

601 Integrated end-of-life care in advanced congestive heart failure: Where are we now? 2015 update.

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Introduction: Congestive heart failure (CHF) is an increasingly prevalent terminal illness in a globally aging population. Despite optimal medical management, prognosis remains poor—a fact seldom communicated to patients and/or their families. Evidence suggests numerous benefits of palliative care consultation in advanced CHF, but to date, their services remain woefully underused. **Objectives:** To identify specific challenges of accessing and implementing palliative care for patients with advanced CHF, and to use this information to formulate recommendations for practice. **Methods** Literature review whereby recommendations for practice were formulated based on primary quantitative/qualitative data and consensus expert opinion. **Results:** Accessing palliative care services for patients with CHF remains a challenge for numerous reasons including prognostic uncertainty, misconceptions about what palliative care is, and difficulty recognizing when a patient is suitable for referral. Strategies to improve access to/delivery of palliative care for this population include education and proper discussion about prognosis/goals of care. A team-based approach is essential as we move towards a model where symptom palliation exists concurrently with active medical disease-modifying treatment. **Conclusion:** Despite evidence that palliative care has a role in improving symptom control and overall quality of life in patients with end-stage CHF, a multitude of challenges exist and this ultimately hinders access to palliative care services. Education to abolish pre-existing misconceptions about the role of palliative care and a movement towards a team-based approach focused on simultaneous palliative and traditional medical care will undoubtedly improve access to, and benefit from, palliative care services in this population.

602 Prescribing money: A primary care approach to treating poverty

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Using an interactive case-based and standardized patient approach, this workshop will provide the opportunity to apply skills for screening and treating poverty in specific patient groups including low-income, Aboriginal, pediatric, geriatric, and individuals with disabilities. Individuals with low incomes face many issues related to poverty including unemployment, food insecurity, affordable housing, and poor health. Direct correlations have demonstrated that an individual's health status improves as income and social status increases. This shows the important interaction between social determinants of health and health status. Therefore, primary care is an opportune place for identifying and implementing an intervention for individuals experiencing the health impacts of poverty, as health and poverty are inextricably linked. This workshop will cover topics such as prescribing money, poverty in Canada, the impact of poverty on health, and the various tools available in each province/territory. Throughout the course of this workshop, information will be provided about how to screen all patients in primary care for poverty and how to navigate the system for appropriate resources. Participants will have the opportunity to practise screening and treating poverty in a hands-on manner. For instance, as participants select a specific federal or provincial intervention or service for their standardized patient, they will be provided with the hypothetical funds that their patient has gained as a direct result. There will be an opportunity for participants to discuss the cases and patients they are presented with, and the ways in which applying these skills has a direct result on improving the health of their patients.

603 Health care partnership in Manawan and teaching Aboriginal health issues

Pascale Breault, MD, Saint-Charles-Borromée, QC; Mathieu Pelletier, MD, CCMF

Introduction: Care of the Aboriginal population, key to the social accountability of Canadian medical schools, is a growing concern for teachers and learners at Université Laval (UL). The family medicine unit of the Nord de Lanaudière (FMUNL) in Joliette is offering decentralized education in UL's network. In 2013, a partnership with Manawan was signed. In addition to providing health care to this Atikamekw community (with a population of 2,000), FMUNL decided to develop teaching tools for residents about Aboriginal health issues. **Methods:** To introduce residents to Aboriginal health issues, an online self-learning module based on the core competencies framework developed by the Indigenous Physicians Association of Canada and the RCPSC was designed by two residents of FMUNL as a scholarship project. They led an extensive review of the literature to create the module. Multiple contributors, including cultural and Aboriginal health experts, are part of the process. **Results:** The main aspects the authors retained as teaching elements are: chronic health issues, maternal health, mental health, youth health, and cultural safety. Reference documents and evidence-based data adapted to first line practice were prioritized. This led to one of the very first teaching programs in family medicine based on the core competencies framework. **Conclusion:** Building on the trust that was established with the Aboriginal population, the module could be exported to other sites. A decentralized teaching site helping a medical school to be more socially responsible towards marginalized populations can be seen as a social accountability 2.0 initiative.

604 A description of family medicine maternity care fellowships across Canada

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Context: Many Canadian medical schools have obstetrics/women's health fellowships to provide family physicians with additional training to increase clinical knowledge, ability, and confidence in maternity care. **Objectives:** To describe the structure and curriculum of family medicine (FM) obstetrics/women's health fellowships in Canada. To ascertain program directors' expectations of FM residents' competencies in maternity care upon completion of residency and fellowship. **Design** Semi-structured telephone interviews with directors of maternity care fellowship programs. **Content analysis** of interviews (audio-recorded and transcribed verbatim) conducted by team members. **Participants:** Program directors from all nine English FM maternity care fellowship programs in Canada. **Results:** Goals and objectives range from reinforcing participants' comfort with low risk obstetrics to Cesarean section capability. Length of programs varies from 3 to 12 months (obstetrics component also variable). Structure varies widely as do characteristics of sites where the program is implemented. Although there is agreement that competence in spontaneous vaginal delivery, second degree tear repair, correcting breastfeeding latch, and neonatal resuscitation is expected by the end of core FM residency, there is disagreement about vacuum delivery and frenotomy. Similarly, although there is fairly consistent expectation that fellowship graduates should have obtained competency in vacuum delivery there is inconsistency in expectation of competence in frenotomy, manual removal of placenta, repair of third degree tear, or breech delivery. **Conclusions:** There is no uniformity across FM maternity care fellowship programs in length, structure, or objectives, which leads to flexibility in meeting learners' needs. The inconsistency in fellowship program directors' expectations of competency of graduating residents from core FM programs may reflect individual opinions. However, it could also point to the underlying challenges in assuring that FM residents achieve confidence and competence in maternity care and, consequently, the inconsistency across core programs. Moreover, this inconsistency continues into fellowship programs, suggesting either differing opinions about what

is required for independent practice or what is achievable in a fellowship. Therefore, residents are advised to research the various programs before selecting one to ensure that the fellowship meets their learning and professional needs.

605 G6PD enzyme deficiency in Syrian refugees

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Context: Between November 2015 and May 2016, approximately 1,500 Syrian refugees arrived in Ottawa, of which 800 were screened at three sites: Bruyere Family Health Team (BFHT), Centretown Community Health Centre (CCHC), and Somerset West Community Health Center (SWCHC). The authors, as members of the Ottawa Syrian Health Task Force, recommended universal screening for the X-linked hemoglobin enzymopathy, G6PD deficiency, based on its prevalence in the Middle East, and due to its potential serious complications of hemolysis with fava foods and oxidizing medications, and because there are some expert recommendations for universal screening in children. Because of the lack of evidence behind existing expert recommendations, the authors are investigating the prevalence of G6PD deficiency in the population of Syrian refugees screened at BFHT, CCHC, and SWCHC, to inform future screening practice, as Syrian refugees continue to arrive in Canada. **Objective:** To determine to prevalence of G6PD deficiency in Syrian refugees who arrived to Ottawa, in order to make recommendations about screening similar groups in the future. **Design:** Cross-sectional review of medical records. **Participants:** All of the approximately 800 Syrian refugees, both adults and children, undergoing initial medical assessments at the three Ottawa clinics. Instrument Data entered into an electronic medical record template at initial medical assessment visits, laboratory results. Outcome Measures G6PD status (deficient, indeterminate, sufficient), hemoglobin (anemic, not anemic), age, sex, gender, refugee status, family linkage. **Results:** We anticipate a prevalence of approximately 3%–4% for G6PD deficiency in all arrivals based on our preliminary results. **Conclusions:** A relatively low level of G6PD deficiency in a population of refugees from Syria will make universal screening in adults unnecessary, but targeted screening prior to the use of oxidizing medications should be considered. Children under the age of 10 should continue to be universally screened, and educational material made available for common medication that could trigger hemolysis in G6PD deficiency.

606 A Standardized patient program using Ariadne Lab's Serious Illness Conversation Guide to improve advance care planning

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Advanced care planning is an important aspect of care for patients that have been diagnosed with a life-limiting illness. For a variety of reasons, advanced care plans are typically not discussed adequately or in a timely manner. This can result in decision making that does not reflect the patient's wishes, and can be a source of significant caregiver conflict. Ariadne Labs, in association with the Harvard T.H. Chan School of Public Health, has developed the Serious Illness Care program. This program includes the Serious Illness Conversation Guide (SICG) that they developed to help health care providers improve their skills and comfort with advanced care planning conversations by providing a quick, easy-to-use framework for these conversations. To strengthen use of the SICG, we developed a standardized patient program that introduces health care professionals to the SICG, and provides an opportunity to practise its steps. This short, simple program begins with a brief presentation introducing the SICG, and is then followed by opportunities for health care professionals to practise its steps with standardized patients. We developed clinical situations and patient descriptions from those used in the Serious Illness Care

program for use by standardized patients. A short debrief is then held with participants to discuss their comfort with the SICG. In the coming months we will hold a pilot night with a group of family medicine residents at various stages of their training. We will have two groups of participants, one that has been introduced to the SICG and one that hasn't. We will conduct pre- and post-experience questionnaires to assess each group's level of comfort with advanced care planning conversations. We hope to show that health care professionals' level of comfort with these discussions increases with use of the SICG. The SICG is currently freely available to all health care professionals through Ariadne Labs. We hope our program will augment the tool developed by Ariadne Labs and will help health care professionals have meaningful advanced care planning conversations and improve outcomes for patients with life-limiting disease.

607 Developing clinical reasoning skills for family medicine trainees using virtual interactive cases

Esther Rosenthal, MD, Toronto, ON

Context: Virtual interactive case (VIC) software was developed by Toronto General Hospital in order to create simulations of clinical patient encounters and assess competency in clinical reasoning. Given the recent emphasis on continuous formative assessment in medical education and the difficulty of faculty providing longitudinal clinical reasoning assessments, VIC provides an adjunct for teaching and evaluation. Recently, we developed cases specifically for training and evaluating students' clinical decision making in family medicine. Each series of cases is based on a differential diagnosis of a presenting complaint; so far, complete sets have been created for chest pain, edema, shortness of breath, headache, and vertigo. For each of these presenting complaints, participants work through taking a history, performing a physical exam, and choosing appropriate investigations and consultations. At the end, the student selects the most likely diagnosis and management. Unique to VIC cases is the opportunity for students to review not only whether they arrived at the correct diagnosis and management plan, but also whether they performed essential actions versus inappropriate actions, and the total time and cost that they spent in order to achieve the diagnosis. In addition, feedback about the reasons for choosing different actions and tests is provided to students. **Objective:** This poster will show screenshots of VIC cases and describe their development. Furthermore, our team intends to disseminate this type of medical education tool and facilitate transferability of cases within family medicine. The cases have been reviewed by staff and students and adjusted based on feedback; feedback comments will be shown on the poster. Overall, these highlight the unique interactive nature of VIC, as well as the comprehensive debrief content. Students enjoy the process involved, and the feedback on their chosen actions as well as time and money spent. **Conclusion:** VIC cases allow students to not simply learn medical content, but actually practise making clinical decisions and consider health system issues such as costs of investigations. We present VIC cases in order to highlight the utility of these types of interactive cases within family medicine education and evaluation.

608 CANCELLED

609 Honour thy mother and father: Truth telling and respect for the elderly

Melodie Adler, MD, Kingston, ON

This was a PGY-2 resident project at Queen's University in Kingston, Ontario. This is not quantitative or qualitative research, but rather an ethics paper that took me on a detailed journey through Jewish and secular health ethics literature. Our Canadian medical training implores us to tell the truth to our patients about their diagnosis and treatment options, always. However, the decision of whether to tell the truth to elderly patients by families is a universal dilemma across

many cultures. In the ethics literature, there is much written on pulling the plug, advance care planning etc., but little on the clinical approach/framework of how we should respect our elderly patients and how to show them that respect. My journey began with looking at the commandment “honour thy mother and father” and thinking about how we can enact this as clinicians with our elderly patients. Unstructured interviews were undertaken with key experts in the field—rabbis from the USA and Canada, a Jewish studies professor, a Jewish ethicist, and a Jewish lawyer with a graduate degree in ethics—for advice on sentinel texts from the ethical, legal, and Jewish literature to review. In my reading, I came across many Biblical sources that indicated that for a clinician to show utmost respect to an elderly patient, it may be done by truth conserving rather than truth telling. I then sought to reconcile this with Ontario's Health Care Consent Act. In this presentation, participants will learn about a potentially thought-provoking or even controversial perspective that in Jewish culture, out of respect for elderly patients, it may be ethically defensible if physicians choose not to share the truth about their diagnosis and treatment options. Participants will be challenged to reflect about how health care providers show respect to our elderly patients from almost any culture, be it through truth telling or, it will be proposed, by shielding them from the truth.

610 Promoting workplace health among nail technicians

Irene Chen, MD(c), Toronto, ON

Context: Nail technicians are often vulnerable immigrant workers with exposure to skin hazards.

Objectives: To describe the occupational health concerns, barriers to improving workplace health, and perceived resource needs among Chinese immigrant women working as nail technicians.

Design: A qualitative study was conducted in Chinese, via purposive sampling, semi-structured interviews, and thematic analysis. Ethics approval was granted by the University of Toronto Ethics Review Board. **Participants:** Five immigrant Chinese women in the nail salon industry who work in Toronto, Canada. **Findings:** Nail technicians were concerned with chemical exposures. Barriers to addressing their workplace health concerns included a lack of self-protection knowledge, the desire to keep their job, and the precarious nature of salon work. Nail technicians would find print resources in simple language and that were visually pleasing to be helpful and informative.

Conclusions: Immigrant Chinese nail salon workers have a number of health concerns, including skin exposure to chemicals. Attitudes toward their job, salon owners, and how to cope with difficulties are barriers to addressing these health concerns. Findings from this study will further inform resource development and knowledge dissemination among this vulnerable population.

611 Stresses, strengths, and resilience in adolescents

Kristen Reipas, PhD, MD (Candidate), Kingston, ON

Context: Resilience mitigates the negative effects of stress, allowing individuals to flourish physically and psychosocially, and is dynamic throughout a person's lifetime. Identification of at-risk youth would provide opportunities for intervention. However, resilience assessments are not routinely performed in clinics, nor do we have a thorough grasp on youths' sources of stress and strength or how to identify those who are struggling. Using a qualitative approach we give voice to adolescents' own insights and aim to identify sources of resilience with a depth that may not be possible using quantitative scales and which may be adapted for use in primary care. **Objective:** To identify the supports, attributes, and strategies youth deem most useful for building strength and managing stress. **Design:** In this qualitative study we conducted in-person interviews, asking youth open-ended questions regarding their sources of stress, strength, and whether they felt they were managing stress adequately. Thematic coding of electronically transcribed responses was

performed using NVivo qualitative data analysis software and conceptual themes were identified.

Participants: Adolescents from 13 to 16 years of age were recruited from a family medicine practice in Kingston, Ontario, and the Marathon Family Health Team, Marathon, Ontario.

Findings: A total of 59 adolescents participated (40% response rate). The majority (83%) of adolescents felt proficient at managing stress. Leading sources of stress were schoolwork and arguments with friends/family. Youth found strength through: 1) social connectedness, such as close relationships with family and friends; 2) self-reliant activities, such as individual exercise, music, and drawing; and 3) personal attributes, such as not easily becoming stressed, maintaining a positive attitude, and feeling proficient at stress management. They used a variety of approaches to working through stress, which demonstrate aptitude in key domains of resilience. **Conclusions:** Most adolescents are resilient and manage to thrive despite stress by drawing on inner attributes and external resources. Directly asking youth whether they feel they are managing stress effectively identifies youth who are struggling and who would have been missed using demographic indicators alone. This is an ideal clinical approach as it is efficient and engages youth in conversation allowing for opportunities to build and reflect on strengths.

612 Changing the course of children's chronic pain: A needs assessment of primary care providers

Sonya Swift, MD (Candidate 2018), Halifax, NS

Context: Due to the limited geographical distribution of pediatric tertiary care facilities, rural Canadian pediatric patients face barriers to accessing care. Pediatric chronic pain patients are one such example of a population significantly affected by this barrier. **Objective:** Using pediatric chronic pain as the example, this study examined rural primary care practitioners' (PCP) successes, challenges, and suggestions for resources to augment the ability of PCPs as they manage unfamiliar patient problems, locally. **Design:** A thematic analysis was applied to qualitative data collected through semi-structured interviews. **Participants:** The target population was PCPs in rural Nova Scotia. Ten PCPs (8 family physicians, 2 pediatricians) from rural areas of Nova Scotia who had referred patients to the Halifax Complex Pain Team and six non-referring PCPs (all family physicians) were interviewed in person or by phone. **Instrument:** The ad hoc database of interview data was transcribed and then analyzed using a qualitative content analysis methodology.

Findings: Three broad categories emerged: rarity, complexity, and awareness and accessibility. PCPs had little knowledge of, and some discomfort with, pediatric pain management. Situational dependence, pharmaceutical wariness, and interacting with parents further compounded management issues and added complexity to the family physician's role in this context. Many PCPs were unaware of the existence of the Complex Pain Team and few reported receiving consult notes from the Team. Participants suggested a chain of communication wherein a pain specialist, upon receiving a patient referral, would send the PCP a one-page information sheet about management techniques and relevant patient (and parent) resources. **Conclusion:** This study provides a picture of the context within which rural PCPs practise, and their knowledge and needs when caring for children and adolescents with chronic pain. Our findings have probable applications for jurisdictions outside of Maritime Canada in regions that are not densely populated or have few tertiary care facilities.

613 Adolescent outreach: An innovative approach to reaching youth

Purti Papneja, Toronto, ON

Adolescents' health and well-being depends on easily accessible medical, reproductive, and mental health care services. In the United States, many school-based health care centres exist and

evidence suggests they are popular among adolescents and provide important health care services. In Ontario schools, health care is available in forms of visits from public health nurses and counsellors for mental health services. Currently, physicians are not regularly involved in providing health promotion and education in schools. In addition, there was limited exposure to adolescent health in family practice residency at our hospital. In order to close the gap between Sunnybrook family medicine residents' exposure to adolescent health and improve accessibility to health care for adolescents, this program was created in 1988. The objectives of program are to provide health education and prevention to adolescents, increase awareness of adolescents' health issues and level of confidence among Sunnybrook's family medicine residents, and to increase adolescents' comfort level approaching family physicians. Teams consisting of a few family medicine residents with staff supervision (family medicine or psychiatrist), dietician or social worker as needed, visit prearranged classrooms of local community schools. Each session is approximately 1 hour long, with approximately 25 students in attendance. The adolescent students have the opportunity to submit written questions anonymously and ask questions directly on pre-identified topics. Topics covered in the past 2 years include depression, anxiety, substance abuse, body image and nutrition, sexual health, stress management, anger management, bullying, and healthy relationships. Teams led by residents use various interactive methods such as games, quizzes, and small group activities to engage adolescents. The results of student surveys show that these sessions result in their increased knowledge and they feel secure and comfortable during these sessions. Current challenges include scheduling and limited human resources as these sessions are typically run during health classes that are semester based. As a result, most sessions occur in December to February. This causes challenges balancing required clinical duties and providing adolescent outreach for both residents and faculty. In order to fully measure the impact of this program, a longitudinal study involving both high school students and residents needs to be done.

614 Barriers and Benefits of Advance Care Directive Discussions in Primary Care

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Context: In the changing landscape of medicine, advance care directives are an important aspect of ensuring that a patient's health care wishes are met. As advocates for their patients, family physicians are key players in the discussion of health care directives. Unfortunately, there is a relative paucity of Canadian literature estimating the rate of advance care planning discussions in Canada and the barriers and benefits perceived by physicians surrounding this topic. **Objectives:** To determine the rate of advance care planning discussions in primary care in both resident and staff physician practices while identifying the perceived barriers and benefits of having these discussions. **Design:** A qualitative and quantitative survey of 95 family practice staff and residents from an accredited family medicine teaching site who have some part of their practice in primary care. This study builds off a 2014 study with similar objectives performed in the same setting. Participants were asked about practice demographic data, whether or not they routinely discuss advance care directives with their patients, and barriers to these conversations. **Results:** Initial results show a response rate of 54%. Of the respondents, only 23% report having routine advance care directive discussions. This is less than that reported in the Canadian literature and much less than initially expected from the similar study in 2014. When compared with staff physicians, residents report less comfort with advance care directives and thus less routine discussion. All respondents list time as the major limiting factor to having advance care directive discussions, but also site lack of knowledge surrounding resuscitation successes and lack of advance care planning resources as barriers. Finally, all respondents confirm that having pamphlets, advance care

directive forms, and other resources more readily available would significantly increase their likelihood of having advance care directive discussions. **Conclusions:** Routine advance care directive discussions are a rarity in family practice across multiple levels of training. While time is the most commonly identified barrier, it is possible that increasing training and easy access to advance care directive resources may increase the rate of advance care directive discussion in primary care and increase patient advocacy.

615 An innovative approach to falls risk management and geriatric assessment: A community partnership

Vivian Ewa, MBBS, CCFP (COE), FCFP, FRCP Edinburgh, Calgary, AB; Lisa Paton

Context: An integrated home program incorporating an existing falls risk management team and the geriatric consult team (GCT) was developed to provide care to complex home care clients. The objectives of this program were to provide in-home comprehensive geriatric assessment in addition to a focused falls risk assessment for high-risk patients, with the goal of reducing acute care use and supporting functional independence at home for patients and their caregivers. In the first year of the program, 601 referrals were received, of which 546 were seen. **Objectives:** To evaluate the impact of the program and the unique opportunities presented by the composition of a fall risk management team being embedded within the GCT home care program. **Methods:** An evaluative study of the integrated home care GCT using data from acute care use of enrolled clients over a 1-year period and qualitative data from semi-structured interviews of integrated home care case managers and caregivers. **Results:** Falls-specific referrals equalled 50%, there was a 51% decrease in emergency department visits post referral, a 17% decrease in emergency department use 6 month post referral, and a 7% decrease in acute care admission 3 months post referral. Caregiver reports suggest improved overall quality of life and satisfaction with program. **Discussion:** The GCT provides a unique service in the health care system. The ability to provide in-home assessment to frail elderly patients who are homebound enables access to comprehensive geriatric care. Continuity of care is achieved by bridging communication between the home care case managers, who attend GCT rounds, and community-based physicians. **Conclusions:** Successful components for implementing this model include: interdisciplinary fall risk in-home assessment, in addition to a comprehensive geriatric assessment; timely and effective communication of client recommendations; and facilitation of fall risk strategies to ensure client safety and improved quality of life.

616 Effect of EMR reminders on evidence-based practice patterns in a family health team

Jennifer Young, CCFP (EM), Collingwood, ON

This poster outlines a quality improvement initiative within a family health team that serves 45 community-based family physicians. A set of reminders within Telus PS Suite EMR were updated in April 2014 and family doctors were informed of the changes. Family doctors subscribed to some or all of the reminders. An analysis of the practice changes was performed 1 year later. The reminders that were analyzed were: screening for diabetes, hypertension, and hypercholesterolemia; over-screening (PSA, mammograms for patients aged 40–49 years old, and serum testosterone); and medication monitoring (Lithium, DOACs, Amiodarone, ACE/ARB, Statin). Significant differences were noted in almost all measures in the direction of better quality of care. This is a good example of the first iteration of a PDSA cycle for quality improvement—areas of success and of need for improvement were clarified.

617 **The evolution of an interprofessional module on management of low back pain in primary care**

Monica Nijhawan, MD, CCFP, Newmarket, ON; David Makary, MD

Context/Background: Low back pain (LBP) is a leading cause of disability and global burden of disease. It affects quality of life, productivity, and uses enormous health resources. In response, the Ontario Ministry of Health and Long-term Care has developed clinical tools and educational programs to facilitate evidence-based assessment and care. However, LBP continues to be managed poorly. New educational paradigms are proposed to train health care students to improve collaborative management of chronic conditions such as LBP. **Objective:** To develop an interprofessional educational (IPE) program about LBP in the primary care setting, and evaluate the impact on learners and faculty. **Design:** An IPE module was developed and delivered by staff members, including faculty from Family Medicine, Nursing, Chiropractic, Medical Radiation Technology, Occupational Therapy, Pharmacy, Physiotherapy, and Radiology at Southlake Regional Health Centre. The program has been delivered in three evolving iterations with cohorts of mixed professional learners. Students completed both pre- and post-evaluations. Faculty debriefing and evaluation results guided improvements for future sessions. The third iteration included a patient who presented experience with LBP and illustrated the importance of a collaborative team approach. **Participants:** The module has been delivered on three occasions in 2014–2015, and included a total of 82 learners from the above professions. Outcome Measures The Health Professional Collaboration Competency Perception Scale (HPCCPS) and a questionnaire with Likert scales and open-ended questions were administered pre- and post-session. **Results:** All iterations demonstrated positive results, with noted improvements pre- and post-session. The highest post-session rating was in the cohort that included the patient experience. Faculty concurred that the module had evolved to a higher quality with the inclusion of the direct patient perspective. **Conclusion:** This LBP IPE module resulted in improved understanding and confidence in the co-management and collaboration amongst learners, and appropriate use of health care resources. There was increased knowledge regarding the role and contribution of professionals caring for patients with LBP, and how to collaborate for maximal outcomes. Future work would include evaluating the impact of the module on practice behaviours of participants.

618 **Initial outcomes of a nurse-led chronic pain self management program in primary care**

Lissa Blair, Masters of Science Candidate, Ottawa, ON; Elizabeth Muggah, MD

Context: Chronic pain affects up to one-fifth of Canadians. An interdisciplinary clinical approach has been shown to lead to improvements in the pain experiences of patients. However, there is a dearth of studies on the effectiveness of these approaches in primary care. **Objective:** As an initial phase in a more extensive planned evaluation, we studied the experiences of patients in an innovative nursing-led chronic pain program in a primary care setting. We also tested a new chronic pain self-management and evaluation tool. **Design:** Observational study. **Participants:** Adult patients, with chronic pain, of the Bruyere Family Health Team in Ottawa, Ontario. **Intervention:** Using electronic medical records, a disease registry of adult chronic pain patients was created, selecting for those with established chronic pain, and/or long acting narcotic use for the purposes of pain control. Cancer patients were excluded. Each patient was assessed to establish baseline pain, functionality, and demographic characteristics, based upon a 1-hour appointment with a chronic pain RN. Each received self-management education on chronic pain using the pain management tool and set goals for care. Patients were subsequently assessed for changes in goal status, perceived pain, and confidence in pain self-management. **Results:** Of 157

eligible candidates, 35 patients (23 women and 12 men) were seen by the RN once; 24 (16 women) were seen for a second visit to assess their improvements. The mean age of those seen a second time by the RN (59.75 years) was significantly higher than that of the initial 35 (50.09 years), $P < 0.05$. Twelve patients showed an improvement in their goal status between the first and second visit; four (all of whom were women) showed an improvement on the function scale; nine showed an improvement (decrease) on the VAS pain scale; nine showed an improvement in confidence, with no significant differences in terms of age. Those completing the program had significantly lower baseline pain ($P < 0.01$). **Conclusion:** Though the program was disproportionately completed by those with lower baseline pain scores, this pilot study demonstrates that a nursing-led chronic pain program in a primary care setting is possible and shows benefits.

619 Flu Vaccine: Why don't people get it? Let's get to target!

Huma Numair, MD, CCFP, Oakville, ON; Shahzana Shahzad; Hammaan N. Khan;
Naghmi Shirin; Sabrina Suleman

Context: According to National Advisory Committee on Immunization (NACI) guidelines, 80% of populations at high risk of complications from the flu should receive the influenza immunization each flu season. **Objective:** To identify the high risk population (HRP) and the reasons for not reaching the NACI target, and identify measures to effectively increase their immunization incidence. **Design:** A cross-sectional study. **Participants:** Three hundred and thirty five patients who visited the HFH Clinic in Burlington, Ontario, from November 2015 to January 2016. Divided according to demographics, underlying health conditions (cardiac/pulmonary, diabetes, cancer, etc.), and providing care to children < 5 years old, etc. Intervention Voluntary survey. **Outcome Measure:** Influenza immunization for HRPs. **Results:** Total 335 patients. Age: > 65 years old = 60; HRP < 65 years old = 129. Received flu vaccine: > 65 years old, 49 of 60 (81.7%); HRP < 65 years old, 72 of 129 (55.8%). Vaccine decliners who changed their mind post-counselling in the HRP: > 65 years old, 22 of 57 (38.6%); also declined the flu shot last year (161 of 170, 94.7%); did not believe it worked (87 of 170, 51.1%). Patients who received the flu vaccine and were also counselled by their family doctor: 120 of 165 (72.7%). **Conclusions:** Our study revealed immunization of only 55.8% for HRPs < 65 years old. Counselling regarding their concerns can increase the rate from 55.8% to 72.8%. There is a strong correlation between vaccine decliners who also declined the vaccine last year (94.7%). Of caregivers for children < 5 years old, 19 of 37 (51%) received the vaccine, 18 of 37 (48.6%) declined the flu shot; only 21 of 37 (56.7%) were counselled. NACI recommends that most people older than 6 months be vaccinated against the flu each year, and it set a national immunization target of 80% for groups at high risk of complications from the flu. According to NACI, only 33% of the high risk group < 65 years old received the flu vaccine in 2013/14 (data released October 2015). We can increase the flu vaccination by: 1) identifying the HRP, besides the obvious > 65 years old; 2) identifying patients likely to decline the vaccine; 3) becoming aware of their common reasons for declining; and 4) having an effective and time efficient approach to convincing them to get the influenza immunization.

620 Care-of-the-elderly physicians in Edmonton: Contributing to the care for older persons

Jean Triscott, MD, CCFP (COE), Edmonton, AB

The long waiting time for outpatient geriatric assessment services could affect the health of older persons. We are going to present five innovative care pathways for older persons in Edmonton and surrounding areas. The pathways are: geriatric services in a primary care network (the Seniors

Community Hub); geriatric consult team in home living and supportive living in Edmonton; geriatric evaluation and management in the emergency department; geriatric services in in-patient units; and geriatric services through telehealth. These pathways are: collaborative, involving multiple disciplines and community organizations; accessible through over 30 care-of-the-elderly physicians and geriatricians across 14 sites in Edmonton and surrounding areas; and responsive to the growing demand for seniors care through capacity building and clinical research.

621 Empowering family medicine residents to be effective communicators using the patient-centered clinical method

David Esho, MD, CCFP, Toronto, ON

Context: The patient-centered clinical method is a framework for empowering physicians to achieve a better understanding of patients and their unique illness experience in a patient-centered and time-efficient manner. **Objective:** Given that the communicator role is one of the CanMEDS-FM competencies, we have taken the opportunity to develop an innovative program where first-year residents can practise different aspects of the model while being observed. **Design:** Each resident is paired with another fellow resident for 4 half-day educational sessions over a period of 1 month. Patients are booked during these sessions. Residents select which part of the model they would like to focus on during the encounter. As one resident is seeing a patient, the second resident, along with 2 staff members, view the interaction in a separate audiovisual room in real time. Once the encounter is complete, the group meets to informally discuss how the model was used effectively and where challenges may have been met. **Findings:** This immediate feedback session allows the resident to self-reflect on the encounter. A unique aspect of this program is the opportunity for residents to view and give feedback to each other. In addition, residents are given the chance to video record and critique their own interactions over the course of the month. Several months after the residents have completed the program, their patients are asked to complete a survey that evaluates their patient-centered clinical methods skills. **Conclusion:** This program has been very well received and is consistently evaluated as a key component of the PGY-1 curriculum at the Toronto Western Hospital Family Medicine teaching site.

622 Improving the health of Alberta students through a provincial run club

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Context: Evidence shows that healthy students are better learners but all too often, the health and education sectors work in silos, rather than in tandem. Collaboration between the health and education sectors, due to their interlinked relationship, has enormous potential to lead to improved outcomes for students. If health advocacy or public wellness groups work with schools to foster healthy attitudes and behaviours among students, there can be a ripple effect that improves multiple outcomes at the school, for the students, within the students' homes, and in the community. In this project, an interested group of physicians aimed to work with schools as partners in a health initiative. **Objective:** To institute a program in schools, structured as a partnership between the health and education sectors, to improve students' physical and mental health. The Alberta Medical Association Youth Run Club (AMA YRC) was created and implemented across the province, from 2013 to 2016, with Alberta students from kindergarten to Grade 12 taking part in semi-weekly running and health promotion activities at lunch and after school. This is based on the Kids' Run Club – Doctors Nova Scotia. **Design:** Program evaluation. **Participants:** Volunteer teacher coaches at each school who work directly with the participating students. Instrument Self-reporting survey accessed by coaches through email. The Ever Active Schools' address database was used. **Findings:** The number of coaches responding equalled 55%

(137 of 250): 88% felt that since their school joined the AMA YRC, physical activity level of students increased; 86% reported that implementing the AMA YRC led to positive changes in students' behavior. Year 1 indicates 11,000 students in 233 schools participated. Year 2 indicates 17,000 students in 305 schools participated. **Conclusion:** The AMA YRC is a successful collaborative initiative between the health and education sectors that has improved Alberta students' physical and mental health. Our plan is to extend the reach of this program within Alberta and potentially to other provinces and territories.

623 Building a maternity care network in urban family practice

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Context: Urban family physicians' (FP) role in maternity care has reduced due to increasing complexity of obstetrical care, difficulty balancing office/hospital practice, and insufficient caseload to maintain competency. The Vancouver Division of Family Practice (VDoFP) has identified maternity care as a priority area, given that all FPs provide care to pregnant women, whether or not they attend births. **Methods:** The workshop series for family physicians who do not attend births is a partnership between VDoFP, the University of British Columbia's Continuing Professional Development (CPD) and the Practice Support Program (PSP). Presentations cover best practices in maternity care on a wide variety of topics such as early prenatal care, perinatal mental health, and prenatal genetic screening. Case studies and resources further facilitate knowledge application while table discussions—facilitated by FPs providing full-spectrum maternity care—maximize mentorship, network building, and referral opportunities. Data for prenatal genetic screening and evidence-based, individualized practice coaching sessions from the PSP serve as tools for practice change. PSP practice coaching is a service that provides physicians and their staff with assistance to implement and sustain changes in their practice that result in higher quality and more efficient maternity care. Pre- and post-surveys and written reflections capture the impact of the workshop. **Results:** A total of 372 participants attended 8 workshops. Participants' comfort providing maternity care increased significantly from before the workshops ($M = 4.27/7$, $SD = 2.41$) to after the workshops ($M = 5.04/7$, $SD = 1.94$); $t(471) = 6.01$, $P < 0.001$. Connectedness to FPs who provide full spectrum maternity care increased significantly from before the workshops ($M = 3.68/7$, $SD = 3.13$) to after the workshops ($M = 4.75/7$, $SD = 2.36$); $t(460) = 7.31$, $P < 0.001$. Of the 258 participants offered coaching sessions, 59 (23%) physicians participated. The impact on maternity care provision includes more systematic visits through higher efficiency workflow, greater resource awareness, timely investigations, and improved referral networks. **Conclusions:** Workshops addressed a perceived need within urban practice. This novel approach of collaboration between CPD providers, physician organizations, and the PSP to facilitate knowledge exchange, mentorship, quality improvement, and cultivation of a maternity care network is timely and applicable to other contexts.

624 Education as identity construction: Training for continuity of care in family medicine residents

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Context: The College of Family Physicians of Canada identified continuity of education and patient care as a key component of the 2011 Triple-C competency-based curriculum for residency training. However, the most effective method of teaching continuity of care (CoC) in training programs is still debated. **Objective:** To understand how residents experience learning CoC, and the effectiveness of a complex educational intervention targeted towards integrating CoC into

residents' identity at multiple levels of the postgraduate curriculum. **Design:** This study is a longitudinal mixed-methods design with two interrelated but distinct phases. We used an identity construction framework to design a CoC training model that would be relevant, transferrable to future practice, and suggest appropriate evaluation outcomes. **Participants:** The population for this study consists of one cohort of residents in the Department of Family and Community Medicine at the University of Toronto, and their clinical preceptors, along with a control group at a comparable community-based teaching site in Toronto. **Intervention:** We will describe a System Resident Preceptor Intervention (SRPI) that is being delivered to one cohort of residents and preceptors, which includes structural initiatives to enhance learning CoC (eg, remote EMR access), an orientation workshop for trainees, and faculty development (initial workshop and ongoing support). Additionally, this intervention has introduced new formative assessments in the form of a reflective practice exercise about specific patient experiences, and a CoC in-training evaluation rating (ITER; CC-ITER) for preceptors to evaluate residents' CoC competencies. **Outcome:** We will present a novel CoC educational approach and preliminary results of a 2-year longitudinal comparative evaluation of a SRPI. New formative assessments will be reviewed. **Conclusions:** Curriculum design for CoC can benefit from adopting identity construction frameworks. The result will be a generalizable framework for teaching and assessment standards for CoC in community-based teaching programs.

625 Advocating for the advocacy role: Key student learning from an advocacy project within the University of Toronto longitudinal integrated clerkship (LIC)

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Background/Purpose: Advocacy is a CanMEDS and Accreditation Council for Graduate Medical Education (ACGME) core competency that can be challenging to teach and evaluate. In 2014, the University of Toronto (U of T) introduced a longitudinal integrated clerkship (LInC), which has 29 students enrolled to date. This LInC provided an opportunity for innovation in advocacy teaching. To address this curricular competency, a formal advocacy project was designed and implemented. **Methods:** Students identified a patient from their longitudinal clinical experience for whom social factors were significantly affecting patient health and prepared an advocacy plan. Projects consisted of a presentation and an abstract reflection, completed over 5 months. To date, 29 students have participated and were formally evaluated on the presentation and abstract/reflection. Faculty and students will provide feedback on the feasibility and utility of the project. The topics chosen and abstract reflections will be qualitatively analyzed to identify themes that the students identify as important in learning the advocate role. **Results:** To date, students have explored interventions regarding medication access, housing, smoking cessation, and food security. Early feedback from the initial 7 students revealed that they found the project feasible and meaningful. Further student and faculty feedback will be collected in the year-2 expanded program. Analysis of the 29 advocacy projects will also be reported. **Conclusions:** The U of T LInC program successfully implemented a feasible advocacy project in its pilot that integrated a formal advocacy experience and evaluation of this core competency. It will continue as part of the LInC, with further evaluation as it expands, guiding future curriculum development of advocacy training within the U of T LInC and its applicability to the block clerkship.

626 Health professional educator (HPE) faculty leads: Role implementation, early impact, and future directions

Judith Peranson, MD, CCFP, MPH, Toronto, ON; Deborah Kopansky-Giles, DC, FCCS, MSc

Context: The transformation of primary care teaching units across Canada into interprofessional teams has created new opportunities for health professional educators (HPEs) to take on roles as educators in family medicine (FM). **Objective:** Historically, the integration of HPEs into FM training programs has been implemented on an ad hoc, informal basis, and there is a growing imperative to identify the structural and process supports that enable a quality cross-professional education experience for both learners and teachers. **Design:** Descriptive case study. Participants HPE teachers in the largest FM teaching program in Canada. **Intervention:** In 2015, the Department of Family and Community Medicine (DFCM) at the University of Toronto created new HPE faculty lead roles housed within its professional development program to identify needs and implement supports for HPEs across the department. An initial needs assessment of HPEs indicated that their ability to fully engage as teachers in FM has been limited by a number of barriers including: limited time carve-out for teaching in their clinical schedules; insufficient formalized training to be teachers; absence of feedback or evaluation on teaching efforts; few opportunities to contribute to learner assessment; and lack of awareness of faculty status and the benefits of faculty appointment. **Outcome Measures:** Facilitators and barriers to implementation of the new HPE faculty lead roles as well as initiative deliverables achieved in year one. **Findings:** Alignment with existing program structures, paired MD and HPE champions, administrative support, broad departmental dissemination, and opportunities to pilot new initiatives were key project enablers leading to improved uptake of faculty appointment applications and the establishment of a new community of practice for HPEs through which future initiatives will be launched. **Conclusions:** The DFCM HPE faculty lead position is a model of a professional development and organization change initiative that could inform other training programs looking to purposefully enhance the integration of HPEs into FM education.

627 Advance care planning in primary care: A survey of resident barriers and facilitators
Sadaf Siddique, MBBS, FCPS, Calgary, AB

Context/Objective: The purpose our study was to identify major barriers and facilitators perceived by family medicine (FM) residents to holding advance care planning (ACP) discussions in their core clinics. **Methods:** We conducted an online survey of both PGY-1 and PGY-2 residents in the University of Calgary Urban Family Medicine program. The questionnaire was developed using the theoretical domains framework proposed in a 2005 study. The domains explored included knowledge, skill, self-efficacy, beliefs about capabilities, beliefs about consequences, role identity, emotions, environmental context, and resources. The questionnaire included 39 close-ended questions using a 5-point Likert scale and three open-ended questions. The statistical analysis was descriptive, detailing various facilitators and barriers in reference to the domain being explored in a particular question or set of questions. Statistical analysis appropriate to the class of variable was performed using SPSS. **Results:** The following factors were perceived as facilitators by residents: exposure to ACP in medical school; ACP sessions in foundations and palliative care blocks; prior documentation of goals of care; patient/family initiation of conversation. Residents believed in beneficial consequences of ACP. Residents perceived lack of patient/family readiness a barrier, as was patient/family emotional discomfort. Lack of role clarity in the clinics, and lack of awareness of resources for ACP and difficulty in accessing them were also perceived as barriers. Residents identified the need for preceptors to facilitate ACP discussions in the clinics. They also mentioned the need for more practise in communication skills via role play. **Conclusions:** We suggest implementing residency program curriculum changes to overcome the identified barriers to ACP discussions and that steps should be taken to promote ACP practice amongst preceptors to improve residents' experience in ACP in outpatient settings.

628 Advance care planning discussions in the primary care setting

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Although the importance of advanced care planning (ACP) is recognized by both physicians and patients alike, conversation surrounding the topic is not consistently broached in primary care settings. Numerous barriers to these discussions have been identified, relating to both the providers as well as the health care system. Some of these include lack of skills, difficulty with timing of conversation, and limited resources. With the advent of electronic medical records, opportunities are available to remind physicians to consider ACP. This project aims to improve the rate of ACP discussion during annual health exams for patients over 65 years old in a regional family medicine clinic, which also serves as a Western University family medicine teaching site. Changes were made to existing annual health exam forms, adding a reminder for physicians to broach the topic of ACP. In addition, an information session was completed to increase physician comfort and knowledge related to ACP discussions. After executing these interventions, the completion rate of ACP discussions during annual health exams for patients over 65 years old increased from a baseline of 0.54% to 62%. In addition, physician comfort level either remained constant or increased after the information session. Differing rates of ACP discussion were found between staff (0%) and residents (100%). Barriers to ACP discussion were likely related to time constraints, and lack of financial incentive. The results of the project are quite promising; however, further research is needed to find more creative ways to encourage physicians to complete these crucial conversations.

629 Preopsys

Ganesan Abbu, MB, ChB, CCFP, FCFP, Winkler, MB

Health care functions in an arena of enormous waste. Millions of dollars are spent each year on unnecessary routine pre-operative tests. Chest X-rays for routine investigations yield very few diagnoses, have many false positives, and do not predict post-operative outcomes. Yet thousands of pre-operative X-rays are routinely ordered. Preopsys is an app that I (a GP Anesthetist) developed in collaboration with a graphic designer and software programmer. It is innovative in that it takes a cumbersome and poorly followed paper-based system and transforms it into an app that is simple to use, quick (< 30 seconds), accurate, and secure for patients having elective surgery; only the required tests are displayed. Patient demographics are not required, so privacy is not an issue. The app can be used free-standing or backed onto existing electronic medical records to provide seamless generation of a laboratory requisition. The app dovetails with Choosing Wisely Canada's initiative to reduce unnecessary routine preoperative tests.

630 Recruiting participants for primary health care (PHC) research projects during medical appointments: Physician and patient views

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Context: Physicians in family medicine teaching units (FMTU) are often asked to recruit participants for primary health care (PHC) research projects during medical appointments. Physician and patient views on this way of recruiting participants is not known. **Objectives:** To assess physician and patient views regarding the recruitment of participants for PHC research projects during medical appointments, and to identify alternative methods to explore. **Design:** Descriptive cross-sectional study. **Participants:** All physicians (n = 17) and training physicians (n = 18) working in one Quebec FMTU for at least 6 months. All patients 18 years and older, able to read French, interested in participating, and presenting for an appointment at the FMTU. Target

sample size was 100 patients (9.8% margin of error). **Intervention:** Self-administered questionnaires, one for physicians and one for patients. Questionnaires were developed by the investigators based on a literature review and field experience. They included multiple choice questions using a 5-point Likert scale and were validated among patients and PHC professionals. **Outcome Measures:** Descriptive analysis. **Results:** A total of 33 physicians (response rate 94%) and 101 patients (response rate 70%) completed the questionnaires. Sixty-four per cent of physicians had already recruited participants. Among the patients, 36% found their experience satisfactory. Only 10% of patients had already participated in a PHC research project and 62% would like to. Physicians and patients found no negative impact of recruitment on quality of care (84% and 99% respectively) and therapeutic relationship (88% and 99%). The main challenges reported by physicians were identifying potential participants (67%) and explaining projects (55%). The consultation of medical records by other PHC professionals working at the FMTU to verify patient eligibility (94% of physicians and 56% of patients agreed) and contact with potential participants by a research agent (91% of physicians and 56% of patients agreed) were alternatives identified. **Conclusion:** Although patients are interested in participating in PHC research projects, recruiting participants during medical appointments is challenging for physicians. Qualitative studies are needed to explore alternative methods and eventually standardize participant recruitment in FMTU in a way that will better respond to physician and patient needs.

631 Évaluation d'un cursus de résidence en médecine familiale triple C à l'UMF du Nord de Lanaudière

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Contexte : Le CMCF recommande aux facultés de médecine du Canada de développer leur cursus de médecine familiale en l'axant sur le développement des compétences, en visant des soins Complets et globaux, orientés vers la Continuité et Centrés sur la médecine familiale. L'UMF du Nord de Lanaudière a conduit une refonte de son cursus en 2014 pour répondre à ces impératifs.

Objectif : Le projet suivant vise à évaluer les impacts d'un nouveau cursus trimestriel intégré de médecine familiale développé et implanté à l'UMF du Nord de Lanaudière. Pour ce faire, nous avons utilisé des questionnaires d'auto-évaluation selon les quatre niveaux de Kirkpatrick (Appréciation, apprentissage, comportement, résultat). Les questionnaires ont été administrés auprès des résidents du programme durant et après la refonte du programme de façon rétrospective et prospective. **Résultats :** Les résidents ayant évolué dans le nouveau cursus trimestriel intégré se sont montrés satisfaits du cursus (>90%). De même, une progression significative de l'auto-évaluation de leurs connaissances dans les différents domaines clés d'apprentissage (livre rouge CMCF 2013) a été observée. Au niveau des comportements, nous avons pu objectiver une progression significative de la perception de leur niveau d'autonomie dans l'accomplissement de différentes activités professionnelles (entrustable professional activities). Le cursus semble même avoir comblé certaines lacunes par rapport à des évaluations antérieures. Enfin, le cursus a démontré sa capacité à préparer les résidents à offrir des soins à des populations variées, dans des contextes différents (selon leur auto-évaluation). De même, les résidents du cursus se sentaient très majoritairement prêts à exercer leur rôle de médecin de famille et avaient dans une large proportion l'intention de pratiquer des soins de prise en charge (>90%).

Conclusion : Le cursus trimestriel intégré développé à l'UMF du Nord de Lanaudière, en respect du programme de résidence en médecine familiale de l'Université Laval, semble apte à développer chez les résidents les compétences requises pour dispenser des soins complets, continus et centrés sur la médecine familiale.

632 **Fiche d'évaluation critériée des compétences pour la résidence en médecine familiale : développement et validation**

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Contexte : Avec l'adoption de son cursus axé sur les compétences, le Collège des médecins de famille du Canada invite les programmes de résidence en médecine familiale à fournir au corps professoral des outils pour guider leur évaluation de la progression des résidents, tels que des jalons observables qui définissent les attentes à des étapes significatives de la formation. **But :** Développer une fiche d'évaluation critériée des compétences (FECC) à utiliser en fin de stage ou comme rapport de progression, qui repose sur des indicateurs de développement (IDD) représentatifs des attentes du corps professoral quant au moment d'acquisition des différentes compétences CanMEDS-MF durant la résidence et précisant les périodes charnières pour différents niveaux de compétence attendus. **Méthodes :** Les intervalles attendus pour démontrer diverses compétences ont d'abord été définis auprès de 33 cliniciens enseignants par méthodologie Delphi pour établir les IDD en médecine familiale de l'Université Laval (IDD-MFUL), dont la validité de contenu et de convergence ont été vérifiées. Un programme informatique a ensuite été développé sous la forme d'une FECC, afin de relier les différents niveaux de compétence (peu autonome, partiellement autonome ou autonome, définis par des comportements observables) aux intervalles des IDD-MFUL, identifiant automatiquement si la compétence est développée de façon précoce, attendue, limite ou tardive. La validité du processus de réponse a été évaluée. Advenant une/des compétence(s) limite(s) ou en retard(s), le système identifie les diagnostics pédagogiques possibles et suggère des prescriptions pédagogiques issues de la littérature. **Résultats :** Les IDD-MFUL en médecine familiale illustrent, dans le temps, le développement de 34 compétences réparties sous les sept rôles CanMEDs-MF selon trois niveaux de compétences. La FECC qui en découle a été ajustée selon les résultats de la validation du processus de réponse. **Conclusions/implication :** Les IDD-MFUL et la FECC peuvent être utilisés comme outils d'enseignement pour guider le développement des compétences ou d'évaluation (fin de stage ou rapport de progression). Une étude de cohorte initiée avant l'implantation du nouveau système permettra de valider les propriétés psychométriques sur un plus large échantillon et d'évaluer l'impact de la FECC sur la qualité des évaluations, sur les cliniciens enseignants et les résidents.

633 **Creating a better letter: Tips From consultant physicians for improving family doctors' referral letters**

Lynn Peterson, MD, Calgary, AB; Lana Fehr

Context: Clear communication between family physicians and subspecialists is vital to safe and efficient patient care. Time is precious; therefore, selecting the right amount and type of information is key. **Objective:** To address the question, how can family physician referrals be improved from the subspecialist point of view? **Design:** A mixed methods approach was used, with an online survey for data collection. Both purposeful and snowball sampling were employed. The study was approved through the Conjoint Health Research Ethics Board at the University of Calgary. **Participants:** A diverse sample of over 100 consultants in the Calgary area participated. Inclusion was broad—any physician who receives referrals from primary care physicians. **Intervention/Instrument:** The short survey included Likert scale questions, rating the aspects of referral letters deemed most to least important, yes/no questions, as well as some open response style. **Outcome Measures:** Quantitative analysis was performed through SPSS; qualitative data was analyzed with thematic analysis based in grounded theory. **Results/Findings:** Quantitative analysis showed the highest ranked elements were specific question(s), relevant recent investigation(s), and a short history of the presenting illness. Least important were allergies and social context.

Qualitative results revealed five themes for great referrals: specificity, appropriateness, clarity, honesty, and completeness. Common things to avoid included pages of labs or investigations, irrelevant information, and sending patients for whom the subspecialists' treatment options were not desired or not appropriate. **Discussion:** Results from our study highlighted the facets of referral letters that are perceived as most important, least important, as well as general overarching themes to consider in creating a great referral. By providing small, practical tips for our family physician colleagues, from the perspective of the receiving physicians, we reinforce the importance of solid communication in striving to have our patients triaged appropriately and quickly. **Conclusion:** Content rated highly important to include in referrals was agreed upon by many subspecialists, and aligned with prior research in the area. The results of our study are helpful reminders for both graduating family physician residents as well as seasoned physicians.

701 Speak up for health! Mammogram patient engagement project

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Context: Numerous studies have demonstrated that immigrant populations are less likely to undergo cancer screening compared with the Canadian-born population. Research from the US and UK illustrates that Black women have a higher mortality rate from breast cancer. There is a paucity of research about the specific barriers to cancer screening and the most effective interventions to increase screening rates in Black and immigrant populations. TAIBU Community Health Centre (CHC) serves the Black community in the Greater Toronto Area as well as the largely immigrant populations of Malvern, Toronto. **Objectives:** To identify community-specific barriers to breast cancer screening and promising practices to increase breast cancer screening rates at TAIBU CHC. **Design:** A mixed methods approach consisting of a questionnaire and focus group was used. An Afrocentric lens was applied to engage the local Black and immigrant communities. **Participants:** Thirty-six women 50–74 years old who were patients or clients of TAIBU CHC completed the questionnaire. Women from the local Malvern community, including clients and patients of TAIBU CHC, participated in the focus group. The majority of participants in the questionnaire and the focus group identified as Black. **Instrument:** Quantitative data was collected using a questionnaire completed by the participants previously described. The questionnaire was comprised of questions that collected sociodemographic data, current knowledge and beliefs related to mammography, and recommendations for increasing mammography rates. TAIBU CHC held a focus group on June 3, 2015, during which facilitators supported a community discussion around access to information about breast cancer, beliefs and concerns around breast cancer and mammography, and how screening rates can be increased. **Findings:** The greatest barriers identified were pain/discomfort, insufficient information about screening, and denial about susceptibility. Cultural representation in media, information sessions, and group discussions were identified as promising practices. **Conclusions:** A mixed methods approach focused on community engagement identified barriers to breast cancer screening and promising practices to increase breast cancer screening rates specific to Black and immigrant communities in Toronto. Addressing barriers and implementing promising practices should lead to increased screening rates and decreased breast cancer mortality in these populations.

702 Patient preferences regarding code status discussions and a facilitated model of advance care planning discussions

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Learning Objectives: At the conclusion of this activity, participants will be able to: 1) Decipher prevalence of code status discussions amongst patients older than 65 years presenting to an acute

care hospital emergency department; 2) Explore current patient experiences, preferences, and perceived barriers with code status discussions; 3) Experience an improved understanding of ACP; 4) Recognize common pitfalls of ACP in primary care settings; and 5) Explore practical solutions to address these issues. **Context** Advance care planning (ACP) is a process of discussing patient values and wishes with regard to future health care needs including but not limited to end of life care. Ideally, ACP occurs prior to acute deterioration; however, many Canadians have not had ACP discussions. In the absence of ACP, patients may receive unwanted and inappropriately invasive care. In addition, prevalence of formal code status amongst adults in Canada is low; in some jurisdictions, only 4.3% to 19.3% of adults over 70 years had formal documentation. Unclear preferences often causes discrepancies between the wishes of a dying patient and actual care. When people discuss their wishes prior to deterioration, there is reported improved satisfaction of care from patients and their support network, and decrease in caregiver burnout and depression. When carried out well, ACP aligns treatment with a patient's wishes and increases patient autonomy. **Objectives:** 1) To determine the prevalence of patients older than 65 years presenting to the Michael Garron Hospital emergency department in the East Toronto Health Link, with prior code status discussions. 2) To explore the perceived barriers to having this discussion with primary care physicians or providers. 3) To identify barriers to code status discussion. By identifying discrepancies between patient preferences and experiences, as well as identifying patient-perceived barriers to ACP discussions, we hope to facilitate a patient-centered framework to approaching these discussions. As such, both physicians and patients may feel more comfortable exploring decisions surrounding ACP and end-of-life care and do so more routinely, thereby respecting patient autonomy, preventing undue harm to patients and their families, and decreasing unnecessary expenditure of resources. **Study Design:** A multiple choice survey was developed by the study co-authors, which included demographic characteristics, health-related characteristics, presence of code status discussion, and code status discussion experiences/preferences. **Population:** The study was administered to patients in the Michael Garron Hospital emergency department at various time periods during January and February 2016. **Outcome Measures:** Assessing prevalence and identifying current patient experience/preference, health status at the time of discussions, setting for discussions, and barriers to code status discussions. **Results/Conclusion:** The majority of patients older than 65 years with low to moderate acuity complaints have not discussed code status with a health care professional. Patients prefer either their family doctor, themselves, or family members to help initiate the conversation. The majority of patients prefer to discuss code status at their doctor's office, though in reality it often also occurs in the emergency department. Patients prefer to have the conversation when they are healthy or first diagnosed with a serious medical condition yet most occur either with diagnosis of a serious medical condition or upon presentation to the emergency department.

703 Through the eyes of family medicine residents: Longitudinal Triple C competency-based curriculum versus rotational training

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Context: The training of FM physicians in Canada is adapting to changing demands in our patient population. The longitudinal Triple C Competency-based Curriculum was designed to train FM physicians using an outcome-focused and FM-centered method. Tracking and documenting set competencies, in contrast to the traditional time-based strategy, allows for a tailored and more individualized training of each resident. **Objective:** To determine if a longitudinal Triple C Competency-based Curriculum is more effective producing family physicians, who can competently serve a varied patient population in more practice environments, than traditional rotational training. **Design:** To achieve our objective, perspectives of FM residents and physicians

who participated in Triple C Competency-based Curriculum residency training are compared with those who participated in rotational training, at Dalhousie University, Annapolis Valley (Dalhousie). Two electronic surveys were used to collect the insights from current residents and recent graduates. These surveys included both qualitatively and quantitatively scored responses. Participants Includes the following 4 groups (n = 10/group): currently enrolled first and second year FM residents in the Dalhousie FM Triple C Competency-based Curriculum residency program; currently enrolled FM residents, training in a rotational based residency program at Dalhousie; graduates from the Dalhousie FM residency program; and graduates from Dalhousie FM rotational residency programs (class of 2014/2015). **Findings:** Response rate to the surveys was 100% among the Dalhousie FM residents and practicing graduates. Based on the preliminary results, current residents in the Dalhousie Triple C Competency-based Curriculum have a greater overall satisfaction rate when compared with residents in a rotational-based program. Likewise, practicing graduates of the Dalhousie program expressed increased confidence and competence to practise FM in a variety of settings including office, hospital in-patient care, and rural emergency departments. **Conclusions:** The Dalhousie Triple C Competency-based Curriculum training provides its residents with the ability to individually tailor knowledge and skills acquisition. The results are optimized competency and confidence in caring for a wide variety of patients across a spectrum of FM practice settings.

704 Postpartum practices in primary care

Adelaida Neata, MD, Toronto, ON; Peter Tzakas; Esther Chan

Objective: To determine the prevalence of patients requiring early postpartum care (prior to 6 weeks postpartum) and identify whether the family physician believes that there is a need for an early postpartum visit dedicated to maternal health. **Methodology:** A cross-sectional chart review was done at South East Toronto Family Health Team (SETFHT) to determine the prevalence of patients requiring early postpartum care; 50 charts were reviewed. In addition, a web-based questionnaire that explored current postpartum care practices and opinions regarding the need for an early postpartum visit was sent to all 23 SETFHT family physicians. **Results:** The chart review revealed that 80% of postpartum patients had at least one early postpartum encounter ($P < 0.0001$, confidence interval ± 11.09) and 64% of visits took place in the first 2 postpartum weeks. First-time mothers had significantly more postpartum encounters than experienced mothers. The survey response rate was 65% (15 respondents) and revealed that only a minority (27%) of family physicians believe that there is a need for a dedicated postpartum visit prior to 6 weeks postpartum; however, a majority (87%) would like more guidelines in this area of practice. **Conclusions:** Given the high prevalence of maternal health concerns at < 2 weeks postpartum, family physicians may want to consider offering a selected population, such as first-time mothers, an early dedicated maternal health check.

705 Medical problems, legal solutions: Surveillance results from a primary care-based medical-legal partnership

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Medical legal partnerships (MLPs) require physicians to recognize medical issues stemming from social determinants of health, and refer such cases to free legal services for further management. While traditionally pediatric in-patient models, an expansion of these partnerships is occurring within the primary care arena. Currently, we are piloting a primary care-based MLP in Windsor, Ontario, as a solution to provide patients improved management for medical issues compounded by social circumstances. Potential patients are first identified through initial screening during

consultation with their family physician using the I-HELP screening model (income, housing, education and employment, legal status, and personal and family stability). Candidate clients are subsequently referred to a centralized triage lawyer, at Pro Bono Law Ontario, for legal advice, and further connected to legal services if appropriate. We present preliminary data from this project, in addition to a completed community-based needs assessment that has revealed that the most frequently encountered medical-legal issues experienced by our patient population involve social assistance, employment, education, and health care access. We also highlight patient cases from those who have been through the program, and discuss how primary care physicians can better screen for medical-legal issues using the I-HELP screening model. Overall, this pilot program aims to provide access to legal services for primary care patients in our community as an additional dimension of clinical care for medical issues they experience as a result of their social and economic status. We hope that showcasing outcomes from this project may spur the establishment of similar medical-legal partnerships in other communities.

706 Approach to family planning in refugee health

Gabrielle Inglis, MD, Toronto, ON; Praseedha Janakiram, MD

Few medical interventions have as far reaching benefits as the promotion of family planning. The ability to acquire the knowledge and means to plan one's family and avoid unwanted pregnancy has been shown to decrease poverty, improve food security, and decrease maternal and child mortality. Unmet contraceptive need worldwide is estimated at around 12.3%, and the World Health Organization identifies refugee women as being at particularly high risk. A previous study conducted at Crossroads Clinic in Toronto, Ontario, found an unmet need of 26.8% among asylum seekers presenting to care in 2011/2012, more than three times the national estimate of 8% unmet need across Canada. In 2015/2016, Canada welcomed 25,000 Syrian refugees, at least 50% of whom are women and girls. Efforts were coordinated across the country to address the primary care needs of this population, involving many community-based family physicians without specialized training in refugee health. Currently, no guidelines exist to address the unique needs of refugee women presenting to primary care in Canada. To address this gap, we undertook an evaluation of the existing and emerging research on this topic, to better inform best practices in family planning for this vulnerable population. This work aims to summarize best approaches to addressing contraceptive need in refugee women, based on current literature, while addressing common misconceptions and barriers to access to care. As migration and diversity increase across Canada, it is crucial that family physicians improve their knowledge and competence in refugee and newcomer health provision. As health advocates and medical experts, this is our social responsibility.

707 Team room 5S: Improving the efficiency of team room layouts at Queen's Family Health Team

Paige Hacking, MD, Kingston, ON

Context: Medical team rooms are used by many health care professionals, often leading to non-standard and disordered workspaces. Disorganized team rooms contribute to breaches in patient privacy, delayed referral times, and inconsistent availability of resources, which can compromise patient care. Many organizations are using quality improvement Lean principles to instigate change. The 5S methodology is a Lean workplace organization technique involving 5 phases (sort, set in order, shine, standardize, and sustain). There are currently no guidelines addressing primary care team room standardization or layouts. **Objective:** To implement and evaluate the 5S methodology applied to team rooms at Queen's Family Health Team in Kingston, Ontario.

Additionally, to explore user perspectives on the utility and challenges of working in the team rooms. **Design:** Blinded investigators, using a standardized checklist adapted for primary care, performed pre- and post-5S implementation (to be conducted May 2016) audits of three medical team rooms. Exploratory surveys were completed by team room users. Descriptive statistics and thematic analysis were used to analyze data, respectively. **Participants:** A total of 44 interprofessional team room users, including receptionists, allied health professionals, physicians, residents, medical clerks, and cleaning staff participated (44% response rate). **Intervention:** Five phases of 5S methodology were implemented in three unique team rooms. Adherence to 5S principles was audited using a standardized checklist adapted for a primary care setting. **Findings:** Team rooms initially scored poorly on the 5S audit, averaging 41.5 out of 100. Our study will discern whether there has been a significant improvement in scores 2 weeks after 5S implementation. Several predominant themes were identified through survey response analysis. Themes included the need for dedicated workspaces, the need for a well-functioning document and workflow system, and the need for improved confidential document disposal. **Conclusion:** The 5S methodology is an effective and maintainable workplace organization technique that can be applied to medical team rooms. Applying this methodology at the Queen's Family Health Team allows for improved efficiency of the physical workspace and may improve patient care and work satisfaction.

708 International primary care research priority setting

Braden O'Neill, MD, DPhil, Toronto, ON

Context: Despite the importance of primary care to health systems around the world, there has never before been a comprehensive, patient-centered study of worldwide primary care research priorities. Therefore, establishment of key international research priorities in primary care would encourage contribution to this growing field of research, and strengthen future evidence in primary care to improve health outcomes. **Objective:** To describe the most important and feasible research questions in primary care in low-, middle-, and high-income countries. A separate analysis of data from this study will determine Canadian primary care research priorities. **Design:** Online survey with Delphi prioritization process. **Participants:** Worldwide primary care stakeholders including clinicians, patients, caregivers, researchers, and policymakers from a sampling frame developed by the Besrou Centre and WONCA. **Intervention:** N/A. **Outcome Measures:** Quantitative description of number of stakeholders engaged and their demographics, number of questions proposed, priority of questions, proportion from low-, middle-, and high-income countries. **Results:** Preliminary results on the above measures will be available in November 2016; final results including identified research priorities are expected to be available in mid-2017. **Conclusions:** The proposed research priorities will guide resource allocation and research agendas in low-, middle-, and high-income countries, as well as specifically for Canadian family medicine and primary care.

710 Development of a motor vehicle collision clinical tool

Elizabeth Faour, St. John's, NL

Context: There is no standardized medical approach to ambulatory motor vehicle collision (MVC) patients that serves medical, insurance, and legal purposes. Evidence suggests that a simplified process would facilitate patient recovery. **Objective:** Create a clinical reporting tool for use by family physicians to standardize collection of information from MVC patients in the office setting for medical, insurance, and potential legal purposes. **Design:** A draft tool was created through consultations with a family physician, an insurance adjuster, and a personal injury lawyer. This draft was put through a Delphi process to generate consensus on what should be included in the

final tool. **Participants:** The Delphi expert panel consisted of 20 family physicians, 10 insurance adjusters, and 10 personal injury lawyers. Experts were considered as those who have been practising in their respective field for at least 5 years and have relevant knowledge of and experience with issues surrounding care of ambulatory MVC patients. **Outcome Measures:** Ninety per cent of respondents ranking an item 3–5 on the Likert scale was considered consensus to include; 90% ranking an item 1–3 was considered consensus to exclude. Items that did not attain consensus overall, but had consensus among doctors were included, as the primary user of the tool will be physicians in patient care. **Results:** In the first iteration of the survey, 30 of 39 items gained consensus. In the second iteration, 3 of 9 items gained weak consensus, 2 of 9 items gained physician consensus, and 1 item gained weak consensus to be excluded. The remaining 3 items went to the third and final iteration, in which none gained consensus and were excluded. On this basis, a standardized MVC clinical reporting tool was created. **Conclusions:** There is consensus on the majority of items that doctors, insurance adjusters, and lawyers believe important to be collected during a patient's first visit post-MVC to the family doctor in the office setting. The result of this project is a clinical reporting tool with the goal of helping ensure proper medical treatment and follow-up while providing a standardized method of physician reporting that could be used effectively when responding to insurance adjusters and lawyers as required. The tool now needs to be studied in practise.

711 The fight against *Aedes Aegypti*: A constant struggle in primary health care

Ana Paula Silva, Goiânia, Brazil

Context: The *Aedes aegypti* (*A. aegypti*) has been an increasing threat in recent years and the fight against it is a matter of public debate. On November 11, 2015, a decree was published declaring that Brazil is in a state of public health emergency of national importance. It falls to basic health to perform actions involving the population, health care professionals, and managers, for prevention, promotion, and protection against the mosquito. Goiás is considered one of the most endemic Brazilian states for: Dengue fever, where 189,030 cases were registered in 2015 (with 81 deaths); 147 cases of Chikungunya; 81 suspected Zika virus cases, of which five were confirmed; 8 cases of microcephaly caused by Zika virus; and 51 occurrences of Guillain-Barré Syndrome. **Objective:** To interpret secondary data analysis about the fight against the *A. aegypti* associated to medical academics' performance in primary health care in the family health team. **Design:** An epidemiological report that highlights the experience of medical students in the UABSF Vila Mutirão (Goiânia) in 2015, in aid and planning of vector control measures. **Participants:** There are 46 students of the second year of medical school of Pontifícia Universidade Católica de Goiás (PUC-Goiás), under a doctor's and professor's orientation. Intervention Students nurses, doctors, and social workers who aim, through primary health care, to pass information to the public about anti-insect forms in order to reduce the number of cases of these diseases. **Outcome Measures:** Throughout the follow-up of medical appointments and home visits, students develop skills and attitudes aiming to support their patients, such as development of doctor-patient communication and doubts enlightenment. Through this work, the patients are made aware of the risks of such vector-borne diseases, learn how to fight the mosquito outbreaks, and learn how to identify the early symptoms of diseases in order to obtain early treatment. **Findings:** According to this study, the prevention service performed by students along with the multi-professional team is an effective tool to relieve hospitals in the public health system, which consequently leads to improved care and fewer deaths from Dengue, Chikungunya, and Zika.

712 **Breastfeeding promotion at primary care facilities in Brazil**

Louise Morais, Goiânia, Brazil

Context: Brazil is a worldwide reference in breastfeeding, and this is mainly due to the efforts of primary care to provide mothers with the information regarding its benefits. It proves to be important to understand the best way to approach mothers in order to keep them breastfeeding for a longer period. **Objective:** To prepare medical students for a better doctor-patient relationship with mothers by understanding the importance of breastfeeding. **Design:** Case report. Participants Breastfeeding mothers at primary care facilities. **Intervention:** For 5 weeks, medical students at the Pontifical Catholic University of Goiás (PUC-Goiás) visited the family medicine unit at Vila Mutirão. At this unit, the influence of breastfeeding in health care was studied and discussed, as well as the public policies helped by primary care through actions directed to the promotion, protection, and support of breastfeeding, an action that is regulated by the Brazilian Breastfeeding and Feeding Strategy (EAAB) published by Decree Number 1.920, September 5, 2013. **Outcome Measures:** The medical students had the opportunity to talk to women participating in breast milk collection, regarding topics that promoted the importance of breastfeeding, as children who are breastfed for a longer period have better intellectual development, which can improve academic performance. The children also are more emotionally stable, and tend to be more loving towards others, developing a strong personality and character, becoming a healthier person in the future. Human milk protects the baby from infections, diarrhea, and allergies, reducing the risk of diseases such as hypertension, high cholesterol, diabetes, and obesity. In addition, each year a mother breastfeeds, the risk of invasive breast cancer development reduces by 6%; we note also that breastfeeding leads to weight loss after childbirth and helps the uterus to recover its normal size, which reduces the risk of bleeding and anemia. **Results:** The medical students comprehended the importance of primary care measures to promote breastfeeding support and complement healthy eating for children. **Conclusion:** These and other actions have enabled Brazil to achieve the Millennium Development Goal number 4, established by the United Nations, to reduce two-thirds of the mortality of children younger than 5 years by 2016.

713 **Integrating the medical home with the medical neighborhood: A family medicine/division of gastroenterology initiative to improve access**

Rick Ward, MD, CCFP, FCFP, Canmore, AB

This poster will describe the care gap, process, and solution to an access challenge experienced by patients in the Calgary zone. It reflects collaboration between family physician-led primary care networks (PCN), the Division of Gastroenterology Alberta Health Services (AHS), and Primary Care AHS. Data will be presented that demonstrates the effectiveness of this intervention. The challenges are: 1) a more than 2-year wait list for patients referred for GI problems, which were triaged as routine—2,600 patients were on this list at the beginning of the project; 2) an influx of 1,900 new referrals a month to GI; 3) and the capacity to see 1,000 new referrals a month, resulting in longer waits for urgent consultation and an even larger wait list for routine referrals. The solutions: i) Division of Gastroenterology working with PCN leadership to create solutions; ii) pathways to manage patients with GERD, chronic constipation, and IBS close to the medical home; iii) re-evaluation of patients on wait lists and guideline support to referring family doctors to manage patients in the medical home; iv) and specialist link (telephone support line) to support family doctors who needed timely, personalized advice from a gastroenterologist for patient challenges as they happen. The poster will highlight challenges, learnings, and outcomes from this successful initiative.

714 **Developing a community-based service for the provision of Medical Assistance In Dying** Jonathan Reggler, Working Group member, Comox, BC

Rationale: Medical Assistance In Dying (MAID; also known as physician-assisted dying) is now legal for Canadians who qualify and who want access. Comox Valley family physicians intending to provide MAID need support and information to allow them to provide this for their patients.

Aim: To develop a community-based coordinated service for the provision of MAID to ensure that physicians offering the service are supported with detailed information about MAID protocols (procedural and pharmacological); physicians wanting to offer MAID can access a provider list of consulting physicians; physicians who want to refer patients have a mechanism and a list of providers offering MAID as attending physicians. **Method:** Email contact with all members of the local division of family practice and the members of the two adjacent divisions. Identification of physicians intending to provide or willing to consider providing MAID. Invitation to them to attend an informational webinar provided by physicians with experience with MAID. Formation of a working group to develop protocols and a provider group list (attending and consulting physicians). Creation of support documentation including intravenous and oral protocols for MAID; procedural checklists (medical-legal compliance forms for completion by attending and consulting physicians); referral/medical information transfer forms. Engagement of local division of family practice for online administrative support. Arrangement of meetings for local physicians for their assistance with final drafts of documentation. Identification of physicians willing to provide MAID to their own patients. Identification of physicians willing to take referrals as both attending and consulting physicians. Identification of health care facilities where MAID may be provided if not in the patient's home (local hospital is Catholic and absent of federal/provincial laws requiring publicly funded hospitals to allow MAID onsite, other facilities are identified) **Result:** A division of family practice-based MAID provider list with online information support for physicians choosing to provide MAID either for their own patients, or by referral.

715 **Improving the data: Cervical cancer screening at health for all** Karuna Gupta, MD, Markham, ON; Alan Monavvari, MD

Aims: To improve the cervical cancer screening rate from 73% to 75% or better. To improve internal data quality at Health For All (HFA) using the Cancer Care Ontario Screening Activity Report (CCO SAR) as a tool. **Background:** Pap smear screening rates in eligible rostered patients at HFA were 60% on January 31, 2015, through electronic medical records (EMR) search; Pap smear screening rates in CCO SAR were 73%. We believed that using a quality improvement methodology we could improve both Pap smear screening rates and data quality in our EMRs at HFA. **Methods:** We developed a process to reconcile data discordance between CCO SAR and EMR data. Processes were developed for both normal and abnormal Pap smears. Data found in CCO SAR but missing from EMRs were downloaded from Ontario Lab Information System (OLIS). This was followed by a process to identify patients for whom no action was needed, patients who should be excluded from screening, and patients for whom action was needed. A stamp was developed to help identify patients who had been excluded from screening (not sexually active, status post total hysterectomy S/P TAH, refusal of Pap smear), and Q coding, if appropriate, was updated. A rigorous chart review process was followed using the flow charts. For those patients identified as screening needed, an outreach process was developed to call and book them for Pap smear. **Process Measures:** A total of 1,782 patient charts were identified in which data was discordant between CCO SAR and Practice Solutions (Electronic Medical Record) (PS). A total of 470 patients were called and 186 patients booked for Pap smears. **Outcome Measures:** As of December 31, 2015, 77% of HFA patients are up to date for cervical cancer screening per CCO

SAR, and 76% are up to date per EMR search. Data concordance between CCO SAR reports and EMR is 98%. **Lessons:** The project took more time than anticipated (10 months rather than 5) due to variation in data cleanliness and increasing clinical demands on the team. CCO SAR and OLIS are powerful tools to help to ensure accurate EMR data. Maintaining an accurate patient roster is essential to good quality improvement.

716 The Diabetes Empowerment Group Program

Fanny Hersson-Edery, MDCM, Hampstead, QC

Context: The Diabetes Empowerment Group Program (DEGP) was developed as a local initiative to provide an intervention that better addressed the need of patients and physicians in diabetes care at the Kildare Medical Clinic, a community-based clinic. DEGP is a clinical intervention that is: 1) patient-led (responds primarily to their perceived needs); 2) interdisciplinary (treating team includes a physician as well as other health care professionals); and 3) based on a solid theoretical framework to effect the empowerment of the participants. Feedback from the first three groups was strongly positive and encouraging. We felt that an effort to replicate the program in other clinics would be desirable. **Objective:** To conceive a multimodal knowledge translation approach to elicit interest at other clinics and help an eventual implementation of the DEGP. **Design:** Qualitative descriptive design (semi-structured individual interviews). Tool design. **Participants:** A total of 17 patients who participated in DEGP, and 6 clinicians and associated professionals who participated in DEGP. **Outcome:** Three distinct communication tools have been developed as part of our knowledge translation plan to introduce and invite interest in our program. These include a description of the program, a patient testimonial-based tool, and the logic model of the DEGP. **Discussion:** The description of the program is an operational guide for clinicians to frame and suggest the content of the group visits. The patient testimonial-based tool was developed using feedback from individual interviews of patients who had participated in the pilot programs as well as the input of patient partners in our working group on strategic planning. It is aimed to interested persons with diabetes. The logic model is a map that can clearly illustrate the aims of our program and its presumed impact—it is intended primarily for administrators and policy deciders. **Conclusion:** The three communication tools will aid in creating interest and the ability for other clinics to implement the DEGP.

717 Research training in family medicine and primary care: Exploration of career paths

Jamie DeMore, MA, Montreal, QC

Context: In order to address a strong demand to increase research capacity in family medicine and primary health care, a thesis-based Master of Science (MSc) and a Doctor of Philosophy (PhD) were developed with an interdisciplinary approach that emphasized community engagement and knowledge translation. The programs provide rigorous training in qualitative, quantitative mixed methods, knowledge synthesis, participatory research, and knowledge translation. It is unclear, however, if the students and graduates come from a family medicine background and if they remain in the primary care field. **Objective:** To investigate the backgrounds of these graduate students and their post-graduation paths. **Design:** Descriptive study using information from a database, which tracks student interest, enrolment, graduation rates, and post-graduation career paths. **Participants:** Current and graduate MSc students from 2009–2015 and current PhD students. **Results:** The backgrounds of 50 MSc and 21 PhD students (including 30 MSc students who have graduated) are quite varied: undergraduate and graduate students with an interest in family medicine research, 56% (40 of 71); international medical graduates (IMGs), 34% (24 of 71); third-year residents, 4% (3 of 71); other health professionals in primary care, 4% (3 of 71); and

Canadian medical graduates, 2% (1 of 71). Upon obtaining their MSc degrees, 43% (13 of 30) assumed positions as research managers; 10% (3 of 30) completed or are in the process of completing a Canadian family medicine residency program (ie, IMGs); 10% (3 of 30) enrolled in PhD programs; 20% (6 of 30) entered medical school with the intent of becoming family medicine clinician researchers; 7% (2 of 30) enrolled in a law program; and 10% (3 of 30) are still seeking employment in primary care. Since no PhD students have graduated yet, there are no results to show for what they do after they graduate. **Conclusion:** Our programs have prepared these students for a broad range of careers in family medicine and primary care. While no PhD students have graduated, it is anticipated that most of these students will be competitive for both academic positions and various research positions in primary care in the public and private sectors. A formal developmental evaluation of our graduate programs is currently under way.

718 The importance of change management in the creation of a patient-centered medical home

Shauna Wilkinson, Calgary, AB

Context: At Crowfoot Village Family Practice (CVFP) our mission is to provide outstanding care in a patient-centred medical home (PCMH). We deliver care to 25,000 patients, from Calgary and the surrounding area. Our health team includes physicians, a nurse practitioner, registered nurses, a dietitian, behavioural health consultants, CDE pharmacists, chronic disease nurse, respiratory nurse educators, and medical office assistants. Our change management process allows our team to provide enhanced care and services by implementing patient attachment, same- or next-day access, routine health screening, proactive care, and population- and disease-based care pathways. **Methods:** 1) A goal is defined, including timeline and measures. 2) A team is formed that will manage the change implementation and maintain the innovation. 3) The team develops a plan to implement the proposed change or innovation, and identifies 1–2 early adopters to trial and measure the process. 4) A number of Plan, Do, Study, Act (PDSA) cycles are completed with the early adopters, and once refined the change is spread slowly to 1–2 providers or panels at a time. 5) The change team meets frequently to manage this process and regularly communicates to the entire clinic. 6) Patients may be part of the change team or engaged through the process for feedback in order to ensure the innovation is patient centred. 7) Once the change or innovation is fully implemented, the change team takes on the responsibility of continuing to manage and measure progress. 8) Engagement and ongoing measurement are key components to success and sustainability. **Results:** •Reduced wait times by 85% to same- or next-day access, and sustained for more than 3 years. •Population management of diabetic patients included an HbA1c reduction in 40% of diabetic patients in an 8-month period. •Implementation of care pathways and protocols ensure that 15% of our patient visits are conducted by the health team. •CVFP patients are seen in emergency departments 29% less frequently, and their length of stay after admission is 36% shorter than the average Calgarian. **Conclusions:** Quality improvement is a necessary component to a Patient Centred Medical Home (PCMH) and requires proper change management to result in high quality care. CVFP can demonstrate examples, results, and key learnings when implementing change that can be adapted and implemented by any medical practice no matter the circumstance.

719 Defining the periodic health examination: An examination of primary care physicians' views

Darren Van Dam, Ilderton, ON

Introduction: The periodic health exam (PHE) has been a staple of primary medical care for many years. The intent behind this traditionally yearly examination was to ensure at least an annual

check-in for patients with their family physician. Over time, this visit expanded to include preventive health screening to reflect the mounting evidence supporting the benefits of early identification and treatment of a variety of illnesses. More recently, these benefits have come under scrutiny, as ongoing research has failed to support the improved health outcomes anticipated through the yearly screening of healthy individuals at average risk for disease. In addition, our health care system continues to struggle under financial strain resulting from an aging population. In a political climate increasingly focused on cost savings, the relatively expensive PHE has started to fall out of favour. One challenge for assessing the value (and costs) of the PHE lies in the lack of a standard agreed-upon definition of what tests and/or investigations should be included in such a health care visit. This pilot study seeks to obtain the perspective of primary care physicians to see which tests and/or investigations they view as important to include in a periodic health examination, and their reasons and rationale for these views. This will then help to inform further research into the utility of the PHE. **Methods:** This stage of the study is a qualitative examination seeking to obtain the thoughts and opinions of family physicians in the London, Ontario, region about PHE, and what they feel should be included in this health visit. Participants are selected from a wide variety of practice profiles, including urban, rural, academic, and community practices. Researchers will also attempt to include a broad range of family practice experience by including participants across the career spectrum, from new graduates to recently retired physicians. The target number of participants is 12–15, which is anticipated to provide adequate data to achieve theme saturation. This data will be analyzed by the researchers in order to identify these themes. **Results:** Data collection is currently in progress, with anticipated analysis completion by September 2016.

720 Clinical outcomes of participation in an interdisciplinary therapeutic lifestyle clinic: Follow-up beyond 12 months

Jessica Fong, MD, CCFP, Toronto, ON

Context: The Primrose Family Health Team Therapeutic Lifestyle Clinic (TLC) was established in 2006 as an initiative to integrate preventive health care and lifestyle change into a primary care setting in Ottawa. It has been effective helping patients achieve significant changes in several clinical parameters, but it is unknown whether these changes are sustained in long-term follow-up. **Objective:** To determine whether select clinical outcomes achieved by the end of the TLC program are sustained beyond 12 months, and assess the extent of participation in program follow-up. Design Retrospective cohort study. **Participants:** The study sample consisted of 61 subjects who completed the TLC program between January 2011 and October 2013. Twenty-two participants (36%) were male and the mean age was 55 (SD 11.0). **Intervention:** Medical records were reviewed to obtain data for each subject's weight, BMI, waist circumference, duration of weekly physical activity, fasting blood glucose, and lipid panel (triglycerides, LDL, HDL). **Outcome Measures:** We identified subjects who achieved clinically significant change in any of these variables at the end of TLC enrolment and a subgroup analysis was conducted to ascertain whether these were maintained at 6 months, 12 months, 18 months, and 24 months after program completion. **Results:** Of the 61 subjects, 60 (98.4%) achieved clinically significant change in at least one variable. In follow-up, at least one of these clinical variables was maintained in 68.4% (SD 20.3) of the subjects at 6 months, 65.8% (SD 34.6) at 12 months, 69.6% (SD 24.7) at 18 months, and 51.3% (SD 29.1) at 24 months. Participation in formal follow-up visits was limited, with subjects attending a mean of 2.4 (SD 2.5) visits for a mean duration of 15.3 (SD 9.1) months. **Conclusions:** The TLC program is an effective resource for assisting local patients with healthy lifestyle modification, with the majority of participants achieving at least one clinically significant change at the time of program completion. Individuals who do engage in follow-up visits appear

to have a high rate of maintaining achieved clinical change, but interpretation of the long-term outcomes of the TLC program is difficult given a paucity of available clinical data.

721 Introduction of formally trained peer resident facilitators to small group learning in residency

Kim Lazare, MD, CCFP, MScCH (Candidate), Toronto, ON; Allyson Merbaum, MD, CCFP, FCFP; Risa Bordman, MD, CCFP (PC), FCFP

Background: The Practice Based Small Group (PBSG) learning program from The Foundation for Medical Practice Education is a well-established method used in residency training. While a formal training program is available to prepare faculty and residents to be resident PBSG facilitators, not all programs use it. **Study Objective:** To assess resident learning and satisfaction after formal resident PBSG facilitator training was introduced to family medicine (FM) residents at North York General Hospital (NYGH), a suburban Toronto academic teaching hospital. **Program Description:** Previously at NYGH, each resident was assigned a PBSG module and asked to lead a 60-minute session during an academic half day (AHD). Most of the residents took the module and created a 30-minute PowerPoint presentation, followed by a large group (20–25 people) discussion. In the new model, 7 residents and 2 faculty volunteers completed a 4-hour resident PBSG facilitation training session; 60–90 minutes were allotted twice a month as part of AHD core curriculum. Pairs of resident facilitators were assigned groups of 6–8 residents so the groups and the trained PBSG facilitators could stay as consistent as possible through the year. A faculty supervisor circulated from room to room to answer clinical questions and to ensure the process ran smoothly. Residents worked through patient cases pertaining to the PBSG topic at hand and were encouraged to draw on their own clinical experiences. **Program Evaluation:** Second year NYGH FM residents who have spent 1 year with the old program and 1 year with the new program participated in a focus group centred around their learning and satisfaction with the new method of teaching PBSG. **Results:** This study will be conducted in the spring of 2016 to allow a full year of the new learning model to be completed. The results will be available for FMF 2016. **Discussion:** At this time, we have informal feedback indicating that peer facilitator-led PBSG sessions engaged NYGH FM residents and that changing the manner in which PBSG modules were delivered resulted in improved satisfaction and learning. Our poster will discuss the formal results.

722 The role of family physicians in emergency preparedness and response on Vancouver Island, British Columbia: An advocacy project

Ahmed Hashim, MD, Burnaby, BC; Alfredo Tura, MD

Introduction: Emergency preparedness, disaster management, and response to public health threats are essential functions of health care systems. Integrating the role of family physicians into these public health initiatives is a key feature of a successful health care system. This project is led by family physicians, is supported by the local division of family practice, and advocates for a community-based public health initiative delivered by five clinics in the Comox Valley, British Columbia. The clinics plan to serve as Disaster First Aid Stations (DFAS) in the event of a devastating natural disaster. This research will explore accomplishments and challenges encountered by the program during the preparedness phase. **Description of Initiative:** Five clinics in the Comox Valley are planning to serve as community-based satellite first aid stations in the event of a natural disaster. DFAS will play a crucial role in supporting the hospitals in the community. DFAS will assist with first aid, pain management, minor emergency procedures, and more urgent primary care medicine. The stations are equipped with experienced medical staff, allied health care workers, and medical and non-medical emergency supplies. Education for the

public and health care professionals is delivered with pamphlets, newspaper articles and ads, radio communiqué and interviews, training sessions, educational events, and forums.

Evaluation/Outcomes: Stakeholders and agencies at different levels were involved in the preparedness phase. GPs, the Comox Valley Emergency Preparedness (CVEP) program, various disaster planning and management experts, and the medical health officer held regular meetings in 2014–2015 to write the preparedness plan that was approved in late 2015. Family physicians assumed the leadership role in this initiative. A number of challenges were also encountered during this exercise including: inter-agency liaising where prior communication did not exist, providing a needs assessment and creating possible solutions without a previous model, and allocating the time and funding for the planning stage. **Conclusion:** The DFAS emergency preparedness plan is the first of its kind on Vancouver Island and it can be a model to be replicated in other jurisdictions. DFAS can be seen as an opportunity to engage family physicians in emergency preparedness and community-based disaster management.

723 **A picture is worth a thousand words: A visual aid for discussing prevention with patients**

Cleo Mavriplis, MD, CCFP, FCFP, Ottawa, ON; Manon Bouchard, NP-PHC, Ottawa, ON; Tawnya Shimizu, NP-PHC, Ottawa, ON

Objectives: To summarize current primary care prevention recommendations from our Canadian Family Physician article (CFP; February 2016) in a visual aid; and to make prevention recommendations for patients more accessible and relevant, using a visual aid of the body.

Methods: We updated our list of prevention recommendations for Canadian primary care providers, and published it in CFP. We conceived a poster of the human body with different systems tagged as important for prevention, then trialed our poster both in the waiting room and in primary care offices as a visual aid to discuss prevention. We collected feedback from primary care providers and patients, and adapted our tool further. We hope this tool may facilitate discussion of prevention with patients, as this is an often neglected subject in our health care system.

724 **Developing competence: A process for creating priority topics and key features**

Lisa Graves, MD, CCFP, FCFP, Ancaster, ON

Introduction: The key features approach is one method of defining competence for the purpose of assessment. This is a two-step process. First, priority topics reflecting important knowledge or skill for a competent clinician are generated. Second, key feature analysis is used to define how each topic is addressed competently. Intrapartum care is an expected competence for Canadian family medicine residents. Intrapartum care provides a unique opportunity to assess competence in procedural skills and challenging complex competencies in a safe and supported environment. A national working group of the College of Family Physicians of Canada involving academic and community clinicians was created to develop competencies using this two-step process. **Methods:** Priority topics for perinatal care for Canadian family medicine residents were developed using a modified Delphi combining surveys and nominal group discussions in an iterative fashion. The Working Group on the Assessment of Competence in Maternity and Newborn Care (7 members) acted as the nominal group, generating a first list of priority topics. A second survey to a larger group of family practitioners (51 respondents from 202), representative from across the country generated another independent list. **Results:** The lists generated by the nominal group and the larger reference group were almost identical, both in the topics named and the priorities assigned (correlation = 0.84). Twenty-two priority topics and three priority procedures were identified. Key features were developed for all 25 topics. A similar process was completed for non-clinical topics

(eg, team, limits, professional). The correlation between the nominal group and the validation group was similar with a correlation of 0.83. Pilot testing of all 25 key features is currently under way. Early feedback suggests these key features have been useful for both teachers and residents. **Conclusions:** Key features in maternity care were developed with clinical input from a broad range of family physicians providing maternity care in a wide variety of settings. It is anticipated that assessment of competence in intrapartum care based on priority topics and their key features will be an effective and valid indicator of overall competence in this domain. The process used to develop these priority topics and key features can be replicated for other areas of competence.

725 Enhancing resident education and social accountability outcomes through the diversification of training sites

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The University of British Columbia (UBC) Family Medicine Residency Program has expanded from 7 sites (2003) to 18 sites (2015). Guided by a social accountability mandate, training is offered in a variety of community settings to prepare residents for diverse community practice. While all sites offer residents comparable training to meet core competencies, some sites are designed to provide unique opportunities in Aboriginal health, marginalized populations, and urban, regional, rural, or remote practice. The purpose of this evaluation was to determine what impact the diversification of training sites has had on residents' education, particularly in terms of preparing them to practice in a way that is socially accountable to the province of British Columbia. This program evaluation used a mixed methods approach. A survey of residents who graduated in 2014 (n = 73 of 117) provided both quantitative ratings and qualitative descriptors of the unique strengths, weaknesses, and 'fit-for-purpose' of each training site. Faculty and staff (n = 40) provided qualitative perspectives of the strengths and challenges of delivering the program. **Results:** Three unique training models were identified using a correlation analysis: urban, regional, and rural. Benefits of diverse sites included enhanced social accountability of the program, meeting the needs of diverse residents by drawing on the unique strengths and resources at each site, increased resident confidence for working in diverse environments, reduced learner load per site, and an increase in innovation among faculty and staff. Challenges included a strain on financial resources, some limitations to the teaching and resources available at some rural and remote sites, and a sense of isolation among some residents. **Conclusions:** This evaluation identified what benefits have been gained by offering residency training across diverse training sites, and what actions could be taken to both maximize the strengths and minimize the challenges. Recommendations included supporting shared learning across rural, regional, and urban training models, strengthening access to resources for remote sites, and developing more formal collaborations across different types of training models. UBC should celebrate and support diversity in its residency training in order to reflect the diverse nature of the province of British Columbia.

726 Pets affect your patients' health

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During Primary Care Today, a large continuing education conference, almost 100 primary care providers (PCPs) were recruited, and committed to asking their patients about pets in the family. PCPs were also recruited at lecture presentations and at a small group workshop. Each participant received an educational intervention that detailed zooeyia: the health benefits of pets, the benefits of pets to child development, the health risks of living with pets, and training for how to ask about pets in the family. All participants were given a hand-out. Over the following 3 months, five emails were sent to all participants, providing new information and reminding them to ask patients about

pets in the family. They were then sent three requests to complete a final survey. Pets have a powerful impact on their owners' health. When PCPs ask about pets in patients' families, they learn much about non-medical determinants of health, how the patient lives, and the risks and benefits provided by the pet. Knowing about pets in the family helps PCPs to both leverage health benefits of pets (zootherapy) and mitigate zoonotic risk. In addition to sharing clinically-relevant and practical knowledge, pet-centered discussions significantly improved communication between patient and provider—an essential element of preventive medicine. Pet owners welcome discussions about their pets. Pet-centered conversations enable PCPs to develop empathy for their patients, removing barriers to effective communication, and strengthening the patient-provider therapeutic alliance. With patient and PCP working in a strong partnership, health care is improved. Educational outreach about the powerful impact pets can have on patients' lives is a simple approach, with high return-on-investment, to significantly improve communication between patient and provider and strengthen the therapeutic alliance. Impact All the health care providers had patients with pets in their practice. Not one health care provider reported any reluctance of patients to talk about their pets. Asking about pets revealed valuable and relevant information about patients' home lives—particularly physical activity, social capital, companionship, and such socio-economic factors as housing. Almost one-third of participants (31%) now routinely ask their patients about pets in the family (13% at baseline). An additional 60% ask about pets when clinically relevant. The majority of participants reported that asking about pets improves communication and rapport with patients.

727 Thriving versus driving: A novel approach to public health preventive screening advocacy
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A novel approach to public health is presented, in which preventive health screening is framed in a manner akin to maintaining a vehicle that an owner would be required to drive for 8 decades. A subset of the population wouldn't attempt to drive a car until it quits on the side of the road because the oil and coolant was never checked. However, some of the same people would never consider preventive screening for things like fecal occult testing, Pap smears, or other recommendations. Since this population would be less likely to attend to a family medicine practice, there is a challenge in making them aware of the benefits of screening. The approach presented is to organize a summary card with two sides: one side is vehicle maintenance for a car needing to run for 8 decades; the other side is the public health screening maintenance to help a person live a full productive life. The purpose is to facilitate discussion for people treating their bodies at least as well as their cars, and to then consider medical follow-up to continue that conversation.

728 Enhanced skills training in family medicine: Define, refine, and align
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This poster will define the criteria for enhanced skills training programs at the University of Toronto and summarize the program curriculum that is offered, including the CanMEDS roles. The growth in enhanced skills training will be addressed through the analysis of applications over the last 3 years. The faculty motivation for teaching enhanced skills will be depicted through the results of a 2016 faculty survey. The evaluation of competency will be demonstrated through sample evaluation formats with an analysis of the range of resident ratings in overall professionalism, communication, and medical expert skills. The importance of family practice skills integration within enhanced skill training will be addressed by describing the diverse

opportunities to facilitate and support continuing development of family practice skills during enhanced skills training. A list of graduate career paths will be listed from program director submissions. Recommendations for future enhanced skills training will be listed with rationale.

729 North Shore GP orthopedics initiative

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North Shore family physicians and orthopedic surgeons identified long wait times for orthopedic consultations, difficulty with timely communication, and an inefficient referral process as areas for improvement. Supported by Shared Care, we developed a centralized referral system, musculoskeletal screening clinic (Rapid Orthopedic Consultation Clinic, ROCC), and telephone advice line. The centralized referral system introduced a standardized referral tool that could be triaged to the most suitable consultant along with proper investigations (medical imaging). Referral acknowledgements with wait time estimates were delivered to family physicians. Orthopedic surgeons (locums) and trained physicians conducted initial assessments in the ROCC and directed patients for the most appropriate non-surgical or surgical care. The group also established a telephone advice line, where a dedicated surgeon discusses patient management with family physicians. This provides timely access to advice and avoids unnecessary referrals. A monthly average of 10 phone calls are received on the advice line. From June 2013 to December 2015, ROCC received 6,557 referrals. Ninety per cent of referrals were for expedited care and 10% indicated a specific physician. The new system has reduced wait times for consultation from 18–24 months to 3–4 months. Seventy-two per cent of patient survey respondents were very satisfied with their experience. Moreover, 94% of family physicians respondents expressed satisfaction with the screening clinic. Following consultation, 17% of patients were referred to surgery, 16% to further medical imaging, and 32% to other non-surgical services, such as physiotherapy, bracing, and injections. From the surgeons' perspective, efficiency improved with 60% of their time spent seeing operative cases, compared with 10% pre-ROCC. In addition to improved efficiencies, patient and provider satisfaction, and decreased wait times, there are also benefits such as avoiding unnecessary investigations, and family physician and emergency department visits.

730 Applying primary care practice-based research network values to a research project led by resident family physicians: Lessons learned

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Context: Various research projects are carried out as part of the academic activities of resident family physicians in Quebec. Applying practice-based research network (PBRN) values—collaboration and sharing, excellence, innovation, equal-value knowledge—to these projects, although it may represent a challenge, could increase their benefits. **Objective:** To describe the application of PBRN values to a research project conducted by resident family physicians, and to identify the facilitating factors and barriers encountered during their implementation in this setting. **Design:** Qualitative and descriptive. **Participants:** Eight residents in two Quebec family medicine units (FMU), one physician-researcher (first FMU), one physician-coach (second FMU), and one project coordinator. **Interventions:** Qualitative analysis of field notes and written questionnaires collected during the project, group and individual interviews with participants at the end of the project. **Outcome Measures:** Identification of the PBRN values addressed in the project and the facilitating factors and barriers encountered. **Results:** The research project selected by the residents, that aimed to assess the readability of documents provided to patients, allowed us to create patient-centered knowledge in primary care. Collaboration between the two FMUs fostered knowledge sharing and generated results on a larger scale. The involvement of the residents

contributed to promoting research capacity and culture. The knowledge generated is being applied in a community project conducted by second-year residents. Facilitators included the plurality of means of communication between FMU (email, Facebook, Dropbox, videoconferencing, in-person meetings, conference calls) and the initial identification of specific time periods for communication that were adjustable when necessary. A strong organization, fostered by a clear working plan from the start, the presence of a project coordinator, and frequent reminders of deadlines were also part of the facilitators. Barriers included fair distribution of tasks, and maintaining motivation and time slots dedicated to academic activities, which were different in each FMU. **Conclusion:** PBRN values are applicable to academic projects conducted by residents. Proper communication, a strong organization, and concern for the motivation of residents are necessary for success.

731 **Partage de la responsabilité médicale lors d'une consultation téléphonique**

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Contexte : Les médecins de famille utilisent régulièrement les consultations téléphoniques avec les spécialistes dans le contexte de soins clinique. Quels sont les impacts sur la responsabilité médicale? **Objectif :** Départager les obligations et responsabilités du médecin traitant et du médecin consultant dans un contexte de consultation téléphonique. **Type d'étude :** Essai juridique rédigé dans le cadre d'une Maîtrise en Droit de la Santé. **Intervention/instrument :** La jurisprudence de 1970 à aujourd'hui a été relevée. C'est 8 causes pertinentes qui ont été entendues devant nos tribunaux québécois. La doctrine a aussi été relevée de 1970 à aujourd'hui et c'est 6 articles d'auteurs renommés qui ont été étudiés. **Paramètre à l'étude :** En premier lieu, les lois ont été étudiées afin de déterminer les obligations du médecin traitant et du médecin consultant dans le cadre d'une consultation classique. Par la suite, c'est le contexte juridique de la télémédecine qui a été analysé. La jurisprudence a été explorée sur l'interprétation des lois par les tribunaux. Finalement, la doctrine a été analysée; les grands auteurs québécois ont été lus et critiqués. **Constat :** Il semble que l'on puisse considérer la consultation selon deux approches : traiter la consultation téléphonique comme une extension de la consultation médicale classique ou plutôt d'y voir une forme de télémédecine. **Discussion :** Bien que le médecin traitant reste généralement responsable de son patient, l'avenu des nouvelles technologies implique de plus en plus le médecin consultant. Les cliniciens doivent être sensibilisés aux implications légales d'une consultation téléphonique. **Conclusion :** Les relations entre le médecin traitant et le médecin consultant au téléphone sont fréquentes et les deux médecins peuvent voir leur responsabilité médicale retenue en cas de faute.