriers and facilitators; supports and interventions; and sustainability-related outcomes including retention, wellbeing, and intent to remain. **Results/Findings:** Seventeen studies met inclusion criteria. Transition to practice was inconsistently defined and often

embedded within broader concepts such as integration or retention. Across studies, transition emerged as a multidimensional process shaped by individual, clinical, organizational/institutional/systemic, and community factors. Common challenges included administrative complexity, unfamiliar clinical workflows, cultural adaptation, and professional identity shifts. Mentorship, orientation, and supportive team environments facilitated transition, while community integration and family adjustment were closely linked to retention. Supports were primarily focused on entry into practice, with fewer addressing ongoing integration. **Conclusion:** Transition to practice for ITPs in rural settings extends beyond entry into independent practice and is shaped by relational and contextual factors. Strengthening coordinated supports across clinical, organizational, and community domains may improve retention and sustainability of the rural family medicine workforce.

Expérience de requalification des médecins formés à l'étranger

Jennifer Hakim*, MD; Saïd Mekari, PhD; Isabelle Gaboury, PhD; Nicole LeBlanc, MD, FRCP; Shane Aubé, MD, CCMF, Mathieu Bélanger, PhD

Poster # 504

Learning objectives:

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

1. Explorer l'expérience de requalification professionnelle des médecins formés à l'étranger

Contexte : Dans un contexte de pénurie de médecins, les autorités compétentes de plusieurs pays ont pris des mesures afin de faciliter le processus d'inscription des nouveaux médecins, notamment ceux ayant reçu leur diplôme à l'étranger. Cependant, plusieurs de ces médecins éprouvent encore des défis lors de leur processus de requalification professionnelle. **Objectif :** Décrire l'expérience des médecins formés à l'étranger (MFE) lors de leur requalification professionnelle dans un nouveau pays. **Type d'étude :** Recension des écrits scientifiques et de la littérature grise. **Paramètres d'évaluation :** Recension dans les bases de données : PubMed, Scopus, APA PsychInfo, Érudit, CINAHL et Google Scholar. Les données ont été extraites à l'aide d'une grille standardisée incluant les caractéristiques des études, les populations, les méthodes et les résultats, puis analysées selon une approche thématique en se basant sur le cadre conceptuel de Potvin et coll (2014). **Résultats :** Vingt-cinq études ont été sélectionnées. Parmi elles figurent une revue systématique, deux revues de portée, dix-neuf articles, un chapitre de livre et deux thèses. Les facteurs façonnant l'expérience de requalification professionnelle des MFE sont regroupés en trois catégories : les facteurs situationnels poussent les MFE à quitter leur pays, les attirent vers un autre pays ou les incitent à y rester. Les facteurs institutionnels regroupent les procédures que les MFE doivent suivre pour faire reconnaître leurs qualifications et sont largement abordés dans les écrits comme ayant un impact sur le succès ou non de la requalification. Les facteurs intrinsèques décrivent les sentiments et les expériences des MFE au cours de leur parcours migratoire et lors de leur processus de requalification. **Conclusion :** Cette revue permet de mieux comprendre les facteurs influençant la requalification professionnelle des MFE, pour mieux soutenir des changements de politiques et faciliter l'accompagnement et l'intégration professionnelle des MFE dans le système de santé.

International Medical Graduate Characteristics in Family Medicine Residency

Mahsa Haghighi*, MSc; Lorelei Nardi, MSc; Ivy Oandasan MD, MHSc, EMBA, CCFP, FCFP; Steve Slade, BA

Poster # 505

Learning objectives:

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

1. Describe key demographic characteristics of international medical graduate family medicine residents in Canada

2. Identify prior training experiences of international medical graduates entering family medicine residency
3. Identify future practice intentions of international and Canadian medical graduates during family medicine residency

Objective: In a period of heightened concern about access to comprehensive primary care, international medical graduates (IMGs) represent an essential segment of Canada's family medicine (FM) workforce. Using national data, we describe the characteristics, training, and intended practice of IMG FM learners to inform education and workforce planning. **Design:** Using weighted responses from the FM Longitudinal Survey, we examined IMGs and Canadian medical graduates (CMGs) at entry into FM residency. Ethics approval was obtained/waved for each participating residency program to implement the survey as part of a program evaluation plan. **Setting:** Across 17 Canadian FM residency programs. **Participants:** The study included 1,570 IMGs and 4,599 CMGs entering residency over a six-year period (2020–2025), with an average response rate of 65%. **Main Outcome Measures:** We characterize key patterns describing who IMG family physicians are, how they experience training, and how they envision their future practice. **Results:** The proportion of IMG respondents increased over time, rising from 17% in 2020 to 35% in 2025. Regionally, the share of IMGs training in western programs declined modestly (40% in 2020 to 36% in 2025), while representation within Ontario-based programs increased (36% to 49%). Agreement that pre-residency medical education provided exposure to principles of comprehensive care increased among IMGs, from 75% in 2020 to 84% in 2025. More than 90% of IMG respondents consistently indicated an intention to practice within a group physician or interprofessional team-based setting. Additionally, approximately 69% of IMGs reported an intention to provide comprehensive care within their first three years of practice. **Conclusion:** IMGs represent a growing proportion of FM trainees, with shifting regional distribution and increasing exposure to principles of comprehensive care prior to residency. Strong early-career intentions to provide comprehensive care underscore the importance of targeted training and workforce planning to support IMG integration into practice.

Elective Pre-Clerkship Undergraduate Family Medicine Immersive Programs: Does early exposure have an impact on career choice and perception of FM? (Work-in-Progress)

Lauren Payne*, MD, CCFP, MPH; Anna Loi, MEd, CPCD; Sandra Fournier, MEd; Tobi Lam, MSc, MHSc

Poster # 506

Learning objectives:

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

1. Examine how early immersive family medicine experiences shape learners' perceptions, identity development, and career intentions
2. Identify program elements that positively shift undergraduate medical students' attitudes toward family medicine practice
3. Determine whether early exposure increases interest in selecting family medicine as a first-choice specialty

Context: Given the current crisis facing family medicine in Canada, it is especially important that we explore new and innovative ways to encourage medical learners' interest in primary healthcare careers. Literature has shown that exposing medical learners early on to family medicine can promote and maintain their interest in the field. **Objective:** To examine how early immersive family medicine programs influence undergraduate medical learners' perceptions of family medicine, professional identity formation, and interest in pursuing family medicine residency training. **Research Design:** Mixed methods (four longitudinal surveys and qualitative interviews). **Setting:** Department of Family and Community Medicine, University of Toronto. **Participants:** First- and second-year medical students (n=30 MD Students). **Intervention:** Participation in a week-long immersive family medicine conference and/or a 7-week long scholarship program in family medicine clinical practice. **Main Outcomes Measures:** Change in learner attitude/perception of family medicine as well as ultimate career choice. **Results/Impact:** Preliminary qualitative findings suggest that early meaningful immersive exposure challenges stigmatized

perceptions of family medicine, reframes generalism as complex and meaningful work, and supports identity alignment through role modeling and belonging. **Conclusion:** Supporting students early in their training to explore and understand family medicine in this way may be an important strategy for strengthening Canada's future primary care workforce.

Predicting Practice Readiness Using Multiple Mini Interviews

Eric Wong*, MD, MClSc (FM), CCFP, FCFP; Wendy Yen, MA; William Tays, PhD

Poster # 507

Learning objectives:

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

1. Describe the role of the MMI within Practice Ready Ontario's Verification and Selection phase
2. Examine early validity evidence supporting MMI-based selection for clinical field assessment and practice readiness
3. Describe limitations of this study and future research directions

Objective: Practice Ready Ontario (PRO) assesses internationally trained physicians (ITPs) for readiness to enter independent family medicine practice in rural Ontario communities. Because eligible applicant volume significantly exceeds available assessment seats, an MMI was developed and incorporated into the program's Verification and Selection phase to identify candidates most likely to succeed in the 12-week Clinical Field Assessment (CFA). This program evaluation examines whether MMI performance is associated with early CFA outcomes. **Design:** The MMI is a 7-station virtual interview assessing Program Suitability, Professional Suitability, and Communicative Competence. Ordinal logistic regression was used to assess whether MMI performance predicts early CFA outcomes. CFA interim summative competence ratings at Week 6 were used as the outcome variable. PRO Eligibility Ranking score was included as a comparator variable. This work was exempt from Research Ethics Board approval (Western University). **Setting:** A provincial practice readiness assessment program where ITPs are assessed in rural Ontario communities over 12 weeks. **Participants:** 79 ITP candidates who completed both the MMI and CFA. **Results:** Of the 79 candidates who completed CFA, 76 were successful (96%). Ordinal regression demonstrated that MMI Overall Suitability scores uniquely predicted CFA interim competence ratings ($p = .038$), while PRO Eligibility Ranking did not ($p = .502$). Overall model fit approached significance ($p = .08$). **Conclusion:** Early evidence supports the use of the PRO MMI as a valid selection tool for identifying candidates most likely to succeed in rural clinical practice assessments. Limitations include small sample size and a restricted range of candidates advancing to CFA, as all those who advance must be successful in MMI. Reanalysis with a larger sample size is indicated to confirm findings.

Infrastructure Supporting Community Based Family Medicine Clerkships: A national survey of undergraduate directors

Lyn Power*, MD, CCFP, FCFP; Ann Lee, MD, MSc, CCFP; Anne Guimond, MD, CCFP; Aaron Johnston, MD, CCFP (EM), FCFP; Martina Kelly, MBBCh, PhD, CCFP, FCFP

Poster # 508

Learning objectives:

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

1. Identify the scale of community based FM clerkship placements in Canada
2. Analyze the infrastructural pressures that shape community based FM teaching sustainability
3. Advocate for infrastructural supports at institutional and government level

Objective: To describe the current scale of community based family medicine (FM) clerkship placements in Canada and examine the infrastructural arrangements that support their delivery. **Design:** We conducted a national survey including quantitative and qualitative items addressing clerkship structure, placement settings, preceptor remuneration, and administrative processes. An interpretive analytic approach, guided by Star's theory on infrastructure, guided analysis. Open ended responses were analyzed inductively, and analytic vignettes were developed to illustrate the administrative work required to support placements. **Setting:** Canadian Undergraduate Family Medicine Directors (CUFMED) network. **Participants:** Undergraduate FM directors, FM Clerkship directors in Canadian medical schools. **Findings:** 19 Canadian medical schools completed the survey (100% response rate). FM clerkship duration varied: one school offered a 4 week block, seven offered 6 week blocks, one offered 7 weeks, six offered 8 weeks, and four offered more than 8 weeks. Collectively, this represents 19,751 learner weeks of community based FM placements annually, supporting 2,966 medical students in 2024. Schools relied heavily on community physicians for FM clerkship; four schools reported more than 100 active community preceptors. Respondents highlighted persistent challenges including variable preceptor capacity, limited clinic space for learners, inadequate rural housing, and substantial administrative workload. Fifteen schools provided financial compensation for FM clerkship teaching, though payment models varied widely and were often insufficient to offset the real costs of teaching in community practices. Directors emphasized that administrative coordination required significant, often invisible labour essential to sustaining placements. **Conclusion:** Community based FM clerkships operate at significant national scale yet depend on infrastructures that are inconsistently supported and increasingly strained. As Canada expands distributed medical education, strengthening the administrative, financial, and relational supports underpinning community based teaching is essential. Without attention to these infrastructures, efforts to scale FM education risk outpacing the capacity of community practices to sustain high quality learning experiences.

Clerkship Review: Highlights and key issues

Tania Riendeau*, MD, CCMF; René Wittmer, MD, CCMF

Poster # 509

Learning objectives:

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

1. Identify key strengths and challenges of the clerkship revealed through stakeholder consultations
2. Analyze gaps in clerkship assessment practices and consider steps toward competency-based evaluation
3. Describe opportunities to strengthen generalism through community, longitudinal, and family-medicine-focused experiences

Objective: With the aim of enhancing generalism and undertaking a pedagogical revision, the University of Montreal's undergraduate medical program launched a reform initiative in 2021. After modifying the pre-clinical curriculum accordingly, a series of consultations were held to identify the challenges, opportunities, and strengths of the clerkship. **Study Design:** Since fall 2026, multiple consultations have been conducted in three formats: focus groups, surveys, and individual discussions. Participants included clerkship students, educational leaders, postgraduate program representatives, administrative staff, and both current and former members of the program's leadership team. **Topics:** A wide range of themes related to the clerkship curriculum were addressed. These included clinical activities, formal and formative assessments, academic activities, the hidden curriculum, rotation evaluations, faculty development, pedagogical innovations, the role of technology in teaching, integration of key concepts, and anticipated challenges such as cohort expansion. **Results:** Major findings highlighted strong appreciation for the clinical experience and the development of professional identity fostered during the clerkship. However, variability in rotation assessments and ad hoc scheduling of academic activities were perceived as significant irritants, as was the organization of in-person examinations. Participants identified several opportunities for improvement, including integrating non-medical expert competencies, implementing a true

competency-based assessment model, emphasizing community-based settings, strengthening longitudinal experiences, and placing greater focus on family medicine. **Conclusion:** The overarching vision of clerkship reform—centered on generalism—aligns closely with the expectations of both students and educational leaders. Key areas for development include integrating technology into teaching and instructional methods, simplifying schedules for all stakeholders, revising academic pedagogical approaches, establishing a genuine competency-based evaluation system, promoting student well-being, and enhancing exposure to family medicine and longitudinal care.

Curricular Influence on Interest in Family Medicine (Work-in-Progress)

Jasmine (Sin Ki) Yip*, MBChB, MScCH (FCM); George Kim, MD, MClSc (FM), CCFP, FCFP

Poster # 510

Learning objectives:

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

1. Identify curricular activities that influence students' decisions to pursue Family Medicine
2. Explore characteristics of various curricular activities in their influence on students' career choice
3. Apply insights from positive components of curricular activities to enhance students' interest in Family Medicine

Context: Over 250 Family Medicine (FM) residency positions were left unfilled after the first iteration of Residency Match under the Canadian Resident Matching Service (CaRMS) in 2026, despite worsening family doctor shortage. Current available evidence explored correlations between interest and personal background/perception of FM/social environment/extra-curricular activities, but there is a significant research gap in influences from the curriculum. **Objective:** To determine how students' first-choice specialty (FM vs. non-FM) has changed during medical school; and to identify the influence of FM and non-FM curricular activities on students' interest in pursuing FM as a career. **Design:** Cross-sectional survey study, approved by Western University Health Science Research Ethics Board. **Participants:** Final year medical students enrolled in an English-speaking Canadian medical school's MD program; sample size is 2900. **Results:** Amongst the 68 respondents so far from 8 different targeted medical schools, the proportion of students chosen FM as their first-choice specialty has increased from 29.9% upon admission to medical school to 38.8% upon CaRMS application. Comparing students who have ultimately chosen FM with those who have not, there were no statistically significant differences in their age (p=0.248), gender (p=0.174), race (p=0.163), and urban/rural background (p=0.210). 74.6% were positively influenced towards FM after a rural FM clerkship and 73.5% after interactions with FM staff. Those who have finally chosen FM had a more positive influence towards FM after pre-clerkship FM (p=0.116*) and non-FM (p=0.012*) observerships, urban FM clerkship (p=0.003*), non-FM clerkship (p <0.0001*), interactions with FM staff (p=0.004*) and residents (p=0.011*), as well as non-FM staff (p=0.0003*) and residents (p=0.002*). **Conclusion:** Proportion of students interested in FM grew during medical school. Both FM and non-FM curricular activities could positively influence students towards FM. Future qualitative analyses should be done to discern positive components from these curricular activities for further enhancement.

Telling Rural Stories: A qualitative study of rural physicians' experiences as human books in a living library

Grace Perez*, Msc; Kaia Thauberger; Aaron Johnston, MD, CCFP (EM), FCFP

Poster # 511

Learning objectives:

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

1. Attendees will learn about the use of narratives as teaching modality to complement traditional curriculum rural medical education

2. Attendees will learn about the dual benefits of living libraries on the medical learners and on the rural family physicians
3. Attendees will learn and about experiential knowledge as a resource for health systems promotion and workforce sustainability

Objective: To explore the impact of storytelling on rural family physicians serving as "human books" in a Living Library, with a focus on reflection, meaning-making, and relational outcomes. **Design:** Qualitative study using a phenomenological approach. **Setting:** A Living Library implemented within a Canadian medical education context since 2021, involving learners across premedical, undergraduate, and postgraduate levels, and rural family physicians as "human books". **Participants:** Rural healthcare professionals (e.g., family physicians and allied health workers) and community members who participated as human books from 4 Living Library events. **Intervention:** Participants engaged in a Living Library, sharing personal and professional stories of rural practice with small groups of medical learners in structured, dialogic sessions. **Main Outcome Measures:** Self-reported experiences of storytelling, including emotional reflection, meaning-making, and perceived personal and professional impacts, collected through 19 semi-structured interviews of 29 human books. **Results:** Three themes emerged. First, "human books" felt a strong responsibility to share their stories to inspire learners and promote rural practice. Second, preparing and telling stories prompted emotional reflection and required psychological readiness, as participants revisited meaningful and sometimes challenging experiences. Third, storytelling offered personal benefits, including a sense of connection with learners, reframing of past experiences, and strengthening personal networks. Many described the process of telling and retelling their stories as leading to new insights and a renewed sense of purpose and meaning in their work. **Conclusion:** Living Libraries engage rural clinicians as experts by experience, offering dual benefits to learners and clinicians while complementing traditional curricula and supporting community-informed education. For rural family physicians, it supports reflection, reinforces professional identity, and fosters connection. Integrating narrative-based approaches such as Living Libraries may offer a valuable strategy to support rural workforce engagement and understanding of rural healthcare practice.

Ready for Tomorrow's Crises? A critical document analysis of emergency preparedness competency frameworks to inform undergraduate medical education

Anila Ramaliu*, MD; Aaron Johnson, MD; Clark Svrcek, MD; Sarah Weeks, MD; Martina Kelly, MD; Andrea Hull, MD; Franco Rizzuti, MD; A.Pham; G. Perez

Poster # 512

Learning objectives:

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

1. Understand how national and international frameworks define but fail to bridge emergency preparedness competency expectations between medical education and emergency management systems
2. Recognize the four universal structural gaps limiting emergency preparedness curriculum development: absent pedagogical guidance, undefined assessment instruments, unaddressed faculty readiness, and missing curriculum integration strategy
3. Translate evidence-based findings from competency framework analysis into actionable priorities for integrated emergency preparedness curriculum reform in undergraduate medical education

Global health emergencies expose critical preparedness gaps in undergraduate medical education, potentially leaving family physicians underprepared for unpredictable and high-stakes disaster surge demands. Despite growing MCC and AFMC accreditation requirements, no unified framework bridges medical education standards and emergency management systems. Understanding how existing frameworks define physician roles and competency expectations is essential to

meaningful curriculum reform for Emergency Preparedness, Response and Recovery. **Context:** Global health emergencies expose critical preparedness gaps in undergraduate medical education, potentially leaving family physicians underprepared for unpredictable and high-stakes disaster surge demands. Despite growing MCC and AFMC accreditation requirements, no unified framework bridges medical education standards and emergency management systems. Understanding how existing frameworks define physician roles and competency expectations is essential to meaningful curriculum reform for Emergency Preparedness, Response and Recovery. **Objective:** To critically analyze how national and international documents define physician emergency preparedness competency expectations to inform UME curriculum development. **Design:** Critical document analysis using NVivo 15.3 thematic and content analysis, with Miller's Framework mapping cognitive demand distribution. Two independent reviewers conducted analysis to ensure coding reliability. This study received formal ethics exemption confirmation from the University of Calgary CHREB, as document analysis involved no human participants. **Setting:** Cumming School of Medicine, University of Calgary. (Participants) **Data Sources:** Documents were purposively selected to represent authoritative national and international medical education, emergency management, and public health governance bodies: AFMC, MCC, CanMEDS, CFPC, RCPSC, PHAC, Health Canada, WHO, NHS, FEMA, USMLE. **Main Outcome Measures:** Competency domains, cognitive demand distribution, disaster cycle coverage, and cross-framework alignment gaps. Findings: Significant misalignment exists between medical education and emergency management frameworks - with no analyzed document bridging both systems. Emergency management documents implicitly assume physician readiness already achieved through existing education - an assumption structurally unsupported by this analysis. Cognitive demand requirements skew heavily toward passive knowledge (42% "Knows"; only 12% Authentic Performance). Disaster cycle coverage is unbalanced: Preparedness dominates (40%), while recovery remains critically underrepresented (10%). Four universal structural gaps emerged: absent pedagogical guidance, undefined assessment instruments, unaddressed faculty readiness, and missing curriculum integration strategy. **Conclusion:** Current frameworks suggest emergency preparedness competency expectations are fragmented, cognitively shallow, and operationally disconnected from real crisis deployment systems. For family physicians - often first community contacts during disasters - this gap carries potential patient safety implications, highlighting an educationally urgent need for evidence-based, integrated curriculum reform that aligns medical education with emergency management systems.

Evaluation of the Predictive Validity of a Situational Judgement Test and the Non-Academic Performance of Family Medicine Residents in Canada

Keith Wycliffe-Jones*, BSc.(Med Sci), MBChB, FRCGP, CCFP, FCFP; Jonathan Gerber, BSc; Michelle Gerber MD, CCFP, FCFP; Mel Washbrook-Brown, BSc,MSc; Emma Morley, BSc, MSc, CPsychol; Máire Kerrin, BSc, MSc, PhD, CPsychol; Fiona Patterson, BSc, MSc, PhD, CPsychol, FASS, FRCGP (Hon)

Poster # 513

Learning objectives:

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

1. Understand the role of a new SJT in Family Medicine residency selection
2. Evaluate the utility and predictive validity of a new SJT used in FM residency selection
3. Know how a new SJT for FM selection has been developed, implemented and evaluated

Objective: The objective was to determine if lower test scores on a new Family Medicine (FM) -specific situational judgement test (SJT), used by Canadian FM programs in their selection process, is predictive of; i) poorer, in-training performance overall and of the 4 attributes assessed by the test (team-working, professional integrity, adaptability and empathy/compassion) and ii) increased instances of remediation. **Design:** This was a prospective cohort study that followed a group of FM residents who had previously completed the the new SJT as part of their application process to FM residency training. In-training and end-of-training assessment data related to the 4 attributes and a global assessment of performance was collected using a

bespoke, assessment tool completed by each resident's supervisor. Data about any instances of remediation was also collected from the participating programs. **Setting:** This study was conducted in 13 participating FM residency programs in Canada. **Participants:** New entry FM residents, who matched to one of the 13 participating programs in 2023, and who had completed the SJT, were invited to participate. **Main Outcome Measures:** Total scores and scores on the ranking and rating questions in the SJT were collected for participating residents and compared to their supervisor ratings of performance on the 4 attributes, overall and to instances of remediation. **Results:** Supervisors' assessment data were collected for 422 residents (mid-training) and for 380 residents (end-of-training). Ranking question scores were positively statistically significantly related to supervisors' overall rating scores (final evaluations). (rs (378) =.09, p = .05). Ranking FMProC question scores were also statistically significantly related to a requirement for remediation (OR = 0.97, 95% CI [.95, .99], p = .009). **Conclusion:** This study provides good initial evidence for the validity of this new FM-specific SJT in predicting FM Residents' in-training performance overall and in relation to the requirement for remediation.

Barriers and Facilitators to Effective Primary Care Models: Findings from a global deliberative dialogue with policymakers, researchers and providers

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Poster # 514

Learning objectives:

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

1. Identify key barriers and facilitators affecting implementation of equitable, effective primary care models globally.
2. Explain how governance, financing, workforce, and service design shape primary care implementation and equity.
3. Describe strategies that strengthen primary care models of care

Context: High-quality primary care is essential to achieving health equity, yet many countries continue to face challenges in implementing effective and equitable primary care models. **Objective:** To identify barriers and facilitators influencing the implementation of primary care models across different regional settings. **Design:** Qualitative study within a larger mixed-methods project. Three virtual deliberative dialogues were conducted between September and October 2024. Transcripts were analyzed thematically using both inductive and deductive approaches. Deductive coding was guided by the World Health Organization Primary Health Care framework. **Setting:** Three virtual deliberative dialogue sessions involving participants from the African, the Americas, and European regions. **Participants:** Nine primary care stakeholders, including researchers, providers, and policymakers. **Main Outcome Measures:** Key barriers and facilitators affecting the implementation of equitable and effective primary care models. **Results/Findings:** Barriers and facilitators were grouped into six categories: health system governance, financing, service design, health workforce, health equity, and public and policy perceptions. Key barriers included weak governance, misalignment between funder agendas and local priorities, workforce shortages, limited recognition of family medicine, fragmented service design, and high costs of care associated with privatization. Key facilitators included expanding multidisciplinary teams, including community health workers, task shifting and task-sharing, integrating vertical disease programs, and implementing empanelment systems to strengthen coordinated primary care networks. **Conclusion:** Effective primary care models require alignment across governance, financing, the health workforce, and service delivery. Promising strategies to strengthen primary care models include increasing opportunities for postgraduate family medicine training, formalizing community health worker roles, and integrating vertical programs into comprehensive primary care. These approaches may improve the quality of care and advance health equity, but they should be implemented in ways that are responsive to local contexts.

Perceptions of Wellness Among Non-Native English Speaking International Medical Graduates (IMGs) in Family Medicine Residency

Azin Dolatabadi, BASc; Alexa Kouroukis, BHSc; Qurrat ul Ain, MD, CCFP; Megan Saad*, MPH, MD, CCFP; Melissa Graham, MD, CCFP, MScCH; Fok-Han Leung, MD, CCFP, FCFP, MHSc

Poster # 515

Learning objectives:

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

1. Identify general and specific challenges affecting IMGs' wellness in family medicine residency
2. Examine protective processes which support IMGs' adaptation and integration during family medicine residency
3. Implement administrative strategies that support IMGs' wellness within family medicine residency programs

Background: Effective healthcare delivery depends on the wellbeing of medical professionals, as it directly affects patient care. International Medical Graduates (IMGs) encounter unique challenges during their medical training that may differentially impact their wellness, such as language barriers, cultural differences, and a lack of familiarity with local healthcare systems. Despite this, the wellness of IMGs has not received robust attention from researchers. Therefore, a study was conducted to explore perceptions of wellness among non-native English-speaking IMGs in family medicine residency. **Methods:** Five semi-structured Zoom interviews (25-45 minutes) were conducted from February-March 2025 with IMGs enrolled in family medicine residency at the University of Toronto. A qualitative inductive thematic analysis identified key themes. **Results:** Five main themes emerged: (1) general challenges of residency, (2) navigating identity and belonging as an IMG, (3) protective processes that support IMG adaptation and integration, (4) wellness as an active and ongoing process and (5) reimagining IMG-centered supports within residency training. **Discussion:** Our results are consistent with previous research highlighting that IMGs have unique and specific challenges that threaten their wellness in residency, in addition to the general demands of residency training. Participants highlighted various factors that helped mitigate these challenges in addition to the need for personal wellness strategies and ongoing program development to better support future IMGs. **Conclusion:** Future research should focus on developing targeted strategies to enhance the wellbeing of IMGs that will, in turn, improve patient care and promote diversity and inclusion in residency programs.

Needs of Early Career Family Physicians: An international study

Kathleen Walsh*, MD, CCFP; David White, MD, CCFP, FCFP; Viola Antao, MD, MHSc, FCFP, CPC(HC); Frantz-Daniel Lafortune, MD, CCFP; Shalomi Premkumar

Poster # 516

Learning objectives:

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

1. Identify ECFP's perceptions of team functioning, shared leadership and mentorship
2. Describe relevant secondary outcomes such as quantitative work demands and psychological well-being
3. Discuss system-level interventions addressing challenges in team-based care, leadership, mentorship, work demand and wellness

It is estimated that 5.9 million Canadian adults do not have a family doctor (CMA, 2025). Despite this, only 15% of graduating family physicians choose comprehensive family practice. Instead, they opt for more focused scopes of practice (CPSO, 2023). We know that internationally, there are similar challenges with recruiting early career family physicians (ECFP) to comprehensive care. We also know ECFPs experience a unique set of challenges in the current environment. For example,

research indicates the working conditions of ECFPs are often characterized by a combination of high workload, financial pressure and psychological stress. It has also been documented that there are significant gaps between the preparation and scope of practice in ECFPs. Team-based care, shared leadership, leadership training, and mentorship are previously proposed strategies to address the family physician shortage. In this session, we will share our multi-national collaborative study designed to identify factors that either encourage or hinder ECFP's to enter or remain in primary care. This study builds upon previous research of team members, which explored physician mentorship, leadership and team dynamics. These 3 areas were specifically included in our survey directed to ECFPs in Canada, Germany and Scotland. Findings from this study will be presented, as well as opportunities for system-level interventions. For example, addressing challenges in team-based care, leadership, mentorship, work demand and wellness for ECFP.

Fostering Social Engagement in Family Medicine Residents: Insights from the Logic Analysis of the "Créneau Résidentes et Résidents Socialement Engagés" at Université Laval

Julie Massé*, PhD; Olivia Gross, PhD; Marie-Claude Tremblay, PhD; Marie-Audrey Brochu-Doucet, MD, CCFP; Charles Boissonneault, MD, CCFP; Chantal Gravel Ms.C; Isabelle Mercure, MsC; Sandra Criales, MD, CCFP; Ahlem Khacha, MD, CCFP; Tim Dubé, PhD

Poster # 517

Learning objectives:

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

1. Identify key elements to consider when developing educational initiatives aimed at training socially engaged family physicians
2. Explore how the proposed integrative framework could be applied to initiatives promoting social engagement in other educational contexts
3. Understand how programs' logic analysis is a valuable method for supporting program transformation

Objectives: In the face of persistent social inequities in health and in access to care, emerges a crucial need to prepare residents to work with individuals and communities experiencing social vulnerability and contribute to health equity. In 2022, Université Laval (Quebec, Canada) launched the "Créneau Résidentes et Résidents Socialement Engagés", an optional longitudinal program offered to a self-selected group of family medicine residents and pursuing such objectives. Launched as a pilot, the program has not been evaluated yet. This presentation aims to present its logic analysis. **Methods:** Through a participatory process, the analysis involved: (1) representing the program theory through a logic model; (2) designing an integrative framework founded in recent interventional literature about the principles, characteristics and activities a medical program should include to foster learners' social engagement and (3) re-examining the logic model based on the integrative framework, through a deliberative workshop bringing together program stakeholders and multidisciplinary experts. **Results:** The results highlight program's strengths and weaknesses in those key areas: community partnerships; mentoring and role-modeling; theoretical and psychological preparation; reflection on experience; interactivity and small group learning. Influencing factors related to learners' profiles and posture and to organizational support are also highlighted. Based on those findings, the deliberative workshop allowed the formulation of specific actionable and acceptable recommandations to foster the better achievement of the program's objectives. **Conclusion:** Those findings identify key elements to consider when developing educational initiatives aimed at training family physicians who are sensitive and well-equipped to meaningfully and sustainably engage with patients and communities experiencing social vulnerability. They can be mobilized both locally to continuously improve the "Créneau Résidentes et Résidents Socialement Engagés" and to develop a broader pedagogical model that could be transferred to other contexts.

Teaching in Seconds: AI-Enhanced Microlearning (Work-in-Progress)

Kheira Jolin-Dahel*, MD; Zack Van Allan, PhD Maddie Venable, PhD, Doug Archiblad, PhD

Poster # 518

Learning objectives:

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

1. Describe how micro-learning formats can be integrated into family medicine residency education to support just-in-time, learner-centered teaching
2. Describe how micro-learning formats can be integrated into family medicine residency education to support just-in-time, learner-centered teaching
3. Interpret early evidence on learner engagement and perceived value of AI-assisted micro-learning, including how different formats align with specific learning objectives

Context: Traditional medical education is often constrained by time, competing demands, and reliance on scheduled teaching. Teaching in Seconds, a micro-learning approach using brief, targeted content, aims to provide flexible, just-in-time learning aligned with resident needs. Evidence on how micro-learning formats influence engagement and perceived value in residency education remains limited. **Objective:** To explore learner engagement, perceived value, and early educational insights from Teaching in Seconds, an AI-enhanced micro-learning initiative. **Design:** Work in progress mixed-methods evaluation informed by the Kirkpatrick model. Preliminary qualitative data were collected through exploratory focus groups and analyzed using rapid thematic analysis. Quantitative survey data collection is ongoing. This study received approval from the local Research Ethics Board. **Setting:** Academic family medicine residency program. **Participants:** Family medicine residents (PGY1–PGY2) involved in early pilot testing. **Intervention:** Faculty-vetted, curriculum-aligned micro-learning videos (30–120 seconds) designed for asynchronous, learner-paced, just-in-time use. Videos were developed with AI-assisted production and included realistic clinical scenarios and metaphorical or narrative formats. **Main Outcome Measures:** Learner engagement, perceived educational value, format preference, and usefulness for learning and exam preparation. **Anticipated Results:** Early findings suggest high acceptability and voluntary engagement, particularly in low-effort learning contexts (e.g., brief downtime). Learners emphasized that perceived value depends on alignment between format and learning objective: realistic formats supported clinically concrete “must-know” content, while metaphorical approaches enhanced engagement for soft skills. Participants reported perceived knowledge gains and potential relevance for exam preparation. Ongoing data collection will further assess engagement patterns and impact. **Learnings to Date:** Teaching in Seconds micro-learning is a feasible, learner-centered adjunct to residency education. Early insights highlight the importance of matching format to learning goals and suggest opportunities to complement existing curricula. Findings will inform future integration, scale-up, and faculty development and support more flexible, learner-centered curriculum design.

Optimizing Women's Health: Cancer screening strategies for long-stay mental health inpatients in Canada

Nasrin Adams (Nejatbakhsh)*, MD, PhD; Jennifer Nicolle, MD; Brian Lo; Elnathan Mesfin; Eleanor Lam; Caroline Chessex, MD; Corwin Burton; Uzma Haider; Sanjeev Sockalingam, MD; Tania Tajirian, MD

Poster # 519

Learning objectives:

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

1. Review strategies for engaging patient's with severe mental illness in preventative screening
2. Indicate possible collaborative strategies for improving patient participation in preventative care screening
3. Highlight some barriers that prevent patients with severe mental illness from completing preventative cancer screening

Context: Individuals with severe mental illness (SMI) have significantly lower rates of cancer screening, leading to increased poor health outcomes, including death. Some of the contributing factors contributing to low screening rates include stigma as well as the lack of access to primary care services. **Objective:** The objective of this study was to assess the impact of individualized education and digital tools on cervical and breast cancer screening rates in individuals with severe mental illness. **Design:** This study analyzed a number of quality improvement initiatives, including collaboration with community partners to deliver women's health cancer screening to individuals with SMI. Using a co- design approach, models of care were developed which included building dedicated processes for referral, follow-up care and education materials. This project was approved by the Quality Project Ethics Review (QPER) Board of the Centre for Addiction and Mental Health. **Setting and Participants:** These models of care were piloted in a mental health hospital in Toronto with a large number of long stay patients with severe mental illness. **Results:** A number of recommendations were identified from the findings of this study. Patient and family education continues to be a significant gap and there needs to be facilitation of dedicated patient education sessions that is trauma-informed. In addition, there is a need to develop dedicated workflows that provide patients a comfortable space to receive the screening. By engaging with clinicians and patient and family specialists, the outcomes of this study can help inform the development of meaningful processes, supports and partnerships for supporting cancer screening in this population. **Conclusion:** These findings can be used by health care administrators and clinicians to adapt and develop similar initiatives to increase screening rates for individuals in their own patient population. Future work should focus on evaluating the impact of these initiatives in other areas.

Antipsychotic-Induced Weight Gain in Primary Care and Psychiatry

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Poster # 520

Learning objectives:

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

1. Describe health perspectives on AIWG management
2. Identify gaps in current AIWG management practices
3. Integrate AIWG management in primary care

Objective: Antipsychotic medications can cause significant weight gain, affecting adherence and long-term health. Managing antipsychotic-induced weight gain (AIWG) remains challenging across primary care and psychiatry, where responsibilities for monitoring and intervention are often shared. This study explored experiences and approaches to AIWG management among patients, physicians, and allied health professionals. **Design:** Qualitative study using semi-structured interviews and thematic analysis. Coding was conductive iteratively with inductive and deductive approaches to identify key themes across participant groups. Approved by institutional Research Ethics Board. **Setting:** Departments of Family Medicine and Psychiatry at a hospital network in Toronto, Canada. Interviews were conducted virtually or in-person. **Participants:** Twenty-seven participants were included: 10 adult patients (mostly men; racially diverse) and 17 health professionals (mostly women; racially diverse), including 5 psychiatrists, 2 family physicians, and 10 allied health professionals. Allied health roles included pharmacists, dietitians, occupational therapists, psychologists, caseworkers, and nurses. **Findings:** Experiences with AIWG management differed across groups. Patients reported mixed experiences with weight counseling; some recalled discussions, while others did not. Acute illness often constrained engagement, but patients emphasized that weight management should be integral care. Physicians' approaches to AIWG varied, with some addressing weight proactively and others waiting for metabolic concerns. Metformin was familiar but rarely used preventatively, and comfort with GLP-1 agonists was limited. Use of clinical guidelines and availability of patient-facing resources were inconsistent across settings. Allied health professionals

highlighted the complexity of AIWG and expressed a need for more training. They frequently supported patients through lifestyle counseling and behavior change strategies, while encouraging discussions about pharmacologic options with prescribing clinicians. **Conclusion:** AIWG management varied across primary care and psychiatry, with gaps in training, counseling, and resource use. Greater clarity in guidance, improved access to resources, and stronger coordination between disciplines may support more consistent, integrated care for patients receiving antipsychotic treatment.

AI Scribes in Residence: Mixed-methods insights

Vikas Bhagirath*, CCFP, MD EM; Kheira Jolin, MD; Adam Jones-Delcorde, MD

Poster # 601

Learning objectives:

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

1. Asses how AI scribes affect clinical productivity across residency training states
2. Evaluate AI scribes' impact on workflow, documentation, and learning in primary care training
3. Identify considerations for the safe and effective integration of AI scribes in residency training

Context: Artificial intelligence (AI) scribes are increasingly integrated into primary care, yet their impact on clinical training and workflow in family medicine remains unclear. **Objective:** To evaluate the effect of an AI scribe on clinic productivity and explore its implications for learning across stages of residency training. **Design:** Prospective mixed-methods observational study with alternating AI-supported and conventional documentation clinic sessions and semi-structured interviews with residents analyzed using thematic analysis. This study received approval from the local Research Ethics Board. **Setting:** Community-based family medicine residency training site. **Participants:** Seven family medicine residents (PGY1 and PGY2). **Intervention:** Use of an AI scribe during clinic sessions compared with usual documentation. **Main Outcome Measures:** Primary outcome was number of patients seen per clinic session. Secondary outcomes included qualitative assessment of workflow, documentation quality, and learning. **Findings:** A total of 126 clinic sessions were analyzed. Mean patient volume was similar between AI and non-AI sessions (12.91 vs. 12.16 patients per session), with no significant adjusted association between AI use and productivity. Differences emerged by training level: PGY2 residents saw more patients with AI, whereas PGY1 residents saw slightly fewer. Qualitative findings suggest that AI scribes reshape, rather than uniformly improve, clinical workflow. Residents described redistribution of cognitive and administrative tasks, enabling real-time documentation and in-visit task completion, but also introducing challenges related to note accuracy, loss of clinical nuance, and increased editing burden. These factors influenced trust in AI-generated documentation and engagement in clinical reasoning. **Conclusion:** AI scribes did not produce uniform gains in productivity but demonstrated variable effects across trainees. The impact appears to depend on stage of training and workflow integration. Findings suggest that AI tools in residency function not only as documentation aids but as technologies that shape both workflow and learning, supporting the need for structured educational approaches to their implementation.

Bridging the Divide: Perceptions, barriers, and enablers of AI and virtual care solutions in rural medical practice

Ameen Alizada*, BSc; Ryan Rahimi, BHSc; Uriel Perez, MD; Matt Machan, MD; Ali Arafa; Grace Perez, MSc; Aaron Johnston, MD

Poster # 602

Learning objectives:

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

1. Attendees will learn about rural physicians' and residents' current use of and attitudes toward AI tools and virtual care delivery in Alberta
2. Attendees will learn about key barriers and enablers influencing the adoption of AI-based tools and virtual care in rural primary care settings
3. Attendees will learn how educational and infrastructural considerations can support the integration of virtual care innovations into rural family medicine practice

Objective: To explore the perceptions, experiences, and attitudes of rural family physicians and family medicine residents toward AI tools and virtual care solutions, and to identify barriers and enablers to their adoption in rural primary care settings. **Design:** Qualitative descriptive study using semi-structured interviews. Thematic analysis was conducted iteratively. This study was approved by the University of Calgary Research Ethics Board (REB25-1206). **Setting:** Rural and regional communities across Alberta. **Participants:** 15 Rural family physicians, generalist practitioners, and Family Medicine rural program residents were recruited through purposive sampling. **Intervention:** AI-based clinical tools and virtual care solutions, including remote diagnostic technologies, AI-generated clinical summaries, and virtual visit platforms. **Main Outcome Measures:** Participant perceptions of virtual care effectiveness, perceived diagnostic gaps during remote encounters, attitudes toward AI-assisted clinical decision-making, and barriers and enablers to technology adoption. **Findings:** Participants reported variable use of virtual care modalities, primarily for follow-up visits, chronic disease management, and minor acute presentations. Diagnostic gaps emerged when physical examination was unavailable remotely, with interest in portable diagnostic tools to augment virtual assessments. Participants expressed cautious optimism toward AI-generated summaries and decision support, though concerns about clinical reliability, workflow integration, and data privacy were prominent. Key barriers included limited connectivity, inadequate training and inadequate technology comfortability, particularly for elderly patients. Enablers included improved patient access, reduced travel burden, and practice flexibility. Participants from diverse rural communities, including those serving Indigenous and underserved populations, emphasized that equity considerations must inform technology implementation to avoid widening existing care disparities. **Conclusion:** Rural physicians recognize the potential of AI and virtual care tools to improve diagnostic capacity and access in resource-limited settings. Sustainable integration requires targeted training, supportive infrastructure, equitable implementation strategies, and evidence-based frameworks tailored to the unique demands of rural family medicine practice.

A Validated Survey To Assess Climate Change Preparedness

Patricia Huston*, MD, MPH, CCFP, FCFP; Maddie J. Venables, PhD; Laura Visentin, MD, CCFP; Mehvish Mehrani, MD, MPH, CCFP; Joseph Abdulnour, PhD; Doug Archibald, PhD

Poster # 604

Learning objectives:

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

1. Describe the role family physicians will increasingly play in addressing the health effects of climate change
2. Identify the six areas of climate change preparedness in primary care
3. Explain the four ways that the survey can be used to generate useful data

Context/Objective: Health effects of climate change are an emerging issue worldwide. Family physicians represent 50% of the workforce in Canada and therefore must be prepared for this new reality. The objective of this study was to create a bilingual, valid and reliable survey on climate change preparedness in primary care. **Design:** Research ethics board-approved survey development **Setting/Participants:** Family medicine residents, and academic family physicians in Ontario and Nova Scotia **Methodology:** A review of the literature, including patient and caregiver experiences of extreme weather-related disasters, informed the development of a 16-item survey with multiple sub-questions, covering areas of preparedness,

perceived barriers, motivators, learning priorities, preferred learning formats, indicators of physician well-being and sociodemographic data. Six expert reviews established validity. Reliability testing included virtual think-aloud focus groups and -- during pilot testing using SurveyMonkey -- test-retest reliability. The reliability of nominal data was assessed with Cohen's Kappa; ordinal data was assessed with Interclass correlation coefficients.**Results:** Six areas of climate change preparedness were identified: Increasing awareness, addressing the health effects of climate change; greening health care; fostering personal preparedness, strengthening emergency preparedness, and advancing planetary health. The pilot study included 17 participants; eight repeated the survey two weeks later (42% response rate). Overall, the survey reliability was good; sub-question results varied from excellent to poor. Excellent and very good sub-questions were retained, those with poor reliability were removed, and good to fair questions were clarified. The revised survey was positively reviewed; pre-testing identified it took approximately 10 minutes to complete. **Conclusion:** To our knowledge, this is the first bilingual, valid and reliable survey of climate change preparedness in primary care. It can be used to explore EDI issues through cross-correlations, inform continuing professional development strategies, establish a baseline for future measurement, and support comparisons across Canada and internationally.

Factors Associated With Family Physicians Leaving Clinical Practice

Qian Yang*, MSc; Shan Jin, MSc; Evelyn Constantin, MD CM, MSc(Epi) FRCPC; Armand Aalamian, MD CM, CCFP, FCFP

Poster # 605

Learning objectives:

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

1. Identify factors that may affect a physician's decision to leave FP clinical practice
2. Show how impact of various factors on physicians leaving FP clinical practice change over time
3. Compare factors associated with International Medical Graduate (IMG) FPs leaving clinical practice with those for non-IMG FPs

Objective: To better understand factors that may potentially affect family physicians (FP) in Canada leaving clinical practice. **Design:** We performed retrospective descriptive and survival analyses of any family physician in Canada leaving FP clinical practice between 1992 and 2024. Ethical approval was obtained from the Canadian ethics review panel of the Advarra Institutional Review Board (Pro00020829). **Setting:** Using a national physician database, we examined FPs leaving their FP clinical practice voluntarily during the study period. **Participants:** The study population contained 48,308 physicians who practiced as a FP between 1992 and 2024. Overall, 13,755 (28%) physicians left FP clinical practice voluntarily during the study period, including 6,437 retired, 384 left Canada, and 6,934 changed to another specialty. **Main Outcome Measures:** We examined the FP characteristics including gender, the age when they started FP clinical practice, whether they received their medical degree in Canada, the US (Canadian/American Medical Graduate, or CAMG), or another country (International Medical Graduate, or IMG), and their urban or rural location based on postal code. **Results:** Among physicians who began FP practice before age 35, men initially had a higher rate of leaving FP practice than women. This difference narrowed over time, and after approximately 25 years in practice, women's attrition rate was higher than men. For physicians who entered FP clinical practice after age 55, women had a higher attrition than men. Compared with CAMG FPs, IMG FPs generally had a lower rate of leaving clinical practice. However, IMG FPs in rural settings had a higher attrition rate than their Canadian- or US-trained counterparts. **Conclusion:** Current shortage of primary care physicians makes understanding FP attrition and retention critical. Multiple factors could affect physicians leaving FP clinical practice. Our study provides insight into some of these factors and how they changes over time.

Redesigning Team-Based Care in Primary Care: Evaluation of a nested team model

Doug Oliver, MD, CCFP; Jill Berridge, BHScPT; Bethany Elliott, MPH; Neha Arora*, MSc

Poster # 606

Learning objectives:

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

1. Describe the structure and implementation of a nested "micro team" model in a large academic primary care clinic
2. Identify key evaluation outcomes

Objective: This evaluation assessed the implementation of this model at McMaster Family Practice (MFP) and its impact on team dynamics, workload distribution, care coordination, and perceived provider support. **Design:** A formative, improvement-oriented evaluation was conducted using an explanatory sequential mixed-methods design. Quantitative surveys assessed perceptions of team functioning and clinic coordination early in the initiative and one year after full implementation. Focus groups were conducted to contextualize and deepen understanding of survey findings. This quality improvement project received an exemption from the Hamilton Integrated Research Ethics Board. **Setting:** MFP is an academic, interdisciplinary primary care clinic within the McMaster Family Health Team in Hamilton, Ontario, serving over 20,000 patients. **Participants:** Physicians, nurse practitioners (NP), physician assistants (PA), registered practical nurses (RPN), and administrative staff working within MFP. **Intervention:** The nested micro-team model consisted of small teams of three physicians, one NP/PA, and one RPN. Micro-teams were paired into dyads with dedicated administrative support and embedded within a larger shared clinic structure. **Main Outcome Measures:** Perceptions of team dynamics, workload distribution, preventative care, coordination of consultations, overall efficiency, and provider support were measured through surveys and explored qualitatively through focus groups using the Theoretical Domains Framework. **Results:** Survey results demonstrated high baseline and sustained post-implementation ratings across key domains, with no statistically significant changes over time. Focus groups highlighted improved communication, stronger interpersonal relationships, enhanced role clarity, and more manageable workloads. Persisting challenges included administrative burden and system-level barriers. **Conclusion:** The nested micro team model was perceived as a positive and sustainable change that enhanced collaboration, communication, and role clarity within a large primary care clinic. Continuous, data-informed refinement and supportive leadership were critical to implementation.

Strengthening Primary Care Through Systemwide Transformation

Nicole Boutilier, MD; Bethany McCormick, MD; Maria Alexiadis, MD; Noella Whelan, BN, RN, MN, CFHI; Katie Heckman*

Poster # 607

Learning objectives:

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

1. Understand the strategy's development, implementation, challenges, and outcomes, offering valuable insights for jurisdictions facing similar primary care shortages
2. Leave with actionable tools and insights that can be adapted across diverse health system contexts to support PHC as a driver of both health and stability
3. Understand program components and lessons learned during the first year of implementation, and highlight outcomes and impacts to provider experience, practice development, and patient access to care

Objective: To evaluate the impact of Nova Scotia's primary health care transformation initiatives— including proactive patient management, panel management, targeted provider recruitment strategy, practice stabilization, rapid onboarding team, and practice facilitation—on patient attachment, continuity, and system readiness for team-based Health Home models. **Design:** This intervention used a multi-method program evaluation drawing on administrative data, patient and provider feedback, panel analytics, and operational metrics from June 2024 to February 2026. **Setting:** Primary health care practices across Nova

Scotia delivering in-person and virtual care, including urban, rural, and underserved communities. **Participants:** Participants included primary care providers, health system staff, and leadership engaged in transformation activities. This group encompassed individuals participating in panel management, practice improvement initiatives, stabilization planning, workforce recruitment, and the onboarding of new patient panels. **Main Outcome Measures:** Primary outcomes were patient attachment rates, accuracy and currency of patient panels, practice stabilization outcomes, provider capacity for quality improvement, and recruitment and retention of primary care teams. **Results:** Transformation efforts yielded substantial systemwide improvements. Panel management enabled providers to validate panels, identify over 3,000 inactive patients, and reassign nearly 6,000 individuals, while stabilizing approximately 55,000 patients The number of known unattached patients decreased from 16.4% in September 2024 to 6.2% in February 2026. The registry evolved from a wait list to a dynamic patient management tool supporting proactive rostering. Practice facilitators supported 500+ improvement projects, and the Rapid Onboarding Team expedited onboarding for an average of 2,000 patients per month. **Conclusion:** Nova Scotia's coordinated transformation approach enhanced patient attachment, strengthened continuity, increased system capacity, and advanced readiness for team-based primary care. These results demonstrate a scalable model for health system improvement in jurisdictions facing similar pressures.

From Principles to Practice: A systems evaluation of palliative care integration in a family health team

Erin Gallagher, MD, CCFP; Henry Siu, MD, CCFP; Karla Freeman*, MSc; Neha Arora*, MSc

Poster # 608

Learning objectives:

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

1. Describe how a palliative approach to care (PAC) is currently operationalized within an interdisciplinary Family Health Team, using a systems lens informed by the Healthcare Services Delivery Framework
2. Explore key system-level barriers and enablers influencing the normalization of PAC in primary care, drawing on mixed-methods findings from chart review, staff surveys, and focus groups

Objectives: To evaluate how a palliative approach to care (PAC), conceptualized through the Healthcare Services Delivery Framework, is enacted within an interdisciplinary Family Health Team (FHT); identify barriers and enablers to consistent PAC delivery; and generate actionable insights to support implementation of a structured PAC pathway embedded in routine primary care. **Design:** A mixed methods evaluation integrating patient chart review, a clinic-wide survey, and interdisciplinary staff focus groups using Normalization Process Theory. **Setting:** A large academic FHT in Hamilton, Ontario, providing comprehensive primary care, including for patients with complex and life-limiting illnesses. **Participants:** Charts of 77 deceased patients were reviewed. Sixty staff (physicians, residents, interdisciplinary health providers, support staff) completed the NoMAD survey; 30 participated in focus groups. **Intervention:** Existing PAC practices, workflows and tools were examined to identify gaps in early identification, documentation, and interprofessional coordination. Findings will inform the co-design of a patient-centred, team-based PAC pathway aligned with primary care workflows. **Main Outcome Measures:** PAC delivery indicators across whole person care, mortality acknowledgement, and quality of life; staff motivation and engagement for PAC implementation; and perceived system-level enablers, barriers, and patient-centred needs. **Findings:** Chart reviews demonstrated variable PAC delivery and inconsistent use of structured tools, signalling opportunities for earlier identification and proactive planning. While staff expressed strong commitment to PAC they reported system-level challenges including unclear processes, inadequate EMR supports, fragmented workflows, and inflexible scheduling. Participants emphasized the need for standardized processes, shared language, identification triggers, and practical tools to enable coordinated, team-based care. **Conclusions:** Embedding a palliative approach in primary care requires intentional systems design. Clear workflows, defined team roles, and supportive infrastructure are essential to normalize PAC delivery. These

findings directly inform the development of a structured family medicine PAC pathway aimed at improving continuity, reducing clinician burden, and strengthening patient and caregiver experience.

Population Level Trends in ADHD Incidence and Stimulant Medication Dispensation in Alberta, Canada (2010 to 2024)

Eric Tredget*, MBBS, MSc, CCFP; Mark Makowsky, PharmD; Doug Klein, MD, MSc, CCFP; Amanda Radil, MEd, PhD; Charlotte Jensen, MSc; Heidi Cheung, MHS, RRT; Erik Youngson, MMath; Nathan Armani, MSc, PhD

Poster # 609

Learning objectives:

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

1. Identify recent trends in ADHD incidence
2. Identify recent trends in stimulant medication dispensation
3. Identify recent trends in ADHD incidence and stimulant medication dispensation by age and sex

Objective: To investigate population-level changes in the incidence of ADHD diagnosis and stimulant medication dispensations in Alberta over the past decade by age and sex. **Design:** Cross-sectional study using administrative data from Health Shared Services (Provincial Registry, Practitioner Claims and Pharmaceutical Information Network [PIN] databases) for individuals aged 4 years and older from 2010 to 2024 was analyzed. This project was approved by the Health Research Ethics Board at the University of Alberta. **Setting:** Province of Alberta. **Participants:** The cohort is defined as patients with a billing claim (ADHD; ICD-9 codes) and a stimulant prescription dispensation within 1 year of the index date (N=194687, 49.5% female, Median age 22 [IQR: 11-35], 89.2% Urban). **Results:** Between 2010 and 2020, ADHD incidence rates followed a moderate upward trajectory, growing from 101.75 to 341.44 per 100,000, with annual increases never exceeding 60 per 100,000. his pattern ended abruptly in 2021, when incidence increased by 213 per 100,000 (nearly 400% of prior increases), peaking at 686.35 per 100,000 in 2023. Who is being diagnosed is also striking. Historically, males saw higher incidence rates than females (by 67.35 to 98.12 per 100,000). However, this trend reversed in 2020. Female incidence rates began to surpass male incidence rates, intensifying through 2022 with a gap of 198.52 per 100,000, primarily driven by increases in incidence in females aged 15-35. **Conclusion:** ADHD incidence and stimulant prescribing have been accelerating in Alberta since 2010, with notable increases since 2021, driven by a marked increase in incidence and prescribing to females. This rise in female-led incidence rates highlights a needed recalibration in how we recognize ADHD beyond traditional stereotypes; moreover, given ADHD's long-term medical and economic impacts, more research is needed to identify the drivers of these diagnostic and prescription trends.

Identifying Priority Research Questions to Strengthen Primary Care Globally: Findings from a deliberative dialogue study

Keshini Abeyewardene*, MBBS; Roxana Rabet, MSc; Radhika Gandhi, MSc; Adelson Guaraci Jantsch, MD; Ramakrishna Prasad, MD, MPH; Jane Zhao, MSc; Maria Sofia Cuba-Fuentes, MD, MSc, PhD; Katherine Rouleau, MD CM, CCFP, MHSc; Andrew D. Pinto, MD, CCFP, FRCPC, MSc; Archna Gupta, MD, CCFP, MPH, PhD

Poster # 610

Learning objectives:

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

1. Identify key priorities for research on models of care and health workforce within primary care

2. Identify key research questions that best support identifying effective primary care models that ensure health equity in service delivery
3. Highlight the importance of collaborative, horizontal and sustainable partnerships between primary care researchers in multiple countries to catalyze initiatives

Context: Primary care is central to strong primary health care (PHC), equitable access, and Universal Health Coverage. Starfield's four C's—first-contact access, continuity, comprehensiveness, and coordination—describe the essential functions of high-quality primary care, which consistently improves population health outcomes and reduces inequities. Despite this, many countries, including high-income and low- and middle-income settings, face persistent challenges in implementing effective, equitable primary care models, and the COVID-19 pandemic further exposed workforce shortages and system vulnerabilities. **Objective:** To identify priority research questions to address gaps in primary care research and delivery globally. **Design:** A qualitative study using a deliberative dialogue (DD) methodology comprising four sequential DDs. The structured DDs were used to identify knowledge gaps, generate and refine research questions, and build consensus on priority topics. **Setting:** Virtual dialogues were conducted between September 2024 and October 2025 with participants from multiple global regions. **Participants:** Nine participants: three primary care providers, two policymakers, and four primary care researchers representing eleven countries. Several participants contributed perspectives from multiple roles. **Main Outcome Measures:** Identification and prioritization of research questions across five thematic domains: Models of Care, Health Workforce, Financing, Health Equity, and Public and Policy Perspectives. **Findings:** Participants emphasized that priority questions should be relevant to local contexts. five priority themes emerged, of which health workforce and models of care were ranked highest. Key subthemes included multidisciplinary team composition, workforce training, education needs, and cost-effectiveness of team-based models. The DD process facilitated meaningful exchange across sectors, though representation leaned toward low- and middle-income country perspectives. **Conclusion:** DDs are a feasible approach for setting global primary care research priorities. Models of care and the health workforce were key research priorities. Our findings informed the development of a broader global survey to further understand regionally relevant research priorities.

Has Specialists' Perceptions of Family Physicians Changed Post-COVID?

Mark Farag*, BSc (candidate); Patricia Wong, MD, CCFP; Rene Wong, MD, PhD

Poster # 611

Learning objectives:

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

1. Describe role of textual analysis as a research technique
2. Use social theory to explore physician-physician dynamics
3. Explore how physician-physician collaboration could be reconceptualized admidst the primary care crisis

Background: Models of collaboration between family physicians (FPs) and specialists (SPs) in chronic disease care is often hierarchical. With the primary care crisis intensified since the COVID-19 pandemic, we examined if and how SPs reconceptualize collaboration with FPs, using type 2 diabetes as a case study. **Methods:** Using critical discourse analysis methodology, we examined language in articles from the Canadian Journal of Diabetes (the leading Canadian diabetes journal). We included articles published from March 2020 onward that referenced FPs' roles. Structured searches and screening yielded 69 articles. We analyzed how language used in these articles shape understandings of FP roles and preferred models of collaboration in type 2 diabetes care post-pandemic. **Results:** Articles portray FPs as needing interventions to address "therapeutic inertia." They seldom acknowledge COVID-19's role in the primary care crisis; instead, the pandemic is framed as a prompt for FPs to adopt system changes (e.g., virtual visits) to meet guideline-recommended care while downplaying increased workload, time pressures, and systemic drivers of care gaps. **Conclusions:** Despite

heightened awareness of primary care strain since the pandemic, narratives in diabetes specialty journals maintain a hierarchical view of FPs and underrecognize the pandemic's impact on primary care capacity. Policy and educational interventions are needed to increase SPs' awareness of the current challenges facing FPs and to promote more collaborative, system-informed approaches to shared care.

Pilot Adaptation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home Survey for Use in Patient Medical Homes in Prince Edward Island, Canada

Guillermo Villegas Molero*, MD, MHM; Shannon Curtis, MD, CCFP

Poster # 612

Learning objectives:

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

1. Assess the contextual relevance and acceptability of the CAHPS PCMH survey in Patient Medical Homes in PEI
2. Identify stakeholder-informed adaptations to the CAHPS-PCMH survey
3. Adapt the CAHPS-PCMH survey based on stakeholder-informed sugestions

Objective: To assess the contextual relevance and acceptability of the CAHPS Patient-Centred Medical Home (PCMH) survey in Patient Medical Homes (PMHs) in Prince Edward Island (PEI) and to identify stakeholder-informed adaptations. **Design:** Qualitative descriptive study using structured focus groups. The study was approved by the Prince Edward Island Research Ethics Board. **Setting:** Sherwood Patient Medical Home. A single provincially designated PMH in PEI. **Participants:** Fifteen participants, including physicians, nursing professionals, allied health professionals, administrative staff, and adult patients affiliated with the PMH. **Intervention:** Participants reviewed the CAHPS PCMH survey and provided structured feedback during 60–90 minute focus group discussions guided by a standardized script. **Main Outcome Measure:** Perceived clarity, relevance, and acceptability of survey items, and identification of required adaptations for the PMH context. **Results:** Participants found the survey clear and well-structured but identified key limitations, including provider-centred language, inadequate representation of interdisciplinary care, ambiguous terminology, and concerns regarding anonymity. Stakeholders emphasized the need for clearer definitions, inclusion of allied health services, and adaptation of demographic items to reflect the Canadian context. **Conclusion:** Standardized patient experience surveys require contextual adaptation to reflect team-based primary care delivery and should be interpreted alongside complementary clinical quality measures. Stakeholder-informed modifications may enhance the validity, acceptability, and utility of patient experience measurement within PMHs in PEI.

Family Physicians' Acceptance of AI Tools for Cardiovascular Assessment

Mhd Diaa Chalati*, MD CM, CCFP, Grad. Dip. (Clinical Research); Mark J. Yaffe, MD CM, MClSc, CCFP, FCFP; Samira Abbasgholizadeh-Rahimi, PhD

Poster # 613

Learning objectives:

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

1. Identify key predictors of family physicians' intention to use AI-enabled tools for cardiovascular assessment
2. Compare the differences in AI experience and training levels between family medicine residents and practicing physicians
3. List the top-ranked AI competency training needs required for family physicians to use AI tools as well as areas for future AI tools development

Context: Despite interest in artificial intelligence (AI)–enabled tools for cardiovascular disease (CVD) assessment, their adoption by family physicians remains limited. This gap reflects challenges related to physicians' acceptance of these tools and a potential lack of the competencies required for their use. **Objective:** To identify predictors of family physicians' and residents' behavioural intention (BI) to use AI-enabled tools for CVD prevention and prediction, and to assess their AI competency training needs. **Design:** Cross-sectional study using an online survey based on the Unified Theory of Acceptance and Use of Technology (UTAUT). Training needs were derived from the AI Family Medicine Education Curriculum Framework (AIFM-ed)[SA1.1][DC1.2]. Results were analyzed using Structural Equation Modelling and the Plackett-Luce model, and reported in accordance with CROSS guidelines. This project was approved by the Research Ethics Board (McGill University). **Setting and Participants:** Family physicians and residents affiliated with academic institutions in Quebec, Canada, who provide care to women at risk of or with cardiovascular disease. [SA2.1]**Outcome:** Predictors of BI and ranked priorities for AI competency domains and future AI development domains in family medicine. **Results:** Our survey was accessed by 191 unique visitors. Of these, 107 (56%) completed ranking data, and 99 (52%) completed UTAUT-based responses. Participants were primarily aged 18–45 (85.1%), female (58.9%), and practicing physicians (57.9%). Overall, 77% reported exposure to AI tools, but only 26% had formal training. Compared with practicing family physicians, residents reported lower experience with AI tools (64% vs 86%) and less formal training (16% vs 44%). **Preferences & Needs:** Top-ranked domains for AI development were triage, documentation, and history-taking. AI competency training needs included understanding how AI generates predictions, interpreting AI-based risk assessments, and critically evaluating AI-generated recommendations[SA3.1][DC3.2]. Predictors of BI: Intent to use AI was high (82.4%). Performance expectancy was the strongest predictor of BI ($\beta = 0.571$, $p < 0.0001$). Facilitating conditions showed a smaller association ($\beta = 0.203$, $p = 0.031$). Trust and social influence showed indirect associations with BI through performance expectancy. **Conclusion:** Family physicians and residents are using AI tools despite limited training, with residents reporting less experience and training. Participants prioritized AI tools that reduce administrative workload rather than replace clinical reasoning and expressed a need for training in AI concepts, interpretation, and critical appraisal. Adoption is mainly driven by perceived clinical usefulness and supportive conditions. Future initiatives should focus on demonstrating the clinical value of AI-enabled tools, building infrastructure, and teaching foundational AI literacy in primary care, especially among residents.

Addressing Community Health Priorities: ECRC-WISH initiative (Work-in-Progress)

Zoe Quill*; Kara Klassen; Isabella DiGirolamo; Karen Morchid; Nina Condo; Amanda Condon, MD, CCFP, FCFP; Ian Whetter, MD

Poster # 614

Learning objectives:

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

1. Examine approaches to identify community health priorities using data from community-informed surveys
2. Describe how community partnerships can strengthen community-based health initiatives
3. Describe how community-informed data informs development of targeted health interventions

Context: The Winnipeg Interprofessional Student-run Health (WISH) Clinic is a community-based health and learning initiative led by Rady Faculty of Health Sciences health professional students. Established in 2009, WISH is undergoing redevelopment and partnered with the Elmwood Community Resource Centre (ECRC) in September 2025. ECRC is a trusted community organization in Winnipeg's Northeast neighbourhood providing integrated family supports, counselling, literacy, youth programming, employment services, and other community-based resources. It serves approximately 20,000 residents and receives 11,000 visitors annually. This phase of program evaluation involved a community health survey to identify priorities and guide initiatives to improve access to primary care and health system navigation. It also supported relationship-building between students and community members. **Objective:** To identify healthcare needs and barriers among community

members and inform development of student-led, community-based health education initiatives. **Design:** ECRC staff and WISH students collaboratively developed and distributed a 16-question survey to community members attending ECRC programs. The survey assessed demographics, healthcare experiences and system navigation, and interest in health education sessions. As a program evaluation, Review Ethics Board review was not required. **Setting & Participants:** A total of 124 community members completed the survey online and in-person between December 9 and 23, 2025. **Anticipated Impact:** Findings identified key barriers to care, including long wait times, transportation challenges, and difficulty understanding medical information. Gaps in healthcare navigation were evident, with 71% of respondents unaware of navigation tools. Interest in basic health assessments (51%) and referrals (42%) were also identified. Findings were shared with ECRC staff, whose insights into service delivery informed the co-development of initiatives, including health navigation sessions, cardiovascular health checks, and diabetes education. **Conclusion:** The ECRC-WISH initiative demonstrates how identifying community priorities can inform targeted interventions. These interventions are co-developed with community partners and health professional students to improve navigation and access to care.

Studying Practice Settings: An analytical approach to understand family physicians and family practice

Steve Slade* BA; Dragan Kljujic

Poster # 615

Learning objectives:

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

1. Define a concise, analytically robust practice setting rubric that reflects the scope of family practice
2. Measure how practice settings relate to a broad range of practice patterns and contexts
3. Interpret what the relationships between practice settings and family practice mean for healthcare planning

Objective: To better understand family physicians and their practices by studying relationships between clinical practice settings, practice scope, health care teams, physician wellness, and professional satisfaction. **Design:** Bivariate and multivariate analysis of a self-report survey of family physicians. **Setting:** Family physicians practising in primary care, hospital, and congregate care settings in May 2025. **Participants:** Responses from 2,689 practising family physician members of the College of Family Physicians of Canada (8.3% of all eligible members). **Main Outcome Measures:** Clinical practice activities, health care team characteristics, workload, wellness, and professional satisfaction. **Results (or, if qualitative methods, "Findings"):** Over half of survey respondents (55.4%) work exclusively in primary care settings; 27.7% in primary care and hospital settings; 13.9% in hospitals and not in primary care; and 3.0% in congregate care homes and specialized clinics. Based on 9 broad clinical domains, primary care family physicians provide a greater breadth of clinical services compared with those who work exclusively in hospital and congregate care/specialized clinics (ranging from a subgroup high of 7.5 services on average to a low of 4.7). Hospital-based family physicians are more likely to share patient care with a variety of health professionals compared with primary care family physicians, including nurses (83% vs 62%, respectively), pharmacists (74% vs 46%, respectively), and social workers (69% vs 40%, respectively). Primary care family physicians have comparatively higher weekly work hours and lower rates of professional satisfaction. **Conclusion:** The practice-setting typology used in this study reveals marked differences in the work experiences, practice arrangements, and experiences of family physicians. These results can inform health system planning and policy through advocacy, practice supports, and targeted action.

Improving Accessibility to Primary Care in PEI: A resident-led quality improvement initiative

Guillermo Villegas Molero*, MD, MHM; Craig Malone, MD, CCFP

Poster # 616

Learning objectives:

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

1. Apply PDSA cycles to improve primary care access for unattached patients
2. Evaluate resident-led clinics as a strategy to address healthcare access gaps
3. Integrate social accountability principles into residency-based quality improvement initiatives

Objective: To evaluate the impact of a resident-led Primary Care Access Clinic (PCAC) on improving access to primary care for unaffiliated patients in Eastern Kings, Prince Edward Island (PEI). **Design:** Quality Improvement (QI) initiative utilizing a Plan–Do–Study–Act (PDSA) cycle framework. **Setting:** Primary Care Access Clinic in Eastern Kings, PEI, within a community-based primary care setting. **Participants:** Unattached adult patients (≥18 years) identified through the provincial waitlist and residing in Eastern Kings, PEI. The intervention was delivered by PGY2 Family Medicine residents under faculty supervision. Over the study period (April–September 2025), approximately 60 unique patients were seen. **Intervention:** Implementation of a resident-led PCAC providing scheduled primary care visits, including episodic and short-term longitudinal care. Clinics were conducted as recurring sessions staffed by PGY2 residents with preceptor oversight. **Main Outcome Measures:** Primary outcome: total number of unaffiliated patients seen during the study period. Process measure: average number of patients seen per clinic session. Balancing measures: resident-reported workload and number of clinic cancellations. **Results:** The PCAC facilitated care for approximately 60 unaffiliated patients over six months, demonstrating improved access to primary care services in the target region. Clinic throughput was consistent across sessions. Resident participation was sustained, with manageable reported workload. Minimal clinic cancellations were observed, supporting feasibility. **Conclusion:** A resident-led PCAC is a feasible and effective model to improve access to primary care for unattached patients in PEI. This initiative demonstrates how residency training programs can operationalize social accountability while contributing to system-level solutions. Iterative refinement through PDSA cycles supports scalability and sustainability, with implications for broader adoption in similar underserved settings.

Implementing a Blended Capitation Funding Model: Creating sustainable primary care and family practices in Newfoundland and Labrador (Work-in-Progress)

Melissa Sullivan*, MBA, MSc; Paula Hanrahan, MN

Poster # 617

Learning objectives:

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

1. Describe early physician uptake and participation in Newfoundland and Labrador's Blended Capitation Model
2. Summarize initial outcomes on population attachment, access, continuity, and patient and physician experience
3. Examine the impact of program supports and onboarding approaches for successful implementation and system sustainability

Context: A blended capitation model has been implemented in Newfoundland and Labrador (NL). The Family Practice Renewal Program (FPRP) is leading a multi-faceted implementation approach to enroll family physicians in a Blended Capitation Model (BCM) with specific program and quality improvement practice supports that enable, promote, and support team-based primary care, comprehensive family medicine, greater attachment, access to and quality of care for patients, and improved recruitment, retention and professional satisfaction for physicians. As a new model, early implementation has presented challenges, and the FPRP is actively engaging family physicians and partners to collaboratively identify opportunities for improvement. **Objective:** To describe early uptake of the BCM in NL and highlight its anticipated impact on population attachment, patient access and continuity to team-based primary care, and physician support. **Design:** Descriptive program implementation review. This work represents a health system program evaluation and was deemed exempt from Research Ethics Board review. **Setting:** Family practices across Newfoundland and Labrador. **Participants:** As of March 9, 2026,

25 Blended Capitation Groups (BCG) have been accepted, representing 95 physicians and more than 100,000 rostered patients, accounting for approximately 18% of the provincial population. **Intervention:** The FPRP supports the implementation of the BCM through structured onboarding and ongoing practice support aligned to the principles of accessible, longitudinal, and continuous team-based primary care. Participating physicians form BCGs to access alternative funding, practice facilitation, and peer learning networks for both physicians and clinic team members. Implementation activities include patient engagement and rostering processes, workflow redesign, panel management, developing practice agreements, and optimizing EMR reporting. These activities aim to enable group-based accountability, coordinated care delivery, and improved quality of care within participating practices. **Main Outcome Measures:** Primary descriptive measures include program uptake and participation indicators such as expressions of interest, onboarding rates, physician participation, and patient rostering volume. Planned evaluation includes access (same/next-day availability), relational continuity, panel/roster size, patient and physician satisfaction, income generated, and recruitment and retention signals. Data sources include program participation records, administrative billing data, EMR extracts, and patient and physician surveys and focus groups. Indicators will be collected at regularly scheduled intervals as defined by the evaluation framework. Anticipated **Results/Impact:** Early implementation data describe growing participation and substantial patient rostering within enrolled groups. While outcome analysis is ongoing, preliminary program experience suggests improved access to structured practice supports and increased physician engagement. Formal evaluation activities beginning in 2026 will examine impacts on access, continuity, professional experience, and sustainability indicators including workload, collaboration patterns, and compensation predictability. **Conclusion/Implications/Learnings to Date:** Initial program uptake demonstrates feasibility of implementing a BCM at scale within a provincially coordinated transformation initiative. Early lessons highlight the importance of structured supports, peer networking mechanisms, and staged onboarding processes to enable physician participation. Ongoing evaluation will clarify the model's contribution to the advancement of population attachment, patient access and continuity to team-based primary care, workforce stability, and system sustainability. Findings will inform iterative program refinement and future remuneration reform strategies of Newfoundland and Labrador.

SCOPE – Optimizing Nurse Led Care (Work-in-Progress)

Divya Garg*, MD, MClSc, CCFP, FCFP; Vishal Bhella, MD, MClSc, CCFP, FCFP; Marsha Kuchera, MD, CCFP, ABOM, MScHQ; Jean Rawling, MD, PhD, FCFP

Poster # 618

Learning objectives:

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

1. Identify key enablers of nursing visits
2. Assess the impact of nursing-led approaches on access and care quality
3. Implement nursing interventions in daily practice to improve clinical capacity

Context: Family Medicine clinics continue to face access pressures driven by high patient demand, increasing clinical complexity, and substantial administrative workload. Nursing led visits have emerged as an effective strategy to expand team based care capacity, improve health outcomes, and enhance patient and provider experience. **Objective:** To design, implement, and evaluate standardized nursing led visit pathways across academic family medicine clinics, examining their impact on patient care processes, health outcomes, and clinic capacity. **Design:** A mixed methods evaluation integrates current state analysis, benchmarking, workflow development, and quantitative and qualitative data collection to assess process and experiential outcomes. Ethics approval obtained from CHREB. **Setting:** Three urban academic family medicine clinics operating within the Patient Medical Home model. **Participants:** Clinical conditions span multiple preventive, time sensitive, and chronic care needs seen in primary care, with nursing and physician teams contributing to pathway development and implementation. **Intervention:** Standardized nursing led pathways were developed for preventive

screening, chronic disease monitoring, acute symptom assessment and administrative or care coordination support. Each pathway incorporates structured workflows, EMR templates, and escalation processes requiring synchronous or asynchronous physician input to ensure safe, consistent, and coordinated care. **Anticipated Results/Impact:** Early findings demonstrate increased nursing visit volumes, improved screening and self management support, strengthened hypertension diagnosis and monitoring, and meaningful workload redistribution, in some cases enabling physicians to accommodate 2–4 additional patient visits per clinic. System level improvements include increased visit capacity, more consistent care processes, enhanced access, and more reliable capture of nursing interventions. The pathways also appear feasible and acceptable for patients who may otherwise experience challenges accessing timely care, supporting more consistent and equitable engagement with primary care services. **Conclusion:** Nursing led pathways are feasible, scalable, and well aligned with team based primary care. The evaluation provides a foundation for ongoing refinement and spread with potential to meaningfully improve access and care quality.

Evaluating the Efficacy of a Community Group-Based Advance Care Planning and Medical Decision-Making Workshop

Rachel Goldfarb*, MD; Joelle Soriano, MD, CCFP (PC); Shannon Poyntz, NP; Kyle Albuquerque-Boutilier; Judy Katz; Michelle Griever, MD, CCFP; Selina Suleman; Wendy Wu; Daphna Grossman, MD, CCFP (PC), FCFP

Poster # 619

Learning objectives:

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

1. Learn about the process of developing, promoting and teaching about medical decision making (MDM) in the community
2. Gain an understanding of participant feedback for this session including impact on understanding and comfort with ACP/MDM
3. Gain skills required to translate and execute similar initiatives in participants' own communities

Context: Effective Advanced Care Planning (ACP) and medical decision making (MDM) require an understanding of illness trajectories and how personal values evolve with illness progression, but many individuals lack this knowledge. Therefore, a community-based ACP and MDM workshop was developed to educate the public. **Objective:** To evaluate whether participation in a group ACP and MDM workshop improved understanding of illness trajectories, comfort discussing ACP, and ability to apply values to healthcare decisions. **Design:** Community-Based Program Evaluation **Setting:** Community settings, including one public library and one community centre. **Participants:** The target population included community members who were interested in learning about Advanced Care Planning and Medical Decision Making. A total of 131 participants attended the workshops. **Intervention:** Two interactive workshops were held using case-based discussions on four serious illnesses: cancer, heart failure, respiratory disease, and dementia. Participants completed anonymous surveys before, immediately after, and 6-9 months post-workshop. **Main Outcome Measures:** Improvement in participants' understanding of illness trajectories and comfort with ACP concepts following workshop participation, and 6-9 months after workshop participation. **Results:** Eighty-four participants completed pre-workshop surveys, 94 completed post-workshop surveys, and 19 completed 6-9-month follow-up surveys. Most (93%, n=78) agreed that understanding chronic illness is important for healthcare planning, but only 11% understood illness progression, increasing to 70% ($p<0.001$) post-workshop. Comfort discussing healthcare planning rose from 28% to 49% with providers ($p=0.006$) and from 35% to 52% with family ($p=0.009$). Effects were sustained at 6-9 months post-workshop, with 68% (n=13) of participants reporting that they spoke to family or care-partners about healthcare wishes, and 100% (n=18) of participants feeling that the information presented in the workshop did or will help guide healthcare decisions. **Conclusion:** Participation in this workshop improved understanding of

illness trajectories and confidence in ACP. The interactive format and non-clinical setting promoted learning and increased engagement in ACP.

KidneyWise: Advancing chronic kidney disease management in primary care

Allan Grill*, MD, CCFP (COE), MPH, FCFP, CCPE; Nick Maclean-Bowman, MPP; Sabrina Padewski, MBA; Scott Brimble, MD, Msc, FRCP (C); Peter Blake, MB, FRCP (C), FRCP (I); Eliot R Beaubien, MD, FRCP (C)

Poster # 620

Learning objectives:

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

1. Identify who in Ontario is at high-risk of chronic kidney disease and screen individuals accordingly in primary care settings
2. Effectively manage patients with early chronic kidney disease in primary care to prevent or slow disease progression
3. Identify when a patient should be referred to nephrology from primary care

Context: There are approximately 600,000 adults with chronic kidney disease (CKD) in Ontario, however, 90% of CKD cases are at low risk of progression and can be effectively managed by primary care. **Objective:** To support earlier detection and treatment of CKD in primary care, to slow disease progression and reduce associated health risks. **Design:** Ontario Health (Ontario Renal Network) undertook a multi-phase approach to update the KidneyWise Toolkit: a provincial evidence-based resource to support primary care providers in the identification, diagnosis, management and referral of patients with CKD. The development process included stakeholder engagement, expert consensus, targeted literature reviews, and jurisdictional scans. **Setting:** KidneyWise tools are intended for use at point of care, in educational settings and during patient referral in Ontario. **Participants:** The KidneyWise Toolkit task group included nephrologists and primary care providers. Toolkit products were reviewed by multidisciplinary care team members, healthcare organizations serving equity-deserving populations, patients and care partners. **Intervention:** The toolkit includes: a print-friendly clinical algorithm for CKD assessment and management; an outpatient nephrology referral template; patient fact sheets, including culturally relevant information for Indigenous and Black population educational slide decks; and a medication access resource. **Main Outcome Measures:** Impact will be assessed through provincial and regional primary care engagement metrics, annual albumin-to-creatinine ratio testing rates, prescribing rates for guideline-directed therapies (RAASi, SGLT2i, nsMRA, GLP-1 RA), and nephrology referral rates for patients meeting KidneyWise criteria. **Results:** The 2026 toolkit builds on previous iterations to include: annual CKD screening for Black people living in Ontario beginning at age 40, lowered ACR referral thresholds for patients without diabetes, guidance for incidental CKD detection through urinalysis, and expanded pharmacologic recommendations involving SGLT2i, nsMRA, GLP-1 RA. **Conclusion:** KidneyWise is a comprehensive and accessible resource that strengthens CKD detection and management in primary care while supporting timely referral to nephrology.

Ultrasound-Guided IUD Placement During Family Medicine Residency Training

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Poster # 701

Learning objectives:

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

1. Describe how ultrasound guidance during intrauterine device (IUD) insertion affects family medicine residents' procedural confidence within a residency training environment
2. Compare patient-reported outcomes—including pain scores and procedure duration—between ultrasound-guided and standard IUD placement techniques
3. Identify practical considerations for incorporating point-of-care ultrasound into family medicine residency curricula to support competency development in IUD insertion

Objective: We sought to determine whether ultrasound-guided versus non-ultrasound-guided intrauterine device (IUD) placement within a family medicine training environment improves resident confidence, as well as patient pain scores and procedural time. **Design:** A prospective, randomised controlled trial. **Setting:** An academic family medicine resident training clinic in Saskatoon, Saskatchewan, Canada from May 2020 to 2024. **Participants:** Patients undergoing IUD insertion were invited to participate. All family medicine resident trainees performing IUD insertion at our clinic were also invited to participate. A total of 49 patients and 30 residents were enrolled. This study received ethical approval from our institutional research ethics board. **Intervention:** Intrauterine device placement is common in primary care, and a required training objective of Family Medicine postgraduate programs. Ultrasound guidance is available to assist medical trainees with determining uterine position and placement, providing immediate confirmation of proper placement. To that end, in this study, we compared IUD placement by ultrasound guidance (intervention group) versus no ultrasound (control group). **Main Outcome Measures:** Resident confidence pre- and post-procedure, patient-reported pain scores at three time points, and total procedure time were compared between the ultrasound-guided and control groups using marginal models. Confidence levels and pain scores were reported using 0-10 point box scales. **Results:** The average increase in resident-reported confidence was greater in the ultrasound-guided group (mean difference = 1.2 points, $p = 0.01$). Patient pain scores were similar between the ultrasound and control groups at all time points (mean difference = -0.2 points, $p = 0.45$). Procedural time in the ultrasound-guided group was longer (mean difference 10.9 minutes, $p = 0.03$). **Conclusions:** Ultrasound-guided IUD placement results in improved family medicine resident-reported confidence without compromising patient comfort.

Sexual Health Experiences Among Patients with Gynecologic Malignancies

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Poster # 702

Learning objectives:

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

1. Describe the sexual health needs of patients with gynecologic malignancies
2. Describe the impact of gynecologic malignancy treatment on sexual health
3. Explore addressing sexual health needs of patients with gynecologic malignancies in a primary care setting

Context: In Canada, 12% of cancers diagnosed yearly in women are gynecologic malignancies. With increasing rates of survivorship, attention to quality of life is crucial to comprehensive patient care, however, follow up is often focused on the disease. Patients experience significant physical, mental, and emotional changes that negatively impact their sexual health, and sexual dysfunction is common amongst survivors. **Objective:** We aimed to determine the experiences of patients with gynecological malignancies surrounding sexual health before, during, and after treatment. **Design:** Qualitative thematic analysis. One-on-one virtual interviews were conducted with patients who were treated for a gynecologic malignancy via surgery, radiation, chemotherapy, or a combination. Interviews were recorded and transcribed and later analyzed using thematic analysis. The study was approved by the Trillium Health Partners' Research Ethics Board (Study#1108). **Setting:** Outpatient gynecological oncology and radiation clinics at Credit Valley Hospital, a tertiary cancer center in Ontario, Canada.

Participants: Purposive sampling was used to ensure representation based on age, relationship status, timing of treatment course, and type of treatment received. Fifteen participants were recruited. **Findings:** All fifteen patients interviewed reported gaps in their sexual health needs which were not addressed by their care team. Participants described sex as lower priority during diagnosis and treatment, becoming more important with time. Significant adjustments to their sex life were required due to physical, mental, and emotional changes. They felt that both information with what to expect with respect to their sexual health and support when running into issues was lacking. They also identified multidisciplinary care as a key resource for sexual health concerns, specifically mentioning primary care providers. **Conclusion:** Patients treated for gynecologic malignancies have sexual health needs that are unmet by their care team, despite being an important aspect of survivorship. Primary care providers may be uniquely suited to addressing these gaps.

What In-House Psycho-Social Services Do Transition Houses in Atlantic Canada Have to Support Children?

Kathy Chan*, BSc, MPH; Francoise Guigné, MA, MD, CCFP; Malin Enström, MA

Poster # 704

Learning objectives:

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

1. To describe barriers for transition houses to support children's psychosocial wellbeing in Atlantic Canada
2. To identify current in-house supports available to children in transition houses in Atlantic Canada
3. To describe gaps in types of supports available for children in transition houses in Atlantic Canada

Context: Children are especially vulnerable to the impacts of exposures of intimate partner violence which can have long-lasting impacts on their neurological, psychological and physiological functioning. While supports are often available to mothers in transition houses, resources remain limited for children. **Objective:** To explore the in-house psycho-social resources available to children in transition houses across Atlantic Canada. **Design:** Mixed-methods qualitative descriptive study. Ethics approval was obtained from the NL Research Ethics Review Board. **Setting:** An online survey, hosted on Qualtrics, was sent to Executive Directors across Atlantic Canada between November 2024 to January 2025. Contact information of transition houses was found online. Qualitative data was analyzed using thematic content analysis and descriptive analysis was used to analyze quantitative data. **Participants:** Eligibility criteria included current Executive Directors of transition houses in Atlantic Canada. Sample size was 17. **Main Outcome Measures:** To better understand the available in-house psycho-social resources available for children staying in transition houses across Atlantic Canada. **Results/Findings:** There was almost an even split in responses from participants from rural and urban areas. The top three in-house psycho-social supports available to children in the transition house are group programming, professional counselling, and recreational therapies. The top three barriers were not enough financial funding, lack of available external healthcare workers from the community to come in to provide in-house care and lack of capacity and time of existing staff. **Conclusion:** This research adds to the body of knowledge by identifying current in-house supports, key barriers and gaps in supports available to children in transition houses. Respondents noted that the biggest gap was the lack of mental health supports for children in transition houses. This emphasizes the increased need for funding and trained healthcare professionals to appropriately manage mental health issues in children during this vulnerable time.

Decision-Making Capacity Assessment Education Using Online Modules

Lesley Charles*, MBChB, CCFP (COE); Eileen Tang; Tara Kilkenny, MSc; Sharna Polard, MLIS; Peter George Jaminal Tian, MD, MSc; Jasneet Parmar, MBBS, MSc

Poster # 705

Learning objectives:

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

1. Describe online modules on decision-making capacity assessment (DMCA) education
2. Compare online with face-to-face DMCA education
3. Discuss the relevance of online DMCA education

Context: Specialized training is necessary for healthcare providers, such as physicians, nurses, and social workers, to be able to accurately perform decision-making capacity assessments (DMCAs). With an increasing demand for flexible, accessible education, there is growing interest in utilizing online training modules to keep healthcare providers up to date on current best practices in DMCAs. **Objective:** This study evaluates the effectiveness of online training modules in enhancing clinicians' self-reported knowledge, confidence, and comfort with the core concepts necessary to conduct DMCAs. **Design:** This was a pretest-posttest study on an online DMCA training. Participants from a regional health authority (Alberta, Canada) took 13 online modules on 15 core DMCA concepts, between March to December 2021. A pretest and a posttest were completed before and after completion of the modules. Agreement to Likert-like items were collected and compared at a group level. Additionally, the ratings were compared with historical data from face-to-face DMCA workshops. This study was approved by the University of Alberta's Health Research Ethics Board (Pro00110551). **Setting:** Regional health authority, Alberta. **Participants:** Staff members of the regional health authority. **Main Outcome Measures:** Agreement to Likert-like items. **Results:** 683 pretests and 241 posttests were completed. All 15 posttest ratings were higher ($p < 0.001$) than pretest ratings. Compared to the historical face-to-face workshops, the self-reported ratings in the online modules tended to be higher both on pretest and posttest. However, the changes in self-reported ratings from pretest to posttest were similar between the online modules and the historical workshops. **Conclusion:** Online learning of DMCA concepts can lead to higher self-reported learning posttest to pretest. Furthermore, the changes in self-reported ratings are similar to those observed in face-to-face workshops.

Assessing the Use of Potentially Inappropriate Medications in Older Patients in a Primary Care Clinic

Marwan Al-Doori, MD; Lesley Charles*, MBChB; Peter George Jaminal Tian, MD, MSc

Poster # 706

Learning objectives:

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

1. Describe the prevalence of potentially inappropriate medications (PIMs) among older adults
2. Discuss the prevalence of PIMs among older adults in a primary care clinic
3. Discuss the relevance of PIMs among older adults in primary care

Context: Potentially inappropriate medications (PIMs) in older adults pose health risks. **Objective:** We describe the prevalence of PIMs among older patients in a primary care clinic. **Design:** This was a retrospective chart review of older patients (65 years or older) seen by 3 physicians in a primary care clinic (Alberta, Canada) from January 1, 2024-December 31, 2024. A total of 100 patients were randomly selected. For each patient, PIMs were extracted using the 2023 AGS Beers Criteria as standard. We used descriptive statistics to summarize the data. **Setting:** A primary care clinic. **Participants:** 100 randomly selected patients. **Main Outcome Measures:** Prevalence of PIMs, number of medications, commonly prescribed PIMs. **Results:** 38, 32, and 30 patients were randomly selected from physicians A, B, and C. Age ranged from 66 to 97 years old, with a mean of 75.7 years (SD = 6.82; median 75.5; n=100). 60% were females. Patients had 0-13 medications with a mean of 5.4 (SD: 3.09; median: 5). 68% of patients had at least one PIM (prevalence), 41% with 2 or more, 21% with 3 or more, and 4% with 4 or more PIMs. Among the 68 patients who had at least one PIM, a total of 135 PIMs were prescribed. The most common PIMs were pantoprazole (20.7%, 28/135), zopiclone (7.4%, 10/135), codeine/acetaminophen (6.7%, 9/135), lorazepam (5.2%, 7/135), acetylsalicylic acid (5.2%, 7/135), and tramadol/acetaminophen (4.4%, 6/135). The most

common categories of PIMs were Proton Pump Inhibitors and Opioids. The prevalence of PIMs in this primary clinic (68%) is higher than the prevalence of PIMs in tertiary care (42-45%) we previously published. However, the prevalence of PIMs varied across physicians: 56.7%, (17/30), 63.2% (24/38), and 84.4% (27/32). **Conclusion:** The prevalence of PIMs in this study's primary care clinic is high. This underscores the need for interventions (e.g., education) to decrease PIMs among older adults seen in the community.

The Association Between Patient-Perceived Empathy and Patient-Perceived Ageism in Patients ≥60 Years age at the Dalhousie Family Medicine Mumford Clinic (Work-in-Progress)

Orrisha Denbow-Burke*, MD, MPH-Gerontology; Cory A. Munroe, PhD BKine; Helena Piccinini-Vallis, MD, PhD, CCFP, FCFP

Poster # 707

Learning objectives:

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

1. Reflect on occurrence of ageism in their practice
2. Able to recognize the role patient perceived empathy plays in patient perceived ageism
3. Participants will be able to define ageism and empathy

Context: Ageism is discrimination against older people based on their age and is associated with adverse outcomes that potentially interfere with healthy ageing. Empathy is a key component of patient-centeredness, a core construct of quality healthcare that is highly valued by patients and enhances the patient-clinician relationship. **Objective:** To measure patient-perceived ageism in patients ≥ 60 years of age and explore its association with patient-perceived-empathy. **Design:** Cross-Sectional Study. **Setting:** Dalhousie Family Medicine Mumford Clinic. **Participants:** 101 patients ≥60 years of age with a good understanding of English, no moderate-severe cognitive impairment or a diagnosis of dementia and who were active patients at the Dalhousie Family Medicine Mumford Clinic. **Intervention:** Paper questionnaires (26 items) were self-administered after participants' clinic appointments with their primary physician being absent. The questionnaire included demographic information, the Perceived Ageism Questionnaire (PAQ) and the Consultation and Relational Empathy (CARE) questionnaire. * (1 question from the CARE measure was omitted in error and so a modified empathy measure was used). **Main Outcome Measures:** Patient-perceived ageism, patient-perceived empathy. **Results/Findings:** 101 participants were enrolled in the study. The mean PAQ score was 3.99 (SD=0.56) which shows that the population studied experienced low ageism, and the mean modified CARE score was 1.46 (SD=0.70), indicating high patient-perceived empathy during physician consultations at the Dalhousie Family Medicine Mumford Clinic. Multiple linear regression was performed controlling for age, gender, race, emotional support, hearing aids, mobility aids, chronic diseases, financial security and education found that patient-perceived empathy was a significant predictor of patient-perceived ageism, B= -.225, 95% CI [-.403, -.048], t= -2.53 p=.002. **Conclusion:** There is an inverse relationship between patient-perceived ageism and patient-perceived empathy, therefore, it can be assumed that the greater the discrimination of older persons by their respective physicians, the less empathy is discerned by the patient.

Impact of Time Constraints on Preventive Care Delivery

Mashal Zaide*, Bsc; Naman Sahota; Ahmed El-Aawar; Martin Robert Chasen, MBChB, FCP(SA), MPhil(Pall Med)

Poster # 709

Learning objectives:

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

1. Identify time-related barriers to preventive care delivery

2. Evaluate the impact of time constraints on preventive services
3. Apply evidence-based strategies to improve preventive care delivery

Context: A crucial aspect of preventative care includes screening, counselling and immunising patients to aid in improving health and reducing morbidity and mortality. Visit lengths are often limited in primary care settings, especially family medicine, which requires physicians to balance acute concerns while also delivering preventative care. **Objective:** To assess how health priorities and visit durations affect care delivery and how to mitigate this to optimise preventative care in shorter time constraints. **Design:** Systematic review of primary care literature. **Setting:** Family medicine and primary care outpatient settings. **Participants:** Adult patients receiving care in outpatient and primary care settings, and primary care physicians. **Intervention:** Different visit durations and clinical priorities, and their influence on preventative care delivery. **Main Outcome Measures:** Prioritization of preventative activities in the clinic and reported barriers to delivery due to allotted visit time. **Results:** Studies demonstrated a significant gap between the time required and the time allotted in the clinic to deliver the recommended preventative care. Studies showed that physicians, on average, require 7.6-8.6 hours a day to comprehensively complete the recommended preventative services. While visit lengths are on average around 20-22 minutes. Shorter visits often had fewer counselling and screening activities compared to longer visits, which correlated with more extensive preventative care delivery. The pressure of limited time led physicians to focus on acute services while sacrificing time for preventative counselling. Barriers in balancing time and care delivery to patients are centred around visit demands and overwhelming patient volume. **Conclusion:** A major barrier to comprehensive care in primary care settings is the time constraints during appointments. Visit lengths require physicians to prioritise acute care, which contributes to incomplete preventative care delivery. Strategies should be implemented, such as workflow redesign and dedicated visits for preventative care, to help with these challenges.

Patient Preferences for Research Collaboration in Family Medicine Groups (FMGs)

Jean-Sébastien Paquette*, MD, MSc, CCMF; Mohammed Akhtar, MSc; Araceli Gonzalez Reyes, PhD; Isabelle Gaboury, MSc, PhD; Isabel Rodrigues, MD, MPH; Alexandra de Pokomandy MDCM, MSc, on behalf of the COPRI research team.

Poster # 710

Learning objectives:

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

1. Describe overall patient preferences for participation in primary care research and their relevance to real-world clinical settings
2. Characterize preferred methods of participation, including non-invasive approaches and passive involvement, within primary care contexts
3. Examine variations in research preferences across subgroups including differences by gender, to better understand population diversity in primary care research

Context: Understanding patient preferences for participating in research is critical for patient-oriented studies. Aligning opportunities with these preferences can increase participation and improve outcomes, while insights from patients can guide patient-centred recruitment and study design. **Objective:** To describe self-reported patient preferences for research collaboration in primary care. **Design:** A descriptive cross-sectional analysis was conducted using data from a prospective cohort study of patients at FMGs. Questionnaires were completed by participants online or with a trained interviewer. The study received ethics approval from the MUHC Research Ethics Board. **Setting:** A multi-site prospective primary care cohort study across FMGs in Québec, Canada. **Participants:** Adults receiving care at one of 24 FMGs who consented and completed a questionnaire between June 2024 and July 2026. **Main Outcome Measures:** Patient preferences for collaboration were measured using 10-point Likert scales, including interest in various methods of participation, engagement, preferred

collaborators, research settings, and themes, with subgroup analyses by gender. **Results/Findings:** The sample consisted of 1,909 participants, of which 68% were Cis-women (mean age = 51, SD age = 16). Participants preferred passive research (70%), with surveys (66%) and biological samples (57.5%) as preferred methods. Participants preferred collaborating with healthcare professionals (59%) and academic researchers (54%), and research on improving the healthcare system (70%) and treatments aimed at improving quality of life (65%). Research settings consisting of existing health databases (45%) and laboratories (41.6%) were preferred compared to hospitals or community settings. Cis-men showed greater interest in providing biological samples (64%, 95%CI: 60-70) for research than Cis-women (58%, 95%CI: 55-61), while Cis-women showed greater interest in research focused on improving the healthcare system (62%, 95%CI: 60-65) than Cis-men (57%, 95%CI: 53-61). **Conclusion:** Research themes meaningful to patients, combined with convenient and noninvasive methods and the involvement of trusted figures, can enhance recruitment strategies and inform study design.

Family Physicians' Attitudes on a Pilot Acute Care Uniprofessional Theatre-Based Simulation Experience

Anthony Seto*, MD, CCFP (EM), FCFPC (EM); William Betzner; Joshua Perka; Connor Hass; William Kennedy

Poster # 711

Learning objectives:

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

1. Discuss how to set up a uniprofessional, physician-only simulation
2. Describe family medicine physicians' perceptions on uniprofessional, physician-only simulation
3. Describe potential benefits of uniprofessional, physician-only simulation

Context: Family physicians report barriers to simulation participation, citing performance anxiety and uncertain value. Designing physician-only simulations could reduce concerns of performing in front of non-physicians and tailor content to physician-scope. **Objective:** The objective of this pilot evaluation was to assess family physicians' perceptions of uniprofessional simulations, their attitudes toward this design, and how they feel it compares with traditional multiprofessional simulations. **Design:** Participants completed a post-simulation survey, rating statements from 1 (strongly disagree) to 5 (strongly agree). Means were calculated. **Setting:** Two pilot, physician-only, three-hour theatre-based simulations were facilitated in 2025 for 16 family physicians. Cases covered chest pain, toxicology, and obstetrics. Participants: Simulation attendees (n=16) were family physicians from urgent care and rural emergency settings. **Main Outcome Measures:** Metrics included agreement to statements in three categories: I) simulation experience, II) attitudes toward uniprofessional simulation, and III) comparison with multiprofessional simulation. Category I covered a) satisfaction, b) engagement, and c) ability to practice team dynamics. Category II included a) connection to colleagues, b) preference over other education activities, c) better suited for staff than trainees, and d) value in playing other healthcare roles. Category III included a) discussed advanced knowledge, b) practiced advanced skills, c) tailored to physician scope, d) greater comfort, and e) increased likelihood to sign up. Results: All participants (16/16, 100%) completed the survey. Scores (/5) were: I-a 4.81, I-b 4.81, I-c 4.69; II-a 4.88, II-b 4.25, II-c 3.56, II-d 4.31; III-a 4.63, III-b 4.31, III-c 4.13, III-d 3.50, and III-e 4.13. **Conclusion:** The pilot physician-only simulations were well-received. They addressed performance and value barriers. Physicians felt more comfortable, connected, and able to discuss knowledge and practice skills not covered in multiprofessional simulations, as content was tailored to physician expertise. Educators can consider introducing uniprofessional simulations to increase physician engagement and complement multidisciplinary simulations.

Culturally Sensitive Grief Resources in Primary Care (Work-in-Progress)

Jastinder Bhandal*, BKin; Caroline Cook, MB ChB, CCFP; Randeep Gill, MD; Andrea Critchley

Poster # 712

Learning objectives:

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

1. Understand the gaps in culturally sensitive grief support within primary care settings
2. Describe the development of a culturally tailored grief resource for diverse patient populations
3. Explore how primary care providers can integrate culturally appropriate grief support into clinical practice

Context: Grief is a universal experience, yet culturally attuned support remains limited in primary care. In South Asian communities, grief may be expressed through physical symptoms, indirect communication, and collective family coping, which can make recognition and support challenging. Family physicians are often the first point of contact but may lack culturally appropriate tools to guide these conversations. **Objective:** To refine culturally adapted grief resources for South Asian families through feedback from primary care clinicians and community stakeholders. **Design:** This project is a community-based educational initiative conducted in two phases. Phase 1 involved development of a clinician-facing guide in collaboration with the Abbotsford Hospice & Grief Support Society (AHGSS). Preliminary findings from Phase 1 were presented at FMF 2025, supporting feasibility and informing the current phase. Phase 2 focuses on pilot use of the guide in primary care settings and iterative refinement based on user feedback. **Setting:** Primary care and community settings in Abbotsford, British Columbia. **Participants:** Family physicians, hospice collaborators, and South Asian community stakeholders. **Intervention:** A culturally adapted clinician guide designed to support grief conversations, incorporating language-accessible tools, culturally relevant communication prompts, and guidance for navigating family-centred grief discussions. **Main Outcome Measures:** Perceived usability, clarity, cultural relevance, and clinician confidence in applying the guide within routine practice. **Anticipated Results/Impact:** The guide is expected to enhance clinician confidence and improve culturally responsive communication in grief care. Feedback will inform practical refinements to improve usability and integration into routine primary care practice. **Conclusion:** This work highlights the role of community–hospice collaboration in developing culturally relevant tools for primary care. Ongoing refinement aims to improve accessibility and responsiveness of grief support for diverse patient populations.

Evaluation of the Sustainability of Healthy Lifestyle Habits Following a Personalized Primary Care Obesity Management Program (Work-in-Progress)

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Poster # 713

Learning objectives:

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

1. Identify how an interdisciplinary, primary care–based program can effectively drive meaningful lifestyle changes in patients with obesity
2. Apply validated clinical tools and biomarkers to monitor lifestyle, metabolic, and aging-related outcomes in real-world practice
3. Recognize key factors influencing the long-term sustainability of lifestyle changes and their implications for primary care practice and scalability

Context: Obesity is a chronic condition requiring sustainable lifestyle changes, yet long-term maintenance of healthy behaviors remains challenging. Interdisciplinary, lifestyle-based interventions show promise, but their long-term impact in primary care settings is insufficiently studied. **Objective:** To assess the adoption and sustainability of healthy lifestyle habits following participation in a personalized, interdisciplinary obesity management program in primary care, as well as to

evaluate changes in body composition and metabolic, inflammatory, and aging-related biomarkers. **Design:** Longitudinal cohort study. This study has been reviewed and approved by the local Research Ethics Board. **Setting:** Groupe de médecine familiale universitaire du Nord de Lanaudière **Participants:** Adults with obesity enrolled in the Méta-Santé program following referral by their family physician. **Intervention:** Méta-Santé is a patient-centered, interdisciplinary care pathway based on six pillars: nutrition, physical activity, sleep, stress management, social connections, and reduction of harmful substances. The program includes group education, individualized follow-up, and multidisciplinary support. **Main Outcome Measures:** Changes in lifestyle habits assessed using validated questionnaires: REAPS (diet), IPAQ (physical activity), PSQI (sleep), GAD-7 and PHQ-9 (mental health), AUDIT and FTND (substance use), and SPS-10 (social support). Secondary measures include body composition (bioelectrical impedance) and metabolic, inflammatory, and aging-related biomarkers. **Anticipated Results/Impact:** It is anticipated that participants will demonstrate improved lifestyle behaviors following the program, with partial or sustained maintenance at 6 and 12 months. Findings will provide insight into the long-term effectiveness of interdisciplinary obesity care in primary care and inform future program refinement. **Conclusion:** This study will contribute to understanding how structured, lifestyle-based interventions can support sustained behavior change in obesity management. Early recruitment is ongoing (55/120 participants), demonstrating feasibility. Results will guide scalability and optimization of similar programs in primary care.

Effectiveness of Teach-Back Methods in Primary Care

Mashal Zaide*, Bsc; Ahmed El-Aawar*; Naman Sahota; Martin Robert Chasen, MBChB, FCP(SA), MPhil(Pall Med)

Poster # 714

Learning objectives:

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

1. Identify core components of teach-back communication
2. Implement teach-back methods in primary care encounters
3. Assess patient comprehension using teach-back strategies

Context: Health literacy plays a crucial role in patient adherence, disease management, and clinical outcomes. In primary care settings, preventable complications can be attributed to miscommunication. With effective communication, disease control can be better managed and can optimize health care utilization. A method primary care physicians can utilize is teach-back, a patient-centred strategy which involves repeating back the information received in their own words to confirm their understanding. Evidence of the effectiveness of this method in primary care settings has not been comprehensively evaluated. **Objective:** To examine the effectiveness of the teach-back method in primary care settings and its ability to enhance patient understanding, adherence, and outcomes. **Design:** Systematic review conducted with PRISMA guidelines. **Setting:** Primary care and outpatient clinics. **Participants:** Adults receiving care in primary or outpatient care settings. **Intervention:** Teach-back method delivered by healthcare staff (i.e. physicians, nurses, or trainees) compared with usual verbal or written explanations. **Main Outcome Measures:** Understanding, knowledge retention, self-management, patient satisfaction and clinical outcomes. **Results:** Teach-back interventions were shown to improve patient understanding and retention of information across multiple studies. Results showed that self-management, particularly in patients with chronic conditions, was enhanced. This method also showed improved communication between the patient and provider as well as enhanced engagement. Several studies also showed a reduction in preventable complications and reported hospitalizations. Barriers in this method were attributed to a lack of clinical training and staff education, as well as limited time during visits. **Conclusion:** Teach-back is an effective method of communication between patients and providers that can improve understanding, adherence and the engagement of patients in primary care settings. Its use in family medicine remains inconsistent despite its benefits. Training and integration should be implemented in primary care settings to improve patient care and outcomes.

Conversation Cards for Pregnancy: A feasibility study

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Poster # 715

Learning objectives:

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

1. Assess barriers to discussing health behaviours in prenatal care
2. Examine how PregnancyCards may support patient-centred prenatal conversations
3. Apply provider feedback to refine dialogue tools for clinical practice

Context: Health behaviours during pregnancy can influence long-term health outcomes, underscoring the importance of clinical discussions on these factors. Initiating conversations about health behaviours are sensitive and challenging. This is the first study examining prenatal care providers' (PCPs) perceptions on a newly developed prototype dialogue tool designed to facilitate conversations about health behaviours in prenatal care. **Objective:** To understand PCPs' perceptions of usability, acceptability, and likability of Conversation Cards for Pregnancy (PregnancyCards). **Design:** Guided by the ORBIT model, this was a multi-methods feasibility study, approved by Concordia University Research Ethics Review Board. **Setting:** Participants completed an online survey at one-time point via Qualtrics. **Participants:** Inclusion criteria included English and/or French-speaking PCPs (e.g., obstetricians-gynecologists, family physicians, nurse practitioners, and midwives). The survey was disseminated across Canada through affiliated partners. **Main Outcome Measures:** Participants reviewed the online PregnancyCards and answered closed-ended questions with open-ended options. Feasibility outcomes included recruitment metrics and sample characteristics. Perceived usability (e.g., how helpful would this tool be in discussing important topics with patients?), acceptability (how receptive would you be to patients using this tool in clinical practice?), and likability (e.g., how satisfied are you with the appearance of the cards?) were measured using 5-point Likert Scales from 1 (strongly disagree) to 5 (strongly agree). **Results:** PCPs (N=35, 94% women; Mage = 46.4years (SD = 9.1)) were recruited December 2025 to February 2026. Participants were primarily obstetricians-gynecologists (60%) and family physicians (31%), from seven provinces, majority from Ontario (40%). Most participants rated usability (68.5%), acceptability (74.2%), and likability (71.4%) at ≥4. Qualitative feedback identified areas for improvement of card content, aesthetics, and language. **Conclusion:** PregnancyCards were perceived favourably with most PCPs rating usability, acceptability, and likability highly. These findings support tool refinement, progression to feasibility testing with pregnant individuals in clinical practice and a proof-of-concept trial to optimize implementation.

Evaluation of the "Mini-BASICS" Faculty Development Program for Rural Family Medicine Clinical Faculty Using the CIPP Model

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Poster # 717

Learning objectives:

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

1. Examine teaching and assessment challenges in adult medical learners
2. Describe the role and limitations of self-assessment in professional development

3. Explain the significance of the educational environment in facilitating learning

Canada has a long-standing shortage of family physicians due to multiple factors. One factor has been the mismatch of postgraduate residency positions with increasing population demand(1). Different provinces are now tackling this issue. In Ontario, the government expanded medical education, including 295 new residency spots over five years(2). The Department of Family and Community Medicine (DFCM) at University of Toronto expanded its teaching infrastructure to develop new sites, most in rural Ontario (3). With increasing trainees, the need to upskill clinical faculty was crucial. Prior research suggests that faculty development (FD) initiatives can enhance teaching competence and support clinical educators working in distributed and rural training environments (6,10,11). A CIPP program evaluation framework was used to guide the evaluation of this FD initiative (7). This study received Research Ethics Board approval (Protocol #00050492). The Mini-BASICS faculty development program was delivered at three DFCM expansion sites in rural Ontario. Clinical faculty involved in teaching FM residents at their new site were invited to participate, including both family physicians and other specialist teachers. Priority workshops were curated from the BASICS for New Faculty program based on a needs assessment. A pilot "Mini-BASICS" session was launched in one community, accessible to two sites. Pre- and post-surveys were collected, along with stakeholder feedback from Program Directors and leadership. Based on these data, the program was iteratively refined to improve accessibility and prioritize key topics. It was subsequently delivered as an evening "Mini-BASICS" session at sites. Participation in Mini-BASICS was associated with consistent improvements in self-reported teaching confidence and knowledge across key domains, including feedback, assessment, and learner integration, with observational evidence supporting enhanced teaching practices. Mini-BASICS is a feasible, context-responsive faculty development model that enhances teaching confidence in rural settings and supports scalable, needs-based strategies to strengthen distributed family medicine training capacity.

Improving Primary Care Access for Unattached Patients: Insights from clinicians and system leaders in Canada

Reuben King*, BSc, MHSc; Sonali Roy; Andrews Tawiah, PhD

Poster # 518

Learning objectives:

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

1. Identify structural barriers that limit access to primary care for unattached patients in Canadian healthcare systems
2. Describe how fragmented digital infrastructure, governance structures, and workforce constraints contribute to gaps in continuity of care
3. Discuss system-level strategies—including interdisciplinary team models and integration with community services—that may improve access to comprehensive primary care

Access to primary care is a growing challenge in Canada, with many patients lacking a regular family physician or nurse practitioner. Unattached patients frequently rely on episodic care through walk-in clinics and emergency departments, resulting in fragmented care and missed opportunities for prevention and chronic disease management. This qualitative study explores clinician and health system leader perspectives on barriers to primary care access for unattached patients. Sixteen semi-structured interviews were conducted with family physicians, primary care administrators, and system leaders involved in primary care planning and delivery in Victoria, British Columbia and Toronto, Ontario. Using framework analysis informed by the OurCare Standards for primary care, the study identifies key structural barriers to attachment and continuity of care. Findings highlight challenges related to fragmented digital health infrastructure, governance accountability, and limited capacity within existing primary care models. Participants also describe how declining walk-in clinic availability and increasing patient complexity are contributing to growing access gaps. The study highlights opportunities to strengthen interdisciplinary care teams, improve integration with community services, and enhance digital health interoperability. These findings provide

practical insights for family physicians and health system leaders seeking to improve access and continuity of care for unattached patients.

Imagerie médicale urgente: de la requête au résultat

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Poster # 519

Learning objectives:

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

1. Établir une cartographie du trajet que prend une requête d'imagerie médicale urgente à partir du moment où elle est rédigée jusqu'à ce que le patient ait son résultat.
2. Identifier les endroits dans le trajet où il peut y avoir des enjeux occasionnant des délais dans le processus.
3. Améliorer la fluidité de ce processus afin d'encourager les cliniciens à emprunter ce chemin plutôt que celui d'une référence vers l'urgence d'un centre hospitalier.

En clinique d'urgence mineure, les médecins de famille doivent fréquemment demander une imagerie rapide (< 24 h) pour des patients ne nécessitant pas autrement une référence à l'urgence hospitalière. L'accès limité à l'imagerie en contexte extrahospitalier entraîne toutefois des références souvent évitables, contribuant à la duplication des évaluations, à l'engorgement des urgences et à des délais diagnostiques potentiellement préjudiciables pour les patients comme pour les cliniciens. Ce projet d'amélioration continue de la qualité (ACQ) vise à optimiser l'accès à l'imagerie urgente en milieu extrahospitalier par l'identification ciblée des défaillances du processus actuel à partir de la demande de l'examen jusqu'à l'obtention des résultats. Dans un contexte où la première ligne assume une part croissante des soins aigus avec des ressources restreintes, cette démarche est essentielle tant sur le plan clinique qu'organisationnel. Une analyse rétrospective d'environ 100 demandes d'imagerie urgente effectuées entre janvier et mai 2024 à l'urgence mineure du GMF-U Charles-Lemoyne a été réalisée. Les données extraites des dossiers ont permis d'évaluer les délais et enjeux administratifs dans les différentes étapes. La collecte rétrospective, permet de dresser un portrait fidèle de la pratique actuelle à l'aide d'une cartographie explicite aidant ainsi à identifier les lacunes systémiques. Les résultats ont permis d'identifier 5 goulots d'étranglement limitant l'efficacité et la sécurité du processus : requêtes incomplètes, erreur d'envoi de télécopieur, patient non rejoint par le département d'imagerie médicale, imagerie faite hors délai, enjeux d'accès au système informatique pour obtenir le résultat de l'examen d'imagerie médicale par le médecin. Nous avons finalement remarqué que, lorsque toutes les étapes sont réalisées de manière adéquate, les délais moyens pour obtenir un résultat d'imagerie sont d'environ 9 heures, ce qui est excellent. Des boucles d'ACQ seront entamées dans la prochaine année à cet effet. Ce projet vise ultimement à réduire les références évitables aux services d'urgences hospitaliers, améliorer l'accès à l'imagerie par les cliniciens de première ligne, renforcer la communication interprofessionnelle et optimiser l'expérience patient.

Dose-Sparing Obesity Pharmacotherapy: Real-world combination success

Alexandro Zarruk*, MD, MSc, FRCP, FACP

Poster # 520

Learning objectives:

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

1. Compare TBWL at 3 and 6 months across regimens
2. Compare incretin dose requirements in combination versus monotherapy

3. Apply dose-sparing combination strategies to improve tolerability and affordability

Background: Obesity is a progressive, relapsing chronic disease requiring multimodal therapy. Incretin-based pharmacotherapy (GLP-1 RAs and GLP-1/GIP agonists) is effective but often limited by adverse effects, access barriers, and cost. Fixed-dose naltrexone/bupropion (NB) may complement incretins through central appetite and reward modulation, potentially enabling lower incretin doses. Real-world evidence on combination therapy remains limited. **Methods:** We conducted a retrospective chart audit of adults treated for obesity at a multidisciplinary clinic in Montreal, Canada (Jan 1–Dec 31, 2025). The first four consecutive patients initiating out-of-pocket therapy were included for each regimen: NB monotherapy, semaglutide monotherapy, tirzepatide monotherapy, semaglutide+NB, and tirzepatide+NB. Extracted variables included demographics, comorbidities, prior therapies, dosing trajectories, tolerability, and body weight. Primary outcomes were percent total body weight loss (TBWL) at 3 and 6 months; secondary outcomes were achieved medication doses at 6 months. **Results:** Twenty adults (12 women, 8 men) were included. Mean age was 47 years, baseline body weight 235 lb, BMI 36.6 kg/m². Women had lower baseline weight (215 vs 265 lb) and BMI (35.4 vs 38.4 kg/m²). At 6 months, TBWL was 7.7% (women) and 8.0% (men) with NB; 12.5% and 13.5% with semaglutide; 16.0% and 16.0% with tirzepatide. Combination therapy achieved similar or greater TBWL: 15.5% (women)/18.0% (men) with tirzepatide+NB and 14.5%/14.5% with semaglutide+NB. Mean achieved weekly incretin doses at 6 months were lower with combination therapy: semaglutide 1.18 mg/week (+2.5 NB tablets/day) vs 2.23 mg/week monotherapy; tirzepatide 6.9 mg/week (+3 NB tablets/day) vs 11.9 mg/week monotherapy. **Conclusion:** In this real-world cohort, NB adjunct therapy produced comparable weight loss with substantially lower incretin exposure, supporting improved tolerability, affordability, and sustainability. Prospective studies are warranted.