

07:30–08:15 **Breakfast / Petit déjeuner**
718AB MTCC

08:15–08:30 **Welcome / Bienvenue** 🎧
718AB MTCC

WM100 🎧 **Keynote / Plénière**
08:30–09:30 **The Teaching, Research, and Practice Journey in Family Medicine: Getting your story “right”**
Le parcours de l’enseignement, de la recherche et de la pratique en médecine familiale : bien connaître « votre » récit
Jeffrey M. Borkan, MD, Pawtucket, RI
718AB MTCC

Learning objectives:

1. elucidate your own personal and professional narrative
2. reflect on your roles as teacher, researcher, and clinician
3. consider the use of narrative as a tool for teaching, research, and practice

Description:

Dr Jeffrey M. Borkan, MD, PhD, is a family physician educator, researcher, clinician, and advocate whose career has bridged two fields, family medicine and medical anthropology, both in the US and abroad. Dr Borkan is an engaging speaker who is sure to challenge and stimulate us to reflect upon the various roles played by family physicians. Dr Borkan joined the Department of Family Medicine at Brown University, Alpert Medical School, as a research professor and chair in 2001. His research interests include medical education, health policy, cultural sensitivity, and primary care, using qualitative and mixed methods techniques. He has been active in Rhode Island and national health care policy, including chairing the Rhode Island Primary Care Physician Advisory Board, serving as president and chair of the Association of Departments of Family Medicine, and the Council of Academic Family Medicine (the national US coordinating body for all academic family medicine). He is also an assistant dean for Primary Care – Population Medicine at Brown.

Objectifs d’apprentissage :

1. élucider votre récit narratif personnel et professionnel
2. réfléchir sur vos rôles en tant qu’enseignant, chercheur et clinicien
3. considérer l’utilisation du récit narratif comme un outil pour l’enseignement, la recherche et la pratique

Description :

D’ Jeffrey M. Borkan, MD, PhD est un enseignant, chercheur, clinicien en médecine familiale et défenseur de la discipline. Sa carrière a touché à deux domaines : la médecine familiale et l’anthropologie médicale, tant aux États-Unis qu’à l’étranger. D’ Borkan est un conférencier captivant qui saura nous interpeller et stimuler notre réflexion sur les divers rôles que jouent les médecins de famille. Depuis 2001, D’ Borkan travaille au département de médecine de famille de la Faculté de médecine Alpert de l’université Brown en tant que professeur-chercheur et directeur du département. Ses intérêts pour la recherche portent sur l’éducation médicale, les politiques en matière de santé, la sensibilité culturelle et les soins primaires à l’aide de techniques qualitatives et de méthodes mixtes. Il a été actif au Rhode Island et à l’échelle nationale en ce qui concerne les politiques sur les soins de santé, a été président du Rhode Island Primary Care Physician Advisory Board, de l’Association of Departments of Family Medicine et du Council of Academic Family Medicine (l’organisme national qui coordonne la médecine familiale universitaire). Il est également vice-doyen en Soins primaires-Médecine de la population à l’Université Brown.

09:45–11:00 **Poster Viewing / Visite des affiches**
716AB MTCC

W96565 **Governing Our Postgraduate Medical Education System: How can we do it better?**
10:30–12:00 Carol Herbert, MD, CCFP, FCFP, FCAHS, Vancouver, BC; Nick Busing, MD, CCFP, FCFP, Ottawa, ON
714B MTCC

Learning objectives:

1. explain the concept of complex adaptive systems in PGME
2. define collaborative governance and consensus-driven decision making
3. identify contentious issues that could be brought to the PGME Governing Council

Description:

Decision making within postgraduate medical education (PGME) is a complex and complicated process, not only in Canada but also in the United States, Australia, and the United Kingdom. There are many stakeholders with legitimate interests, including educators, certifying bodies, regulators, governments, and learners. The Future of Medical Education PG (FMED-PG) project recognized the complexity of the Canadian PGME environment and explicitly made a recommendation to develop a collaborative governance structure to achieve efficiency, reduce redundancy, and provide clarity on strategic directions and decisions in order to prepare socially accountable physicians to produce high-quality health care for Canadians. This session will begin with a description of the process used by the FMED-PG Governance Implementation Committee to consider various models of collaborative governance for PGME and to choose a principle-based model for consensus-based decision making that involves a memorandum of understanding (MOU) among participating organizations with appropriate terms of reference (ToR). Next, the session will describe the challenges in creating ToR that respect the need for autonomy and distinct

objectives of participating organizations while recognizing that compromises will be required to achieve joint goals. The proposed Canadian PGME Governing Council (GC) will be described. This session will then engage participants in an analysis of issues that could reasonably be brought to the GC to generate consensus-based recommendations. Participants will be challenged to create a hierarchy of issues that need a collaborative solution, outlining the risks and benefits of making a given decision.

W115053 Teaching and Assessing the Collaborator Role: An interactive workshop with a national focus

10:30–12:00

Deborah Kopansky-Giles, BPHE, DC, FCCS, MSc, Toronto, ON; Christie Newton, MD, CCFP, FCFP, Vancouver, BC; Alison Eyre, MD, CM, CCFP, Ottawa, ON; Steve Balkou, MSc, Sherbrooke, QC; Tanya Magee, BN, RN, Halifax, NS

714A MTCC

Learning objectives:

1. discuss the current frameworks that guide the development of competency in the realm of the Collaborator Role
2. discover at least one tool or strategy to integrate into teaching and promoting the Collaborator Role
3. describe examples of how to assess the competencies in the Collaborator Role within the participant's setting

Description:

How do we teach and assess the Collaborator Role in family medicine? Are we doing it well enough? How can we improve? Do we need more tools? Collaboration is an essential competency for a family doctor. It is also an accreditation standard that family medicine programs teach and assess as the Collaborator Role. However, identifying and assessing this role's competencies through residency training remains challenging. The Collaborator Role Working Group at the College of Family Physicians of Canada has been tackling these questions over the past two years. Working Group members have reviewed the relevant frameworks, provided input into the CanMEDS 2015 and CanMEDS-FM rewrites, and developed a set of best practices to teach and assess the acquisition of competency in this role. Providing best practice tools and strategies will not only facilitate these processes in family practice teaching but also help to ensure comparability of programming across the country so that all family medicine residents in Canada are supported in the attainment of these Collaborator Role competencies. This session will be of interest to teachers, program directors, health professional educators, and curriculum/assessment leads. After a brief didactic presentation we will work in small break-out groups (both French and English) to apply the information provided to develop approaches that can be used to teach and assess the Collaborator Role within the participants' own environments.

W100411 Using Nominal Group Technique for Triple C Competency-based Curriculum Development

11:00–12:00

Eric Wong, MD, CCFP, MClSc(FM), London, ON; Jamie Wickett, MD, CCFP, London, ON

717B MTCC

Learning objectives:

1. describe how to use nominal group technique (NGT) to achieve consensus
2. describe how NGT can assist Triple C Competency-based Curriculum transformation through the development of educational objectives and assessment criteria, and the provision of faculty development opportunities

Description:

The NGT is a structured, group-consensus-building technique that has been shown to generate a greater quantity of unique ideas and participant satisfaction than traditional interacting groups (Van de Ven and Delbecq, 1974). In our experience, NGT is very effective in generating consensus around educational objectives and assessment criteria. At Western University, we have been using NGT to build consensus on Entrustable Professional Activities that will guide our Triple C Competency-based Curriculum in terms of curricular development and assessment. Additionally, NGT generates great opportunities for faculty development. This interactive workshop will engage participants in a live NGT session to build consensus around a topic of participants' choice. Examples of how NGT can assist in Triple C Competency-based Curriculum transformation will be shared.

W101592 Want to Teach? An interactive workshop for new teachers in family medicine

11:00–12:00

Jamie Wickett, MD, CCFP, London, ON; Daniel Grushka, MD, CCFP (EM), London, ON; Julie Copeland, MD, CCFP, Mount Brydges, ON

715A MTCC

Learning objectives:

1. understand and use the One-Minute Preceptor model and SNAPPs with learners
2. provide effective feedback to learners
3. understand how to teach procedures

Description:

Family physicians are frequently involved in teaching medical students and residents. Having an understanding of some core teaching concepts and techniques is essential. In addition, finding time to teach in a busy practice can be very challenging, and using efficient and effective teaching techniques is critical. This workshop will help enhance new teachers' effectiveness by reviewing key topics in education including giving feedback, the One-Minute Preceptor model, and teaching procedures. The workshop learning objectives will be met using a variety of techniques including interactive discussions with participants, review of audio video vignettes, role-play scenarios, and PowerPoint presentation.

W102913 Questions in Practice (QUIPs): Teaching residents to use clinically relevant EBM skills

11:00–12:00

Norah Duggan, MD, CCFP, St. John's, NL; Susan Avery, MD, CCFP, St. John's, NL; Lisa Bishop, PharmD, St. John's, NL; Stephen Darcy, MD, CCFP, FCFP, Mount Pearl, NL

715B MTCC

Learning objectives:

1. describe an effective method of teaching learners to find evidence-based answers to daily clinical questions
2. lead a group of learners through a clinically relevant EBM (QUIPs) session
3. write a field note providing effective feedback on EBM skills to a learner

Description:

Questions in practice (QUIPs) sessions are designed to aid family medicine residents to acquire and apply evidence-based medicine (EBM) research and analysis skills relevant to daily practice. Residents are taught to identify questions during their clinical experience, to perform a literature search using the highest level of evidence available, and to critically appraise the "one best paper" they identify. They must also be able to identify any change to practice they would make based on the evidence. In this workshop, participants will be taught to lead a resident or group of residents through a literature search using various databases (DynaMed, Cochrane, etc.) to find the best available publication to answer their clinical question. The steps in analyzing the literature will be reviewed, with teaching tips for participants to use in helping their learners understand each step in the process. Steps for providing a useful field note with constructive feedback to help a learner further develop their EBM skills will also be taught.

W102838 Assessment in Competency-Based Medical Education: Finding assessment strategies that fit your program
11:00–12:00

Shelley Ross, PhD, Edmonton, AB; Shirley Schipper, MD, CCFP, Edmonton, AB;
Paul Humphries, MD, CCFP, FCFP, Edmonton, AB; Michel Donoff, MD, CCFP, FCFP, Edmonton, AB
717A MTCC

Learning objectives:

1. discuss basic assessment theory, particularly as it applies to competency-based assessment
2. describe how workable, competency-based assessment can be done
3. identify at least one assessment strategy or tool for use in participant's own program

Description:

As medical education moves globally toward a competency-based approach, programs need good strategies to track learners' progress toward competency. Multiple frameworks for competency-based medical education (CBME) exist; deciding upon strategies, instruments, or approaches (entrustable professional activities? progress testing? milestones? formative feedback?) is a daunting task. Trying to determine the whys and hows of assessment has been a barrier to CBME implementation. This primarily interactive workshop is for anyone with questions about how to implement workable competency-based assessment, and for those who are already carrying out competency-based assessment and would like to share experiences—positive and negative—with others. In the first half of the workshop, there will be a summary overview of assessment theory in the context of practical application in CBME, with a bibliography provided for those who wish to explore theories more deeply. Participants will next be introduced to a sampling of approaches and tools for CBME assessment, along with examples and bibliographies. In the second half of the workshop, participants will apply what they have learned in themed small groups (each group based on one aspect its members have selected to assess from their own programs), discussing the possible tools they could use to assess their selected program example.

**Presentation by the Recipient of the CFPC Outstanding Family Medicine Research Article
Présentation par le récipiendaire du Prix du CMFC pour un article exceptionnel de recherche en médecine familiale**
W121589 Effect of Payment Incentives on Cancer Screening in Ontario Primary Care
11:00–11:15

Tara Kiran, MD, MSc, Toronto, ON; Andrew S. Wilton, MSc; Rahim Moineddim, PhD; Lawrence Paszar, MD, MSc;
Richard Glazier, MD, MPH, CCFP, FCFP, Toronto, ON
718AB MTCC

Description:

Purpose: There is limited evidence for the effectiveness of pay for performance despite its widespread use. We assessed whether the introduction of a pay-for-performance scheme for primary care physicians in Ontario, Canada, was associated with increased cancer screening rates and determined the amounts paid to physicians as part of the program. Methods: We performed a longitudinal analysis using administrative data to determine cancer screening rates and incentive costs in each fiscal year from 1999/2000 to 2009/2010. We used a segmented linear regression analysis to assess whether there was a step change or change in screening rate trends after incentives were introduced in 2006/2007. We included all Ontarians eligible for cervical, breast, and colorectal cancer screening. Results: We found no significant step change in the screening rate for any of the 3 cancers the year after incentives were introduced. Colon cancer screening was increasing at a rate of 3.0% (95% CI, 2.3% to 3.7%) per year before the incentives were introduced and 4.7% (95% CI, 3.7% to 5.7%) per year after. The cervical and breast cancer screening rates did not change significantly from year to year before or after the incentives were introduced. Between 2006/2007 and 2009/2010, \$28.3 million, \$31.3 million, and \$50.0 million were spent on financial incentives for cervical, breast, and colorectal cancer screening, respectively. Conclusions: The pay-for-performance scheme was associated with little or no improvement in screening rates despite substantial expenditure. Policy makers should consider other strategies for improving rates of cancer screening.

**Presentation by the Recipient of the CFP Best Original Research Article
Présentation par le récipiendaire du Prix du MFC pour le meilleur article de recherche originale**

W123303 **Improved Outcomes for Elderly Patients Who Received Care on a Transitional Care Unit**
11:15–11:30 Margaret L. Mainville, MD, CCFP, FCFP, Victoria, BC; Michael Klein, MD, CCFP, FCFP, Roberts Creek, BC;
 Lesley Bainbridge, Vancouver, BC
718AB MTCC

Description:

Context: Transitional shelters provide safe and temporary accommodation for women in crisis. In 2011/2012, shelters across Canada reported over 60 000 admissions of women. Many of these women have suffered interpersonal violence, complex trauma, and major financial burden. They are at disproportionate risk of health deterioration. To date, little is known about the health care experiences of Canadian women living in shelters. Objective: To explore the health care experiences of women living in Vancouver's transitional shelters, specifically, to 1) determine how health care is accessed; 2) identify specific barriers to access; and 3) examine how the health care system could better serve these women. Design: A qualitative study using focus groups. Participants: Sixteen women residing in two transitional shelters located in Vancouver, British Columbia. Instrument: Three focus groups were conducted to explore the health care experiences of the study participants. Interviews were audio recorded and transcribed verbatim. NVivo software was used for data analysis to help identify units of meaning for key themes. Findings: Six main themes were identified: Women in transition want family doctors; transportation is a barrier to care; relocation inhibits access; out-of-pocket costs are unaffordable; access to specialists is limited without a GP; continuity of care is highly valued. Conclusions: Conventional health care services are failing women living in transitional shelters, leaving them doctorless and unengaged. While they most often use walk-in clinics, this fragmented care does not meet their complex needs. Given their histories of trauma and crisis, continuity of mental and physical health care is essential. Family physicians should create specific plans to connect with and care for these vulnerable women.

**Presentation by the Recipient(s) of the Research Awards for Family Medicine Residents
Présentation par les récipiendaires des Prix de recherche pour les résidents en médecine familiale**

W108011 **A Prospective Comparison of Emergency Department Crowding Scores: A single centre cross-sectional study**
11:30–11:45 Robin Clouston, PGY-2, MD, Saint John, NB
718AB MTCC

Description:

Context: Emergency department (ED) crowding is a significant problem in emergency care. The most widely known tools to measure crowding are EDWIN and NEDOCS; both validated. The International Crowding Measure in EDs (ICMED), seeks to measure crowding but has not yet been validated internationally. In New Brunswick, there are three tools used in local EDs (DEC, SJRH, Moncton). Objective: To determine which of these 6 tools, as well as 5 single variables, is the best measure of crowding and safety in our local ED, as compared to physician rating via Visual Analogue Scale (VAS). A secondary goal will determine which tool best predicts ED crowding and safety up to four hours before VAS. Design: We conducted observations in crowding capturing all times of day, over 2 weeks, and compared the resultant scores to VAS. Five single variables (#pts in ED; #pts in ED beds/waiting; #pts To Be Seen; # wait room pts; # boarders) were also analyzed. Participants: ED was observed at 2-hour intervals. Charge physicians and charge RNs participated at each interval to give their clinical rating. Intervention: All 11 predictor variables were calculated using a data collection form. Outcome Measure: Physician rating, based on 10cm VAS. A clinician rating is the standard of face validity in ED crowding, based on previous research for EDWIN, NEDOCS and ICMED. Charge nurse rating was used in kappa calculation. Results: We recorded 143 events. VAS showed the ED to be crowded 60.8% of time using a binary cut point. The “#pts waiting” had highest predictive value for crowding at t=0 (sens=81%, spec=64%). DEC Score had highest predictive value for crowding at t=2h (sens=89.5%, spec=60.0%), with NEDOCS similar (sens=89.5% and spec=53.3%). For safety at t=2h, NEDOCS was most predictive (sens=92.7%, spec=89.5%). No variable could accurately predict crowding or safety at t=4h. For binary crowding VAS, k=0.424. For binary safety VAS, k=0.345. Conclusions: For current ED crowding and safety, single variables are as sensitive and specific as formal crowding scores. In determination of crowding and safety 2 hours in the future, the validated NEDOCS Score and similar DEC Score showed greatest sensitivity and specificity.

**Presentation by the Recipient(s) of the Research Awards for Family Medicine Residents
Présentation par les récipiendaires des Prix de recherche pour les résidents en médecine familiale**

W121610 12:00 Melatonin for the Prevention of Delirium and Management of Evening Behavioural Disturbances 11:45–12:00
A systematic review and meta-analysis
 Karen Leung, MD, CCFP, Edmonton, AB
718AB MTCC

Description:

Introduction: Delirium is independently associated with accelerated cognitive decline, prolonged hospitalizations, and mortality among older adults. Currently, few effective pharmacotherapies are available to prevent the onset of delirium or to ameliorate its acute confusional state as well as the chronic agitated behaviours seen in patients with dementia. Melatonin has been proposed as an adjunctive therapy, with early trials suggesting significant reductions in the incidence and symptom severity. Methods: This systematic review examines whether melatonin reduces the incidence of delirium or the severity of evening agitation in patients with dementia. Database searches (1966 to 2014) of MEDLINE, EMBASE, HealthStar, and CENTRAL were conducted without language restrictions. Dersimonian-Laird random effect models were calculated to summarize the pooled relative risks (RR) of delirium and standardized mean differences (SMD) in agitation severity. Results: Five trials examined delirium and six trials examined the severity of dementia associated behavioural disturbances. Although heterogeneity was evident, melatonin use significantly reduced the incidence of delirium (RR=0.43, 0.95%CI: 0.19–0.96) but did not significantly improve dementia-associated agitation (SMD=-0.23, 95%CI: -0.87–0.41). No significant adverse events were observed with melatonin use. Conclusion: Early evidence suggests that melatonin may reduce delirium, but findings need to be interpreted cautiously in the presence of heterogeneity and possible publication bias.

12:00–12:30 Lunch / Dîner
12:30–13:00 Section of Researchers Chair's Report / Rapport du président de la Section des chercheurs
718AB MTCC

**Presentation by the 2015 Family Medicine Researcher of the Year
Présentation par le récipiendaire du Prix du Chercheur de l'année en médecine familiale pour 2015**

W121614 13:15–13:45 Complexity and Future of Family Medicine Research
 Ross Upshur, MA, MD, MSc, MCFP, FRCPC, Toronto, ON
718AB MTCC

W101719 13:15–14:30 Master of the Universe: Can I be a better educator?
 P. Yee-Ling Chang, MD, MScCH, CCFP, FCFP, Toronto, ON;
 Jean Hudson, MD, MScCH, CCFP, FCFP, Mississauga, ON;
 Abbas Ghavam-Rassoul, MD, MSc, CCFP, FCFP, Toronto, ON
715B MTCC

Learning objectives:

1. formulate a personal list of academic career goals
2. incorporate faculty development activities to help achieve career goals
3. design three personal strategies to strengthen confidence and competence in medical education

Description:

More and more faculty members are questioning the wisdom of “see-one-do-one-teach-one” methodology. The response to this awakening has been an increase in the number of opportunities for faculty development in the area of medical education. Faculty can now choose between a variety of options ranging from online resources, workshops, certificates, fellowships, and / to graduate degrees. In addition, goals of faculty differ, depending on their career stage and their other professional responsibilities.

This workshop will begin by asking faculty to reflect on their relative strengths by reviewing the College's Fundamental Teaching Activities Framework. We will review case examples of faculty members who have undertaken Master's level work and leadership opportunities available to them.

Discussions on how faculty members managed personal and other career obligations, as well as empirical and evidentiary impact of this training on one's professional career, will be reviewed.

Participants will engage in small-group activities to share and expand their individual goals and develop action plans to achieve them. We will conclude the session by reflecting upon these plans and creating opportunities to establish supports through mentorship and developing a community of learning.

W107079 Family Medicine Residents' Perceptions of Patient-Centred Care: Is it time to make the implicit, explicit?**13:15–14:30**

Elaine Van Melle, PhD, Kingston, ON; Nancy Dalgarno, PhD, Kingston, ON

713B MTCC**Learning objectives:**

1. describe Stewart et al's 2014 patient-centred care framework
2. compare and contrast patient-centred care, person-focused care, and relationship-centred care
3. recognize how values shape approaches to patient-centred care and describe potential teaching and learning strategies regarding patient-centred care

Description:

Across the globe, family medicine has adopted patient-centred care (PCC) as a core value. To date much of the research has focused on developing instruments that measure PCC. Little is known, however, about residents' insight into PCC. The purpose of our research was to explore family medicine residents' perceptions of PCC, particularly the learning experiences that contribute to the development of their awareness. We chose the patient-centred clinical method (PCCM) as our conceptual framework. Consisting of four integrated components and a series of elements, this framework is widely used in the context of family medicine. In this highly interactive workshop we will share the findings of our research and implications for teaching in residency education. We will begin with a brief presentation of the purpose of our research. Participants will then be asked to write down on large sticky notes what they think are the main components, ingredients, and behaviours contributing to patient-centred care. As a group we will then construct a concept map of patient-centred care. This map will be compared to Stewart et al's 2014 patient-centred care framework and lead to a discussion of the difference between patient-centred care, person-focused care, and relationship-centred care and how our values inform how we practise patient-centred care. We will finish by comparing the group's work to our analysis of how family medicine residents characterize patient-centred care. At the end of the workshop we will discuss our recommendation that it could be time to make the implicit explicit when it comes to teaching family medicine residents about patient-centred care.

W118005 Calling on Peers: UGEC's Peer Consultative Review Process**13:15–14:30**

Amy Tan, MD, MSc, CCFP, Edmonton, AB; David Keegan, MD, CCFP (EM), FCFP, Calgary, AB;

Kathleen Horrey, MD, CCFP, FCFP, Halifax, NS; Ian Scott, MD, MSc, DOHS, CCFP, FRCPC, FCFP, Vancouver, BC

715A MTCC**Learning objectives:**

1. describe the benefits of a collegial peer consultative review for educational programs, including national collaboration with the sharing of best practices and feedback on new initiatives
2. apply these lessons learned to one's local environment in order to develop a framework for implementing similar collegial peer consultations in a variety of different learning and practice settings

Description:

The Undergraduate Education Committee (UGEC) of the CFPC has conducted peer consultative reviews of family medicine undergraduate education programs since 2008, in collaboration with the members of the Canadian Undergraduate Family Medicine Education Directors (CUFMED). In this workshop, we will share the outcomes of the first cycle of peer consultative reviews across the country (2008–2014), including the experiences of the peer consultants and the accreditation teams, who had the perspectives of an undergraduate educator for the postgraduate accreditation surveys. These peer consultations were carried out in conjunction with the CFPC Postgraduate Family Medicine Education accreditation visits, whereby a member of CUFMED reviewed the peer's undergraduate education program. The aim of the peer consultative review is to provide feedback on existing educational programs within national contextual norms, and consultation on areas of uncertainty or ideas for future implementation and the resources required for sustainability. The peer consultant meets with a variety of local stakeholders who influence the work of the undergraduate education team, including students, staff administrators, the department chair, members of the Family Medicine Interest Group, and the associate dean of the MD program at the school, in an effort to provide review and feedback on information gathered from a variety of perspectives. We will share how the reports from these peer consultations have been used at local schools to implement revisions or new initiatives, and to generate proposals for more resources to further the work of the undergraduate programs. Participants will share their experiences and will provide guidance on the review process to make it better.

W101309 Teaching Professionalism: Collegial conversations with our learners**13:15–15:30**

James Goertzen, MD, MCISc, CCFP, FCFP, Thunder Bay, ON

717A MTCC**Learning objectives:**

1. describe the contextual nature of professionalism
2. describe the critical role of preceptors in the development of professionalism by their learners
3. apply strategies for addressing learner unprofessional behaviour

Description:

Although professionalism is a core competency for medical students, residents, and practising physicians, the teaching of professionalism is often haphazard. Professionalism is contextual and best understood as a series of behaviours within a clinical setting rather than personal traits or attributes. Preceptors have a critical role in assisting learners with their professional development. Lapses in professional behaviour by students and residents are common and are to be expected as they apply and integrate the principles of professionalism within the clinical setting. A lapse provides an opportunity to have a crucial and collegial conversation to better understand the learner's context and the rationale for their behaviour. Collegial conversations encourage reflection and assimilation of new professional behaviours.

W101485 Accreditation of Postgraduate Programs: Demystifying the process

13:15–15:30 Louise Nasmith, MD CM, CCFP, FCFP, Vancouver, BC; Keith Wycliffe-Jones, MB, ChB, CCFP, Calgary, AB; Shirley Schipper, MD, CCFP, Edmonton, AB; Judith Scott, Mississauga, ON
714B MTCC

Learning objectives:

1. recognize elements of the PG accreditation process that are relevant to participants' situations and roles
2. prepare for an accreditation survey and its various components (eg, PSQ completion, local preparation)
3. develop specific skills needed as a surveyor (eg, interviewing, deliberating)

Description:

This workshop will review the various elements involved in an accreditation survey visit, from the pre-survey questionnaires (PSQs) to the use of checklists during the actual site visit. Examples of good practices will be shared and discussed. Based on the needs of the participants, small-group exercises will be conducted. These might include how best to fill in a PSQ, how to prepare residents and faculty for a survey visit, how to question residents and faculty during a site visit, and what evidence meets accreditation standards. By the end of the workshop, it is anticipated that participants, whether members of a program or potential surveyors, will have gained a better understanding of the accreditation process.

W102578 Recognizing Your Hidden Faculty: Integrating and supporting the role of health professional educators in family medicine

13:15–15:30 Judith Peranson, MD, CCFP, MPH, Toronto, ON; Deborah Kopansky Giles, BPHE, DC, FCCS, MSc, Toronto, ON; Ian Waters, MSW, RSW, Toronto, ON
717B MTCC

Learning objectives:

1. describe the involvement of health professional educators (HPEs) in family medicine teaching nationally and at the University of Toronto
2. identify common challenges faced by HPEs in medical education
3. identify and showcase strategies for effective integration of HPEs into education activities within clinical teaching units

Description:

Nationally, the transformation of family medicine teaching units into interprofessional primary care teams has created opportunities for health professional educators (HPEs) to take on new roles as educators in family medicine. However, the integration of HPEs has historically been implemented on an ad hoc, informal basis, with implications for the quality of the education experienced by both learners and teachers. This workshop will provide an environmental scan of the roles, experiences, and challenges faced by HPEs as family medicine teachers, leveraging the growing expertise of members of the HPE Network (HPEN) of the CFPC Section of Teachers and referencing research conducted at the University of Toronto on HPE experiences. Strategies for optimizing HPE integration within clinical teaching units will be offered, with opportunity for participants to share local best-practice examples.

W115052 The Preceptor as THE Assessment Tool

13:15–15:30 Theresa Van der Goes, MD, CCFP, Vancouver, BC; Tom Laughlin, MD, CCFP, Moncton, NB; Karen Schultz MD, CCFP, FCFP, Kingston, ON
714A MTCC

Learning objectives:

1. develop your understanding as a preceptor of why you are the best judge of competence in your trainees
2. encourage you to explore and challenge the evidence behind this conclusion and suggest the essential programmatic changes that will ensure that your assessment becomes the cornerstone to each learner's trajectory toward competence
3. assist you and your program to craft appropriate faculty development to support and enhance preceptors' confidence in their ability to recognize and coach to competence

Description:

As medical education, and postgraduate family medicine in particular, moves increasingly toward competency-based training programs, teachers and programs seek tools and skills that will ensure the appropriate assessment of competence. The challenges to rigorous assessment over the past 30 years have moved medical education toward the development of objective assessment instruments such as OSCEs, enhanced MCQs, SAMPs, and SOOs. These instruments, although useful for assessment, do not tell the whole story and do not translate well into the workplace, which is now recognized as the most authentic environment for assessment for postgraduate training. Objectivity and reliability have been two major constructs in medical education assessment that have been recently scrutinized. We will argue that the most reliable assessment of residents is the day-to-day assessment by experts in the discipline: preceptors in family medicine.

W102517 To Brief or Not to Debrief: That's facilitation!

13:30–15:30 Kerry Knickle, LLM (ADR), Toronto, ON; Nancy McNaughton, PhD, Toronto, ON
713A MTCC

Learning objectives:

1. understand the relationship between briefing, debriefing, feedback, and the process of facilitation
2. review a practical facilitation model for small group experiential learning
3. practise effective communication skills and strategies

Description:

Challenging student behaviours, attitudes, and diverse world views present an opportunity for the educator to develop and consolidate a toolbox of facilitation skills that optimize the learning experience. The experiential needs and practical concerns of the learner and the cultivation of unconditional positive regard are critical considerations for the facilitator. Strong communication, awareness of personal and professional group dynamics, and understanding of the many facets of debriefing and feedback are critical for an effective facilitation process. Effective facilitation skills within the medical educator repertoire are broadly applicable across a breadth of teaching modalities and practical learning contexts. The transition from lecture hall to small group process is more challenging than many assume. Myriad issues, clinical or theoretical, that arise within the context of small group learning require acknowledgement and discussion, but the "how" of facilitation always eclipses the "what."

W121622 Community-Based Primary Health Care Teams: Key messages**13:45–14:00 718AB MTCC****Description:**

Each Team will provide a one-minute presentation to the audience highlighting the key finding that will be explained on their poster.

Top 4 Oral Presentations / Les 4 meilleures présentations orales

W107940 Longitudinal Evaluation of Physician Payment Reform and Team-Based Care for Chronic Disease Management and Prevention study

15:00-15:15

Tara Kiran, Md, Msc, CCFP, Toronto, ON; Alexander Kopp, BA; Rahim Moineddin, PhD; Richard Glazier, MD, MPH, CCFP, FCFP, Toronto, ON

706 MTCC

Description:

Context: Transitioning primary care physicians from fee-for-service to capitation or blended payments and incorporating team-based care are widely regarded as desirable transformations for patient-centred medical homes, but there are few studies evaluating the effects of these changes. Objective: To assess the impact of capitation payment and team-based care on chronic disease management and prevention by evaluating a large-scale transition of primary care physicians to medical homes in Ontario, Canada. Design: We conducted a longitudinal population-wide study using routinely collected administrative data. We used Poisson regression models to examine the association between type of medical home and diabetes and cancer screening in 2011. We calculated outcomes for each fiscal year between 2001 and 2011 and used a fitted non-linear model to compare changes in outcomes between type of medical home over time. Participants: All Ontario patients enrolled to a medical home in 2011 (N = 10 675 480). Intervention/exposure: Patient enrollment in a team-based capitation, non-team capitation, or enhanced fee-for-service medical home as of March 31, 2011. Outcome measures: Proportion of eligible patients receiving testing for diabetes and screening for cervical, breast, and colorectal cancer. Results: Patients in team-based capitation were more likely to receive recommended testing for diabetes in 2011 than were patients in non-team capitation or enhanced fee-for-service (40%, 36% and 32%, respectively) and this was true even after adjustment for patient and physician characteristics (RR [95% CI] compared to enhanced fee-for-service: team-based capitation 1.22 [1.18 to 1.25]; non-team capitation 1.10 [1.07 to 1.14]). Patients in team-based capitation experienced the greatest improvement in recommended testing for diabetes over time, followed by patients in non-team capitation (absolute difference in improvement [95% CI] compared to enhanced fee-for-service: team-based capitation 10.6% [7.9% to 13.2%]; non-team capitation 4.1% [1.5% to 6.8%]). Patients in team-based capitation experienced the greatest improvement in cervical cancer screening but there were no significant differences in change over time between medical homes for breast and colorectal cancer. Conclusions: The shift to capitation payment and the addition of team-based care in Ontario were associated with moderate improvements in diabetes care but the impact on cancer screening was less clear.

W107964 Using Automated, Regularly Extracted Electronic Medical Record (EMR) Data for Intervention Research

15:00-15:15

Simone Dahrouge, PhD, Ottawa, ON; Danielle Rolfe, RKin, PhD, Ottawa, ON; Laura Muldoon, MD, MPH, FCFP, Ottawa, ON; Jyoti Kotecha, MPA, MRSC, CChem, Kingston, ON; Richard Birtwhistle, MD, MSc, CCFP, FCFP, Kingston, ON; David Barber, MD, PhD, FCFP, Kingston, ON; David Barber, MD, PhD, FCFP, Kingston, ON; Clare Liddy, MD, MSc, PhD, FCFP, Ottawa, ON; Janusz Kaczorowski, MA, PhD, Montreal, QC

707 MTCC

Description:

Context: The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) is a multidisease surveillance system that collects quarterly electronic medical record (EMR) health data from over 800 primary care practices across Canada. The data extracted are standardized and used to inform quality monitoring at the practice level, and to conduct epidemiological research using the large dataset. Objective: Assess the feasibility of using CPCSSN to obtain chart data required for use in an intervention, the Cardiovascular Health Awareness Program (CHAP). Design: A pilot evaluation of pre- and post-intervention data extractions. Participants: Six urban primary care practice sites (three community health centres, three interprofessional capitation-based) and 48 primary care providers (PCP) in Eastern Ontario, Canada, participating in CHAP. Intervention: CPCSSN was used to replace direct chart extraction for four purposes: 1) identify eligible patients: CPCSSN produced a list of all individuals aged over 65 years and their coordinates, which was used to automate CHAP recruitment letters; 2) evaluate participation bias: comparison of participants' and non-participants' baseline data (eg, age, sex, diagnoses, risk factors, attachment to practice); 3) calculate risk scores: lipid profile and diagnoses of hypertension and diabetes were added to CHAP session data to calculate the Framingham and CANRISK scores of participants; 4) assess the intervention impact: 12 months post CHAP, modifiable risk factors (blood pressure, lipids profile, BMI, and waist circumference) will be extracted to assess changes from baseline. Results: 1) CPCSSN identified 3084 seniors; PCP excluded 934 (deceased or too frail/had dementia). 2) Participation bias was assessed successfully. 3) Lipid data to calculate Framingham was available for 94% and 62% of participants in practices with established and new (1 to 2 years) EMR systems, respectively. 4) Intervention impact will be assessed in one year. Discussion/conclusions: The cost of chart extraction often precludes the feasibility of studies relying on clinical data. The growing penetration of EMRs opens the opportunity to use automated processes for data extraction. However, the lack of standards across EMR systems means that one approach cannot be used across practices. The existing processes for data extraction and standardization developed by CPCSSN for 12 EMR vendors can be used to provide accurate data efficiently for studies requiring clinical data extraction.

FREE STANDING PAPER (ORAL) PRESENTATIONS PRÉSENTATIONS LIBRES (ORALES)

WEDNESDAY • MERCREDI

W108012 Using Archived Resident Data to Improve CaRMS Selection Through Evidence-Based Interview Questions

15:00–15:15

Michelle Morros, MD, CCFP, Edmonton, AB; David Ross, MD, CCFP, Edmonton, AB; John Chmelicek, MD, CCFP, FAAFP, Edmonton, AB; Paul Humphries, MD, CCFP, FCFP, Edmonton, AB; Fred Janke, MD, CCFP, FCFP, Edmonton, AB; Michel Donoff, MD, CCFP, FCFP, Edmonton, AB; Shirley Schipper, MD, CCFP, Edmonton, AB; Shelley Ross, PhD, Edmonton, AB

709 MTCC

Description:

Context: Selecting the most appropriate candidates for residency training is crucial. A poor match between a resident and a specialty or program can result in the need for interventions that are costly, time-intensive, and stressful for both the resident and faculty member. Developing better methods of selection of residents should result in a better match between residents and programs. **Objective:** In this study, we triangulated evidence from different sources to develop evidence-based interview questions for use in the Canadian Resident Matching Service (CaRMS) selection process. **Design:** Literature review, data-mining. **Intervention/instrument:** In Phase 1, a literature review was carried out to determine common factors found among residents who encounter difficulty in training. In Phase 2, files of past residents in difficulty were examined to look for common indicators that could be targeted through interviews. In Phase 3, evidence was triangulated to develop evidence-based interview questions. In Phase 4, an expert panel reviewed the questions multiple times until consensus was reached. **Results:** The literature review revealed that deficiencies in professionalism, resiliency, and problem-solving approaches were common factors among residents who encountered difficulty in training. The file review confirmed these areas, as well as sincere interest in the specialty. Key papers from the literature review were re-examined to determine if there were validated questions to ask of candidates. Once essential aspects of key factors were identified, a preliminary list of questions was generated. The expert panel reviewed the questions, and questions went through multiple iterations before finalized forms. Lastly, a scoring schematic for the individual questions was determined, which included specific elements to watch for in responses. Informally, faculty reported that they were pleased with the new questions; answers given by candidates were more informative than previously. Additionally, scores for candidates showed greater range than in previous CaRMS rankings, indicating that the new interview questions distinguished between candidates better than previous questions did. **Conclusion:** While much effort is required to develop evidence-based interview questions, initial results suggest that the new questions better distinguish between candidates. Long-term evaluation will include determining how many residents encounter difficulty in training.

W106060 Transition Into Residency of Canadians Studying Abroad: Stigmatization and the clinical practice gap

15:00–15:15

Teresa Cavett, MD, CCFP, FCFP, MEd, Winnipeg, MB

710 MTCC

Description:

For most people, chronic life-limiting illnesses such as cancer and dementia will result in a period of decline towards end of life that necessitates palliative care. Only one-third of Canadians receive palliative care from specialist teams and most primary care settings do not have a palliative care specialist. The role of family physicians in providing primary palliative care will become increasingly important. Patient-centred comprehensive family medicine equips family physicians and other primary care providers to care for patients with advancing illness as they approach end-of-life. Drawing on their longitudinal relationship, knowledge of the patient's life circumstances and the patient's health status puts family physicians in an ideal position to support the transition to palliative care. Handing over all palliative care to palliative care specialists is unsustainable, may result in fragmented care, and diminishes an opportunity for primary care providers to develop the skills and confidence to deliver palliative care. Although family physicians today are delivering palliative care, there are gaps in coverage and room for quality improvement. There are calls in Canada to integrate palliative care in the health care system as part of "comprehensive" family medicine. These calls to action must be interpreted through an understanding of the strategies family physicians currently use to manage their patients with advancing life-limiting illness. Our research suggests that certain primary care provided to patients with advanced life-limiting illness is not being correctly recognized as palliative care. We will share the results of our qualitative interviews with primary care practitioners, from a diverse array of practices, who have so far elucidated interesting and surprising aspects of what we would consider palliative care. Of particular importance is the establishment of a proactive relationship, as waiting for an event to occur before delivering a palliative approach to care reduces the value and quality of this care. Our data may offer an alternative and more encouraging view of palliative care integration in primary care settings. This session will explore the existence and emergence of indicators reflecting the provision of primary level palliative care.

W102688 Strengths in Caring for Patients With Advancing Illness as Opportunities for a Primary Palliative Care

15:15–15:30 Michelle Howard, PhD, Hamilton, ON; Samantha Winemaker, MD, CCFP, Hamilton, ON; Joy White, PHC-NP, BScN, Hamilton, ON; Nicolle Hansen, PHC-NP, MScN, Hamilton, ON; Alex Rewegan, BA, Hamilton, ON; Sharef Danho BSc(candidate), Hamilton, ON
707 MTCC

Description:

For most people, chronic life-limiting illnesses such as cancer and dementia will result in a period of decline towards end of life that necessitates palliative care. Only one-third of Canadians receive palliative care from specialist teams and most primary care settings do not have a palliative care specialist. The role of family physicians in providing primary palliative care will become increasingly important. Patient-centred comprehensive family medicine equips family physicians and other primary care providers to care for patients with advancing illness as they approach end-of-life. Drawing on their longitudinal relationship, knowledge of the patient's life circumstances and the patient's health status puts family physicians in an ideal position to support the transition to palliative care. Handing over all palliative care to palliative care specialists is unsustainable, may result in fragmented care, and diminishes an opportunity for primary care providers to develop the skills and confidence to deliver palliative care. Although family physicians today are delivering palliative care, there are gaps in coverage and room for quality improvement. There are calls in Canada to integrate palliative care in the health care system as part of "comprehensive" family medicine. These calls to action must be interpreted through an understanding of the strategies family physicians currently use to manage their patients with advancing life-limiting illness. Our research suggests that certain primary care provided to patients with advanced life-limiting illness is not being correctly recognized as palliative care. We will share the results of our qualitative interviews with primary care practitioners, from a diverse array of practices, who have so far elucidated interesting and surprising aspects of what we would consider palliative care. Of particular importance is the establishment of a proactive relationship, as waiting for an event to occur before delivering a palliative approach to care reduces the value and quality of this care. Our data may offer an alternative and more encouraging view of palliative care integration in primary care settings. This session will explore the existence and emergence of indicators reflecting the provision of primary level palliative care.

W104798 The Experience of Primary Care at a Provincial Detention Centre

15:15–15:30 Samantha Green, MD, CCFP, Toronto, ON; Fiona Kouyoumdjian, MD, CCFP, Hamilton, ON; Jessica Foran, Hamilton, ON
705 MTCC

Description:

Context: Little is known about the health status of Canadian inmates in provincial detention centres or about their access to health care in the community. US and European data show that the health of the incarcerated is poor, with a disproportionate burden of mental illness, infectious diseases, chronic diseases, and premature mortality. Recently released individuals in the US and Europe have been shown to have poor access to primary care. Objective: To describe the primary care experience of adult inmates at the Hamilton-Wentworth Detention Centre. Design: Written surveys were distributed to blocks of men and women at the Hamilton-Wentworth Detention Centre. Inmates were allowed to complete surveys in their cells at any time. Completed surveys were placed in sealed envelopes and returned to the nurse manager. Participants: Adult men and women with working knowledge of English were included in the study. Four hundred nineteen surveys were distributed and 125 were returned (33%). Of the respondents, 16.8% indicated they were female; 80%, male. The mean age was 36 years. Instrument: A two-page survey with multiple choice questions and space for extended written responses. Results/Findings: Among respondents, 38% ($P < .001$) report that they do not have a family doctor or primary care provider, compared with 15% of the Canadian population. Those with no family doctor noted several barriers, including difficulty finding a physician who is accepting new patients; difficulty navigating the health care system; and frequent incarcerations. Among respondents, 43% reported having had unmet health care needs in the year before coming to jail, compared with 8.8% of the Canadian population. Barriers included prior experience of stigma in the health care system and inaccessible clinic locations and schedules. Participants reported an average of 2.1 emergency department visits in the year prior to incarceration, compared with 0.29 visits per year for the Canadian population. Discussion/Conclusion: Those incarcerated at the Hamilton-Wentworth Detention Centre report having poorer access to primary care and higher unmet health care needs than average Canadians. Incarceration could provide an opportunity to connect inmates with primary care and thus improve health care and health.

W106309 Continuity of Care and Identity Formation: A critical review of interventions in postgraduate training

15:15–15:30 Allyson Merbaum, MD, CCFP, FCFP, Toronto, ON; Kulamakan Mahan Kulasegaram, PhD, Toronto, ON; Rebecca Stoller, MD, CCFP, FCFP, Toronto, ON; Risa Freeman, MD, MEd, CCFP, FCFP, Toronto, ON
710 MTCC

Description:

Context: Continuity of care (CoC) is a critical aspect of practice in generalist disciplines and across several dimensions of clinical care. To date, there have been several interventions at the level of residency training to inculcate CoC. Their mechanisms and impact on the formation of a caring physician identity is unknown. In this critical narrative review, we analyzed the existing literature to understand the pedagogic rationales and effectiveness of these interventions. Method: We searched the existing medical education literature via MEDLINE, EMBASE, and CINAHL for English-language articles since 1975 that described or evaluated continuity-of-care interventions at the level of postgraduate training. We excluded commentaries and non-postgraduate papers. We analyzed the extracted literature for themes across interventions, for the proposed pedagogic mechanisms or rationales, and for evidence of effectiveness. Results: Twenty-two papers dealt with CoC at the postgraduate level but only 15 described interventions, with the remaining describing satisfaction with training. Studies describing interventions have focused on organizational changes to the structure of residency programs. Examples of such interventions included a longitudinal family medicine component, a resident patient panel, and increasing dedicated time for practice in family medicine settings. There is a lack of rigorous evaluation of most interventions. Our analysis suggests that the pedagogic mechanisms are not clearly articulated in the literature. Furthermore, current structural interventions do not conceptualize continuity of care as a part of the identity of the physician.

Conclusions: Pedagogic evidence suggests that to be effective training must help integrate the practice of CoC as an essential part of physician identity. Current interventions in the literature do not describe a programmatic approach to integrating CoC into emerging physician identity and have not been rigorously evaluated for outcomes. Adopting an identity formation framework can help training become more relevant and transferrable to future practice, and suggest appropriate outcomes for evaluation.

W108008 Mental Health Screening in Pregnancy: Methods women prefer; barriers and facilitators to disclosure

15:15–15:30

Anne Biringer, MD, CCFP, FCFP, Toronto, ON; Marie-Paule Austin, MD, FRCPC, Victoria, Australia; Sheila McDonald, PhD, Calgary, AB; Maureen Heaman, RN, PhD, Winnipeg, MB; Gerri Lasiuk, RN, Edmonton, AB; Katherine Hegadoren, RN, PhD, Edmonton, AB; Sarah D. McDonald, MD, Hamilton, ON; Sander van Zanten, MD FRCPC, Edmonton, AB; Wendy Sword, RN, PhD, Rebecca Giallo, PhD, Victoria, Australia; Dawn Kingston, RN, PhD, Edmonton, AB

PhD,
FRCSC, MSc,
Hamilton, ON;

704 MTCC

Description:

Context: Access to mental health services during pregnancy is most commonly mobilized through formal mental health screening. However, despite recommendations by international organizations, fewer than 20% of prenatal care providers routinely conduct mental health screening. A prominent barrier is providers' perceived concern regarding the acceptability of screening and its results to women. Objective: To describe pregnant women's views of mental health screening, including screening methods and personal and system-related barriers and facilitators that influence their responses to provider-initiated mental health screening. Design: Multisite, cross-sectional survey. Setting: Five maternity clinics and prenatal classes at two community hospitals in Edmonton and Medicine Hat, Alberta, Canada. Participants: All pregnant English-speaking women presenting for care in the seven sites were recruited consecutively. Intervention: Self-report questionnaire completed on computer tablet. Results: Of 500 women approached, 460 (92%) participated. Overall, 98% were very (75%) or somewhat (23%) comfortable with being asked about their mood in pregnancy. Women were most comfortable with paper-based (>90% very or somewhat comfortable) and computer-based (>83%) screening that was coupled with discussion of results with their provider. Comfort levels were similar whether the screening was completed in clinic or home. Telephone-based screening by a nurse was least favoured (62% very or somewhat comfortable). Significant barriers to disclosure included others' normalizing emotions, desiring to handle their mood on their own, preferring to discuss feelings with significant others, and not knowing what emotions were "normal." Significant facilitators included characteristics of the care provider (sensitive, interested), reassurance that emotional health was part of normal care, hearing that other women have emotional issues in the perinatal period, and reassurance that help (in addition to medications) is available. Conclusions: Women are receptive to a variety of screening approaches. Efforts to minimize barriers and enhance facilitators of screening are key strategies in implementing universal, routine perinatal mental health screening.

W108016 Examining Past Resident Files to Improve CaRMS Selection Through an Evidence-Based File Review Process

15:15–15:30

Michelle Morros, MD, CCFP, Edmonton, AB; Rosslynn Zulla, MEd, Edmonton, AB; Lisa Steblecki, MD, CCFP, Edmonton, AB; Sandra Robertson, Edmonton, AB; Shelley Ross, PhD, Edmonton, AB

709 MTCC

Description:

Context: Despite best efforts in selection, 6% to 10% of accepted residents in family medicine experience difficulties. Interventions can be time-consuming and expensive. One strategy to reduce the number of interventions needed is to improve the resident selection process, ensuring that the best match possible is being made between resident and program. Objective: The Canadian Residency Matching Service (CaRMS) applications of past residents who encountered difficulty were examined to determine if there were common indicators of difficulty. The goal was to use these data to develop an evidence-based CaRMS file review process. Design: Secondary data analysis, literature review. Instrument: Program directors identified 30 residents who encountered difficulty ("cases"). Matched controls (residents who did not encounter difficulty; "controls") were also identified. Outcome measures: CaRMS application materials were extracted from resident files (de-identified and coded). Each component of the CaRMS application was analyzed, with a focus on differences within the application elements between the residents who encountered difficulty and those residents who did not. Factors were triangulated with existing findings in the literature. Results/findings: Multiple indicators were identified (commonalities among cases/notable differences between cases and controls); several reflected findings in literature. In the curriculum vitae section, cases did not have much variety in their work or volunteer roles, and had few leadership positions. For clinical electives, total time was less of an indicator than was the degree to which applicants described their electives. Cases gave vague descriptions, while controls gave detailed descriptions. For reference letters, there were certain words that occurred with much greater frequency for the controls, such as "exceptional" and "well-rounded." For the personal letter, cases were more likely to be vague, especially about specialty choice, and have inconsistencies within the personal letter. Controls had highly descriptive personal letters that emphasized and gave supporting evidence for specialty choice. The new file review form was piloted with 10 faculty reviewers and their current residents. Greater agreement was seen than with the previous form. Conclusions: The new evidence-based form shows promising results in pilot use. Long-term evaluation of the 2015 cohort will indicate if this process is valid as a better way to select residents.

W108072 Using Narrative to Enhance Team-Based Care in Older Adults Who Have Fallen

15:15–15:30

Lara Nixon, MD, CCFP, FCFP, Calgary, AB; Laurie Pereles, MD, MSc, CCFP, FCFP, Calgary, AB

706 MTCC

Description:

Context: Falling as an older adult is a common and complex phenomenon with potentially serious consequences; however, there has been a relatively low uptake and acceptance of falls prevention strategies in this population. Clinical approaches are needed to

identify factors that may facilitate or impede older adults' acceptance of risk status and need for intervention. Objective: We hypothesize that a narrative approach to interviewing older people who have fallen will reveal important gaps compared to clinical history-taking that could better inform collaborative clinical decision-making. Design: A series of comparative case studies based on a convenience sample of fifteen older adults referred to a falls prevention clinic was used, each including the: 1) patient narrative elicited by a member of the research team; 2) clinical history generated by the falls clinic team; and 3) clinicians' impressions elicited through team interviews. We compared these three components within and across cases using thematic analysis to generate an enriched understanding of each participant's experience of falling. Strategies used to improve trustworthiness included: field notes, verbatim transcription, member checking, audit trail of analysis meetings, presentation of preliminary findings to multidisciplinary audiences, and external review. Findings: Three key concepts emerged from patient narratives: 1) perception of falls etiology, internal vs external locus of control; 2) significance of fall; and 3) perceived need for and benefit/risks of action. Interviews with the falls clinic team identified instances of salient information in patient narratives that was missed by clinical history taking or noted, but excluded from the clinical report for a variety of reasons. Whether the missing narrative information was due to failing to elicit or opting to not report, falls team clinicians confirmed that the inclusion of this missed information may have resulted in more holistic understanding of patient context and facilitated collaborative management, particularly in patients not readily engaging with falls prevention strategies. Conclusion: Important insights into older adults' experiences with having fallen were revealed using a narrative approach. In concert with clinical history taking, a narrative approach could be of particular use with patients who do not readily accept interventions based on traditional falls risk assessments.

W101716 **IV Opiate-Assisted Treatment (iOAT): Participants' characteristics might impact intensive treatment Options**
15:30–15:45

LD. Scott MacDonald, MD, Vancouver, BC

704 MTCC

Description:

For opioid-dependent patients not benefiting from conventional treatments (ie, oral methadone), evidence suggests that supervised injectable medications are effective. This baseline analysis aims to describe participants' characteristics at entry into a study comparing injectable diacetylmorphine and hydromorphone and factors independently associated with prior access to methadone at high doses. SALOME is a phase III, randomized, double-blind controlled trial comparing injectable diacetylmorphine and hydromorphone in 202 chronic, opioid-dependent, current injection-opioid users in Vancouver who had at least one prior episode of opioid maintenance treatment. An analysis has been done to determine characteristics associated with reaching a stable dose of oral methadone in the five years prior to trial recruitment. These data emphasize that study participants were in need of alternative treatments at the time of enrolment and fit the profile of patients to whom supervised injectable treatment should be offered. Implications of prior methadone treatment experience in these individuals who might be eligible for injectable opioid-assisted treatment (iOAT) will be reviewed.

W107286 **Women's Experience Using Marijuana to Cope With the Pain and Other Symptoms of Menstrual Periods**
15:30–15:45

Ellen Wiebe, MD, CCFP, FCFP, Vancouver, BC; Beata Byczko, MD, Vancouver, BC;
 Siavash Jafari, MD, MHSc, FRCPC, ASAM, Vancouver, BC

705 MTCC

Description:

Context: Our patients tell us they are using marijuana for period symptoms but there is no reported evidence for gynecologic indications. There is evidence for cannabinoid receptors in the uterus. Before starting clinical trials, we need to know how marijuana is being used. Objectives: To understand how women have been using marijuana for relieving the pain and other symptoms of menstrual periods. Methods: Questionnaires were provided online and on paper to marijuana vendors in retail shops in Vancouver, and to women recruited through the shops; by word of mouth; from advocacy groups; and using a classified advertisement website (Craigslist). The vendors were asked if they had recommended marijuana for period symptoms and how it was used. The women's questionnaire asked demographics plus whether the respondent had (current or past) pain with her periods, whether she had ever used marijuana for her period pain, and, if so, how she used it (smoked, eaten, etc.) and if she had experienced any benefit. Results: There were 192 out of 201 usable questionnaires received from women and nine from vendors. The mean age of respondents was 30.9 years with a range of 18 to 62 years. The worst period pain reported was a mean of 8.3 out of 10 and usual period pain was 5.9 out of 10. Women also complained of headaches (66.7%), nausea (54.2%), diarrhea (50.5%), feeling angry (27.1%), dizziness (66.1%), feeling sad (66.1%), fever/chills(25.5%), weakness (56.3%), and vomiting (20.3%). For period symptoms, 170 women (88.5%) said they had used marijuana and 152 (89.4%) said it helped. One hundred fifty-three women (79.7%) said they knew other women who used marijuana for periods. Eight of the nine vendors had been recommending marijuana and all said it helped their clients. Women had been using it in many forms, however, mostly they smoked or ate it. Specific recommendations from the women included using high-CBD (cannabidiol), low-THC (delta-9-tetrahydrocannabinol) forms and titrating doses so that it allowed women to function. Conclusions: Many women are using marijuana successfully to relieve the symptoms of menstrual periods. Clinical trials are needed to assess if low-THC, high-CBD products are helpful, because they may have fewer side effects and risks.

W107400 **Use of Cognitive Task Analysis to Support Change Management**
15:30–15:45

Lee Green, MD, MPH, Edmonton, AB

707 MTCC

Description:

Context: Our patients tell us they are using marijuana for period symptoms but there is no reported evidence for gynecologic indications. There is evidence for cannabinoid receptors in the uterus. Before starting clinical trials, we need to know how marijuana is being used. Objectives: To understand how women have been using marijuana for relieving the pain and other symptoms of menstrual periods. Methods: Questionnaires were provided online and on paper to marijuana vendors in retail shops in Vancouver, and to women recruited through the shops; by word of mouth; from advocacy groups; and using a classified advertisement website (Craigslist). The vendors were asked if they had

recommended marijuana for period symptoms and how it was used. The women's questionnaire asked demographics plus whether the respondent had (current or past) pain with her periods, whether she had ever used marijuana for her period pain, and, if so, how she used it (smoked, eaten, etc.) and if she had experienced any benefit. Results: There were 192 out of 201 usable questionnaires received from women and nine from vendors. The mean age of respondents was 30.9 years with a range of 18 to 62 years. The worst period pain reported was a mean of 8.3 out of 10 and usual period pain was 5.9 out of 10. Women also complained of headaches (66.7%), nausea (54.2%), diarrhea (50.5%), feeling angry (27.1%), dizziness (66.1%), feeling sad (66.1%), fever/chills (25.5%), weakness (56.3%), and vomiting (20.3%). For period symptoms, 170 women (88.5%) said they had used marijuana and 152 (89.4%) said it helped. One hundred fifty-three women (79.7%) said they knew other women who used marijuana for periods. Eight of the nine vendors had been recommending marijuana and all said it helped their clients. Women had been using it in many forms, however, mostly they smoked or ate it. Specific recommendations from the women included using high-CBD (cannabidiol), low-THC (delta-9-tetrahydrocannabinol) forms and titrating doses so that it allowed women to function. Conclusions: Many women are using marijuana successfully to relieve the symptoms of menstrual periods. Clinical trials are needed to assess if low-THC, high-CBD products are helpful, because they may have fewer side effects and risks.

W107719 Assessing the Needs of Family Physicians Caring for Cancer Survivors: A Montreal survey

15:30–15:45 Genevieve Chaput, MD, MA, CCFP, Montreal, QC; Desanka Kovacina, MD, CCFP, Montreal, QC

706 MTCC

Description:

Context: Due to earlier detection and better treatments, the number of cancer survivors has risen significantly in the past three decades. In addition to higher risk of recurrence or second malignancy, over 50% of survivors are afflicted with late effects. Cancer survivors visit a wide variety of specialists during treatment, yet 75% of them also see their family physician (FP), and this proportion does not decrease after treatment. Upon treatment completion, FPs are expected to play an integral role in cancer survivors' care. However, literature reveals low confidence levels in family physicians with regards to survivorship care. Furthermore, major deficits currently exist in the transition of care from specialists to FPs. Objective: In 2014, we conducted a survey targeting FPs, which aimed to identify their needs and perceived barriers in providing optimal care to cancer survivors. Design: A brief survey containing Likert-type and short-answer questions was designed and distributed to FPs practising within academic, public, and private settings in Montreal, Canada. Based on a targeted FP population estimated at 500, sample size was set at 75. Survey design aimed to identify specific outcome measures including current needs and perceived barriers to cancer survivor care. Data analysis comprised descriptive statistics, an open-coding approach to identify major themes, and Student t-tests. Ethics approval was obtained. Results: Of 165 surveys distributed, 93 were completed, for a 56.3% response rate. Among respondents, 94% were already caring for cancer survivors, and of these, 73% expressed a willingness to take on new cancer survivors. A statistically significant number of FPs disagreed more than agreed to "receiving summary reports" ($P = .001$), as well as for "familiar with guidelines" ($P = .01$). The biggest barriers to cancer survivor care were lack of communication with specialists (53%), and lack of knowledge of survivorship care (36%). Conclusion: Our findings demonstrate the need to improve communication with specialists, as well as to educate FPs about survivorship. In response, a MAINPRO-accredited pilot workshop was created and has thus far been delivered to 123 FPs at four sites. Preliminary findings indicate high relevance of pilot content (95%).

W107999 Patient Safety in Family Medicine Residency: A thematic content analysis of accreditation standards and curriculum objectives

15:30–15:45 Aliya Kassam, MSc, PhD, Calgary, AB; Nishan Sharma, EdD, Calgary, AB; Pierrette Leonard, APR, FCPRS, Ottawa, ON; Maeve O'Beirne, PhD, MD, CCFP, Calgary, AB

710 MTCC

Description:

Context: Remediation of residents who encounter difficulty is costly and time intensive, more so when problems have been occurring for an extended time; it is also stressful for family medicine clinical faculty. Improvement in identification of residents in difficulty is one of the goals of competency-based assessment, and was one of the objectives when we implemented the Competency-Based Achievement System (CBAS) in our residency program in 2009. Through improved detection of residents who are struggling, we can improve training outcomes. Objective: To determine if there has been a change to rotation flag patterns for residents experiencing difficulty pre- and post-implementation of CBAS. Design: Secondary data analysis (descriptive comparative cohort study) using archived resident data files (three years pre-CBAS implementation, and three years post-CBAS). Setting: Large Canadian family medicine residency program. Participants: Archived files were examined for all residents in the 2005-2007 and 2009-2011 entry cohorts (Total N= 393). Main and Secondary Outcome Measures: Files were searched for evidence of flags on In-Training Rotation Evaluations (ITERs) and Summative Progress Reports. Results: Overall, the total number of ITERs with flags has decreased since implementation of CBAS (40% in 2005 to 17% in 2011); as well, there has been a steady increase in flagged residents who are remediated (from a low of 4% in 2006 to 23% in 2011). Total remediations have decreased from 8% in 2005 to 4% in 2011. Rotations where residents are likely to be flagged have mostly remained constant (family medicine, obstetrics, pediatrics, critical care, internal medicine), with the exceptions of general surgery and orthopedics. Conclusions: Post-CBAS, residents in difficulty appear to be detected earlier, and problems are addressed more quickly. This may be due to CBAS resulting in more detailed comments from the preceptors, leading to resolution of existing issues quicker by making the resident aware of their deficiencies and providing resources to overcome those difficulties. Overall, implementation of CBAS appears to have increased the likelihood that residents encountering difficulty obtain the attention they require earlier in their training, resulting in fewer flags on rotations.

W108022 Trends in Resident Rotation Flags Before and After Implementation of the Competency-Based Achievement System**15:30–15:45**

Shelley Ross, PhD, Edmonton, AB

709 MTCC**Description:**

Background: The College of Family Physicians of Canada (CFPC) is responsible for setting standards for accreditation and the curriculum that individual family medicine residency training programs must follow. There are no specific criteria for patient safety and quality improvement content at this level. Objective: To conduct a thematic analysis of the CFPC's current documentation for accreditation (The Red Book) and family medicine curriculum (Triple C Reports 1 and 2) with respect to patient safety competencies as outlined by the Canadian Patient Safety Institute (CPSI). Method: Thematic analysis of the family medicine (FM) competencies was conducted as outlined by the Triple C curriculum (using the Four Principles of Family Medicine, the CanMEDS-Family Medicine framework, and an in-depth curriculum guide for implementation), as well as by overarching Red Book standards for accreditation and enhanced skills training programs, with respect to the six CPSI patient safety competencies. The CPSI patient safety principles were used as nodes to which the CFPC documentation was coded by two researchers. Researchers met to discuss any discrepancies in coding until consensus was reached. Results: Across the CFPC documentation, the most commonly found patient safety competencies were work in teams (n = 24 coding references) and create a culture of patient safety (n = 23 coding references). The least commonly found patient safety competencies were "optimize factors" (n = 1 coding references) and "recognize, respond to, and disclose adverse events" (n = 1 coding references). The patient safety competency of "manage safety risks" was also not common (n = 5 coding references). Conclusions: A relevant framework for patient safety and quality improvement education is needed for family medicine residency training programs across Canada. This framework should focus on optimizing human factors and disclosing near misses/adverse events, as well as on managing patient safety risks in primary care. This is to ensure that programs address patient safety across the full continuum of care, including community-based care. Standards for accreditation and the curriculum from CFPC could help to create a patient safety culture in family medicine training. Future research should include a needs assessment of family medicine residency training programs with regards to patient safety and quality improvement content.

W95286 The BC Clinical Care Management (CCM) Initiative as a Case Study in Large-Scale Change**15:45–16:00**

Carol Herbert, MD, CCFP, FCFP, FCAHS, Vancouver, BC; Allan Best, PhD, Vancouver, BC

707 MTCC**Description:**

Context: The British Columbia Ministry of Health's Clinical Care Management (CCM) initiative was used as a case study to better understand large-scale change within BC's health system. Eleven guidelines have been introduced into hospitals across all BC health authorities in an attempt to improve evidence-based clinical practice. Fifteen additional CCM guidelines are to be implemented over the next three years, with many priorities touching on family medicine. Objective: Using a complex system framework, this study examined mechanisms that enable and constrain the implementation of clinical guidelines across various clinical settings. Design: Qualitative descriptive. Participants: Purposively selected respondents in each health authority; three purposively selected guidelines. Intervention: Researchers applied a general model of complex adaptive systems plus two specific conceptual frameworks (realist evaluation and system dynamics mapping) to define and study enablers and constraints. Focus group sessions and interviews with clinicians, executives, managers, and board members were validated through an online survey. Findings: The functional themes for managing large-scale clinical change included creating a context to prepare clinicians for health system transformation initiatives; promoting shared clinical leadership; strengthening knowledge management, strategic communications, and opportunities for networking; and clearing pathways through the complexity of a multilevel, dynamic system. Discussion: Recommended action-oriented strategies included engaging local champions; supporting local adaptation for implementation of clinical guidelines; strengthening local teams to guide implementation; reducing change fatigue; ensuring adequate resources; providing consistent communication, especially for front-line care providers; and supporting local teams to demonstrate the clinical value of the guidelines to their colleagues. Conclusions: Bringing a complex systems perspective to clinical guideline implementation resulted in a clear understanding of the challenges involved in large-scale change.

W106807 Relational Continuity Experiences of Residents and Preceptors in a Family Medicine Residency**15:45–16:00**

Ann Lee, MD, MEd, CCFP, Edmonton, AB; Shelley Ross, MA, PhD, Edmonton, AB;

Sandra Robertson, MN, Edmonton, AB; Shenay Khera, MD, MPH, FCFP, Edmonton, AB

709 MTCC**Description:**

Context: Relational continuity is defined as the "ongoing therapeutic relationship between a patient and one or more providers." It has been found to be a predictor of positive outcomes for both patients and physicians. Given this, teaching and modeling relational continuity in family medicine residency training is highly important. The challenge lies in how to measure relational continuity for residents in training programs. Objectives: To determine to what extent the electronic medical record (EMR) is a useful tool in understanding relational continuity experiences of family medicine residents. To determine relational continuity experiences of family medicine residents at the end of a two-year residency and the factors influencing the opportunities for developing relational continuity between residents and patients. Design: Mixed methods. Participants: Purposive sample of residents (n = 5) and preceptors (n = 5) at an academic teaching clinic. Instruments: EMR data was used to measure relational continuity. A constructivist grounded theory approach was used to conduct semistructured interviews with all participants, and constant comparative analysis was used to determine factors that influence relational continuity for residents. Outcome measures: Quantitative: Relational continuity, as determined by the Usual Provider Continuity (UPC) Index, a commonly used measure of continuity of care (ratio of patient visits to usual care provider). Results/Findings: Residents were found to have relatively low relational continuity. For most residents, 49.3% to 67.5% of patients were in the UPC Index of 0 to 0.24, and a low proportion of patients were seen at a UPC index of 0.50 or greater. Qualitative findings resulted in a model of relational continuity, where continuity of care in family medicine, relational continuity with patients, therapeutic alliance, and ownership all interacted and were affected positively or adversely by program and systems factors, patient factors, and attitudes and experiences of both the resident and the preceptor. Conclusions: EMR data provide a

good picture of continuity rates. However, the factors that affect relational continuity can only be found by interviewing residents and preceptors. While most residents valued relational continuity, factors such as patient schedules and program or system factors made it difficult to establish high rates of continuity with patients.

W107244 Facilitators, Barriers, and Strategies for Clinical Faculty Conducting Research: A qualitative study

15:45–16:00

Cathy Thorpe, MA, London, ON; Stephen J. Wetmore, MD, MCISc, CCFP, FCFP, London, ON; Merrick Zwarenstein, MBBCh, MSc, PhD, London, ON; Jamie Wickett, MD, CFPC, London, ON
710 MTCC

Description:

Context: Research skills empower family physicians to produce and appraise new knowledge and to evaluate improvements in their clinical work. The College of Family Physicians of Canada, Section of Researchers has developed a blueprint for family medicine research success with the vision that research is a core component of training, scholarship, and clinical practice. This context is the impetus for developing a program for building research culture and capacity in the Department of Family Medicine at Western University. This study represented the first step in the design of our research capacity development initiative. The objective of this descriptive qualitative study was to describe facilitators, barriers, and strategies for clinical faculty to conduct research. Method: Key informant interviews were conducted with 10 members of the department with different roles: clinician-teachers, researchers, administrative leaders, and research staff. Interviews were audio-recorded and transcribed verbatim. Interviews were analyzed individually by two team members, who identified themes, and then reviewed by the entire team, where themes were further elaborated and refined. Findings: Findings were organized around individual, organizational, and external factors that acted as facilitators and barriers to clinical faculty research, and around the success and limitations of research capacity development initiatives already in place. Individual themes centred on motivation and the knowledge, skills, and confidence necessary for clinical teachers to conduct research. Organizational themes included the need for role clarity, collaborations, and organizational support. External themes focused on organizations both within and outside the university setting, including the College of Family Physicians of Canada. Conclusion: These results are being used to design a strategy for strengthening research capacity among clinical faculty in the Department of Family Medicine at Western University. The ultimate goal is to enhance research culture, as measured by increased research interest, skills and confidence, and institutional support; and to increase research capacity, measured by publications and presentations. These findings will be of interest to other departments of family medicine in Canada interested in building research culture and capacity.

W107250 Effect of Continuity of Care in Primary Health Care on Hospitalization and Emergency Department Use

15:45–16:00

Yvonne Rosehart, Ottawa, ON; Tanya Flanagan, Toronto, ON; Geoff Ballinger, Ottawa, ON; Geoff Ballinger, Ottawa, ON; Lili Liu, Ottawa, ON; Gladys Osien, Ottawa, ON; Husam Alqatami, Ottawa, ON

706 MTCC

Description:

Context: Research skills empower family physicians to produce and appraise new knowledge and to evaluate improvements in their clinical work. The College of Family Physicians of Canada, Section of Researchers has developed a blueprint for family medicine research success with the vision that research is a core component of training, scholarship, and clinical practice. This context is the impetus for developing a program for building research culture and capacity in the Department of Family Medicine at Western University. This study represented the first step in the design of our research capacity development initiative. The objective of this descriptive qualitative study was to describe facilitators, barriers, and strategies for clinical faculty to conduct research. Method: Key informant interviews were conducted with 10 members of the department with different roles: clinician-teachers, researchers, administrative leaders, and research staff. Interviews were audio-recorded and transcribed verbatim. Interviews were analyzed individually by two team members, who identified themes, and then reviewed by the entire team, where themes were further elaborated and refined. Findings: Findings were organized around individual, organizational, and external factors that acted as facilitators and barriers to clinical faculty research, and around the success and limitations of research capacity development initiatives already in place. Individual themes centred on motivation and the knowledge, skills, and confidence necessary for clinical teachers to conduct research. Organizational themes included the need for role clarity, collaborations, and organizational support. External themes focused on organizations both within and outside the university setting, including the College of Family Physicians of Canada. Conclusion: These results are being used to design a strategy for strengthening research capacity among clinical faculty in the Department of Family Medicine at Western University. The ultimate goal is to enhance research culture, as measured by increased research interest, skills and confidence, and institutional support; and to increase research capacity, measured by publications and presentations. These findings will be of interest to other departments of family medicine in Canada interested in building research culture and capacity.

W107807 Effectiveness of Maintenance SSRI Treatment in Primary Care Depression to Prevent Recurrence: Randomized controlled trial

15:45–16:00

Dee Mangin, MB ChB, DPH, FRNZCGP, Hamilton, ON; Claire Dowson, PhD, Christchurch, NZ;

Roger Mulder, MD, Christchurch, NZ; Elisabeth Wells, PhD, Christchurch, NZ; Les Toop, MD, Christchurch, NZ; Tony Dowell, MD, Wellington, NZ; Bruce Arroll, MBChB, PhD, Auckland, NZ; Evan Begg, MBChB, PhD, Christchurch, NZ

704 MTCC

Description:

Context: The increasing SSRI prescription numbers in the population are being driven in part by continuation of medication after acute treatment as maintenance therapy to prevent recurrence. Most depression is treated in the primary care setting. There is no evidence from randomized controlled trials of the effectiveness of this long-term maintenance treatment in primary care patients. Objectives: 1) To assess the effectiveness of long-term maintenance treatment with fluoxetine in prevention of depression recurrence in primary care. 2) To compare outcomes at 18 months for those who trialed discontinuation, compared to those who did not. Design: Multicentre double-blinded randomized controlled trial. Intervention: Ongoing maintenance fluoxetine treatment compared with tapered withdrawal to placebo. Participants: Participants identified from electronic medical records' prescribing data had initial eligibility screening by their family doctors: they were aged 18 to 75 years, had historical diagnosis of depression, and were taking fluoxetine as maintenance treatment to prevent recurrence for at least 15 months. Follow-up: Weeks 1, 2, and 4, and months 3, 6, 9, 12, 15, and 18 to monitor recurrence, side effects, withdrawal effects, other reasons for exiting treatment, and general functioning. Primary outcome: Recurrence of depression over 18 months. Secondary: Comparison of all outcomes at 18 months for those who trialed withdrawal with those who did not. Results: Among identified patients, 33% (419/1273) responded to the invitation to participate. Of these, 156 were ineligible or did not consent, and 263 were randomized into taper and continuation arms. There were 30 (23.3%) depression recurrences in the taper arm and 14 (10.5%) in the continuation arm (absolute difference 12.8%; 96% CI 3.4% to 23.3%; $P = .005$). For every 17 patients taking maintenance antidepressant medication, 1 was unable to discontinue because of withdrawal symptoms. At 18 months, 47% of the taper group and 4% of the continuation group were no longer taking antidepressants (absolute difference 43% [96% CI 33% to 53%]). Conclusions: The absolute benefit (12.8%) is similar to that for acute treatment. Most patients taking maintenance antidepressant medication experienced no benefit over 18 months. It seems reasonable to present these data to patients and offer a trial of discontinuation: the NNTRial for one patient to successfully discontinue medication at 18 months is 2. There was no difference in outcome measures at 18 months for those who trialed discontinuation.

W108050 Closing the Gap: Enhancing knowledge and access to clinical prevention services for South Asian population
15:45–16:00

Rachel Douglas, MPH, Surrey, BC; Victoria Lee, MD, MPH, MBA, CCFP FRCPC, Surrey, BC;
Kendall Ho, MD, FRCPC, Vancouver, BC; Arun Garg, MD, PhD, FRCPC, FACP, FASCP, Surrey, BC;
Gary Thandi, MSW, RSW, Surrey, BC

705 MTCC
Description:

Context: Ethnic minorities are less likely to access clinical prevention services, but there is limited evidence about how to facilitate uptake for these populations. Objective: The purpose of this study was to examine the barriers and facilitators to clinical prevention uptake for the South Asian population in Surrey and to identify effective methods to increase the use of services. Design: The study used an inductive, qualitative design based on a series of focus groups with members of the South Asian community. Transcripts were analyzed using thematic data coding and responses were compared based on clinical prevention topic area and group characteristics. Participants: A total of 62 adults between the ages of 40 and 80 participated in 1 of 8 focus groups in health care and community settings. Instrument: The focus group guide for the study covered a total of 10 priority clinical prevention topics and each group discussed 3 of these topics. In order to facilitate open discussion participants were asked to respond to questions based on a scenario about a fictitious person who learns about a clinical prevention topic and then chooses not to access it. Participants also completed a brief demographic interview. Findings: The findings from this study can be classified into 3 levels of recommended changes. At the micro level, themes included barriers to effective communication with care providers and logistical concerns. At the meso level, participants suggested exploring different delivery models and locations for services. At the macro level the discussion focused on the creation of stronger policies in the interest of the public good. Conclusion: Based on these findings we concluded that barriers to culturally accessible and acceptable care occur at multiple levels of the health system. These findings can be used to inform how existing and emerging programs, educational materials and services can be tailored to meet the values and needs of South Asians in order to increase the uptake of clinical prevention services for this population.

W107274 Potentially Avoidable Emergency Department Visits for Family Practice Sensitive Conditions
16:00–16:15

Geoff Paltser, PhD, Toronto, ON; Josh Fagbemi, Toronto, ON; Cheryl Gula, Toronto, ON

707 MTCC
Description:

Context: Canadians visit the emergency department (ED) frequently, at times for minor medical problems that might be more appropriately treated elsewhere. Many jurisdictions are evaluating strategies to reduce avoidable ED visits, and identifying and quantifying these visits can help efforts to improve appropriateness of care. Objective: This study from the Canadian Institute for Health Information (CIHI) examines ED utilization to identify visits that might be more appropriately managed at a family physician's office or clinic, known as family practice sensitive conditions (FPSCs). Design: ED visits for primarily low acuity reasons where patients were not admitted to inpatient beds were calculated and compared to rates of visits for other reasons. Possible explanatory factors including diagnosis and acuity, time of visit, length of stay, and patient age, SES, and rurality were examined. Target population: Included in the analysis are all unscheduled visits to EDs (excluding urgent care centres) in 2013–2014 where patients were discharged home. Instrument: This study uses data from CIHI's National Ambulatory Care Reporting System (NACRS). The following jurisdictions submitted ED data with complete ICD-10-CA diagnoses in 2013–2014 and are included in the results: Ontario (all facilities); Alberta (all facilities); Nova Scotia (5 facilities); Saskatchewan (4 facilities); PEI (1 facility); and Yukon (1 facility). Results: Overall, 1 in 5 non-admitted ED visits were for FPSCs, totaling more than 1.4 million visits in 2013–2014. The most common reasons for these visits included upper respiratory infections (13%), antibiotic therapies (13%), sore throats (8%), ear infections (7%), and care following surgery such as dressing changes and removal of stitches (5%). More than one-third (35%) of non-admitted visits for children younger than age 18 were for FPSCs, compared with only 12% for patients age 65 and older. Additionally, 32% of non-admitted ED visits among rural-dwelling patients were for FPSCs, versus 17% among urban-dwelling patients. Conclusions: Providing care for patients presenting with FPSCs in settings such as doctors' offices and clinics might improve continuity of care and the patient experience, and allow ED resources to be focused on those who more appropriately require them.

W107800 Case Management In Primary Care for Frequent Users: A qualitative study of patients' and family physicians' experience

16:00–16:15

Catherine Hudon, MD, PhD, CCMF, Sherbrooke, QC; Maud-Christine Chouinard RN, PhD; Fatoumata Diadiou, MA; Danielle Bouliane MA(c); Mireille Lambert, MA

706 MTCC

Description:

Context: Although case management (CM) is increasingly implemented to address the complex needs of vulnerable clientele, few studies have examined patients' and family physicians' (FPs') experience. The aim of this study was to examine the experience of people with chronic diseases, frequent users of health care services, and FPs who participated in a CM intervention. Design: A descriptive qualitative approach. Setting: Four family medicine groups in the Saguenay region, Quebec, Canada. Participants (n = 45): People with chronic diseases (n = 25), frequent users of health care services and FPs (n = 20) who participated in a CM intervention by a nurse in primary care. Methods: Data were collected through in-depth interviews (frequent users) and four focus groups (FPs). Thematic analysis of the verbatim transcripts used the six dimensions of services' integration proposed by the National Collaboration for Integrated Care and Support: 1) consideration of patient and family needs; 2) communication with the patient and between providers; 3) access to information; 4) involvement in decision making; 5) care planning; and 6) transitions between various health professionals. Results: Patients confirmed that the CM nurse was usually their privileged contact with primary care. S/he actively involved them in developing and carrying out their individualized services plan with other health care partners. Patients and FPs felt that patients' needs were taken into consideration. They considered that the case manager facilitated communication and coordination with and among health care partners as well as better access to relevant information, but a few patients and FPs had not fully understood case management at the beginning of the intervention. Some FPs would have wished to have had more interactions with the case manager. A few people considered that this implies too many appointments. Patients and FPs agreed on the fact that patients were actively involved in decision making. The individualized services plan was considered helpful to improve transitions between services. Conclusions: The experience of people with chronic diseases, frequent users of health care services, and FPs who participated in a CM intervention in primary care was, overall, positive, regarding care integration.

W108046 Developmental Outcomes of Children Born to Methadone-Maintained Mothers: Implications for primary care providers

16:00–16:15

Alice Ordean, MD, CCFP, MHSc, FCFP, ABAM Dip, Toronto, ON; Lauren Self, MD, CCFP, Toronto, ON; Kare Querengesser, MD, CCFP, Toronto, ON; Brian C. Chisamore, MD, MHSc, FRCPC, FAAP, Toronto, ON

704 MTCC

Description:

Context: Perinatal opioid use is highly prevalent in primary care and has been linked to adverse neonatal outcomes. Therefore, integrated care including methadone maintenance treatment (MMT) is the standard of care for the management of opioid use disorders during pregnancy. The most significant complication of perinatal MMT is neonatal abstinence syndrome (NAS). NAS is an acute time-limited consequence of MMT and has been extensively studied. However, long-term developmental outcomes of children with in utero methadone exposure are not well known. Objective: To describe developmental outcomes of a Canadian cohort of children with antenatal methadone exposure. Design: Retrospective chart review. Participants: Opioid-dependent pregnant women who attended an integrated primary-care based program and their infants who were born between 2009 and 2011 and followed over 2 years at the Neonatal Follow Up Clinic at St. Joseph's Health Centre were included in this study. Outcome Measures: Maternal and neonatal demographics, developmental outcomes. Results: Twenty-three maternal-newborn dyads met inclusion criteria. The majority of mothers had a history of prescription opioid use disorder requiring MMT. The mean birth parameters were as follows: birth weight 2881g, length 49cm and head circumference 34cm. Almost half of these neonates were in part breastfed and 87% were discharged home in the care of a biological parent. Fourteen of these children attended for developmental assessments with nine lost to follow-up. The overall prevalence of gross motor abnormalities was 36.3% before 12 months and decreased to 12.5% thereafter. Fine motor and communication delays were observed after one year of age in 25% and 37.5% of infants, respectively. Abnormal social development was rare. Conclusions: Our study demonstrated that gross motor delays seemed to resolve after one year of age while communication and fine motor delays becoming more prevalent on subsequent assessments. These results also emphasize the importance of early screening and intervention programs for this vulnerable population. Primary care providers play a critical role in supporting families with parental substance use disorders to optimize the environment in which these children are raised and to positively influence their development.

W108070 Cervical Cancer Screening and HPV Vaccine Uptake Among Immigrant Women Versus Canadian-Born Women

16:00–16:15

Omolayo Famuyide, MD, BScPharm, Vancouver, BC; Ellen Wiebe, MD, CCFP, FCFP, Vancouver, BC; Gina Ogilvie, MD, MSc, FCFP, DrPH, Vancouver, BC

705 MTCC

Description:

Context: Cervical cancer screening (CCS) and human papillomavirus (HPV) vaccines are used to prevent disease caused by HPV. Objective: The primary objective of this study was to compare CCS between immigrant versus Canadian-born women. Secondary outcomes included comparing knowledge, attitudes, and HPV vaccination in the two groups. We also assessed the predictors of screening. Design: This was a quantitative study using questionnaires to ask women about their demographics, sexual history, screening history (defined as a Pap test within three years), and HPV vaccination, as well as their perceptions about screening and the HPV vaccine. Data collected from the questionnaires were entered into SPSS Statistics software for analysis. Participants: Consecutive women presenting for medical abortion between September 2014 and February 2015 were offered questionnaires. Results: There were 446/600 completed questionnaires (74.3%); 223 (50%) were Canadian-born women and 222 were immigrant women. There

were 184 Canadian-born women (87.6%) compared to 134 immigrant women (66.3%) who participated in the CCS program ($P = <.001$). There were 103 immigrant women who were not considered low risk (more than one sexual partner). In univariate analyses, predictors of having a Pap were age, having heard of HPV, years in Canada, age of sexual debut, and number of sexual partners. In logistic regression analyses, older age (AOR 1.1; 95% CI 1.0 to 1.2), more sexual partners (AOR 1.224; 95% CI 1.0 to 1.5), and more years in Canada (AOR 1.1; 95% CI 1.0 to 1.2) were factors predictive of having a Pap smear. HPV vaccine rates among both groups were low, with only 44 out of 223 (21.1%) of Canadian-born women and 23 out of 222 (12.0%) of immigrant women having had the HPV vaccine ($P = 0.47$). Conclusions: Our study found that cervical cancer screening rates are lower in immigrant women versus Canadian-born women. The women at greatest risk of HPV, that is, older women with more sexual partners, were more likely to be screened. The rates of screening and vaccination are still too low and this implies that we need to continue to work on continued establishment of effective programming and education that will help to address knowledge perceptions.

W101610 Socioeconomic Status and Risk of Hemorrhage During Warfarin Therapy for Atrial Fibrillation: A population-based cohort study

16:15–16:30

Alex Cressman, MSc, MD (C), Toronto, ON; Erin M. Macdonald, MSc, Toronto, ON;
Zhan Yao, MSc, Toronto, ON; Peter C. Austin, PhD, Toronto, ON; Tara Gomes, MSc, Toronto, ON;
Michael Paterson, MSc, Toronto, ON; Moira K. Kapral, MD, MSc, Toronto, ON;
Gina Ogilvie, MD, MSc, FCFP, DrPH, Vancouver, BC; Muhammad M. Mamdani, PharmD, MPH, Toronto, ON;
David N. Juurlink, MD, PhD, Toronto, ON

705 MTCC

Description:

Context: Among patients taking warfarin, lower socioeconomic status is associated with poorer control of anticoagulation. However, the extent to which socioeconomic status influences the risk of hemorrhage is unknown. Objective: To examine the extent to which socioeconomic status influences the risk of hemorrhage in older individuals newly commencing warfarin therapy for atrial fibrillation. Design: Population-based cohort study using health care administrative data. Participants: Patients aged 66 years or older with atrial fibrillation who commenced warfarin therapy between April 1, 1997, and November 30, 2011, in Ontario, Canada. Validated ICD-9 and ICD-10 codes were used to identify a diagnosis of atrial fibrillation. We used neighbourhood-level income quintiles as a measure of socioeconomic status. Outcome measures: The primary outcome was an emergency department visit or hospitalization for hemorrhage and the secondary outcome was fatal hemorrhage. Validated ICD-9 and ICD-10 codes were used to identify a diagnosis of hemorrhage. Results: We studied 166 742 older patients with atrial fibrillation who newly commenced warfarin therapy. Of these, 16 371 (9.8%) were hospitalized for hemorrhage during a median follow-up of 369 (interquartile range 102 to 865) days. After extensive multivariable adjustment using Cox proportional hazards regression, we found that those in the lowest income quintile faced an increased risk of hospitalization for hemorrhage relative to those in the highest income quintile (adjusted hazard ratio [HR] 1.18; 95% confidence interval [CI] 1.12 to 1.23). Similarly, the risk of fatal hemorrhage ($n = 1802$) was increased in the lowest relative to the highest income quintile (adjusted HR 1.28; 95% CI 1.11 to 1.48). Conclusions: Among older individuals receiving warfarin therapy for atrial fibrillation, lower socioeconomic status is a risk factor for hemorrhage and hemorrhage-related mortality. This factor should be carefully considered by clinicians when initiating and monitoring warfarin therapy.

W107284 Polypharmacy and Chronic Disease Surrogate Markers in Nursing Home Patients: A cross-sectional survey

16:15–16:30

Rita McCracken, MD, CCFP, Vancouver, BC; Charmaine Lam, medical student, Vancouver, BC; Jonathan Berkowitz, PhD, Vancouver, BC; Scott Garrison, MD, FCPC, PhD, Edmonton, AB

704 MTCC

Description:

Context: Polypharmacy is a recognized source of harm for frail elders, yet many experimental approaches to try to reduce the numbers of medications in nursing homes have failed. Some studies suggest that a focus on disease management, rather than on frailty-appropriate treatments, might be contributing to polypharmacy. A provincial pharmacy data analysis published in September 2014 suggested that prescribing continues to rise for elders in nursing homes. Objective: 1) Describe prevalence of polypharmacy for a representative group of frail elders in nursing homes in British Columbia and their associated patient characteristics. 2) Determine if there are potential associations between hypertension and diabetes surrogate markers and numbers of medications prescribed. Design: Cross-sectional survey. Participants: Two hundred and thirteen randomly selected nursing home patients from six nursing homes in BC's lower mainland with a total population of 950 patients and with a highly regarded physician and pharmacist care model in British Columbia's lower mainland. Intervention: Patient data collated from pharmacy database, patient chart, and local administrative database. Main outcome measures: Mean number medications prescribed, systolic blood pressure (SBP), hospital visits for each patient, and demographic characteristics. Results: The mean number of medications prescribed was 7.5 ± 3.4 . Among the patients in the study, 70.4% had a diagnosis of hypertension and 100% had a measured SBP, mean 126 ± 18 mmHg. Only 27% had a diagnosis of diabetes, mean HgA1c 6.5 ± 1.19 . The average number of hospital visits in the preceding year for each patient was 0.7 ± 1.5 . A diagnosis of hypertension was associated with more medications ($P = .04$) and increasing age was associated with fewer ($P = .002$). No association was found between number of medications and a diagnosis of diabetes or dementia, nor with length of stay, prescribing MD, or number of hospital visits. Conclusions: The number of medications prescribed to frail elders remains high. Chronic disease treatment might be contributing to this large number. In the case of hypertension, the mean systolic blood pressure was surprisingly low and relaxation of surrogate targets might result in fewer medications. Future efforts to address polypharmacy might have more success if they directly address appropriate drug therapy for frail elders with chronic diseases.

W108023 How Safe Is This Emergency Department? A comparison of ED crowding scores**16:15–16:30**

Robin Clouston, MD, CCFP, Saint John, NB; Michael Howlett, CCFP (EM), MHA, Saint John NB; Paul Atkinson, MB, BCh, BAO, MA (Cantab), MRCP (UK), FCEM, CFEU, Saint John NB; Jacqueline Fraser, RN, Saint John, NB; Dylan Sohi, BSc, Saint John, NB; Tashina McCluskey, RN, Saint John, NB; Scott Lee, BSc, MD (C), Saint John, NB; Joshua Murray, Saint John, NB

707 MTCC**Description:**

Context: Emergency department (ED) crowding is a significant problem in emergency care. The most widely known tools to measure crowding are EDWIN and NEDOCS, both validated. The International Crowding Measure in EDs (ICMED) seeks to measure crowding but has not yet been validated internationally. In New Brunswick, there are three tools used in local EDs (DEC, SJRH, Moncton).

Objective: To determine which of these six tools, and which of five single variables, is the best measure of crowding and safety in our local ED, as compared to physician rating via visual analogue scale (VAS). A secondary goal is to determine which tool best predicts ED crowding and safety up to four hours before VAS. Design: We conducted observations in crowding, capturing all times of day, over two weeks, and compared the resultant scores to VAS. Five single variables (#pts in ED; #pts in ED beds/waiting; #pts to be seen; # wait room pts; # boarders) were also analyzed. Participants: ED was observed at two-hour intervals. Charge physicians and charge RNs participated at each interval to give their clinical rating. Intervention: All 11 predictor variables were calculated using a data collection form. Outcome measure: Physician rating, based on 10 cm VAS. A clinician rating is the standard of face validity in ED crowding, based on previous research for EDWIN, NEDOCS, and ICMED. Charge nurse rating was used in kappa calculation. Results: We recorded 143 events. VAS showed the ED to be crowded 60.8% of time using a binary cut point. The “#pts waiting” had highest predictive value for crowding at t = 0 (sensitivity = 81%, specificity = 64%). DEC Score had highest predictive value for crowding at t = 2h (sensitivity = 89.5%, specificity = 60.0%), with NEDOCS similar (sensitivity = 89.5% and specificity = 53.3%). For safety at t = 2h, NEDOCS was most predictive (sensitivity = 92.7%, specificity = 89.5%). No variable could accurately predict crowding or safety at t = 4h. For binary crowding VAS, k = 0.424. For binary safety VAS, k = 0.345. Conclusions: For current ED crowding and safety, single variables are as sensitive and specific as formal crowding scores. In determination of crowding and safety two hours in the future, the validated NEDOCS Score and similar DEC Score showed greatest sensitivity and specificity.

W108416 Case Finding and Managing COPD**16:15–16:30**

Cathy Faulds, MD, CCFP, FCFP, London, ON

704 MTCC**Learning Objectives:**

1. build a chronic disease program with quality improvement and evidence-based guidelines
2. prevent patients from becoming the top 5% of system users
3. follow COPD patients through the system and measure their journey of Canada, new committees and staff, this is a good time to have a warm conversation sharing our hopes for family medicine teaching, scholarship and research.

W122373 Fireside Chat with Section of Teachers Council Chair, Dr. Ian Scott**16:00–17:00**

Ian M. Scott, MD, CCFP, FCFP, Vancouver, BC

714B MTCC**Description:**

Join us to wrap up the Family Medicine Innovations in Research and Education Day with an opportunity to share your reflections about the day and provide suggestions for future directions. With the organizational changes occurring within the College of Family Physicians

POSTER PRESENTATIONS / PRÉSENTATIONS D'AFFICHES

NOVEMBER 11 NOVEMBRE - 716AB MTCC

501 Cancer Diagnosis and Treatment Time Intervals: Urban and rural differences in Ontario, Canada

Andriana Barisic, MPH, Toronto, ON; Eva Grunfeld, MD, DPhil, CCFP, FCFP, Toronto, ON; Julie Gilbert, PhD, Toronto, ON

Description:

Context: Despite evidence demonstrating differences in cancer survival between provinces, and between regions within Ontario, the reasons for these differences are not fully understood. Previous research has suggested that diagnostic/treatment delay might be a contributing factor; however, little is known about geographic differences in diagnostic/treatment delay, especially in the Canadian context. Objective: To examine urban/rural differences in the time intervals between the onset of first symptom(s) to cancer diagnosis and treatment. Design: This work was part of the International Cancer Benchmarking Partnership (ICBP), an international collaboration involving nine countries. It is comprised of five separate areas of research (modules), each examining reasons for observed differences in cancer survival. The focus of this research is Module 4, which was a cross-sectional survey that examined the underlying causes of cancer diagnostic and treatment delay. Participants: In Ontario, adults aged 40 years and older diagnosed with breast, colorectal, lung, or ovarian cancers were identified through the population-based cancer registry. Eligible individuals were first contacted by Cancer Care Ontario for consent to be contacted by ICBP research staff. Those who consented were mailed a survey between May 2014 and October 2015. Instrument: The survey examined the pathway to diagnosis (eg, screening, emergency department, or primary care presentation); patient, diagnostic, and treatment time intervals; perceived health status; treatments for comorbidities; and sociodemographic factors. Outcome measures: The primary outcome is the patient (onset of symptom[s] to presentation to health care provider [HCP]), diagnosis (presentation to HCP to cancer diagnosis), treatment (cancer diagnosis to start of treatment), and total (onset of symptom[s] to start of treatment) time intervals. The predictor variable is urban/rural status (defined using the 2011 Canadian Census). Results: Recruitment will be completed by October 2015. To date, 2510 individuals have consented (breast [n = 1205]; colorectal [n = 745]; lung [n = 475]; ovary [n = 85]), of which 88.5% have returned a completed survey (breast [n = 1091]; colorectal [n = 634]; lung [n = 402]; ovary [n = 79]). Differences in the patient/diagnostic/treatment time intervals by urban/rural status, by pathway to diagnosis, and by cancer type will be presented. Conclusions: The results will inform Cancer Care Ontario's strategy to improve the diagnosis/treatment time intervals, thereby potentially improving cancer survival.

502 Factors Influencing Colorectal Cancer Screening Five Years After an Educational Intervention

June Carroll, MD, CCFP, FCFP, Toronto, ON; Joanne Permaul, BSc (Hons), MA, CCRP, Toronto, ON; Kara Semotiuk, MS, (C)CGC, Toronto, ON; Ellen Warner, MD, MSc, FRCPC, FACP, Toronto, ON; Elizabeth Dicks, PhD, St. John's, NL; Sean Blaine, MD, Stratford, ON; Mary Jane Esplen, PhD, RN, Toronto, ON; Heidi Rothenmund, MSc, (C)CGC, Winnipeg, MB; John McLaughlin, PhD, Toronto, ON

Description:

Context: Screening for colorectal cancer (CRC) decreases mortality yet screening is suboptimal. In Phase 1, we demonstrated that a CRC risk assessment/management point-of-care tool for family physicians (FPs) significantly increased confidence in CRC risk assessment/management for CRC patient vignettes. The patient booklet significantly increased knowledge. Objective: To determine the self-reported CRC screening practices of these same FPs and their participating patients five years following the intervention (Phase 2) and the factors influencing screening. Design: Self-complete surveys. Participants: In Phase 1, a random sample of 75 Ontario and Newfoundland FPs participated in the educational intervention and recruited the next five patients with CRC family history (FH). Phase 2 includes those who agreed to re-contact. Intervention: CRC risk-assessment/management tool for FPs and patient booklet. Outcome measure: Correct self-reported CRC screening. Results: Forty-nine of 63 (78%) FPs who agreed to re-contact (mean age = 45, 41% female) and 171 of 236 (72%) of their patients (mean age = 54, 75% female) participated. Of these patients, 4% were high risk of CRC; 29% were moderate; 56% were low; and 12% were population risk (assessed from patient-completed FH). Patient-reported CRC screening with the "correct" test increased from 72% to 76% (NS) from Phase 1 to 2, with FP's recommending of screening since Phase 1 being the strongest predictor of correct screening (OR 3.0, 95% CI 1.2 to 7.2). Sixty-nine per cent of patients reported discussing CRC FH with their FP since Phase 1, with the majority (83%) saying they initiated it. Correct patient self-assessment of CRC risk dropped from 55% to 39% (P = .002), with the majority underestimating. Those underestimating risk were significantly less likely to have the "correct" test but this did not remain significant in the logistic regression analysis. Patient knowledge (score \geq 8/15) significantly increased (44% to 65%, P < .001). Among the FPs, 96% reported routinely asking cancer FH, and 60% of FPs continued to use the CRC tool. Discussion/conclusion: Recommendation from their FP was the strongest predictor of "correct" CRC screening in those patients with a CRC FH who had higher self-reported CRC screening than is generally reported in Canada (25% to 30%). Findings suggest educational efforts directed at patients might increase screening. The tendency for patients to underestimate CRC risk reinforces the FP role in recommending screening.

503 Early Integration of Palliative Care in Primary Care: INTEGRATE Project

Sandy Buchman, MD, CCFP, FCFP, Toronto, ON; Marnie MacKinnon, BPE, Toronto, ON; Hardeep Johal, PMP, BSc, Toronto, ON; Erin Arthurs, MSc, Toronto, ON; Tara Walton, MPH, BSc, Toronto, ON

Description:

Objective: The goal of the INTEGRATE Project is to identify and manage patients to benefit from a palliative care approach early and across health care settings. Objectives of the INTEGRATE Project are to adapt and disseminate educational resources to build the capacity of primary care providers to identify, link, and deliver palliative care in communities; and to test integrated models in the primary care setting to enable providers to take ownership for early identification and management of patients who would benefit from a palliative approach. Method: Four primary care practices (three family health teams and one family health group) will identify patients that might benefit from early identification using the Surprise Question "Would you be surprised if this person died in the next 6 to 12 months?" and then initiate a palliative care approach with an interdisciplinary team. Implementation will focus on a quality improvement (QI) approach at select sites

and then on evaluating what is scalable at a provincial level. This session is relevant for clinicians, residents, students, administrators, and researchers. The material will be presented through an interactive presentation. Results: The provider education component of the project will measure changes in knowledge, attitude, and behaviour of primary care providers before and after completion of the education. The integrated model in primary care assesses current practice and perception of palliative care through a baseline survey, which will be repeated mid- and post-implementation to evaluate change over time. The process of identifying patients within the practice and their health care utilization patterns will be measured for the duration of the project. Results from the provider education activities and baseline survey will be available for the conference. Early results on the identification of patients in the participating practices will also be available. Conclusion: This project has the potential for significant impact on organizational and health system design for patients and their families who will benefit from earlier identification of palliative care in the primary care setting. The results of evaluation will translate into provincial recommendations for Ontario.

504 **Comprehensive Video-Module Instruction as an Alternative for Teaching IUD Insertion**

Juan Garcia-Rodriguez, MD, CCFP, MSc (Med Edu), Dip Sports Med, Calgary, AB;
Tyrone Donnon, BSc, BEd, MEd, PhD, Calgary, AB

Description:

Context: IUD insertion has been traditionally taught at scheduled training sessions or during rotation at contraception teaching clinics. The limited number of skilled faculty who can teach procedural skills, and issues of time and access, have made it difficult for residents to learn this procedure. Objective: To determine how effective the use of video-module instruction is as an alternative procedural skill-teaching method to deliver IUD insertion training for family medicine residents. Design: This randomized, two-group (n = 39) pre-/post-test (written) experimental research design focused on the comparison of residents' post-test performances based on the traditional instructional (designated site demonstration) and video-module approaches to teaching the IUD insertion procedure. Participants: Incoming 2012 first-year family medicine residents (n = 39), 53.8% (n = 21) of whom were males and 46.2% (n = 18) of whom were females. Exclusion criteria: Previous IUD insertion during clinical training or previous medical practice that involved IUD insertion (eg, international medical graduates). Intervention: Exposure to traditional instruction or video-module approaches to teaching the IUD insertion procedure. Outcome measures: Assessment of knowledge and performance of the procedure. Results: Although the traditional and intervention instructional groups improved significantly in their clinical knowledge scores from pre- to post-test, there was found to be no difference between the groups on the written exams. On the post-test IUD insertion performance assessment, residents in the video-module intervention group performed significantly better than the traditional instructional group ($P < .05$, mean effect size difference Cohen's $d = 0.75$). The internal reliability (Cronbach alpha) of the 27-item performance checklist was $= 0.77$. Conclusion: Both the traditional and video-module instructional methods were found to be reliable and valid approaches for the teaching and learning of the IUD insertion procedure. The results provide support for the use of a video-module teaching session as a potential method to supplement or enhance IUD insertion procedural skill training. The ability to access this method of instruction online makes this approach highly feasible for residents. In addition, the performance assessment and patient interview checklists that were developed as part of the video-module instructional method might prove to be useful to guide and evaluate the IUD insertion procedures with actual patients.

505 **We Need Something BETTER: Patients' perspectives on a novel approach to chronic disease prevention and screening**

Donna Manca, MD, MCISc, FCFP, Edmonton, AB; Nicolette Sopcak, PhD, Edmonton, AB;
Candace Nykiforuk, PhD, Edmonton, AB; Carolina Aguilar, MA, MSc, Edmonton, AB; Mary Ann O'Brien, PhD, Toronto, ON;
Kris Aubrey-Bassler, MD, MSc, CCFP (EM), St Johns, NL; Richard Cullen, BSc, St. John's, NL;
Melanie Heatherington, MEd, Edmonton, AB; Eva Grunfeld, MD, DPhil, FCFP, Toronto, ON

Description:

Context: BETTER (Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Primary Care) is a chronic disease prevention and screening (CDPS) program that has been implemented in various primary care settings in Newfoundland and Labrador. The program aims to improve CDPS for cardiovascular disease, diabetes, cancer, and associated lifestyle factors in patients aged 40 to 65 years. The key component of BETTER is the prevention practitioner (PP)—a health care professional with specialized skills in CDPS who structures and complements physicians' CDPS practices in the primary care setting. Some physicians involved in BETTER were skeptical of the benefits of having a PP. Objective: To explore patients' perspectives on their visit(s) with a PP in three primary care settings in Newfoundland and Labrador. Methods: Of 154 patients who received one or more prevention visit(s) with a PP, 90 volunteered to provide written feedback. Besides their demographics, patients were asked what they liked about their visit(s), what they would have liked to have been different about their visit(s), and to provide other comments. We employed qualitative description to analyze the data. Findings: We identified four main themes regarding patients' perspectives on their visit(s) with a PP: 1) Value of visit: All 90 patients who provided feedback unanimously reported their visit with a PP to be positive and appreciated having a PP as part of the health care team. 2) Visit characteristic: Patients valued the focus on health (as opposed to disease) and that the visit was personalized, comprehensive, and motivating. 3) PP characteristics: The patients saw their PP as key to their positive experience with the program. Patients characterized the PPs to be compassionate, attentive, thorough, knowledgeable, motivating, and supportive. 4) Access concerns: Patients perceived their prior access to preventative care to be limited and expressed concerns about the termination of the program. Conclusion: Patients' views that a PP should be an available resource within primary care settings were a contrast to the perception of some physicians involved in BETTER. Our findings may help inform stakeholders in primary care settings as they consider implementing programs to enhance their current CDPS practices.

506 Engaging Patients and Clinicians in Establishing Research Priorities for Gestational Diabetes in Alberta Using the James Lind Alliance Priority-Setting Process

Sandra Rees, BScPharm, Edmonton, AB; Sudha Koppula, BSc (Hons), MD, MClSc, CCFP, Edmonton, AB

Description:

Background: Patients and front-line clinicians are traditionally not included in decisions around research priorities. There is increasing focus on engaging patients in the health research process to ensure research undertaken is patient-oriented. The James Lind Alliance (JLA) has developed a process for engaging patients and clinicians in the research priority-setting process. We employed the JLA process to determine research priorities in gestational diabetes in Alberta. Methods: A steering committee was established, with equal representation of patients and clinicians, to guide the process. A survey was developed and administered across Alberta, in various formats over four months. Survey submissions were organized into categories. Management uncertainties were identified from clinical practice guidelines. Steering committee members (in patient-clinician pairs) reviewed the submissions and developed summary questions for submissions in a similar theme. The steering committee individually ranked the list of indicative questions, identifying the top 30 uncertainties. The steering committee reviewed all of the individual rankings and came to consensus on a list of 29 research priorities for a priority-setting workshop, with an equal number of patients and clinicians, who identified the top 10 research priorities, using a nominal group format. Results: Across the survey formats, 75 individuals submitted 389 uncertainties. The majority [44 (59%)] of submissions came from patients. We removed 9 questions as either out of scope or unclear. An additional 41 uncertainties were identified on a review of clinical practice guidelines, resulting in a total of 421 research uncertainties. From these, the steering committee developed 48 summary questions, plus 26 unique questions, for a total of 74 research uncertainties. These were then pared to the top 29 uncertainties, which were considered at the workshop. The facilitated workshop had 15 participants (8 patients, 3 physicians, 3 nurses, and 1 dietitian). The top 10 research uncertainties were then chosen. Conclusions: Through a comprehensive process involving equal representation from patients and clinicians, a list of 10 research priorities that are important to women who have experienced gestational diabetes and the clinicians that treat them were determined. These priorities will be disseminated to funding agencies, researchers, and the provincial health delivery organization.

507 Using Mobile Applications for Knowledge Dissemination in Cataract Surgery Patients

Harry Dang, BSc, MD (Cand), Markham, ON

Description:

Objective: To assess the effectiveness of the iOphthalmology mobile application in enhancing patients' knowledge and satisfaction of cataract surgery at the Kensington Eye Institute, a high-volume Canadian cataract centre. Design: Cross-sectional study. Participants: Seventy-seven patients who were undergoing cataract surgery at the Kensington Eye Institute for the first time with no previous ocular pathology. Intervention: To improve patient knowledge on surgical procedures, we developed the iOphthalmology mobile application in Toronto, Ontario, in 2014. This application is currently available for no cost on the Google Play digital distribution platform in Android devices, including smartphones and tablets. This application was used by cataract surgery patients with the goal of increasing patient knowledge of cataract surgery and increasing patient satisfaction. Outcome measures: Following patient consent, we administered a questionnaire to assess the following: knowledge of cataract surgery, perceived outcome of surgery, decisional conflict level, uncertainty level, sex, occupation, age, highest education level, Ontario Health Insurance Plan status, and literacy status. After using the application, we measured the overall satisfaction by all patients. Results: Both decisional conflict scores and cataract surgery knowledge scores significantly improved after using the application (mean difference +7.1, $P = .02$ and +3.4, $P < .01$, respectively). Multiple regression analysis revealed being illiterate, decisional conflict level, and female sex to be critical factors in the degree to which the application increased patients' knowledge on cataract surgery ($\beta = 3.1$, $P < .003$ for literacy level, $\beta = 2.0$, $P = .01$ for decisional conflict, and $\beta = -0.9$, $P < .01$ for female sex). Seventy-one of 77 (92.2%) patients were satisfied with the mobile application. Patient satisfaction score was significantly correlated with the overall change in patients' knowledge of cataract surgery score (correlation coefficient: 0.31, $P = .01$). Conclusions: The iOphthalmology mobile application for Android devices is effective in enhancing patients' knowledge regarding cataract surgery, and in decreasing their anxiety in their decision to proceed with cataract extraction surgery. This open-source mobile application can potentially benefit patients who might have restricted access to health care, including patients in countries with low literacy rates. The use of this application prior to cataract surgery can help to alleviate the worldwide burden of cataract blindness.

508 A Meta-analysis of the Efficacy of Procedures for the Management of Open Angle Glaucoma

Harry Dang, BSc, MD Candidate, Markham, ON

Description:

Objective: To compare the efficacy of surgical procedures for the management of open angle glaucoma (OAG). Design: Meta-analysis. Literature searches of EMBASE, Pubmed, MEDLINE, and the Cochrane Library were conducted up to June 2014 with no data or language restrictions. Randomized trials involving trabeculectomy and one or more of the following procedures were eligible for inclusion: viscocanalostomy, deep sclerectomy, and canaloplasty. Participants: B/A Intervention: N/A. Outcome measures: The primary endpoint of this study was the mean difference between procedures in the reduction of intraocular pressure (IOP) preoperatively to 6-months postoperatively. Results: Of the 196 retrieved citations, 14 were considered topically relevant, for a total of 18 comparisons (9 trabeculectomy vs. deep sclerotomy; 1 trabeculectomy vs. canaloplasty; 8 trabeculectomy vs. viscocanalostomy) in 790 eyes from 681 patients. Of the four procedures, trabeculectomy had the best IOP-reducing effect (mean difference of -2.32, 95% CI: -3.11 – 1.54, attached figure). Subgroup analysis revealed no heterogeneity ($I^2=0$). Conclusions: Overall, trabeculectomy was the most effective procedure in lower IOP in open angle glaucoma patients.

509 Evaluation of Chronic Hepatitis B Management and Monitoring Among Asian Immigrants: A practice-reflective project

James Leung, MD, CCFP, FCFP, Toronto, ON; Andrea Leung, MD (Cand), Toronto, ON; Stephen Lau, Toronto, ON; Simon Cheung, BSc (Hons), Toronto, ON

Description:

Introduction: In Canada, chronic hepatitis B infection is largely a disease of immigrants from endemic countries, with approximately 600 000 cases, based on 6% rate in immigrants. Among untreated chronic hepatitis B patients, 20% to 25% can progress into cirrhosis, chronic liver failure, and hepatocellular carcinoma. **Objective:** To evaluate chronic hepatitis B management and monitoring in primary care practice with a high prevalence of cases from Asian immigrants. The project identified HBsAg-positive patients and assessed the care according to Canadian hepatitis B guidelines for monitoring. **Design:** Retrospective chart review from a primary care office with predominantly immigrants from Asia. **Setting:** Toronto. **Participants:** A total of 2100 patients were screened. We identified 97 (4.6%) patients with HBsAg-positive status. All patients were Asian immigrants. **Methods:** The study assessed the data from lab results in ALT, HBeAg status, HBV DNA viral load, platelets counts, abdominal ultrasound, and other data for liver cirrhosis assessment. Three groups of patients were assigned. The "red" high-risk group included high-viral-load patients for therapy consideration. The "yellow" missing-lab-results group included patients missing at least one of the results; the "green" group was the low-viral-load group. **Results:** Among these 97 patients with hepatitis B, 33.0% of the patients were in the "red" high-viral-load group, with only 11.3% under treatment for hepatitis B, and 51.5% of the patients were in the "yellow" missing-lab-results group, missing one of HBeAg, HBV DNA, ALT, or platelet results; 42.3% of patients were not undergoing regular abdominal ultrasound, with more than 12 months' interval. Only 23.7% of patients were in the "green" low-viral-load group. **Conclusion:** This project has identified that a significant care gap exists in chronic hepatitis B monitoring. The Canadian hepatitis B consensus guidelines (2012) recommend close regular monitoring for chronic hepatitis B. More resources for hepatitis B care from federal and provincial governments should be given, due to the expected increase of hepatitis B from immigrants. As with treating other chronic diseases, primary care physicians should have more support to establish a vigilant monitoring system for chronic hepatitis B to reduce the rates of cirrhosis and liver cancer in future.

510 Web-Based Intervention for Chronic Back Pain

Shashank Garg, MD, CCFP, Calgary, AB; Divya Garg, MD, CCFP, Calgary, AB; Faruq Chowdhury, MD, Calgary, AB; Gary Barron, MSc, Calgary, AB; Tanvir Chowdhury Turin, MD, PhD, Calgary, AB

Description:

Background: Chronic low back pain is one of the most common presenting complaints to the physician's office. Treatment is often challenging and recovery depends on various factors, often resulting in significant investments of time and resources. This review addresses the question "Which web-based interventions aimed at chronic low back pain are of benefit to patients?" **Methods:** Randomized controlled trials (RCTs) studying web-based interventions directed at adults with chronic low back pain were included. Retrospective studies, narrative reviews, non-randomized trials, and observational studies were excluded. Electronic databases and bibliographies were searched. **Results:** Eight unique RCTs were identified (n = 1414). The number of patients randomized in each trial ranged from 51 to 580. Four trials studied online cognitive behavioural therapy (CBT), two studied moderated discussion through email or chat, and two trials studied other web-based interventions with interactive features. Use of CBT was associated with reduced catastrophization among patients. Mixed results were reported with regards to reduction in pain levels and disability. One study that measured health care utilization reported reduced utilization with the use of moderated email discussion. **Conclusions:** Limited data are available regarding effective web-based interventions to improve outcomes for patients with chronic low back pain. Eight RCTs with small sample sizes were identified in this review. Online CBT appears to show some promise in terms of reducing catastrophization and improving patient attitudes. Further research in this area with larger-scale studies focusing on appropriate outcomes appears to be a priority.

511 An Open-Label True-to-Life Randomized Controlled Trial for Cough as a Trick Measure to Reduce Pain for Skin Puncture During Intra-Articular Knee Joint Injection

Jeetandera Rathi, Cork, Ireland; Tony Heffernan, MBBCH, MICGP, FFSEM, Cork, Ireland; Maeve Davis, MBBCH, MRCP, MICGP, Cork, Ireland

Description:

Context: Intra-articular (IA) knee injections are carried out routinely in primary care for alleviation of symptoms associated with flares of osteoarthritis (OA). Various strategies are used to reduce the discomfort associated with the procedure. **Objective:** The purpose of this study was to evaluate the effectiveness of the "cough trick" (CT) in reducing perceived pain in patients undergoing routine IA steroid injection for knee OA in a primary care setting. **Participants:** This true-to-life, open-label, multicentre randomized controlled trial was conducted at three separate family practices in Mallow Primary Health Care Centre (MPHC) in Cork, Ireland, from December 2013 to April 2014. Patients (>18 years) with radiographic evidence of OA were enrolled. **Intervention:** Participants were randomized 1:1 according to a randomization table involving study number to one of two groups: the CT intervention group and no CT intervention group. **Outcome measures:** Difference in the self-administered 100 mm visual analogue score (VAS-100) was employed as the primary outcome measure. As psychogenic factors associated with chronic musculoskeletal conditions might influence pain scores, participants were asked to fill out Patient Health Questionnaire (PHQ9) and Hospital Anxiety and Depression Scale (HADS) questionnaires prior to the procedure. **Results:** 21 adults were recruited in this study (11 in the intervention group and 10 in the control group). On average, pain scores were higher in the control group (mean [SD]: 39.40 [18.96]) than in the intervention group (mean [SD]: 13.09 [17.47]) and the difference was statistically significant (difference in means [95% CI]: -26.31 [-9.67 to -42.94], P = .004). The difference in means was also clinically significant as it was greater than the minimal clinically important difference of 11 mm. The mean HADS anxiety scores and PHQ9 depression scores were lower in the intervention group, but the differences were not statistically significant (P = .517 and P = .158, respectively). **Conclusion:** Our study demonstrated that

the CT implemented during IA knee steroid injections has proven to be statistically significant in reducing pain associated with the procedure. Discussion: Distraction is a well-known cognitive method of pain reduction through the direction of attention to a non-noxious stimulus in the immediate environment. CT might be a distraction at the moment of skin puncture.

512 **Musculoskeletal Disorders (MSDs) Among Medical Students: A study measuring prevalence and awareness**

Ahmad Allaf, Riyadh, Saudi Arabia; Hamzah Naji, Riyadh, Saudi Arabia;
Baraa AlGhalyini, MD, CCFP, MHSc, Riyadh, Saudi Arabia; Ibrahim Muhssen, Riyadh, Saudi Arabia;
Abdullah ALSanaa, Riyadh, Saudi Arabia; Sultan ALSaud, Riyadh, Saudi Arabia; Mohamad Kazimi, Riyadh, Saudi Arabia; Baraa AlGhalyini, MD, CCFP, MHSc, Riyadh, Saudi Arabia

Description:

Context: According to some statistics, musculoskeletal disorders (MSDs) account for about 40% of occupational problems, resulting in a loss of workdays and a decrease in productivity. Despite the magnitude of the problem, very few studies have looked into the MSDs affecting medical students. Objective: To study the prevalence of MSDs among medical students, the differences in MSDs encountered at different educational levels (ie, preclinical versus clinical), as well as their impact on their education. Design: A survey-based cross-sectional study. Participants: Our sample size is 250 medical students aged from 18 to 26 years, in both clinical and preclinical years in the city of Riyadh, Saudi Arabia. Instrument: We created a survey adapted from the standardized Nordic questionnaire, which addresses prevalence, severity, impact, and awareness. Findings: Analysis showed results that depict a high prevalence of MSDs in medical students (84.21%). The regions affected most during a 12-month period were the neck and lower back, at 50% each; the shoulders, at 32.5%; and the upper back, at 27.5%. The data showed that most MSDs affecting medical students were usually of mild severity, with the exception of back pain, which was reported mostly to be moderate to severe. Among the students, 52.63% reported not considering ergonomics when studying or working, though 61.64% acknowledged that it was the best way to prevent MSDs. Despite the high prevalence of MSDs, only 13.89% of students met with a physician regarding their MSDs; however, only 11.84% took leaves of absence for more than one day during the past year due to an MSD. Expectedly, medical students reflected high awareness regarding how to treat MSDs, with 48.68% choosing exercise and lifestyle modifications over immobilization and the immediate use of pain relief medication. Conclusion: The results suggest that despite the high level of awareness exhibited by medical students regarding MSDs and preventive measures, the prevalence of such disorders remains high. This emphasizes the role of family physicians in promoting and encouraging ergonomics and the need for its application. Further studies are needed in other populations for comparison, as well as to investigate the reasons for such findings.

513 **A Pilot Feasibility Study of a Primary Care and Addiction Medicine Collaborative Care Model, SUN:SHARE**

Sheryl Spithoff, MD, CCFP, Toronto, ON; Meldon Kahan, MD, CCFP, FCFP, Toronto, ON; Kate Hardy, MSW, Toronto, ON; Geetha Mukerji, MD, MSc, FRCPC, Toronto, ON; Sarah Clarke, PhD, Toronto, ON; Angela Robertson, Toronto, ON;
Laura Pripstein, MD, CCFP, Toronto, ON; Geetha Mukerji, MD, MSc, FRCPC, Toronto, ON;
Leslie Molnar, MSW, Toronto, ON; Ashok Krishnamurthy, MD, CCFP, Toronto, ON;
Wiplove Lamba, MD, FRCPC, Toronto, ON

Description:

Substance use disorders (SUDs) are a major cause of morbidity, mortality, and health care utilization. Few patients are in treatment, largely as a result of poor access to and retention in specialized addiction treatment programs. Primary care might be the solution: outcomes are as good as specialized care, retention is better, and capacity is greater. However, because of a lack of training and support, few primary care providers (PCPs) screen and appropriately care for patients with SUDs. As well, PCPs continue to inappropriately prescribe high doses of opioids, increasing the risk of harms (including addiction) to patients. Although there is substantial evidence that shared-care models between PCPs and addiction physicians are the solution to service and knowledge gaps, this model is rarely used in addiction medicine in Canada. We are conducting a program evaluation of a shared-care addiction medicine pilot, SUN:SHARE. In the intervention, addiction physicians facilitate addiction education sessions, assess patients with SUDs, and have case discussions with PCPs at the community sites. The addiction physicians also provide urgent telephone and email consultations with PCPs. The three participating sites are an inner-city community health centre, an inner-city family health team, and a community family health team affiliated with an academic centre. Our objective is to determine if the PCPs participating in the SUN:SHARE pilot improve their management of SUDs. We will survey PCPs at baseline and at six months to look for reported changes in knowledge and behaviour (counselling, prescribing, and referrals to ancillary services). Additionally, we will conduct patient and provider satisfaction interviews, and track how frequently the phone and email consultation services were used. We will use each site's EMR to track participating PCPs' prescribing patterns at baseline, six months, and 12 months. We will look for changes in 1) the number of prescriptions for medications to treat alcohol use disorders (naltrexone, acamprosate, and disulfiram) and opioid use disorders (buprenorphine/naloxone) and in 2) high-dose opioid prescribing (above 200 mg morphine equivalent per day).

514 **Antipsychotics Use in a Real World Setting in Quebec Between 1998 and 2006**

Alain Vanasse, MD, FCFP, Sherbrooke, QC; Lucie Blais, PhD, Montreal, QC; Josiane Courteau, PhD, Sherbrooke, QC; Marie-France Demers, BPharm, Quebec City, QC; Pasquale Roberge, PhD, Sherbrooke, QC;
Sylvain Grignon, MD, PhD, Sherbrooke, QC; Marie-Josée Fleury, PhD, Montreal, QC;
Alain Lesage, MD, PhD, Montreal, QC; Danielle St-Laurent, MSc, Quebec City, QC;
Laurence Nedelec, MD, Sherbrooke, QC; André Delorme, MD, FRCPC, Quebec City, QC;
Marc-André Roy, MD, FRCPC, MSc, Quebec City, QC

Description:

Context: Several studies have shown clinical differences in the evolution of schizophrenia and the response to antipsychotics (AP) according to patients' age and sex. However, few clinical guidelines take this into account in their pharmacological recommendations. Objective: To describe, in a real-world context, the use of antipsychotics (oral or long-acting injectable) according to patients' age and sex among those living with schizophrenia. Methods: This is a retrospective cohort study using medical administrative databases available in Quebec. The study cohort consists of all adult patients living in the province of Quebec, diagnosed with schizophrenia, admissible to the public drug insurance

plan, and initiating an AP (with a clearance period of one year) between January 1998 and December 2006. Results: A total of 16 225 patients (46.2% women) met the inclusion criteria. The median age at AP initiation differed considerably between women (49 years) and men (38 years). The first claimed AP was mainly prescribed by psychiatrists (women: 56.7%, men: 61.0%, decreasing with age) and general practitioners (women: 30.6%, men: 27.3%, increasing with age). Moreover, 92.3% of women and 89.2% of men received an AP in monotherapy, 77.9% from a second-generation (women: 77.2%, men: 78.5%), with a slight difference in the molecule used between women and men (olanzapine: 42.3% vs 47.9%; risperidone: 45.6% vs 39.3%; quetiapine: 10.6% vs 10.1%; clozapine: 1.5% vs 2.7%). Since long-acting injectable second-generation APs were not available before 2004, only 7.0% of patients in monotherapy used this type of AP (women: 6.7%, men: 7.3%). As many as 11.7% of patients did not pursue their treatment after the first month. Conclusions: This study reveals statistically significant differences according to age and sex regarding AP utilization in a "real-world" setting. Ongoing studies will evaluate if these differences in AP treatment lead to different outcomes.

515 **Ambulatory Care Sensitive Avoidable Hospitalizations: Assessing predictive factors in COPD hospital episodes of care**

Alain Vanasse, MD, PhD, FCMF, Sherbrooke, QC; Josiane Courteau, PhD, Sherbrooke, QC; Mireille Courteau, MSc, Sherbrooke, QC; Pierre Larivée, MD, Sherbrooke, QC; Shengrui Wang, PhD, Sherbrooke, QC; Jianfei Zhang, PhD (Cand), Sherbrooke, QC; Thomas Poder, PhD, Sherbrooke, QC; Pierre Dagenais, MD, PhD, FRCPC, Sherbrooke, QC; Marie-France Beauchesne, PharmD, Sherbrooke, QC

Description:

Introduction: The high rates of "unplanned" hospital admissions are an increasing source of pressure on health system resources. Ambulatory care sensitive conditions (ACSC), such as heart failure, diabetes and chronic obstructive pulmonary disease (COPD), are conditions for which hospitalization could be avoidable with ambulatory care management. The COPD is the main cause of emergency admissions and hospitalizations in Canada, with a mean length of stay of 10 days and one of the highest rates of rehospitalization. The purposes of this project are to develop a predictive model for future readmissions of patients with COPD, based on the analysis of their hospital episode of care (EOC), and to identify factors (or "missed opportunities") that can be modified to reduce the readmission rate. **Method:** This project is a secondary analysis of hospital data on a cohort of patients hospitalized between April 2012 and March 2013 with a primary diagnosis of COPD (ICM-10 J40-J44, J47). The hospital EOC starts at the patient admission (index admission) and ends at the hospital discharge, passing through temporal succession of treatments. The main outcomes are the time until the next readmission (COPD and all cause), the number of readmissions, and the total number of days in hospital during the year after the index admission. Independent variables will be analyzed following the temporal sequence: 1) status before admission (eg, medical history, comorbidity); 2) status at admission (eg, pulmonary condition); 3) status and care during hospitalisation (eg, pharmacological treatments); and 4) status and prescribed treatments at hospital discharge (eg, respiratory conditions, pharmacological prescription, pulmonary rehabilitation). Data mining algorithms and improved survival analysis with adjusted cox regression will be used to detect sequential patterns of predictive variables of readmission. **Anticipated results and conclusion:** To our knowledge, introducing sequential patterns of predictive variables on EOC is a new methodological approach to identifying factors of rehospitalization for an ACSC. A validated methodology for COPD could be then transferred to other ACSC such as heart failure and diabetes, and might improve the identification of "missed opportunities" to reduce rehospitalization rates.

516 **Variations Among Spirometry Interpretation Algorithms: The push towards standardization**

Florence Mok, Mississauga, ON; Amy Liao, Toronto, ON; Tony D'Urzo, MD, MSc, CCFP, FCFP, Toronto, ON

Description:

Context: Asthma and COPD are two of the most common respiratory illnesses encountered in primary care. Though patients often present with similar symptoms, it is important to distinguish between the two diseases because their pathophysiology and management are very different. Simple spirometry is an objective pulmonary function test that can support a diagnosis of asthma or COPD, but recent evidence has demonstrated that patients with moderate to very severe COPD also meet spirometric criteria for asthma diagnosis. Spirometry interpretation algorithms (SIA) should conform to diagnostic guidelines while acknowledging this overlap and prompting the clinician to consider further clinical assessment where such an overlap exists. **Objectives:** To determine the variations in SIA that exist in the published literature and online sources. **Design:** MEDLINE, EMBASE, and mainstream search engines were used to identify all SIA-related material dating back to 1990. **Keywords used** were "spirometry," "algorithm," "algorism," and "algorhythm." **Results:** Seventeen out of 27 SIA are unable to serve well as stand-alone documents. Twenty-four SIA lack a logic string to post-bronchodilator FEV1/FVC ratio, potentially impeding COPD diagnosis. Ten SIA rely solely on post-bronchodilator improvement to distinguish asthma from COPD. Twenty-three SIA lack a prompt for bronchodilator challenge when FEV1/FVC is normal. Four SIA unnecessarily recommend DLCO testing to confirm COPD diagnosis. **Conclusions:** Twenty-five out of 27 SIA feature variations might lead to disease misclassification. Further studies are needed to confirm whether this link truly exists. This study points to the need for minimizing SIA variability, including the need for a standardized approach to the spirometric diagnosis of asthma and COPD.

517 **Airway Hyperresponsiveness Among Patients Attending a Primary Care Clinic With Symptoms Compatible With Asthma**

Amy Liao, BSc, Toronto, ON; Florence Mok, Mississauga, ON; Anthony D'Urzo, MD, MSc, CCFP, FCFP, Toronto, ON

Description:

Context: Asthma is one of the most common chronic inflammatory lung conditions encountered by primary care physicians. Asthma diagnosis is based on clinical symptoms, physical exam findings, simple spirometry, and other objective tests if necessary. Since most patients with mild asthma in primary care have normal lung function, spirometry might lack the sensitivity to provide objective diagnostic confirmation at time of testing—a feature that might delay diagnosis. Furthermore, lack of objective testing has been implicated in over-diagnosis of asthma. While it has been well documented that methacholine challenge testing (MCT) is

more sensitive than spirometry for inclusion or exclusion of asthma diagnosis, MCT is promoted as a second-line test in clinical guidelines. The latter might be related to the widespread and timely availability of simple spirometry compared to MCT. Objectives: This study explores airway hyperresponsiveness among patients attending a primary care clinic with symptoms compatible with asthma, using a pragmatic approach that might be suitable for more widespread adoption in the family medicine setting. Design: Retrospective chart review. Participants: Seventy-three patients who attended a primary care clinic with symptoms compatible with asthma, normal spirometry at time of testing, and without a prior diagnosis of asthma were retrospectively reviewed. Intervention: All patients received timely access to simple spirometry and MCT. Some patients were referred to the clinic by physicians in the local community, including same-day testing. Results: Airway hyperresponsiveness was confirmed in 34.2% of patients (PC20 = 4.1 ± 2.8). The average turn-around time from time of referral to MCT testing was 21 days. Conclusions: This study shows that about one-third of patients in primary care with symptoms compatible with asthma will exhibit airway hyperreactivity with MCT. This information can be obtained in a timely fashion in the community setting and might be useful for objective confirmation of asthma. Larger studies are required to determine whether our approach might be associated with reductions in asthma over-diagnosis in the primary care setting.

518 **Effects of Community-Based Palliative Care on Health Care Utilization in Patients With Advanced Heart Failure**

Leah Steinberg, MA, MD, CCFP, Toronto, ON; Meghan White, Toronto, ON; Susanna Mak, MD, PhD, Toronto, ON; Jennifer Arvanitis, MD, CCFP, FCFP, North York, ON; Russell Goldman, MD, MPH, CCFP, FCFP, North York, ON; Amna Husain, MD, MPH, CCFP, Toronto, ON

Description:

Introduction: In 2000, patients with advanced heart failure accounted for the second-highest number of hospital days in Canada. The condition is responsible for a high burden of hospitalization for symptoms that are currently difficult to manage in the ambulatory setting, and are associated with high mortality. We propose that providing home-based palliative care (PC) for these patients can meaningfully reduce the number of hospital visits and days in hospital, with the ultimate goal of improving patients' overall satisfaction with care and quality of life. **Methods:** In a quality improvement (QI) analysis of health care utilization of a sample of patients with advanced heart failure (HF) in a tertiary hospital in an urban setting, we measured and compared the rate of clinic visits, emergency department (ED) visits, hospital admissions, and days in hospital before and after implementing home-based palliative care. **Results:** A total of 32 patients with HF (69% female, M = 83.6 years of age) were seen in the home-based PC program over a two-year period. In a pre- and post-intervention comparison, meaningful reductions were seen in rates of clinic visits (pre: M = 0.3 visits/month; post: M = 0.1 visits/month), ED visits (pre: M = 1 ED visit/month; post: M = 0.2 ED visits/month), hospital admissions (pre: M = 1.5 admissions/month; post: M = 0.2 visits/month), and days in hospital (pre: M = 12.5 days/month; post: M = 4 days/month). Median length of stay on the home-based PC program was 2.73 months (range 0.1 to 25.6). Once in the home-based PC program, patients received an average of 2.18 visits/month from a PC physician. **Conclusion:** Home-based care of patients with advanced heart failure can lead to decreased health care utilization, including a decreased number of clinic visits, ED visits, and hospitalizations. In turn, we hope it can reduce both patient and system burden and result in greater health-related quality of life for patients with advanced heart failure.

519 **Circadian Rhythms and Cardiovascular Disease: A systematic mixed studies review**

Justin Gagnon, BSc, MA, Montreal, QC; Michael Cardinal-Aucoin, MSc, PhD, Montreal, QC; Araceli Gonzalez Reyes, BSc, Montreal, QC; Reem El Sherif, BSc, Montreal, QC; Carolyn Arbanas, BSc, MSc, MD, Toronto, ON

Description:

Context: Cardiovascular disease (CVD) is the world's leading cause of death. In Canada, it is estimated that CVD is the cause of over 69 500 deaths annually. Substantial evidence from both animal and human studies now links circadian desynchronization and sleep disturbance with adverse health outcomes, including metabolic and cardiovascular dysfunction. Disruption of the circadian system is also associated with increased incidence and severity of intermediate CVD risk factors such as obesity, diabetes, hypertension, and hyperlipidemia. Given the prevalence of chronic circadian disruption (ie, shift work, electric lighting, and social jet lag), it is crucial to examine current literature pertaining to CVD and circadian disruption, and make a case for their acknowledgement in the primary care setting. **Design:** We present the results from a systematic mixed studies review incorporating quantitative, qualitative, and mixed methods studies, using both animal models and human subjects. **Objective:** The purpose of the review is to describe current research linking circadian disruption with CVD and its intermediate risk factors in terms of themes covered, methodology, discipline, intended audience, and the extent to which studies refer to primary care as a potential field of application. **Findings:** A preliminary literature search suggests a strong, likely causal, link between chronic circadian disruption and CVD. We identified only a small number of articles that discussed the implications of these findings in primary health care. The vast majority of relevant articles we identified were published in basic research (mostly animal studies) and specialist, non-family medicine medical journals. Several papers recommended the potential value of chronopharmacotherapy (drug timing) for CVD treatment, but only a limited number of studies were designed to specifically address the impact of such an approach. **Conclusions:** Based on preliminary findings, we consider chronic circadian disruption a potential modifiable risk factor for CVD. Our results suggest the need to clearly target the primary health care provider audience regarding the causes and consequences of circadian disruption. We recommend future studies address the effect of the application of circadian concepts in preventative and therapeutic interventions for CVD.

520 **The Cardiovascular Health Awareness Program: A pilot project in two family medicine groups in Laval, Quebec**

Magali Girard, PhD, Montreal, QC; Marie-Thérèse Lussier, MD, MSc, FMCF, Laval, QC; Janusz Kaczorowski, PhD, Montreal, QC; Emmanuelle Arpin, MSc, Montreal, QC

Description:

Introduction: The Cardiovascular Health Awareness Program (CHAP) is a community-based, interdisciplinary, patient-centred cardiometabolic prevention and management program, based on Wagner's chronic care model, which has been developed and rigorously evaluated in a variety of settings over the last 15 years. However, CHAP has never been implemented and evaluated in Quebec or in interprofessional health care teams such as family medicine groups (FMGs) in Quebec. **Objective:** To determine the feasibility of integrating in FMGs CHAP health

awareness and cardiometabolic diseases management sessions for registered adult patients. Design: A CHAP intervention was pilot-tested in two FMGs in Laval (Quebec) during a six-week period (January to February 2015). Participants: Eight hundred and thirty FMG-registered patients aged 40 years and over received a personalized invitation letter from their physicians to attend a CHAP session. Intervention: During CHAP assessment sessions, participants completed a cardiovascular risk profile form, underwent blood pressure measurement using an automated blood pressure measuring device, received targeted healthy lifestyle and preventive care materials, and were informed about and linked with locally available community resources. Each CHAP session was supervised by a FMG nurse, and staffed by two to four volunteers (peer health educators) recruited by Laval's Volunteer Bureau and trained by each FMG nurse using standardized protocols developed by the CHAP team and adapted for FMG settings. Results: In total, 18 three-hour sessions were held in two FMGs, attended by 118 FMG-registered patients. The participation rate of 14% was lower than in previous CHAP projects. This can be attributed to the following factors: unseasonably cold weather; having invited younger participants to some sessions; expensive parking at one of the FMGs; and the requirement to confirm patient attendance by phone prior to the CHAP sessions. Results from a focus group with participating volunteers and individual interviews with nurses will be presented, as well as a profile of CHAP attendees. Conclusion: Results from this pilot project provide insights for a wider implementation of a CHAP intervention in interprofessional health care teams. The project also led to the development of CHAP interventions in other settings, as a result of collaborative work with Laval health authorities.

521 Involving Family Physicians in Early Identification of Eating Disorders: A national survey

Ahmed Boachie, MB, ChB, MRCPsych, DCH, FRCPC, FAED, Newmarket, ON; Pierre-Paul Tellier, MD, CCFP, FCFP, Montreal, QC; Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON; Karin Jasper, Ph.D. Newmarket, ON; Debra Katzman, MD, FRCPC, FAED Toronto, ON

Description:

Context: Children and adolescents with early onset eating disorders, who receive treatment within two years show better outcomes, particularly with family-based treatment. Early identification and treatment may also lower health care costs. Family physicians are in a unique position to identify eating disorders early. The revisions of the DSM 5 endeavour to address the issue. Objective: To understand factors that will assist family physicians in the early identification and management of eating disorders in children and adolescents, specifically to learn family physicians' current awareness of early warning signs of eating disorders and the extent to which they manage these disorders in their own practices. Design: The study is a survey with multiple-choice questions, requiring 5 minutes of physicians' time. It has been implemented as a pilot and will be implemented on a national level. Participants: In the pilot, family physicians who referred patients to an eating disorder program were called and asked if they would consider completing the questionnaire. It was faxed to those who agreed. In the National study, all family physicians registered with the College of Family Physicians of Canada will be invited to complete an online version. Results: Pilot study physicians assessed patients between the ages of 12 and 18 over the preceding year. Most common diagnoses were bulimia, anorexia, and avoidant/restrictive food intake disorder (ARFID). Physicians were effective in recognizing classic eating disorder symptoms but most missed the non-specific symptoms characteristic of early onset. All physicians endorsed as either likely or very likely that they would use a screening tool, immediate referral to a specialist service, and a practice-based learning program (PBLP) for eating disorders, if these were available. A PBLP was endorsed as increasing the likelihood that family physicians who do not currently manage these patients in their practices would do so. Conclusions: The pilot study suggests that without further training for family physicians, we will continue to struggle with early identification. A PBLP, an initial screening tool, and immediate referral to a specialist service would be valued by family physicians. The National study will provide greater understanding of these important issues.

522 Are Eligible Diabetic Obese Patients Offered Bariatric Surgery as per the 2013 CDA Guidelines?

Hammaan Khan, Oakville, ON; Shahzana Shahzad, Milton, ON; Bilal Khan, London, England; Huma Numair, MD, CCFP, Oakville, ON

Description:

Context: According to the 2013 Canadian Diabetes Association (CDA) guidelines, bariatric surgery should be considered for type 2 diabetes mellitus (DMII) with obesity II (BMI = 35.0 kg/m² to 39.9 kg/m²) with comorbidities (CM) and obesity III (BMI ≥ 40 kg/m²), after failure of standard weight loss medical therapies. An estimated 80% to 90% of patients with DMII are overweight/obese. Higher BMI in DMII is associated with increased overall mortality. Objective: To determine if eligible type 2 diabetic patients with obesity were offered bariatric surgery. Design: Cross-sectional study. Participants: We identified 248 DMII patients with obesity II (with/without microvascular complications, ie, retinopathy, neuropathy, nephropathy, cataracts and/or macrovascular complications such as erectile dysfunction, coronary artery disease, cardiovascular disease) and with obesity III, who visited Halton Family Health Centre Clinic (HFHC), Burlington, Ontario, between 2013 and 2014. They were divided according to age—40 to 69 years and ≥70 years—and HbA1C—7.0 to 7.9 and ≥ 8.0. Intervention: Analysis of EMR data from HFHC. Outcome measures: Offers of bariatric surgery to eligible patients and the influencing factors. Results: Out of 248 DMII with obesity II/III, 133 were male and 115 female. Of these 248, 219 patients were in the aged 40 to 69 years group, and 39 were 70 years or older. HbA1C was 7.0 to 7.9 for 52, and ≥8.0 for 41 patients. Eighty-three patients had obesity II(CM), and 85 had obesity III. Only 31 patients (16 male, 15 female) were offered bariatric surgery regardless of HbA1C and comorbidities; 28 were aged 40 to 69 years and 3 were ≥70 years. Twenty-five patients were obesity III and 6 were obesity II (CM). In all, 155 patients were eligible for bariatric surgery. Conclusions: Only 28 out of 155 (18%) eligible patients were offered bariatric surgery, despite it being covered by OHIP. All parameters, eg, age, gender, HbA1C, were comparable except BMI. Obesity III patients were four times more likely to be offered bariatric surgery, compared to obesity II (CM) patients. Despite the CDA guidelines, 127 (82%) eligible patients were never offered bariatric surgery. Obese DMII patients have greater difficulty with weight loss. Even a modest weight loss of 5% to 10% substantially improves insulin sensitivity, glycemic control, hypertension, and dyslipidemia, decreasing overall mortality. Bariatric surgery is a safe and effective option resulting in sustained weight loss and significant improvement in obesity-related comorbidities. Increasing physicians' awareness of the 2013 CDAG recommendation through continuing medical education, medical journals, peer discussion, etc., is required.

523 Development and Dissemination of a Preconception Health Care Tool in Primary Care

Lindsay Bevan, BAH, Toronto, ON; Rebekah Barrett, MN, NP-PHC, Toronto, ON; Lena Salach, BA, MA, Toronto, ON; Amanda van Hal, BSc, Toronto, ON; Deanna Telner, MD, MEd, CFPC, FCFP, Toronto, ON

Description:

Context and objective: Good health begins even before conception. Recommendations from the No Time to Wait: The Healthy Kids Strategy suggest that optimizing patients' health before conceiving will improve their children's chances of enjoying good health throughout their lives. In response to these recommendations, the Ontario Ministry of Health and Long-Term Care engaged the Centre for Effective Practice (CEP), in partnership with the Ontario College of Family Physicians, to develop and disseminate the Preconception Health Care Tool (PHCT). The tool is designed to improve maternal and infant health outcomes in primary care by guiding providers' discussions of health promotion and illness prevention strategies with all patients of reproductive age. **Design:** The tool was developed using CEP's integrated knowledge translation approach. A working group comprised of a primary care nurse practitioner, a family physician, and CEP staff conducted a comprehensive search, review, and appraisal of existing clinical evidence. Through this process the working group integrated all available evidence and resources into one tool. The tool was tested and refined based on feedback from individuals and organizations with expertise in maternal and infant care, and from providers who practise comprehensive family medicine. **Results:** The tool presents information for providers to use over a series of visits with their patients of reproductive age to encourage patients to develop a reproductive life plan; assess and optimize patients' preconception physical and mental health; optimize chronic medical conditions prior to conception; choose safe medications for women who might become pregnant; and counsel on lifestyle habits (nutrition, physical activity, alcohol, tobacco, and other substances). Current patient and provider resources are included throughout the tool. Preliminary data on dissemination has been collected and analyzed. Since the launch of the PHCT webpage in March 2015, it has received over 2100 views. Additional dissemination data will be presented and discussed. **Conclusion:** The PHCT might help standardize primary care providers' approach to preconception health care with all patients of reproductive age, and provide guidance and resources to both providers and patients.

524 Impact of Breast Reduction Surgery on Breastfeeding: Systematic review and meta-analysis

Roni Kraut, MD, Edmonton, AB; Christina Korowynk, MD, CCFP, Edmonton, AB; Lauren Katz, BSc, Winnipeg, MB; M. Shirley Gross, MD, CCFP, Edmonton, AB; Sandy Campbell, MLS, Edmonton, AB; G. Michael Allan, MD, CCFP, Edmonton, AB

Description:

Context: The World Health Organization recommends exclusive breastfeeding up to six months, with continued breastfeeding, along with appropriate complementary foods, up to two years of age or beyond, due to breastfeeding's significant health benefits. Breast reduction is a common plastic surgery performed in Canada and United States. The impact of this surgery on breastfeeding is currently unclear in the literature. **Objective:** To determine the impact of breast reduction surgery on breastfeeding. **Design:** Systematic review and meta-analysis. **Participants:** Studies were included if they provided both the absolute number and percentage of women successful at breastfeeding or lactation following breast reduction surgery. **Intervention/Instrument:** A medical librarian conducted the literature search. Two independent reviewers reviewed each paper. References of papers meeting the inclusion criteria were reviewed for completeness. Within the search, two systematic reviews were identified; references of these were also reviewed. For each accepted study, two independent data extractors captured data on the profession of the study authors, study characteristics, type of breast reduction surgery, patient satisfaction with surgery, preoperative discussion on breastfeeding, and number successful at breastfeeding. **Outcome measures:** Number of weeks of exclusive or any breastfeeding, percentage of patients satisfied with surgery, percentage of patients with whom breastfeeding was discussed preoperatively, and breastfeeding outcomes by surgery type. **Results:** Preliminary results of the literature search yielded 495 unique papers; 384 were excluded by title or abstract and 60 were excluded on full paper review, leaving 51 papers for data extraction. A further 15 papers were accepted following reference review. The accepted papers were published from 1946 to 2014, and the main outcome in approximately 40% of the papers was breastfeeding postsurgery. **Conclusion:** The final results will provide guidance to plastic surgeons as well as general practitioners on counseling women about breastfeeding before and after surgery, and on whether additional breastfeeding support should be provided to these women.

525 Maternal Food Choice and Infant Feeding

Melanie Hnatiuk, MSc, MD, CCFP, Calgary, AB; Monica Kidd, MSc, MD, CCFP, Calgary, AB

Description:

Context: Exclusive breastfeeding for the first six months of life has long been considered part of optimal infant nutrition, yet many women discontinue breastfeeding before this. Anecdotal clinical experience suggests that concerns about which foods are safe and appropriate for women to eat while breastfeeding, particularly women's concerns about foods that are thought to cause "gas" or colic, contribute to early cessation. In spite of limited published evidence of any causal link between maternal diet and infant behaviour, we have seen women adopt extreme avoidance diets or stop breastfeeding altogether. **Objectives:** To investigate patterns of food restriction while breastfeeding among women in Calgary, and to explore the reasons why some women food restrict while breastfeeding. **Design:** Qualitative study using semistructured interview guide, followed by thematic analysis. **Outcome measures:** Women's experiences breastfeeding young infants, especially with respect to diet choice. **Findings:** Data collection is ongoing at the time of abstract submission, but preliminary analysis suggest it is very common for breastfeeding women of young infants to attribute unsettled infant behaviour (eg, crying or other pain behaviours, sleep disturbance) to breastfeeding, especially perceived milk supply. Also, women heard from peers, family, and sometimes health care providers that certain foods "cause" colic, and some women subsequently avoided those foods. Women felt judged on their infant-feeding choices,

and remarks made by those around them contributed to their feelings of being a good or bad mother. Women expressed frustration at receiving conflicting information on breastfeeding, and often ranked information from family and friends as more important than information received from health care providers. Discussion/conclusions: Infant behaviour, though multifactorial, is often considered by mothers to be a proxy measure of milk “goodness,” and when an infant is fussy, women are quick to blame their milk and themselves. Women’s ability to breastfeed is tightly linked to their self-esteem and confidence as mothers, so in the absence of causal links between maternal diet and infant behaviour, health care providers should help support breastfeeding women to eat balanced diets, and reassure them that infant fussiness is often developmental, not pathological.

526 **Keeping Kids in the Conversation: Understanding children’s perspectives of visits to the general physician**

Jessica Dalley, BA, Guelph, ON; C. Meghan McMurtry, PhD, CPsych, Guelph, ON

Description:

Context: Visits to the general practitioner (GP) play an important role in the promotion of Canadian children’s health, yet research regarding children’s perspectives of GP visits is scarce. Objective: Obtain children’s perspectives of GP visits to determine how these experiences can be improved. In particular, this study focused on children’s reports of their positive and negative experiences at the GP visits, as well as children’s desire for increased information and involvement in their health care. Design: This is a qualitative, descriptive study. Consistent with the principles of patient-centred care, which emphasize the importance of actively involving patients in their own medical care, this study involved interviewing children directly. Introduction: Greater understanding of children’s medical fears is essential to informing interventions for managing procedural distress and pain during GP visits. The current study aims to understand children’s fears specific to GP visits, including fear of medical procedures (eg, needles), fear of experiencing pain, fear of illness, and fear of feeling uninformed about upcoming medical procedures. Equally as important, we asked children to describe their positive experiences at GP visits so these can be increased. Method: One hundred sixty-seven participants (sufficient to detect medium effect size at $P = .80$, $\alpha = 0.05$) in grades two to four (ages 7 to 10 years, Mage = 8.07) underwent structured interviews regarding their perspectives of GP visits. Anticipated results: All study data has been collected. Participant interview responses will undergo content analysis, which is the systematic and objective description of spoken communication. Participant responses will be coded into the following general categories: what children like/dislike about GP visits, how GP visits can be improved, children’s medical fears, and how to involve children in conversations about their health care. Conclusion: By obtaining children’s perspectives directly, the current study can provide information and guidance for improving GP visits for Canadian children through the lens of patient-centred care. This includes promoting positive experiences at GP visits, managing procedural pain and fear, and increasing preparatory information provided to children about medical procedures. Involving children in their primary health care might help increase children’s understanding of health concepts and prepare them for making medical decisions in adulthood.

527 **Examining Patterns in Medication Documentation of Trade Names and Generic Names in an Academic Family Practice Training Centre**

Carly Ruderman, MSc, MD, CCFP, Toronto, ON; Alexander Summers, MD, CCFP, Toronto, ON; Morgan Slater, MSc, PhD, Toronto, ON; Fok-Han Leung, MD, CCFP, Toronto, ON

Description:

Context: Medical education is increasingly recognizing and addressing the influence of the pharmaceutical industry on academic physicians and trainees. Among many changes medical institutions have made to try to eliminate directing biased information toward trainees is a restriction on the use of trade names in formal lectures and teaching settings. It is unknown whether there has been a similar trend toward generic name use and documentation in the clinical teaching setting. Objective: To compare the use of generic versus brand names for pharmaceutical products in clinical documentation in an urban academic family practice centre. Methods: A systematic retrospective chart review of the electronic medical records for St Michael’s Academic Family Health Team (SMAFHT) was completed, analyzing data present in each patient’s cumulative patient profile on August 1, 2014. Charts were analyzed for their documentation patterns of 20 commonly prescribed medications, with respect to generic or trade name use. The data were also analyzed for the significance of physician characteristics, such as years from graduation and clinic site, associated with documentation patterns. Results: For the 20 medication combinations of interest, only 32% of patient charts contained generic nomenclature exclusively. Conversely, 45% of patient charts contained only trade nomenclature, and 23% contained a mix of generic and trade nomenclature. Among the physicians at the SMAFHT included in the study, there was large variation in the use of generic nomenclature in charts, which ranged from less than 10% to nearly 90%. There was no association seen between the exclusive use of generic nomenclature and the number of years since graduation from medical school. No significant difference in documentation patterns was found between the five sites of the SMAFHT. Conclusions: Trade names continue to be used abundantly in documentation in medical charts at an academic family health team. The use of generic names and trade names varies widely by both the medication of interest and the prescribing physician. Further study is necessary to determine the characteristics of a physician that influence the use of generic or trade nomenclature.

528 Implementation of Pharmacogenomics Into Primary Care In British Columbia

Martin Dawes, MBBS, CCFP, MD (Lond), DRCOG, FRCGP, Vancouver, BC; Diana Dawes, MSc, Vancouver, BC; David Chong, MBBS, Vancouver BC; Lily Edelson, MBBS, Vancouver, BC; Marta M. Guarna, PhD, Vancouver, BC; Hagit Katzov-Eckert, PhD, Vancouver, BC; Nathan Heinrichs, MBBS, Vancouver BC; Paul Stanley, MBBS, Vancouver, BC; Robert Fraser, PhD, Vancouver, BC; Pieter R. Cullis, PhD, Vancouver, BC

Description:

Context: Physicians cannot predict whether a patient will gain the desired benefit from a prescribed medication or whether they will experience harmful side effects. Genetic tests might reduce this potential harm for many medications. Objective: To determine whether it is feasible to use genetic information to drive a decision support tool. Design: Feasibility cohort study. Setting: Family physician offices and pharmacies. Patients: Two hundred fifty patients in total: 200 from five family practices, 50 from a pharmacy. Inclusion criteria: Adults aged ≥ 18 years that have a diagnosis of gout, chronic obstructive pulmonary disease, depression, osteoarthritis, hypertension, hyperlipidemia, atrial fibrillation, asthma, osteoporosis, and/or epilepsy. Exclusion criteria: Pregnant or breastfeeding. Intervention: The participant gives a saliva sample, from which the genotype is analyzed. A panel of single nucleotide polymorphisms (SNPs)—33 SNPs in five genes that involve in the absorption, distribution, metabolism, and excretion (ADME) of medications used for common chronic diseases—is tested. Within the research computer (TreatGx) are medication logic trees that combine genetic information with data from the EMR (past medical history, medication prescriptions, and laboratory test results). Using this information, and the highest levels of published medical evidence, TreatGx makes recommendations of medications to prescribe. Next time the patient sees the family physician/pharmacist, information is exchanged between the two servers enabling prescribing recommendations to appear on the family physician's/pharmacist's screen. Outcome measures: Feasibility of recruitment, feasibility of obtaining SNP data, feasibility of integrating SNP data into EMR, use of decision support by family physicians and pharmacists, reported usability of tool. Anticipated results: Recruitment of, and saliva samples from, 250 people over a three-month period. Samples analyzed within five days of donation. Decision support accessed for more than 75% of patients recruited. Future: Information will be used to design a randomized controlled effectiveness trial. The primary outcome will be adverse drug events.

529 Targeted Genetic Testing to Increase Efficacy and Safety of Medications in Primary Care

Martin Dawes, MBBS, CCFP, FRCGP, PhD, Vancouver, BC; Hagit Katzov, PhD, Vancouver, BC; Diana Dawes, MCSP, Vancouver, BC; Marta Guarna, PhD, Vancouver, BC; Hagit Katzov, PhD, Vancouver, BC; Lily Edelson, MBBS, Vancouver, BC; David Chong, MBBS, Vancouver, BC; Nathan Heinrichs, MBBS, Vancouver, BC; Paul Stanley, MBBS, Vancouver, BC

Description:

Objectives: To describe the role of genetic variation that affects individual response to drugs; to outline the process to select genetic markers that have clinical utility; to assess the application of pharmacogenomics in primary care. Background: Adverse drug reactions (ADRs) are a significant cause of morbidity and mortality. These ADRs might be avoided through personalized drug treatment based on genetic markers. Studies in pharmacogenetics have shown that genetic variants such as single nucleotide polymorphisms (SNPs) in genes involved in drug metabolism and transport influence an individual's drug response. Here we describe the selection of a pharmacogenetic SNP panel developed as part of a decision support tool and its application in primary care. Aim: To integrate a panel of clinically effective SNPs using an evidence-based approach into a decision support tool for prescription known as TreatGx. Methods: Evidence for genotype-guided dosing recommendations was compiled for a wide selection of drugs commonly prescribed by family physicians to treat multiple acute and chronic diseases. SNP variants were ranked according to clinical annotations from PharmGKB, Clinical Pharmacogenomics Implementation Consortium, and FDA guidelines. Commercially available SNP panels were evaluated for inclusion of clinically relevant genetic markers. These were cross-matched against potential medication selection algorithms and current guidelines for relevance and applicability. Results: We have identified a validated pharmacogenetic SNP panel that includes genes involved in the absorption, distribution, metabolism, and excretion (ADME) of drugs developed by the PharmaADME Consortium and available from Life Technologies. This panel included 33 of the top-ranking SNPs in five genes of relevance: CYP2D6, VKORC1, CY2C9, CYP2C19, and SLCO1B1. Conclusions: The addition of clinically relevant genetic markers to the decision support tool will optimize personalized prescription recommendation in primary care and might result in clinically important reduction in ADRs.

530 Engaging Inner-City Populations and Stakeholders in Health Services Research

Lara Nixon, MD, CCFP, FCFP, Calgary, AB; Ginetta Salvalaggio, MSc, MD, CCFP, FCFP, Edmonton, AB; Elaine Hyshka, MSc, Edmonton, AB; Jennifer Nichol, MD, FRCPC, Calgary, AB; Kathryn Dong, MD, FRCPC, Edmonton, AB; Shireen Surood, PhD, Edmonton, AB

Description:

Context: Inner-city populations are characterized by medical and social complexity, low uptake of chronic disease prevention and screening (CDPS), and low primary care attachment. Hospital visits are a primary health care access point—providing an opportunity to respond to unmet needs as well as to connect individuals to primary and community-based care. Objective: To determine whether an inner-city acute care team intervention is associated with reduced emergency department (ED) use, increased primary care attachment, and increased CDPS. Inner-city populations are generally understudied due to challenges in recruitment, retention, and data quality; these challenges need to be carefully considered in study designs. Design: Two-group pre and post quasi-experimental design. Community liaisons (CLs) meet regularly with the research team, convene a community advisory group quarterly, and provide support for follow-up efforts in the community. Participants provide informed consent for 1) collection of primary survey data (baseline, 6 months, and 12 months); 2) secondary health, housing, income support, and policing administrative data over the same time period; and 3) data linkage. Participants: Patients presenting to acute care with active substance use, unstable housing, or unstable income. Intervention: The Addiction Recovery and Community Health (ARCH) team utilizes a multidisciplinary team-based approach to address unmet medico-social needs, population-specific care coordination and discharge planning. Outcome measures: 1) Total ED use; 2) attachment to a primary care provider; 3) family practice sensitive condition presentations to the ED; 4) stabilization or reduction of substance use; and 5) uptake of CDPS. Results: ARCH launched in July 2014 and conducts approximately 20 consultations weekly. Baseline characteristics of the study sample will be presented. Based on past local data,

we expect CL-supported follow-up activities to achieve a 50% retention rate. One hundred per cent of participants have consented to data linkage of survey and administrative data sets, allowing for comprehensive characterization of all participants both medically and socially, regardless of retention. Conclusions: ARCH is designed to provide interim supports for a vulnerable population, traditionally underserved and understudied by primary care. Strong partnerships with service providers, data custodians, and community members create an environment in which inner-city health services research is feasible.

531 Endoscopic Knowledge, Skills, and Practice Patterns of Canadian Family Physician Endoscopists

Michael Kolber, MD, MSc, CCFP, FCFP, Edmonton, AB; Shelley Ross, PhD, Edmonton, AB

Description:

Context: Currently excessive wait times highlight a shortage of colonoscopists in Canada. Patients in rural communities also face substantial geographic challenges in accessing care for their gastrointestinal concerns or symptoms. To fill this need, some rural family physicians have been trained in gastrointestinal medicine and provide endoscopic services to their local communities. However, there is a paucity of evidence on skill set, practice patterns, and knowledge (and educational needs) of Canadian family physician endoscopists. Objective: To determine the training, practice patterns, endoscopic skillset and knowledge of Canadian family physicians who routinely perform endoscopy. Design: Cross-sectional survey. Participants: Family physician endoscopists at an annual educational event aimed at family physician endoscopists (January 2014), with additional recruitment targeted to previous conference attendees. Instrument: Self-report survey accessed online. Results: Family physician endoscopists (n = 20; 90% male; representing 5 provinces [BC, AB, SK, ON, NWT]) completed the survey. Among respondents, 95% practised in rural settings; 65% were in communities without a local general surgeon, and 55% were at least a two-hour drive from the nearest gastroenterologist. Respondents reported both formal and informal training. All respondents performed gastroscopies, and 90% performed colonoscopies and polypectomies. On average, respondents performed endoscopy 4 days per month. All but one physician performed their own sedation at least some of the time, most commonly with fentanyl and midazolam. The majority routinely photograph cecal landmarks (76%) and tattoo advanced polyps or cancers (70%), while 94% feel able to intubate the terminal ileum when needed. Most felt they had adequate knowledge on the majority of general gastrointestinal or endoscopic topics but identified needing education in areas such as advanced care of patients with inflammatory bowel disease and staging rectal cancer, and Barrett's esophagus nomenclature. All endoscopists except one felt supported by their local colleagues and the majority felt supported by their colleagues in gastroenterology to whom they refer. Conclusion: Family physician endoscopists appear to be filling a need in caring for rural Canadian patients with gastrointestinal symptoms or concerns. Ongoing studies to directly measure endoscopic performance of these physicians should be performed and knowledge gaps should be addressed at future educational events.

532 Working Together for Rural Patients: Supporting sustainable rural practice through improved access to specialist care

Ella Monro, MD, Princeton, BC; Lisa Needoba, Shared Care Project Lead

Description:

As a result of a shared care project to locate specialist care in a small rural community, family physicians feel less isolated and better supported to provide quality care to patients—and specialists feel they are making a significant contribution to more equitable health care in British Columbia. Located in the southern interior, the Princeton area population is approximately 5400 people, served by a small local hospital. There are no specialists residing in the region and the ability to retain family physicians has been a persistent challenge. Traveling 1.5 or more hours through mountainous terrain to see a specialist is a real difficulty for many, resulting in frequently missed appointments. In 2013, Penticton specialists and Princeton physicians discussed the challenges of isolation from specialist care and advice in rural practice. With the support of the Shared Care Committee (a collaborative committee of Doctors of BC and Ministry of Health) and the South Okanagan Similkameen Division of Family Practice, a shared care project started to improve Princeton access to specialist care and support for family physicians. Representatives from the Princeton family physician medical clinic, Interior Health Authority, Penticton specialists, and Shared Care project staff set out to attract specialists to hold outreach consultation clinics in Princeton. When the project started there were four specialties available through the outreach clinics to Princeton area patients. In one year this number had grown to 13 specialists from 11 different specialties, many offering a lunchtime continuing medical education opportunity for Princeton physicians and the nurse-practitioner. In 2014, approximately 400 patient trips were avoided, through nearly 50 outreach clinics. Among the patients, 96% kept their appointments, and 30% of patient respondents said they either would not have seen a specialist or don't know how they would have gotten to an appointment in a larger centre. A participating general surgeon remarked, "It is the most rewarding thing I've done in 10 years." The family physicians find it is a model of care that makes rural practice more attractive and sustainable.

533 Can We Meet the Needs of Regina's Emergency Department and Hospitalist Frequent Users?

Sarah Liskowich, MD, CCFP, Regina, SK; Erwin Karreman, PhD, RHIS, Regina, SK; Kiel Lunning, MD, Halifax, NS

Description:

Context: In Regina, a small percentage of patients repeatedly access acute care services at a huge cost to the medical system. In 2013, the Hospitalist Referral Program (HRP) was implemented with a goal to better meet the needs of these frequent users who are seen repeatedly in the emergency department (ED) and frequently admitted briefly to the hospitalist program without outpatient follow-up. These patients continually return to the hospital for their ongoing care, propagating a cycle of numerous brief admissions, creating dependency on acute care services for non-emergent problems. Physicians from the family medicine unit accepted HRP referrals and provided outpatient care at a community clinic. Objective: The purpose of this study is to evaluate the success of the HRP by taking into account medical as well as monetary parameters. Design: Data collection entailed six months' prior and post referral to measure the varying outcomes. To this end, the charts of 24 patients with a mean age of 39.6 (\pm 15.8) years were reviewed. Patients were categorized as successful or unsuccessful referrals based on whether they showed up for their first appointment and whether they regularly showed up for ensuing ones. This categorization was used to compare reduction in ED visits and monetary

savings. Monetary savings were calculated by comparing pre- and post-referral expenses associated with cost of transportation, hospital-related costs, and costs of outpatient appointments. Results: Fifty per cent of referred patients were considered successful referrals. Patients in the unsuccessful group showed an average drop of 2.0 (\pm 2.7) ED visits compared to a drop of 3.3 (\pm 4.3) visits for patients in the successful group. In addition, monetary savings through implementation of the HRP were estimated to be an average of \$6.6K (\pm \$9.7K) for the unsuccessful referrals and almost double that (\$12.6K \pm \$18.3K) for the successful referrals. Conclusions: Future research examining the traits of patients that successfully used the HRP would indicate whether more programs of this kind are needed or whether other solutions to this problem are required. Measuring this program's success informs ways to make positive impacts on health delivery in the Regina Qu'Appelle Health Region.

534 **Provider Perceptions of Knowledge Exchange and Communication Within a Multisite Family Health Team**

Morgan Slater, PhD, Toronto, ON; Emily Nicholas, BSc, Toronto, ON; Fok-Han Leung, MD, MHSc, CCFP, Toronto, ON; Aisha Lofters, MD, PhD, CCFP, Toronto, ON

Description:

Context: Team-based care is common in today's primary health care system. However, team members might be spread across multiple locations. While this allows for greater access throughout a community, separation of team members might negatively affect communication and lead to disparate patient access. Objective: To describe the self-reported knowledge and utilization of family health team (FHT) services and to explore communication issues among health care professionals active within a large, multisite FHT. Design: Electronic survey. Participants: All health care professionals active within a multisite FHT in Toronto, Ontario, were invited to participate (n = 90). Interventions: The survey captured: 1) demographics, including the respondent's role and length of experience, 2) knowledge and use of services within the FHT, and 3) perceived communication issues within the FHT. Main outcome measures: This descriptive study assessed self-reported awareness of FHT services, perceptions of patient access, and communication issues. Results: Forty-six health care professionals participated (51% response rate). While respondents were highly aware of the clinical resources and services offered at their site of practice (95% agreed/strongly agreed), only 54% were aware of services offered at other sites within the FHT. While internal referrals for certain specialty services were high (ie, methadone management, obstetrical care, IUD insertions, and psychiatry), less than 50% of other referrals were internal despite physicians within the FHT having the expertise (eg, sports medicine, joint injections). Only 60% of respondents believed that patients have equal access to all FHT services and 42% reported that patients are unlikely to travel between sites. Roughly one-quarter of respondents believed that physicians were unlikely to refer patients to another site within the FHT for health care services. A majority of respondents (68%) agreed that the geographic separation of the sites negatively affected communication. Conclusions: Geographical separation of team members in a multisite FHT had a negative impact on provider knowledge of available services, perceived patient access, and communication within the team. As the majority of FHTs are spread across multiple locations, finding ways to improve communication among team members is key to maximizing the effectiveness of the patient care provided by these team-based models of care.

535 **Introducing Diagnostic Ultrasound in an Academic Family Health Team**

Brent Wolfrom, MD, CCFP, Kingston, ON; Emily Pollock, MSc, Kingston, ON; David MacPherson, MD, CCFP, Kingston, ON; Eric Sauerbrei, MD, FRCP, Kingston, ON; Jyoti Kotecha, MPA, CChem, MRSC, Kingston, ON

Description:

Context: Diagnostic ultrasound provides a powerful tool for point-of-care investigations, cost-effective screening, clinical decision making, and medical education. However, it has not made significant inroads to outpatient-based care. There is very little data available on how to best teach diagnostic ultrasound to family medicine residents. Objectives: To determine the feasibility of introducing a diagnostic ultrasound into a family medicine teaching practice. Using the abdominal aortic aneurysm (AAA)-focused screening examination, this study aims to 1) assess the identification rate of AAA, 2) assess the competency of family physicians in the performance of basic diagnostic ultrasound, and 3) determine the perceived educational value to and comfort of family physicians in the performance of basic diagnostic ultrasound. Design: Department of family medicine faculty physicians and R1 residents are trained in basic diagnostic ultrasonography. Patients who meet the Canadian Society for Vascular Survey guidelines are recruited ad hoc, and screened for AAA by either a faculty physician or resident under supervisor. The same patient is also referred to the Radiology Department to receive a diagnostic ultrasound scan by a trained ultrasonographer with interpretation by a radiologist. Results are contrasted for consistency and reliability. At six months post ultrasound training, participating faculty physicians and residents are surveyed to determine their self-reported comfort and the perceived educational value of training. Participants: 1) Patients who consented and fit the Canadian Society for Vascular Surgery screening criteria; 11 have been scanned to date. 2) Faculty physicians and residents who participated in training; 7 have consented to date. Intervention: A diagnostic AAA scan by a recently trained family physician. Results: Analysis is ongoing. Conclusions: Preliminary results indicate that the diagnostic ultrasound is being used by family physicians as a point-of-care tool and is being well received by patients.

536 **Accessibility and Use of Primary Health Care Among Immigrants in the Niagara Region**

Irene Lum, BAsC (Hons), North York, ON; Rebecca Swartz, BScN, St Catharines, ON; Matthew Kwan, PhD, St Catharines, ON

Description:

Context: Research on immigrant health in Canada has been fairly well established; however, the focus has typically been on large urban centres such as Toronto, Montreal, and Vancouver, which have large immigrant population. As a result, immigrants and their experiences with the healthcare system in smaller regions remain largely unknown. Objective: The purpose of this study was to examine the lived experiences of immigrants in the Niagara Region, in order to identify specific barriers to use and access of the primary healthcare system and to better understand the unique challenges they faced when requiring primary care. Design: This was a qualitative study employing semi-structured interviews with all participants. Each interview was recorded, transcribed, and coded for emergent themes using a constant comparison approach on NVivo software. Participants: The study included 14 participants that were OHIP-eligible immigrants currently residing in the Niagara Region. Age of the participants ranged from 31 to 62, with the majority being female (64%). Half of the participants had lived in

Canada for less than 4 years. Findings: Overall, five emergent themes were found to impact primary care access, the primary care experience, or both. Specifically, social isolation, lack of OHIP coverage, the existence of a language barrier, difference in treatment preferences and geographic distance were found to be salient contributors to difficulties in accessing primary healthcare. Conclusion: This study is the first to examine the primary healthcare experiences of immigrants in a smaller urban centre. In comparison to similar studies conducted in larger cities, these findings suggest that immigrants identify similar barriers to primary care. It is likely, however, that these barriers may be further exacerbated in places such as the Niagara Region due to a smaller immigrant population, fewer services for immigrants, and less diversity in practicing physicians. Strategies to improve immigrant healthcare experiences in larger cities may not necessarily be effective in smaller regions due to differences in geographic and demographic characteristics. Thus, more research is required to understand effective ways to overcome primary healthcare barriers for immigrants moving to smaller urban centres.

537 Knowledge Translation for Family Physicians: Making good strategies even better

Joanne Permaul, BSc (Hons), MA, CCRP, Toronto, ON; June C. Carroll, MD, CCFP, FCFP, Toronto, ON

Description:

Context: Knowledge translation (KT) involves transferring knowledge acquired through research to application in practice. KT interventions have the potential to bridge the gap between knowledge and practice, potentially leading to improved health outcomes. It is important to evaluate the effectiveness of knowledge dissemination and implementation strategies and to make recommended improvements. Objective: To evaluate three KT strategies: an interactive educational workshop with resource materials (GenetiKit), including a just-in-time knowledge support tool called Gene Messenger (GM); a hereditary colorectal cancer (CRC) risk triage/management point-of-care tool; and an electronic knowledge dissemination service (e-Gene Messenger), to determine what improvements can be made to KT strategies based on recommendations from family physicians (FPs). Design: Quantitative and qualitative data were analyzed from evaluation questionnaires completed at the end of each study to determine if the KT programs were useful, the aspects that were valued by FPs, and how KT efforts could be improved. Participants: Canadian FPs. Results: Overall, these three KT strategies were evaluated highly by participating FPs. Of 42 FPs who evaluated the GenetiKit program, 88% found it useful; 76% said their practice changed a little and 21% said it changed a lot; 93% would recommend GMs to colleagues. Of 73 FPs who used the CRC risk triage/management tool, 70% found the risk triage tool, and 86% found the management tool, easy to use; and 90% stated that the tool would improve their practice. The GM program was evaluated by 381 FPs: 88% were somewhat/very satisfied with the service; 88% found this method of learning somewhat/very useful; and 76% found it useful for clinical practice. A synthesis of qualitative comments from the studies revealed the following recommendations for further improving KT strategies for FPs: practical point-of-care clinical tools; concise information with links to additional material if needed; convenient access to a trusted source of information; information tailored to FPs; website for future reference; and tools for hand-held devices and the electronic medical record. Conclusion: KT strategies have the potential to influence physician behaviour and improve health outcomes. Future KT strategies for FPs should be designed based on lessons learned from their feedback and recommendations.

538 Scoping Study of Communication Barriers Between Physicians and Immigrant Patients

Tanvir Turin Chowdhury, MD, PhD, Calgary, AB; Salim Ahmed, MSc, Calgary, AB; Nusrat Shammu, MSc, Calgary, AB; Nahid Rumana, MD, PhD, Calgary, AB

Description:

Introduction: Immigrant people all around the globe are commonly challenged by communication barriers in their everyday life. This barrier becomes severe when they must communicate with their doctors about their health conditions. As a vast number of people of the world are now immigrants (1 in every 7 people is living outside his or her country of origin), we need to understand the causes of this communication barrier and its effects on both doctors and immigrant patients. So far numerous original studies have taken the effort to shed light on the communication barriers between immigrant patients and doctors, but a synthesis of existing knowledge is required to identify the gaps as well as opportunities for future research and study. Method: We have done a scoping review of the literature to synthesize knowledge according to the research objective stated above. We used a standard scoping review framework according to Arksey and O'Malley (2005). We searched electronic databases of journal articles and grey literature and also used the snowballing technique to further expand the number of relevant literature. We limited our search to English-language literature only. Results: The searches returned 567 entries after removal of duplicates. Screening based on titles and abstracts selected 131 articles for full-text read. After full-text read, 61 articles were found for the synthesis. Language discordance between doctor and patient appeared as the most critical barrier in communication. However, cultural difference, religion, lack of knowledge, and socioeconomic status significantly impair effective communications. Lack of appropriate communication creates frustration among doctors and patients, mistrust and anxiety among patients, and ultimately worsen patients' condition and psychological well-being. Conclusion: Based on existing literature, this study depicted the facts and gaps in research about communication barriers that immigrant people encounter while accessing health care. Therefore, it can be considered as evidence of information which professionals such as doctors, policy makers, and researchers can use in finding their future directions on this issue.

539 Geographic Distribution of Scientific Contributions in Family Medicine: A bibliometric analysis of Canada's contribution

Tanvir Turin Chowdhury, MD, PhD, Calgary, AB; Fahmida Yeasmin, MSc, Calgary, AB; Salim Ahmed, MSc, Calgary, AB; Arfan Raheen Afzal, MSc, Calgary, AB; Nahid Rumana, MD, PhD, Calgary, AB

Description:

Introduction: Publication of scientific articles in peer-reviewed medical journals is considered as a measure of research productivity. The aim of the present study was to quantify the research contributions of different countries in family medicine and to critically discuss the results through the prism of recent socioeconomic parameters. Materials and methods: All the articles on "family medicine" published between 2009 and 2013 (five years) were selected and downloaded from the MEDLINE database. The following

key words were used for the search: "General Practitioner," "Family Practice," "Family Physician," "General Practice," "Family Medicine," and "Family Doctor." These articles were coded for publication year, country of first author's affiliation, and article type. We have investigated the share of research output of the top-ranking 20 countries along with the trend over time. Also, we have investigated this share of research output weighted by other factors such as gross domestic product (GDP), population, per capita income, and research-and-development expenditure of GDP of each country. Results: The search generated 12 129 papers (853 clinical trials, 331 case reports, 55 meta-analyses, 908 reviews, and 9982 original articles). In terms of publication volumes, the United Kingdom (20.7%), the United States (19.76%), and Australia (10.1%) were the most productive countries. Canada was the fifth-most productive country, with 5.6% of the articles. When adjusted for country population, Denmark (6.1 out of 105), Netherlands (5.5 out of 105), and New Zealand (5.4 out of 105) occupied the highest ranks. These three countries also occupied the top three positions while GDP was accounted for. Canada was in ninth position for publication/population and was in tenth position for publication/GDP. Conclusion: Along with the United Kingdom, the United States, and Australia, Canada is one of the top contributors for family medicine-related research. But a comparison using GDP and the percentage of GDP spent on research and development showed that smaller European countries are more productive. With primary care being one of the important aspects of Canada, the barriers to boosting quality research in Canada should be determined and, accordingly, appropriate measures should be taken forthwith.

540 POEMs Reveal Candidate Clinical Topics for the Choosing Wisely Canada™ Campaign

Roland Grad, MD CM, MSc, FCFP, Montreal, QC; Sarah Ousalem

Description:

Objectives: We propose a method of identifying clinical topics for expert panels involved in campaigns like Choosing Wisely Canada. **Methods:** POEMs are tailored synopses of original research or systematic reviews, selected by searching over 100 journals. Delivered to over 20 000 members of the Canadian Medical Association (CMA) by email, the daily POEM is rated by physician members of the CMA with the validated Information Assessment Method (IAM), in the context of an ongoing continuing medical education program. From the readers' perspective, the IAM questionnaire captures the perception of the clinical relevance of this information, the intention to use this information for a specific patient, and any expected health benefit. We analyzed all ratings submitted by CMA members on all POEMs delivered in 2014. Given the objective of the Choosing Wisely Canada campaigns, we focused our analysis on one specific item in the IAM questionnaire, namely the expected health benefit from "avoiding an unnecessary diagnostic test or treatment." For each POEM, we obtained frequency counts of the number of these "avoid" ratings. This allowed us to identify the top 20 POEMs in 2014 associated with this type of health benefit. Then, to determine if the clinical topic of these 20 POEMs was included in the master list of the Choosing Wisely Canada campaign, two of us independently searched this list by keyword and topic area, in March 2015. Disagreements were resolved by consensus. Results: In total, 291 804 ratings were submitted on 254 POEMs in 2014. For the set of 20 POEMs of interest, we received an average of 1245 ratings per POEM (range 468 to 1459). Of the clinical topics addressed by these 20 POEMs, just two were the subject of a recommendation from the Choosing Wisely Canada campaign. The clinical topics of the other 18 POEMs were not addressed. We grouped these 18 POEM-topics into three categories: 1) diagnostic testing (n = 3), 2) medical intervention (n = 12), 3) surgical intervention (n = 3). Conclusion: The selection of new recommendations for Choosing Wisely Canada could be informed by a systematic crowd-sourcing approach based on POEMs.

541 Une étude pilote d'implantation du site web Discutons Santé en milieux cliniques de première ligne.

Marie-Thérèse Lussier MD, BSc, MSc, FCFP Montréal QC; Catherine Hudon MD, PhD, Sherbrooke, QC;
Élie Boustani, MD; Holly Wittman, PhD; Claude Richard, PhD; Fatoumata Binta Diallo, PhD, Montreal, QC;
Marilou Croteau, MD

Description:

Contexte : La gestion optimale des maladies chroniques exige que les patients jouent un rôle actif dans leurs soins. Une des stratégies pour y arriver est d'améliorer les habiletés communicationnelles des patients. La présente recherche vise à décrire et évaluer l'adoption et l'implantation du site web francophone, Discutons Santé, en contexte clinique, et à apprécier l'expérience de son utilisation. **Méthode :** Devis : Une étude de cas multiples. Sites : Trois UMF-GMF du Québec. Participants : Cinq professionnels de la santé et cinquante patients par clinique. Les critères d'inclusion des patients sont : 1) âgés de 40 ans ou plus; 2) atteints de deux maladies chroniques ou plus et 3) capacité à naviguer sur Internet. **Description du site web Discutons Santé:** un site web francophone composé de trois outils (Mes habiletés PIVO; Mes rendez-vous et Mon carnet de Santé) pour aider le patient à optimiser ses visites médicales. Chaque outil s'accompagne de vignettes cliniques audio et d'exemples. La personne est invitée à réfléchir aux problèmes qu'elle désire aborder et à les prioriser. Un sommaire de la visite du site est généré automatiquement et peut être partagé avec le clinicien. **Instruments :** Des questionnaires auto administrés et des groupes de discussion auprès des cliniciens et des patients ciblés serviront à recueillir des données sur la portée, l'efficacité, l'adoption, la mise en œuvre des outils dans les milieux cliniques participants. **Résultats :** Au moment de la présentation, les données sur l'expérience des professionnels à suggérer la visite du site web aux patients éligibles dans le cadre de leur suivi régulier seront disponibles. Aussi, les données sur l'expérience des patients quant à l'utilité perçue des trois outils et leur impact sur la visite médicale seront également présentées. **Conclusion :** La présente recherche permettra d'identifier les conditions nécessaires pour intégrer l'intervention au suivi habituel des patients en soins de première ligne.

542 Discutons Santé: A website to help chronic disease patients and providers engage in productive interactions

Marie-Thérèse Lussier, MD, MSc, CCFP, FCFP, Montreal, QC; Claude Richard, PhD, Montreal, QC;
Binta Diallo, PhD; Collectif Capsana, Montreal, QC; Fatoumata Binta Diallo, PhD, Montreal, QC;
Fatoumata Binta Diallo, PhD, Montreal, QC

Description:

Context: Communication interventions directed at patients, including self-learning websites, can increase patient participation, but few are available in French. Communication skills training is part of medical curricula. However, there have been few attempts at concurrent training approaches to improve both patient and health care provider (HCP) communication. The project aim is to develop and validate a French-language website intended to help patients and HCPs engage in productive interactions. **Methods:** Phase 1: Development of website materials. Patient training is based on Cegala's PACE model. HCP training is inspired by the Health Beliefs and Transtheoretical models. Many

formats are combined: texts, figures, graphs, video and audio excerpts, and interactive exercises. Phase 2: Capsana, a community organization that specializes in production of health education materials, teamed with us to create the website. Phase 3: Validation of website content, relevance, usefulness, ease of use, and intention to recommend it, preceded by 1) observing test users during website exploration, 2) self-administered individual questionnaires, and 3) patient and HCP focus groups to discuss the website strengths and weaknesses. Evaluation of distinct methods to promote the website within primary care (PC) practices followed: 1) passive diffusion, 2) active diffusion: website visit recommendation by either clinic receptionists or PC providers. Results: Validation data reveal that website presentation and content are relevant and useful and that the users intend to recommend its use. Patients suggested adding more instructions to improve navigation. Providers wished a greater number of clinical cases to illustrate the theoretical principles presented. Data from the evaluation of website promotional methods indicate increased patient visits when the HCPs suggested it. Discussion: This is the first French-language website aiming at simultaneously improving both patients' and HCPs' communication in the primary care context. A pilot study to study the implementation of the website in routine primary care practices in three Quebec teaching clinics is under way.

543 Exploring the Development of a Canadian Taxonomy of Primary Health Care

Mary Byrnes, Toronto, ON; Geoff Ballinger, Ottawa, ON; Tanya Flanagan, Toronto, ON

Description:

Context: Construction of taxonomies in health care has become an important feature of health services research, especially for those that want to use data to inform planning and policy. Objective: The objective of this study was to begin to explore whether individual fee codes in two provincial fee schedules could be classified or grouped as primary health care. Most primary health care studies based on patient-level clinician billing data simply focus on physician fee codes billed by general practitioners. However, not everything a general practitioner does is necessarily a primary health care service and some services provided by other specialty clinicians are in fact related to primary health care. Design: A clinical subject matter expert conducted a comprehensive review of fee codes from two Canadian jurisdictions to identify a set of codes in each province that were primary health care services. A small working group was then established to provide jurisdictional subject matter expertise and feedback on the development of decision rules. The fee codes were subject to these decision rules as well as to a set of validation processes intended to capture codes that were not included in the initial grouping. Results: The study identified 64 fee codes out of a total of 3079 fee codes that were "clearly primary health care" in one province, and 89 fee codes out of 4196 that were clearly primary health care in the other province. Conclusions: The results of this study suggest that individual fee codes in two provincial fee schedules can be classified or grouped as primary health care. Further work is required to assess the validity of this methodology as a suitable taxonomy of primary health care within and across jurisdictions. Additional analytical work is recommended to understand how the grouping could be used as a tool to aid primary health care research.

544 Examining the Relation Between the Type of Record System Used and Time Spent in Patient Care

Dragan Kljucic, MA (Psych), Mississauga, ON

Description:

Context: Electronic medical records (EMRs) provide health care teams with a holistic perspective of their patients' health, and can enhance communication among team members and between them and their patients. Moreover, EMRs improve the health care system efficiencies (eg, reduce the ordering of duplicate tests). This could provide family physicians with more time to focus on patient care. Objectives: 1) To identify the percentage of family physicians using electronic records, paper charts, and a combination of electronic and paper charts; 2) To compare these physicians in terms of hours spent providing patient care. Design/method: The presentation will use FP data from the 2007, 2010, and 2014 National Physician Survey (NPS). The NPS is an ongoing collaborative initiative led by the College of Family Physicians of Canada, the Canadian Medical Association, and the Royal College of Physicians and Surgeons of Canada. The surveys were sent to all practising physicians in Canada; all physicians had the opportunity to complete the survey, with voluntary participation. Data was then weighted to produce estimates of the total population of physicians in Canada. Results: The percentage of family physicians using electronic records exclusively has increased from 12% in 2007 to 22% in 2010 and 42% in 2014. In contrast, the percentage of family physicians using only paper charts has decreased from 63% in 2007 to 41% in 2010 and 20% in 2014. In 2007 and 2010, physicians using paper charts or a combination of paper and electronic charts spent an average of 40 hours weekly providing patient care. On the other hand, those using electronic records indicated an average of 44 hours in 2007 and 43 hours in 2010. Similarly, in 2014, FPs using paper charts or a combination of paper and electronic charts reported 36 and 37 hours on patient care, respectively, while those using electronic charts indicated 40 hours of patient care. Conclusion: Family physicians who are using electronic charts exclusively seem to have more time to focus on providing patient care than those using a combination of electronic and paper charts, or paper charts only.

545 Analyzing Health Data Across Care Systems: The NYFHT-NYGH Joint Data Warehouse

Michelle Greiver, PhD, MSc, CCFP, FCFP, Toronto, ON; Frank Sullivan, PhD, FRCP, MRCP, FRCGP, MRCP, Toronto, ON; Babak Aliarzadeh, MD, MPH, Toronto, ON; Karim Keshavjee, MD, CCFP, Toronto, ON; Michael Wood, Toronto, ON; Michael Wood, Toronto, ON; Kevin Katz, MD, FRCP, Toronto, ON; Eugene Wong; Sumon Acharjee, Toronto, ON; John A. Aldis, CPA, CA, Toronto, ON; Rita Reynolds, Toronto, ON; Kimberly Wintemute, MD, CCFP, Toronto, ON, Susan Griffis, RN, MA, DBA, CHE, Toronto, ON

Description:

Context: Complex patients frequently transition between primary care and hospital. We need to identify these patients and know more about them so that care can be organized to best meet their needs. However, the necessary data are found in multiple unconnected electronic systems and the information to enable identification and analysis is often not available to care providers. Objective: To build an integrated hospital–primary care data warehousing system. Design: The processes undertaken were 1) survey of the literature on data for care transitions, 2) stakeholder engagement and joint data warehouse design process (including

governance, privacy infrastructure), 3) trial linkage of patients from the primary care EMR database and the hospital's clinical database, 4) system architecture and feasibility assessment, and 5) generation of the demonstration database. Participants: North York General Hospital (NYGH) and North York Family Health Team (NYFHT). Intervention: We interviewed key stakeholders from primary care, hospital, and regional oversight organizations. These included clinicians (MD, RN, pharmacist, etc.), managers, data analysts, hospital leadership (CEO, COO, CFO), lead physicians, patients, privacy experts, and information services and decision support personnel. An initial slide presentation described key elements underlying a data warehousing system, followed by iterative changes based on informant feedback. We undertook a trial match of chronic obstructive pulmonary disease and congestive heart failure patients in the primary care EMR database with the hospital database to demonstrate feasibility. Results: There was agreement and strong support to move forward with design and implementation from clinicians and from senior management. In total, 1650 patients with chronic obstructive pulmonary disease (3% of population) or congestive heart failure (1% of population) were identified in the primary care EMR database. Data were linked and we determined that 78% of those patients had been seen in the hospital at least once, and 24% had had at least one in-patient admission in the past three years. Seven per cent of medical admissions in the past two years at NYGH were patients at NYFHT. Ten per cent of high-risk admissions (Hospital Admission Risk Prediction score >8) were NYFHT patients. Conclusions: A joint data warehouse system appears to be feasible. High-risk patients jointly managed by a family health team and hospital can be identified and studied.

546 Using EMR-Based Search Algorithms to Assess Primary Health Care Service Use and Costs for People Living With HIV

Anjori Pasricha, MD, MSc, Toronto, ON; Andrew Pinto, MD, CCFP, FRCPC, MSc, Toronto, ON;
Samy Mekhail, MD, MSc, Toronto, ON; Gordon Arbess, MD, CCFP, Toronto, ON

Description:

Context: With effective antiretroviral therapy, HIV is now increasingly managed as a chronic disease in the primary care setting. Previous research suggests that the cost of providing care to people living with HIV is high. Electronic medical records (EMRs) provide a unique opportunity to evaluate costs of care. No formal analysis of HIV-related health care utilization and costs using EMR search algorithms has been completed in Canada. Objective: To use EMR-based search algorithms to quantify contact with health care professionals for people with HIV and to estimate the associated cost of care. Setting: St Michael's Hospital Academic Family Health Team (FHT) serves approximately 1400 patients living with HIV. Design: This study will be a retrospective chart review applying previously validated EMR search algorithms to estimate health service use and cost of care for patients living with HIV. Participants: All adults over the age of 18 years with a diagnosis of HIV, engaged in care between January 1, 2014, and December 31, 2014, will be included. We will exclude patients who receive HIV care (defined as viral load testing and monitoring) in an alternative care setting (eg, infectious disease specialist). Instrument: We will extract data from the St Michael's Hospital FHT EMR software (PS Suite). Outcome measures: Outcomes of interest will include the number of patient encounters with health care professionals, associated costs based on billings and allied health professional salaries, and health outcomes. Results: Health care utilization (number of encounters with health care professionals) and related costs will be calculated using health insurance claims for physicians. For non-physicians, costs will be estimated based on available data on allied health professional salaries. Conclusions: This study will provide valuable information on the cost of care for people living with HIV, utilizing EMR-based search algorithms to assess resource use in a primary care setting. In addition, the results of this study will shed light on the relationship between costs of care and health outcomes to better understand the factors that impact HIV-specific resource use in primary care.

547 Menopause-specific Quality of Life Questionnaire (MENQOL) Dissemination and Use: A scoping review

Jacqueline Lewis, MD, CCFP, MSc, FCFP, Calgary, AB; Beate Sydora PhD Edmonton, AB; Hilary Fast BSc Edmonton, AB; Nese Yuksel PharmD Edmonton, AB; Sandra Campbell MLSc Edmonton, AB; Susan Ross PhD Edmonton, AB

Description:

CONTEXT: The Menopause-specific Quality of Life questionnaire (MENQOL™ & derivative MENQOL-Intervention™) are patient reported outcome (PRO) measures developed in a Canadian primary care setting and published before there was close attention to intellectual property rights. OBJECTIVE: The purpose of the scoping review is to determine the extent of worldwide use in 1996-2012 inclusive publications and to assess researcher and clinician fidelity to item and domain integrity, scoring and analysis strategy, and publication reporting of pertinent questionnaire characteristics. DESIGN: comprehensive scoping review. INCLUSION: All English and non-English papers using MENQOL as an investigative measure. METHOD: The scoping exercise systematically searched 13 biomedical and clinical databases using 'menqol' as a search term. Review articles, conference abstracts, proceedings, dissertations, and incomplete trials were excluded. Google Scholar was searched for 'grey' literature. Two independent reviewers extracted data reflecting study design, intervention, sample characteristics and MENQOL questionnaire version, recall period, questionnaire modification, analysis detail and language of questionnaire delivery. Data analyses included categorization and descriptive statistics. RESULTS: Data extraction identified 957 records of which 166 papers met inclusion criteria. Studies were performed in 38 countries, with MENQOL translated into 30 languages in addition to 18 known professional translations. To date, designs include surveys (71), RCTs (65), experimental trials (27), pilot studies (10), psychometric evaluations (6), and case reports (3). Interventions studied hormonal (30), non-hormonal (13) and complementary drugs (20), and physical (20) and psychological (16) treatments. The majority of papers (125) report questionnaire version but not recall period. Fifteen papers explicitly report modified items. CONCLUSIONS: The MENQOL outcome measure contributes evidence to evaluate a number of interventions used in primary care menopause management. Its research use has steadily increased in countries and languages unknown before this comprehensive review. The original lack of license and limited contact between researchers and developers may have permitted unexpected alterations, use of unofficial versions, informal or duplicate translations, and misunderstandings of item intent, especially related to translation or cultural adaptation.

548 Evaluation of a Distributed Health Research Methods Course for Family Practice Residents

Brian Ng, MD, CCFP, FCFP, CCFP (EM), Vancouver, BC; John-Jose Nunez, BSc, Vancouver, BC;
Evelyn Cornelissen, RD, PhD, Kelowna, BC; Ruth Elwood Martin, MD, CCFP, FCFP, Vancouver, BC

Description:

Context: Primary health care providers often lack the skills to develop research proposals from clinical questions. Most family medicine residency programs do not provide instruction on research methods. At the University of British Columbia, we developed a Distributed Health Research Methods Course (DHRMC) to address this gap. Objective: To investigate the effect of the DHRMC on the research knowledge, skills, and attitudes (KSA) of family practice residents. Design: Cohort study. Instruments: 1) A cross-sectional 25-item survey to assess research KSA. Participants will enter their survey responses in Fluid Survey. Open-ended qualitative responses will be analyzed using content thematic analysis for recurring themes. Closed-ended quantitative responses will be analyzed with simple descriptive statistics using frequencies. Associations between variables will be examined using cross-tabulations and Chi-square analysis. 2) Residency program records will determine number of prizes awarded for resident research projects. Setting: UBC family practice residency program. Participants: First- and second-year family practice residents across 16 teaching sites. Main outcome measures: 1) Improved research KSA for residents whose teaching sites participated in the DHRMC, compared with research KSA of residents whose teaching sites did not participate in DHRMC. 2) Increased numbers of prizes awarded for resident research projects in intervention group compared with control group. Results: Since September 2013, 111 (of a total of 320) UBC family medicine residents have enrolled in DHRMC, providing sample sizes of 111 and 209 for intervention and comparison groups, respectively. High response rates are anticipated because all residents will be surveyed in one location during Resident Research Days in June 2015 and June 2016. Findings of this work-in-progress will be presented at CFPC's Family Medicine Forum. Research ethics board certificate is pending. Conclusions: We anticipate that the effect of DHRMC will be improved self-reported research KSA, and increased numbers of prizes for research projects, among family practice residents.

549 Needs Assessment for Point-of-Care Ultrasonography Training in a Canadian Family Medicine Residency Program

Pierre Robichaud, MD, Ottawa, ON; David Gruber, MD, Ottawa, ON; Douglas Archibald, PhD, Ottawa, ON;
Michael Y. Woo, MD, CCFP (EM), FCFP, RDMS, Ottawa, ON; David Gruber, MD, Ottawa, ON;
Douglas Archibald, PhD, Ottawa, ON; Michael Y. Woo, MD, CCFP (EM), FCFP, RDMS, Ottawa, ON

Description:

Context: Point-of-care ultrasound (PoCUS), defined as "ultrasonography brought to the patient and performed by the provider in real time," is becoming rapidly recognized and adopted as a valuable tool across many fields of medicine. Formal bedside ultrasound training is a prominent component of several non-family medicine residency programs. However, despite its availability, wide applicability, and rapid learning curve, PoCUS has yet to be adopted in many Canadian family medicine residency programs. Objective: To assess the perceived need for PoCUS training in a Canadian family medicine residency program. Design: An anonymous survey was distributed online to family medicine residents. The survey assessed demographic information, baseline exposure to PoCUS, perceived utility of PoCUS, and the perceived need for PoCUS training as part of a family medicine residency curriculum. Target population: PGY-1 and PGY-2 residents at a Canadian family medicine residency program. Main outcome measures: Perceived utility of PoCUS and perceived need for PoCUS training as part of family medicine residency training. Results: Despite limited exposure, most respondents perceived PoCUS as a useful clinical tool and perceived a need for PoCUS training in their residency. More than three-quarters of residents anticipate they would regularly use PoCUS in their clinical practice if they were adequately trained and competent. There was no clear correlation between main outcome measures and the respondents' training environment, anticipated clinical practice environment, or baseline exposure to PoCUS. Conclusions: Our study demonstrates that the residents of our family medicine training program perceive PoCUS as a useful clinical tool and have a significant interest in accessing formal PoCUS training during their residency.

550 "How Is It for You?" Residents' and faculty experience with a new family medicine competency-based curriculum

Maria Palacios, DDS, MSc, PhD, Calgary, AB; Keith Wycliffe-Jones, MB ChB, CCFP, Calgary, AB;
Sonya Lee, MD, CCFP, FCFP, Calgary, AB; Vishal Bhella, MD, CCFP, Calgary, AB

Description:

Context: The University of Calgary Family Medicine (FM) residency program introduced a new "Triple C" competency-based curriculum in 2012. This presented an opportunity to study in depth the impact of such a major change on both faculty and residents. Methodology: Semistructured interviews were completed with 10 second-year FM residents and 16 faculty involved in the introduction of the new curriculum. Study participants were selected using a purposeful sampling method. Interviews were recorded and subsequently transcribed verbatim for thematic analysis. Results: The analysis revealed a wide variation in residents' and faculty members' understanding of the elements of a Triple C competency-based curriculum. Study participants identified issues relating to the delivery of quality, consistent, and equitable learning experiences in a large residency program. Scheduled learning experiences with non-physician health care professionals appeared to be less valued by residents than were experiences with physicians, and significant challenges around providing experience of continuity of care were also identified, especially in larger academic teaching clinics. Integration of residents into the FM clinics was better and continuity of supervision throughout the training was improved. A potential trade-off with experiences in inpatient care and acute care settings was identified. Some challenges relating to clinical opportunities and program delivery were attributed in part to program expansion as opposed to curriculum change. Conclusions: For a new curriculum to be successful, an ongoing process of evaluation and monitoring of learning experiences is essential. Despite some deficiencies and implementation challenges identified by study participants, residents and faculty both acknowledged that these were expected and were willing to commit to and engage with the new curriculum. Understanding how the Triple C curriculum impacted our learners and faculty provided essential feedback to curriculum developers, and enhanced our ongoing processes of quality assurance and improvement within the program.

551 Survey of Family Medicine Residents' Comfort With Home Care Core Competencies: Can a longitudinal curriculum yield improvements?

John Kirk, MD, CCFP, FCFP, Montreal, QC; Fanny Hersson-Edery, MD, CCFP, Montreal, QC

Description:

Context: The exposure of family medicine residents to home care teaching is recommended by the College of Family Physicians of Canada. In developing our longitudinal home care teaching program we sought to create core competencies for the teaching of family medicine residents. Objective: To determine if a structured home care teaching program can increase the comfort of family medicine residents in acquiring new home care competencies over the span of their residency training. Design: We performed a teaching program evaluation using a survey design. Outcome measures: The family medicine residents responded to an online survey. Questions used a Likert scale to assess their level of comfort with selected core competencies in home care at 0, 12, and 18 months of training. Participants: A cohort of 23 family medicine residents training at the Herzl Family Practice Clinic teaching unit from 2013 to 2015. Findings: As the residency progressed, a majority of residents experienced an increase in comfort level with core competencies such as adapting the physical exam to the home setting. However, their comfort with other competencies, for instance, assessing patient competency in the home, did not improve. Conclusions: Family medicine residents exposed to home care practice longitudinally during their residency training can develop increasing comfort with selected core competencies. This improvement was not observed for certain competencies, perhaps because of increased complexity or a lack of exposure. These findings might have important implications for the development and refinement of a family medicine home care teaching program.

552 Training on Underserved Population: From a student project to a part of the medical curriculum

Christine Ouellette, Montreal, QC; François Venne, Montreal, QC; Samantha Coulombe, Montreal, QC

Description:

Context: So-called "underserved populations" are those whose socioeconomic, cultural, or legal context prevents them from benefiting from the opportunities afforded to the rest of society. These populations face significant stigma from health care providers, who often fail to grasp this context because of a lack of exposure to these populations during their training. This stigma, in turn, might lead to delivering lower quality care to these patients. Objectives: To increase medical students' understanding of various underserved communities and social issues surrounding them. Medical students will then be more prepared to manage patients by addressing the specific needs of these communities. Furthermore, we aim to stimulate students' interest in working with these communities. Methods: Our extracurricular project, the INcommunity immersions, was founded by medical students, who put together a one-month summer immersion program in four communities that are thought to suffer from a lack of understanding by health care providers: the "Inner-city populations," "Migrants," "Aboriginals," and "Offenders." In partnership with local organizations, students learned about the challenges faced by the community in which they were immersed through internships, training sessions, reflective writing, and group discussions. In addition, wanting to bring the INcommunity concept to a wider audience, medical students collaborated with the University of Montreal's faculty of medicine in order to have all students exposed to underserved populations. Classes were added to the first- and second-year curricula, and a one-week immersion session was implemented in the last two years of medical school. Outcomes: After four editions of the INcommunity immersions, more than 75 students participated in a four-week extracurricular immersion and reported a deeper understanding of the issues faced by underserved populations. For the first time at the University of Montreal, a whole class (graduating in 2015) experienced a full week dedicated to underserved population and social determinants of health. To further investigate the evaluation of our projects, an impact assessment will be performed, starting with next summer's participants. Conclusion: Through these immersion projects, we wish to fight stigma, advocate for underserved populations, and train medical students to become better doctors, by socially and culturally adapting the care they provide to these communities.

553 Panel Management Curriculum to Teach Emerging Competencies for Family Medicine Residents

Sohil Rangwala, MD, CCFP, Ottawa, ON; Douglas Archibald, PhD, Ottawa, ON; Anne Balkissoon, MD, Ottawa, ON; Elizabeth Muggah, MD, CCFP, Ottawa, ON; Sharon Johnston, MD, CCFP, Ottawa, ON

Description:

Context: Panel management (PM) is a new approach to care where providers proactively address the health of their entire patient population (or panel) rather than react to health issues presented at visits. Curriculum guides to teach this new approach are scarce. Objective: To develop and evaluate a PM curriculum for family medicine residents to improve collaboration, communication, practice management, and care coordination; to enhance resident experience in patient ownership and continuity of care; to strengthen teaching and quality of care (chronic disease management, health promotion, and disease prevention). Design: Pilot project using a mixed-method program evaluation approach. Setting: A single academic training site for family medicine in Ottawa, Ontario. Participants: Seven first-year and eight second-year family medicine residents. Intervention: Residents were assigned a panel of 50 patients meeting pre-established criteria to ensure diversity in age, gender, and morbidity. Residents received dedicated PM time to review their panels and target specific activities, applying knowledge from evidence-based literature. PM activities were recorded in activity logs, and communicated to preceptors as well as to the allied health team through the electronic medical record. Outcome measures: An activity log was developed as both a teaching and an evaluation tool for formative feedback. Ongoing resident evaluation and a robust program evaluation were embedded in the curriculum to enable iterative adaptation and improvement. An assessment instrument of panel management competencies was developed for supervisors to evaluate residents' skills in PM during quarterly reviews, using information from chart audits, resident activity logs, and resident self-reflection surveys. A validated resident self-evaluation instrument was used to assess competencies in collaborative care. Conclusions: A PM curriculum provides an opportunity to teach and evaluate key clinical competencies for family medicine residents including collaboration, practice management, and care coordination, while promoting patient ownership and continuity of care.

554 Teaching Through Near-Peer Led Simulations

Sanjay Aggarwal, MA, MD, CCFP, Montreal, QC; Daniel Ince-Cushman, MD, CCFP, Montreal, QC

Description:

Context: Residents in family medicine expect both 1) teaching that is directly applicable to their residency and subsequent career and 2) opportunities to teach. Teachers and curriculum developers want lessons that are internalized by the learner and feasible within resource constraints. Objectives: To assess the experiences of PGY-1s and PGY-2s in a novel teaching technique: near-peer led clinical simulations. Design: Anonymous self-administered survey. Participants: Family medicine residents (PGY-1 and PGY-2) at two Montreal-based family medicine units of McGill University. Intervention: Stations were developed to simulate clinical scenarios. Instead of the marking grids typically associated with OSCEs, the stations were structured by the script of the clinical scenario as well as by key teaching point sheets. A staff physician briefed the second-year resident teachers (R2s) on their stations and the key teaching points. The cases were based on on-call scenarios that R2s would have experienced during their first-year hospitalist rotations. The R2s in turn guided the R1s through the clinical scenario, supplementing the key teaching points with their own experience. Results: Teaching and non-teaching residents evaluated the experience highly. No negative outcomes related to lack of content expertise were encountered. Conclusions: In reformulating the OSCE as a clinical simulation led by near-peers, multiple pedagogical benefits were gained. This included the experience of near-peer teaching for R2s and of active learning for R1s, fostering the internalization of curricular content for both groups. In transforming the teaching resident into both an educational resource and recipient, this tool might hold attractive human resource implications. Future directions for research could include examining the effects of this teaching technique on quality of patient care.

555 What Is the Usability of a Mobile Application to Prepare Residents for Their Board Examinations?

Diana Ramos, MD, L'île bizard, QC; Roland Grad, MD CM, MSc, FCFP, Montreal, QC; Alenoush Saroyan, MEd, PhD, Montreal, QC

Description:

Context: We developed a mobile app for residents to assist preparation for their certification examinations. Our vision is that interested parties—eg, Departments of Family Medicine—will promote the app as a study tool, and that locally, expert teachers will participate by adapting the clinical information in the app for their residents. The app (called IAM) was developed for tablet computers, iPhone, and Android devices. The IAM presents information on the “99 Priority Topics” at four levels: priority topics, their key features, clinical information on key features, and hyperlinks to online information. In addition the app contains a validated questionnaire for residents to provide feedback on this information. By means of alerts, residents can become aware of one topic per week. Objective/design: To better understand residents' experiences with the IAM app and its usability through a qualitative descriptive study. Participants: Twenty family medicine residents from McGill University consented to this six-month study in October and November 2014. Method: Data collection is performed by logging of page hits, whenever a page in the app is opened by a resident. Usage data will be analyzed from October 2014 to May 2015. Individual open-ended semistructured interviews have already been conducted, and a final interview is planned for May 2015 following the certification examination. Based on log files of app use, we will interview three types of residents (never users, former users, and users of the app). Inductive thematic analysis will be employed to classify data into codes and themes. Reliability of data coding will be assessed. This process will lead us to develop naturalistic generalizations to represent the data. Expected findings: This study is in progress. We will present our findings in a table by type of user according to emerging themes and corresponding excerpts such as barriers—notifications—alert overload. Study findings will help to improve the app.

556 To What Extent Do Residents Use an App for Self-Learning Related to the 99 Priority Topics?

Stefan Kegel, MD, CCFP, Toronto, ON; Roland Grad, MD CM, MSc, CCFP, FCFP, Montreal, QC; Inge Schabert, MB ChB, CCFP, FCFP, Hamilton, ON

Description:

Context: We developed a mobile app as a study tool for residents, by combining the concept of spaced education with smartphone technology. Objective/design: In the context of a usability study, we offered a smartphone tool (the IAM app) to residents, for self-learning related to the 99 priority topics. We sought to examine use of the IAM app and to determine the most read topics, the extent of app use by residents, and the effect of weekly alerts on topic readership. Participants: In all, 146 residents (64 second-year and 82 first-year) from the McMaster Family Medicine Program were consented in December 2014 and January 2015. Intervention: Page tracking: Whenever a page in the app was opened by a resident, the tracking system would log this event. Data were analyzed from December 24, 2014, to March 2, 2015. Results: Of the 146 residents who consented, 86 (59%) used the IAM app during the study period. We documented a mean number of page hits of 40.3 per resident (range 1 to 473). The number of users declined from 76 to 60 after the first study month; however, the number of hits per user per month increased from 26.6 to 28.9. The most popular topics were Abdominal pain (386 hits), Asthma (301 hits), and Anemia (200 hits). There were 5 topics that did not have any hits: Chest pain, Dyspepsia, Dysuria, Elderly, and Immunizations. We sent alerts on topics 1 to 7 to prompt residents. For these topics, 18.3% of total hits were logged within 5 days of the alert. Conclusion: In the first 60 days, use of the IAM app was relatively high and likely influenced by the novelty effect. The alert system seemed to prompt a fair user response. In the next cohort of residents, the app will serve as a platform for a study of the effectiveness of alert messages prompting the reading of priority topics.

557 Targeting Communication Problems: Knowledge or process issue

Dawn Martin, Dawn Martin MSW RSW MEd PhD, Toronto, ON; Sue Glover Takahashi, MA, PhD, Toronto, ON

Description:

Background: Problems with communication in the clinical encounter during postgraduate training are frequently identified. Clarity on the type of problem(s) experienced helps guide the selection of resources, sequence of intervention and the educational strategy used. Unravelling whether it is content (knowledge), process (skills) or a perceptual (attitude) issue can be challenging. **Methods:** A pilot study was done retrospectively exploring Board of Examiners (BOE) University of Toronto, Office of Postgraduate Medicine cases where residents were identified as needing additional support from a Communication coach. Cases were deconstructed to identify problem type and educational interventions using multiple assessment strategies. **Results:** The most frequently identified assessment strategy was role play with standardized cases. Content knowledge was assessed using the provided answer key whereas process and perceptual issues were assessed using Martin's Communication Map (a conceptual map of an organized, patient-centered clinical encounter). When the strategies were used together, it became evident whether the communication problem was related to content, process or perceptual. Clearly identifying the problem made it possible to sequence the educational intervention and establish effective educational interventions. For example, a disorganized approach might be due to knowledge gaps or to the absence of an organizing framework. The former would be addressed with a targeted reading program whereas the latter would focus on providing a framework. Knowledge gaps need to be addressed before process problems. **Conclusion:** Communication problems take many forms. Clearly differentiating and correctly characterizing the problems helps determine the educational interventions, learning sequence and strategies to provide targeted remediation.

558 Research and Quality Improvement in Postgraduate Family Medicine Residency

Kelsey Klages, MSc, London, ON; Fred Ross, BACS, CHRP, London ON; Eric Wong, MD, MCIsc(FM), CCFP, London, ON

Description:

Context: To stress the importance of research and quality improvement in family medicine, postgraduate programs will need to implement innovative curricula. Literature suggests experiential learning as preferred when training learners. **Objective:** A transformed resident project curriculum focusing on research and quality improvement was designed and implemented. **Design:** Program evaluation. **Participants:** Western University family medicine residents. **Intervention/instrument:** The curriculum was set after literature review, environmental scan of other programs, and committee meeting discussions. With a focus on active participation, curriculum deliverables included the Institute for Healthcare Improvement's Improvement Capability modules, a Model for Improvement quality improvement proposal or research proposal, and a final report. Residents had access to a trained expert, resources, meetings, and templates. Department- and university-specific resources were aligned to advance the curriculum. **Outcome measures:** Improvement Capability module data, Quality Improvement Confidence Instrument, Quality Improvement Proposal Assessment Tool, final project assessment tool, lecture assessments, curriculum evaluations, and program committee informal discussions. **Challenges** in creating and implementing the curriculum were described along with resident project topics, challenges, and successes. **Results:** Improvement Capability scores ranged from 90% to 95%. Residents completing the new curriculum had higher confidence in performing quality improvement than had the previous year's residents. Percent agreement for evaluative tools were high. Residents were satisfied with content delivered during resident project lectures. The reformed curriculum positions quality improvement and research on opposite ends of the same scholarly inquiry spectrum and this approach appeared effective for research-involved stakeholders and early adopters. Other stakeholders were concerned the approach focused on quality assurance, highlighting the need for additional training in quality improvement. Residents completing research largely worked alone and projects involved surveys and chart reviews. Quality improvement projects were largely completed in groups and the projects involved patient care (vaccination rates, appropriate prescription, screening rates) and documentation. Residents found it challenging to collect data from the electronic medical record, and the data collected often had accuracy issues. Project proposals often involved testing large tests of change instead of small tests of change through plan-do-study-act phases. **Discussion/conclusions:** Research and quality improvement might become a priority through practice settings with strong scholarly inquiry culture and departmental, university-wide, and community supports.

559 Resident Selection in Canada: What do program directors think about best practice recommendations?

Keith Wycliffe-Jones, MB ChB, FRCGP, CCFP, Calgary, AB; Glen Bandiera, MD, MEd, FRCPC, Toronto, ON;

Nick Busing, MD, CCFP, FCFP, Ottawa, ON; Sandra Banner, Ottawa, ON; Anurag Saxena, MD, FRCPC, Saskatoon, SK; Matt Raegele, Ottawa, ON

Description:

Introduction: Residency selection processes across Canada are often poorly understood by applicants and their advisers, resulting in significant stress and uncertainty. In such a high stakes and competitive environment where there is often perceived inequity, students can become over-focused on maximizing their chances of selection by a chosen program, potentially at the expense of their overall undergraduate learning. Furthermore, residency Program Directors often struggle to identify and implement reliable and valid assessment strategies to optimize match results to their programs. There is an overall need to improve the transparency and fairness of these processes and also to gather information on the current selection processes used across the country in resident selection. **Method:** One medical school recently convened a diverse working group to develop a series of 24 best practice recommendations around resident selection. We invited approximately 600 Residency Program Directors in Canada, including all Family Medicine Program Directors, to complete an online survey investigating their i) level of agreement with the recommendations ii) thoughts on the feasibility of implementing each recommendation nationally and iii) the current level of compliance with each of the 24 recommendations in their Program. Respondents were also asked to provide narrative comments on each recommendation. Likert-scale scores and narrative responses will be analysed quantitatively and thematically. **Results:** Program Directors' levels of agreement, impressions of implementation feasibility and current level of compliance will be presented for each recommendation, as well as a thematic analysis of the narrative comments by program type. **Conclusion:** This study will provide valuable baseline information on current residency selection processes across Canada and will also provide important feedback from Program Directors on their levels of support for implementation of each of the best practice recommendations.

560 Anxiety, Depression, and Frequent Binge Drinking Among Medical Students

Nora Magyarod, MD, MSc, CCFP, Kingston, ON; Eva Purkey, MD, MPH, CCFP, Kingston, ON

Description:

Context: Medical school is a time of significant stress for future physicians, and students' mental health frequently deteriorates over the course of training. It has been suggested that students under psychological stress might use alcohol as a means of coping. Objectives: 1) To quantify the prevalence of anxiety, depression, and frequent binge drinking among Queen's medical students across their four years of medical training. 2) To assess the relationship between anxiety, depression, and frequent binge drinking among Queen's medical students who drink alcohol. Design: Cross-sectional e-survey, from January 18 to February 14, 2015. Target population: In all, 400 students attending Queen's School of Medicine, a medical school at Queen's University in Kingston, Ontario, Canada. Instrument: Anxiety and depression were assessed using the Generalized Anxiety Disorder 7-item scale (GAD-7) and Patient Health Questionnaire-9 (PHQ-9), respectively. Binge drinking was defined as consuming 4 or more standard drinks in one sitting for women, and 5 or more standard drinks in one sitting for men. Outcome measures: The variables of primary interest were generalized anxiety disorder (GAD-7 score ≥ 10), major depression (PHQ-9 score ≥ 10), and frequent binge drinking (binge drinking at least twice in the last two weeks). Statistical techniques included calculations of frequencies, means, and Tukey tests. Findings: There were 82 (20.5%) respondents, with 76 (19.0%) providing valid data. Overall, 15.8% of respondents were found to have generalized anxiety disorder, and generalized anxiety disorder was most prevalent among third-year students (27.8%). Similarly, the overall prevalence of major depression was 14.5%, and was most common among third-year students (22.2%). The overall prevalence of frequent binge drinking was 28.9%, and was most common among first-year students (40.9%). Among drinkers, mean GAD-7 and PHQ-9 scores did not differ significantly between frequent and non-frequent binge drinkers ($P = .679$ and $P = .537$ respectively). Discussion/conclusion: This study suggests that anxiety, depression, and frequent binge drinking might be highly prevalent among Queen's medical students. No significant relationship was identified among the symptoms of anxiety and depression and drinking frequency. There is a strong need for supportive programming for medical students with anxiety and depression, and further research regarding the risk factors for frequent binge drinking among medical students.

561 Personal Health Care Practices in Residency: A cross-sectional survey

Laura Vance, MD, Kingston, ON; Kelly Howse, MD, CCFP, Kingston, ON

Description:

Context: Residency training can be a very stressful time and might precipitate or exacerbate both physical and mental health problems. Research has shown that many residents do not have an easily accessible family physician and might turn to colleagues for prescriptions or ignore their personal health concerns altogether. Objectives: This study examines the personal health practices of Queen's University residents and the factors affecting residents' health behaviour. It also makes comparisons to documented practices of a similar group of Queen's residents over a decade ago, to speculate whether the recent increased emphasis on resident wellness has translated into objective changes. Design: Cross-sectional survey. Participants: Queen's University residents across all years of all postgraduate programs; $N = 113$ survey respondents. Instrument: An electronically distributed survey, modeled on a similar study from 2001, gathered important demographic data, as well as participants' self-reported actions when faced with two hypothetical health scenarios (pneumonia and depression). Results: Among respondents, 57% have a family doctor within one hour's travel; 29% must travel longer than one hour; and 14% have no family physician. Residents with children are more likely to have a local family physician. Those with a chronic illness or mental health condition, or who regularly take prescription medications, are not. Most residents would seek help appropriately in response to a physical health scenario but not necessarily in response to a mental health one. Of the respondents, 30% report they would confide in another resident when faced with depression, as opposed to getting formal medical help or counseling. Conclusion: Overall, a greater proportion of current residents, compared to residents in 2001, have a local family physician and would choose seemingly appropriate courses of action for their physical and mental health concerns. Lack of time and attitudes about needing a physician remain important barriers, and residents might need to be educated about encouraging colleagues in distress to seek formal help. Conceivably, though, by emphasizing resident wellness over the past decade, some gains have been made in the personal health practices of Queen's residents.

562 Evaluating the Impact of Mindfulness Meditation on Family Medicine Residents' Well-being

Joan Horton, MD, CCFP, FCFP, Calgary, AB; Aliya Kassam, PhD, Calgary, AB; Doug MacLean, EdD, Calgary, AB

Description:

Context: Professional competence in medicine requires self-regulation in stressful situations, yet few doctors are taught stress management during their training. The high cost of physician burnout, depression, and loss of empathy has been well documented. Mindfulness-based stress reduction (MBSR) has been extensively studied and found beneficial in medical personnel. Objective: To determine if an adapted program of in-person training and online coaching in mindfulness meditation has an impact on the well-being of family medicine residents. Design: A convenience sample of family medicine residents self-selected to participate in either the active intervention or the comparison group. The study questionnaire was administered at baseline, after the eight-week intervention, and at 16 weeks. Active participants completed weekly mindfulness meditation practice logs and final evaluations of the program's usefulness and feasibility. Participants: All University of Calgary family medicine residents, $N = 179$, were eligible. Prior MBSR instruction mandated exclusion. Intervention: A two-hour introduction to mindfulness meditation, daily practice using a collection of guided mindfulness meditations, and seven weekly coaching messages via email were given to all active participants. Outcome measures: The study questionnaire consisted of the Copenhagen Burnout Inventory, the Perceived Stress scale, the Prime-MD Depression screen, the Interpersonal Reactivity Index, and the Two-Facet Mindfulness scale. Results: Seven active and 10 comparison participants completed all three questionnaires. Repeated measures ANOVA and independent t-tests

revealed borderline significant decreases in Personal and Work-related Burnout after 8 weeks. These regressed to insignificant differences at 16 weeks. Mindfulness was significantly improved in the active group and persisted to 16 weeks ($d = 2.07$, $r = 0.72$). The evaluations rated the introduction, recordings, and feasibility highly, but identified fatigue, conflicting schedules, and lack of group time as limitations. Conclusions: This pilot study, the first done with only residents, was limited due to low enrollment and competing demands on residents' free time. The abbreviated mindfulness meditation course had an impact on burnout and improved mindfulness over the 8 weeks of the intervention, but only mindfulness was significantly improved after 16 weeks. Protected program time for stress management skill acquisition might benefit residents' development of professional competence and patient care outcomes.

563 **Benefit of a Nutrition and Exercise Session to Medical Students in First-Year Courses**

Riad Al Sabbagh, BSc, Oakville, ON; Riad Al Sabbagh, BSc, Oakville, ON;
Jean Hudson, MScCH, MD, FCFP, CCFP, Mississauga, ON

Description:

Context: Lifestyle habits such as healthy eating and regular exercise are extremely beneficial when it comes to disease prevention and management. Patients expect physicians to be knowledgeable and competent in discussing nutrition and physical activity; however, the majority of physicians feel ill prepared to do so. Currently there is a clear deficiency in the practical nutrition and exercise education in undergraduate medical curricula and therefore the benefits of introducing a nutrition and exercise session to medical students in first-year clinical skills courses will be explored. Objective: To review the status of nutrition and exercise education in Canadian undergraduate medical education and to propose a nutrition and exercise session for medical students in first year. Design: A literature search and review of 60 studies. Participants: None. Instrument: Databases used include PubMed, Scopus, Web of Science, and University of Toronto Libraries. Findings: Nutritional and physical activity education is deficient in undergraduate medical programs in Canada. Because healthy habits take time to develop, it is essential that medical students be exposed to the benefits of healthy eating and regular exercise in their first year. Moreover, the attitude and behaviour of the physician toward nutrition and exercise are indicative of the counseling behaviour of the physician. A physician with a strong understanding and conviction about the benefits of healthy eating and exercise will be significantly more likely to counsel his or her patients. It is therefore in the best interest of undergraduate medical programs to begin teaching their medical students about healthy lifestyle habits early on in the medical curriculum and to provide hands-on training through a session dedicated to nutrition and exercise. Conclusion: It is in the best interest of undergraduate medical programs to begin teaching their medical students about healthy lifestyle habits early on in the medical curriculum and to provide hands-on training through a session dedicated to nutrition and exercise.

T101025 Residency PBSGL Networking Meeting
07:00–08:00 Tom Elmslie, MD, CCFP, FCFP, FRCPC, Ottawa, ON; Linda Mayhew, Hamilton, ON
715A MTCC

Description:

Looking for tips for running PBSG sessions in your residency program? Interested in how PBSG can be used to help residents with transition to practice? Or are you a resident who wants to learn more about PBSG? Learn from others across the country who participate in the residency PBSG program. Representatives from the Foundation for Medical Practice Education will be leading this session. Please join us for an open discussion about using PBSG in residency programs. This session provides an opportunity for those involved in residency PBSGL (practice-based small group learning) to interact with and learn from key contacts and other programs across the country.

T101830 Mental Health and Addictions Networking Breakfast on Concurrent Disorders in Family Practice
07:00–08:00 Ellen Anderson, MD, MHSc, Sooke, BC; Sharon Cirone, MD, CCFP (EM), FCFP, Toronto, ON
707 MTCC

Learning Objectives:

1. discuss practice experience in dealing with concurrent disorders
2. create a resource guide for their practice to support patients with concurrent disorders
3. network with other physicians with an interest in improved management of concurrent disorders

T102744 General Practice Psychotherapy Networking Breakfast
07:00–08:00 Victoria Winterton, MD, CCFP, FCFP, Owen Sound, ON; Chris Toplack, MD, CCFP, FCFP, Wolfville, NS
717B MTCC

Learning Objectives:

1. reflect on the role of psychotherapy in one's family practice
2. integrate knowledge of the models of psychotherapy and how these can be applied in family medicine
3. meet and exchange ideas and experiences with colleagues

Description:

During this session we will explore how comprehensive care family physicians can integrate psychotherapy into their practices in a variety of ways. We will review models of psychotherapy and how these approaches can be adapted for family medicine. The role of the therapeutic relationship will be addressed. In addition, participants will be encouraged to reflect on their own practices and will have an opportunity to share ideas and experiences with colleagues.

T103764 Panel Discussion on Topics in FP Anesthesia – Networking Breakfast
07:00–08:00 **703 MTCC**

Description:

Join the CAGA CPMF group to discuss "Challenges Facing the Rural Family Practice Anesthetist". FMF delegates are invited to share their knowledge and expertise in this specific area of interest at the CAGA Networking Breakfast.

T103766 Health Care of the Elderly Networking Breakfast
07:00–08:00 **705 MTCC**

Description:

FMF delegates are invited to share their knowledge and expertise in this specific area of interest at the Health Care of the Elderly Networking Breakfast.

T103866 Stories of Hospital Medicine: How do you incorporate hospital medicine into your practice? Networking Breakfast
07:00–08:00 Benjamin Schiff, MD, CCFP, Montreal, QC
709 MTCC

Learning Objectives:

1. discuss ways to incorporate hospital medicine into the family physician's practice, be it in an urban, suburban, or rural location
2. discuss tools to help maintain competencies in hospital medicine
3. discover "tricks of the trade" in examples from the practices of colleagues

Description:

The networking breakfast is being organized to provide an opportunity for family physicians who care for hospitalized patients to meet and share their experiences. The session will open with a brief introduction, to be followed by interactive sharing of personal stories.

T115047 Researchers in Education Networking Breakfast

07:00–08:00 713A MTCC

Description:

Please join us for our Fourth Annual Family Medicine Researchers in Education Networking Breakfast to connect with colleagues conducting like-minded research and to share your current and prospective research ideas.

T115054 New Teachers Networking Breakfast

07:00–08:00 715B MTCC

Description:

Just starting out in your academic career? Join a group of new family medicine teachers for an informal breakfast, stimulating discussions, and networking opportunities!

TJ200 Keynote: The Gift of Leadership in Health Care / Le don du leadership en soins de santé

08:00–09:30 Sister Elizabeth Davis, BA, Bed, MA, MhSc, LL, St. John's, NL

HALL FG MTCC

Learning Objectives:

1. appreciate the significant implications of the deceptively simple CFPC motto (In Study Lies Our Strength) for the practice of family medicine in Canada in light of the intense social, political, technological and environmental changes of this time in our history
2. understand what "study" means for family physicians today as the understanding of health and health care is being transformed in these changing times
3. see in a new way the kinds of "strength" which family physicians, individually and collectively, must bring to the citizens of Canada who give family medicine its privileged professional status

Description:

Accomplished health care advocate and educator, Sister Elizabeth Davis, Congregational Leader of the Sisters of Mercy of Newfoundland, is recognized for her dedicated work in health policy, advocacy, social justice, and social determinants of health. She presents a unique and inspiring perspective on the leadership of family doctors and the significant difference they make in the lives of their patients and in advancing health care no matter where they practise.

Sister Elizabeth has served as Assistant Medical Director and Executive Director of St Clare's Mercy Hospital in St John's, Newfoundland, as well as President and CEO of the Health Corporation of St John's. She has served with distinction on national and international organizations including the Royal College of Physicians and Surgeons, the Canadian Institute of Health Information, the National Board of Medical Examiners, the Council of Licensed Practical Nurses, and the Association of Canadian Teaching Hospitals.

Objectifs d'apprentissage :

1. prendre conscience des implications importantes de la devise du CMFC (L'étude est notre force), qui n'est pas aussi simple qu'elle n'y paraît, pour la pratique de la médecine familiale au Canada, compte tenu des de l'envergure des changements sociaux, politiques, technologiques et environnementaux de notre époque
2. comprendre ce que veut dire « étude » pour les médecins de famille d'aujourd'hui, à une époque où la compréhension de la santé et des soins de santé fait l'objet d'une transformation
3. voir sous un autre angle les types de « forces » que les médecins de famille, individuellement et collectivement, doivent apporter à la population canadienne, apport qui donne à la médecine familiale son statut professionnel privilégié

Description :

Éducatrice et défenseure de la santé accomplie, soeur Elizabeth Davis, responsable de la congrégation des Soeurs de la Miséricorde de Terre-Neuve, est reconnue pour sa dévotion envers les politiques en matière de santé, la représentation des intérêts, la justice sociale et les déterminants sociaux de la santé. Elle présente une perspective unique et inspirante sur le leadership des médecins de famille et l'importante influence qu'ils ont sur la vie de leurs patients, ainsi que sur la progression des soins de santé peu importe le lieu de pratique.

Soeur Elizabeth a occupé les fonctions de directrice médicale adjointe et de directrice générale de l'hôpital St. Clare's Mercy, à St. John's (Terre-Neuve), ainsi que celles de présidente et chef de la direction du Health Corporation of St John's. Elle a fait un travail remarquable auprès d'organismes nationaux et internationaux, notamment le Collège royal des médecins et des chirurgiens, l'Institut canadien d'information sur la santé, le Bureau national des examinateurs, le Conseil des infirmières auxiliaires autorisées et l'Association canadienne des hôpitaux d'enseignement.

T96493 An Approach to Establishing Levels of Intervention in the Hospitalized Patient

10:00–10:30 Benjamin Schiff, MD, CCFP, Montreal, QC

714AB MTCC**Learning Objectives:**

1. discuss the legal and ethical factors regarding levels of intervention
2. develop an approach to engaging patients and/or families in discussions around levels of intervention
3. describe some tools used to guide and document level-of-intervention discussions

Description:

One of the responsibilities of doctors caring for hospitalized patients (in particular “orphan” patients) is determining the appropriate level of intervention while respecting the wishes of the patient and/or family in the context of whatever medical conditions may be present. This can be particularly challenging when conflicts arise between the treating team and the patient/family. The types of interventions that can be discussed include (but are not limited to) resuscitation, ICU transfer, artificial feeding, antibiotics, and simple IV hydration. In some cases these discussions have taken place prior to the current hospitalization, but in many instances the hospitalization is the first time these questions are being addressed. In this session, I will review some of the legal and ethical aspects regarding determination of appropriate levels of intervention. I will then provide some guidance with respect to the process of establishing the level of intervention, specifically how to approach patients and/or families, with whom to discuss, when to discuss, and what to discuss. Finally, I will discuss the policy for determining levels of intervention currently in place at my hospital, including the form we use, how it has evolved over time, and the recommended approach to conflict resolution.

T99995 Ionizing Radiation and Health

10:00–10:30 Dale Dewar, MD, CCFP, FCFP, Wynyard, SK

717A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. describe ionizing radiation
2. guide patients in the appropriate mitigating response to medical, environmental, or accidental exposure to ionizing radiation

Description:

This session builds definitions of ionizing radiation through an open discussion with participants. Participants will learn about the history of X-rays and how they affect cellular structures – why we use lead aprons and other changes in their uses. More specifically, they will see exactly how ionizing radiation causes cellular damage and how the damage might affect the entire patient. Examples of environmental and clinical exposure to each type of radiation will be given as well as the degree of exposure. Physicians will be able to improve their understanding of and rationalization of patient exposures to X-rays, CT, PET, and the host of other scans as well as the use of ionizing radiation in cancer treatment either from external use or from implantable permanent or temporary devices (brachytherapy). Information on the manufacture and transportation of medical radiopharmaceuticals will also be discussed. Inadvertent environmental exposure such as from nuclear power plant accidents or uranium mining tailings will be discussed along with the means by which physicians should (or should not) offer mitigation. We can briefly cover controversial topics such as nuclear power plant disposal, transportation of nuclear wastes, West coast exposure to Fukushima radiation, and current environmental standards.

T100521 Childhood Mental Health Problems: When should family physicians worry?

10:00–11:00 Alice Charach, MD, MSc, FRCPC, Toronto, ON; Suneeta Monga, MD, FRCPC, Toronto, ON;

William J. Watson, MD, CCFP, FCFP, Toronto, ON

713A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. identify key features of preschool children who require assessment for common mental health problems (disruptive behaviour and anxiety)
2. utilize a brief parent report questionnaire to evaluate functional impairment in preschool children due to mental health problems
3. recommend and demonstrate a parenting intervention to assist with management of the mental health problems identified in the office setting

Description:

Childhood mental health problems such as temper tantrums, disruptive behaviour, and separation anxiety are expected in preschool children, but when is it too much? Ten to fifteen per cent of preschool children have diagnosable mental health problems. Symptom presentations of common psychiatric disorders in preschool children are similar to those in older children, yet many families of young children who could benefit from parenting interventions do not receive them. What is the role of the family practitioner in identifying children and encouraging parents to accept treatment? This workshop will utilize interactive small-group case discussions to highlight the key features of disruptive behaviour and extreme anxiety that may signal clinically significant disorders. Clinical tools such as the brief parent report behavioural questionnaires, as well as management strategies and resources, will be reviewed and demonstrated.

T101079 Techniques for Management of Symptoms of PTSD

10:00–10:30 Victoria Winterton, MD, CCFP, FCFP, Owen Sound, ON; Chris Toplack, MD, CCFP, Wolfville, NS

701AB MTCC**Learning Objectives:**

1. identify when a specific intervention to manage symptoms of PTSD is required in the office setting
2. practise and be able to demonstrate three techniques for managing emotional distress
3. apply three techniques for managing emotional distress both in the office setting and elsewhere

Description:

Post-traumatic stress in its various presentations is a common problem in family practice, manifesting as both physical and emotional distress. Patients experience a variety of symptoms, and often will exhibit distress in the office setting and describe certain experiences of distressing symptoms in their daily life. In this session we will learn three simple techniques that a family physician can use both as an intervention in the office and as a strategy patients can use on their own. These techniques include grounding, managing a flashback, and an intervention to deal with high anxiety.

T101050 How Non-Pharmacologic Factors Influence the Effectiveness of Antidepressants: Improving outcomes

10:30–11:00 Victoria Winterton, MD, CCFP, FCFP, Owen Sound, ON

701AB MTCC**Learning Objectives:**

1. recognize how non-pharmacologic factors influence antidepressant medication effectiveness, and therefore outcome, in treatment of depression
2. define and identify specific factors that influence both placebo and "nocebo" effects
3. review specific approaches in prescribing antidepressants that will improve response

Description:

Family physicians treat the majority of depressive illness in Canada and provide the majority of prescriptions for antidepressant medications. Both pharmacologic and psychologic factors influence the effectiveness of antidepressant medication and therefore influence outcome in the treatment of depression and related disorders. In this presentation we review the non-pharmacologic factors that influence antidepressant response, and describe specific interventions that will improve outcomes for your patients on these medications

T101445 Where Evidence and Expectations Meet: The art and science of using Patient Decision Aids

10:00–10:30 Jamie Falk, PharmD, Winnipeg, MB; Clayton Dyck, MD, CCFP, FCFP, Winnipeg, MB

802AB MTCC**Learning Objectives:**

1. identify what Patient Decision Aids (PDAs) are (and are not) and how they can improve outcomes in comprehensive patient-centred care
2. efficiently access a large variety of reliable PDAs for common chronic conditions
3. utilize PDAs more efficiently and effectively to further incorporate and translate relevant evidence into their busy clinical practice

Description:

While patient-centredness is valued as an essential component of health care provision in family medicine, numerous studies demonstrate a disparity between the preferences of patients and the judgments of physicians when making treatment decisions. Further adding to the complexity, patients are frequently challenged by multiple treatment options, and often end up uncertain of the trade-off between benefits and harms. In this interactive session, we will discuss how Patient Decision Aids (PDAs) can be used to assist clinicians and patients reach evidence-informed treatment decisions for a variety of common conditions, in keeping with patients' values and preferences. We will also discuss facilitators and barriers to the use of PDAs in a busy clinical practice, focusing on how to access them efficiently, assess their reliability, and consistently incorporate them into treatment decisions.

T101114 Tools for Practice: Using the online CAMH/Portico Primary Care Addiction Toolkit to optimize your clinical practice

10:00–11:00 Lisa Lefebvre, MDCM, MPH, CCFP, DABAM, Toronto, ON; Meldon Kahan, CCFP, FCFP, Toronto, ON; Kingsley Watts, MD, CCFP, FCFP, Toronto, ON


715A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. explain how Addiction Toolkit can screen, assess, and treat patients with alcohol, tobacco, or opioid problems
2. apply the Toolkit to several case studies to increase skill in treating patients with substance use disorders
3. discuss what additional tools may be useful to include in the Toolkit for primary care professionals

Description:

The recently reviewed and revised Primary Care Addiction Toolkit, edited by Drs Meldon Kahan and Kingsley Watts, provides evidence-based point-of-care tools, information, and patient resources for health care providers regarding alcohol, opioid, and tobacco use issues. Using case studies and personal devices, this interactive workshop will allow participants to learn how to use the Addiction Toolkit as a point-of-care tool in their practice. Participants will require their own or a shared personal device such as a smart phone, tablet, or laptop computer to participate. Presenters will provide an overview of the Addiction Toolkit through a live demonstration of the website content and

will guide participants as they work in small groups on clinical case studies, using the Toolkit. Finally, participants will be engaged in a discussion regarding the expansion of the Toolkit to suit their clinical needs, including the possibility of developing an online Community of Practice.

T101237  **Simplified Approach to Red Eye: Evidence, pearls, and medico-legal pitfalls**
10:00–11:00 **Approche simplifiée pour les yeux rouges : données, perles et pièges médico-légaux**
Simon Moore, MD, CCFP, Mono, ON
718AB MTCC

Learning Objectives:

1. confidently differentiate various red-eye diagnoses, avoiding common medico-legal pitfalls
2. safely prescribe therapeutics for red eye, including antibiotics, according to recent evidence
3. quickly identify simplified Red-Eye Red Flags requiring urgent referral

Description:

Through use of the visually engaging and innovative Prezi presentation software (rather than PowerPoint), this lecture will help the learner confidently differentiate which red-eye patients need urgent referral vs those that can be safely discharged home. The talk also emphasizes three pearls that every family physician should know about red eye. The focus of this lecture is not only the scientific content, but also helping the learner apply clinical, patient-is-in-front-of-you management. Learners will discover the basics of relevant ophthalmic anatomy, a stepwise approach to managing a red eye, and practical evidence that can be applied immediately in a clinical context. This presentation is the updated version of a 2014 FMF presentation, which was evaluated with an average rating of 3.8/4 in all five categories. It incorporates updated recommendations and feedback from the 2014 presentations. Dr Simon Moore has consistently received outstanding teaching evaluations at past conferences, and has presented at the Family Medicine Forum in 2011–2014 on “Basics of Starting Insulin in Type 2 Diabetes WITHOUT Losing Sleep at Night.”

Objectifs d'apprentissage :

1. différencier sans tracas les divers diagnostics relatifs aux yeux rouges, tout en évitant les pièges médico-légaux courants
2. prescrire en toute sécurité un traitement pour les yeux rouges, y compris les antibiotiques, en fonction des données probantes récentes
3. identifier rapidement les signaux d'alerte simplifiés, relativement aux yeux rouges, qui nécessitent une recommandation d'urgence

Description :

À l'aide du logiciel de présentation innovateur et visuellement attrayant Prezi, au lieu de PowerPoint, cette présentation aidera l'apprenant à différencier sans tracas les patients aux yeux rouges nécessitant une recommandation d'urgence de ceux qui peuvent recevoir leur congé en toute sécurité. La présentation souligne également trois perles que tout médecin de famille doit connaître au sujet des yeux rouges. En plus de s'attarder au contenu scientifique, cette présentation aide l'apprenant à appliquer la prise en charge clinique du patient « en face de lui ». Les apprenants découvriront les fondements de l'anatomie ophtalmique pertinente, une approche par paliers de prise en charge des yeux rouges et des données pratiques pouvant être appliquées immédiatement en contexte clinique. Cette présentation est une mise à jour de la présentation du FMF 2014, laquelle a été évaluée à 3,8/4 en moyenne dans les cinq catégories. Elle incorpore une mise à jour des recommandations et commentaires reçus en 2014. Lors des conférences antérieures, Dr Simon Moore a constamment reçu des évaluations exceptionnelles au sujet de son enseignement; il a également présenté la séance *Basics of Starting Insulin in Type 2 Diabetes WITHOUT Losing Sleep at Night* lors des éditions 2011 à 2014 du Forum en médecine familiale.

T101628 **The Unbearable Lightness of Being Mortal: Improving our skills with advance care planning**
10:00–11:00 Chris Frank, MD, CCFP, FCFP, Kingston, ON; Mireille Lecours, MD, CCFP, Stratford, PE
801AB MTCC

Learning Objectives:

1. discuss goals of care with people during office visits, during admission to hospital, and in long-term care facilities
2. describe the ethical and legal principles that guide ACP and goals of care communication
3. use one of several frameworks to guide their own communication strategies and styles

Description:

Although there is greater awareness of the importance of Advance Care Planning (ACP), patients often receive care that does not align with their goals of care. Family physicians play an important role in ACP and in discussing goals of care with patients in the office, hospital, and long-term care facilities. However, these discussions still cause discomfort and distress for physicians and patients alike. This session will provide approaches to guide difficult discussions in different clinical settings. We will use role play, videos, and audience expertise to improve participants' skills and comfort. Goals-of-care discussions are hard enough with a clearly terminal diagnosis such as cancer; this session will also consider communication skills needed to discuss goals of care with a frail older patient. We expect strong audience participation and would welcome discussion of challenging situations experienced by participants. At the end of the session, participants will feel prepared to introduce the topic of advance care planning in the office, hospital, or nursing home, and will have a variety of strategies to improve the patient's experience.

T102797 **Calling a Spade a Spade: Barriers to identifying poor performance clearly on assessment**
10:00–11:00 Alison Eyre, MD, CCFP, FCFP, MD, CCFP, FCFP, Ottawa, ON; Carol Geller, MD, CCFP, FCFP, Ottawa, ON; Gary Viner, MD, CCFP, FCFP, Ottawa, ON; Eric Wooltorton, MD, CCFP, FCFP, Ottawa, ON
709 MTCC

Learning Objectives:

1. identify the barriers to preceptors clearly identifying poor performance on in-training evaluation reports and daily assessment tools
2. list at least two approaches to helping evaluators identify poor performance
3. identify approaches to help preceptors support the learner who is below competency, while making honest assessments

Description:

So we have done it! We have the fancy competency-based curriculum and the new tools to assess our learners, but what holds us back from identifying the learner who is below competency? Why do some preceptors still avoid making the hard calls? While our focus on competency has made benchmarking easier, there still remain barriers to the honest assessment of the learners who are not meeting competency. It is critical to identify them in a competency-based curriculum early and to put supports in place. In this interactive workshop, we will look at the barriers identifying poor performance on in-training evaluation reports and daily assessment tools and share approaches for use at the preceptor and program levels. Participants will gain tools and strategies for honestly sharing their identifications with learners in difficulty and for providing these learners with support.

T102046 **Common Musculoskeletal Injuries in the Child/Adolescent Athlete**
10:00–11:00 Lisa Fischer, BScPT, MD, CCFP, DipSportMed, London, ON; Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON; Roxanne MacKnight, MD, CCFP, FCFP, Miramichi, NB
HALL G MTCC

Learning Objectives:

1. define the musculoskeletal differences between a child/adolescent athlete and an adult athlete
2. identify the signs and symptoms of common musculoskeletal injuries in the child/adolescent athlete
3. create a management plan for common musculoskeletal injuries in the child/adolescent athlete

Description:

By the end of this session, the learner will be able to define the musculoskeletal differences between the child/adolescent athlete and the adult athlete, give examples of common injuries in child and adolescent athletes, and be able to formulate an effective management plan for these injuries.

T102423 **Interactive ECG Workshop: Rate and rhythm**
10:00–11:00 Constance LeBlanc, MD, CCFP (EM), FCFP, MAEd, Halifax, NS; Janet MacIntyre, MD, FRCPC, Halifax, NS
716B MTCC

Learning Objectives:

1. effectively interpret common rate and rhythm disturbances
2. use clinical data to augment interpretation and therapy for rate and rhythm disturbances
3. recognize key rate and rhythm disturbances requiring emergency management

Description:

This interactive workshop on electrocardiogram (ECG) rate and rhythm will cover the breadth of rate and rhythm disturbances commonly encountered in emergency medicine, and include tips to help distinguish between rhythms and approaches to undifferentiated rhythms. Two speakers will review the essentials of rate and rhythm interpretation on the ECG. This interactive workshop will cover basic office-based ECG interpretation, clinical correlation, and initial management for common rate and rhythm disturbances. This is a case-based session using red laser pointers (provided) for many participants and green laser pointers for each presenter, allowing participation and interaction throughout the session. This session will include clinical scenarios, ECG interpretation, and management tips for physicians working in all types of emergency care settings. Pearls for care will complete the session.

T102739 **Teaching a Man to Fish: Finding the right app**
10:00–11:00 Wes Jackson, MD, CCFP, FCFP, Airdrie, AB
501 MTCC

Learning Objectives:

1. choose useful, safe, evidence-based apps for mobile devices
2. find quality websites dedicated to medical app reviews
3. use three or more different methods to locate quality medical apps

Description:

“Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime.”—Maimonides
 In 2015, mobile devices have proven their utility in the practice of medicine, leading to the development of hundreds of thousands of medical apps, created for physicians and their patients, with new ones appearing daily. Some apps, like fish, are indispensable, while the utility of others depends on the user; still others are potentially dangerous. How does a busy physician efficiently find useful, safe, and evidence-based apps in this environment? This workshop will “teach a man to fish” through the discussion of not only “fish” (apps), but also “fishing holes” (eg, websites), and “tackle” (eg, aggregating tools) useful for finding just the right app. The presenter has been interested in mobile devices in medicine for the last 20 years and would like to be an avid fisherman—once he finds the time.

T102555 Improving Coordination of Care Between Family Physicians and Cancer Care**10:00–11:00**

Eva Grunfeld, MD, DPhil, CCFP, FCFP, Toronto, ON; Patti Groome, PhD, Kingston, ON;
Bo Miedema, MA, PhD, Halifax, NS; June Carroll, MD, CCFP, FCFP, Toronto, ON;
Melissa Brouwers, MA, PhD, Hamilton, ON

401 MTCC**Learning Objectives:**

1. recognize the factors associated with coordination of cancer care (from diagnosis to survivorship) and how they vary across Canada
2. describe models of care to improve coordination between family physicians and cancer care and how those vary across Canada
3. relate family physicians' experiences and needs related to cancer risk assessment and other aspects of personalized cancer medicine

Description:

Family physicians (FPs) are the first and most frequent point of contact for cancer patients within the health care system during most phases of cancer care. Coordination of care between FPs and cancer specialists is vital to improve the quality and outcomes of care and yet is known to be problematic. Patients often need to consult many health professionals across multiple health care settings, which often leads to fragmented and uncoordinated care. The introduction of models of care and tools to improve coordination of care is essential to optimize the role of FPs along the breadth of the cancer care continuum, including cancer risk assessment. The Canadian Team to Improve Community-Based Cancer Care along the Continuum (CanIMPACT) is a pan-Canadian multidisciplinary team of FPs, cancer specialists, and researchers who have undertaken a comprehensive analysis of coordination of cancer care (from diagnosis to survivorship) across Canada. At this workshop, we will present the findings of CanIMPACT related to the coordination and quality of cancer care and how that varies across Canada, based on 1) patient care during cancer diagnosis, chemotherapy treatment, and follow-up/survivorship using administrative health databases; 2) patient and provider experiences and perspectives derived from focus groups and individual interviews; 3) models of care, tools, and strategies to improve coordination of care that have been introduced across Canada or in other countries; and 4) FPs' experiences, desired roles, and needs regarding education and practice tools related to personalized cancer risk assessment and other aspects of personalized cancer medicine. We will present a model of care that has been developed, based on these findings, to improve the coordination of cancer care. Workshop participants will have an opportunity to provide feedback on the proposed model of care, which will then be revised for later testing in a randomized clinical trial.

T107236 Safeguarding Caring and Compassion in an Era of Competence-Based Education**10:00–11:00**

Elaine Van Melle, PhD, Kingston, ON; B.D. Hodges, MEd, PhD, MD, FRCPC, Toronto, ON

711 MTCC**Learning Objectives:**

1. describe the tension between the concepts of "caring" and "competence"
2. develop a personal stance on the need to develop "a call to caring"
3. consider the role of professional self-identity in integrating caring and competence

Description:

Competence-based education models are increasingly popular in medical education. The premise is to define more clearly discrete, observable competencies and to monitor the trajectory of learners using concepts such as milestones. This is relatively straightforward for competencies that are knowledge- or skills-based but more challenging for complex domains such as professional self-identity formation and the ability to demonstrate caring. Further, much of the drive toward competence-based models arises from a desire to shorten training and render it more efficient. These imperatives might run counter to ensuring the development of qualities such as compassion. This interactive workshop, based on the work of both the Royal College of Physicians and Surgeons of Canada's 2015 CanMEDS revisions and the Associated Medical Services (AMS) Phoenix Project, explores these challenges and focuses on ways to safeguard caring and compassion in an era of competence-based education.

T108248 What's New? The top 10 research studies that will impact clinical practice for family physicians / Quoi de neuf? Les dix meilleures études de recherche qui changeront la pratique clinique pour les médecins de famille**10:00–11:00**

David Kaplan, MD, CCFP, Toronto, ON; June Carroll, MD, CCFP, FCFP, Toronto, ON;
David White, MD, CCFP, FCFP, Toronto, ON;
Moderator / Modératrice : Wendy Norman, MD, CCFP, FCFP, Vancouver, BC

HALL F MTCC**Learning Objectives:**

1. synthesize clinically relevant research presented at the primary care annual research meeting (NAPCRG)
2. stimulate the interest of practising family physicians in primary care research

Description:

In a repeat of hugely successful presentations from the past two years, three outstanding speakers will present the top 10 studies clinically relevant to family physicians from among over 500 presented at the North American Primary Care Research Group (NAPCRG) conference. Three family physician researchers will discuss what presentations they found most meaningful for their own practice and what they think every practising family physician should know. Each speaker will outline three or four studies, emphasizing what is new, why it is important, and how it can change practice. The focus will be on problems that are common and important in the family medicine setting. Copies of the original abstracts and presentations will be available. NAPCRG is the premier

international forum for communicating new knowledge in primary care; this presentation will showcase the best of NAPCRG for a clinical audience. This session might be of interest to family medicine researchers. .

Objectifs d'apprentissage :

1. synthétiser des recherches cliniquement pertinentes qui ont été présentées lors de la conférence annuelle du NAPCRG
2. stimuler l'intérêt des médecins de famille praticiens en matière de recherche en soins primaires

Description :

Dans un rappel des présentations qui ont fait un tabac au cours des deux dernières années, trois conférenciers hors pair présenteront dix études des plus pertinentes sur le plan clinique pour les médecins de famille, choisies parmi plus de 500 études présentées lors de la conférence du North American Primary Care Research Group (NAPCRG). Ces trois chercheurs en médecine familiale parleront des présentations qu'ils ont trouvées les plus pertinentes pour leur propre pratique et de ce qu'ils croient que tout médecin de famille devrait savoir. Les conférenciers présenteront trois ou quatre études, souligneront ce qui est nouveau, pourquoi ces études sont importantes et comment elles changeront la pratique. L'accent sera mis sur les problèmes qui sont communs et importants dans le contexte de la médecine familiale. Des exemplaires des résumés et des présentations originaux seront disponibles. La conférence du NAPCRG est le plus important forum international de diffusion de nouvelles connaissances en soins primaires; cette séance fera état des meilleures présentations effectuées au cours de la conférence du NAPCRG pour un public clinique. Cette séance pourra intéresser les chercheurs en médecine familiale

T108667 Mainpro+ ... A New Look, With New Ways to Learn (1)
10:00–11:00 Mainpro+ ... Un nouveau look; de nouvelles façons d'apprendre (1)

Eric Wong, MD, CCFP – Regional Educator, Ontario Region / Édicateur régional, région de l'Ontario, London, ON;
 Scott MacDonald, MD, CCFP (EM), FCFP – Regional Educator, Atlantic Region / Édicateur régional, région de l'Atlantique, Bedford, NS
803A MTCC

Join us for an informative session on Mainpro+ and the new, practice-centred ways to earn CPD credits for activities you do on a daily basis. Also, hear the latest updates on fellowship, accreditation, and CACs. The CFPC is committed to providing quality CPD to meet your changing interests and learning needs. Participants may claim an additional Mainpro-M1 credit for this session.

Soyez des nôtres pour une séance d'information sur Mainpro+ et sur les nouvelles façons d'obtenir des crédits de DPC pour des activités que vous effectuez au quotidien. De plus, vous pourrez vous renseigner sur les nouveautés concernant le titre de Fellow, l'agrément et les CCA. Le CMFC s'est engagé à fournir des programmes de DPC de qualité qui conviennent aux intérêts de ses membres et répondent à leurs besoins en matière d'apprentissage. Les participants peuvent réclamer un crédit Mainpro-M1 additionnel pour cette séance.

T115050 "You Want Me to Teach?" Get ready with the new CFPC Fundamental Teaching Activities Framework

10:00–12:15 Viola Antao, MD, CCFP, MHSc, FCFP, Toronto, ON; Marion Dove, MD, CCFP, Montreal, QC;
 Allyn Walsh, MD, CCFP, FCFP, Hamilton, ON; Stewart Cameron, MD, CCFP, FCFP, MAEd, Halifax, NS;
 Sudha Koppula, MD, CCFP, Edmonton, AB; Teresa Cavett, MD, CCFP, FCFP, Winnipeg, MB
703 MTCC

Learning Objectives:

1. describe and apply concepts of fundamental teaching activities (FTAs)
2. use the FTA Framework to develop a personal learning plan for professional development
3. Identify tools and resources for implementation of this plan

Description:

This session will begin with a brief interactive presentation providing the background concepts and the supporting literature behind the development of the Fundamental Teaching Activities (FTA) Framework. Working in small groups, participants will use the framework to develop their personal learning plan. In a group, participants will share the results of their planning activities, and discuss how this framework could be useful for their professional development.

T119659 Understanding and Using the Triple C Evaluation Survey Data Within Your Own Program: Opportunities for program evaluation

10:00–12:15 Shelley Ross, PhD, Edmonton, AB; Douglas Archibald, PhD, Ottawa, ON
705 MTCC

Learning Objectives:

1. describe the Family Medicine Longitudinal Survey and the methodology used for implementation
2. consider ways to interpret the sample data emerging for the purposes of improving curricula design or conducting further research
3. discuss opportunities and challenges related to the use of the Family Medicine Longitudinal Survey as part of Triple C's program evaluation and define ways to address areas where further data are needed

Description:

As part of the Triple C Evaluation Plan, the Triple C Working Group for Survey Development is continuing to collect data from residents about multiple aspects related to the Triple C. Surveys are administered at start of residency program (T1), at time of graduation from residency

Small group interactive workshop – limited seating. (T2), and early in practice (within the first five years of practice; T3). All data are anonymous, but coding allows researchers to link T1, T2, and T3 data. In this interactive workshop, we will first introduce and describe

the methodologies used and offer examples of the dataset, including an overview and interpretation of results to date. Time will be dedicated to explaining how to interpret the data, with examples from some ongoing projects. In the second half of the workshop, participants will work in small groups to test ways to interpret and use the data for their own contexts. Opportunities to consider enhancing curricula design or developing research questions will be explored.

T101227 Caring for Patients by Video Telemedicine: How does this fit into family practice?

10:30–11:00 Ellen Wiebe, MD, FCFP, Vancouver, BC; Rosanna Lima, MD, CCFP, Pitt Meadows, BC

716A MTCC

Learning Objectives:

1. describe which patients and which situations are best suited to video telemedicine visits
2. troubleshoot scheduling, billing, and technical issues with video telemedicine
3. address privacy concerns and informed consent

Description:

In the past, telemedicine was used successfully for remote communities, but now it can be part of a city doctor's practice, too. We will present our findings from a qualitative study in which we interviewed family doctors and their patients about how they used video telemedicine for ordinary office visits. Telemedicine visits can benefit patients who have difficulty coming into the office, for example, patients caring for young children or elders and those with disabilities. We will discuss using free video platforms, such as Skype and FaceTime, as well as medical video platforms. We will show how a busy family practice can mesh video telemedicine visits smoothly and efficiently into the daily schedule and how well communication between doctor and patient occurs via video. Video visits can take the place of some of the old-fashioned house calls where family doctors saw their patients in context and learned more about them (but without the cup of tea and piece of homemade cake!).

T94713 Fire Over Ice: In the face of recalcitrant non-genital warts

10:30–12:15 Lawrence Leung, MD, MA, MBBChir, MFM(Clin), DipPractDerm, CCFP, MRCP, FRACGP, FRCGP, Kingston, ON

501 MTCC

Learning Objectives:

1. recall the pathology, prevalence, and behaviour of recalcitrant non-genital warts
2. identify the mechanisms of actions, benefits, and cautions of using hyfrecation for treating non-genital warts
3. apply the knowledge and skills of hyfrecation in treating non-genital warts in daily practice

Description:

Verruca vulgaris (non-genital common wart) is a common skin condition in general practice that often resolves without treatment. For lesions needing treatment, our first-line treatment in family practice includes topical salicylic acid and liquid nitrogen application. In clinical practice, almost half of these lesions often persist despite repeated treatment and become recalcitrant warts, which then pose a challenge to treatment for the family physician. Hyfrecation is a form of electrosurgery that was described more than a century ago and has been used sporadically for skin lesions, including recalcitrant warts. The author would like to illustrate a step-by-step approach, with aid of photos and videos, to elucidate the benefits of hyfrecation for recalcitrant non-genital warts, aiming to support its value as an effective treatment modality for the busy family physician.

T94714 Coaching Competencies for Physicians

11:15–12:15 Nancy Merrow, MD, CCFP, CFPF, Queensville, ON; Cecile Andreas, MD, CCFP, CEC, Cranbrook, BC; James Read, MD, CCFP(EM), CEC, Warkworth, ON

717B MTCC

Learning Objectives:

1. structure a patient encounter to change a complaint into a goal
2. use artful questions to stimulate insight and move patients from goal to action
3. create a cycle of accountability that promotes patient ownership of their problems

Description:

Coaching is gradually entering mainstream health care as an adjunct to traditional advice giving and problem solving between practitioners and patients. In the move to a more patient- focused health system, coaching competencies add to the clinician's tool kit in managing competent patients with complex chronic conditions and lifestyle-related health issues. The change of mindset for physicians to be effective coaches for their patients requires new knowledge and practice of specific techniques. A coach holds the person being coached as fully capable in their own life, and holds the person accountable for their stated goals and action plans. The coach is non-judgmental about why the person does what they do, and remains curious about what the person wants to achieve. This workshop is designed to introduce physicians to what coaching is in the health care setting, to describe how coaching is emerging in the health literature, and to engage participants in exercises that can be immediately applied as new competencies in the clinical setting.

T99453 Dangerous Ideas Soapbox – Tribunes aux idées dangereuses

11:15–12:15 Wendy Norman, MD, CCFP, FCFP, DTM&H, MHSc, Vancouver, BC

714AB MTCC**Learning Objectives:**

1. acquire new perspectives on the scope and approach to primary care practice, innovation, and research
2. understand new leading-edge or unusual issues in family practice
3. engage in discussion and idea generation with national and international colleagues

Description:

The Dangerous Ideas Soapbox – Tribunes aux idées dangereuses is the wildly popular session offered at FMF since 2013. This session offers a platform for FMF innovators to share important ideas. It is a rigorous competition. The finalists participate in lightning presentations. The audience uses electronic voting to select the winner and the presentations are published in CFP.

T99899 Mood Disorders in Pregnancy and Postpartum

11:15–12:15 William Watson, MD, CFPC, FCFP, Toronto, ON; Simone Vigod, MD, MSC, FRCPC, Toronto, ON

713A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. identify updated risk factors for mood disorders in pregnancy and postpartum
2. describe techniques and new screening tools for diagnosing mood disorders in pregnancy and postpartum
3. explain newer approaches to treatment including psychotherapy and drug treatment

Description:

Mood disorders in pregnancy and postpartum are common (prevalence of 10–20%) and have an important impact on mothers, their children, and the entire family. They affect the quality of the mother's relationship with her child and the child's cognitive and social development. In addition, these mothers often face a lifetime of increased risk for recurrence of their illness. Unfortunately, mood disorders are under-treated during pregnancy and after childbirth. Family physicians are uniquely positioned in the health care system to help mothers and their families with perinatal mood disorders. Knowledge of risk factors, diagnostic tools, and up-to-date treatment recommendations can help family physicians manage mood disorders in a timely and effective manner. Using interactive case scenarios, this workshop will emphasize the prevention, diagnosis, screening, treatment, and therapeutic techniques that can assist family physicians in managing mood disorders in pregnancy and the postpartum period.

This is a small group interactive workshop. Seating is limited. The session will be closed when the seating reaches maximum capacity.

T100363 If Sex Sells, I'm Buying: Men's sexual health update 2015

11:15–12:15 Ted Jablonski, MD, CCFP, FCFP, Calgary, AB

701AB MTCC**Learning Objectives:**

1. define normal male sexual function
2. review the diagnoses and treatments of major male sexual dysfunctions
3. debate the "hot button" issues of men's sexual health in 2015

Description:

While most practitioners would agree that the sexual health of their male patients is important, many find this area of medicine challenging. Even the understanding and communication of what is "normal" can be fraught with myths and misconceptions. This session hopes to provide an updated review of male sexual dysfunctions and their current treatment options. As there are always controversies, a review of some of the most contentious issues of 2015 will be presented and debated. Dr Ted Jablonski is a family physician based in Calgary, Alberta, where he is currently in full-time practice within an innovative, inter-disciplinary community family practice. In addition to family medicine, Jablonski does consultancy work in men's health (with urologist Dr Jay Lee), and sexual and transgender medicine for Southern Alberta and central British Columbia at the Jablonski Sexual Health Clinic in Calgary. Ted has a special interest in CHE for physicians, medical professionals, and the public, and has been involved in the creation and delivery of a wide range of programs at provincial, national, and international levels. Ted is a sought-after speaker, trainer, media spokesperson, and educator with many conference, radio, television, and video credits.

T101345 Pan-Canadian Models of Care for Pregnant Substance-Using Women: Primary care-based approach

11:15–12:15 Eric Cattoni, MD, CCFP, Edmonton, AB; Ron Abrahams, MD, CCFP; Suzanne D. Turner, MD, MBS, CCFP, ABAM, Toronto, ON; Lisa Graves, MD, CCFP, FCFP, Ancaster, ON; Alice Ordean, MD, CCFP, MHSc, FCFP, Toronto, ON; Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON

715A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. describe various approaches for care of pregnant women with substance use disorders
2. explain trends in perinatal addiction relevant to clinical practice
3. utilize novel strategies for the care of women encountered in practice

Description:

Substance use disorders in pregnancy are common in urban and rural settings across Canada. Due to medical and social complexity, the care of these women largely rests with family physicians. This workshop will identify approaches of Canadian family physicians reflecting unique regional needs. Topics will include ambulatory integrated care for addiction in pregnancy, inner city perinatal addiction and trauma-informed care, special considerations for rural substance-addicted mothers, development of programs for care in poorly resourced regions, and new trends in substance use treatment and pregnancy. This session will include didactic and interactive components to encourage discussion. Participants will gain an enhanced understanding of perinatal addictions across Canada, and strategies from front-line providers to apply in their communities.

T101508 Unlocking the Secrets: How we approached the development of a Web-based resident assessment system

11:15–12:15

Eric Wong, MD, CCFP, MCIsc(FM), London, ON; Fred Ross, MD, CCFP, Winnipeg, MB; Charles Mehagan
709 MTCC

Learning Objectives:

1. describe key considerations for the development of a Web-based resident assessment system
2. Describe key insights from the authors' experience with the design and implementation of a Web-based resident assessment system

Description:

The family medicine residency program at the Schulich School of Medicine & Dentistry embarked on the development of a Web-based resident assessment system in response to new CFPC accreditation standards published in 2013. The assessment system was first rolled out in July 2014 and is under continuous improvement and development. The purpose of this workshop is to share lessons learned and insights from the design and implementation of the resident assessment system. The presenters (a faculty member, a program manager, and a Web developer/programmer) will start with an introduction to the resident assessment system, then discuss the principles used in design and implementation and the insights gained from the design and implementation process. The majority of the session will be a Question & Answer session to assist in the design and development of similar assessment systems at the participants' programs.

T101606 It's Overgrown Toeskin NOT Ingrown Toenail!

11:15–12:15

Henry Chapeskie, BSc, MD, CCFP, FCFP, CAME, Thorndale, ON
716A MTCC

Learning Objectives:

1. recognize the cause of "ingrown toenails"
2. perform minor surgical procedure for "ingrown toenail"

Description:

"Ingrowing" toenails are a common and painful problem. This is an innovative approach to an old problem. The term "ingrown toenail" incriminates the nail as the causative factor; however, there is excellent evidence-based research demonstrating that there is no nail abnormality and that the problem is due to an excessive amount of soft tissue. Removal of the excessive soft tissue results in less bulging over the nail with weight bearing. The nail is not touched! Physicians will stop removing toenails. Patients with "ingrown toenails" can expect to have an excellent cosmetic result. The technique is technically simple and can easily be performed in the physician's office.

T101676 Screening for Chronic Disease: A review and update on screening for depression, diabetes, hypertension, and obesity

11:15–12:15

Lisa Freeman, MD, CCFP, Edmonton, AB
HALL G MTCC

Learning Objectives:

1. review new non-cancer screening guidelines for 2015, including those from the Canadian Task Force on Preventive Health Care
2. evaluate recent non-cancer screening guidelines to weigh the benefits and risks of screening for patients
3. integrate screening and other preventive health and health promotion interventions into their busy practice

Description:

More and more Canadians are affected by chronic, non-cancer diseases like obesity, hypertension, diabetes, and depression. Family physicians strive not only to provide exemplary treatment to patients with these diseases, but also to prevent and screen for such conditions. This session will cover new 2015 guidelines for non-cancer screening, review recent guidelines, and provide practical strategies to integrate screening and other preventive health and health promotion interventions into a busy family practice. Participants will become comfortable with the Canadian Task Force on Preventive Health Care 2015 guideline for obesity in adults, as well as numerous other screening guidelines for common chronic conditions, including hypertension, diabetes and depression. Skills to evaluate screening recommendations in the context will be covered; participants will become comfortable evaluating and communicating the risks and benefits of screening with their patients. Practical methods to integrate screening and other preventive health and health promotion strategies will be learned, including how to effectively work with staff and technology to optimise screening and preventive care. This session is intended for practicing family physicians but will be suitable for medical students, residents and allied health providers who wish to master best practices in non-cancer screening.

T101785 A New Algorithm for the Diagnosis of Hypertension: CHEP 2015 recommendations

11:15–12:15 Mark Gelfer, MD, CCFP, FCFP, Vancouver, BC

715B MTCC

Learning Objectives:

1. understand the new algorithm for diagnosis of hypertension
2. explain why electronic BP measurement is preferred over auscultation; perform and interpret ambulatory blood pressure measurement (ABPM)
3. describe the importance of identifying patients with white-coat hypertension

Description:

The Canadian Hypertension Education Program (CHEP) has reviewed the published literature and determined two important gaps in current practice: 1. Auscultatory measurements performed in routine clinical settings have serious accuracy limitations that have not been overcome despite great efforts to educate health care professionals over several years. Thus, alternatives to auscultatory measurements should be used. 2. Recent data indicate that patients with white-coat hypertension (WCH) must be identified earlier in the process and in a systematic manner rather than on an ad-hoc or voluntary basis so they are not unnecessarily treated with anti-hypertensive medications.

T102055 Management of Persistent Post-Concussive Symptoms11:15–12:15 **Prise en charge des symptômes persistants post-commotion cérébrale**

Lisa Fischer, BScPT, MD, CCFP, DipSportMed, London, ON

HALL F MTCC

Learning Objectives:

1. define "sport concussion" and "post-concussive symptoms"
2. create a management plan for a patient with post-concussive symptoms
3. identify up-to-date resources to assist with management of post-concussive symptoms

Description:

Concussions continue to increase in number and it is often the responsibility of the family physician to manage patients with persistent sport concussive symptoms. By the end of this session, participants will be able to identify resources and create a management strategy for patients with post-concussive symptoms, including advice on their return to activity/sport.

Objectifs d'apprentissage :

1. définir la « commotion cérébrale dans le sport » et les « symptômes post-commotion cérébrale »
2. concevoir un plan de prise en charge pour un patient qui présente des symptômes post-commotion cérébrale
3. choisir des ressources à jour pour aider à prendre en charge les symptômes post-commotion cérébrale

Description :

Le nombre de commotions cérébrales continue de grimper et il revient souvent au médecin de famille de prendre en charge les patients qui présentent des symptômes persistants post-commotion cérébrale liée au sport. À la fin de la séance, les participants pourront choisir les ressources et concevoir une stratégie de prise en charge pour les patients qui présentent des symptômes post-commotion cérébrale, y compris des conseils sur la façon de reprendre leur activité ou leur sport.

T102064 Pearls in Thrombosis for Family Physicians: A case-based approach

11:15–12:15 Alan Bell, MD, CCFP, Thornhill, ON; Benjamin Bell, MD, FRCPC, Toronto, ON

717A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. manage patients presenting with diseases requiring consideration of anticoagulation

Description:

Topics to be covered include appropriate dosing of anticoagulants in atrial fibrillation; diagnosis and management of venous thromboembolic disorders (VTE), including deep venous thrombosis and pulmonary embolism; duration of therapy in VTE for secondary prevention; and perioperative management of anticoagulants. Current guidelines, including those of the Canadian Cardiovascular Society and the American College of Chest Physicians, are the standard upon which the session is based. Participants will be provided with point-of-care clinical tools, developed and peer reviewed by Thrombosis Canada, with which to apply the principles of this presentation to their practice.

T101078 First Five Years in Family Practice: Using social media and online technology safely in your practice

11:15–12:15 Scott MacLean, MD, CCFP, Edmonton, AB

716B MTCC

Learning Objectives:

1. identify medico-legal issues surrounding the use of social media and online tools in patient care
2. recognize effective methods of using social media tools safely in patient care and practice
3. employ guide to using social media and online technology in early practice

Description:

The First Five Years in Family Practice Committee will review the use of social media and online technology in family medicine, including a review of how these tools are used internationally, and the medico-legal concerns in Canada surrounding these methods. Several effective methods of using social media and online tools in primary care will be demonstrated; and a one-page guide to using social media effectively will be provided to participants during the session.

T102171 Suffering and Finding Meaning

11:15–12:15 Peter Selby, MBBS, CCFP, FCFP, Dip ABAM, FASAM, Toronto, ON; Ellen Anderson, MD, MHSc, Sooke, BC; Dori Seccareccia, MD, CCFP (EM), MCISc, Toronto, ON; Chris Frank, MD, CCFP, FCFP, Kingston, ON
711 MTCC

Learning Objectives:

1. relate and discuss how the experience of witnessing patient and family suffering affects one's level of compassion and acceptance
2. co-create a practical framework to support patients to find meaning in their suffering
3. co-create a practical framework to support one's self and colleagues in maintaining balance in coping with distress, suffering, and difficulty in practice

Description:

Human suffering takes many forms and occurs throughout the lifespan. Physical, emotional, spiritual, and existential suffering are an integral part of human existence, and family physicians encounter it on a daily basis. Finding meaning in experience is a fundamental human desire. This facilitated small group session will use the art of story weaving (narrative and improvisation) to safely and gently explore some of the difficult and painful emotions family physicians might experience when caring for those who are suffering. We will also evoke the participant's experience and wisdom to discuss how we can support our patients to find meaning and resolution of suffering in their own distress. The session concludes with the co-creation of ways to be aware of these effects on ourselves and of how we can be renewed by finding meaning in our practice.

T102341 Ongoing Management of Depression in Adolescents and Young Adults

11:15–12:15 Jan Young, MD, CCFP, FCFP, Hamilton, ON; Debra Earl, BScN, RN, Hamilton, ON; Debbie Nifakis, PhD, Hamilton, ON; Catharine Munn, MSc, MD, FRCPC, Hamilton, ON
401 MTCC

Learning Objectives:

1. describe the prevalence and functional impact of depression in adolescents and young adults and the current best practices for initial treatment and ongoing management
2. explain the value of using a simple motivational interviewing template to encourage self-management
3. employ strategies to integrate initiatives into one's own practice to screen for mental health problems and to monitor the severity of symptoms and progress of treatment

Description:

This interactive session will update providers on depression diagnosis and management in adolescents and young adults. We will describe a quality improvement initiative used in a collaborative shared-care team of family physicians, counselors, a mental health nurse, and a psychiatrist, employing the Patient Health Questionnaire-9 to screen for, and guide the management of, depression in the emerging adult population (ages 18 to 25). There has been substantial media coverage of the increased demand for mental health services at Canadian postsecondary campuses, particularly over the last decade. In 2013/2014 the McMaster Student Wellness Centre engaged in a clinic-wide initiative to improve our ability to detect, monitor, treat, and track students with depressive symptoms using a plan-do-study-act model for promoting quality improvement. Also examined were the processes of intake triage; scheduling appointments; goal setting for self-care; referral to groups for education, skill-building, or therapy; and referral to other providers.

T102871 Practical Approach to Integrating Advance Care Planning Into Primary Care

11:15–12:15 Nadia Incardona, MD, CCFP, MHSc, Toronto, ON
802AB MTCC

Learning Objectives:

1. describe an interprofessional approach to initiating advance care planning conversations in primary care through the use of conversation guides and e-learning modules
2. differentiate advance care planning from goals of care, plans of care, levels of care, and consent for treatment
3. integrate advance care planning for healthy adults, adults living with chronic illness, and adults in the last year of life

Description:

Advance care planning (ACP) incorporates value-based decision making into early discussions surrounding end-of-life care. There is growing recognition that ACP is a valuable process to improve end-of-life care by supporting patient autonomy, reducing unwanted medical interventions, and improving patient and family satisfaction. However, despite this recognition, many Canadians have not been engaged in advance care planning conversations. Improved health care provider education has been called for. In Ontario, the Ministry of Health has set up the Health Links initiative, with a mission to provide coordinated, efficient, and effective care to patients with complex needs. The East Toronto Health Link has been charged with developing an ACP framework. As part of the focus on health care provider, education, workshops, and e-learning modules have been developed. This session is intended for all health care providers who work in primary care. This workshop will provide a brief overview of how to initiate advance care planning conversations with patients at different stages of their health. Participants will be able to distinguish important differences between ACP, advance directives, goals of care, and treatment plans. Relevant legal issues relating to consent, capacity, and substituted decision making will be defined. The session will include role-modeling of ACP conversations and introduce participants to the conversation guides, workbooks, and e-learning modules developed by the East Toronto Health Link.

T95406 Red and Itchy: How to approach and manage common skin conditions and avoid pitfalls

13:45–14:15 Lawrence Leung, MA, MB BChir, MFM(Clin), DipPractDerm(Wales), MRCP, FRACGP, FRCGP, CCFP, Kingston, ON
701AB MTCC

Learning Objectives:

1. identify common skin conditions in family medicine including the “big five” diagnoses
2. recognize evidence-based management in reference to treatment guidelines
3. acquire clinical pearls for effective management and avoidance of pitfalls

Description:

Skin conditions constitute up to 15% of all consultation issues presented to family physicians practising in Canada. However, dermatology is one of the least-taught subjects, in both the undergraduate medical curriculum and family medicine residency program. As a result, family physicians often feel unsure of the correct diagnoses, let alone proper management, of skin problems commonly presented to their clinics. This either leads to (1) unnecessary referrals to dermatologists which often translate to long waiting times for the patients before receiving proper treatment, or (2) reflex-arc type prescriptions for steroids which can sometimes do more harm than good. In this session, a systematic approach will be adopted for presenting the common skin conditions seen in family medicine, in particular the “big five” diagnoses. Emphasis will be placed on how to make the correct diagnoses with an update on guidelines for evidence-based management. Ample clinical pearls will also be shared with the audience, and additional cautionary notes for potential pitfalls.

T95413 Odd and Scary: How to approach and manage unusual skin conditions and avoid pitfalls

14:15–14:45 Lawrence Leung, MA, MBBChir, MFM(Clin), DipPractDerm(Wales), MRCP, FRACGP, FRCGP, CCFP, Kingston, ON
701AB MTCC

Learning Objectives:

1. recognize overview spectrum of unusual conditions of skin and its appendages seen in family medicine
2. adopt a systematic and effective approach for investigations, diagnosis, and management
3. gain clinical pearls for odd and scary skin conditions and avoid pitfalls

Description:

Skin conditions constitute up to 15% of all consultation issues presented to family physicians practising in Canada. However, dermatology is one of the least-taught subjects, both in the undergraduate medical curriculum and family medicine residency program. As a result, family physicians often feel unsure of the correct diagnoses, let alone proper management, of skin problems presented to their clinics. Such scenarios are further worsened if the skin conditions look unusual or daunting. This leads either to 1) unnecessary referrals to dermatologists which often translate to long waiting times for the patients before receiving proper management, or 2) reflex-arc decisions for skin biopsies which can sometimes do more harm than good. In this session, a systematic approach will be adopted for presenting the spectrum of unusual skin conditions that can be encountered in family medicine, in particular the “odd and scary” ones. Emphasis will be placed on how to arrive at the correct diagnoses and judicious use of investigations like skin biopsies and dermatoscopy. Relevant guidelines for evidence-based management will be given. Finally, ample clinical pearls will be shared with the audience, together with cautionary notes for potential pitfalls.

T96072 Trauma-Informed Care: Why it matters for you and your patients

13:45–14:45 Eva Purkey, MD, CCFP, Kingston, ON; Tracey Beckett, Gerontology, BSW, MSW, RSW, Kingston, ON
HALL G MTCC

Learning Objectives:

1. recognize the prevalence of adverse childhood experiences in the general population
2. identify patients in your practice with a history of adverse childhood experiences (trauma) using the ACE tool
3. anticipate how adverse childhood experiences might impact the future health of your patients and consider how to adjust your practice accordingly

Description:

A major issue in health care is the high incidence of trauma and adverse experiences in the lives of many patients. Despite extensive awareness and over one hundred years of documentation, this issue remains inadequately addressed by mainstream medicine. Recognizing the prevalence of trauma, adjusting risk based on adverse childhood experiences, and understanding how to approach patients with a history of trauma is essential in providing appropriate and effective care. While the field of mental health and addictions has increasingly recognized trauma-informed health care as a standard, this is not the case in general practice and primary care. The Adverse Childhood Experiences (ACE) study and the ACE score have been used to examine the relationship between childhood experiences and long-term physical, mental, and public health problems. Research from the ACE study shows increasingly that early childhood adverse experiences are risk factors not only for mental health and addiction but also for behavioural risk factors (smoking, obesity, etc.). They are also associated with so-called physical or non-psychiatric medical conditions, in addition to somatic syndromes including various chronic pain syndromes and IBS. Finally, there is increasing understanding of the biological link between adverse childhood experiences and risk of cardiovascular disease, respiratory disease, and cancer. These associations and increased rates persist irrespective of traditional risk factors. Given the high prevalence of trauma in society, there is a responsibility to bring awareness of trauma-informed techniques into the provision of excellent primary care.

The principles behind this type of care include a deep integration of the concepts of physical and emotional safety; trustworthiness and consistency; choice; collaboration with service users; and empowerment. These are arguably principles that should inform all primary care delivery, all the more so given the prevalence of trauma and the challenges in identifying all trauma survivors.

T96386 Mood Disorders in Women During the Reproductive Years

13:45–14:45 Christiane Kuntz, MD, CCFP, FCFP, NCMP, Ottawa, ON

501 MTCC

Learning Objectives:

1. increase awareness of impact of, manifestations of, diagnostic criteria for, and treatment options for mood disorders in reproductive-age women
2. identify specific mood disorders associated with or affected by hormonal fluctuation during the menstrual cycle, pregnancy, postpartum, and perimenopause
3. apply learning pearls through a review of cases

Description:

This session will seek to improve the participants' awareness of the impact of, manifestations of, diagnostic criteria for, and treatment options for mood disorders in reproductive-age women. We will review factors that increase suicidal risk. Specific mood disorders associated with or affected by hormonal fluctuation during the menstrual cycle, pregnancy, postpartum, and perimenopause will be highlighted. PMS will be covered in detail, recognizing its impact on health and society. The etiology and pathophysiology of PMS will be discussed. Clinical assessment tools will be highlighted and treatment options for PMS will be explored. Learning pearls will be applied through a review of cases.

T100740 FASD 2015: Updated Guidelines and Toolkit

13:45–14:45 Murray Trusler, MD, CCFP, FCFP, Fairmont Hot Springs, BC; Ken Trusler, Invermere, BC; Pat Mousmanis, Lisa Graves, Liz Grier, Bill Watson, Courtney Green, Jocelyn Cook, Audrey MacFarlane, Tracey Milner, Nancy Pool

713A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. define the updated/revised guidelines for FASD
2. describe the role of family physicians in the prevention and diagnosis of FASD and ongoing support of persons living with FASD
3. use one of the toolkits described and cite one example of an FASD centre of excellence

Description:

Family physicians have an important role in prevention of Fetal Alcohol Spectrum Disorder (FASD) during the prenatal period, supporting families and patients during the diagnostic process and providing care to individuals living with FASD. Workshop participants will review the NEW 2015 updated diagnostic guidelines, approaches to prevention during the preconception and prenatal periods, and the role of family physicians in the ongoing care of persons living with FASD. Toolkits designed for use in the family medicine setting will be described. The Lakeland Centre for FASD will be showcased as a leader in developing unique rural-based FASD services.

T101080 First Five Years in Family Practice: Improving efficiency and time management in your early career

13:45–14:45 Scott MacLean, MD, CCFP, Edmonton, AB

716B MTCC

Learning Objectives:

1. relate the factors contributing to inefficiency and poor time management in family medicine
2. discuss strategies to improve efficiency, time management, and well-being in early career physicians
3. apply methods to improve physician well-being and work-life balance in early career

Description:

The First Five Years in Family Practice Committee has invited Dr John Crosby to discuss his experiences related to improving practice efficiency with a focus on early career physicians. Factors contributing to inefficiency and poor time management will be outlined, and strategies to mitigate the role of these factors in day-to-day practice will be discussed and examined by the group.

T101307 Borderline Personality Disorder: Strategies for self-management and resiliency

13:45–14:45 James Goertzen, MD, MCIsc, CCFP, FCFP, Thunder Bay, ON

716A MTCC

Learning Objectives:

1. apply strategies for the effective management of patients with a borderline personality disorder
2. increase resilience while providing care to patients with a borderline personality disorder
3. develop physician-patient relationships that encourage patients with a borderline personality disorder to increase their self-management skills

Description:

Patients with a borderline personality disorder struggle with instability in self-image, affect regulation, impulse control, and interpersonal relationships. Frequent self-injury and testing of patient-physician boundaries can lead to frustration and/or burnout.

Effective management strategies incorporate principles from dialectical behavioural therapy that can be readily embraced by family physicians and applied within their clinical settings. Key is developing a supportive physician-patient relationship where appropriate boundaries are defined, ongoing negotiation becomes a key feature, and mutual respect by both physician and patient is nurtured.

T101354 Mental Health and Workplace Challenges

13:45–14:45 Ellen Anderson, MD, MHSc, Sooke, BC; Nick Kates, MB, Dundas, ON; Joel Andersen, MD, CCFP, Sudbury, ON
401 MTCC

Learning Objectives:

1. use a clear framework for assessment and treatment of a work-related mental health problem
2. use strategies to determine whether and when a medical leave of absence is warranted
3. apply principles to develop a treatment plan while collaborating with the patient and completing necessary paperwork

Description:

Family physicians are dealing with work-related mental health issues on a daily basis. This can include assessing the impact of a work-related issue on individuals' well-being and helping them cope with workplace-engendered stress, determining whether and when a medical leave of absence is warranted, supporting individuals who have lost their job, helping individuals return to work after a medical leave, helping individuals with mental health problems who have been out of the work force retrain and rebuild their confidence, and completing necessary forms and paperwork. Using a case-based format, we will discuss an approach to the assessment and treatment of work-related mental health problems, which will provide practical tips for a family physician when handling any of these situations. It will include taking a work history, the different ways in which workplace factors can affect someone's mental health, assessing the severity of symptoms, when and how to manage time away from the job, and how to assist someone return to work after a period of time away. We will also offer tips on completion of necessary paperwork.

T101502 Maintaining Hope Through the Cancer Journey

13:45–14:45 Ian MacDonald, MD, CCFP, FCFP, LM, Fredericton, NB
711 MTCC

Learning Objectives:

1. recognize patients' personal cancer experiences
2. recognize the doctor's role in supporting cancer patients
3. recognize the role that doctors have played in destroying Hope for cancer patients

Description:

I am a family physician, and have been a cancer patient. I describe some of the issues I faced early in my cancer journey. I have had surgery, chemotherapy, and radiotherapy for pancreatic cancer. Having been extremely fortunate to survive this cancer, I became a volunteer with Cancer Connection. In that role I have supported over 100 cancer patients, as they needed to talk to someone who had "been there." I became very distressed by the stories from these people. They described how their hope was destroyed by their attending physicians, the very doctors who should have offered support, empathy, and hope for their patients. I offer direct quotes from these patients illustrating their frustrations. I then talk about setting goals and maintaining hope. I wish to make family doctors aware of how their comments and attitude can destroy hope for their cancer patients. This could be a stand-alone talk or part of a workshop to discuss these issues.

T101662 A Field Note Practicum: Challenges assessing postgraduate trainees in CanMEDS–FM roles and six skill dimensions across the competency continuum

13:45–17:30 Perle Feldman, MDCM, CCFP, FCFP, MHPE, Toronto, ON; Viola Antao, MD, CCFP, DFCM, Toronto, ON; Barbara Stubbs, MD, CCFP, FCFP, Toronto, ON
707 MTCC

Learning Objectives:

1. discuss the challenges with assessment, in particular using Field Notes as an assessment tool
2. assess residents, particularly remedial residents and high-performing residents, in non-expert and non-communicator roles
3. apply framework to assess postgrad trainees using the CanMEDS–FM roles and the CFPC six skill dimensions, and its links with the competency curriculum

Description:

The assessment of postgrad trainees within a CBC using Field Notes has garnered much focus and attention over the past five years. Assessment of outlier residents (either remedial or excellent) in the less intuitive roles (non-expert, non-communicator) continues to pose challenges for teachers. This workshop uses a Field Note tool for teachers, developed at University of Toronto, for formative feedback on clinical interactions. The tool combines the CanMEDS–FM roles and the CFPC's six skill dimensions as criteria to assess performance. In this workshop we will focus on the evaluation of candidates at different levels of skill and training with respect to an office-based clinical encounter. We explore the translation of these evaluating criteria to competencies established within a Triple C curriculum. Attention will be given to use of field notes with remedial and exceptionally strong residents. During the workshop, teachers will practise assessment with the tool using case-based videos. Our aim is to provide a better understanding of the assessment process in a competency curriculum, particularly of the more elusive CanMEDS–FM roles.

T102394 Improving Family Medicine Research With Standardized Reporting Guidelines**13:45–15:45**

Aaron Orkin, MD, MSc, MPH, CCFP, FRCPC, Toronto, ON; William R. Phillips, MD, MPH, Seattle, WA; Lars E. Peterson, MD, PhD, Lexington, KY; Nick Pimlott, MD, PhD, CCFP, Toronto, ON; and the Annals of Family Medicine Editorial Team

712 MTCC**Learning Objectives:**

1. identify and describe reporting guidelines relevant to conducting, interpreting, and using family medicine research in practice, education, research, and policy
2. explore as producers and consumers of research the strengths and weaknesses of using reporting guidelines
3. improve family medicine research, reporting, peer reviewing, and practice through use of reporting guidelines

Description:

Reporting guidelines have been established for most qualitative, quantitative, and review methods in health research. However, the growing number of such guidelines can leave researchers drowning in alphabet soup: CONSORT for randomized trials, STROBE for observational studies, PRISMA and MOOSE for systematic reviews and meta-analyses, SQUIRE for quality improvement studies, SAMPL for statistical reporting. Standardized reporting guidelines were created to improve the description of original research methods and results, to help in the critical appraisal of literature, and in the synthesis of research. These guidelines are largely an unproven technology with an inadequate evidence base. Use of these guidelines might improve family medicine research, but they might also be obstructive or inappropriate in some circumstances. How can family physicians and researchers use reporting guidelines to design better studies, write better papers, and interpret the literature for application in their practices? Editors of Annals of Family Medicine and Canadian Family Physician will present a summary of essential reporting guidelines applicable to family medicine research and provide resources to find and utilize appropriate guidelines. We will illustrate the do's and don'ts of working with reporting guidelines to strengthen study design, compose effective research reports, and write effective peer reviews. Instead of using reporting guidelines as a cookbook for research and writing, we will suggest strategies to use these tools to help your work flourish. We will break into groups to explore and critique the reporting guidelines that are most relevant to research in family medicine. Participants will interactively critique the reporting guidelines that apply to their own research, and discuss how they have made best use—sometimes selective use—of the guidelines. Are reporting guidelines useful tools in family medicine research, or do they stifle scholarly creativity and sterilize literary style? We will close with a conversation on reporting guidelines in family medicine research and publication. Participants will hear arguments for and against the use of standardized reporting guidelines in the variety of methods and topics characteristic of family medicine research and contribute their own perspectives and experiences to the discussion.

T102762 Care at the End: Transitioning to a palliative approach for frail elders at home**13:45–14:45**

Jay Slater, MD, CCFP, Vancouver, BC

714AB MTCC**Learning Objectives:**

1. identify some of the challenges faced when palliating patients with chronic disease in the home setting and consider strategies to mitigate them
2. describe the "tool kit" that assists the clinician in providing good home-based palliative care (assessment aids, equipment, medications)
3. apply palliative approaches to common conditions at end of life and use cases to highlight strategies for symptom management in common diseases

Description:

Care of frail elders is often made challenging by any one or a combination of multimorbidity, cognitive decline, functional deficits, and dwindling support networks. A patient-centred approach to primary care for these elders, the "medical home," is an effective and compassionate way to provide service. As their health inevitably deteriorates over time, the focus of care typically evolves from a chronic disease model to a more palliative approach. A significant number of seniors say that their preference is to remain in their home and to ultimately die there. Unfortunately, gaps in care systems and the challenges of providing comprehensive home care are such that some patients end up spending their last days in acute care or in nursing homes. Addressing those gaps and challenges is important not only for enhancing the quality of elders' experience but also for the health system as a whole, which is facing increasing demographic demand and limited budgets. We will discuss one approach to home-based care, the Home ViVE (Home Visits to Vancouver's Elders) program that is a collaborative, multidisciplinary primary care team. The practical issues of balancing patient preferences, their competency to make health care decisions, and the provision of safe, appropriate care at home will be reviewed. This 45-minute session will include both a large group presentation and small-group, case-based discussions to identify the challenges related to supporting end-of-life care in the home. It will focus on practical tools and approaches to caring for older adults (and their families) as their condition progresses.

T102818 Traditional Healing Practices Within the Western Medical System**13:45–14:45**

Marlyn Cook, MD, CCFP, Winnipeg, MB

703 MTCC**Learning Objectives:**

1. discuss traditional healing practices that family physicians with aboriginal patients can use
2. discuss the negative effect of residential schools on the health status of aboriginal people
3. discuss racism in the health care system and ways to address it

Description:

In many aboriginal communities in Canada today, there are traditional healing programs being established to run in parallel with the Western medical systems. Many health care practitioners do not have an understanding of these programs or of how the healers work. Traditional healers look at all aspects of the person they are helping: the body, the mind and the spirit. They use ceremonies and medicines from the Earth to help the person heal. There were many residential schools across Canada, affecting many aboriginal people. The negative effects of these schools on the person, the family, and the community were profound and contributed to poor health, early death, and suicides. Racism exists in the health care system, and if we cannot acknowledge this fact, we cannot address it. This fact will be discussed, and ways of dealing with it will be brought forward. Dr Marlyn Cook is a First Nations physician as well as a traditional person who carries the sacred pipe and the sweat lodge. She is a sundancer and has danced for the last 24 years. She will utilize this traditional knowledge to educate and share this healing system that has been in Canada for thousands of years.

T102837 Medical Education Research 101 Revisited: An overview of the basics of methodology and design

13:45–14:45 Shelley Ross, PhD, Edmonton, AB; Douglas Archibald, PhD, Ottawa, ON

710 MTCC

Learning Objectives:

1. describe some common methodologies and research designs for medical education research
2. identify the most appropriate methodologies and designs for participants' own research questions
3. apply ideas and examples from the workshop to medical education projects

Description:

Many preceptors, residents, and clinical teachers have an interest in medical education research but do not know how to start to answer their research questions. Choosing a methodology and a research design can be overwhelming. If you are nodding right now, this workshop is for you! The first half of this workshop is an overview of the most common research methodologies and research designs used in medical education research. Both quantitative and qualitative methodologies will be presented and briefly described, and some sample research questions will be included for each methodology and design presented. A very brief overview of possible statistics will be incorporated. In the second half of the workshop, participants will work in small groups to discuss research questions and choose appropriate methodologies and designs to answer those research questions. The presenters will aim to group the participants by types of research questions (and, consequently, by possible methodological approaches). A large group discussion near the end of the session will include a question-and-answer exchange between participants and presenters to clarify areas of concern. Presenters will also provide some possible resources that participants can explore at their own institutions to help support their medical education research. Participants will leave the workshop with a preliminary plan for a medical education research project.

T103009 🎧 Top 10 Apps for Your Smartphone or Tablet: Teaching and learning in the office

13:45–14:45 Les 10 meilleures applications pour votre téléphone ou votre tablette : Enseigner et apprendre en cabinet

Andrew Sparrow, MD, CCFP, Toronto, ON; David Esho, MD, Toronto, ON

HALL F MTCC

Learning Objectives:

1. identify smartphone/tablet applications that will help primary health care providers with both clinical practice and teaching
2. use applications to make clinical practice more efficient and fun in a working and teaching environment
3. use tools to identify new apps that may be of use to physicians on an everyday basis

Objectifs d'apprentissage :

1. identifier les applications pour téléphones intelligents et tablettes qui aident les professionnels de la santé en soins primaires dans leur pratique clinique et pour l'enseignement
2. utiliser des applications pour rendre la pratique clinique plus efficace et amusante dans un milieu de travail et d'enseignement
3. utiliser des outils pour identifier de nouvelles applications qui pourraient être utiles aux médecins sur une base quotidienne

Description :

This session will review the use of technology tools such as websites and phone or tablet applications that might help you with managing clinical practice and teaching. In this interactive session, we will demonstrate several solutions and hear from other participants how they are already using technology for this purpose. We will be highlighting solutions you can use with your patients, your learners, and yourself. Examples include clinical tools, useful recommendations you can give your patients, and apps you can use to aid with teaching. This session will be suitable for participants at all levels of familiarity with technology. You are welcome to bring your smartphone/tablet to the session and we will make use of these during the session.

Description :

Cette séance examinera l'utilisation d'outils technologiques comme des sites Web et des applications pour téléphone ou tablette, qui pourraient vous aider dans la gestion de votre pratique clinique et dans l'enseignement. Pendant cette séance interactive, nous ferons la démonstration de plusieurs solutions, et d'autres participants expliqueront de quelle façon ils utilisent la technologie à ces fins. Nous mettrons l'accent sur des solutions auxquelles vous pourrez avoir recours, pour vous ou dans vos interactions avec vos patients et vos apprenants. Citons à titre d'exemple les outils cliniques, les recommandations utiles que vous pouvez faire à vos patients et les applications dont vous pouvez vous servir pour enseigner. Tous peuvent participer à cette séance, sans égard au niveau de familiarité avec la technologie. Vous pouvez apporter votre téléphone intelligent ou votre tablette, que nous pourrions tester pendant la séance.

T115045 Rural Educators' Forum

13:45–17:30 Alain Papineau, MD, CCFP, FCFP, New Richmond, QC; Colin Newman, MD, CCFP, Twillingate, NL; Ruth Wilson, MD, CCFP, FCFP, Kingston, ON, Kathy Lawrence, MD, CCFP, FCFP, Regina, SK
709 MTCC

Description:

This year's Forum will be focusing on the work currently being led by the Advancing Rural Family Medicine Canadian Collaborative Taskforce (Taskforce). Attendees will be given the opportunity to provide their perspectives on findings to date from the environmental scan describing rural medical education offered at both the undergraduate and postgraduate levels of training and provincial policies on recruitment and retention. In addition, participants will provide feedback on preliminary results from the qualitative study conducted to understand experiences of rural family physicians in Canada. The Forum is intended to allow participants to share and learn about leading best practices in rural education and training and to identify gaps. The session aims to support participants in generating recommendations for action to inform the work of the Taskforce.

T102796 Vertigo Diagnosis and Management: A family physician's perspective

14:15–14:45 Vikram Dalal, MD, CCFP (EM), FCFP, London, ON; Andrew Maeng, MD, London, ON
801AB MTCC

Learning Objectives:

1. develop stepwise approach to differential diagnosis and distinguish between central and peripheral causes of vertigo
2. identify functional anatomy of the vestibular system and review common vestibular physical examinations
3. describe common medical treatment of benign causes of vertigo, including vestibular rehabilitation therapy

Description:

"Dizziness" is among the most common reasons for which patients present to the family doctor's office and the emergency department. The report of symptoms can be vague, inconsistent, or unreliable such that life-threatening disorders can masquerade as benign disorders, and tests ordered to screen for life-threatening conditions are often insensitive. Of the various causes of dizziness, vertigo is the most common and often self-limiting. Vertigo can be caused by both peripheral and central etiologies, with the latter being more predominant among the elderly. Vertigo is a symptom that predominantly arises from an acute asymmetry of the vestibular system. Despite vagueness in the history, the patient's description, as well as collateral information, is the most sensitive in making the diagnosis of vertigo. Physical examinations, including special manoeuvres, help to further narrow or clinch the diagnosis. It is a symptom that is best managed by family and emergency room physicians. In most cases there is never a need for further referrals or more intense investigations. This session for the family and emergency physician focuses on review of the functional anatomy of the vestibular system, as well as on key features of the history and physical examinations that will allow physicians to efficiently separate patients into a "peripheral vestibular" or a "central stroke" category with near-perfect accuracy. For the more benign causes of vertigo, this session will review common medical management, as well as vestibular rehabilitation therapy.

T101160 EBM for Clinical Practice 1: Diagnosis

15:15–15:45 David Chan, MD, CCFP, MSc, FCFP, Hamilton, ON; Henry Siu, MD, CCFP, Oakville, ON

713A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. derive EBM values such as specificity, sensitivity, and likelihood ratios when given a 2x2 table
2. use EBM values to justify physical examination, ordering diagnostic tests, and diagnosis
3. help patients understand how the evidence applies to their diagnosis

Description:

Finding EBM far-fetched, irrelevant, and impractical in clinical practice? Feeling overwhelmed and confused by the constantly changing guidelines? Afraid of the math involved in EBM? Using clinical scenarios, online tools, and calculators, this workshop will work through basic concepts of the principles of evidence-based practice including 1) prevalence, incidence, and pre-test likelihood—why do they matter? 2) understanding diagnostic tests and clinical uncertainty—review of sensitivity and specificity, use of likelihood ratios in clinical practice; 3) how to determine the clinical utility of a physical examination maneuver or diagnostic test for diagnosis; and 4) how to explain these numbers to patients. This workshop aims to familiarize and demystify EBM vocabulary that can often paralyze a clinician during routine practice. We will show you how these principles can be effectively incorporated into your clinical practice.

T100795 EBM for Clinical Practice 2: Therapy

15:45–16:15 David Chan, MD, CCFP, MSc, FCFP, Hamilton, ON; Henry Siu, MD, CCFP, Oakville, ON

713A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. be comfortable deriving advanced EBM values such as number needed to treat, relative risk and odds ratios
2. be more rational in making therapeutic decisions for common medical conditions
3. be comfortable in helping patients understand how the evidence applies to their treatment

Description:

This session builds on the foundations and definitions taught in “EBM for Clinical Practice 1: Diagnosis.” This session will help the clinician become comfortable with identifying the important EBM concepts and values that most impact therapeutic decisions. Using clinical scenarios, online tools, and risk calculators, this workshop will work through more advanced concepts of the principles of evidence-based practice including effect size and how it can be expressed; comparing treatments—use of NNT and NNH; confidence intervals—why it matters; and odds ratio and relative risk—what these values mean; and how to explain these numbers to patients. This workshop aims to familiarize and demystify EBM vocabulary, which can often paralyze a clinician during routine practice. We will show you how these principles can be effectively incorporated into your clinical practice.

T101640 Smoking Cessation in Primary Care: Safe and effective prescribing for patients with co-morbidities

15:15–16:15 Peter Selby, MD, CCFP, FCFP, Toronto, ON

801AB MTCC**Learning Objectives:**

1. apply smoking cessation approaches that are appropriate for primary care practices
2. appropriately prescribe and titrate smoking cessation pharmacotherapy
3. tailor smoking cessation support for patients with mental health problems or other physical co-morbidities or both

Description:

Tobacco dependence is the leading cause of preventable death in Canada, killing nearly 37,000 Canadians every year. Primary care settings are optimal for addressing tobacco use; however, a lack of specialized knowledge in smoking cessation interventions poses a challenge to adapting and tailoring psychosocial and pharmacological approaches for tobacco dependence treatment. Additionally, primary care physicians often see patients with complex co-morbid conditions, such as depression and COPD, for whom quitting smoking requires a personalized approach. This dynamic and interactive session will give family physicians practical, relevant knowledge and skills to incorporate evidence-based approaches to tobacco dependence treatment in their practice, with particular emphasis on adapting and tailoring pharmacotherapy for patients with co-morbid conditions. Family physicians will leave the session with a better understanding of how to recommend and prescribe pharmacotherapy for tobacco dependence and explore evidence-based approaches for patients with mental health problems and COPD. This session emphasizes learner engagement, interaction, and practice through large and small group discussions, case-based learning, and reflective exercises. Workshop participants will receive links to clinical tools and resources to facilitate sharing with colleagues and community stakeholders.

T101965 6 for 6: Building a scholarly research program for rural and remote family medicine faculty – lessons learned two years down the road

15:15–16:15 Wendy Graham, MD, CCFP, Channel-Port-aux-Basques, NL; Patricia McCarthy, St John's, NL; Shabnam Asghari, St John's, NL

710 MTCC

Learning Objectives:

1. recognize barriers for rural and remote family medicine physicians who engage in scholarly research
2. describe the planning, design, and implementation phases of the 6 for 6 program
3. explore strategies for the design and implementation of a scholarly research program in other rural contexts using a participatory action approach

Description:

Family medicine faculty working in rural and remote areas experience barriers to participating in scholarly research, including lack of time, geographic isolation, and limited access to professional development opportunities. Memorial University has responded to these barriers by developing 6 for 6, a scholarly research program tailored to the needs of rural family medicine physicians. Now in its second year of development, this longitudinal program uses a participatory action approach and is designed to minimize the challenges associated with conducting research in rural regions by providing education, support, and resources to rural faculty. Workshop attendees will take part in interactive small group break-out activities and large group discussions related to the development and implementation of a scholarly research curriculum for rural and remote clinical faculty. Participants will be given the opportunity to identify and discuss barriers to research engagement for rural faculty and explore approaches to addressing and accommodating identified needs. Using Memorial University's 6 for 6 program as a model, attendees will gain insight into the initial steps of building a curriculum development plan, and discuss strategies and key lessons for designing and implementing research curricula in a rural context.

T95570 Back to the Future: The family physicians of today meet the family doctors of tomorrow

15:15–16:15 Pierre-Paul Tellier, MD, CCFP, FCFP, Montreal, QC; Kathy Lawrence, MD, CCFP, FCFP, Regina, SK

803B MTCC

Learning Objectives:

1. gain valuable insights on a career in family medicine
2. discuss practice opportunities in family medicine
3. ease the transition into primary care

Description:

In this session, students and residents have the opportunity to meet and speak with recipients of the Reg L. Perkin Award, who have been named Canada's Family Physicians of the Year. This unique event allows students and residents to ask questions regarding work-life balance and easing into practising family medicine, and to discuss the challenges they might face. This session also gives award winners the chance to share their insights and their experiences of starting out in family medicine.

T102077 Providing Trauma-Informed Care to Patients With Addictions and Other Mental Health

15:15–16:15 **Problems in Primary Care Settings**

Dispenser des soins à des patients aux prises avec une toxicomanie et d'autres troubles de santé mentale en soins primaires tout en tenant compte des traumatismes

Sheryl Spithoff, MD, CCFP, Dip. ABAM, Toronto, ON

718AB MTCC

Learning Objectives:

1. screen appropriately for interpersonal trauma
2. find trauma therapy resources in the community
3. teach basic grounding techniques to patients with post-traumatic stress disorder

Description:

Many patients with addictions and other mental health problems have a history of interpersonal trauma in childhood (abuse, neglect) and/or in adulthood (intimate partner violence, sexual assault) and suffer from post-traumatic stress disorder (PTSD). Providing trauma-informed care will minimize the risk of re-traumatizing patients and increase retention in treatment. Screening for trauma and connecting patients to appropriate treatment can have a significant positive impact on outcomes. However, most family physicians have had little education and training in trauma and PTSD, and do not feel comfortable with these interventions. In this session, we will review the prevalence of interpersonal trauma and the link with addiction and other mental and physical health problems. Using cases, we will describe how to offer trauma-informed care, including how to screen for trauma and how to connect patients to trauma therapy resources.

Objectifs d'apprentissage :

1. dépister les traumatismes interpersonnels de façon appropriée
2. localiser les ressources communautaires pour le traitement des traumatismes
3. enseigner les techniques de base de la prise de conscience de l'ici et maintenant aux patients souffrant d'un état de stress post-traumatique

Description :

Nombreux sont les patients aux prises avec une toxicomanie ou d'autres troubles de santé mentale qui ont subi un traumatisme interpersonnel durant l'enfance (violence, négligence) et/ou à l'âge adulte (violence commise par un partenaire, agression sexuelle) et qui souffrent d'état de stress post-traumatique (ESPT). La prestation de soins qui tiennent compte du traumatisme réduit au minimum le risque de retraumatiser le patient et améliore la rétention thérapeutique. Le dépistage du traumatisme et l'orientation du patient au traitement approprié peuvent se répercuter de manière significativement positive sur les résultats. La plupart des médecins de famille ont toutefois reçu très peu de formation sur les traumatismes et l'ESPT, et sont mal à l'aise face à ce type d'intervention. Dans cette séance, nous allons examiner la prévalence des traumatismes interpersonnels et de leur lien à la toxicomanie et à d'autres problèmes

de santé mentale et physique. À l'aide de cas, nous allons décrire comment dispenser des soins qui tiennent compte des traumatismes, y compris la façon de dépister un traumatisme et de mettre le patient en relation avec les ressources qui pourront traiter le traumatisme.

T102162 **Keeping Your Elderly Patients Out of Hospital: A physician's and a pharmacist's insights into the top 10 drug interactions**

15:15–16:15

Michelle Hart, MD, CCFP, MScCh, Thornhill, ON; Pauline Giancroce, BScPhm, RPh, ACPR, PharmD, Toronto, ON

HALL G MTCC

Learning Objectives:

1. identify the top 10 clinically significant drug interactions in the elderly and apply this information to practice in order to prescribe more safely and prevent unnecessary admissions to hospital
2. describe the common mechanisms involved in drug interactions, with a focus on QTc prolongation
3. identify system challenges in drug interaction monitoring and discuss possible solutions for interdisciplinary collaboration

Description:

Drug interactions represent a serious problem that can result in preventable adverse drug events. A growing body of studies are demonstrating an increase in hospital admissions (up to 5 per cent) related to drug interactions. The elderly population is particularly vulnerable, given pharmacokinetic, pharmacodynamic, and physiological changes with aging, as well as the high number of concomitant drugs elderly patients are taking! In theory, drug interactions and adverse drug events are largely preventable. In practice, however, the understanding around the mechanisms causing dangerous drug interactions, as well as the recognition and detection of drug interactions, has been suboptimal. In fact, only in the last few years has the medical community started to focus more on the importance of recognizing drugs that cause QTc prolongation, as an example. This session will review the top 10 clinically significant drug interactions in the elderly and the challenges in identifying drug interactions, and discuss suggestions and solutions for monitoring and prevention through interdisciplinary collaboration.

T102251 **Pearls of Diagnosis and Management of STEMI of Different Coronary Territories in the Emergency 15:15–16:15**

16:15

Vikram Dalal, MD, CCFP (EM), FCFP, London, ON

715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. rapidly identify and differentiate between STEMI of different coronary territories, based on an electrocardiogram
2. discuss and evaluate medical management of various STEMI
3. recognize and manage complications of STEMI and review indications for rescue PCI

Description:

Acute myocardial infarction (MI) accounts for approximately 30% of all acute coronary syndromes. Rapid diagnosis and treatment of MI is one of the hallmark specializations of emergency medicine because emergency departments are a common health care entry point for patients experiencing MI-associated symptoms. Blockage of particular coronary arteries leads to predictable regions of infarction. Identification of the anatomic distribution of ischemia and/or infarction is an essential step in the diagnosis and subsequent management of ST-elevation myocardial infarction (STEMI), because specific areas of infarction increase the likelihood of certain complications and affect morbidity and mortality. Many hospitals are not equipped with facilities that can perform primary percutaneous coronary intervention (PCI); hence fibrinolytics remain an essential reperfusion treatment option for STEMI patients in most emergency departments. In such situations, American College of Cardiology/American Heart Association guidelines recommend the initiation of fibrinolytic therapy within 30 minutes of a STEMI patient's contact with the medical system. Reperfusion outcomes with this therapy, at 30 days post-intervention, are comparable to those with PCI. It is also prudent to note that reperfusion is not always achieved in patients who receive fibrinolysis. For optimal patient care in such situations, familiarization with indications for rescue PCI, which can be done up to 24 hours after fibrinolysis, is then of paramount importance. This interactive case-based workshop, aimed primarily at family physicians working in a smaller/rural emergency department setting, will help participants review medical management and potential complications of STEMI of various coronary territories. We will also review indications for rescue PCI.

T102275 **Bedside Ultrasound for the Family Physician**

15:15–16:15

Peter Steinmetz, MD, CCFP, Outremont, QC; John Lewis, MD, CCFP (EM), FCFP, Montreal, QC

714AB MTCC

Learning Objectives:

1. define bedside ultrasound as an adjunct to the clinical assessment of a patient
2. describe 10 common clinical scenarios found in outpatient family practice for which bedside ultrasound can improve diagnostic accuracy
3. recognize how and where to pursue learning activities that will confer proficiency in bedside ultrasound

Description:

The primary care clinician is faced with a wide variety of clinical scenarios for which bedside ultrasound can assist in diagnoses, therapeutics, management, procedures, and, ultimately, improved patient outcomes. Here we will present 10 common outpatient clinical scenarios for which the family physician can use bedside ultrasound as a powerful point-of-care diagnostic tool. Bedside ultrasound in the approach to dyspnea, chest pain, leg swelling, abdominal pain, joint pain, vaginal and pelvic bleeding, vision loss, and kidney injury will be reviewed in a problem-based practical audiovisual presentation of cases managed by the authors. We will also review how family physicians can acquire the skills necessary to safely and effectively use this important clinical tool.

T102278
15:15–16:15

Top 10 Contemporary Topics in STI Care for the Family Physician / Les 10 meilleurs sujets actuels de soins des ITS pour le médecin de famille

Charlie B. Guiang, MD, CCFP, Toronto, ON; Hannah Feiner, MD, CCFP, Toronto, ON;
Kent To, MD, CCFP, Toronto, ON

HALL F MTCC

Learning Objectives:

1. address safe antibiotic stewardship in the treatment of STIs: alternative antibiotic use, and gonorrhea resistance and proper treatment
2. identify STIs (syphilis, HCV, HSV, asymptomatic infection/swabbing) requiring attention with respect to testing, interpretation, and identification of those at risk
3. recognize clinical manifestations of PID and identify the appropriate patients for IUDs, while being mindful of STI risk

Description:

In Canada, the rates of chlamydia, gonorrhea, and syphilis have been rising since the late 1990s (1). Although not generally a reportable disease, herpes simplex also continues to be an ongoing sexually transmitted infection (STI) issue. Primary care providers are often the first point of contact for STI screening, diagnosis, and management. This presentation is intended for primary care clinicians involved in STI care (including family physicians, allied health care professionals, residents, and medical students). We aim to explore contemporary topics in STI care using clinical cases and highlighting clinical pearls. We have carefully chosen 10 concise topics in STI care for relevance to office practice, and clearly highlight the take-home messages for each. Where appropriate, differences between provinces/territories will be pointed out. Session participants will gain valuable insight into confidently and safely addressing STI screening, diagnoses, and management, focusing on clinically relevant and up-to-date topics that occur in the office. Beyond the basics of STI care, this inclusive list will provide the tools that will make an impact on patients at risk for STIs and also follow the Public Health Agency of Canada's guidelines on sexually transmitted infections. 1) what we don't know can harm us ... and others—asymptomatic STIs: testing other at-risk anatomical sites, 2) making sense of new screening for an old foe—syphilis testing and management, 3) miss-me-not—pelvic inflammatory disease (PID) manifestations, 4) treating me right—emerging gonorrhea resistance, 5) doing it right the first time—choosing the right swabs/tests for STIs, 6) widening your lens—increasing hepatitis C virus (HCV) incidence in special populations and identifying who is at risk, 7) risky business—intrauterine device (IUD) use in those at risk for STIs, 8) offering a vaccine shouldn't be a pain in the neck—recommending the meningococcal vaccination, 9) can you test me for that?—type-specific herpes simplex virus (HSV) serological testing, and 10) safer options, please—alternative antibiotic options for the treatment of STIs. 1. Public Health Agency of Canada; 2013.

Objectifs d'apprentissage :

1. parler de l'administration sûre et raisonnée d'antibiotiques dans le traitement des ITS : solutions de rechange aux antibiotiques, et résistance de la gonorrhée et traitement approprié
2. identifier les ITS (syphilis, VHC, VHS, infection asymptomatique/prélèvement avec un coton-tige) qui exigent l'attention en ce qui a trait aux tests, à l'interprétation et à l'identification des personnes à risque
3. reconnaître les manifestations cliniques d'AIP et identifier les candidates appropriées pour le stérilet, tout en gardant à l'esprit le risque d'ITS

Description :

Au Canada, les taux de chlamydia, de gonorrhée et de syphilis grimpent depuis la fin des années 1990 (1). Quoique non généralement une maladie à déclaration obligatoire, l'herpès simplex continue aussi d'être une infection transmise sexuellement (ITS) problématique. Les fournisseurs de soins primaires sont souvent le premier point de contact pour le dépistage, le diagnostic et la prise en charge des ITS. Cette présentation est destinée aux cliniciens en soins primaires qui participent aux soins des ITS (soit les médecins de famille, le personnel paramédical, les résidents et les étudiants en médecine). Par l'intermédiaire de cas cliniques, nous entendons explorer les sujets actuels des soins des ITS et mettre en lumière les perles cliniques. Nous avons minutieusement choisi 10 sujets concis pour leur pertinence à la pratique au bureau ou en clinique, et pour chaque sujet, nous avons clairement souligné les messages à retenir. Les différences entre provinces et territoires seront relevées, le cas échéant. Les participants à la séance comprendront mieux comment s'occuper avec confiance et en toute sécurité du dépistage, du diagnostic et de la prise en charge des ITS au bureau ou en clinique, en examinant les sujets pertinents et actuels sur le plan clinique. Mis à part les soins de base des ITS, cette liste inclusive fournit des outils qui auront des répercussions sur les patients à risque d'ITS et est conforme aux lignes directrices de l'Agence de la santé publique du Canada en matière d'infections transmises sexuellement. 1) ce que nous ne connaissons pas peut nous faire du mal... et autres—ITS asymptomatiques : tester d'autres sites anatomiques à risque; 2) comprendre les nouvelles techniques de dépistage pour un ancien ennemi—dépistage et prise en charge de la syphilis; 3) à ne pas manquer—manifestations de la maladie inflammatoire pelvienne (MIP); 4) traitement approprié—émergence de la résistance de la gonorrhée; 5) bien faire les choses la première fois—choisir les bons prélèvements/tests pour les ITS; 6) élargir votre point de vue—augmentation de l'incidence du virus de l'hépatite C (VHC) au sein de populations spéciales et identifier les personnes à risque; 7) activité risquée—utilisation d'un dispositif intra-utérin (DIU) chez les personnes à risque d'une ITS; 8) offrir un vaccin ne devrait pas être embêtant—recommandation du vaccin méningococcique; 9) pouvez-vous me tester pour ça?—test de dépistage sérologique pour un type spécifique du virus herpès simplex (VHS); 10) des options plus sécuritaires, s'il vous plaît—options alternatives aux antibiotiques pour le traitement des ITS. 1. Agence de la santé publique du Canada; 2013.

T102360
15:15–17:30

Improving the Residency Experience for Our International Medical Graduates

Douglas Archibald, PhD, Ottawa, ON

705 MTCC

Learning Objectives:

1. apply a deeper understanding of the cross-cultural challenges that faculty members face when teaching international medical graduate residents
2. discuss clinical teaching tools and possible intervention strategies aimed at increasing the success of the changing demographic of international medical graduates
3. develop approaches to operationalizing these strategies

Description:

The assimilation and optimal education of international medical graduates (IMGs) continues to be a challenge for residency programs due to areas of cultural discordance between IMGs and the Canadian medical systems. The problems related to cultural discordance are often perceived by residency educators and administrators as communication, collaboration, and professionalism issues. These can be compounded when there is a lack of clinical reasoning skills. In this interactive workshop we will share highlights and examples of existing tools that can help to improve the residency experience for our IMGs and how participants can use these tools in their own teaching environments. Some examples will include the Impact of Cultural Differences on Residency Experiences (ICDRE) questionnaire, which we have implemented across departments in the Faculty of Medicine at the University of Ottawa.

T102616 Concurrent Disorders in Youth

15:15–17:00 Sharon Cirone, MD, CFPC (EM), ASAM (Cert), Toronto, ON; Ellen Anderson, MD, Sooke, BC; Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill; Sanjeev Bhatla, MD, CCFP, FCFP, Calgary, AB
171A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. using a developmental framework, practise universal screening, brief intervention, and referral for treatment for youth presenting with concurrent disorders
2. explain connections between early life attachment, developmental trauma, and subsequent mental health and substance use, and how these impact provision of health care
3. create a framework for collaborative treatment planning using locally available resources

Description:

In a case-based workshop format, we will offer participants an opportunity to understand and practise a practical comprehensive approach to the assessment and treatment of concurrent disorders in children and youth. This approach will include universal screening, taking a developmental, mental health, and substance use history. The workshop will explore the different ways in which attachment issues and trauma can affect a person's developmental trajectory, mental health, and substance use. We will also discuss strength-based assessment and collaborative care planning, and offer tips on using locally available resources to support ongoing treatment.

T102442 Music Care for Families Living With Dementia

15:15–16:15 Bev Foster, MA, BEd, BMus, ARCT, AMus, Port Perry, ON
171 MTCC

Learning Objectives:

1. demonstrate knowledge of the music care approach
2. identify reasons how and why music, especially singing, work in dementia care
3. utilize Pathways, a comprehensive singing program for families living with dementia

Description:

The World Health Organization recognizes that dementia will reach epidemic proportions globally in this century. "Too many of Canada's baby boomers will spend their retirement years with Alzheimer's or caring for someone who has it"—Alzheimer's Society of Canada. In Ontario's 1999 "Strategy for Alzheimer's Disease and related dementias," it was noted that there was a lack of quality programming in dementia day care. In addition, the importance of providing caregiver respite was the subject of a separate white paper. While there is no surgical or pharmaceutical cure for dementia, research has shown that music, and in particular singing, can have a positive impact on people living with dementia by improving memory and recognition, improving quality of life, and reducing agitation and apathy. Despite the documented research, there is still a lack of high-quality, well-researched programming that can lighten the load and enhance the well-being for those with dementia and their caregivers and contribute to the goals of improved health and wellness in the community. Pathways is a comprehensive singing program designed especially for people living with dementia. It consists of 13 thirty-minute videos facilitated by a singing host, a companion activity booklet, and online training modules. Pathways invites engagement and connection for enjoyment and better quality of life. Designed and facilitated by music care experts, the Pathways Singing Program is accessible and easily delivered by family caregivers. The program is flexible in order to adapt to long-term care, hospital, community, day programming, and in-home settings and does not require participants and caregivers to be musically proficient. This workshop will be advantageous for clinicians who serve families living with dementia and who are looking for meaningful activities and engagement for their patients, especially for those living at home. Through media, music, and results of evidence-based practice, participants will situate music and singing in the context of dementia care literature and experience an innovative singing resource, designed specifically for persons living with mild to moderate cognitive impairment, that can be used by patients and their families.

T102683 Exploring Requests to Hasten Death (1)

15:15–17:00 Monica Branigan, MD, MHSc (Bioethics), Toronto, ON; Doris Barwich, MD, CCFP, Delta, BC
171B MTCC

Learning Objectives:

1. describe the current literature regarding desire-to-die statements (DTDS) and requests to hasten death
2. explore evidence-based interventions in responding compassionately to DTDS, including dignity therapy principles, therapeutic communication principles, and others
3. identify and respond to barriers to open conversation

Description:

Requests to hasten death are common in those with life-threatening illness or irremediable conditions. These requests can vary over time and with disease trajectory, symptom load, or perceived burden to others. Importantly, these statements and requests vary significantly regarding their underlying intention. Some patients are expressing a readiness to die; some, a plea to assist with living; and a small minority, a request for physician assistance in hastening death. With the anticipated change in legislation to allow for physician-assisted death, the options in how we might respond to these statements will change profoundly. As baby boomers who value control and autonomy approach aging, chronic illness, and death, these conversations will become more compelling. A compassionate exploration between patient and physician is necessary to help the patient clarify his or her intention, and to help the physician assess the nature of the request; consider interventions to mitigate suffering; or address questions, concerns, or fears. This exploration itself has the potential to be experienced as therapeutic by the patient. However, many barriers exist—in ourselves and in our institutions—that make these open conversations difficult. Fortunately, resources exist to support these conversations, as well as evidence-based interventions with which we can respond. In this workshop we will begin with a short didactic session, then view and discuss some videos and reflect on cases in small groups. We will brainstorm as a group about emerging best practice in responding to these requests, as well as ways to overcome common barriers to open conversations. This workshop will not focus on questions regarding possible participation in physician-assisted death but rather on the true exploration of a desire-to die-statement. Presenters will include facilitators from the Canadian Society of Palliative Care Physicians.

T102890 **Putting on the Oxygen Mask: Coping with compassion fatigue, stress, and burnout in primary care**
15:15–16:15 Shailla Vaidya, MD, MPH, CCFP (EM), E-RYT200, Toronto, ON; Heather Van Laare, BSc, BScN, MN, Toronto, ON
715B MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. recognize the symptoms of compassion fatigue, vicarious trauma, or burnout within oneself
2. acquire tools and techniques to better take care of oneself as a primary care provider
3. develop a strategic plan for recovery and well-being

Description:

Being a primary care provider is hard work and it can certainly take its toll on our lives, and on the care we provide. In this workshop, primary health care providers will become aware of the prevalence and recognize the effects of compassion fatigue on their personal and professional lives. How to differentiate between compassion fatigue, vicarious trauma, moral distress, and burnout will be explained. Participants will develop an understanding of how their own unique situations can contribute to the development of these common states. Participants will then review evidence-based techniques, including mindful movement and compassionate/ loving-kindness meditation, to experience how to restore and rebuild resilience.

T115051 **Adapting Accreditation Standards to 21st-Century Medical Education**
15:15–17:30 Keith Wycliffe-Jones, MBChB, FRCGP, CCFP, Calgary, AB;
 Pamela Eisener-Parsche, MD, CCFP, FCFP, CCPE, Mississauga, ON; Judith Scott, MA, Mississauga, ON
703 MTCC

Learning Objectives:

1. discuss the ongoing, tri-College (CFPC, RCPSC, CMQ) development of new accreditation standards and processes relating to postgraduate medical training in Canada
2. collect feedback about the new proposed standards and processes for family medicine
3. collect feedback about the new proposed standards and processes for new enhanced skills standards

Description:

The goal of this session is to share and discuss the proposed major changes in both accreditation standards and accreditation processes for core family medicine and enhanced skills residency training. A short presentation will cover the ongoing development process around new accreditation standards and processes for residency training and also updated standards for enhanced skills training in family medicine. Following the presentation, there will be ample time for questions and feedback on the proposed changes.

T101353 Trauma-Informed Primary Care

16:30–17:00 Christina Toplack, MD, CCFP, Halifax, NS; Victoria Winterton, MD, CCFP, FCFP, Owen Sound, ON

802AB MTCC**Learning Objectives:**

1. define trauma-informed practice and trauma-specific care
2. learn the impacts of trauma on mental and physical health
3. learn strategies that foster a safe environment for patients and reduce the risk of re-traumatization

Description:

All family physicians encounter survivors of interpersonal violence. The setting and nature of our work, including examinations and procedures that seem innocuous and routine, can be distressing for patients with unresolved trauma. This distress manifests in a myriad of ways and our responses can either foster growing trust and safety or unwittingly lead to re-traumatization. There are a number of core competencies in sensitive practice that can be learned by family physicians to be used with all patients, and that do not require special training in mental health, psychotherapy, or working with survivors of violence. A trauma-informed health care practice acknowledges the far-reaching effects of trauma on mental and physical health and routinely applies that knowledge in the provision of health care. This approach to primary health care fits in well within a trauma-informed service culture

T102541 Minority Stress: Recognizing the signs and reducing the harm

17:00–17:30 Christina Toplack, MD, CCFP, Halifax, NS; Victoria Winterton, MD, CCFP, FCFP, Owen Sound, ON

802AB MTCC**Learning Objectives:**

1. define minority stress and its distal (external) and proximal (internal) elements
2. recognize the mental and physical health presentations of minority stress in primary care
3. identify strategies to reduce health disparities related to minority stress and to foster resilience, at the individual patient, practice, policy, and social levels

Description:

Meyer's minority stress theory (1995) suggests that difficult social situations cause chronic stress in minority individuals that builds over time, resulting in negative health outcomes. The theory has three basic tenets: Minority status leads to increased exposures to distal (external) stressors, such as direct experiences of rejection, prejudice, discrimination, and violence. Minority status leads to increased exposure to proximal (internal) stressors, such as concealment of one's minority identity, internalized negative beliefs about oneself and one's minority group, mistrust of others, and fear of further victimization—due to distal stressors. Minority individuals suffer adverse health outcomes due to exposure to distal and proximal stressors. Numerous empirical studies—focusing mainly on racial and sexual minority groups—have tested these tenets and confirmed that minority stress helps to explain coping strategies and health behaviours that lead to increased levels of high blood pressure, type 2 diabetes, depression, anxiety, posttraumatic stress disorder, harmful involvement with substances, higher HIV rates, etc. Attachment and health-seeking behaviour are also affected in the presence of minority stress. These studies also identify factors that foster resilience, such as affirming identities, development of strong community connections, and advocacy. Teaching patients about the biopsychosocial nature of minority stress using strengths- or affirmative-based and harm-reduction primary care strategies will be discussed.

T95470 Managing Challenging Behaviours in Dementia Care: The rational use of antipsychotics, benzodiazepines, and more

16:30–17:30 Linda Lee, MD, MCISc(FM), CCFP, FCFP, Kitchener, ON; Tejal Patel, BScPharm, Pharm D, Waterloo, ON

713A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. review common challenging behaviours in dementia care and an approach to medication management when necessary
2. describe the rational use of antipsychotics and benzodiazepines, and practical strategies for antipsychotic and benzodiazepine withdrawals

Description:

With the aging Canadian population and estimates of approximately one-quarter of persons over age 65 suffering from either mild cognitive impairment or dementia, family physicians will be increasingly challenged to manage behavioural and psychological symptoms associated with these conditions. This session will provide practical tips on medications used to manage common neuropsychiatric symptoms in the senior who is cognitively impaired.

T99991  **The Carter Case: How does it affect our palliative care practice?**
16:30–17:30 **Implications de l'arrêt Carter sur la pratique clinique en soins palliatifs**
 Edith Larochelle, MD, LLB, Quebec, QC
HALL F MTCC

Learning Objectives:

1. explain the main concepts of the Supreme Court Carter case
2. identify the rights and obligations of physicians regarding physician-assisted death
3. apply the above concepts to common situations in palliative care

Description:

This presentation aims to inform participants about the details and implications of the recent Supreme Court of Canada decision (the Carter case) in palliative care practice. Through interactive case discussions we will discuss the details of physicians' rights and obligations with respect to physician-assisted death.

Objectifs d'apprentissage :

1. expliquer les principaux concepts de l'affaire Carter entendue par la Cour suprême
2. nommer les droits et obligations des médecins en matière d'aide médicale à mourir
3. appliquer les concepts ci-dessus aux situations courantes en soins palliatifs

Description :

Cette présentation vise à renseigner les délégués sur les détails et les répercussions de la récente décision rendue par la Cour suprême du Canada (affaire Carter) sur la pratique des soins palliatifs. À l'aide de discussions de cas interactives, la séance traite des détails quant aux droits et aux obligations des médecins en matière d'aide médicale à mourir.

T100707 **Happy Feet: Managing the diabetic foot**
16:30–17:30 Mark Karanofsky, MDCM, CCFP, Montreal, QC; Michael Yan, BMedSc, MD, CCFP, Edmonton, AB
HALL G MTCC

Learning Objectives:

1. demonstrate a quick, easy, and validated approach to screening and classification for the high-risk foot
2. assess an ulcer in a diabetic patient and select appropriate dressings, devices, and treatments for initial office management
3. select appropriate footwear and community resources for primary and secondary ulcer prevention

Description:

Patients with diabetes are at high risk of foot complications including neuropathy, deformity, ulcers, and, ultimately, amputation. Family physicians can help prevent such outcomes by screening for early changes of the diabetic foot and instituting protective measures. Some patients may already have foot ulcers and/or infection upon presentation. This workshop will cover an approach to screening for the diabetic foot, techniques and common dressings for initial office management of diabetic foot ulcers, and strategies for prevention of primary and recurrent foot wounds.

T99446 **FMF Pearls: Clinically relevant research from Family Medicine Innovations in Research and Education Day**
16:30–17:30 Judy Belle Brown, PhD, Londong, ON
712 MTCC

Learning Objectives:

1. synthesize clinically relevant research presented by the CFPC Section of Researchers at Family Medicine Innovations in Research and Education Day
2. stimulate interest in primary care research

Description:

Please join us for this year's "Top 4 Oral Abstracts" session. The CFPC Section of Researchers hosts a pre-conference forum inviting the best research from across Canada. After a rigorous peer-review process determined three dozen or so high-quality projects qualified for oral presentation at Family Medicine Innovations in Research and Education Day, the best of these were chosen to present in this "Best of" session at FMF. The Top 4 clinically relevant research papers of 2015 FMF will be showcased in this special session. Come out to challenge the presenters, share your ideas on the clinical relevance or how to do a better study next time, and cheer on family physicians working to understand how we all can provide the best care for Canadians!

T100352 I Want to Be Trans-friendly: The basics of transgender medicine

16:30–17:00 Ted Jablonski, MD, CCFP, FCFP, Calgary, AB

501 MTCC

Learning Objectives:

1. define "transgender"
2. review the basics of male-to-female and female-to-male transition (hormonal/surgical)
3. debate the concept of being "trans-friendly"

Description:

While most practitioners want to be "trans-friendly," many find this area of medicine very challenging. Even basic diagnoses, definitions, and wording can make simple communication fraught with mistrust and confusion. Most practitioners want to maintain a therapeutic relationship with their patients during and after transition but sometimes get left out of this "specialty area" due to perceived disinterest or miscommunication. This presentation is geared for all practitioners who just want to be more comfortable with the basic fundamentals of transgender medicine. This review will provide education for practitioners who wish to better understand and communicate with their patients so as to remain an integral part of their ongoing medical care. The fundamentals of male-to-female (MTF) and female-to-male (FTM) transition (hormonal and surgical) will be reviewed. Hopefully many pearls will be presented to assist all attendees in becoming more "trans-friendly." Dr Ted Jablonski is a family physician based in Calgary, Alberta, where he is currently in full-time practice within an innovative, inter-disciplinary community family practice. In addition to family medicine, Jablonski does consultancy work in men's health (working with urologist Dr Jay Lee) and sexual and transgender medicine for Southern Alberta and central British Columbia at the Jablonski Sexual Health Clinic in Calgary. Dr Jablonski has a special interest in CHE for physicians, medical professionals and the public, and has been involved in the creation and delivery of a wide range of programs at provincial, national, and international levels. Ted is a sought-after speaker, trainer, media spokesperson, and educator with many conference, radio, television, and video credits.

T101420 Meeting the Reproductive Needs of LGBTQ Families

17:00–17:30 Carrie Schram, MD, CCFP, Toronto, ON

501 MTCC

Learning Objectives:

1. describe how Canadian reproductive legislation applies to people who wish to have children outside of traditional heterosexual relationships
2. reflect on the challenges LGBTQ people may encounter when trying to conceive and develop compassion for their unique experiences
3. assist and support LGBTQ patients who wish to have children through education and counseling about their reproductive options

Description:

With advances in reproductive technology and greater societal acceptance, increasingly more LGBTQ people are having children. ¹ In 2011, there were over 64,500 same-sex couples in Canada, and 9,600 children age 24 and under reported living with same-sex parents. ² Family physicians are often the first point of contact for people wishing to conceive and are uniquely positioned to support their LGBTQ patients who wish to have children. Therefore, it is important that family physicians are aware of Canada-wide legislation that directly impacts the ability of LGBTQ people to conceive and to have general knowledge about the challenges this population may face when seeking reproductive assistance.

Some LGBTQ people conceive with fertility partners outside of the medical system; knowledge of this practice is valuable as it allows family physicians to assist with risk management, offer practical advice, and maintain open dialogue and supportive relationships with their patients. 1. Moskovtsev SI, Dacanay D, Baratz A, Sharma P, Glass K & CL Librach. Significant increase in utilization of donor sperm by lesbian couples after legalization of same sex marriages in Ontario. *Fertil Steril* 2013; 100(3):S67.

2. Statistics Canada <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/tbt-tt/Rp-eng.cfm>

T101198 Cognitive Behavioural Therapy for Anxiety and Depressive Disorders: Clinical pearls for family physicians

16:30–17:30

Thérapie cognitive-comportementale pour les troubles anxieux et dépressifs : précieux conseils cliniques pour les médecins de famille

Casandra Wendzich, MD, CCFP, Cayuga, ON

718AB MTCC

Learning Objectives:

1. identify the key components of CBT for various anxiety and depressive disorders
2. model and guide patients through progressive muscle relaxation as well as box breathing relaxation techniques
3. identify when CBT is appropriate as a first-line therapy

Description:

As family physicians are first line in the identification and treatment of anxiety and depression, I will present a summary of the clinically helpful and key components of cognitive behavioural therapy as it applies to the various anxiety and depressive disorders. This presentation will provide an overview of the major and key components of CBT for depressive disorders as well as anxiety disorders that include

generalized anxiety disorder, social phobia, obsessive-compulsive disorder, specific phobia, panic disorder, and health anxiety (post-traumatic stress disorder will not be covered); clinical pearls for family physicians facilitating CBT, which will include but will not be limited to when CBT is appropriate as a first-line therapy; a list of websites and/or workbooks/books that physicians can recommend to their patients with the aforementioned disorders; a description of as well as in-session audience participation in box breathing and progressive muscle relaxation exercises that can be modeled and taught to patients. This presentation will not address pharmacotherapy.

Objectifs d'apprentissage :

1. identifier les éléments clés de la thérapie cognitivo-comportementale à l'égard de différents troubles anxieux et dépressifs
2. faire la démonstration pour les patients de la technique de relaxation musculaire progressive et de respiration 4-4-8 et les guider lorsqu'ils en font l'essai
3. définir à quel moment une thérapie cognitivo-comportementale est adéquate comme traitement de première intention

Description :

Comme les médecins de famille sont les intervenants de première ligne en matière d'identification et de traitement de l'anxiété et de la dépression, je présenterai un résumé des éléments clés et utiles d'un point de vue clinique en ce qui a trait à la thérapie cognitivo-comportementale, car elle s'applique aux différents troubles anxieux et dépressifs. Dans cette présentation, je donnerai un aperçu des principaux éléments clés de la thérapie cognitivo-comportementale appliquée aux troubles dépressifs et anxieux, ce qui comprend le trouble d'anxiété généralisé, la phobie sociale, le trouble obsessionnel-compulsif, la phobie spécifique, le trouble panique et l'anxiété face à la santé (l'état de stress post-traumatique ne sera pas traité); des précieux conseils cliniques pour les médecins de famille visant à faciliter la thérapie cognitivo-comportementale, ce qui comprendra, sans s'y limiter, les moments où la thérapie cognitivo-comportementale est appropriée comme traitement de première intention; une liste de sites Web et/ou de livres d'exercice/d'ouvrages que les médecins peuvent recommander à leurs patients aux prises avec un des troubles mentionnés ci-dessus; une description ainsi que la participation du public, pendant la séance, à des exercices de respiration 4-4-8 et de détente musculaire progressive pouvant être démontrés et enseignés aux patients. La pharmacothérapie ne sera pas traitée dans cette présentation.

T101334 Untangling the Helix 2015: Genomics for primary care providers
16:30–17:30 June C. Carroll, MD, CCFP, FCFP, Toronto, ON; Shawna Morrison, MS, CGC
715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. discuss results of direct-to-consumer genetic tests, limitations, and next steps, as well as prenatal screening options with patients
2. identify patients at increased risk of breast and ovarian cancer, and discuss appropriate screening and management including genetic counseling
3. find high-quality genomics educational resources appropriate for primary care

Description:

This seminar will use a primary care case-based approach to discuss new advances in genomics and their impact on practice. Cases will include direct-to-consumer genetic testing, prenatal genetic testing (non-invasive prenatal testing, microarray), and hereditary breast/ovarian cancer. Participants will be introduced to the GEC-KO website: www.geneticseducation.ca. There will be time for a question-and-answer session so bring your clinical genetics questions.

T101503 Healing the Wounds: Stories from where the office meets the street
16:30–18:00 Susan Phillips, MD, CCFP, Kingston, ON
711 MTCC

Learning Objectives:

1. recognize how colleagues have shaped practice to correct for social inequities that harm health
2. translate the role of advocate into practice
3. be inspired about how to blend social activism with family practice

Description:

What is an advocate to do? Can individual family physicians address social inequities in practice and policy? In this interactive workshop stories of making change will be presented then discussed by all present. Making change means going beyond diagnosis and treatment to consider and act upon the inequities, social circumstances, and life experiences that are so central to health and yet so elusive in clinical practice. We will present stories of practice experiences that build upon those submitted by attendees following a similar workshop offered by the CFPC's Equity and Diversity Committee at last year's FMF. These examples of how inequities in patients' social circumstances shape health will set the stage for discussion. Our aim is to inform and inspire, to develop ways that family physicians can address and ameliorate the inequities that harm and hurt. We will encourage attendees to challenge and to champion methods for family physicians to become agents of advocacy and change.

T101786 First Trimester Pregnancy Loss: An office-based approach
16:30–17:30 Hannah Feiner, CCFP, MD, Toronto, ON; Emmanuelle Britton, CCFP, MD CM, Toronto, ON
401 MTCC

Learning Objectives:

1. describe an approach to the diagnosis of first-trimester bleeding
2. confidently exclude ectopic pregnancy using the physical exam, ultrasound, and serial blood work as required
3. manage spontaneous abortions in the office with surgical referral where appropriate

Description:

This presentation will cover an office-based approach to first-trimester bleeding, and the diagnosis and management of spontaneous abortion. The intended audience is practising family physicians, residents, and medical students, but can also expand to include all allied health care professionals who may care for clients with first-trimester bleeding. Approximately 20 percent of pregnancies are complicated by bleeding before 20 weeks of gestation, and, of these, about half will continue without problems 1) approximately 15 per cent of pregnancies are complicated by spontaneous abortion in the first trimester 2) patients with first-trimester bleeding often present to primary care clinics. This session will present flow chart decision aids for the diagnosis of first-trimester bleeding, as well as the management of spontaneous abortions. These decision aids will be used to work through several clinical cases with the audience. At the end of this presentation, audience members will demonstrate increased confidence in their diagnosis and management of spontaneous abortions, as well as in their ability to rule out ectopic pregnancies with the judicious use of diagnostic resources.

1. SOGC. Miscarriage & Stillbirth. <http://pregnancy.sogc.org/other-considerations/miscarriage-and-stillbirth/>. Accessed February 16, 2015.

2. Spontaneous miscarriage in the first trimester. *BMJ* 2006;332:1223.

T101925 Simple Spirometry in Family Medicine Made Even Simpler

16:30–17:30 Tony D'Urzo, MD, BPHE, MSc, CCFP, FCFP, Toronto, ON

701AB MTCC

Learning Objectives:

1. become familiar with the spirometric criteria for asthma and COPD diagnosis
2. understand how to use a new evidence-based SI algorithm in a timely fashion to interpret a variety of spirograms typical of patients presenting with respiratory complaints in primary care
3. become familiar with the spirometric overlap between asthma and COPD and learn how to distinguish between these conditions using both spirometric and historical data

Description:

Simple spirometry is recommended for objective confirmation of common conditions like asthma and chronic obstructive pulmonary disease (COPD). Many physicians report a lack of confidence relating to spirometry interpretation (SI). Physicians also report difficulty in distinguishing between asthma and COPD in clinical practice, a challenge that is reflected by an overutilization of first-line asthma therapy for COPD patients in whom this therapy is not recommended. At the present time there is no standardized approach promoted to aid clinicians in the interpretation of spirometry data in day-to-day practice. This session will provide a very pragmatic, evidence-based, and user-friendly approach to SI in primary care. A recently published paper (He X-O, D'Urzo A, Jugovic P, Jhirad R, Sehgal P, Lilly E. Differences in spirometry interpretation algorithms: Influence on decision making among primary care physicians. *NPJ Prim Care Respir Med* 2015;25:15008.) by some members of the Primary Care Respiratory Alliance of Canada will be used to describe an approach to SI that can be easily adopted in primary care. This session will focus on using a new SI algorithm developed by primary care physicians to facilitate SI in a manner that recognizes the spirometric overlap between asthma and COPD and that reduces the risk of disease misclassification. A case-based approach will be used to highlight how spirometric overlap might limit the utility of spirometry in distinguishing between asthma and COPD in the absence of a thorough and tailored clinical history.

T102076 Primary Care Medical Management Approach to Alcohol Use Disorders (AUDs)

16:30–17:30 Sheryl Spithoff, MD, CCFP, Dip. ABAM, Toronto, ON; Meldon Kahan, MD, CCFP, FCFP, Toronto, ON

716A MTCC

Learning Objectives:

1. be able to provide ongoing counseling and to prescribe medications to patients with AUDs
2. have tools to address underlying mental health problems in patients with addictions
3. recognize when to report a patient for drinking and driving risk

Description:

The typical family doctor has 25 patients in his or her practice with a moderate-to-severe alcohol use disorder (AUD) or alcohol dependence. Many of these patients have failed to connect to specialized addiction treatment and are solely under the care of their family doctor. Studies show that, with minimal additional training, family doctors can be as effective as specialized addiction clinics at treating alcohol use disorders. In our session, we will present the evidence-based primary care medical management approach to caring for patients with AUDs. In the model, family doctors give brief ongoing counseling sessions, prescribe first-line medications (naltrexone, acamprosate, and disulfiram) and connect patients to other resources (Alcoholics Anonymous, case management, trauma therapy). We will also give an approach to concurrent mental health problems, including post-traumatic stress disorder. We will discuss drinking and driving risk and the duty to report. We will review how to determine if patients need medical management of alcohol withdrawal and how to provide clinic-based day detoxification.

T102600 A Diagnostic Approach to Strabismus in Children

16:30–17:00 Radhika Chawla, OD, Richmond Hill, ON; Catherine Chiarelli, OD, Toronto, ON

801AB MTCC

Learning Objectives:

1. identify risk factors and signs and symptoms for strabismus in children
2. perform simple in-office techniques for assessment of strabismus
3. differentiate between urgent vs. non-urgent presentations and identify where and when to refer children for further comprehensive evaluation

Description:

Strabismus is one of the earliest signs of abnormal visual development in children that prompts parents to consult with family physicians. Evaluation is a complex process, considering the various etiologies of strabismus. Emphasis will be placed on differentiating between urgent vs. non-urgent presentations.

T102702 Implementing a Fentanyl Patch Exchange Program: Reducing overdose risk in our communities

16:30–17:00 Jennifer Wyman, MD, CCFP, Toronto, ON; Irene Leibrandt, RPh, BScPhm, Oshawa, ON;
Paul McGary, MSW, Oshawa, ON

715B MTCC— Small group interactive workshop – limited seating.

Learning Objectives:

1. recognize the impact of fentanyl diversion/misuse in our communities
2. understand the rationale for a patch exchange program
3. be prepared to implement a patch exchange program in conjunction with community pharmacy and team members

Description:

Fentanyl accounts for the greatest increase in opioid overdose deaths in Ontario. Even after proper usage, patches contain large amounts of active drug that can be accessed by chewing, smoking, or steeping. Patch diversion and misuse have been identified as major sources of fentanyl access in the community. A patch exchange program requires that patients return their used patches to the pharmacy before they can pick up a new supply. The Durham Region model, implemented in 2014, is closely modeled on those of the North Bay and Peterborough regions. The program involves coordination between prescribers and pharmacists, and has been strongly supported by regional police associations. The rationale, protocol development, roll-out, and practical application in the community will be reviewed.

J102861 Mentorat de la prochaine génération de chercheurs en médecine familiale

16:30–17:30 Matthew Menear, PhD, Quebec City, QC; Claire Kendall, MD, PhD, CCFP, Ottawa, ON

710 MTCC

Objectifs d'apprentissage :

1. décrire la communauté de pratique en recherche que développe la Section des chercheurs du CMFC
2. expliquer les avantages du mentorat en recherche et la stratégie de mentorat développée par le groupe de travail de la communauté de pratique en recherche
3. formuler des recommandations pour améliorer l'accès à un mentorat de grande qualité dans la recherche en médecine familiale

Description :

Le plan directeur visant la réussite de la recherche en médecine familiale du CMFC identifie le développement des capacités comme domaine stratégique pour le succès de la recherche en médecine familiale au Canada. Un nouveau groupe de travail de la Section des chercheurs a été formé afin de développer la capacité grâce à une nouvelle communauté de pratique pancanadienne en recherche. Un objectif important de cette communauté de pratique sera de faciliter les relations de mentorat entre les médecins de famille et les résidents tôt dans leur carrière de chercheurs ainsi qu'avec des chercheurs chevronnés de différentes disciplines qui peuvent fournir des conseils sur les projets de recherche, la formation et la planification de carrière. Dans cet atelier interactif, les médecins, résidents, enseignants et chercheurs sont invités à une présentation et à une discussion sur l'avenir du mentorat en recherche pour la médecine familiale au Canada. Dans la première moitié de l'atelier, les membres du groupe de travail présenteront et décriront la communauté de pratique, présenteront des données probantes et des exemples pratiques de l'importance du mentorat en recherche, et dévoileront une stratégie de mentorat pour la communauté de pratique en recherche en fonction d'initiatives précédentes à l'échelle canadienne et internationale. Dans la deuxième partie de l'atelier, les participants travailleront en petits groupes pour fournir des commentaires sur cette stratégie de mentorat et rédigeront des recommandations sur la façon dont la communauté de pratique pourrait davantage aider les cliniciens, les résidents et les éducateurs à accéder à du mentorat de grande qualité afin d'appuyer leurs activités de recherche et leur carrière. Cet atelier aidera à former la nouvelle communauté de pratique en recherche mise en place par la Section des chercheurs.

T106727 Research Advocacy: Your voice can make a difference

16:30–17:30 Alan Katz, MB ChB, MSc, CCFP, Winnipeg, MB; Richard Fleet, MD, PhD, CCMF, MU, Quebec City, QC

712 MTCC

Learning Objectives:

1. discuss your research advocacy experiences with like-minded colleagues
2. apply insights from the experiences of others and build collaborative relationships to support your advocacy efforts
3. influence the research advocacy agenda of the CFPC

Description:

This workshop will explore the current state of research advocacy for family medicine research. Participants will benefit from the experiences of others by sharing their challenges and achievements. The research advocacy action group of the Section of Researchers is looking for your input about their efforts to advocate on your behalf.

TJ108669 **Mainpro+ ... A New Look, With New Ways to Learn (2)**
16:30–17:30 **Mainpro+ ... Un nouveau look; de nouvelles façons d'apprendre (2)**

Eric Wong, MD, CCFP – Regional Educator, Ontario Region / Édicateur régional, région de l'Ontario, London, ON;
 Scott MacDonald, MD, CCFP (EM), FCFP – Regional Educator, Atlantic Region / Édicateur régional, région de l'Atlantique, Bedford, NS

803A MTCC

Join us for an informative session on Mainpro+ and the new, practice-centred ways to earn CPD credits for activities you do on a daily basis. Also, hear the latest updates on fellowship, accreditation, and CACs. The CFPC is committed to providing quality CPD to meet your changing interests and learning needs. Participants may claim an additional Mainpro-M1 credit for this session.

Soyez des nôtres pour une séance d'information sur Mainpro+ et sur les nouvelles façons d'obtenir des crédits de DPC pour des activités que vous effectuez au quotidien. De plus, vous pourrez vous renseigner sur les nouveautés concernant le titre de Fellow, l'agrément et les CCA. Le CMFC s'est engagé à fournir des programmes de DPC de qualité qui conviennent aux intérêts de ses membres et répondent à leurs besoins en matière d'apprentissage. Les participants peuvent réclamer un crédit Mainpro-M1 additionnel pour cette séance.

T102409 **An Approach to Consumer Health Mobile Apps: What your patients are using and what you need to know**
17:00–17:30

Puneet Seth, BSc, MD, CCFP, London, ON

714AB MTCC

Learning Objectives:

1. discover and categorize the different types of mobile health apps commonly used by patients
2. develop an approach to discussing mobile apps and their current limitations with patients
3. discuss the major advancements in mobile health apps anticipated in the coming years in Canada and beyond

Description:

Health care delivery is undergoing enormous change. More than ever, patients are demanding to be at the centre of their own health issues—they want to know more about their health, to be involved in making decisions about their health, and to be engaged in their care beyond visits to their doctor. A key enabler of this change has been access to a world of information, made possible through tools at people's fingertips—mobile devices. The ubiquity of apps on smartphones, tablets, and other mobile devices for health-related uses is indisputably on the rise. In fact, a recent US report by Manhattan Research stated that 50 per cent of patients surveyed used mobile devices to gain access to health information. The mobile health—or mHealth—industry today is primarily driven by the patient/consumer, as opposed to the clinician. This presents new challenges to primary care clinicians, who are beginning to see patients coming into their clinics geared with health information stored, viewed, and analyzed on their mobile devices. Presently there is no regulatory body in Canada that overviews health apps and their use, leaving many clinicians in the dark about how they should approach patients using such apps. When a patient asks which app to use to manage a particular medical issue, how should a clinician respond? What apps are out there, and what sources should clinicians turn to if they need more information? And most importantly, are they leaving their patients and themselves vulnerable in any way by using such apps? As medical experts, managers, and leaders of health care delivery, clinicians have a responsibility to respond to such questions with a basic level of knowledge. In this brief session, we hope to help clinicians develop an overall understanding of the consumer mHealth market and will explore practical uses and limitations of such technologies today. In addition, we will explore ideas of what lies ahead in the future of mHealth.

T118642 A **Professionalism and Quality Improvement in Family Medicine: Better has no limit**
17:45–18:45

Joshua Tepper, MD, MPH, MBA, Toronto, ON; Moderator – Emily Gruenewoldt, CMA, Ottawa, ON

801AB MTCC

Learning Objectives:

1. define the intrinsic relationship between medical professionalism and the pursuit of continuous quality improvement
2. leverage patient engagement opportunities to define quality improvement initiatives
3. identify tools to collect and apply patient data to improve care and enhance quality outcomes

Description:

This interactive, one-hour ancillary session will engage participants in a discussion about medical professionalism and the intrinsic motivation of physicians to continuously pursue best-quality care. Participants will engage in an interactive, online survey tool to identify and trend matters of medical professionalism relative to family practice. The results of this survey will be contrasted with findings from across the country, and across medical specialties.

This session will heavily emphasize new and emerging approaches to enhance quality improvement in family practice. Dr Joshua Tepper, a family physician and president and CEO of Health Quality Ontario, will describe two tools available to Ontario GPs. The first tool, the Primary Care Practice Report provides physicians with the opportunity to access and leverage confidential, customized patient data to inform quality improvement initiatives within their day-to-day practice. The tool provides insight to inform interventions which can facilitate improved patient flow as well as to compare one patient population to another. The second tool, the Patient Experience Survey, is a validated tool to help family physicians develop a deeper understanding of their patients' experience in primary care. Participants will discuss how both reports facilitate practice change and enhance patient outcomes. Participants will also discuss opportunities to advance tools such as these within their own jurisdiction.

Participants may claim an additional Mainpro-M1 credit for attending this session

RESIDENT POSTERS / AFFICHES DES RÉSIDENTS

NOVEMBER 12 NOVEMBRE -700 FOYER MTCC

640 Iliac Artery Endofibrosis: An elite Canadian triathlete case study

Nazanin Baradaran, MD, Victoria, BC; Robert Brunelle, MD, Victoria, BC; Steven Keeler, MD, CCFP (CASEM), Victoria, BC

Description:

Iliac artery endofibrosis, an under-recognized condition, is characterized by intimal thickening of the iliac arteries and most commonly affects elite endurance athletes. Although not limb-threatening, it can have serious career implications in professional athletes. Its relative obscurity is not surprising; to the best of our knowledge no previous Canadian report has been published on the topic so far. A 26-year-old elite male triathlete presented with prolonged abdominal pain and left leg claudication that occurred only after maximal cycling efforts. By the time he sought medical attention, he had withdrawn from a World Cup event due to his symptoms, and was at risk of losing his livelihood as a professional triathlete. Standardized tests were inconclusive. Ultimately, severe iliac artery flow restrictions in flexed hip MRA confirmed the diagnosis. Corrective surgery with unremarkable post-operative course resulted in his return to previous level of competition. Interestingly, he subsequently developed endofibrosis in the contralateral limb, again requiring surgery, putting him in the 15% of athletes to do so. A focused history, physical examination along with specific investigations is essential; including CTA and flexed hip MRA and provocative studies. The condition should be suspected early in any athlete who experiences reproducible claudication symptoms with exercise. With this case study, we hope to highlight the importance of keeping a high index of suspicion in these patients.

641 Development of a Rourke Baby Record Parent Resource Mobile App

Laura Butler, MD, Kingston, ON; Heidi Wells, MD, Kingston, ON; Leslie Rourke, MD, CCFP, FCFP, MClInSc, St John's, NL; Meg Gemmill, MD, CCFP, Kingston, ON; Todd Pardy, BA, St John's, NL

Description:

Context: As evidence mounts regarding sensitive periods in the first 5 years of life for all aspects of future health including learning, personality, physical and mental health, so does the importance of preventive healthcare for infants and young children. Access to parent-friendly, reliable health care resources is a challenge for parents of young children. Parents often wonder about their child's health, leading to the frequently asked question "Is my baby healthy and growing normally?" Often, well child visits can be overwhelming for parents, and anticipatory guidance may be lost in translation. Objective: This poster will introduce the development of a Rourke Baby Record (RBR) mobile application (app). This app is intended to be a supplementary resource for anticipatory guidance at well baby/well child visits, directed towards parents of young children. After a physician visit, they can review evidence-based information that was discussed by their physician, in layperson terms, and have access to additional parent resources through the app and RBR website (www.rourkebabyrecord.ca). Design: Development of a RBR parent-resources app, where parents can access preventative pediatric health information and resources, following the 2014 RBR. Target Population: Parents of children ages 1 week to 5 years, who will attend well child visits with their family physician or primary paediatrics care provider. Intervention: Evaluation of parent information mobile application on common health issues and anticipatory guidance related to infant and young children through focus groups with parents of children aged 1 week to 5 years. Outcomes Measured: Satisfaction and feedback survey from participants of focus group. Findings: Will be highlighted. Conclusion: Findings from this study will be used to revise the parent resources for the next revision of the RBR in 2017. This app will appeal to family physicians, paediatricians, nurse practitioners, community health nurses, other primary healthcare providers, students/residents - and of course to parents of young children!

642 Quality Road Map: Teaching QI in the community

Josephine Lee, MD, Toronto, ON

Description:

Context: Quality improvement (QI) in community primary care has been delivered through QI training of family medicine residents and faculty. Our study in 2011 determined the major driving forces and barriers of integrating QI into community primary care. These include leadership, QI tools, capacity building, and continuity. This poster describes how the structure, training, and integration of QI in North York have since evolved to meet these goals. Objective: To evaluate the growth of QI culture through incorporation of QI at various levels of primary care. Design: Implementation of QI initiatives and assessment of their impact through a survey study. Participants: Family physicians in North York, Ontario. Intervention: Local QI interventions, including local QI educators and leaders, department-wide QI initiatives, mentoring, online resources, QI database, data management tools, and departmental rounds. Outcome Measures: Online survey regarding individual QI involvement, current QI drivers/barriers, and assessment of initiatives. Findings: 44 physicians (58.1%) completed the survey. 81% were involved in at least one QI project in the past year, compared to 47% in our 2011 survey. Factors identified as most helpful for QI growth were resident projects, participation in North York Family Health Team initiatives, local mentoring, and QI exchange as part of departmental rounds. The strongest barriers were lack of time, knowledge, and IT support. Conclusions: We demonstrate how implementation of a QI program in community primary care has been achieved through developing local initiatives. We aim to continue spreading this QI culture by aligning with QI at the hospital and North York Family Health Team. We plan to improve upon QI mentorship amongst residents, faculty, and allied health professionals at a local level.

643 Driving With Dementia: Comparing physician attitudes and practices when determining fitness to drive

Mitch Vainberg, MD, Toronto, ON; Fok-Han Leung, MHSc, MD, CCFP, Toronto, ON

THURSDAY • JEUDI

Description:

Context: Physicians in Ontario are legally required to report patients thought to be unfit to drive due to medical reasons. With an aging population, reporting drivers with dementia is an important public health action that family physicians will be growingly confronted with. Objective: This study seeks to assess family physician reporting attitudes and reporting practice for drivers with cognitive impairment. Design: Family physicians from our academic centre were recruited to complete a survey on their knowledge and attitudes toward reporting practice on drivers with cognitive impairment. A retrospective chart review of selected patient records was conducted to assess actual reporting practice. Participants: 32 family physicians, including 11 resident physicians, anonymously completed our survey. For our retrospective chart review, we selected records meeting the following inclusion criteria: 1) the records were recorded between July 2009 and July 2014 inclusive; 2) the patient was aged 65 or over within that time span; and 3) a relevant keyword was present somewhere in the record. Instrument: We searched all current electronic medical records of our patients from our database stored in PS Suite. Outcome Measures: We used a previously validated survey measuring attitudes toward driving assessment, self-reporting practice, and basic practice information. Our retrospective chart review measured degree of cognitive impairment and reporting status. Results: For our survey, the majority of family physician respondents (84%) believed that assessing fitness to drive is an important part of their practice. Few respondents (16%), however, were confident in their ability to assess fitness to drive, and the majority (97%) reported wanting further education. Self-report rates for drivers with dementia were high, with over half (56%) indicating reporting drivers with mild dementia, and the majority (81%) answering reporting drivers with moderate dementia. 11 electronic records were analyzed for our retrospective chart review. 10 of these 11 patients had a diagnosis of mild cognitive impairment, and none of them were reported to driving authorities. Conclusions: This study calls for more education for family physicians on their duty to report unsafe drivers with dementia. Reported physician attitudes and knowledge were not in keeping with current driving guidelines.

644 Statin Prescribing for Primary Versus Secondary Prevention in Primary Care Practices in Manitoba

Felicity Huisma, MD, Winnipeg, MB; Alex Singer, MD, CCFP, Winnipeg, MB

Description:

Context: The 2012 Canadian Cardiovascular Society (CCS) Guidelines recommends calculating individual Framingham Risk Scores (FRS) for all women ≥ 50 and men ≥ 40 years old to guide the utility of statin therapy. All patients with an FRS $\geq 20\%$, and some between 10-20%, are recommended to commence a statin. Since the FRS does not take into account whether the patient has a history of cardiovascular disease, these guidelines do not discriminate patients into primary versus secondary prevention treatment groups, which may be of concern because the evidence for statins in primary prevention is weak. Objective: To determine how well primary care practices in Manitoba are adhering to the CCS guidelines and what proportion of patients prescribed statins is done so for primary versus secondary prevention. Design: Retrospective electronic chart review. Population: All women ≥ 50 and men ≥ 40 who have been seen in clinic within the past 18 months. In our original pilot study we assessed one academic teaching unit in Winnipeg, Manitoba. We are in the process of assessing provincial-wide data from a cohort of 180,000 patients, which we will have in time for FMF. Instrument: The Manitoba Primary Care Research Network, which extracts data from a longitudinal database created from de-identified electronic medical records from consenting primary care providers across the province. Results: Our preliminary results found a total of 2363 patients were found to be in the age ranges recommended for routine screening. Of those, 1794 (75%) had an LDL recorded in the past 18 months, and only 507 (28%) had both an LDL and a FRS recorded. Of all patients in the screening age range, 563 (23%) were on a statin, and of those, 415 (73%) were on it for primary prevention, and 148 (27%) for secondary prevention. Conclusions: Given that there is weak evidence to support the use of statins in primary prevention, it is concerning that this group of patients forms the majority of those treated in this preliminary study. There are risks and costs associated with statins, and therefore a more informed discussion between physicians and their patients may be warranted.

645 The Mini-Cog: An easy and effective tool for MCI screening in family practice

Brenna Velker, MD, PhD, London, ON; James P. Mather, MD, CCFP, MSc, London, ON; Darren VanDam, MD, CCFP, London, ON

Description:

The Mini-Cog: an easy and effective tool for MCI screening in family practice Velker, B.A.M., Mather, J.P., VanDam, D. Context: Identification of patients with MCI (mild Cognitive impairment) is essential to ensure patients receive adequate support to promote independence, minimize risks and improve quality of life. Self-identification of memory concerns is unreliable, with only half of individuals with MCI endorsing any Cognitive symptoms. We believe that MCI is being grossly under diagnosed however formal memory testing on all individuals is unrealistic with time constraints during primary care visits. Objective: We believe the Mini-Cog; a validated screening tool incorporated into the annual health exam, is an efficient and practical tool to improve the identification of patients with Cognitive issues. Design: A prospective chart review of patients screened using the Mini-Cog was performed, and compared retrospectively to patients screened the conventional way in the 6 months prior to initiation of the study. Participants: All patients > 65 years of age in our Family Health Team seen for an annual health checkup during the study period. Outcome Measures: Detection of MCI in our practice population. Intervention: Standard practice vs integration of the Mini-Cog test into the annual health exam with follow up MOCA testing as needed based on Mini-Cog score. Results: Of 188 patients screened using the conventional subjective question, only one patient identified concerns with memory, and no diagnoses of MCI occurred. Of the 81 AHEs that occurred during the first PDA cycle, the Mini-Cog was performed in 70% of cases. Of the patients who were investigated, 7% screened positive for MCI and an additional 15% scored in the indeterminate range. When patients in the indeterminate range were brought back for formal neuro-cognitive testing MOCA scores ranged from 24- 28 and additional diagnoses of MCI were made. Conclusion: Overall, implementation of the addition of the Mini-Cog to the AHE of patient's age >65 was quick, easy, and resulted in a dramatic increase in the number of patients identified with a potential diagnosis of MCI.

646 A Guide for Introducing Balint Groups Into the Canadian Family Medicine Curriculum

Caitlin Christie, MD, MPH, Toronto, ON; Nena Watson, MD, MA, Toronto, ON; Charlie Guiang, MD, CCFP, Toronto, ON; Holly Knowles, MD, CCFP, Toronto, ON

Description:

Objectives: 1. To highlight the prevalence of burnout and depressive symptoms among resident physicians 2. To discuss an evidenced-based

intervention that has been demonstrated to decrease burnout and depressive symptoms among resident physicians.³ To describe how Balint groups could be effectively integrated into Canadian family medicine residency programs Context: Resident physicians experience a considerable amount of stress dealing with the somatic and psychological concerns of their patients. Long work hours and the substantial body of medical knowledge that must be mastered during the residency program often compound this stress. Consequently, burnout and depressive symptoms are a prevalent phenomenon among residents. Much research has been conducted on interventions designed to decrease burnout and depression amongst resident physicians. In particular, Balint group participation is a well-studied intervention in the medical education literature. Objective: To describe how Balint groups could be effectively integrated into Canadian family medicine residency programs. Design: Literature review. Target Population: Canadian Family Medicine residency training programs. Intervention: N/A. Outcome Measures: N/A. Findings: Balint groups are a formal component of many American family medicine residency-training programs. However, few (if any) Canadian family medicine residency programs provide their residents with an opportunity to participate in a Balint group. Similar to our American colleagues, Balint groups could effectively be integrated into the current behavioural medicine curriculums of Canadian family medicine training programs. Important considerations when implementing a Balint group as part of a residency curriculum are: appropriate facilitation, mandatory versus voluntary participation, timing of the sessions, confidentiality and appropriate evaluation of the impact of the group on participants. Conclusions: Previous research has demonstrated that by providing members with an opportunity to meaningfully discuss patient encounters, residents who participate in Balint groups develop an improvement in their self-confidence as a physician, feel more in control of their clinical environments, report less burnout and depressive symptoms and are more satisfied with their medical careers. Given the documented positive outcomes associated with Balint group participation, implementation of Balint group into family medicine residency programs may be a useful tool to help address burnout and depression among resident physicians.

647 **Paging Primary Care: On-call service in a family health team**

Charlene Antony, MD, Hamilton, ON; Joan Li, MD, Hamilton, ON; Jennifer Brooks, MD, Hamilton, ON; Harkiran Mallhi, MD, Hamilton, ON

Description:

Paging Primary Care: On Call Service in a FHT Charlene Antony, Joan Li, Jennifer Brooks, Harkiran Mallhi Context: Family Health Teams (FHT) provide access to a comprehensive team based approach to primary family healthcare services. The McMaster FHT offers evening and weekend on-call access that function as a point of care and triage service. Objective: To assess the effectiveness of phone management by examining the CTAS scores of patients sent to the emergency department (ED) and to improve the efficiency of the on call service by identifying issues that could be addressed at a clinic visit. Design: This is an observational, cross-sectional, retrospective study, which will examine all calls made to the on-call service for a 7-month period between November 2013 and May 2014. Target Population: Our inclusive sample is composed of all after-hours calls within a FHT comprised of 33,241 patients. Instrument: The data was collected from answering service logs and through OSCAR, the FHT's electronic medical record (EMR). Outcome Measures: 1. The percentage of patients that utilizes the on-call service and their reasons for calling. 2. Disposition of the patients and accuracy of the phone diagnosis compared to the ED. Results: In a 7-month period, the on-call service logged 1210 calls. This correlates to only 3.6% of the FHT who are users of the service. Of patients who accessed the service, 17.3% required further assessment in clinic, and 14.5% were sent to the ED. Of the patients sent to the ED, 83.1% were appropriate consults with an average CTAS score of 3 ± 0.7 . The three most common reasons for calls were 1) infections of the respiratory, urinary, or gastrointestinal (GI) tracts (33.6%), 2) practice management issues (e.g. prescriptions and results) (13.4%), and 3) other GI concerns (e.g. abdominal pain and nausea) (8.6%). Conclusions: The majority of calls were handled solely by phone; however, the significant frequency of practice management calls identifies the need for reviewing the means that patients can access this information. Furthermore, a greater emphasis on raising awareness of the on-call service should be undertaken. In addition, clinicians appear to appropriately send patients to the ED.

648 **Exploring Gender-Specific Screening Practices in Family Medicine in Alberta: A pilot study**

Todd Hill, PhD, Calgary, AB; Peter Eppinga, Calgary, AB; Cathlin Mutch

Description:

Increasingly, we are aware that physician gender influences medical screening practices, and that gender-concordance is a relevant factor in preventive screening. Previous work has been done analyzing rates of screening practices through retrospective analysis of databases, physician surveys about personal practice, and patient surveys about physician recommended screening practices. None of these studies have been able to control for neither patient variables nor physician-patient relationship variables. The present study was performed using a survey of Family Medicine residents and practitioners, asking how they would apply screening tests to specific clinical vignettes. This method was utilized in order to better control for patient variables and physician-patient relationship variables, and to allow analysis of self-reported screening recommendations based more on physician characteristics (i.e. gender and experience). Clinical vignettes were developed to assess cancer screening recommendations. They included two (2) gender-specific and one (1) gender non-specific scenarios. We chose cancer screening due to the availability of both gender specific and gender-neutral cancer screening guidelines with similar characteristics. In total we had 90 participants (41 Family Medicine preceptors, 49 Family Medicine residents) from the University of Calgary. The only significant gender-concordant result was that females (both residents and preceptors) were significantly more likely to endorse mammography screens for the 55 year old healthy female patient. All other results reflected gender and experience differences for the gender non-specific screening vignette, and therefore did not reflect gender-concordance. Male practitioners endorsed FIT testing significantly more than did females for a 48 year old healthy patient, whether the patient was gender unspecified, male or female. Residents were significantly more likely to suggest FIT screening for the healthy 48 year old male, and for the healthy gender unspecified patient. Male practitioners were significantly more likely to endorse FIT screening for a 48 year old patient (male or female) either if the patient had a family history in an 80 year old primary relative, or if the patient had previous screening. With the exception of mammography, our results did not support the original hypothesis of gender concordance, but did uncover some interesting and significant differences in screening recommendations.

STUDENT POSTERS / AFFICHES DES ÉTUDIANTS

NOVEMBER 12 NOVEMBRE

623 Improving Patient Education in Family Practice: How and what you share with patients

Cathy MacLean, MD, CCFP, FCFP, St. John's, NL; Jessica Dwyer, St. John's, NL

Description:

This poster deliberately uses plain language to demonstrate writing that does not preclude patients who read below a sixth grade level from reading its content. The purpose of this project was to become more aware of how family doctors educate their patients and to suggest simple ways in which to improve these methods of sharing knowledge. The first part of this project critically appraised the patient education materials (PEMs) currently on display in local family practices. This insight led to the development of the D-O-C-E-R-E guidelines. This original method, as its acronym outlines, can be used to assess the quality of PEMs based on their display, obtainability, consistency, effectiveness, readability, and explanation. The focus of this project then shifted towards determining how PEMs in the waiting room could be used to enhance a patient's educational experience. Further insight was gained through the development of a needs assessment survey distributed to the four teaching clinics in St. John's, NL. The survey asked patients to report their highest school level obtained, comfort level in reading the survey, health concerns of interest, and medium through which they would prefer to receive such additional information. The results of this survey serve as a reminder to consider readability of PEMs, as patients are diverse in educational attainment. As for receiving additional materials, patients reported an interest in information on eating healthy, weight loss, physical activity, and healthy aging. Since physician-patient interactions often include education about acute health concerns and chronic disease processes, PEMs may be purposefully geared towards preventative health. Lastly, the survey revealed a trend towards electronic options to self-educate. With a shift to more patient-centered care and continuous advances in technology, patients now express a preference for researching their own health information. To ensure patients receive credible information, reliable Internet sources can be offered in addition to traditional written PEMs. From this project, it is evident that physicians may integrate patient education materials into their practices effectively when mindful of health literacy and patient preferences. The next part of this project will involve applying and disseminating this knowledge to encourage positive change.

624 Adherence to Metabolic Monitoring Guidelines for Atypical Antipsychotics in Family Medicine

Timothy Rudd, MA, MD candidate, Kitchener, ON; Thomas Muir, MD; Andrew Costa, PhD

Description:

Context Atypical antipsychotics (AAPs) are increasingly being prescribed by primary care providers as first-line treatment for psychiatric disorders, as well as for off-label use. However, they have a known side effect profile that includes hyperglycemia, hyperlipidemia and weight gain. Adherence to metabolic monitoring guidelines is important in family practices to ensure that AAPs are not adding to the already heavy burden of metabolic disease. Objective This research project was designed to determine baseline rates of metabolic monitoring for patients taking AAPs. Design and Participants Eight family physicians in an academic centre consented to retrospective chart review with a study period from July 19 2013 to July 19th 2014. The study population included all patients of the eight participating physicians who were taking an AAP during the study period, providing a total sample size of 62 patients. Abstracted Data Abstracted data included patient age and gender, name of AAP taken, and the number of times each metabolic monitoring parameter was recorded while the patient was taking an AAP. Outcome Measures The metabolic monitoring parameters used as outcome measures (BMI, waist circumference, fasting glucose, fasting lipids, blood pressure) were chosen based on guidelines provided by the Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Results Adherence to the metabolic monitoring guidelines for these patients over the course of the 12 month study period was 4.5% for BMI, 1.6% for waist circumference, 2.2% for fasting glucose, 8.3% for fasting lipids and 40.6% for blood pressure. Adherence at baseline was 3.2% for BMI, 1.6% for waist circumference, 0% for fasting glucose, 3.2% for fasting lipids and 32.3% for blood pressure. Conclusions The data shows that adherence to metabolic monitoring guidelines for AAPs is extremely poor. It demonstrates that the issue deserves further study to determine whether the findings are representative of other academic and non-academic centres. If they are, it is likely that there are many patients suffering from metabolic side effects of AAPs currently going undetected. Improving adherence to metabolic monitoring guidelines could significantly reduce this burden of illness, improving patient health outcomes and decreasing demands on the healthcare system.

625 Language Barriers in Family Practice Offices in BC: A pilot study of using telephone-based medical interpreters

Sarah Grant, BS, New Westminster, BC; Christina Liciu, MD, CCFP; Adaora Ezeaputa, MD

Description:

Context: Having limited English proficiency (LEP) results in health disparities which can be effectively addressed using medical interpreters. However, in British Columbia there is no system for using and funding interpreters in community-based family physicians' offices. Objective: To determine the feasibility of using free telephone based professional medical interpreters through the pre-existing Provincial Language Services (PLS), in family physicians offices in four cities in British Columbia. Design: Program implementation and evaluation. Participants: All 240 family physicians who are members of the Fraser Northwest Division of Family Practice (FNDFP) were eligible for inclusion in the study. Intervention: All family physicians in the Fraser Northwest Division of Family Practice were given information on and provided access to PLS. Through PLS family physicians had access to free telephone based professional medical interpreters in over 150 languages. Participants were advised that they may be contacted after using the service to provide feedback on their experience. Outcome Measures: Quantitative outcomes included frequency of use, length of call, and languages used. Qualitative outcomes assessed were benefits and barriers of using telephone interpretation. Findings: After one year, there were 65 calls by 10 doctors in 14 different languages. Each doctor used the service from 1 to 12 times. The average length of call was 14 minutes. Five of the physicians who had used the interpretation services and five physicians who had not yet used the service were interviewed. Despite reported challenges to using telephone interpretation there was an overall positive view about having the service available. Conclusions: This pilot study demonstrates the feasibility of using telephone

interpreters in family doctors offices. Overall attitudes towards future use of telephone interpreters were positive. Ongoing evaluation is needed to increase uptake of the service and improve efficiency.

626 Hesitancy of Transitioning Care Of Cancer Survivors From the Oncologist to the Family Physician

Trevor Morey, Whitby, ON; Geoff Liu, MD, Toronto, ON; Lindsay Herzog, Toronto, ON

Description:

Objective: The number of cancer survivors is increasing in Canada. However, there is currently no standardized system for transitioning from oncologist to family physician follow-up care. Few studies have investigated cancer survivors' preferences, and the reasons behind them. Participants: were cancer survivors (older than 18, had an established diagnosis of a malignant tumor with curative treatment intent, able to communicate in English, with no significant cognitive impairment) at Princess Margaret Cancer Centre who were candidates for transition back to their family doctor. Instrument: Through a cross-sectional survey, we created a hypothetical alternative model of follow-up care to assess hesitation towards transitioning directly back to family physicians. This alternative was a transitional specialist clinic, where patients would receive care from a specialist nurse or physician to assist in the transition to the family physician. Hesitancy is then measured as preferring this hypothetical model to direct transitioning. Outcomes: We assessed the importance of 11 difference physician characteristics factors and their influence on a cancer patient's preference to receive follow-up care directly from their family physician. Results: Of 230 cancer survivors, 55% were males; with a mean age of 56 years. The diagnoses included 20% breast, 20% colorectal, 14% testicular 12% lung and 33% with other cancers. While 23% preferred to transition directly from oncologist to family doctor, 77% preferred the hypothetical transitional specialist clinic. Patients were more likely to prefer direct transition from oncologist to family doctor if they valued the trust (OR=2.27 [95% CI:1.6-3.1]; $p<0.001$), and comfort (OR: 1.89 [1.41-2.56]; $p<0.001$) of seeing their family doctor. In addition, preference for the alternative model of transition was associated with prioritization of their doctor's skill at diagnosing new cancers (OR: 0.52 [0.32-0.82]; $p=0.005$), and their doctor's knowledge of long-term effects of medications (OR: 0.58 [0.38-0.90]; $p=0.01$) as factors in their choice. Conclusions: Up to three quarters of cancer survivors are variably hesitant to receive cancer follow-up care from their family physicians. Overcoming such hesitancy through patient and physician education may improve the cancer survivor's transition from oncologist to family physician.

627 Identifying Barriers to Physician Provided Smoking Cessation Interventions in the Community

Navjot Rai, MSc, RRT, MD candidate, Etobicoke, ON; John Abrahamson, MD, FRCP, Toronto, ON

Description:

Background: Smoking is the leading cause of preventable death in Canada with more than 37,000 Canadians dying prematurely from tobacco use each year. Physician advice to quit smoking is a known effective component to smoking cessation interventions. Toronto East General Hospital (TEGH) is a funded demonstration site for hospital-initiated smoking cessation interventions that has actively collected smoking profiles on patients that has revealed a lack of community physician counseling and provision of other smoking cessation interventions to patients. To better assess and bridge this healthcare gap, this study examined the health services determinant of health through assessment of barriers and needs of primary care practitioners within the TEGH community in the provision of smoking cessation interventions. Methods: A mixed-methods structured survey was administered to family physicians within the TEGH catchment area to assess the identifiable barriers to providing smoking cessation interventions (primary research question) and identifiable needs to address these barriers (secondary research question). Findings: Preliminary data analysis (N=86) reveals a combination of physician and patient factors cited as common barriers to the provision of smoking cessation interventions including patient motivation, time constraints, cost of interventions, lack of patient compliance and lack of community resources. Further, results have indicated a need for improved access to counseling, reduced cost of interventions and improved physician training. Study Implications: Family physicians have identified a need for further training and supports in the provision of smoking cessation interventions to their patients. By providing targeted resources, the needs of community physicians can be met and can better the health services provided to help achieve better health outcomes.

628 A Family Physician's Guide to Exercise Recommendation

Josh Webb, MD, NCCP1, NCCP2, Fall River, NS; Brittany Webb, BA, BEd, MEd, Halifax, NS

Description:

Objective: To provide family physicians and nurses with a simple, yet comprehensive expansion to the current physical activity guidelines Design: Grounded theory The current JOINT CANADIAN NURSES ASSOCIATION AND THE COLLEGE OF FAMILY PHYSICIANS OF CANADA POSITION statement of: "Children and youth "should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily" and adults "should accumulate at least 150 minutes of moderate- to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more." Does not go far enough to equip family physicians and nurses with the tools and knowledge to best support their community through positive lifestyle modifications. This guide will address preventative measure for preventing loss of muscle and bone density that accompanies aging. This is a relevant and important topic, as family clinicians and nurses are faced with a plethora of illnesses, many of which require remediation through exercise before, during and after surgeries and treatments. Clinicians and residents will be provided with tangible examples to help define exercise recommendations for their patients based on recent studies and research. Participants will be able to apply these principles with confidence when assessing exercise needs for their patients. This poster will aim to provide an expansion on the recommendations from the Joint Canadian Nurses Association and the College of Family Physicians of Canada. These recommendations are based on meta analysis of recent studies in order to provide family physicians with a simple, yet comprehensive list of suggestions that address strength, endurance, and joint mobility. These will be provided by way of photographs, detailed summary of physical activity based

on broader categories of age and patient need. The results of this poster are influential in everyday practice, and will provide concrete, practical exercise programs that are feasible for patients, and easily suggested by practitioners. Family physicians and nurses will be able to apply these principles in a way that is concrete and succinct. This will save time, and increase the likelihood of patient compliance to exercise recommendations and ultimately positively influence health and longevity.

629 **Needs Assessment: The utility of prenatal patient education resources within the SMH AFHT**

Samantha Dunnigan, Toronto, ON; Karen Swirsky, MD, CCFP, Toronto, ON

Description:

Context: Prenatal care reduces perinatal morbidity and mortality, and supports women's medical, social and psychological needs. Pregnant women and unborn children, especially from at-risk, low socioeconomic or non-Western backgrounds, are likely to utilize prenatal care and experience improved health outcomes with prenatal education tailored specifically to their unique healthcare needs. Objective: This study was designed to investigate the utility of the prenatal patient education resources within the St. Michael's Hospital Academic Family Health Team (SMH AFHT), which serves the inner city population in Toronto, Canada. The ultimate goal was to understand care providers' perspectives on strategies for enhancing prenatal patient education resources within this setting to better meet patients' unique needs. Design: This needs assessment study involved mixed methods divided into three phases: 1) Environmental Scan, 2) Survey of Care Providers, and 3) Production of Recommendations. Participants: Staff physicians, nurse practitioners and residents within the SMH AFHT. Instrument: The Environmental Scan of the SMH AFHT involved observing clinic, reviewing the website, performing a document analysis of prenatal patient education materials on Practice Solutions Suite EMR, and meeting with members of the interprofessional team. This process informed the design of the Survey of Care Providers, a four page online survey with questions on current prenatal education practices and future directions. Results and Findings: Of the 110 care providers (68 Staff MD/NP and 42 Residents) in the study population, 27 completed the survey (21 Staff MD/NP and 6 Residents), providing a response rate of 25%. From the environmental scan and survey results, six recommendations have been identified: 1) standardization for sites and visit schedule, 2) identifying specific measurable clinical outcomes, 3) engaging and educating nurses, 4) developing resources, 5) making resources publicly available, and 6) continuing this work as a service learning project. Conclusions: This study has led to an enriched understanding of care providers' perspectives on specific strategies for improving prenatal patient education within the SMH AFHT. By creating a working group to implement these recommendations, we hope to improve prenatal patient education resources within this setting to better meet patient's unique needs.

630 **The Impact of Multi-thematic Longitudinal Curriculum in Family Medicine on Career Choices in Undergraduate Medical Students**

Sreyoshi Alam, Riyadh, Saudi Arabia; Fariha Eshrat, Riyadh, Saudi Arabia; Syeda Mina, Riyadh, Saudi Arabia; Baraa Alghalyini, MD, CCFP, MHSC, Riyadh, Saudi Arabia

Description:

Background To explore the impact of the undergraduate family medicine curriculum that influence the career choice of medical students in this field. We also aim to assess whether any factors in the course have an impact on their interest, which can be reinforced to enhance student interest in family medicine. Summary of work A cross-sectional study, using an anonymous, self-administered online questionnaire, was conducted. Sample included 4th year undergraduate male and female medical students since they were the only batch with equal gender representation, to have completed the family medicine course. Summary of results Overall response rate was 72% (n=105/144). Study respondents were 48.6% males and 51.4% females. Majority of them did not consider family medicine as a career choice before (75.2%) or after (74.3%) completing the course. Assessment of the factors within the course showed that most students considered it to be well-structured, and relevant. Majority understood the relevance of the course at undergraduate level and its relevance to clinical practice. Students agreed/strongly agreed that introduction of family medicine rotations would significantly influence them. A significant majority disagreed that the course positively influenced them. Furthermore, 56.2% of the students did not find the course instructors to be a motivating factor to pursue a career in family medicine. Conclusions In general, most of the participants considered family medicine as an important aspect of the undergraduate medical curriculum. They believe the course illustrated its relevance to clinical practice and delineated the roles and responsibilities of family medicine physicians. However, overall the course failed to stimulate any further learning in the students and had no positive influence on their perceptions towards family medicine as a career choice. Take-home message There is a scope for modification of the course to increase student interest in the field of Family Medicine, and thus encourage more students to pursue a career in Family Medicine.

POSTERS / AFFICHES NOVEMBER 12 NOVEMBRE

610 **Family Medicine--Based Latent TB Screening for Government-Assisted Refugees in Ottawa: Does it work?**

Françoise Guigné, MA, MD, Ottawa, ON

Description:

Introduction: Canadian Guidelines for Immigrant health note the risk of active Tuberculosis amongst refugees is two-fold above the immigrant population in the first year of arrival. Studies state anywhere from 64-67% of reported TB cases in Canada are amongst foreign-born individuals. Effective screening and treatment of Latent Tuberculosis infection (LTBI) amongst refugees is thus imperative but Canadian studies are limited and are based on Montreal data on refugee claimants and immigrants. This retrospective quality improvement project sought to assess how effectively Government-Assisted Refugees (GARs) are being screened and treated for LTBI by the family medicine clinic based Ottawa Newcomer Clinic's (ONC) LTBI screening program. Based on the Ottawa Newcomer Clinic results this study considers whether LTBI screening programs can be effectively designed and operated out of a family medicine setting. Methods: The "New Booking Notification" sheets listing all GARs arriving between January 1st 2012 and December 31st 2012 was used to identify the number of GARs

in the study. GARs were searched in the ONC electronic medical record to identify active charts, documentation of two-step TST results and referrals to the ONC Latent TB Infection Clinic (LTBIC). LTBIC referral charts were screened for LTBI treatment plan and associated side effects. Results: Of 409 GARs identified in the study period, 305 (74.57%) had active charts, 240 of 305 (78.69%) patients completed TST, 64 of 257 (24.90%) completed TSTs were positive and 68 patients were referred to the LTBIC. Of 42 referrals that were followed at the LTBIC, 33 started isoniazid (INH). Of 33 patients, 20 (60.61%) completed nine months of INH. INH discontinuations were primarily from hepatotoxicity and gastrointestinal side effects. Conclusion: High levels of TST completion, and LTBI preventative treatment were observed suggesting that the ONC program is comparable to the Montreal programs and that with the right volume of refugees and centralized set-up family medicine clinic based screening programs can be effective LTBI screening settings for GARs.

611 The Effect of a Structured Versus Non-structured Homebound Seniors Program on Resident Attitudes Toward House Calls

Rahul Jain, MD, CCFP, MScCH(c), Toronto, ON; Jocelyn Charles, MD, MScCH, CCFP;
Debbie Elman, MD, CCFP, FCFP, Toronto, ON; Jennifer Kong, MD, CCFP, Toronto, ON; Annie Hadi, MD, Toronto, ON

Description:

Context: As the number of Canadians aged 65 years and older continues to rise, more attention has been given to home-based healthcare. Homebound seniors have higher rates of diseases, chronic medication use, emergency department visits, hospitalizations, and challenges in accessing care. Despite this growing concern, the number of physicians participating in house calls is declining. Family Medicine residents have generally perceived lack of training as a significant factor limiting their likelihood of pursuing house calls in the future. Many academic centres have looked into instituting a structured homebound seniors program as part of residency training to improve resident knowledge, skills, attitudes, and confidence in performing house calls. Objective: To determine the effect of a structured versus non-structured homebound seniors program on resident attitudes towards house calls Design: Survey research Participants: Family Medicine residents (PGY1 and PGY2) from all 15 teaching sites at the University of Toronto (sample size 94 residents). Intervention: A survey was distributed to Family Medicine residents at the University of Toronto. Outcome Measures: Sites having either a structured or non-structured homebound seniors program implemented in the residency curriculum were compared to assess if there is a difference in resident perception of house calls. A needs assessment of resident perspective on improving the house call curriculum was also performed. Findings: The study demonstrated with strong statistical significance that structured programs compared to non-structured programs increase resident exposure, positive attitudes, confidence and plans of pursuing house calls in their future practice. Similarly, a strong correlation of increasing exposure to house calls was associated with higher resident satisfaction. The needs assessment demonstrated that training on billing, procedures, having increased supervision, and greater exposure to house calls would improve their experience during residency. Conclusions: There are positive implications of this study for the healthcare system, medical education system, practitioners, patients and families in improving and sustaining care for homebound seniors which can be implemented at a national level.

612 Atelier de formation professorale sur la supervision clinique hospitalière en médecine familiale

Sarah Numainville, MD, CCMF, Saint-Augustin-de-desmaures, QC; Johanne Théorêt MD, CCMF, FCMF, MA;
Bernard Boudreau MD, PhD;

Description:

Contexte : Le Collège des médecins de famille du Canada (CMFC) recommande que les résidents en médecine familiale dispensent des soins cliniques en milieu hospitalier supervisés par des médecins de famille. Cette attente du CMFC nécessite une formation du corps professoral à ce sujet. Objectifs : Identifier les besoins de formation professorale concernant la supervision en milieu hospitalier; Implanter un atelier de formation professorale selon les besoins identifiés; Évaluer un atelier de formation professorale. Plan : Développement, implantation et évaluation d'un atelier de formation professorale. Participants : Les médecins de famille supervisant les résidents en milieu hospitalier lors de leur stage en médecine familiale, affiliés aux douze Unités de Médecine Familiale (UMF) de l'Université Laval. 14 médecins de famille ont participé à l'atelier de formation professorale pilote. Intervention : Une étude de besoins à devis descriptif mixte a été réalisée auprès de la population cible. L'atelier de formation professorale a été développé selon le modèle de Kern. L'évaluation de l'atelier a été réalisée selon le modèle de Kirkpatrick. Mesure des résultats : L'évaluation de l'atelier a été réalisée sous forme de questionnaire électronique avant, immédiatement après et six semaines après l'atelier. Le questionnaire a évalué l'appréciation, les apprentissages effectués et l'impact de la formation sur la supervision en milieu hospitalier. Résultats : L'étude de besoins a démontré les sujets prioritaires pour l'atelier. L'atelier a été apprécié par les participants, qui ont eu une amélioration globale de leurs connaissances. Les attitudes, en termes de degré de confort et de réalisme, se sont améliorées, à l'exception du réalisme ressenti concernant l'intégration des moments d'enseignement lors d'une erreur médicale et l'évitement de toute poursuite médico-légale impliquant un résident. Ils ont augmenté la fréquence d'application des activités enseignées, à l'exception de l'enseignement au résident lors d'une erreur médicale. Conclusion : L'atelier de formation professorale a répondu aux besoins de formation des médecins de famille superviseurs en milieu hospitalier. L'enseignement au résident lors d'une erreur médicale est jugé difficile. Une formation professorale plus approfondie à ce sujet serait recommandée, surtout avec la venue des CanMEDS 2015 et l'intégration de la sécurité au patient.

613 The Transition Into Academia of New Family Medicine Faculty

Michelle Levy, MD, CCFP, FCFP, London, ON; Judith Brown, PhD, London, ON; Sudha Koppula, MD, MCIsc, CCFP,
Edmonton, AB

Description:

Capacity building in academic Family Medicine needs not only the continued infusion of talented new faculty, but also the successful transition and growth of such individuals within the academic setting. There is a paucity of literature on the process of becoming an academic faculty in Canadian Family Medicine Departments and the impact this may have on recruitment and retention.

Objective: To examine the experience of new, full-time academic faculty in Canadian Departments of Family Medicine as they transitioned into academia. **Design:** Qualitative study using a phenomenological approach. **Setting:** Eight Canadian Departments of Family Medicine. **Participants:** English speaking academic family physicians, on faculty at a Canadian Department of Family Medicine for more than one and less than five years. **Purposeful sampling** was done to represent geographical and gender differences. Thirteen interviews were performed before saturation was achieved. **Instrument:** Data was collected using semi-structured in depth interviews. Interviews were audiotaped and transcribed verbatim. The transcriptions were reviewed by all investigators independently and then analyzed together in an iterative and interpretive manner. **Outcome Measure:** Themes emerging from the qualitative analysis. **Findings:** Key themes identified included orientation, transition to academia, and seeking a balance. Orientation was often lacking or suboptimal, leaving participants discontented and left to navigate the transition process alone. Challenges in transitioning to academia crossed over multiple roles including clinician, teacher, researcher and administrator. Uncertainty of role categories and time allotted to each led to participants facing the third theme, seeking a balance, between their professional roles and personal needs. **Conclusions:** The transition to an academic faculty position in family medicine is substantial, often with minimal preparation. The presence of an orientation appears to be one of the factors needed to ameliorate the sense of being overwhelmed. Senior leadership needs to guide new faculty in the preparation and adaptation to their various role categories.

614 **Un nouveau diplôme de santé de la famille et santé communautaire en 2015 au Maroc**

Josette Castel, MD, MSc, CCMF, FCMFC, Quebec, QC; Safwane Mouwafaq, MD, Enseignant Chercheur à l'École Nationale de Santé Publique du Maroc (ENSP); Chakib Nejari, MD Professeur en Médecine, Directeur de l'École Nationale de Santé Publique du Maroc (ENSP)

Description:

Introduction : Au Maroc le Ministère de la Santé fait le constat de l'inadéquation de la formation du médecin généraliste (MG) par rapport aux exigences de la première ligne, de la nécessité de redynamiser les soins de santé primaires et de revaloriser la médecine générale. Le Ministère s'est engagé à offrir une formation orientée vers la prise en charge de la santé de la famille et de la communauté. La discipline de la médecine familiale n'existe pas au Maroc. **Objectifs :** Développer un diplôme de santé de la famille et santé communautaire pour la mise à niveau des MG **Participants :** MG dans les établissements de soins de santé de base (ESSB) **Méthodes :** Suite à une étude de faisabilité, création d'un programme de formation en partenariat entre l'ENSP et la direction des hôpitaux et des services ambulatoires du Ministère. Conception de contenus par un coordonnateur pédagogique de l'ENSP et les enseignants de l'école, soutenu par un appui technique d'une consultante du Québec. **Résultats :** Formation de 2 ans adaptée à la réalité de la pratique des MG dans les ESSB selon les caractéristiques de la médecine générale/médecine de famille de la WONCA. Le programme se base sur un référentiel de compétences en 4 domaines : prise en charge intégrée et globale du patient, prévention et promotion de la santé et développement communautaire, gestion de la circonscription sanitaire, encadrement et développement professionnel. 10 modules avec enseignement en classe et stages permettent l'intégration du nouveau rôle du MG en plus de séminaires de mises à niveau clinique selon les besoins d'acquisition de compétences exprimés par les MG. **Discussion :** La pertinence de tenir cette formation dans une école de santé publique est à souligner. **Conclusion :** Ce programme innovateur est une initiative d'envergure pour développer la médecine de famille au Maroc et améliorer la prestation des soins de santé primaires.

615 **Development and Evaluation of a Program to Introduce Medical Humanities to Teachers of Clinical Medicine**

Leonard Bloom, MDCM, CCFP, FCFP, Ottawa, ON; Lynn Bloom, MSW, RSW; Doug Archibald, PhD, CCFP; Ottawa, ON; Catherine Robertson, MD, FRCPC; Robert Parson, MEd; Mary Arseneau, PhD; Jean Roy, MD, FCMF

Description:

Introduction: Within the Faculty of Medicine, University of Ottawa, as well as elsewhere, the medical humanities have been identified as a focus of curriculum enrichment. While an increasing number of University of Ottawa medical faculty have introduced humanities into their teaching, and a compilation of creative works has been developed, there are no specific faculty training workshops demonstrating how these works can be used. The overall goal of this workshop series is to increase the knowledge base and skills of our clinical educators in the medical humanities. It is anticipated that the provision of a theoretical overview of four defined areas – Narrative Medicine, History of Medicine, Visual Thinking Strategies, and Theatre-Based Methods – combined with reflective exercises and teaching tools within these areas, will assist faculty in the subsequent introduction of humanities-based material in small group teaching. **Methods:** A multiple methods approach is being used to evaluate the impact of the four training modules. Informed consent to participate in the study is requested at the beginning of each workshop. Participants complete brief surveys about their experiences with the relevant facet of medical humanities immediately before and after each workshop, and again 3-6 months later. Semi-structured interviews are being conducted to determine the impact of the workshop on the teaching practices of participants. This method will allow for the triangulation of aggregate data from the session evaluation surveys with the qualitative information from semi-structured interviews. **Results:** Results from three of the four workshops will be presented. Findings to date include a positive response to a workshop on Narrative Medicine, History of Medicine, and Visual Thinking Strategies, and newly inspired teaching goals among workshop participants. Participants have indicated greater awareness of humanities-based resources after attending sessions. More concrete examples have been requested on how to incorporate humanities based resources into teaching. More time is needed to determine impact: not all tutors have had a chance to teach small group sessions **Conclusion:** Feedback to date shows a receptiveness to medical humanities among educators and a growing interest in incorporating narrative techniques, a historical context and arts-based methods into medical teaching.

616 **Patients Living With Disabilities: The need for quality primary care**

Aisha Lofters, MD, PhD, CCFP, Toronto, ON; Sara Guilcher; James Milligan; Joseph Lee; Niraj Maulkhan

Description:

Objective: To compare potential risk factors for lower quality primary care, potential markers of unmet needs in primary care, and willingness to link medical records with provincial databases for research among primary care patients with versus without disabilities. **Design:** A waiting room survey using a convenience sample. **Setting:** A Family Health Team in Kitchener-Waterloo, Ontario. **Participants:** 40 patients seen at a designated Mobility Clinic and 80 patients from the general patient population. **Main outcome measures:** Socioeconomic status and social capital, number of self-reported emergency room visits and hospitalizations in the preceding year, and willingness of the patients in the two groups to link their medical records and primary data with provincial administrative databases for future research studies. **Results:** Patients

from the Mobility Clinic were more than twice as likely to be on benefits or social assistance (75.0% vs. 32.1%, $p < 0.001$), were twice as likely to report an annual household income of less than \$40,000 (58.6% vs. 29.2%, $p = 0.006$), and were more likely to report their health status as fair or poor (42.5% vs. 16.3%, $p = 0.002$). Half of Mobility Clinic patients had visited the emergency room at least once in the preceding year, compared to 29.7% in the general patient population ($p = 0.027$). When asked if they would be willing to provide their health card number in the future so that it could be linked to health care data for research, 82.5% of Mobility Clinic patients agreed versus 55.0% of those in the general patient population ($p = 0.004$). Conclusion: In this study, patients with disabilities were at a social disadvantage to their peers without disabilities and were more likely to use the emergency department, suggesting that they had unmet health needs. Future research should continue to explore this patient population and to investigate if an inter-professional primary health care team approach focussed on patients with disabilities can help to increase quality of care.

617 Performance of Family Medicine Residents on the CFPC Certification Exam

Shirley Schipper, MD, CCFP, Edmonton, AB; Shelley Ross, PhD, Edmonton, AB; Judith Belle-Brown, PhD, London, ON; Carlos Brailovsky, MD, Laval, QC

Description:

BACKGROUND: All Family Medicine residents in Canada, including International Medical Graduates (IMGs), write the national certification exam in the last 6 months of training. Nationally, in both the written and oral parts of the exam, IMGs perform less well than Canadian trained Medical Graduates (CMGs). Candidates who fail the certification exam are not able to practice in some regions in Canada, and only with a restricted license. To rewrite the exam is both stressful and expensive. **OBJECTIVE:** To determine the reasons why candidates fail the certification exam, particularly the simulated office oral (SOO) portion of the exam. **METHODS:** SOO exam papers for those candidates that failed were reviewed for scoring and examiner comments. Themes of comments were analyzed and categorized. **RESULTS:** We outline the 2013 and 2014 Spring and Fall exam results, themes in examiner comments on failed papers and explore patterns seen in candidates who failed the SOO (simulated office oral) portion of the exam. **DISCUSSION:** Providing insight into performance for both CMGs and IMGs may help residency programs in exam preparation activities, knowing which areas to focus in remediation training, and tailoring programs to increase exposure in specific areas. This may improve the pass rate for all residents in the future.

618 Knowledge and Interest in the Postcoital Intrauterine Device Among Women Seeking Emergency Contraception

Sheila Dunn, MD, MSc, CCFP (EM), FCFP, Toronto, ON; Dilzayn Panjwani, MSc, Toronto, ON; Ciara Pendrith, MSc, Toronto, ON; Anna Ly, Toronto, ON; Christine P. Edwards, Toronto, ON

Description:

Context: There are two methods of emergency contraception (EC) which can be used to reduce the risk of pregnancy after unprotected intercourse: hormonal EC (levonorgestrel pill) and insertion of a copper intrauterine device. The IUD offers much higher effectiveness and also provides highly effective ongoing contraception, but many women are unaware of its use for emergency contraception. **Objective:** This study sought to determine knowledge and interest in the postcoital IUD among women seeking emergency contraception. **Design:** Paper-based survey. **Participants:** convenience sample of women aged 16-50 years, able to read English and requesting emergency contraception at 2 sexual health clinics in Toronto from January 2013-July 2014. **Study Instrument:** A 39-question survey was adapted for a Canadian context from 2 US questionnaires used to determine knowledge and interest postcoital IUDs. Questions asked about demography, sexual health history, and respondents' knowledge about IUDs and their interest in using the postcoital IUD. **Outcome measures:** Knowledge about the IUD and interest in using it for EC. **Results:** One hundred and twenty-four women completed questionnaires. Mean age was 25.6 years (SD 6.6). Most respondents were Canadian-born (69%), single (80%), students (40%) or in full-time employment (38%), and had post-secondary diploma or degree (73%). The most common reasons for needing EC were condom failure (37%) and failure to use birth control (28%). Seventy-six percent of respondents had previously use EC and 36% had had a prior abortion. Most women (77%) had heard of the IUD but only 21% knew it could be used for emergency contraception. Sixty-six percent of women indicated they did not want an IUD, but 18% were interested, 6% booked to have one inserted that day and 9% were unsure. The most common reasons for not wanting an IUD were, not knowing enough (24%), needing time to think (16%) and not having the time for insertion (15%). **Conclusions:** Most women seeking EC were unfamiliar with the postcoital IUD, but a sizeable minority were interested in using it. This study emphasizes the need for promoting knowledge about all options for EC.

619 Management of Osteoporosis Through an Evidence-Based Pilot Program

Anne Souter, MD, CCFP, FCFP, London, ON; Emily Stoll, London, ON; Andrew Dawson, London, ON; Cathy Faulds, MD, CCFP, FCFP, London, ON; Ciara Walsh, BA, London, ON

Description:

Context: Although osteoporosis has significant system and patient impact, little has been done to develop effective programs for management at the primary care level. Using evidence-based guidelines, physicians from the Primary Care London FHO have developed a pilot program to better manage osteoporosis through improved patient outcomes. **Objective:** The aim was to improve outcomes for patients with osteoporosis, while ensuring that our care was patient-centered, evidence-based, and applicable in a primary care setting. **Design:** We have created a before-and-after study that examines how our intervention has impacted our outcomes. **Participants:** From an initial target screening population of 2468, 451 patients have been diagnosed with osteoporosis and managed and treated through our program. **Intervention:** We designed our program using evidence-based guidelines to determine appropriate methods of treatment, timelines for screening and management, and outcome parameters. We built EMR templates for clinical visits and tracking of outcome measures. Standardized BMD orders, blood work requisitions, and the FRAX calculator were embedded into our EMR to ensure ease of ordering and to assist in risk categorization. Currently, low-risk patients are sent a standardized letter through the EMR containing their diagnosis and healthy lifestyle information. Moderate and high-risk patients

are booked for an appointment using the Osteoporosis Treatment Plan template. Data is recorded on a spreadsheet containing the process, outcome, and balance measures deemed appropriate by local specialists and our Osteoporosis Pilot Group. Outcome Measures: Patients that were diagnosed with moderate to severe osteoporosis were tracked for: frequency of visits for osteoporosis, frequency of BMD, prior and recent T-scores, ordering of thoracolumbar x-ray, FRAX score, self-management, fragility fractures, falls, and pharmacotherapy. Results: Baseline data has been collected and monthly review of our measures has begun. We have seen an increase in visits dedicated solely to osteoporosis. Additionally, the percentage of the eligible patient population sent for diagnostic BMD scans has improved from 30% to over 50%. Conclusions: Our results indicate a stronger focus on preventative management of osteoporosis by the physicians within the Primary Care London FHO.

621 Selection for Family Medicine Residency Training: Is it time to sharpen our tools? A study of the consistency of selection processes between programs in Canada

Keith Wycliffe-Jones, MBChB, FRCGP, CCFP, Calgary, AB; Shirley Schipper, MD, CCFP, Edmonton, AB; Maureen Topps, MB, ChB, CCFP, FCFP, PBDM, Calgary, AB; Kent Hecker, PhD, Calgary, AB; Jeanine Robinson, BA, MPA; Tasnima Abeda, Calgary, AB

Description:

Context This study examines the consistency of the ranking of Canadian Medical Graduates (CMG's) who applied to Canadian Family Medicine Residency Programs between 2007 and 2013. Previous UK research revealed a very low level of consistency in the ranking of medical student applicants to General Practice training. Canadian FM Programs are more heterogeneous than in the UK but the expected outcome of training is still a Family Physician who can practice anywhere in Canada and many of the listed selection criteria by programs are the same. Objective This study questions whether there is a high level of consistency in the ranking of the same applicants by Family Medicine Residency Programs, particularly those seeking similar attributes. Methods Anonymised ranking data from all 17 FM Residency Programs for the first iteration of the Canadian Resident Matching Service process for CMG's who applied to more than one Family Medicine Residency Program or site between 2007 and 2013 was used for this study. Ranking data of applicants were analyzed for inter-school (within student) agreement using hierarchical linear models. The within- and between- student covariance parameters were also used to calculate the intra-class correlation (ICC). Overall inter-school analysis was completed for years 2007 to 2013. In addition, sub-set analysis on groups of programs and sites identified as similar (e.g. rural) was also carried out for the 2013 match cycle. Results Overall, there is weak consistency in the ranking of the same students amongst Canadian FM Residency Programs. (ICC =0.365). More detailed analysis shows there is slightly less variability in the ranking of students who apply to programs identified as being "rural"(ICC 0.362-0.552) but still very low consistency of ranking of students by programs/sites identified as being more urban-based (ICC=0.271). Conclusions The current selection processes for Canadian Family Medicine Residency Programs are inconsistent. This could have implications for selection for Family Medicine Residency training in the future.

622 A Canadian Needs Assessment of Health Care Professionals in Binge Eating Disorder Management

Richard Ward, MD, CCFP, FCFP, Canmore, AB; Michael Vallis, PhD, R.Psych, Halifax, NS; Hany Bissada, MD, FRCPC, Ottawa, ON; Josée Guérin, DtP, BSc, Montreal, QC

Description:

Objective: To identify the learning needs of Canadian health care professionals (HCPs) in binge eating disorder (BED) management. Methods: Between December 2014 and January 2015, over 15,000 Canadian HCPs specialized in eating disorders (EDs) (dietitians, family physicians, psychiatrists, psychologists, combined) were invited to complete an online questionnaire to assess their level of understanding and comfort in the management of BED. A total of 365 HCPs seeing ED patients in their practice completed the questionnaire. Results: Dietitians, family physicians, psychiatrists and psychologists comprised 38%, 31%, 17% and 9% of respondents, respectively. The survey revealed that 90% of respondents never received formal training on BED. Only 30% of respondents describe BED as a distinct diagnostic entity, while 60% consider BED as part of a spectrum of EDs. While 41% recognize the lack of compensatory behaviour as the main differentiator of BED, 13% relate it to poor impulse control. Responses showed high levels of ambivalence with respect to prevalence, onset and diagnosis. Only 24% attested to making a positive diagnosis of BED. Only 39% of respondents consider the psychopathology underlying the condition as the main treatment goal for patients. Several inconsistencies in the level of understanding and comfort in managing BED between specialties were apparent. Lack of training, communication and psychiatric co-morbidity management were identified as common challenges. Conclusions: This assessment suggests significant knowledge gaps in the optimal management of BED patients. There is a need to improve the expertise amongst various HCP specialties involved in BED patient care.

631 FIFE Yourself: Two minutes of mindfulness a day toward physician resilience

Douglas Cave, MSW, RSW, PhD, RPsych, MA, AMP, Vancouver, BC

Description:

Physicians who learn the Patient-Centred Care Model learn to FIFE their patients. They learn to assess the patients' feelings, ideas, function and expectation regarding the patients' chief complaint. Physicians are well trained in how to care for others. They are less well trained in how to care for themselves. Medical education engenders competitiveness, perfectionism and impression management. One way impression management presents is that many physicians struggle to seek personal help when it is needed. Unfortunately, burnout and other critical effects are the result. Mindfulness-based techniques are beneficial and mitigating tools to manage some of the ill effects of working in medicine. Self FIFE is an innovated technique whereby physicians use a memory cue each day as a reminder to ask themselves a set of 4 reflective questions regarding their own feelings, ideas, function and expectation. This research is about testing the efficacy of the 2-minute-per-day self-FIFE tool. Being prompted by a self-selected memory cue, participants of this study were invited to ask themselves 4 self-reflective questions. The study occurs over an 8-week period which is the standard length of time given to assess other mindfulness programs. Participants were invited to complete a battery of measures including the Beck Depression Inventory II, Beck Hopelessness Scale, Maslach Burnout Inventory, State-Trait Anxiety Inventory, Life Satisfaction Scale and some demographic questions as baseline measures. After an 8-week period the participants will be invited to complete the test battery again as a post-test measure of change. Cohen's d will be used to

measure any effect of the 8-week program. Results are pending because data is being collected at this time. Since the study is being done with people who are motivated to participate in research; it is anticipated they will already score in the more positive range of the scales. As a result, the effect of the self-FIFE tool will likely be measured as small. If self-FIFE does have an effect, then it may be taught with greater confidence to help maintain physician resilience.

632 Village Health Empowerment Programme: Engagement and evaluation

Vivian Ramsden, RN, PhD, Saskatoon, SK; Jessica Winter, Regina, SK ;Erin Russell, Saskatoon, SK;
S. Kanchana, RN, PhD, Chennai, India; K.R. Rajanarayanan, MD, Chennai, India; Kim Sanderson, PhD, Saskatoon, SK;
Vivian Ramsden, RN, PhD, Saskatoon, SK

Description:

Context: To engage and empower rural villages served by Omayal Achi Community Health Center (OACHC), Arakampakkam, India. Objective: To evaluate the non-communicable diseases screening programme (e.g. high blood pressure, diabetes) being undertaken by Village Health Workers at a Kiosk. Design: The overall design of this study was informed by the integration of community-based participatory research, transformative action research and program evaluation. Participants: Village Health Workers. Instrument: Checklist co-created by Registered Nurses, researchers and undergraduate medical students (India & Canada). Outcome Measures: The Checklist included all procedures and measurements expected to have been performed at the Kiosks where the Health Empowerment Programme had been implemented. Results: Generally, height, weight, and waist circumference were correctly measured. The significance of values such as BMI, blood pressure and blood glucose were not well understood by the Village Health Workers. Areas for improvement included: proper blood pressure measurement; recording of measurements; and, explanations of procedures and measurements. Participants indicated that the Kiosk was convenient; however, there was a lack of awareness about its presence within the villages. In addition, participants expressed a desire for medicines to be made available at the Kiosk because it was closer to their homes. Conclusions: The Kiosk was well received by those villages that participated. Improving adherence to the procedures and measurements listed on the Checklist may result in enhanced prevention and management of chronic disease within villages served by OACHC.

633 Interprofessional Collaboration in Family Medicine Simulation: Experience with a pilot mini-course

NatalieKennie-Kaulbach, BScPharm, PharmD, Halifax, NS; Joanna Zed, MD; Karen McNeil, MD; J Szabo; K Hayward

Description:

Context: A focus of primary health care reform has been a shift to teams of providers delivering comprehensive services. Currently, there are limited opportunities for students to participate in interprofessional education (IPE) experiences in the primary health care setting. Objective: This project describes the delivery and student evaluation of a pilot mini-course for interprofessional collaboration in Family Medicine. Design: Description of course developed and course evaluation Participants: Undergraduate students from medicine, nursing, pharmacy and social work Intervention: A six hour, three week mini-course was developed. Over a three week period students were introduced to key concepts (role definition, interprofessional communication, collaboration, primary health care) through a combination of online audio presentations, readings, and discussion groups and utilization of high contextual fidelity simulation. Working together student teams interviewed a simulated patient, played by an actor, and developed a collaborative care plan. The session concluded with a debriefing on the interprofessional experience and opportunities for collaboration in primary health care. Outcomes Measures: Students were e-mailed a feedback survey at the end of the course to evaluate student satisfaction and experiences. Results: A total of 18 students making up 5 teams of undergraduate students from medicine, nursing, pharmacy and social work completed the course. Seventeen (17) feedback surveys were completed. Respondents indicated a better understanding of their professional role and how they might work with other providers, as well as more confidence in and a stronger commitment to practicing interprofessionally. Respondents indicated they most liked the case, simulated patient interaction and team work. Suggestions made to improve the program will be considered for the next offering. Conclusions: This IPE course was well received by students and was successful in fostering competencies and commitment to interprofessional collaboration.

635 A Checkup on Clinical Tools: Needs assessment of primary care providers in Ontario

Katie Hunter, MSc, Toronto, ON; Amanda van Hal, BSc, Toronto, ON; Apurva Shirodkar, PhD, Toronto, ON;
Lena Salach, MA, Toronto, ON

Description:

Context: The Centre for Effective Practice (CEP) is collaborating with the Ontario College of Family Physicians (OCFP) and Nurse Practitioners' Association of Ontario (NPAO) to develop and disseminate health information and clinical tools for primary care providers (PCPs; family physicians and primary health care nurse practitioners). As a first step in this initiative, a needs assessment was conducted with PCPs in Ontario to determine their information needs and communication preferences. Objectives: To better understand the perspective of PCPs on: 1. Key elements of clinical tools; 2. Clinical topic prioritization from a pre-determined list; and 3. How to best communicate with and engage PCPs. Methods: An online survey was developed in order to gain input from PCPs across the province in a cost effective and timely manner. The survey was developed, pilot tested and distributed to family physicians (via OCFP) and primary health care nurse practitioners (via NPAO). Over 10 weeks, 810 responses were received. Only complete responses (n=640) were included in the final analysis. Results: Respondents were asked to rate the importance of a number of factors that would determine whether they would utilize a clinical tool. The three factors most frequently identified by respondents as being important to them were: relevance to their practice (97%), topic area (97%), and having the time available to utilize the material (94%). PCPs responding to the online survey indicated that they preferred clinical tools to be communicated via email (84%), from

a recognized expert (63%) or posted on a website (57%) and survey respondents most often indicated that they would like to receive clinical tools at least once a month (29%). Additional results, including preferred topic area(s), will be presented and discussed. Conclusion: The findings will be used to inform activities for the Knowledge Translation in Primary Care Initiative. Results will help to ensure the development and communication of clinical tools for PCPs is reflective of their needs and preferences.

636 Social Accountability and Rural Generalist Training at Memorial University

James Rourke, MD, CCFP (EM), MCISc, FCFP, FRRMS, FCAHS, LLD, St John's, NL; Kristin Harris Walsh, PhD, St John's, NL; Danielle O'Keefe, MD, CCFP, MSc, St John's, NL; Scott Moffatt, MD, CCFP, FCFP, St John's, NL; Mohamed Ravalia, MD CCFP, FCFP, Twillingate, NL; Wanda Parsons, MD, FCFP, St John's, NL; Norah Duggan, MD, CCFP, St John's, NL; Katherine Stringer, MB ChB, CCFP, St John's, NL; Janelle Hippe, MA, St John's, NL

Description:

Context: Memorial's Faculty of Medicine's social accountability mandate focuses on educating physicians for rural generalist practice in a province with large geographic space and widely disbursed population. It supports many "pathways to rural generalist practice" and provides training for the specialized skills and contextual learning required. Objective: To determine Memorial's success in recruiting rural students, providing rural educational opportunities, and producing rural doctors. Design: Data was drawn from the Learners and Locations database at Memorial University and includes admissions, One45, Canadian Medical Directory, and Statistics Canada population data. SPSS was used to analyze statistics and ArcGIS was used to produce maps. Participants: Participants are MUNMED grads 2011-2012 (N=120). Intervention: Memorial's MD Education program. Outcome Measures: This study measured the educational pathways for MUNMED 2011-2012 graduates: their backgrounds, where they completed their education, their residency locations, and their current practice location. Results: Of 120 students who graduated from 2011 to 2012, 31.7% had rural backgrounds. MUNMED students graduating in 2011 and 2012 spent 18% of all placement weeks in rural areas: 89% in first year and 95% in third year (Family Medicine). For 25 MUNMED grads 2011-2012 who did FM residencies at MUN, 34% of placement weeks were spent in small rural communities or small rural cities. Of 30 MUNMED grads 2011-2012 practicing Family Medicine in Canada as of January 2015, 13 (43%) were practicing in small rural communities or small rural cities. Of 22 MUNMED grads 2011-2012 practicing Family Medicine in NL as of January 2015, 11 or 50% were practicing in small rural communities or small rural cities. Conclusions: There is excellent external evidence that Memorial's pathways to rural generalist practice approach is effective and successful. In 2010 and 2013, Memorial received the Keith award from the SRPC for having the highest percentage of Family Medicine training program graduates (52% and 44% respectively) working in rural practice 10 years after graduation. The results of this study indicate continuing success.

637 Involving Family Physicians in Early Identification of Eating Disorders: A national survey

Ahmed Boachie, MB, ChB, DCH, MRCPsych, FRCPC, FAED, Newmarket, ON; Pierre-Paul Tellier, MD, CCFP, Montreal, QC; Patricia Mousmanis, MD, CCFP, Richmond Hill, ON; Karin Jasper, PhD, RP, Newmarket, ON; Debra Katzman, MD, FRCPC, FAED, Toronto, ON

Description:

Context: Children and adolescents with early onset eating disorders, who receive treatment within two years show better outcomes, particularly with family-based treatment. Early identification and treatment may also lower health care costs. Family physicians are in a unique position to identify eating disorders early. The revisions of the DSM 5 endeavour to address the issue. Objective: To understand factors that will assist family physicians in the early identification and management of eating disorders in children and adolescents, specifically to learn family physicians' current awareness of early warning signs of eating disorders and the extent to which they manage these disorders in their own practices. Design: The study is a survey with multiple-choice questions, requiring 5 minutes of physicians' time. It has been implemented as a pilot and will be implemented on a national level. Participants: In the pilot, family physicians who referred patients to an eating disorder program were called and asked if they would consider completing the questionnaire. It was faxed to those who agreed. In the National study, all family physicians registered with the College of Family Physicians of Canada will be invited to complete an online version. Results: Pilot study physicians assessed patients between the ages of 12 and 18 over the preceding year. Most common diagnoses were bulimia, anorexia, and avoidant/restrictive food intake disorder (ARFID). Physicians were effective in recognizing classic eating disorder symptoms but most missed the non-specific symptoms characteristic of early onset. All physicians endorsed as either likely or very likely that they would use a screening tool, immediate referral to a specialist service, and a practice-based learning program (PBLP) for eating disorders, if these were available. A PBLP was endorsed as increasing the likelihood that family physicians who do not currently manage these patients in their practices would do so. Conclusions: The pilot study suggests that without further training for family physicians, we will continue to struggle with early identification. A PBLP, an initial screening tool, and immediate referral to a specialist service would be valued by family physicians. The National study will provide greater understanding of these important issues.

638 1-800-Imaging Pilot: Building partnerships between primary care and medical imaging

Karen Weiser, MBA, Toronto, ON; Lilly Whitham, Toronto, ON; Pauline Pariser, MSc, MD, CCFP, FCFP, Toronto, ON; Heidi Roberts, MD, FRCPC, Toronto, ON; Catherine Wang, Toronto, ON; Paul Cornacchione, Toronto, ON; Corwin Burton, Toronto, ON; Christina Ciapanna, Toronto, ON

Description:

The 1-800-Imaging pilot is a virtual hub designed and implemented by The Joint Department of Medical Imaging in partnership with Women's College Hospital Institute for Health System Solutions and Virtual Care (WHIV) and Seamless Care Optimizing the Patient Experience (SCOPE). The pilot was designed according to the Institute for Healthcare Improvement principles of the "Triple Aim" to improve patient/provider experience of care, better population health, and lower per-capita costs of care. Primary Objective: To improve integration between community primary care providers (PCPs) and a tertiary sub-specialized medical imaging department to facilitate urgent imaging (when appropriate) and provide navigational and consultative services. The goals of the pilot were to reduce inappropriate imaging orders and emergency department visits, and to improve patient and provider experience. Participants: Sixty Toronto physicians registered in the SCOPE Program and who are not members of a Family Health Team. Intervention: Calls to the virtual hub were answered and coordinated by a

clerical staff in real-time and directed to a radiologist as required. The following services were offered: 1. Appropriateness Consult 2. Radiology Consult 3. Urgent Imaging 4. Urgent Reporting 5. General Informational Requests Findings: From May 2014 to March 2015, the following results were found: • 227 calls received - 103 requests for urgent imaging - 40 appropriateness consults - 10 radiology consultations - 7 requests for expedited reports - 67 requests for information • 36 unique callers (60% of pilot audience) • 22 users accessed the call centre multiple times (61% of callers) Participating physicians reported that 40 emergency department visits were avoided by accessing the call centre and 40 appropriateness consultations supported callers in ordering imaging that was most appropriate for their patients. Of 42 post-call surveys, 100% were satisfied with the service and 100% stated that they would recommend the call centre to their colleagues. Conclusions: • A call centre is an effective model for PCPs to ask questions and navigate complex medical imaging centres • PCPs value conversations with radiologists to gain clinical insights and validation • Sustainability and scalability require dedicated operational resources and a roster of on-call radiologists

639 Use of a Quality Improvement Strategy to Increase Flu Immunization Rates Among Racialized Groups

Ankur Jain, MD, Toronto, ON; Abel Gebreyesus, MHI, Toronto, ON; Liben Gebremikael, MA, Toronto, ON; Nancy Akor, RN, Toronto, ON; Onye Nnorom, MD, CCFP, MPH, FRCPC, Toronto, ON;

Description:

Context: Previous studies have shown influenza vaccination rates remain low across Canada (30-40%), but rates also vary by subpopulation. TAIBU Community Health Centre has a mandate to provide primary healthcare services to the Black Community and also serves the largely immigrant population in Malvern. Despite efforts to provide regular flu clinics, vaccine rates at TAIBU were less than 10% for three years. In 2013, TAIBU conducted a qualitative assessment, documenting reasons for flu vaccine refusal in patient charts and analyzing the most common responses, which included: (1) lack of familiarity with the influenza vaccine; (2) mistrust of the vaccine; (3) and the statement "I never get the flu." Based on these results TAIBU's Prevention & Screening Taskforce identified key interventions to address immunization barriers. Objective: To evaluate the impact of targeted initiatives in increasing influenza vaccination rates at TAIBU CHC. Design: Quality Improvement Planning & Evaluation Population: Patients at TAIBU CHC Intervention: A multi-pronged approach was used to address barriers to influenza immunization. (1) Reminder calls were made to the clients of TAIBU CHC about the upcoming flu clinics, prioritizing high-risk patients. (2) Flu vaccine posters specifically targeting the Black community were also placed at noticeable locations with details about upcoming flu clinics. (3) Healthcare providers were reminded regularly to offer the influenza vaccine to clients. (4) Flu fact sheets from Toronto Public Health were distributed to providers guide conversations with patients and nursing staff provided counselling on the flu vaccine to patients. Results: 300 calls were made to clients (majority were high-risk) between October 1 and November 30, 2014. Overall, influenza vaccinations increased from 9% in the 2013-14 flu season to 21.78% in the 2014-15 season. High-risk influenza vaccinations were up to 45.06%. Conclusions: Although patient misconceptions about the influenza vaccine and underestimation of susceptibility to influenza have been barriers at TAIBU CHC, the use of a multifaceted strategy to respond to patient concerns resulted in a 12% increase in influenza immunization rates.

649 The Virtual Ward: How to keep patients at home? ... (safe) L'Unité Virtuelle : Garder les patients à la maison en sécurité

Bernardo Kremer, Montreal, QC; Isabelle Vedel; Mina Ladores; Hanane Saad; Genevieve Arsenault Lapierre; Justin; Gagnon; Vinita D'Souza; Genevieve Gray

Description:

Introduction: Aging population with complex care needs (chronic medical, psycho-social) is increasing the demands on the current healthcare system. Patients are vulnerable during transitions in care especially at post-hospitalization discharge. Weaknesses in transitional care contribute to high rates of readmission, longer stays and even death. The Virtual Ward (VW) at the Herzl Family Practice Centre provides multidisciplinary care for elderly patients identified as high risk for future hospitalization. Our main research objective is to determine and evaluate the current performance and the potential for transferability of this family medicine based virtual ward. Method This is an effectiveness-implementation trial with a multiphase sequential design. Throughout the phases of the study, a Participatory Approach is used beginning with a panel of experts who describe the intervention, identify key components and develop indicators for the evaluation of the impact and transferability of the VW. This includes a quasi-experimental study with a historical control group followed by a qualitative descriptive study with healthcare professionals who will evaluate the implementation dynamics and transferability of the VW. Preliminary Results • Assembled a team including researchers, clinicians, students, medical residents and patient representatives. (Core group meets weekly, extended partners meet bi-annually). • Refined current VW clinical practices by documenting VW procedures, identifying key features and creating standardized templates i.e. medication reconciliation, telephone calls and social evaluation. • Received detailed feedback from 3 physicians and 2 patient representatives on VW practices. • Continually compiling a list of transferability ideas to be shared with other clinical sites. Conclusion This project is important not only because it assesses a novel family medicine based intervention but it also begins to address the possibility of transferring what is learned at the Herzl Family Practice Centre to other clinical sites. This study is unique because it is led by a family physician and follows a participatory approach where clinical researchers, clinical staff and patient representatives can contribute to its success.

F111302 A **SHARE the Decision in Stroke Prevention in Atrial Fibrillation**
06:45–07:45 Anil Gupta, MD, CCFP, FCFP, Etobicoke, ON; Jeff Habert MD, CCFP, FCFP, Thornhill, ON
801AB MTCC

Learning Objectives:

1. determine stroke risk stratification for patients according to the CCS 2014 guidelines and identify the benefits and risks of current oral anticoagulants based on recent clinical trials and real-world data
2. assess and understand patient perspectives on treatment options, including concerns, misconceptions, and treatment preference
3. effectively communicate with and engage the patient in the decision-making process to ensure adherence to treatment plan, and include guidance at subsequent visits

Description:

Patients with atrial fibrillation have a significant increased risk of stroke and have increased post-stroke mortality and morbidity. Oral anticoagulation is a powerful treatment to prevent strokes and the novel oral anticoagulants have proven to be a major therapeutic advancement in the treatment of stroke prevention in atrial fibrillation. As the treatment decision for anticoagulation entails balancing the risk of stroke and the risk of bleeds, it is important for physicians to engage patients in this decision. This evidence-based session will provide family physicians with the opportunity to increase their knowledge and comfort level on treatment options, includes a review of clinical guidelines and real-world data, and provides physicians with a tool to help them effectively SHARE The Decision in Atrial Fibrillation with their patients.

Participants may claim an additional Mainpro-M1 credit for attending this session

F115446 A **Current Approach to Obesity Management: A new framework for front-line health providers**
06:45–07:45 Sean Wharton, MD, FRCPC, Hamilton, ON
701AB MTCC

Learning Objectives:

1. understand the current principles of obesity management and gain confidence in identifying and addressing barriers
2. know how to conduct a personalized obesity assessment and appropriately match patients to different management strategies
3. be aware of the new treatment options available in Canada

Description:

Obesity is a complex condition driven by several factors. This makes obesity management a complex and sometimes frustrating challenge. As research and clinical experience has shown, the traditional advice to “eat less and move more,” accompanied by meal and exercise plans, falls short of what most patients need. This slide presentation outlines an obesity management road map that goes beyond the traditional paradigm and draws on the latest research into the deep drivers of obesity. The presentation follows the evidence-based “5As of Obesity Management” framework developed by the Canadian Obesity Network. Extensively tested among primary care providers, the 5As framework offers a sensitive and sustainable management strategy that seeks to improve health and well-being, rather than to simply aim for numbers on a scale.

Participants may claim an additional Mainpro-M1 credit for attending this session I

F96068 **Respiratory Medicine Networking Breakfast: What's new in 2015 and what articles should you know about?**
07:00–08:00 Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON; Suzanne Levitz, MD, CCFP, Montreal, QC; John Li, MD; Chris Fotti, MD; Elaheh Mousa Ahmadi, MD
705 MTCC

Learning Objectives:

1. highlight new issues in respiratory medicine
2. review the top 5 articles in respiratory medicine from the past year
3. review the relevance of these highlights to clinical practice

Description:

2015 has brought us a plethora of new medications for pulmonary fibrosis, respiratory infections, asthma, and COPD. We will also highlight the articles that you should know about from the past year that WILL change your practice. Come and meet other family physicians who have a passion for respiratory medicine; I promise it will be worth getting up early for (and you get breakfast too!).

F99994 **Networking for Teachers of International Medical Graduates (IMGs)**
07:00–08:00 Susan Phillips, MD, CCFP, Kingston, ON; Inge Schabert, MD, CCFP, FCFP, Hamilton, ON
715B MTCC

Learning Objectives:

1. review the current pathways from medical school training outside Canada to Certification in Family Practice
2. network with others in the academic community involved in the selection and training of IMGs
3. discuss changes in requirements for application to residency via CaRMs and review recent experiences of family medicine residency programs with the CaRMs IMG process

Description:

Susan Phillips and Inge Schabert are both academic family physicians in Ontario with years of experience co-ordinating IMG programs and assessing data regarding indicators of IMG success in residency.

F101390 Maternity and Newborn Care Networking Breakfast**07:00–08:00**

Lisa Graves, MD, CCFP, FCFP, Ancaster, ON; Anne Biringier, MD, CCFP, FCFP, Toronto, ON; Sudha Koppula, MD, CCFP, Edmonton, AB; Rose Anne Goodine, MD, CCFP, Woodstock, ON; Balbina Russillo, MD, CCFP, Montreal, QC; Shanna Fenton, MD, CCFP, FCFP, Saskatoon, SK; Eve-Lynne Kyle, MD, CCFP, Montreal, QC

707 MTCC**Learning Objectives:**

1. identify current issues in maternity and newborn care for family physicians
 2. discuss successes and challenges in maternity care
 3. network with colleagues who share similar interests
-

F102181 The Risks of Family Practice: Introduction to the occupational medicine foundations course – Networking breakfast**07:00–08:00**

Joel Andersen, MD, CCFP, Sudbury, ON; R. Douglas Hamm, MD, CCFP, Victoria, BC

709 MTCC**Learning Objectives:**

1. understand the methodology of course delivery in a distant learning format
2. demonstrate the applicability of the course content to enhance the physicians' skills in managing day-to-day, common occupational health problems, to the benefit of their patients and their community, and to industry
3. outline details of access to enrolment in the course in different regions of practice in Canada

Description:

There is a documented lack of undergraduate and postgraduate training in occupational medicine for family physicians. This has impacted on practising family physicians' capability to effectively handle the wide range of occupational medical demands of family practice that present to the physician on a daily basis. This gap in training has been shown to negatively affect the timely and safe return-to-work process required by patients, the community, and industry. An occupational medicine training program has been developed and is currently delivered across Canada by the University of Alberta, Edmonton. This session will inform physicians in detail of the methodology used to deliver this distant learning program to family physicians, with the objective of allowing them to remain in their community while taking the course. The program, on completion, is accredited by the CFPC to provide 109 CPD credits.

F102799 Moving Forward as a Community of Practice Engaged in Global Health**07:00–08:00**

Katherine Rouleau, MD, CCFP, Toronto, ON

715A MTCC**Learning Objectives:**

1. summarize the activities of the Global Health Committee for 2015
2. identify three priority issues around which to engage the CFPC Global Health Community of Practice
3. develop a summary action plan to engage the CFPC Global health Community of Practice

Description:

In keeping with the nature of the field of global health itself, the CFPC Global Health Community of Practice is highly diverse. This diversity has challenged the ability of the Global Health Committee to engage members more fully. During this session, participants will be asked to identify the three most pressing needs of the community of practice and to propose actions to begin to address them.

FV300 🎧

08:00–09:30

Keynote / Plénière**Choosing Wisely Canada / Choisir avec soin Canada**

Wendy Levinson, MD, Toronto, ON; Lynn Wilson, MD, CCFP, FCFP, Toronto, ON

HALL FG MTCC**Learning Objectives:**

1. describe the reasons that physicians may order tests that don't add value or may harm patients
2. describe the Choosing Wisely Canada campaign and the role of primary care
3. share specific strategies to implement Choosing Wisely in medical education and practice

Description:

Choosing Wisely Canada (CWC) is a campaign to help physicians and patients discuss tests, treatments, and procedures, and make smart and effective choices to ensure high-quality care. It is modeled after the Choosing Wisely® campaign in the United States, launched by the ABIM (American Board of Internal Medicine) Foundation in April 2012. Choosing Wisely Canada launched in Ontario and has quickly been adopted by all provincial and territorial medical associations. It is now a truly national campaign in Canada and leads the international effort. This campaign has created patient-friendly educational materials and is working with various groups to disseminate these materials widely. CWC is also working with medical schools to introduce new content into the undergraduate, postgraduate, and continuing medical education curricula. Join Dr Levinson and Dr Wilson for this relevant and important keynote presentation.

Objectifs d'apprentissage :

1. décrire les raisons que les médecins évoquent pour demander des tests qui n'ajoutent pas de valeur ou qui peuvent causer un préjudice aux patients
2. décrire la campagne Choisir avec soin Canada et le rôle des soins primaires
3. partager des stratégies précises afin de mettre en œuvre Choisir avec soin dans la formation médicale et la pratique

Description :

Choisir avec soin est une campagne visant à aider les médecins et patients à discuter des examens, traitements et interventions dans le but de faire des choix judicieux et efficaces afin d'assurer des soins de grande qualité. Cette campagne s'inspire de l'initiative américaine Choosing Wisely® lancée par la Fondation de l'American Board of Internal Medicine (ABIM) en avril 2012. Choisir avec soin a d'abord été lancée en Ontario et a rapidement été adoptée par les associations médicales de l'ensemble des provinces et territoires. Il s'agit maintenant d'une campagne à l'échelle du pays qui se trouve à l'avant-plan de l'effort international. Dans le cadre de la campagne, du matériel de formation convivial a été créé pour les patients, et divers groupes de travail s'affairent à diffuser ce matériel à grande échelle. Choisir avec soin travaille également avec les facultés de médecine pour intégrer du nouveau contenu au cursus des programmes d'études prédoctorales, postdoctorales et de développement professionnel continu. Joignez-vous aux D^{res} Levinson et Wilson pour cette présentation à la fois pertinente et importante.

F96062

Should Physicians Recommend Electronic Cigarettes to Help Patients Quit Smoking?

10:00–10:30

Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON; Suzanne Levitz, MD, CCFP, Montreal, QC; John Li, MD

801AB MTCC**Learning Objectives:**

1. describe the possible benefits of using electronic cigarettes for smoking cessation
2. describe the concerns regarding the use of electronic cigarettes for smoking cessation
3. personalize the issues for the smoking patient in front of you in the office

Description:

One of our priorities in practice is to assist our patients to quit smoking, but are electronic cigarettes the right answer? Do their benefits in assisting smokers to quit outweigh their costs of potential side effects and teratogenicity? Are there societal changes that need to occur to ensure the responsible use of these products? Should they include nicotine? Should they be flavoured? Listen to two colleagues in a friendly but passionate debate over these issues and come away with your own conclusions.

F101444

Palliative Sedation: The what, when, and how

10:00–10:30

Irene Ying, MD, MHSc, CCFP, Toronto, ON

701AB MTCC**Learning Objectives:**

1. define palliative sedation and distinguish it from physician-assisted dying
2. appreciate clinical scenarios where palliative sedation should be considered
3. develop an approach to palliative sedation and understand why opioids should never be used for palliative sedation

Description:

Even with the wide range of therapies available for symptom management at the end of life, there is a subset of patients for whom adequate symptom control is not achieved with standard interventions and for whom palliative sedation (PS) is a potential treatment option. However, there is often misunderstanding around what PS is and the circumstances under which it is legally and ethically appropriate. This session will clarify what PS is (including distinguishing it from physician-assisted dying), provide an approach to PS, and discuss common pitfalls in its implementation.

F102597 What to Expect When She's Expecting: Integrating prenatal and preconception health evidence
10:00–10:30 into your practice and community
Sarah Gower, MD, CCFP, Elora, ON
714AB MTCC

Learning Objectives:

1. describe which aspects of preconception and prenatal health give the biggest bang for the buck
2. implement techniques to bring about concrete change in your communities without involving massive funding or hours of free time
3. explain how helping women make healthy changes has long-term effects on their babies, families, and communities—be inspired!

Description:

Pregnancy is an ideal time to intervene in unhealthy lifestyles, and to empower women to change themselves and their families. Pregnant women trust their health care providers and look to us for evidence-based information and guidance. But what do we focus on? How do we make suggestions around weight gain and parenting readiness that are quick and useful and don't make patients feel bad about themselves? And how can we intervene even before conception occurs, getting changes underway before it's too late? In our rural community, we decided, as prenatal health care providers, that we could do better. We assembled a multidisciplinary group and are developing a "Healthy Pregnancy Strategy." We aim to develop supportive, non-shaming interventions to educate and support our pregnant women, as well as to start a new community focus on preconception health. In a short time, we have already been able to educate our local health care providers around healthy prenatal parameters and early identification of women at higher risk, to establish a common set of prenatal resources that every pregnant woman in our region can easily access, to work with our public health unit to trial a preconception screening tool, and to partner with local epidemiology students to answer research questions. This session will outline the most up-to-date evidence around preconception and prenatal health lifestyles, and discuss ways to address these issues quickly and effectively in prenatal appointments. The case study of our "Healthy Pregnancy Strategy" will include pearls on making lasting changes in your community as a physician without a lot of time or funding. We all want to improve the overall health of our communities, and this session will inspire you with the knowledge that targeting preconception and prenatal health is an excellent way to really make a difference.

F96240 **What Are the Benefits of Group Prenatal Care and How Interested Are Most Women in It?**
10:30–11:00 Sarah McDonald, MD, FRCSC, MSc, Hamilton, ON
714AB MTCC

Learning Objectives:

1. assess the extent of maternal and infant benefits of group prenatal care compared to traditional prenatal care
2. describe participants' views on group prenatal care, from the perspective of both women and care providers
3. identify the level of interest in group prenatal care among women receiving traditional prenatal care

Description:

Group prenatal care (GPC) originated in 1994 as an innovative model of prenatal care delivery. In GPC, eight to twelve pregnant women of similar gestational ages meet with a health care provider to receive their prenatal check-up and education in a group setting. GPC offers significant infant and maternal health benefits in comparison to traditional, one-on-one prenatal care. Many women in GPC actively engage in their health care and experience a supportive network with one another in the group visits.

FF96962 **The ABC's of Exercise Assessment and Prescription for the Prevention and Management of Chronic Disease / L'ABC de l'évaluation et de la prescription d'exercice dans la prévention et la prise en charge des maladies chroniques**
10:00–11:00 Pierre Frémont, MD, PhD, FCFP, Dip Sport Med, Quebec, QC
HALL F MTCC

Learning Objectives:

1. discuss the scientific basis of the spectacular potential and safety of exercise for the prevention and management of chronic diseases with patients
2. integrate the "exercise vital sign" as part of the periodic health examination
3. use the exercise referral and prescription tool developed by "Exercise is Medicine Canada" and the CFPC for exercise assessment and basic prescription

Description:

The "Exercise is Medicine Canada" collaborative task force has developed a tool to assist family physicians and health care providers in assessing physical activity participation and providing basic exercise prescription as part of a periodic health examination. This project was supported by the Sports and Exercise Medicine committee of the Section of Communities of Practice in Family Medicine (CPFM).

Objectifs d'apprentissage :

1. L'ABC de l'évaluation et de la prescription d'exercice dans la prévention et la prise en charge des maladies chroniques
2. intégrer le « signe vital de l'exercice » dans l'examen périodique de santé
3. être en mesure d'utiliser l'outil de prescription d'exercice et d'orientation mis au point par « L'exercice : un médicament Canada » et le CMFC pour évaluer l'exercice et en rédiger une ordonnance de base

Description :

Le groupe de travail « L'exercice : un médicament Canada » a mis au point un outil visant à aider les médecins de famille et autres professionnels de la santé à évaluer la participation à l'activité physique et à prescrire l'exercice de base dans le cadre de l'examen de santé périodique. Ce projet a bénéficié de l'appui du Comité de la médecine du sport et de l'exercice de la Section des Communautés de pratique en médecine familiale.

F101889  **Work Related Exams and Forms / Examens et formulaires liés au travail**

10:00–11:00 Craig Karpilow, MD, CCFP, FCFP, Hamilton, ON

718AB MTCC

Learning Objectives:

1. discover how to manage work-related examinations in a typical family practice so that they do not interfere with other patient care or take disproportionate time, and so that staff can schedule them appropriately
2. determine the appropriate manner to approach work related, disability, and return to work forms and examinations
3. describe time-effective methods of performing a work-related examination or completing disability or return-to-work forms

Description:

As family physicians, we are often asked to perform Ministry of Transport exams and to fill in various other fitness-to-work or employment forms, including return-to-work and disability documents. These tasks can be time-consuming in a busy practice and not significantly remunerative. They can also be very important in determining if your patient can physically and safely perform a certain job. Failure to make this determination properly can have long-lasting consequences for the patient, and if improperly done, have serious ramifications for the physician. This session clarifies these points and presents a comprehensive, simple, and time-effective method for the physician to use in completing these exams.

Objectifs d'apprentissage :

1. découvrir comment gérer les examens liés au travail dans une pratique familiale typique afin qu'ils n'interfèrent pas avec les soins aux patients ou ne prennent un temps disproportionné, et que le personnel peut les préparer de façon appropriée
2. déterminer la manière appropriée de remplir les formulaires et effectuer les examens liés au travail, à un handicap ou à un retour au travail
3. décrire les méthodes efficaces pour effectuer des examens liés au travail ou remplir des formulaires d'invalidité ou de retour au travail

Description :

En tant que médecins de famille, on nous demande souvent d'effectuer des examens pour le ministère des Transports et de remplir divers formulaires liés à la capacité de travailler et à l'emploi, y compris les documents d'invalidité et de retour au travail. Ces tâches peuvent prendre beaucoup de temps dans une pratique occupée et ne sont pas très rémunératrices. Elles peuvent également être très importantes afin de déterminer si votre patient peut physiquement effectuer un certain travail de façon sécuritaire. L'impossibilité de faire cette détermination correctement peut avoir des conséquences à long terme pour le patient, et si elle est effectuée incorrectement, elle peut entraîner des conséquences sérieuses pour le médecin. Cette séance précise ces points et présente une méthode complète, simple et efficace à suivre pour permettre au médecin d'effectuer ces examens.

F102078 **Iron Deficiency Anemia: Recognition and management in the office and the emergency department**

10:00–11:00 Yulia Lin, MD, FRCPC, Toronto, ON; Dominick Shelton, MD, CCFP, FCFP, Toronto, ON

HALL G MTCC

Learning Objectives:

1. recognize iron deficiency anemia
2. prescribe treatment for iron deficiency anemia
3. manage patients with iron deficiency anemia in the emergency department

Description:

Iron deficiency anemia (IDA) is the most common cause of anemia worldwide. The prevalence of iron deficiency anemia has been found to be as high as 4 per cent in women, 16 per cent in pregnant women in the third trimester, and 6 per cent in elderly patients. However, IDA is underrecognized and undertreated. In severe cases, patients are often referred to the emergency department for red blood cell transfusion. The first objective is to learn how to recognize iron deficiency anemia. Anemia is defined as hemoglobin less than 120 g/L in women and less than 130 g/L in men. Iron deficiency is defined as a ferritin level less than 30 ug/L OR less than 100 ug/L with a transferrin saturation less than 20 per cent. A mean cell volume (MCV) less than 80 fL when previously documented as normal can also be an indicator of IDA. Causes of iron deficiency anemia will be reviewed. The second objective is to learn how to prescribe treatment for iron deficiency anemia. The available oral iron formulations will be discussed, along with their side effects. Indications for intravenous iron and its side effects will also be presented. The final objective will be to learn about a quality improvement project aimed at improving the management of patients with IDA in the emergency department. An algorithm will be presented on how to decide whether or not to transfuse a patient with IDA. The risks of transfusion will also be discussed, including the risks of alloimmunization (formation of red blood cell antibodies), which in women of childbearing age increases the risk of hemolytic disease of the newborn in future pregnancies. A case-based approach will be used to increase interaction with the audience.

F102400 Ominous and Awesome: New trends in addiction and its treatment**10:00–11:00** Meldon Kahan, MD, CCFP, FRCPC, Toronto, ON; Anita Srivastava, MD, CCFP, Toronto, ON**716B MTCC****Learning Objectives:**

1. outline a primary care approach to managing cannabis use disorders
2. describe how family physicians can reduce the risk of opioid overdose and addiction through patient selection, dose titration, tapering, and prescribing buprenorphine
3. discuss the role of medications in the treatment of alcohol use disorders

Description:

This presentation will review three major trends in substance use. 1) Both recreational and medical marijuana strains have become much more potent. Licensed producers are producing strains with THC concentrations of 20 per cent or higher. The acute and chronic harms of marijuana are linked with the THC dose, and include psychosis, addiction, impaired work and school performance, and motor vehicle accidents. Family physicians need a strategy for dealing with requests for medical marijuana. They can help daily cannabis smokers through screening, advice, referral, and medications. 2) Prescribing of potent opioids, such as hydromorphone and fentanyl, has increased since the removal of OxyContin from the Canadian market. Canada is now the highest per capita consumer of opioids in the world, and prescription opioid overdose is now a leading cause of death in young adults in Canada. Family physicians can reduce opioid harms through careful patient selection and dose titration, opioid tapering when indicated, and prescribing buprenorphine/naloxone for opioid addiction. 3) New research suggests anti-craving medications should be prescribed routinely for patients with alcohol use disorders. Medications such as naltrexone, disulfiram, acamprosate, and topiramate can be safely prescribed by family physicians and have been shown to reduce alcohol consumption and alcohol-related morbidity.

F102289 Building a Quality Improvement Curriculum Into Your Department of Family Medicine: Exploring effective approaches**10:00–12:15** Elizabeth Muggah, MD, MPH, CCFP, Ottawa, ON; Phil Ellison, MD, CCFP, FCFP, North York, ON; Karen Hall Barber, MD, CCFP, FCFP, Kingston, ON**705 MTCC****Learning Objectives:**

1. discover different approaches to integrating quality improvement into family medicine residency programs
2. describe how CANMeds 2015 and the Triple C Competency-based Curriculum methods can support the integration of teaching and evaluating quality improvement skills and knowledge
3. discuss best evidence and experiences with family medicine faculty who are leaders in quality improvement

Description:

This interactive workshop targets family medicine faculty—including administrators, teachers, and researchers—who are interested in building quality improvement (QI) into their learning environments. QI is an essential part of the effort to close the gap between what we know, what we can learn from our clinical environment, and what we do in our clinical practice to improve. The integration of QI into academic family medicine has emerged in Canada and beyond as an important objective. Doing so requires teaching, modeling, and applying QI skills and theory in a curriculum, and faculty and professional development in the teaching environment. This workshop will be an opportunity to explore an emerging area in family medicine and will result in the sharing of best practices from QI leaders in family medicine from across the country. The workshop will be facilitated by faculty from Queen's, University of Toronto, and Ottawa who are leaders in QI in their departments.

F102747 Post-Traumatic Stress Disorder: A primer for primary care physicians**10:00–11:00** Alexandra Heber, MD, FRCPC, CCPE, Ottawa, ON; Catherine Classen, PhD, Toronto, ON**501 MTCC****Learning Objectives:**

1. recognize the signs and symptoms of posttraumatic stress disorder, and describe the mental, physical, and behavioral problems often comorbid with it
2. explain the rationale and principles of trauma-informed care, and strategies for its delivery
3. propose appropriate pharmacological and psychotherapeutic treatment for posttraumatic stress disorder

Description:

In his groundbreaking 1978 research on the prevalence of mental disorders in the US population, Darrel Regier discovered that only one-fifth of those affected by mental illness were seen by specialty mental health providers, while three-fifths were treated by general practitioners. He therefore designated primary care as the "de facto ... mental health services system." Today, primary care practitioners continue to treat the majority of those with mental health problems. This session's presenters, both experts in the treatment of posttraumatic stress disorder (PTSD), developed this course for family physicians who care for patients with PTSD. The authors designed the course around two cases that would typically present to a family doctor's office: a young woman who is having physical complaints and then discloses a history of childhood sexual abuse, and a military veteran who presents with complaints of poor sleep. The cases illustrate best practices, including making the diagnosis; principles of trauma-informed care; risk factors for PTSD; common comorbidities; and evidence-based pharmacologic and psychotherapeutic treatment. Video clips illustrating principles of PTSD treatment will be shown and discussed. Testimonials (live and videotaped) of people with PTSD, describing their history, symptoms, and experiences with their family physicians, will augment the presentation. Audience participation will be encouraged.

F102790 Advancing Global Family Medicine Through the Besroure Centre: Updates and inputs

10:00–11:00 Katherine Rouleau, MDCM, CCFP, MHSc, Toronto, ON; François Couturier, MD, FCFP, MSc, DTM&H, Sherbrooke, QC; Ryan McKee, MD, CCFP, Kitchener, ON

715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. describe the vision and activities of the Besroure Centre
2. discuss some of the achievements and challenges of the Besroure collaboration
3. propose ways to further pursue the overall goals of the Besroure Centre

Description:

In 2015, after a three-year consultation process, the College of Family Physicians of Canada established the Besroure Centre, a hub of international collaboration to advance family medicine globally. The Centre brings together all Canadian departments of family medicine, collaborators from 18 countries, and key stakeholders such as the World Bank and WONCA (World Organization of Family Doctors). Through case presentations, structured activities, and interactive discussions, this workshop will deepen participants' knowledge of the Centre and invite perspectives on how to further enrich the work of this innovative collaboration.

F102879 Experiencing Touch in Family Medicine: Transforming the ordinary

10:00–11:00 Martina Kelly, MBBCh, MA, MICGP, FCRCF, CCFP, Calgary, AB; Lara Nixon, MD, CCFP, FCFP, Calgary, AB

711 MTCC

Learning Objectives:

1. reflect on your experiences of touch as a family doctor
2. experience touch from a new perspective by joining in interactive exercises
3. re-evaluate the role of touch in clinical practice

Description:

Touch is part of the everyday practice of a doctor: shaking a patient's hand, the intimacy of physical examination, performing procedures. It is, however, something we take for granted. Touch is rarely the subject of specific inquiry in medicine and our understanding of touch as a communication process and form of knowledge is rudimentary. How we touch and interact with patients is influenced by our personal experience, culture, family life, education, and the varying contexts in which we practice. Increasingly we are becoming a "no touch society" and concern has been expressed about the concept of "touch hunger" within North America. The aim of this workshop is to pause, to invest our senses in the experience of touch. We will explore touch as a concept and experience. Touch can be a form of care and connection. It is also described as an issue of risk. We aim to open the "black box," have some fun, and provoke discussion among family doctors. Starting with small group discussion, participants will reflect on the role of touch in health care, stimulated by a poetry reading. Then, adopting a phenomenological perspective, participants will focus on the tactile/haptic experiences of a doctor's day-to-day activities by means of "hands-on" activities. We will "make the familiar strange" and use contrasting embodied senses (dance, taste) to facilitate articulating a descriptive account of our touch experiences. Discussing the relevance of these exercises to clinical practice, our personal ideas, concerns, and expectations will follow. Implications for future work, research, and education will conclude the workshop.

F102883 Dealing With Conflict as a Medical Leader

10:00–12:15 Difat Jakobovics, MD, CCFP, FCFP, Toronto, ON; Paul Philbrook, MD, CCFP, FCFP, Mississauga, ON; Pauline Pariser, MD, CCFP, FCFP, Toronto, ON

707 MTCC

Learning Objectives:

1. discuss the elements of effective meetings, the chair's role, and challenges and conflict styles that can be encountered when working with others
2. develop and integrate into practice leadership skills in managing conflict and conducting effective meetings

Description:

In 2009, as part of its strategic plan, the Department of Family and Community Medicine at the University of Toronto decided to foster leadership development among the faculty. Among other strategies, this workshop on conflict management was developed. This interactive workshop will provide a background on conflict styles and how to conduct effective meetings. Through cases and active participation, we will explore dealing with conflict, specifically in the setting of conducting a meeting. Assessing conflict styles and how this relates to the management of conflict will be addressed as well. The themes inherent in this workshop include the critical role of an effective chair; self-awareness of one's personal leadership and conflict management style; elements to consider in planning, conducting, catalyzing, and following up on meetings; and addressing challenging conflicts, such as managing a disruptive physician. By combining didactic presentation and experiential learning, the workshop will cover basic principles on conflict management and running effective meetings and will enable participants to examine and integrate these principles into their approach.

F106732 SOR/SOT Symposium – Evidence to practice by: What do we need and what are we getting?

10:00–12:15 Michael Allan, MD, CCFP, FCFP, Edmonton, AB; Michael Kolber, MSc, MD, CCFP, FCFP, Edmonton, AB; Tina Korownyk, MD, CCFP, Edmonton, AB

716A MTCC

Learning Objectives:

1. recognize robust information worthy of guiding patient care
2. recognize and avoid pitfalls inherent in commonly used resources
3. discuss short- and long-term strategies for managing your information needs

Description:

Whether trying to stay up-to-date on the treatment of common problems or looking for information on less common problems at the point of care, family physicians will spend their entire career looking for new information to guide the treatment of their patients. What constitutes useful and reliable information? How useful and reliable are some of the more common sources of information that are available to us?

FV108670 Mainpro+ ... A New Look, With New Ways to Learn (3)
10:00–11:00 Mainpro+ ... Un nouveau look; de nouvelles façons d'apprendre (3)

Eric Wong, MD, CCFP – Regional Educator, Ontario Region / Éducateur régional, région de l'Ontario, London, ON;
Scott MacDonald, MD, CCFP (EM), FCFP – Regional Educator, Atlantic Region / Éducateur régional, région de l'Atlantique, Bedford, NS

803A MTCC

Join us for an informative session on Mainpro+ and the new, practice-centred ways to earn CPD credits for activities you do on a daily basis. Also, hear the latest updates on fellowship, accreditation, and CACs. The CFPC is committed to providing quality CPD to meet your changing interests and learning needs. Participants may claim an additional Mainpro-M1 credit for this session.

Soyez des nôtres pour une séance d'information sur Mainpro+ et sur les nouvelles façons d'obtenir des crédits de DPC pour des activités que vous effectuez au quotidien. De plus, vous pourrez vous renseigner sur les nouveautés concernant le titre de Fellow, l'agrément et les CCA. Le CMFC s'est engagé à fournir des programmes de DPC de qualité qui conviennent aux intérêts de ses membres et répondent à leurs besoins en matière d'apprentissage. Les participants peuvent réclamer un crédit Mainpro-M1 additionnel pour cette séance.

F102424 Moving Towards Outcomes-Based Accreditation Systems

10:00–12:15 Nick Busing, MD, CCFP, FCFP, Ottawa, ON; Louise Nasmith MDCM, MEd, FCFP, FRCPSC(Hon), Vancouver, BC

703 MTCC

Learning Objectives:

1. differentiate between process-based accreditation and outcomes-based accreditation and provide two examples of each
2. identify the strengths, limitations, and potential outcome measures of our current accreditation system
3. recognize the need to challenge our current accreditation processes to be more outcomes-focused

Description:

This session on medical education accreditation will be of interest to family medicine program directors, clinical teachers, residents, and clinicians. Canada has internationally recognized accreditation systems for undergraduate medical education, postgraduate medical education, and continuing professional development. However, outcome measures of our system do not directly reflect practice patterns and clinical outcomes, and they need to be socially accountable. The Future of Medical Education in Canada Postgraduate Report recommended alignment of accreditation standards and processes across the continuum of medical education to achieve greater efficiency at less cost. This workshop will present how our current accreditation systems assess competence in relation to measuring outcomes, and address how to move towards the assessment of outcomes rather than of processes primarily. Participants will engage in a brainstorming session about potential clinical, safety-related, and quality-related outcome measures. Participants will gain a better understanding of, and be able to influence, outcomes-based accreditation and its potential to improve both the training environment and clinical practice.

F96260 Social Networking: the National OSCAR EMR User Group Meeting

10:00–17:30 Colleen Kirkham, MD, CCFP, FCFP, Vancouver, BC; David H. Chan, MD, CCFP, MSc, FCFP, Hamilton, ON;
Morgan Price, MD, PhD, CCFP, Victoria, BC

CALEDON/OAKVILLE – INTERCONTINENTAL HOTEL

Learning Objectives:

1. interactive working meeting for OSCAR users to learn new features and functions of the EMR
2. potential new users will be introduced to the EMR's features and the open source community
3. academic multi-province projects will be discussed

Description:

OSCAR is an 'open-source' (free), Canadian browser-based EMR, developed and driven by its users. Users pay no licensing costs and have the freedom to choose who provides support. There are large numbers of users in Ontario, BC, Quebec, PEI and Alberta. OSCAR is an academic, not-for-profit, national EMR adopted by several University family medicine departments including McMaster, Queen's, McGill and UBC. It is the only EMR that integrates with a Patient Controlled Health Record (MyOSCAR) and a Knowledge Exchange Social Networking web service (Know2Act).

Users will learn from other users and the development team about new features and how to maximize their use of OSCAR. They will

learn about exciting projects that use OSCAR, MyOSCAR, and Know2Act to deliver innovative care to patients at home utilizing volunteers in their communities. They will learn how to use tools that can improve clinical practice (decision support, research and QI). Non-OSCAR users are welcome to attend to see the EMR and see how the OSCAR community works together.

F96050 Asthma-COPD Overlap Syndrome
11:15–11:45 Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON
801AB MTCC

Learning Objectives:

1. define what this new condition means, and what it means to your patient
2. describe the diagnostic approach to a patient with ACOS
3. review the treatment options and follow-up for a patient with ACOS

Description:

The new international guidelines for both asthma (GINA) and COPD (GOLD) have developed a consensus recommendation on a not uncommon and definitely high-risk condition called asthma-COPD overlap syndrome (ACOS). Distinguishing between asthma vs COPD vs ACOS will be reviewed and it will be clear to you how to approach this newly described but complicated condition in your patients. The first step is assessing lung function, as the patient has to have fixed airway obstruction (FEV1/FVC ratio < 70%) but also have significant bronchodilator reversibility. New and exciting information for participants to use and gain comfort in managing respiratory illness.

F96127 Preschool Pediatric Asthma: Who needs treatment?
11:45–12:15 Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON
801AB MTCC

Learning Objectives:

1. identify the different types of "asthma" seen in a preschooler
2. identify which children need longer-term treatment and which will "outgrow" their asthma
3. review treatment approaches for these children

Description:

Preschool children often wheeze. The diagnostic test for asthma is spirometry, but they are too young to do it. Which wheezing children need inhaled steroids long term and which ones will likely "outgrow" the condition? Can you predict it? We will review the approach to preschool wheezing children.

F96421 Medical and Forensic Aspects of Care for the Victim of Acute Sexual Assault
11:15–12:15 Susan McNair, MD, CCFP, FCFP, London, ON; Saadia Hameed, MD, CCFP, London, ON
709 MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. recognize types of genital and non-genital trauma associated with acute sexual assault
2. identify key elements of the forensic assessment of victims of acute sexual assault
3. recall key aspects of the medical management of victims of acute sexual assault

Description:

This one-hour session will address key issues in the medical examination/assessment and management of victims of acute sexual assault. The three types of blunt superficial trauma (bruises, abrasions, and lacerations) will be explored in detail. Photos will be used extensively, where appropriate. Important issues in the documentation of such injuries will be detailed. Key elements of the forensic evidence collection will be covered and the forensic evidence collection kit utilized in Ontario will be mentioned. The important aspects of the medical and psychological management of victims of acute sexual assault will be reviewed, including pregnancy prophylaxis and STI prophylaxis, including the appropriate utilization of HIV post-exposure prophylaxis.

F101340 Introducing Palliative Care in Chronic Disease Within My Family Practice: Who, why, and how
11:15–12:15 Mirielle Lecours, MD, CCFP, Stratford, PE; Janet Baker, MD, CCFP, Gloucester, ON
802AB MTCC

Learning Objectives:

1. understand and define "palliative care" and the "palliative care approach" and identify patients in your practice who could benefit from a palliative approach earlier in their illness
2. review prognostication using the Gold Standards Framework: General and Disease-Specific Indicators and become familiar with some useful tools (ESAS, PPS, PRFS)
3. explore and define your role and the role of family physicians in providing palliative care in your setting(s)

Description:

At least 70 per cent of individuals faced with a life-threatening illness will never receive palliative care through a standardized palliative care program. At this moment, less than 30 per cent of Canadians receive this kind of service. In order to be available to every Canadian, it needs to be incorporated into every physician's practice. Family physicians play a critical role in the provision of palliative care to their patients; their knowledge of the family unit is invaluable in the provision of person- and family-centred care. In addition, the provision of continuing, comprehensive care and the ability to collaborate is innate to family physicians and an asset to the provision of palliative care. This interactive workshop will review scenarios faced in everyday clinical practice, use tools to recognize which of these patients could benefit from early palliative care interventions, and use helpful tools, including the ESAS, to implement these approaches. Although not the focus, advanced care planning communication tools will be included in this workshop.

F96975 🎧 **Rehabilitation Innovations for Common Knee Conditions**
11:15–11:45 **Innovations en réadaptation pour les blessures courantes du genou**

Agnes Makowski, FCAMPT, Toronto, ON; Pierre Frémont, MD, CCFP, FCFP, PhD, Dip Sport Med, Quebec, QC
HALL F MTCC

Learning Objectives:

1. understand the evidence-based rehabilitation approach to common knee injuries
2. be familiar with common muscle imbalances and training myths that affect optimal knee function
3. use injury prevention strategies and exercise prescription tools appropriate for patients of diverse abilities and activity levels

Description:

This session will allow participants to integrate the rehabilitation perspective in the multidisciplinary approach for the prevention and management of common knee injuries.

Objectifs d'apprentissage :

1. comprendre les approches factuelles de réadaptation pour les blessures courantes du genou
2. se familiariser avec les déséquilibres musculaires et les mythes courants concernant l'entraînement qui peuvent perturber le fonctionnement optimal du genou
3. faire appel à des stratégies de prévention des blessures et à des outils de prescription d'exercice appropriés auprès des patients de diverses habiletés et niveaux d'activité

Description :

Cette séance permet aux participants d'intégrer la perspective de la réadaptation dans une approche multidisciplinaire de prévention et de prise en charge des blessures courantes du genou.

F96979 🎧 **Evaluation and Imaging of Common Knee Injuries in Primary Care /**
11:45–12:15 **Évaluation et examens d'imagerie des blessures courantes du genou en soins primaires**

Tatiana Jevremovic, MD, CCFP(EM), Dip Sport Med, London, ON; Pierre Frémont, MD, CCFP, FCFP, Quebec, QC
HALL F MTCC

Learning Objectives:

1. make a relevant differential diagnosis based on the clinical history of common knee injury
2. use relevant evaluation techniques to test the diagnostic possibilities suggested by the clinical presentation
3. make rational use of diagnostic imaging to complete the evaluation

Description:

This session will allow the family physician to optimize his clinical evaluation skills of knee injuries through an improved understanding of the relation between key elements of the clinical presentation, examination, and investigation of common knee injuries.

Objectifs d'apprentissage :

1. poser un diagnostic différentiel pertinent basé sur l'évolution clinique des blessures courantes du genou
2. faire appel aux techniques d'évaluation pertinentes pour tester les possibilités diagnostiques évoquées par le tableau clinique
3. utiliser l'imagerie diagnostique de façon rationnelle pour compléter l'évaluation

Description :

Cette séance permet au médecin de famille d'optimiser ses aptitudes d'évaluation clinique des blessures du genou par l'intermédiaire d'une meilleure compréhension de la relation entre les éléments clés du tableau clinique, l'examen et l'investigation des blessures courantes du genou.

F101346 **Chronic Pain: An approach during pregnancy**

11:15–12:15 Lisa Graves, MD, CCFP, FCFP, Ancaster, ON
714AB MTCC

Learning Objectives:

1. distinguish between chronic pain and dependence during pregnancy
2. define appropriate treatment options for chronic pain during pregnancy
3. build a treatment plan for women experiencing chronic pain in pregnancy

Description:

Chronic pain is common in family medicine. Pain and chronic pain can be part of pregnancy. Management of chronic pain in pregnancy requires special considerations including impact of treatment on development and concerns about dependence. An approach to chronic pain during pregnancy will be developed.

F101613 Colon Polyp Follow-Up: When does my patient need another scope?

11:15–11:45 Nichelle Desilets, BSc, MD, CCFP, ESS, Prince Albert, SK

HALL G MTCC

Learning Objectives:

1. review the theory of the polyp-adenoma-carcinoma sequence
2. understand some potential colonic pathology results
3. discuss the appropriate follow-up of abnormal colonic biopsy results

Description:

With the implementation of provincial colorectal cancer screening programs across Canada, family physicians are faced with increased demand for colonoscopic services, and subsequent pathology results. We'll review the polyp-adenoma-carcinoma sequence, and the rationale for colorectal cancer screening. Several common colonic pathology results will be covered, including the implications of each. Polyp, adenoma, and carcinoma follow-up will be reviewed to enable GPs to more confidently recommend appropriate follow-up to their patients.

F101698 Primary Care Approaches to Working With Youth Who Use Alcohol and Substances

11:15–11:45 Sharon Cirone, MD, CCFP(EM), ASAM(Cert), Toronto, ON

716B MTCC

Learning Objectives:

1. identify rapport development as a priority for working with adolescents and young adults in the primary care setting
2. define and describe the components of SBIRT---screening, brief intervention, and referral to treatment---for youth who use alcohol and drugs
3. translate and integrate the tools and skills for SBIRT into their practice

Description:

Adolescents and young adults have the highest rates of alcohol and drug use in our society and in our primary care practices. Some young people have progressed to alcohol and substance use disorders and some are experiencing considerable risk related to their use. Successful engagement with our young patients is critical to supporting change and healthy behaviours. Universal screening tools can be easily integrated into your practice. Brief interventions to support insight and motivation for change can be implemented into even the busiest of primary care settings. Many family physicians are unfamiliar with their local resources for referral to further treatment for those at higher risk. Referring physicians and families can become informed and confident in navigating the local addiction treatment systems.

F101702 Prescribing Income: A three-step tool to reduce the impact of poverty in primary care

11:15–12:15 Larisa Eibisch, MD, CCFP, MPH, Toronto, ON; Danyaal Raza, MD, CCFP, MPH, Toronto, ON

803B MTCC

Learning Objectives:

1. discuss a simple, three-step tool for intervening to address poverty as a health risk, endorsed by the OCFP and targeted at family physicians in office-based practice
2. explore examples of interventions family physicians can employ to address poverty as a risk to health, at individual, community, and societal levels
3. review Canadian evidence linking poverty with health issues including diabetes, heart disease, mental illness, and children's health

Description:

This is our third consecutive year presenting this powerful session on the impact of poverty on health! Evidence continues to reinforce what many family physicians know from practical experience: income is THE greatest determinant of health. While physicians are generally aware of this impact, they are often at a loss as to how to intervene to decrease its effect on the health of their patients and communities of practice. The Ontario College of Family Physicians' Committee on Poverty and Health has developed a practical, office-based tool to equip family physicians to directly address inadequate income as a risk to health with patients. Using a case study, this session will introduce the clinical tool, shifting the dialogue about poverty and health from defining the problem to taking action. This session will present practical interventions family physicians across the country can employ in their everyday practices to address the health risks posed by poverty.

F102001 Returning Your Patient to Work

11:15–11:45 Avram Whiteman, MD, MPH, CCFP, FCFP, FCBOM, FACOEM, Westmount, QC

713B MTCC

Learning Objectives:

1. understand the role of the family doctor in return to work (RTW)
2. identify barriers (and solutions) to RTW
3. appreciate RTW as a therapeutic modality

Description:

Returning a patient to work can sometimes be a very difficult undertaking for the busy family physician. This presentation reviews the extent and parameters of this issue, then looks at the common medical and non-medical barriers patients might experience in going back to work after a period of illness or injury. Solutions to these common barriers are discussed. The role of the family physician in this process is clarified, so that roles and responsibilities are clear for the various stakeholders in this process (eg, doctor, patient, employer, insurance company, etc.).

F102083 **Quality Improvement in the Office: *The Quality Book of Tools***
11:15–12:15 Frank Martino, MD, CCFP (EM), FCFP, Brampton, ON; Cheryl Levitt, MB BCH, CCFP, FCFP, Hamilton, ON
501 MTCC

Learning Objectives:

1. discuss quality improvement as it pertains to the primary care setting and physician's office
2. discover how the Quality Book of Tools can be a resource in the quality improvement process
3. plan first steps for quality improvement in the practice setting

Description:

We are all so busy providing patient care, it is hard to imagine how we can include quality improvement on a day-to-day basis in the office. *The Quality Book of Tools* is an accessible practical guide to topics on how to improve practice management and clinical care in an evidence-informed way. This session will provide an overview of quality improvement, discuss how to get started with quality, and what skills you can learn to integrate quality in the office. We will be referencing *The Quality Book of Tools* as a foundation and resource to launch quality improvement initiatives.

F102732 **The Healing Power of Song**
11:15–12:15 Roslyn Schwartz, MD, CCFP, Kingston, ON
711 MTCC

Learning Objectives:

1. discover the power of songs to illuminate and reframe experiences and to support and heal
2. discover a repertoire of songs that can be used in various different contexts
3. describe the therapeutic use of songs in various settings

Description:

Songs can be a source of inspiration and renewal. They can comfort and support, articulate and illuminate common experiences, and bring new perspectives to life's challenges. This performance of original compositions explores the power of song to enlighten and heal. The songs include "Courage," describing strength in the face of a frightening diagnosis; "Wishing Well," which reframes the experience of disappointment; and "The Village Effect," about the importance of community support. Other, humorous songs—such as "Complaining!" and "Ode to the Parking Lot at Expo 67"—can bring laughter to common misfortunes. The use of these and other songs in various contexts will also be discussed.

F102802 **Responding to the CFPC Global Health Community of Practice**
11:15–12:15 Katherine Rouleau, MD CM, CCFP, Toronto, ON
715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. summarize the activities of the Global Health Committee for 2015
2. identify three priority issues around which to engage the CFPC Global Health Community of Practice in Family Medicine
3. develop a summary action plan to engage the CFPC Global Health Community of Practice in Family Medicine

Description:

In keeping with the nature of the field of global health itself, the CFPC Global Health Community of Practice in Family Medicine is highly diverse. This diversity has challenged the ability of the Global Health Committee to engage members more fully. During this session, participants will be asked to identify the three most pressing needs of the community of practice and to propose actions to begin to address them.

F120750 **Home Improvements: Using PMH pillars to guide quality improvement activities in family practice clinics**
11:15–12:15 Rob Wedel, MD, CCFP, FCFP, Taber, AB
401 MTCC

Learning Objectives:

1. describe the elements of the Patient's Medical Home model that can guide quality improvement (QI) activities in family practice clinics
2. describe QI techniques and the supports they need that can be applied in family practice clinics
3. describe practical examples of QI initiatives that have made a measurable difference in quality of care

Description:

Though we recognize our need to continuously work toward improving the care we provide in our clinics, the ongoing demands of a busy family practice seem to always get in the way. The Patient's Medical Home (PMH), CFPC's vision for family practice, is a model that can act as a focus and a guide to our improvement activities. The model is intentionally flexible, allowing us to define and prioritize directions based on our clinics' unique needs and community characteristics. The experiences of clinics across Canada are showing that successful improvement initiatives can be undertaken by utilizing the pillars identified in the PMH, along with the known principles of quality and process improvement. The resources needed will include physician leadership, some dedicated staff time, and basic measurement and facilitation tools. Examples of successful activities, along with practical, available resources, will be discussed.

F101615 Chronic Non-Cancer Pain Management in Patients With Addiction

11:45–12:15 John R. Fraser, MD, CCFP, FCFP, Halifax, NS

701AB MTCC

Learning Objectives:

1. apply strategies to manage CNCP patients with a history of addiction and with active addiction
2. identify the differential diagnoses of opioid-related aberrant behaviours in CNCP
3. apply strategies to determine the cause of and manage opioid-related aberrant behaviours in CNCP

Description:

The incidence of addiction in chronic non-cancer pain (CNCP) patients is estimated to be 19 to 26 per cent. Opioid therapy is a common strategy in chronic pain management, but opioid prescribing in patients with addiction can pose significant risks and challenges. Patients with comorbidities of chronic pain and addiction can be separated into three groups: 1) patients with a history of addiction, 2) patients with active addiction, and 3) patients in whom the diagnosis of addiction has not been clearly established but is suspected due to the presence of recurrent opioid-related aberrant behaviours. In the latter group, there are various explanations for aberrant behaviours that are not related to addiction and thus careful consideration of the differential diagnosis is important. This session will provide recommendations regarding the use of opioids in CNCP patients with a history of addiction or with active addiction. The focus of the session will include a discussion of the differential diagnoses related to aberrant behaviours, and guidance on how to determine the diagnosis and how to manage it.

F123179 Estate, Will, and Charitable Planning

12:15–13:15 Elaine Blades, Director, Fiduciary Services, Scotia Private Client Group, Scotiabank, Toronto, ON;

Paul Fensom, Director, Scotia Private Client Group, Scotiabank, Toronto, ON

713A MTCC

Description:

Plan for your practice, your family, and your legacy. Plan to attend this important Scotiabank seminar on estate and charitable planning. Understand why you need a will, gain insight into the tax implications of your bequests, consider what will be required of your executor, and learn how important it is to prepare a power of attorney. This session will provide important information on all of these issues, as well as give you options for charitable planning as part of your legacy. A question-and-answer period will follow.

F119829 A FPAGC Respiratory Updates: Visiting new and current data in COPD

12:30–13:30 Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON

801AB MTCC

Learning Objectives:

1. optimize knowledge on disease-state and interventions to prevent, diagnose, and manage COPD and to reinforce and measure behaviour change through multi-touch point testing
2. recognize the role of new and emerging treatments and implement practical tools and strategies into day-to-day practice to help improve patient outcomes
3. measure knowledge transfer, uptake of key messages, and behaviour change using Moore's Outcomes Framework for Planning and Assessing CME and disseminate results through peer-reviewed publications

Description:

Respiratory diseases affect at least 20 per cent of Canadians, with over 3 million Canadians having serious respiratory disease such as asthma or chronic obstructive pulmonary disease (COPD). Asthma is the most common respiratory disease and COPD is largely underdiagnosed, but despite the considerable burden imposed on patients, the management of these respiratory diseases remains suboptimal. The Family Physician Airways Group of Canada (FPAGC) has designed a program to meet the needs of primary physicians, physician assistants, registered nurses, and other primary care providers who treat patients with asthma or COPD. This program is accredited for one Mainpro M1 credit and includes multiple choice questions and case-based assessments.

Participants may claim an additional Mainpro-M1 credit for attending this session

V101201 Publier en français dans *Le Médecin de famille canadien*

13:45–13:45 Roger Ladouceur, MD, CCMF, FCMF, Verdun, QC; Yves Lambert, MD, CCMF, FCMF, Longueuil, QC;

Suzanne Gagnon, MD, CCMF, FCMF, Quebec, QC

712 MTCC

Objectifs d'apprentissage :

1. découvrir les avantages de publier en français dans *le Médecin de famille canadien*
2. connaître les exigences et les directives aux auteurs
3. comprendre le rôle des réviseurs et des rédacteurs

Description :

Cet atelier permettra aux participants de découvrir les possibilités et les avantages de la publication en français dans *Le Médecin de famille canadien*. Ils passeront en revue les types d'articles pouvant être soumis, les directives aux auteurs ainsi que les directives concernant chaque catégorie d'articles. La façon de soumettre un texte et le processus d'évaluation par les pairs seront également abordés. L'atelier se veut interactif et participatif. Des exemples et des séances pratiques sont prévus.

F96972 Family Physicians Can Prevent ACL Injuries ... Really!**13:45–14:45** James Carson, MD, CCFP, FCFP, Dip Sport Med, Toronto, ON**HALL G MTCC****Learning Objectives:**

1. become advocacy champions in their communities to prevent over 75% of ACL injuries
2. discuss the evidence-based research that supports the usage of the FIFA 11+ prevention exercises by all youth soccer teams across Canada
3. identify and optimally manage ACL injuries until they can return patients to play

Description:

This presentation will be based on the recent position statement published by the Canadian Academy of Sport and Exercise Medicine on ACL injury prevention. Participants will learn about the spectacular potential of neuromuscular training programs to prevent ACL injuries in youth sports such as soccer. ACL injury evaluation and management by the family physician will also be discussed.

F99344 Turning "Queasy" Into Easy: Simple approaches to nausea in palliative care**13:45–14:15** Stephen Singh, MD, CCFP, Cert Pall Med, Ancaster, ON; Mireille Lecours, MD, CCFP, Stratford, PE**802AB MTCC****Learning Objectives:**

1. identify the relevant receptors involved given a patient case of nausea
2. logically choose an anti-nauseant depending on the type of receptors involved
3. re-evaluate and treat refractory nausea

Description:

Nausea is a common and distressing symptom in the palliative care setting. The underlying cause of a patient's nausea will dictate the ideal choices of anti-nauseants. Sometimes this choice can seem daunting. This talk will discuss an easy, logical overview of nausea pathways. Using cases, we will discuss possible choices for anti-nauseants depending on the receptors involved. Lastly, we will discuss refractory nausea and its possible treatment. You will leave feeling more confident about nausea and its management. Live tweeting during this talk will allow for group online discussion and networking.

F100365 The Everlasting Song: Music and doctors – from medical school to retirement**13:45–14:45** Ted Jablonski, MD, CCFP, FCFP, Calgary, AB**711 MTCC****Learning Objectives:**

1. recognize the connection between music and physicians' health through anecdotal stories, historical reference, and scientific literature review
2. define various proto-typical "life cycles" of music in physicians' careers
3. employ a simple tool to maximize the healing role of music throughout career transitions

Description:

While music therapy is increasingly recognized as an adjunctive therapy for palliative care, geriatrics, and childhood illnesses, the use of music as a self-therapeutic tool for the physician is less well established. It is often said that there is an unusually high number of physicians that are musicians (or perhaps, more correctly, musicians who happen to become doctors). This presentation will explore the important connection between music and medical practitioners. In their formative years many future physicians mastered a musical instrument, played in bands or orchestras, or sung in recitals—music being a significant part of their lives. With busy residencies, early career responsibilities, and the start of families, the pursuit of music is commonly left behind as a "luxury" that limited time no longer affords. As careers and families mature, physicians sometimes lament the loss of their "musical soul" and either try to revive it or allow its death, living vicariously through their children's (or patients') musical pursuits. At retirement the goal of learning a musical instrument or singing in a community choir is not uncommon, and physicians feel a spiritual rebirth as music is re-introduced into their lives. Many physicians believe in the importance of music and its healing powers but are sometimes the first to abandon it. This presentation will introduce a simple tool that can be used by practitioners at any time in their career to tap into the healing power of music in their lives, to introduce/explore or to re-introduce and enhance. Whether it be classical violin or hip-hop, electronica or aboriginal drumming, the power of music in our personal and professional lives will be explored and celebrated. Ted "dr j" Jablonski is an award-winning multi-instrumentalist singer-songwriter and family physician in Calgary. Classically trained in piano as a child, he has released seven independent CDs in blues/folk genre, and has had numerous television appearances and some radio play throughout Canada, USA, Europe, and Australia.

F101427 The Best of Both Worlds: Ensuring optimum health in refugee populations**13:45–14:45** Meb Rashid, MD, CCFP, Toronto, ON; Praseedha Janakiram, MD, CCFP, Toronto, ON;

Vanessa Wright, RN-EC, Toronto, ON; Vanessa Redditt, MD, CCFP, Toronto, ON

715A MTCC — Small group interactive workshop – limited seating.**Learning Objectives:**

1. understand the demographics of refugee migration to Canada
2. plan an approach to the most common health issues that confront refugee populations
3. understand health insurance coverage available to refugee patients and how health care workers have advocated to obtain such coverage.

Description:

Over 25,000 refugees are accepted to stay in Canada each year. Many have endured unimaginable pre-migration stressors including exposure to war, torture, and sexual violence. Most originate from source countries where the epidemiology of disease is different than within the Canadian context. Many have not had access to primary care before their arrival in Canada. Many have nuanced health issues that differ from other immigrants and from patients that are Canadian-born. For example, current Canadian research shows high rates of PTSD, depression, infectious diseases, and unmet contraceptive needs. This workshop will provide a background into the demographics of refugee migration to Canada. Using case-based approaches, it will provide participants with an approach to dealing with health issues in different groups of refugee patients in the primary care setting. It will review issues such as immunization needs, screening for infectious diseases, women's health, and recognizing and addressing mental health issues in refugee populations. Given recent changes to health insurance coverage for refugee patients, the workshop will update the current status of the Interim Federal Health Program (IFHP), which provides insurance coverage for refugee patients. Health care workers have been at the forefront of advocating against cuts to the IFHP and the workshop will provide a background into the strategies that have been used to ensure newly arrived refugees have access to primary care.

F101663  **Rapid-Fire Pearls for Common Practice Problems**
13:45–14:45 **Tir rapide de perles pour les problèmes courants de la pratique**

Tina Korownyk, MD, CCFP, Edmonton, AB

HALL F MTCC

Learning Objectives:

1. apply simple solutions to common questions that arise in primary care
2. understand the evidence or lack thereof for certain medical practices

Description:

This is a rapid-fire, *Jeopardy*-style presentation. Multiple topics will be covered, ranging from pediatric infectious disease, to supplements, to care of the elderly. Key evidence will be presented briefly and the bottom-line answers to relevant clinical questions.

Objectifs d'apprentissage :

1. appliquer des solutions simples aux questions souvent posées en soins primaires
2. comprendre les données, ou l'absence de données, justifiant certaines pratiques médicales

Description :

Cette présentation est un tir rapide, du style *Jeopardy*. Elle couvre de multiples sujets, allant des maladies infectieuses de l'enfance aux suppléments, en passant par les soins aux personnes âgées. Des données importantes sont présentées brièvement et les résultats répondent aux questions cliniques pertinentes. La participation de l'auditoire et l'interaction sont encouragées.

F101678 **Facilitating Entry to Psychosocial Treatment for Patients With Substance Use Disorders**

13:45–14:15 Yelena Chorny, MD, MSc, CCFP, ABAM, Guelph, ON

501 MTCC

Learning Objectives:

1. identify the different types of psychosocial interventions that are available for treatment of substance use disorders
2. determine an appropriate level of care for initial treatment of substance use disorders
3. identify where to get assistance with finding and accessing psychosocial treatment for patients with substance use disorders

Description:

Patients with substance use disorders are commonly encountered in primary care. They present with a wide range of severity, medical and psychiatric co-morbidities, personal strengths, external supports, and levels of readiness to change. While family physicians provide a number of effective pharmacological and non-pharmacological interventions in the primary care setting, many patients will benefit from additional support or more intensive psychosocial treatment. Barriers to accessing and completing treatment are many, and lead frequently to frustration on the part of both the patient and the referring clinician. This presentation will help practising physicians identify the psychosocial treatment options available for patients with substance use disorders in their practice, along with clinical criteria that may be used to select an appropriate type and level of treatment. Barriers to treatment at the patient, provider, and systemic levels will be reviewed, and (province-specific) resources for finding and accessing treatment will be shared.

F94660 **Five Fundamentals of Civility for Physicians**

13:45–14:45 Michael Kaufmann, MD, CCFP, FCFP, Toronto, ON; Ted Bober, MSW, RSW, PHP, Toronto, ON

715B MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. define civility as relevant to the behaviour of doctors in the professional environment
2. recognize the impacts of professional behaviour, both civil and uncivil, on colleagues, co-workers, health care teams, and patient care
3. identify a grouping of strategies that are associated with and promote civil professional comportment among doctors and integrate them into your professional training and practice

Description:

In recent years there has been increasing attention placed upon physician behaviour in the workplace, mostly in a negative sense. As a result, a variety of approaches have been developed to address so-called disruptive behaviour by doctors. Less has been written about the

understanding and promotion of a desired style of physician behaviour that can be conceptualized as civility. Civility is about more than politeness and courtesy, although it begins there. High-quality professional comportment is essential for health care teams to function effectively. Physician incivility, often revealed at times of tension, can cause stress, distress, and poor productivity in co-workers of all kinds. Incivility can propagate itself and erode the very culture of a workplace and, indeed, a profession. On the other hand, civil behaviour results in positive social interactions. Civility among colleagues is associated with lower rates of professional burnout. Civil collegial relationships create comfortable and energizing workplaces with lower turnover rates and higher worker satisfaction. Everyone, including patients, benefits from civil professional behaviour. The impacts of civility (and its absence) in the professional environment, even if self-evident, have been demonstrated by research and the evidence will be reviewed in this workshop. Even so, the various dimensions of civility do not always surface in a deliberate manner in medical training and beyond. It appears, then, that a civil approach to physician behaviour in the workplace has merit, but there are questions to explore. When the many dimensions of civility are reviewed, it appears that there are specific strategies that can be adopted to foster civil behaviour in doctors, even at times of risk. A practical selection of these strategies, grouped into five categories as “Five Fundamentals of Civility for Physicians,” are respect others, be aware, communicate effectively, take good care of yourself, and be responsible. These Five Fundamentals are offered as a framework for the promotion of civil professional behaviour in doctors at all career stages. A variety of ideas as to how to build upon this framework will be explored.

F101900 From Great to Outstanding: Take your medical presentations to the next level – a review of the literature, best practices, and idea-sharing

Simon Moore, MD, CCFP, Mono, ON

707 MTCC

Learning Objectives:

1. discuss the published literature on increasing the effectiveness of medical presentations
2. list best practices for more effective use of visual aids (i.e. Prezi, PowerPoint) and overcome presentation pitfalls
3. discover presentation tips and pearls from other attendees and share your own

Description:

Many physicians are required to present at rounds, conferences, and teaching sessions—and some doctors even enjoy doing so. However, physicians are often not formally trained to give high-impact presentations. This presentation will overview the published literature on what makes an effective medical lecture and what improves learning outcomes, summarize pearls on the best practices for use of visual aids, and review common presentation pitfalls and how to easily overcome them. This session’s experienced presenter has often been asked by audience members “how to give a talk.” In response, he will share what he has learned over the years giving medical lectures and the top negative and positive feedback items he (and other conference speakers) have received. Finally, through a facilitated discussion, participants will have an opportunity to share the techniques they have used to increase the effectiveness of their medical presentations and to learn about others’ techniques.

F102088 Becoming a Resident: It’s not as bad as you think!

Michelle van Walraven, MD, CCFP, Barrie, ON

709 MTCC

Learning Objectives:

1. prepare for transitioning from being a medical student to a family medicine resident
2. use other residents’ tips and recommendations on CaRMS, financial concerns, and self-wellness to begin planning for residency
3. discover answers to questions about being a new resident in family medicine

Description:

It seems like only yesterday you were accepted into medical school. But when should you start thinking about residency? Whether you are in your first or your last year of medical school, it’s not too early to start planning for the transition. This session for medical students will present some tips and recommendations to help with preparing for residency. It will touch upon the many steps along this natural continuum, including preparing for electives, getting ready for CaRMS, selecting a family medicine residency program, and dealing with financial concerns, lifestyle issues, and adjustment into your new role of being a doctor. This session is presented by a current resident and a recent graduate in family medicine, with participation from the Section of Medical Students and the Section of Residents of the CFPC.

F102150 Pearls for Menopause Management: I’m ready – now what?

Susan Goldstein, MD, CCFP, FCFP, NCMP, Toronto, ON

701AB MTCC

Learning Objectives:

1. describe the new evidence-based guidelines related to menopause management
2. develop an approach to managing and treating menopausal symptoms
3. use newly developed practice tools for menopause management

Description:

Physicians continue to endorse knowledge gaps around deciding what to treat, when to treat, and how to treat menopausal symptom presentations. After reviewing the newest evidence-based guidelines for menopause management, we will discuss an algorithmic approach to treatment, introduce newly developed practice tools and apps, and will review the specific treatment options. (This presentation has been developed as a follow-up to the presentation at FMF 2012 – Menopause Pearls for Practice.

F102306 Managing Medevacs in Rural and Remote Family Practice: Do's and don'ts

13:45–14:45 W. Alexander Macdonald, MD, CCFP, FCFP, Iqaluit, NU

717B MTCC

Learning Objectives:

1. learn the importance of knowing the medevac system's role in the provision of quality care in rural and remote family practice
2. develop a short list of do's and don'ts regarding management of medevacs in rural and remote family practice
3. explore actual cases illustrative of the challenges involved in managing medevacs in rural and remote family practice

Description:

Managing emergency air medevacs is an integral part of rural and remote family practice in Canada. A thorough knowledge of the physiology of flight and of the logistics of the provincial/territorial medevac system is critical to providing high-quality care to our patients. Based on experience in Nunavut (over 1,700 air medevacs per year) and other regions of Canada, the session will focus on developing a short list of do's and don'ts of air medevac management for family physicians working in rural and remote practices. Flight physiology will be addressed in the context of understanding the impact of the logistics of air medevacs on clinical decision making. The discussion will focus on the family physician as 1) the base hospital physician arranging medevacs coming to the hospital; 2) the sending physician for medevacs to tertiary care centres; and 3) the accompanying physician on acute-care air medevacs. Several actual case histories will be discussed to illustrate the challenges of managing medevacs, and participants will be encouraged to present some cases from their own practices for group consideration. Participants should come away from this session with a good knowledge of the salient points of managing air medevacs. Through an iterative process we will develop a short list of do's and don'ts for improving the management of air medevacs. With participants' permission, the presenter will email the short list of do's and don'ts to all participants after the session.

F102329 Where Is Continuity of Care in a Family Medicine Residency Program?

13:45–14:45 **Résidence en médecine familiale : où est la continuité des soins?**

Manon Denis-LeBlanc, MD, CCFP, St Isidore, ON; Lyne Pitre, MD, CCFP, FCFP, Ottawa, ON

705 MTCC

Learning Objectives:

1. define continuity of care in family medicine as described by the College of Family Physicians of Canada
2. describe realistically where the residents encounter continuity of care
3. construct appropriate tools to demonstrate how continuity of care is achieved in your residency program

Description:

Continuity of care is the basis of family medicine practice. However, in a residency program, with all the skills and knowledge that must be taught, it is often difficult to ascertain that continuity of care is achieved. It is even harder to demonstrate when accreditation comes along. Geared to residents and faculty in family medicine, this workshop is aimed at revisiting what is continuity of care, where it is encountered, and how residents can be exposed to the most valuable continuity of care. Also, there are inherent differences between the academic and community settings; these will be defined. Once continuity of care is recognized, it is also imperative to record it in a way that can be demonstrated to the residents, the departments, and the College. This workshop will focus on strategies to define, apply, and record continuity of care. Practical tools will be developed during the workshop.

Objectifs d'apprentissage :

1. définir la continuité des soins en médecine familiale telle que décrite par le Collège des médecins de famille du Canada
2. décrire de façon réaliste où, quand et comment le résident peut assurer la continuité des soins
3. établir des outils pour démontrer comment la continuité des soins a été assurée au programme de résidence

Description :

La continuité des soins de santé est la base de la médecine familiale. Cependant, en résidence, avec toutes les connaissances et habiletés nécessaires à enseigner, il est difficile d'assurer cette continuité. Ceci l'est encore plus si l'on tient compte de l'agrément. Le but de cet atelier, qui s'adresse aux résidents et aux enseignants de médecine familiale, est de répondre aux questions suivantes : qu'est ce que la continuité des soins?, quand est-elle rencontrée? et comment les résidents peuvent-ils être exposés à l'importance de la continuité des soins? Il existe également une différence entre le milieu académique et communautaire, ce qui sera défini lors de la session. Une fois que la continuité des soins a été établie, il est impératif de documenter le processus afin de le démontrer aux résidents, aux départements et au Collège. Cet atelier se concentrera sur les stratégies visant à définir, appliquer et documenter cette continuité. Des outils pratiques seront également développés au cours de l'atelier.

F102338 Building Research Culture and Capacity in Family Medicine: The Canadian landscape

13:45–15:45

Bridget L. Ryan, PhD, London, ON; Cathy Thorpe, MA, London, ON; Stephen J. Wetmore, MD, CCFP, FCFP, London, ON; Merrick Zwarenstein, MD, London, ON; Jamie Wickett, MD, CCFP, Melbourne, ON; Leslie Boisvert, MPA, London, ON

710 MTCC

Learning Objectives:

1. discuss strategies to increase research culture and capacity in family medicine in Canada
2. create a distilled list of ideas to pursue and explore possibilities for collaborations across departments
3. identify a set of best practices, which participants can consider implementing in their own departments

Description:

Participants will explore strategies to increase research culture and capacity in family medicine departments in Canada. This session will be of particular interest to chairs, directors of research, and faculty charged with increasing research capacity in their departments, and to clinicians and teachers interested in conducting research. The Section of Researchers' Blueprint for Family Medicine Research Success envisions

research as a core component of training, scholarship, and clinical practice. Twenty-six chairs and research directors from all 17 family medicine departments have expressed interest in participating. Representatives from family medicine departments will share and discuss the strategies they have successfully employed to support research culture and increase research capacity. Participants will distil these ideas as a group. Possibilities for collaborations across departments will be discussed. Participants will leave with a set of best practices that they can consider implementing in their own departments.

F102579 **Improving Transitions in Care Between Hospital and Home: How house calls are an important clinical intervention**
13:45–14:15

Amanda Condon, MD, CCFP, Winnipeg, MB; Paul Sawchuk, MD, CCFP, FCFP, MBA, Winnipeg, MB

716A MTCC

Learning Objectives:

1. identify high-risk patient populations mostly likely to benefit from home-based primary care
2. list aspects of care beyond medicine that can be delivered in a patient's home
3. measure quality indicators and health care outcomes for patients from home-based primary care

Description:

The pillars of a patient's medical home include ensuring timely access to medical care; coordination of care with other team members; providing continuity of care, relationships, and information for patients while providing services to meet the needs of the population. A traditional office-based model makes it difficult to achieve these elements for those patients who are housebound. Patients are unable to attend office appointments for many reasons: severity of medical illness, mental illness and addiction, transportation issues and lack of caregiver support. When medical needs arise, often the only way to access medical care is a 911 call and an ambulance transfer to the hospital. How are the patients most in need of more intense home and community care identified? What tools exist in Canada to identify high-risk patients? What do we do for them? Do they have improved health outcomes with this level of care? These are a few of the many questions that arise while contemplating a care model that includes this level of in-home care. This session will bring experienced clinicians from multiple jurisdictions together to discuss the challenges, successes, and outcomes with delivering home-based primary care as part of their practice, along with its role in reducing avoidable emergency room visits and hospitalizations.

F96052 Doc, I Can't Breathe: How to approach this in your office!
Part A: 13:45–16:15; Part B: 16:30–17:30
801AB MTCC

Learning Objectives:

1. use approach to make the correct diagnosis of a dyspneic patient
2. review treatment strategies
3. review follow-up of these conditions in your office

Description:

Dyspnea is the presenting symptom for many conditions, from respiratory to cardiac to metabolic causes. It is easy to see that a patient is short of breath, but sometimes the cause is less clear. The executive of the Respiratory Medicine Community of Practice of the CFPC will give you a clear review on how to narrow down the differential, come up with the right diagnosis, and institute therapy for the correct issue to maximize your patient's recovery. We will help clarify common, uncommon, clear, and difficult issues including asthma COPD, COPD vs CHF, asthma COPD overlap syndrome, and restrictive lung diseases. Come in with questions; you will leave with the answers!

Part A

1. **Case and Differential** – Elaheh Mousa Ahmadi, MD, Edmonton, AB
2. **Tests Required for Work-up** – Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON
3. **COPD and Restrictive Lung Disease** – Suzanne Levits, MD, CCFP, Montreal

Part B

4. **Asthma** – John Li, Mocton, NB
5. **COPD versus CHF and Asthma-COPD-Overlap Syndrome** – Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON

Moderator – Chris Fotti, MD, CCFP, East St. Paul MB

QUESTION PERIOD

F102690 Water Birth
13:45–14:15 Elizabeth Brandeis, RM, Toronto, ON
714AB MTCC

Learning Objectives:

1. describe the current evidence about the safety of water birth
2. describe practice protocols for water birth
3. identify the research gaps about water birth and opportunities for further inquiry

Description:

Water birth, an alternate method of pain relief for birth, will be explored in this session. The history and current practices of birthing in water will be reviewed. The safety of water birth will be discussed in the context of the research evidence.

F102008 Procedural Pain Management in Infants: Translating evidence into clinical practice
14:15–14:45 Vibhuti Shah, MD, MRCP, FRCPC, MSc, Toronto, ON
714AB MTCC

Learning Objectives:

1. describe the epidemiology and potential long-term consequences of procedural-related pain in neonates and infants
2. review the evidence regarding the effectiveness of various pharmacological and non-pharmacological strategies to reduce or prevent pain
3. summarize strategies that can be easily adopted in clinical practice

Description:

Procedural-related pain continues to be a significant burden in infants and children in both the hospital and community settings. Even a healthy neonate is exposed to a minimum of two painful procedures (intramuscular injection and heel lance) soon after birth. Further, despite the evidence of long-term consequences of cumulative pain in neonates and infants, effective strategies to mitigate pain are not universally adopted by health care professionals who provide care of these vulnerable infants. In this session, we will review the evidence regarding the burden of illness, the potential long-term implications of cumulative pain, and the effectiveness of various pharmacological and non-pharmacological strategies to prevent or reduce procedural-related pain. At the end of the session, strategies that can be easily implemented by clinicians in office settings will be summarized.

F102483 Family Medicine Resident and Medical Student Leadership Workshop - BY INVITATION

13:45–17:30 Louise Nasmith, MD CM, CCFP, FCFP, Vancouver, BC; Ian M. Scott, MD, CCFP, FCFP, Vancouver, BC; Guillaume Charbonneau, MD, CCFP, Messines, QC
717A MTCC

Learning Objectives:

1. develop leadership attributes and skills
2. describe a model for analyzing change
3. discuss leadership career development

Description:

This dynamic workshop on developing leadership skills and attributes is offered to the 34 recipients of the Family Medicine and Medical Student Leadership Awards, and led by three of the College's most talented leaders and educators, Drs Louise Nasmith, Ian Scott, and Guillaume Charbonneau. The workshop is offered by invitation only.

F115034 Instilling Social Accountability and Addressing the Hidden Curriculum in Postgraduate Medical Education: Recommendations from the Future of Medical Education in Canada Postgraduate (FMEC-PG) Implementation Project

13:45–16:15 Nick Busing, MD, CCFP, FCFP, Ottawa, ON; Jill Konkin, MD, CCFP, FCFP, Edmonton, AB; Roger Strasser, MBBS, BMedSc, MCISc, DA, DipRACOG, FRACGP, FRACRRM, FRCGP, AM (Australia), Sudbury, ON; Jim Rourke, MD, CCFP (EM), MClInSc, FCFP, FRRMS, FCAHS, LLD, St John's, NL
703 MTCC

Learning Objectives:

1. describe best practices in social accountability in residency training programs by examining the diversity of learning environments
2. identify the hidden curriculum within our undergraduate and postgraduate training programs and develop strategies to address the negative aspects of this curriculum

Description:

To better understand how individual residency programs are addressing the issue of social accountability, the FMEC-PG project developed and disseminated a survey to all program directors. The survey asked about the diversity of learning environments that can reinforce our collective social accountability mandate, and explored issues such as scholarship in social accountability. We will present the survey's results, then will break into small group discussions to look at best practices in addressing social accountability, as well as barriers and challenges to these practices. The FMEC PG project's recommendation relating to the learning and work environment has a number of action items, one of which is to address the positive and negative aspects of the hidden curriculum. The Working Group addressing this issue has identified the following challenges: How can programs increase awareness among learners of the hidden curriculum and its messages? How can programs take stock of their hidden curricula? What reflective strategies will reveal the hidden curriculum so that its messages can be appreciated, critiqued, and mitigated if necessary? How can programs be more deliberate in their use of role models in clinical teaching? The workshop will put forward these issues, and participants will be asked to work towards finding common approaches and solutions to addressing them.

F102290 HIV Risk, Testing, and Prevention: Practical advice for in-office intervention


14:15–14:45 Charlie B. Guiang, MD, CCFP, Toronto, ON; Gord Arbes, MD, CCFP, Toronto, ON
716B MTCC

Learning Objectives:

1. identify opportunities in the office to assess HIV risk, test when appropriate, and provide risk-reduction counseling
2. using the session's practical advice, discuss HIV risks with patients in an open, comfortable, nonjudgmental environment
3. review PEP for patients with potential HIV exposure, including evidence for HIV risk reduction, appropriateness, and counseling

Description:

Approximately 71,300 people in Canada were living with HIV in 2011 (prevalence). New HIV infections (incidence) have remained relatively stable in Canada over the years. In 2011, the incidence of HIV infection was approximately 3,175. There were an estimated 65,000 people in Canada living with HIV infection by the end of 2008. The Public Health Agency of Canada estimates that among these, 16,900 people, or 26 per cent, were not aware of their Infection. Family physicians are pivotal in many aspects of HIV prevention. We can assess HIV risk in all our patients, decide appropriately for HIV testing, and provide risk-reduction counseling for those same individuals. Identifying new HIV patients and connecting them to the proper resources gives these patients an opportunity to reduce their viral load with antiretroviral medication and potentially reduces the burden of HIV with the notion of treatment as prevention. Post-exposure prophylaxis (PEP) exists to decrease HIV risk after a high-risk exposure—family physicians are often the first clinicians aware of such exposures and can intervene at a most crucial time. Intended for family physicians, residents, and medical students, this session will review basic HIV epidemiology, highlighting the need for ongoing HIV prevention strategies. The need for proper HIV risk assessment of all patients by their family physicians will also be highlighted. Acknowledging the most common risk factors for HIV in Canada, we will provide practical advice about what to ask, and how to ask it, in the office setting. We will highlight common daily clinical scenarios where opportunities exist to include HIV risk assessment and testing. Understanding HIV test results and their limitations will be reviewed. Recognizing acute HIV infection, as well as late-stage manifestations in those where HIV diagnosis is missed, will be considered. Finally, we will review PEP for patients with potential HIV exposure, including appropriateness, the importance of timely intervention, and the reduction in HIV risk it can provide. By the end of the session, family physicians will be equipped to take a considerable role in the overall reduction of HIV burden in their communities.

F102698  **Benzodiazepines and BZD Use Disorder: A primary care approach to tackling the black box**
14:15–14:45 **Benzodiazépines et trouble de consommation des benzodiazépines : approche de soins primaires pour s'attaquer à la boîte noire**
 Jonathan Bertram, MD, CCFP, Toronto, ON; Francesca Di Paola, MB ChB, CCFP, Toronto, ON
718AB MTCC

Learning Objectives:

1. describe effective approaches to screening and assessment
2. address complications of withdrawal and indications for inpatient detoxification
3. identify existing and novel options for taper and pharmacotherapeutic management in the community, including low-dose BZD maintenance

Description:

There is a high rate of benzodiazepine (BZD) use in the population. Used for multiple indications (anxiety, seizures, alcohol withdrawal, muscular relaxation), BZDs are also addictive substances, and a notable percentage of regular users develop dependence. There is currently no approved pharmacotherapy for treatment of benzodiazepine use disorder, and optimal strategies for assessment and treatment are unclear. Topics will include the emergence of benzodiazepine and sedative hypnotic use and dependence in both the mainstream and older adult populations; the subsequent complications encountered, especially in relation to withdrawal and when and how a medicalized detox can help; evidence around the classical approach, providing a slow taper associated with counseling; the growing use of pharmacotherapy for subacute withdrawal management; the long-term strategies of maintenance therapy (with BZDs) that could provide some clinical benefit but have not yet been tested appropriately. This session will include didactic and interactive components to encourage discussion. Participants will gain an enhanced understanding of BZDs and use disorder.

Objectifs d'apprentissage :

1. décrire les approches efficaces de dépistage et d'évaluation
2. aborder les complications liées au sevrage et les indications de la désintoxication à l'hôpital
3. nommer les options nouvelles et existantes de retrait graduel et de prise en charge pharmacothérapeutique communautaire, y compris le traitement d'entretien par une benzodiazépine à faible dose

Description :

Le taux d'usage de benzodiazépines est élevé dans la population. Administrées dans beaucoup d'indications (anxiété, crises convulsives, sevrage de l'alcool, relâchement musculaire), les benzodiazépines peuvent aussi créer une dépendance, et d'ailleurs, un pourcentage notoire d'utilisateurs réguliers en développent une. À l'heure actuelle, il n'existe aucune pharmacothérapie homologuée pour le traitement du trouble de consommation des benzodiazépines, et les stratégies optimales d'évaluation et de traitement sont nébuleuses. Les sujets de cet atelier sont l'émergence de l'emploi des benzodiazépines et des sédatifs hypnotiques et de la dépendance à leur égard tant dans la population générale que chez les personnes âgées; les complications subséquentes, surtout en relation avec le sevrage, et quand et comment une désintoxication médicalisée peut être utile; les données étayant l'approche classique, qui consiste à retirer graduellement le traitement associé au counseling; le recours croissant à la pharmacothérapie pour la prise en charge subaiguë du sevrage; les stratégies à long terme de traitement d'entretien (par les benzo) qui pourraient procurer des bienfaits cliniques, mais qui n'ont pas fait l'objet de tests appropriés. L'atelier comporte une facette didactique et une facette interactive visant à encourager la discussion. Les participants comprendront mieux les benzodiazépines et les troubles de la consommation.

F95713 **Delirium in Palliative and Elder Care: Useful tips for identifying and managing a distressing problem**
15:15–16:15 Gail Saiger, MD, CCFP, FCFP, diploma in palliative care, Victoria, BC;
 Daphna Grossman, MD, CCFP, FCFP, Toronto, ON
701AB MTCC

Learning Objectives:

1. identify delirium and develop an approach to investigation of reversible causes
2. recognize which patients and which medical conditions may be especially susceptible to delirium (advanced cancer, dementia, kidney and/or liver failure)
3. describe pharmacologic and environmental approaches to management of delirium in various settings (home, residential care, hospital)

Description:

This session will be presented jointly by Dr Gail Saiger, a palliative care physician (with special interest in complex pain and delirium management) who works on a tertiary palliative care in-patient unit in Victoria, BC, and by Dr Daphna Grossman, who works in palliative care at a geriatric hospital in Toronto. Using a combination of didactic teaching and case studies, they will attempt to demonstrate how delirium in elder and end-of-life care is common, ubiquitous, often predictable, and always unsettling. They will offer tools for identification, investigation, and treatment of reversible causes of delirium; discuss the importance of environmental manipulation to manage the distress of delirium; and offer appropriate pharmacologic suggestions for prevention and management of delirium. Dr Saiger will concentrate on delirium in advanced cancer; Dr Grossman will discuss delirium in the elderly and those with non-cancer diagnoses.

F99343 **ALS Primer: A palliative approach**
15:15–16:15 Stephen Singh, MD, CCFP, Cert Pall Med, Ancaster, ON; Mireille Lecours, MD, CCFP, Stratford, PE
802AB MTCC

Learning Objectives:

1. recognize signs and symptoms of ALS at various stages
2. discuss interventions that can prolong life and/or increase quality of life
3. understand the importance of an interdisciplinary team in ongoing management

Description:

Amyotrophic lateral sclerosis (ALS) is a devastating, incurable disease currently affecting almost 3,000 Canadians. In this talk, we will discuss some of the signs of ALS at various stages. Through a case study, we will discuss some of the symptoms of ALS and how a palliative care approach can help with management to improve quality of life. Riluzole will be discussed as a possible treatment to prolong tracheostomy-free survival. The importance of an interdisciplinary team will be examined. You will leave feeling more confident about ALS symptoms and their management. Live tweeting during this talk will allow for group online discussion and networking.

F100906 Using Video to Teach Interview Skills

15:15–17:30 William Eaton, MD, CCFP, FCFP, St John's, NL; Vlna Broderick, MD, CCFP, FCFP, St John's, NL; Heather Flynn, MD, St John's NL; Steve Lee, MD, CCFP, FCFP, St John's, NL

709 MTCC – Small group interactive workshop – limited seating.

Learning Objectives:

1. recall novel protocol for teaching interview skills using video review of recorded resident-patient interactions
2. reproduce approaches to teaching using video review
3. apply the novel protocol to teaching plans

Description:

As part of the educational mandate of family medicine residencies, community preceptors provide now, and will into the future, much of the ongoing teaching of clinical skills for family medicine residents, especially how to conduct a patient-centred interview. Family medicine is the main, if not only, discipline that teaches such skills using video review.

We wish to present a novel protocol for family medicine preceptors for video review teaching sessions with family medicine residents and clerks. This novel protocol breaks the interview into sections, each requiring unique interview skills. We will discuss how the educational contract helps the resident focus on specific interview skills and how the preceptor's feedback can reinforce this learning. We will present a series of video-recorded interactions between residents and mock patients and between these residents and preceptors reviewing the resident-mock patient interviews.

Using this novel protocol will help family medicine preceptors to focus their teaching efforts on resident learning needs.

F101343 Reefer Madness From Cradle to Grave: Considering medical marijuana

15:15–16:15 Lisa Graves MD, CCFP, FCFP, Ancaster, ON; Sharon Cirone, MD, CCFP(EM), FCFP, Toronto, ON; Mel Kahan, MD, CCFP, FCFP, Toronto, ON; Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON

401 MTCC

Learning Objectives:

1. describe the evidence for use of marijuana (dried cannabis) in treatment of medical conditions
2. outline the risks of marijuana use for teens, young children, pregnant women, and breastfeeding mothers
3. use the guidance document to support clinical decision making

Description:

Recent changes in the regulation of medical marijuana have created challenges for family physicians. The risks of marijuana to young children, adolescents, and pregnant and breastfeeding women will be reviewed. Participants will be able to use the CFPC's preliminary guidance document to guide clinical decision making surrounding the authorizing of marijuana use in chronic pain and in the presence of specific mental health concerns. Participants will develop an approach to requests for marijuana in day-to-day practice. This workshop will lead participants through the 2014 guidance document *Authorizing Dried Cannabis for Chronic Pain or Anxiety*.

F101484 Stories in Family Medicine: AMS-Mimi Divinsky awards

15:15–17:30 Joyce Zazulak, MSc, MD, CCFP, FCFP, Hamilton, ON

711 MTCC

Learning Objectives:

1. recall stories that bear witness to the physician-patient relationship and the power of humanity in care delivery
2. recognize how stories can help family physicians communicate their values and beliefs to students, residents, and colleagues
3. find inspiration to put thoughts on paper and submit stories to the project

Description:

"When Stories nestle in the body, soul comes forth."—Deena Metzger, poet, novelist, essayist, storyteller, teacher, healer, and medicine woman.

Family physicians have traditionally relied on scientific evidence to guide care for their patients. New research is encouraging physicians to tell their own stories of caring for patients as a way to rehumanize medicine. This type of reflection can help physicians develop empathy and a greater understanding of the patient's experience of illness. These stories, now a connection between the doctor and the patient, can ultimately guide in delivering patient-centred care.

Join us to hear the stories written by the recipients of this year's AMS-Mimi Divinsky awards and the insights of our guest lecturer.

F101809 Treating High-Risk Chronic Pain Patients: What you need to know to prescribe safely

15:15–16:15 Robert Hauptman, BMSc, MD, St Albert, AB

716A MTCC

Learning Objectives:

1. describe characteristics of high-risk patients
2. describe tools to assess and stratify patients with chronic pain into low-, moderate-, and high-risk categories
3. implement strategies and boundaries in managing high-risk patients with chronic pain

Description:

Chronic pain afflicts thousands of Canadians. Current estimates are that 20 per cent of Canadians suffer from chronic pain. Of particular difficulty for physicians is treating patients with chronic pain who have a past history of addiction, a family history of addiction, or a current substance abuse problem. These patients with chronic pain are at high risk for medication misuse and diversion. However, at the same time, they can have significant pain problems. This session will review the management of high-risk chronic pain patients with the goal of increasing participants' confidence in managing this group of patients.

F101892 Professionalism Issues: An educational opportunity

15:15–17:30 Erika Abner, LLB, LLM, PhD, Toronto, ON; Susan Goldstein, MD, CCFP, FCFP, NCMP, Toronto, ON

705 MTCC

Learning Objectives:

1. discuss approaches one can take with trainees who present professionalism lapses
2. identify different management strategies for different trainee presentations
3. develop specific, targeted reflective assignments and activities

Description:

Students presenting with behaviours that raise professionalism issues are challenging for family physicians. At the same time, these events are often valuable educational opportunities that offer teachable moments for delivering appropriate feedback. This workshop will help participants to recognize and address common student presentations that raise professionalism concerns, including typical major and minor professionalism lapses. These include, for example, consistently late assignments, poor communication, difficulty prioritizing work, and general disorganization. We will discuss management strategies, resources, and documentation at the student and institutional levels. The workshop will employ a variety of instructional methods, including case-based discussion, document review, and brief lectures.

F102322 Mosquitoes Could Spoil Your Vacation: Chikungunya virus and other mosquito-borne diseases

15:15–16:15 Michel Deilgat, MD, MPA, CCPE, Ottawa, ON

716B MTCC

Learning Objectives:

1. review the epidemiology of recent outbreaks in the Caribbean and surrounding countries
2. describe the clinical manifestations and provide a differential diagnosis
3. prescribe the appropriate diagnostic testing and provide effective management

Description:

Since 2005, chikungunya fever, a viral disease transmitted by *Aedes aegypti* and *Aedes albopictus* mosquitoes, has become a global public health issue. Acute symptoms include fever, rash, backache, headache, and joint pain. Although fatal outcomes are relatively rare, after-effects are common—particularly arthritis, which can persist long-term. In December 2013, the local transmission of the chikungunya virus (CHIKV) was confirmed for the first time in several Caribbean islands. In a given year, Canadians can make more than 2.5 million visits to the Caribbean countries—thus the potential increased risk of travel-related cases. In 2014 alone, the National Microbiology Laboratory confirmed over 100 imported cases of CHIKV diagnosed in Canadian travelers returning from endemic regions, and this number is expected to grow in the coming years. The spread of the disease has reached Central America and South America, and, in 2015, the mosquitoes have been seen for the first time in the San Diego region. A recent assessment by the Public Health Agency of Canada suggests that the current risk of autochthonous (ie, local or indigenous) spread of CHIKV in Canada is very low. However, family physicians must be vigilant to recognize an increased number of cases coming from travelers visiting the southern hemisphere and to provide preventive measures and advice, as no vaccine or specific treatment is available at the moment.

F102477 Hypoglycemia: A major reason for not achieving targets

15:15–16:15 Michele MacDonald Werstuck, RD, MSc, CDE, Hamilton, ON; Bruno DiPaolo, BSc, MD, Hamilton, ON

501 MTCC

Learning Objectives:

1. use case-based scenarios to identify the signs and symptoms of hypoglycemia and patients at increased risk
2. describe the implications of hypoglycemia on diabetes and driving and senior health, from a clinician perspective and a patient perspective
3. identify and practice strategies to use in family practice to reduce risk of hypoglycemia, including medication management and patient education approaches

Description:

How often do your patients with diabetes experience hypoglycemia? Balancing the benefits of optimizing care with reducing risk of adverse events such as hypoglycemia is always forefront in the minds of clinicians. Whether it is an elderly patient at risk of falls or atrial fibrillation or a driver living with diabetes, preventing hypoglycemia is the top priority. "Fix the lows first, then go after the highs" is a common mantra in

diabetes education. Our physician-dietitian-nurse practitioner team has developed a collaborative approach to diabetes care, with a focus on hypoglycemia prevention. From medication management options to diabetes education strategies, this session will highlight cases you will commonly see in family practice and discuss how to manage care to reduce hypoglycemia risk and ensure patients receive the hypoglycemia message each and every visit.

F102493 **I'm Not Injecting Poison Into My Child!: How to confidently debunk your patients' anti-vaccination myths**

15:15–16:15

Simon Moore, MD, CCFP, Mono, ON; Kaitlin Dupuis, MD, CCFP, Hamilton, ON

HALL G MTCC

Learning Objectives:

1. review common patient objections to vaccines
2. learn practical facts to counsel patients on the benefits (and the known adverse reactions) of vaccines
3. use patient handouts and practical tools for physicians

Description:

Counseling a vaccine-hesitant parent goes far beyond knowing how to respond to the myth that “vaccines cause autism.” In an honest effort to keep their children safe, some parents have done extensive research, and ask their physician’s opinion on the incorrect information that they find. Other parents have multiple and sophisticated rebuttals when a doctor suggests their child be vaccinated.

Through a dynamic discussion, hosted by two speakers, common patient objections to vaccines will be reviewed, including “The formaldehyde/arsenic/aluminum/mercury in vaccines is harmful”; “Vaccines are made from aborted fetal cells and have baby bits, and my religion opposes this”; “Disease rates were declining before vaccines were introduced”; “My daughter will be more promiscuous if you vaccinate her for HPV”; “It’s better to get the diseases naturally—they’re not so bad”; “A baby’s immune system can’t handle all these”; “The vaccines haven’t been around long enough to know they’re safe.” To review these objections, participants will be shown practical facts and pearls to counsel patients on the benefits (and the known adverse reactions) of vaccines; anti-vaccination literature—along with the science to debunk claims; patient handouts and tools for physicians; and licensing bodies’ policies for physicians who refuse to see vaccine-hesitant parents.

Finally, a group discussion will be facilitated to share experiences with patient objections and ways to overcome them.

F102738 **Approach to Interviewing the Young Patient With Borderline Personality Disorder: Pearls for practice**

15:15–15:45

Approche d'entrevue du jeune patient atteint d'un trouble de la personnalité limite : conseils précieux pour la pratique

Natalie Raso, MD Candidate McMaster 2016, BAsC, MPP, Hamilton, ON;

Olabode Akintan, MD, FRCPC, MBA, Hamilton, ON;

Dominik Nowak, MD Candidate McMaster 2016, BSc (Hons), Hamilton, ON

718AB MTCC

Learning Objectives:

1. use an evidence-based framework to interview young patients with borderline personality disorder (BPD) in a typical practice
2. develop strategies for building an effective therapeutic relationship with young patients with BPD in a typical practice
3. develop an approach for managing a patient with BPD who presents in a crisis situation

Description:

Patients with BPD can be challenging to treat. Youth with BPD or BPD-related traits exhibit emotional volatility, self-injurious behaviour, and undergo recurrent crises. Physicians involved are often left feeling overwhelmed, frustrated, and helpless. The condition is associated with an alarming prognosis, as successful suicide rates for this population are 8 per cent to 10 per cent. Although there exists a sound body of evidence supporting specific treatment frameworks for BPD patients, there is nonetheless a paucity of literature and training for family physicians wishing to better care for this demographic in community or critical contexts. This interactive presentation, featuring role-play with simulated patients, will be of interest to generalists, primary care providers, residents, students, and allied health care professionals. We will provide a brief introduction to BPD, including prevalence and prognosis, and then outline the pitfalls and challenges that family doctors face when interviewing and forming a relationship with a patient who has BPD (such as setting boundaries, managing the therapeutic relationship, and setting up appropriate venues for follow-up). Although family doctors might not be providing long-term psychotherapy to their patients with BPD, they can use simple clinical interventions in the primary care setting that can be surprisingly productive. Through role play, we will demonstrate effective techniques for interviewing patients with BPD in a primary care setting, based on principles of dialectical behavioural therapy, which involves establishing goals that are clear and feasible, being direct, and encouraging patients to generate solutions to their problems. Providing care to patients with BPD can be challenging and draining for the family physician. We will also highlight strategies to employ to help manage the stresses that go along with caring for this patient population.

Objectifs d'apprentissage :

1. utiliser un cadre de travail factuel pour interviewer les jeunes patients atteints d'un trouble de la personnalité limite en pratique typique
2. élaborer des stratégies visant à nouer une relation thérapeutique efficace avec les jeunes patients atteints d'un trouble de la personnalité limite en pratique typique
3. développer une approche de prise en charge des patients atteints d'un trouble de la personnalité limite en situation de crise

Description :

Les patients atteints d'un trouble de la personnalité limite peuvent être difficiles à traiter. Les jeunes atteints de ce trouble ou de symptômes connexes font preuve de volatilité émotionnelle, de comportements d'automutilation et traversent des crises récidivantes. Les médecins se sentent souvent dépassés, frustrés et inutiles. Le trouble est associé à un pronostic alarmant, car le taux de suicide dans cette population est de 8 à 10 %. Bien qu'un bon nombre de données probantes étayent des cadres thérapeutiques spécifiques pour les patients atteints de trouble de la personnalité limite, il existe néanmoins peu de publications et de formation s'adressant aux médecins de famille qui souhaitent mieux traiter cette population en contexte communautaire ou critique. Cette séance interactive, qui présente des jeux de rôles avec des patients simulés, intéressera les médecins omnipraticiens, les fournisseurs de soins primaires, les résidents, les étudiants et les professionnels paramédicaux. Nous introduirons brièvement le trouble de la personnalité limite, y compris sa prévalence et son pronostic, puis mettrons en lumière les pièges et les défis auxquels les médecins de famille doivent faire face lorsqu'ils interviewent et nouent une relation avec un patient atteint de ce trouble (comme établir les limites, prendre en charge la relation thérapeutique et organiser un endroit approprié pour le suivi). Bien que les médecins de famille ne fournissent pas une psychothérapie prolongée à leurs patients atteints du trouble de la personnalité limite, ils peuvent avoir recours à des interventions cliniques simples en soins primaires pouvant être étonnamment productives. Par l'intermédiaire de jeux de rôles, nous ferons la démonstration de techniques efficaces pour interviewer les patients atteints du trouble de la personnalité limite en soins primaires, fondées sur le principe de la thérapie comportementale dialectique, laquelle implique des objectifs établis qui sont clairs et atteignables, d'être direct et d'encourager les patients à trouver des solutions à leurs problèmes. Il peut être difficile et exténuant pour le médecin de soigner des patients atteints du trouble de la personnalité limite. Nous mettrons aussi en lumière des stratégies pour aider à gérer le stress souvent lié aux soins des patients de cette population.

F102749 Clinical Population Medicine: Inventing collaborative models for population medicine and clinical practice
15:15–16:15

Aaron Orkin, MD, MSc, MPH, CCFP, FRCPC, Toronto, ON;
 Ross Upshur, MD, MA, MSc, CCFP, FCFP, FRCPC, Toronto, ON;
 Kate Bingham, MD, MSc, CCFP (EM), FRCPC, Toronto, ON; Samantha Green, MD, CCFP, Toronto, ON;
 Matthew Hodge, MD CM, PhD, CCFP (EM), FRCPC, Toronto, ON; Noah Ivers, MD, PhD, CCFP, Toronto, ON;
 Fiona Kouyoumdjian, MD, MPH, PhD, CCFP, FRCPC, Hamilton, ON;
 Onye Nnorom, MDCM, CCFP, MPH, FRCPC, Toronto, ON;
 Andrew D. Pinto, MD, MSc, CCFP, FRCPC, Toronto, ON; Danyaal Raza, MD, MPH, CCFP, Toronto, ON;
 Tomislav Svoboda, MD, MSc, PhD, CCFP, FRCPC, Toronto, ON

717B MTCC
Learning Objectives:

1. define and explore opportunities for shared care between patient-centred clinical practice and population health
2. describe different ways to incorporate population medicine and public health approaches and practitioners into clinical practice
3. invent models for partnership between specialists in family medicine and public health and preventive medicine

Description:

This workshop will engage participants to develop and advance "clinical population medicine," a new approach to shared patient and community health care delivered by family medicine, health organizations, and population health practitioners. Population health issues manifest as clinical problems—from measles outbreaks to uninsured populations, from cancer screening to poverty. Family doctors work at the front lines of population health issues. Yet public health practitioners and agencies sometimes implement policy and population-level prevention efforts without careful consideration of the role of clinical practice, primary care, and patient-oriented services. The result is a critical gap for our patients, our practices, and our communities. Can we collaboratively build our practices, hospitals, and health care systems to better meet community needs? Participants will be challenged to identify ways to close the gap between clinical practice and population health. Workshop organizers will present clinical population medicine as a way of embedding population health expertise into clinical settings. Like other shared care models, the goal is to share responsibility for organizing and delivering care that addresses both patient and community health priorities. We will call on participants to help us develop and critique this model, and determine whether it would serve their patients and practices. We will break into small groups facilitated by family doctors and public health and preventive medicine specialists. Participants will develop an inventory of community and population health needs in family medicine. With specific cases and opportunities ripe for a clinical population medicine approach, participants will explore how these needs present in practice, what resources and expertise would help to address them, and the strategies that would make the effort rewarding and worthwhile. Participants will leave with an enhanced understanding of what clinical population medicine could bring to their practices and communities.

F102777 Practice-Based Research for Beginners: Research redefined, simplified, demystified
15:15–16:15

Anwar Parbtani, PhD, MD, CCFP, Barrie, ON; Matthew Orava, MSc, MD, CCFP, Oro-Medonte, ON

712 MTCC
Learning Objectives:

1. define research in context of primary care practice
2. dispel misperceptions that research is alien to primary care practice and only doable in academic institutions
3. initiate practice-based research through a mock exercise and group interactions

Description:

Family medicine is perpetually evolving as new diagnostic and therapeutic modalities are imagined and old dogmas are challenged. A family physician is hence a lifelong learner who continually evaluates the existing practice and keeps abreast of shifting practice paradigms. Fulfilling this CanMEDS-FM "Scholar Role" also requires assessing practice modalities through scientific rigour—the crux of practice-based research. However, some primary care providers are reluctant to engage in research, believing that research is a complex, time-consuming exercise, alien to clinical practice and only doable in academic institutions. This interactive session aims to dispel those misperceptions.

The workshop moderators begin by defining "research" in the context of clinical practice, before participants divide into groups to formulate a research question or clinically relevant enquiry. Then, following intergroup discussion, each group refines its question to fit its objectives and value to practice. Finally, each group determines the methodology, data collection, and analysis for its question, learning to keep the project simple and avoid undue complexity. This workshop will be of interest to new researchers, including family physicians, allied health care professionals, and residents/trainees. It will enhance understanding of research in the context of primary care practice and encourage participants to look at research as part of their practice improvement endeavours. It might also result in participants forging long-term collaborations.

F103091 🎧 **Test Your Contraception IQ / Mettez à l'épreuve vos connaissances sur la contraception**

15:15–16:15 Jennifer Blake, MD, MSc, FRCSC, Ottawa, ON

HALL F MTCC

Learning Objectives:

1. separate fact from myth with respect to common beliefs about birth control
2. identify opportunities to change contraceptive practices, reduce failure, and improve satisfaction
3. reassure patients about the relative safety of contraception and provide information with confidence

Description:

This session will be presented in a question-and-answer format. Questions about current contraceptive methods and their indications, contraindications, and effectiveness, based on the 2014/2015 updated guideline, will be covered.

Objectifs d'apprentissage :

1. distinguer les faits des mythes concernant les croyances courantes sur les contraceptifs
2. identifier des occasions de changer les pratiques en matière de contraception, réduire les échecs et améliorer la satisfaction
3. rassurer les patientes sur l'innocuité relative de la contraception et offrir de l'information avec assurance

Description :

Cette séance répondra aux questions sur les méthodes actuelles de contraception et leurs indications, contre-indications et efficacité, selon une formule « période de questions » basée sur la mise à jour 2014-2015 du guide de pratique.

F102364 **Practical Tips for Teaching Residents to Teach in Busy Ambulatory Care Settings**

15:15–17:30 Judy Baird, MD, MEd, FCFP, Dundas, ON; Heather Waters, MD, FCFP, Hamilton, ON

707 MTCC

Learning Objectives:

1. describe a framework for teaching residents to teach, which can be applied in the patient care setting
2. apply the "Parallel Framework for Teaching to Teach" in the ambulatory care setting
3. apply microskills principles to resolve difficult "teaching to teach" encounters in the ambulatory setting

Description:

Clinical preceptors in ambulatory environments are often challenged to provide clinical care and teach learners in layered learning models, under significant time constraints. Helping residents to develop skills as clinical teachers in the midst of these other demands can be extremely challenging. Practical resources to manage this layered teaching are limited. Existing tools are primarily directed at residents themselves, rather than at the clinicians who are supporting the development of resident teaching skills. In addition, residents frequently receive very little direct feedback on their teaching. Many residency programs are developing sets of entrustable professional activities (EPAs), to guide resident competency assessment, among which the "teaching and supervision of learners" is often included. CanMeds-FM highlights the importance of residents as teachers under the Scholar Role, "facilitating the learning of ... trainees and health professional colleagues." In this workshop, we will review strategies for supporting residents in achieving relevant CanMeds-FM competencies, such as delivering a learner-centred approach to teaching, and assessing/reflecting on a teaching encounter. In this workshop, participants will be introduced to a Parallel Framework for Teaching to Teach, which can be used to support residents in their teaching role. Participants will apply this framework in common teaching scenarios. Participants will be provided with a toolkit of resources for supporting the development of residents as teachers. Strategies to manage difficult "teaching to teach" situations will be discussed.

F102035 **Writing for Publication: The 90-minute workshop**

15:45–17:30 Frank Sullivan, MD, CCFP, North York, ON

710 MTCC

Learning Objectives:

1. identify the main characteristics of an article that is likely to be accepted by a journal
2. make informed decisions on time management and journal choice
3. set a "writer's brief" by making decisions in five key areas

Description:

The aim of this workshop is for participants to draft a journal article that has a good chance of being accepted by their target journal. Participants should bring an idea that they have been meaning to turn into a scientific article for some time. They can expect to complete 80% of the work of writing the article during the workshop and to go away with an electronic support network that will enable them to complete the process over the next month or so. This will be achieved by using a 25-page workbook that has been used effectively in similar conferences with similar groups in the past by the workshop leader, who has published 207 papers in peer-reviewed journals, has undertaken more submissions to journals than he cares to recall, and has been a member of the British Medical Journal's "Hanging Committee." Some of the session will be didactic, but most of the time will be spent with participants committing their ideas to paper.

F95474  **Driving and Dementia: Practical tips for the family physician**
16:30–17:30 **Conduite et démente : Conseils pratiques pour le médecin de famille**

Linda Lee, MD, MCISc(FM), CCFP, FCFP, Kitchener, ON

HALL F MTCC

Learning Objectives:

1. list findings in the cognitively impaired patient that may indicate that fitness to drive is a concern
2. explain office-based tests that can help in the assessment of the potentially unsafe cognitively impaired driver and the role of on-road driving assessments
3. discuss ways of communicating concerns about driving fitness that are less likely to harm the patient-physician relationship

Description:

With the aging Canadian population and estimates of approximately one-quarter of persons over age 65 suffering from either mild cognitive impairment or dementia, family physicians will be increasingly challenged with concerns about fitness to drive. In most provinces including Ontario, it is mandatory to report potentially medically unfit drivers to transportation authorities. This session will provide the busy family physician with practical tips on dealing with driving fitness in the senior who is cognitively impaired.

Objectifs d'apprentissage :

1. dresser la liste des observations pouvant indiquer que l'aptitude à conduire chez les patients atteints d'un déficit cognitif est une préoccupation
2. expliquer les tests administrés en cabinet pour aider à évaluer un conducteur atteint d'un déficit cognitif potentiellement dangereux et le rôle des évaluations de conduite sur la route
3. discuter des façons de communiquer ses préoccupations au sujet de l'aptitude d'un patient à conduire sans heurter la relation entre le patient et le médecin

Description :

Face au vieillissement de la population canadienne et à des estimations selon lesquelles environ le quart des personnes de plus de 65 ans souffrent d'un déficit cognitif ou de démente, les médecins de famille devront de plus en plus faire face à des préoccupations en matière d'aptitude à conduire. Dans la plupart des provinces, y compris en Ontario, il est obligatoire de signaler au ministère des Transports les conducteurs potentiellement inaptes à conduire pour des raisons médicales. Cette séance fournit au médecin de famille occupé des conseils pratiques sur la façon de composer avec l'aptitude à conduire chez les personnes âgées atteintes d'un déficit cognitif.

F96996 **Urine Drug Screens: Who, what, where, when, why, and how?**

16:30–17:30 Megan Brunskill, MD, CCFP, Marathon, ON

713A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. review why urine drug screening is integral to effective and safe chronic pain opioid prescribing
2. identify differences between available urine drug screens and how to interpret/manage the results
3. create a clinic-wide opioid prescribing program that includes systematic random urine drug screening

Description:

Most available guidelines recommend the routine use of urine drug screening (UDS) for safe opioid prescribing in chronic pain. This presents many challenges for a busy family physician. A clinic-wide opioid prescribing program systematizes who to screen and when, which simplifies how to incorporate random UDS into your practice. This session will introduce our FHT-based opioid prescribing program including our clinic's UDS protocol plus opioid monitoring ladder (a systematic approach to managing UDS results and other aberrant behaviour.) We will review the differences between point-of-care testing products and laboratory confirmatory tests. Common pitfalls in UDS interpretation plus the concept of confirmation testing of unexpected screens will be addressed. Case presentations will be used to demonstrate a stepwise approach to the management of opioid therapy in complicated chronic pain patients. The goal of this session is to have participants leave feeling confident in the use of UDS in their everyday practice.

F99145 **Primary Health Care, Health, and Obesity: Lessons across the 49th parallel**

16:30–17:30 Lawrence C. Loh, MD, MPH, CCFP, FRCPC, Toronto, ON; Shafik Dharamsi, BEd, MSc, PhD, Vancouver, BC; Adam Hoverman, DO, DTM&H, Yakima, Washington; William Cherniak, MD, CCFP, Toronto, ON

802AB MTCC

Learning Objectives:

1. differentiate the key elements of obesity prevention, management, and outcomes between Canadian and American health care systems, and identify areas of improvement and lessons learned from each system's experience
2. identify key elements of success that contribute to effective collaboration on obesity prevention between family medicine and public health in both countries
3. evaluate potential avenues to fight obesity in each national context, with a particular emphasis on activities that promote greater alignment between family medicine and public health practitioners

Description:

Obesity influences the practice of family physicians (FPs) and public health physicians (PHPs) in Canada and the United States, with collaboration between these groups and clinical approaches having slight variation between national contexts. In both settings, however, multi-component interventions and guideline implementation are typically constrained by inadequate resources, limited time, and isolated practitioners. Each national family practice context has developed promising solutions. Some examples include greater cross-sector collaboration with public health, with the benefit of addressing modifiable risk factors through aligned health promotion efforts, and new interdisciplinary models, such as family health teams in Canada, which provide novel opportunities for knowledge sharing, implementation, and service integration. This session will be of interest to Canadian/American FPs/PHPs; resident physicians and medical students; senior leaders, researchers, and advocates from government, academic, non-profit, and/or private sectors. Front-line FPs in Canada and the United States confront the complexities of the obesity epidemic together with PHPs, academics, advocates, and government. Engaging participants in all these fields from both sides of the border will help open a conversation and foster the development of a community that is aware of strategies employed in both national contexts and is able to collaborate in applying best practices appropriate to their national context through their clinical and advocacy work. A World Café format will allow representatives from family medicine and other related sectors to compare and contrast Canadian and American obesity prevention approaches within the primary care and public health sector. The aim will be to produce an publishable evaluation of discussed themes that highlights key strategies to addressing the obesity epidemic. Outcomes will be knowledge sharing, professional reflection, development of a community of practice, greater intersectoral collaboration within national contexts, and greater transnational collaboration, data sharing/research, and guideline development/alignment.

F102304 Vision Loss and Diabetes: The primary care practitioner's key role in reducing the burden of blindness**16:30–17:00**

Sarah MacIver, OD, FFAO, Waterloo, ON

716A MTCC**Learning Objectives:**

1. describe and review diabetic retinopathy
2. apply new strategies in the primary care provider's role in management of diabetic retinopathy
3. discuss the *Guidelines for the Collaborative Management of Persons with Diabetes Mellitus* published by the Eye Health Council of Ontario

Description:

This session provides an update on best practice patterns for all primary care providers to apply in routine practice to help decrease vision loss and blindness in patients with diabetes. Diabetic retinopathy is the leading cause of blindness in the working age population and, with the growing number of people with diabetes, the burden of vision loss is projected to increase significantly over the next 20 years. In Canada, only 32 per cent of patients with type 2 diabetes follow the Canadian Diabetes Association guideline to get annual eye exams. Vision loss can be prevented if caught in time but early disease is asymptomatic. Literature shows that recommendations from primary care providers can significantly improve a patient's adherence to seeing an eye care provider. The session's pearls will include a review of diabetic retinopathy, including the prevalence and the factors for development of vision loss; an identification of strategies for primary care providers to help improve adherence for eye exams in practice; a review of the management that might be required by the primary care provider to help decrease vision loss; and a review of recently published guidelines for the collaborative management of persons with diabetes mellitus, developed by the Eye Health Council of Ontario. A collaborative strategy between primary care and eye care providers is necessary to decrease vision loss in patients with diabetes.

F102568 Mifepristone (RU-486): A new drug for Canada, an old drug for Europe**16:30–17:30**

Konia Trouton, MD, MPH, CCFP, FCFP, Victoria, BC; Dawn Fowler

714AB MTCC**Learning Objectives:**

1. relate the history of mifepristone use worldwide for safe abortion
2. describe the indications, screening, and consent process for mifepristone and misoprostol use in Canada
3. identify common reactions, appropriate follow-up, and management of possible complications

Description:

Mifepristone and misoprostol have been long awaited in Canada by women's health advocates. Available in France since 1988, the United Kingdom since 1991, and the United States since 2000, the mifepristone tablet, combined with misoprostol, allows women and their physicians to terminate unplanned/unwanted pregnancies safely without surgery. In Canada, women who seek pregnancy termination and do not live in major centres face many access barriers. Rural communities might have limited operating room access and/or trained physicians. Privacy is a concern for many, and travel costs can be prohibitive. Appropriate patient selection and physician training in the use of this new medication might reduce those barriers to access. This workshop will use clinical scenarios after a thorough review of the history and pharmacology of this new medication so that participants will feel confident in offering this option to women.

F102858 Measles Gate: An approach to the management associated with a measles exposure in the office setting
16:30–17:00

Allan Grill, MD, CCFP, Toronto, ON; Lisa Ruddy, RN, Markham, ON
716B MTCC

Learning Objectives:

1. review the clinical signs and symptoms associated with measles and the appropriate tests to confirm the diagnosis
2. outline the infection control steps to prevent exposure to the measles virus, or other airborne infections, to other patients and staff present in the office setting

Description:

Measles, also known as rubeola, is a viral infection that classically presents with fever and the 3 “Cs”: cough, coryza, and conjunctivitis. Patients also develop a red maculopapular rash that starts on the face and spreads to the rest of the body. While most people with measles are sick for a few days and recover completely, measles can lead to ear infections, pneumonia, encephalitis, and even death. Measles is a vaccine-preventable disease, and infants are at highest risk until they are immunized with the MMR (measles/mumps/rubella) vaccine at age one. In Canada, due to high immunization rates, cases of measles are rare. The current two-dose regimen administered at ages one year and five years provides 95 per cent protection. However, several factors have contributed to recent outbreaks, including a) patients born after 1970 who only received one immunization against measles, b) patients who refuse to be immunized due to a discredited claim that there is a link between autism and the MMR vaccine, and c) unintended exposures to the virus in countries endemic to measles due to a poor public health infrastructure that lacks universal immunization programs. This presentation will describe a case associated with a measles outbreak in the Greater Toronto area in January 2015. Because the virus is spread easily through respiratory droplets, multiple exposures can occur when an infected patient presents to the busy waiting room of a primary care practitioner’s office. Participants need to be comfortable responding to such a scenario and this session will provide them with a practical step-by-step approach on how to manage a measles exposure. Topics including close communication with public health, leveraging one’s electronic medical record (EMR) system to help with contact tracing, and the importance of transparent messaging to all patients and staff will be reviewed. Participants will also be imparted with valuable lessons learned, such as the importance of using universal infection control practices to prevent the spread of infections, knowing the immunization status of office staff and providers to ensure protection in the event of a measles outbreak, and being familiar with which laboratory tests to order for a suspected case.

F103867 Discussion on Cultural Competence and Acceptance of LGBTQ Patients Within the Family Medicine Community
16:30–17:30

Noel Garber, Mississauga, ON; Eric Mang, Mississauga, ON
713B MTCC

Learning Objectives:

1. discuss the results of a pilot study done in Mississauga to evaluate cultural competence and acceptance of LGBTQ patients within the family medicine community
2. identify potential strategies for improvement
3. identify opportunities to implement in practice these strategies for improvement

Description:

In recent years, there is a greater acceptance of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people. However, evidence surrounding practices and perceptions among family medicine physicians caring for these patients is not well defined. As such, in early 2015, a small pilot study was conducted to evaluate relevant factors within a sample of family physicians and patients in Mississauga. We will present the results of the study and also offer a venue to identify ways to improve on the major points discussed. We will use a didactic section at the beginning of the session to show our findings. Then, by way of a guided discussion in an open environment, we aim to develop potential solutions that could effectively be adopted into practice. These could include a blend of existing strategies, such as the safe space framework, and new ideas developed during the session.

FV108671 Mainpro+ ... A New Look, With New Ways to Learn (4)
16:30–17:30 Mainpro+ ... Un nouveau look; de nouvelles façons d’apprendre (4)

Eric Wong, MD, CCFP – Regional Educator, Ontario Region / Édicateur régional, région de l’Ontario, London, ON;
 Scott MacDonald, MD, CCFP (EM), FCFP – Regional Educator, Atlantic Region / Édicateur régional, région de l’Atlantique, Bedford, NS
803A MTCC

Join us for an informative session on Mainpro+ and the new, practice-centred ways to earn CPD credits for activities you do on a daily basis. Also, hear the latest updates on fellowship, accreditation, and CACs. The CFPC is committed to providing quality CPD to meet your changing interests and learning needs. Participants may claim an additional Mainpro-M1 credit for this session.

Soyez des nôtres pour une séance d’information sur Mainpro+ et sur les nouvelles façons d’obtenir des crédits de DPC pour des activités que vous effectuez au quotidien. De plus, vous pourrez vous renseigner sur les nouveautés concernant le titre de Fellow, l’agrément et les CCA. Le CMFC s’est engagé à fournir des programmes de DPC de qualité qui conviennent aux intérêts de ses membres et répondent à leurs besoins en matière d’apprentissage. Les participants peuvent réclamer un crédit Mainpro-M1 additionnel pour cette séance.

F121370 Methadone for Analgesia: Online training tool for physicians

16:30–17:30 Mike Harlos, MD, CCFP, FCFP, Winnipeg, MB; Cornie Woelk, MD, CCFP, FCFP, Winkler, MB;
 Dori Seccareccia, MD, CCFP(EM), MSISc, Toronto, ON

717B MTCC

Learning Objectives:

1. review the indications and contraindications for using methadone in a cancer setting
2. review mechanisms of action/basic pharmacology, drug interactions, dosing frequency and titrating, adverse effects, routes of administration, safety/disposal, working with patients and families, and when to consult a specialist
3. discover where to access the Methadone for Analgesia Online Training Tool in order to share its content with colleagues

Description:

Methadone is a valuable analgesic in the palliative care of patients with cancer pain and can improve care outcomes in situations where other analgesia have proven ineffective or intolerable, but as a restricted opioid it can only be prescribed by a physician exempted from prescribing restrictions by his or her province's or territory's licensing body. Methadone prescribing by palliative care and pain and symptom management teams is limited by the paucity of family doctors able to provide ongoing prescriptions for methadone for analgesia in patients discharged to care in the community. In collaboration with the Canadian Society of Palliative Care Physicians (CSPCP) and leading methadone experts, and using the latest research and clinical best practices, the Canadian Virtual Hospice has created the Methadone for Analgesia Online Training Tool. It provides core competencies in methadone prescribing in palliative care and will lead to standardized, evidence-based care. This project has been endorsed by the CSPCP and the CFPC. Participants will be guided through all the components of this tool: indications and contraindications for using methadone in a cancer setting, mechanisms of action and basic pharmacology, drug interactions, dosing frequency and titrating, adverse effects, routes of administration, safety and disposal, working with patients and families, and when to consult a specialist. Specific considerations for pediatric patients will be addressed. Participants will also learn where to access the tool in order to share the content with colleagues.

F101839 Sun Protection Behaviours in Primary Care 17:00–17:30 Comportements de protection solaire en soins primaires

Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON; Christie Freeman, MD, CCFP, FCFP, Peterborough, ON; Lisa Graves, MD, CCFP, FCFP, Ancaster, ON

718AB MTCC

Learning Objectives:

1. discuss and review the evidence for sun protective behaviours in different age groups
2. outline specific strategies to protect infants and children from excess ultraviolet radiation to protect skin health (against cancer, photoaging, etc)
3. integrate sun protective strategies into routine primary care visits through clinical tools and EMR reminders

Description:

Skin cancer is the most common cancer diagnosis in Canada and numbers diagnosed are expected to more than double in the next 15 years. Melanoma, basal cell, and squamous cell carcinomas are highly preventable through sun protection behaviours. The importance of educating young children and their parents may lead to lasting benefits on our population as a whole. This workshop will review the evidence-based research on various sun protective behaviours. We will review specific strategies for different age groups and showcase clinical tools for use in primary care. We will suggest tools, such as an information sheet for provider information and an electronic medical record template for office use, and ways to integrate this education using existing clinical management tools (ie, preventative health visits) and patient education materials (eg, bookmark for kids, brochure for patients' caregivers, cellphone app for teens [tweets of 140 characters]).

Objectifs d'apprentissage :

1. examiner les données liées aux comportements de protection solaire dans différents groupes d'âges et en discuter
2. souligner des stratégies précises pour protéger les nourrissons et les enfants d'un excès de rayonnement ultraviolet afin de préserver la santé de la peau (contre le cancer, le photovieilissement, etc.)
3. intégrer les stratégies de protection solaire dans la routine des visites en soins primaires par l'intermédiaire d'outils cliniques et de rappels dans les DMÉ

Description :

Le cancer de la peau est le diagnostic de cancer le plus répandu au Canada et l'on s'attend à ce que le nombre de diagnostics se multiplie par plus que le double au cours des 15 prochaines années. On peut facilement prévenir le mélanome, le carcinome basocellulaire et le carcinome squameux grâce à des comportements de protection solaire. L'importance d'éduquer les jeunes enfants et leurs parents peut entraîner des bienfaits durables dans la population en général. Cet atelier se penche sur la recherche factuelle portant sur divers comportements de protection solaire. Nous examinerons les stratégies spécifiques à différents groupes d'âge et présenterons les outils cliniques à utiliser en soins primaires. Nous proposerons des outils, tels que les feuillets d'information visant à renseigner les fournisseurs et un modèle à appliquer dans les dossiers médicaux électroniques à l'usage du cabinet, de même que des façons d'intégrer cette éducation à l'aide d'outils de prise en charge clinique existants (p. ex., visites de santé préventives), et du matériel d'éducation des patients (p. ex., signets pour les enfants, brochures pour les soignants, appli pour téléphone cellulaire des adolescents [tweets de 140 caractères]).

F102184 Lifestyle Medicine in Obesity Management

Kan Sivalingam, MD, Devon, AB

715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. learn a lifestyle scoring method
2. classify obesity and comorbidities
3. devise appropriate therapy/treatment modality in obesity management

Description:

Seventy to 80 per cent of chronic diseases are related to lifestyle. Lifestyle medicine is a much-needed specialty for primary care physicians. Helping our patients make lifestyle changes to prevent or treat chronic diseases is a pressing problem, with nearly 70 per cent of adults being either overweight or obese. Diet, physical activity, stress management, sleep, alcohol, and smoking are primary areas of interest. Participants will learn how they can use an innovative 20-point scoring system to evaluate and monitor the effects of patients' lifestyle changes on their obesity, as assessed using the Edmonton Obesity Staging System and weight, BMI, and body composition scans. The session includes a discussion of how to treat the cause and its comorbidities using a five-path treatment modality of obesity management.

F114793 A Initiating and Intensifying Insulin: Best practices

17:45–18:45 Peter Lin, MD, CCFP, North York, ON

701AB MTCC

Learning Objectives:

1. understand the patient and physician barriers to insulin therapy and how to overcome them
2. recognize potential candidates for insulin therapy and understand how to initiate and adjust basal and mealtime insulin
3. be aware of resources that can help physicians and their patients successfully manage insulin therapy

Description:

For all the recent advances in glucose-lowering therapy, insulin remains the most effective means of controlling blood glucose. While people with type 1 diabetes depend on insulin at the outset, many people with type 2 diabetes can also benefit from insulin at some point. However, research has shown that many physicians perceive insulin management as complicated and delay insulin therapy until they have run out of other options. This slide presentation was designed to bridge this gap, so that physicians can confidently prescribe insulin at the optimal time for the right patients. To this end, the presentation demystifies the components of insulin management and offers a simple, graduated approach that matches patients' evolving needs.

Participants may claim an additional Mainpro-M1 credit for attending this session

RESIDENT POSTERS / AFFICHES DES RÉSIDENTS

NOVEMBER 13 NOVEMBRE

742 Opioid Risk Tool Utilization by the Queen's Family Health Team in Kingston, Ontario

Jeff Martin, MD, MSc, Kingston, ON; Michael Pham-Nguyen, MD, Kingston, ON; Megan Gao, MD, Kingston, ON; Maaz Kamal, MD, Kingston, ON; Harpal Ubhi, MD, Kingston, ON

Description:

Context: The Opioid Risk Tool has Grade B evidence for assessing the suitability of opioids for patients with chronic pain, and some guidelines promote its use to assess patients prior to initiation of prescribing opioids. Objective: In this study, we sought to determine whether prescribers at the Queen's Family Health Team (QFHT) in Kingston, Ontario were familiar with the Tool. We also wished to learn their attitudes towards the tool and why they have or have not chosen to use it in assessing patients who will be prescribed opioids. Design/ Participants: We constructed an online multiple choice and short answer survey for dissemination to all physicians who are permitted to prescribe opioids at the QFHT. The study population consisted of PGY1 and PGY2 resident physicians, staff physicians, and locum physicians, totaling approximately 100 individuals. Intervention: N/A Outcome measures: The proportion of physicians who used the Opioid Risk Tool or some other method to determine safety of initiating opioids. Results: 35 participants responded to the survey. 60% are aware of the existence of an opioid risk tool; approximately 33% felt it would be useful in determining management of chronic, non-cancer pain. Interestingly, about 40% of respondents use a subjective type of assessment or "gestalt" to determine suitability of opioids for management of chronic pain. Conclusion: In conclusion, opioid therapy for patients with chronic pain appears to be very much a subjective decision on the part of the physician, based on past experience and a "gestalt" of the clinical situation faced by him/her. Given the widespread use of opioids for chronic, non-cancer pain, the use of an objective clinical tool would seem imperative to improve the management of chronic pain.

743 Demographic, Socioeconomic, and Geographic Analysis of Frequent Users at Stonechurch Family Health Team

Stanley Lam, MD, Hamilton, ON; Avinash Ramsaroop, MD, Hamilton, ON; Anna Czynny, MD, Hamilton, ON; Kalyani Vimalasan, MD, Hamilton, ON; Lily Wei, MD, Hamilton, ON; Inge Schabert, MB ChB, CCFP, Hamilton, ON

Description:

Context: Studies consistently report that lower socioeconomic status (SES) can negatively impact one's health. Furthermore, literature suggests that a substantial portion of Canadian healthcare dollars is spent on a small, unique, patient population of frequent visitors. Objective: To characterize frequent users at Stonechurch Family Health Centre (SFHC) by their demographics, geographic location, health visits, socioeconomic status, and economic cost to the healthcare system. Methods: We conducted a quantitative analysis of all weekday OHIP billed patient visits over a two year time period (January 1, 2011 to December 1, 2012) at SFHC. Patient demographics including gender, age, postal code, frequency of visits, and billing codes were extracted from our electronic medical records. Patients were divided into two groups based on the frequency of visits: frequent users (Top 10% of clinic users) and non-frequent users (rest of the population). Using Canadian Census data, we matched each patient's FSA code to several markers of socioeconomic status. The aforementioned demographic and socioeconomic markers were then compared using paired t-tests and Cohen's d to identify potential differences. Results: A total of 16,059 patients visited the clinic for a total of 99,630 visits between January 1, 2011 and December 1, 2012. Frequent users were identified as more elderly (average age 48.7 years, $p < 0.01$), and female (67% of frequent users, $p < 0.01$). They incurred significantly higher OHIP billings compared to non-frequent users (\$649.83 vs. \$166.30 per patient, $p < 0.01$). The Primary Mental Health code (K005A) was billed twice as

often, but a Complete Assessment (A003A) was billed 3-times less frequently in the frequent user group. Lastly, frequent users were found to come from neighborhoods with lower average household incomes ($p < 0.01$), lower rates of employment ($p < 0.01$), higher percentage living in subsidized housing ($p < 0.05$) and higher prevalence of low-income status ($p < 0.01$). Conclusion Frequent users at SFHC are more elderly, female, socioeconomically marginalized, and have a higher proportion of visits for mental health concerns. Given the known impacts of poverty and low socioeconomic status on health outcomes, future policies to address these issues may help improve health outcomes and healthcare costs.

744 **Transitioning Complex Pediatric Patients to Adult Health Care: The family physician perspective**

Nisha Arora, MD, Markham, ON; Margo Stevenson, MD, Winnipeg, MB; Nisha Arora, MD, Stratford, ON; Christina Grant, MD, FRCPC, Hamilton, ON

Description:

Context: In the last 4 decades, there has been a boom of adult patients surviving diseases that were previously lethal in early childhood, such as cystic fibrosis. The importance of a well-coordinated, developmentally appropriate transition from pediatric to adult-oriented healthcare is compelling. Family physicians are uniquely situated to maintain continuity of care throughout the lifespan; however, most of the research on transitioning adolescent patients has focused on pediatric and internist perspectives. **Objective:** To examine the family physician perspective on barriers, available resources, and role in relation to subspecialists when transitioning youth with childhood-onset disorders from pediatric to adult-oriented care in Canada. **Design:** This is an observational, descriptive survey study. **Participants:** A convenience sample of >200 family physicians currently practicing in Sault Ste. Marie, Ontario and Hamilton, Ontario. **Instrument:** A 10-point Likert scale survey to rate barriers and beliefs, with opportunity for free-form input. Survey was derived from previous studies and modified with informal family physician input. **Outcome Measures:** The primary outcome measure is the percentage of family physicians experiencing barriers. Secondary outcomes are beliefs and practice patterns as it relates to transitional care, and the degree to which proposed barriers limit the physician's ability to provide transitional care. This is determined by mean Likert ratings and standard deviations. **Multivariable regression analyses** assess associations between physician characteristics and perceived barriers, beliefs, and practice patterns. **Results:** Commonly identified barriers by subspecialists in the existing literature include: insufficient knowledge of "pediatric" conditions to care for these patients as adults; managing family involvement; and difficulty accessing superspecialists. **Conclusions:** We anticipate that our results will inform Canadian physicians of the perceived barriers that family physicians face, which we expect will be different from the subspecialist perspective. This may potentially lead to interventions addressing these barriers, help delineate the roles of different healthcare providers, and make better use of family physicians as an integral part of the transitional healthcare team. We hope that the challenges faced by adolescents who are transitioning to the adult system may be better addressed by bringing family physicians into the centre of discussions on healthcare transition.

746 **Improving Care for Complex Patients in Primary Care Through Implementing Coordinated Care Plans in the Electronic Medical Record: A quality improvement project**

Hana Thomas, MD, Toronto, ON; Caroline Jeon, MD, Toronto, ON; Andrew D. Pinto, MD, CCFP, FRCPC, Toronto, ON

Description:

Context: Coordination of care for complex patients in primary care has been demonstrated to improve patient outcomes and reduce overall health-care expenditure. Increasingly, many primary care centers in North America are adopting a complex care management team-based approach to streamline care for these patients. However, significant issues remain around identifying and scaling-up any model of care. **Objective:** To increase the number of complex patients in each of two St. Michael's Family Health Team physician practices who have a simple, up-to-date coordinated care plan in place on their electronic medical record (EMR). **Design:** A quality improvement project consisting of two separate Plan-Do-Study-Act (PDSA) cycles conducted throughout a three month period. **Target Population:** Complex patients were identified based on the number of visits with their primary care physician (PCP) within a 12 month period and based on the presence of at least 3 out of 43 chronic conditions consisting of the Charlson's Comorbidity Index conditions, listed on the patient's medical record. **Intervention:** PDSA #1: Identify the top 10% of complex patients in two separate physician practices using a standardized EMR query. PDSA #2: Meet with each PCP and other allied healthcare professionals involved in the patient's care to design a complex care plan (CCP) for five complex patients in each practice. **Process Evaluation:** At the end of the second PDSA, at least five complex patients in two physician practices will have a patient-oriented needs assessment and care plan and an up-to-date patient information and summary of medical issues in place on their respective EMRs. **Findings:** From each of the two practices examined, a total of 20 patients were identified as complex. The top five from each practice were selected and a CCP was devised and placed in their respective EMRs. **Conclusions:** The identification of patients with complex care needs in an urban primary care practice and the implementation of a coordinated care plan is both relevant and feasible. Such care plans for complex patients may improve patient outcomes. Further research is needed to determine the sustainability, scalability and to measure patient outcomes resulting from a care coordination plan.

747 **Improving Outcomes for Pregnant Women in Thorncliffe Park via a Prenatal Exercise and Education Program**

Emilie Boucher, MD, Toronto, ON; Eileen Ten Cate, MD; Karen Fleming, MD, MSc, CCFP; Emmanuelle Britton, MD CM, CCFP; Maureen Gans, MEd; Nawal Al-Busaidi

Description:

Context: For women in Thorncliffe Park, the main health care gaps identified are accessing services in the areas of reproductive and sexual health, pre-natal and post-partum care, chronic disease (particularly diabetes and cardiovascular disease) and mental health. Ontario's Better Outcomes Registry and Network data demonstrates that compared to Toronto as a whole, within the Thorncliffe Park community, there is a lack of access to early pre-natal care. Additionally, there is an increased risk of gestational diabetes mellitus, intrauterine growth restriction and excessive weight gain during pregnancy. By working with the Thorncliffe Neighbourhood Office,

we hope to demonstrate how exercise and prenatal education improves health for women and their newborns. Objectives: 1. To determine if participation in this program a. increases women's knowledge about healthy lifestyle in pregnancy. b. improves mother and newborn health outcomes as measured by rates of gestational diabetes mellitus, weight gain, birth weight, mode of delivery, breastfeeding rates and other medical complications compared to Ontario's Better Outcomes Registry and Network data. c. improves mood and decreases social isolation. Design and intervention: Our goal is to recruit 45 pregnant women in the Thorncliffe Park community who will participate in 11 sessions: 10 in person (intake session, 8 exercise and education sessions and a debrief session) and 1 post-delivery telephone survey. Education will be based on national recommendations for a healthy pregnancy including nutrition, exercise and mental health. After each education session, participants will engage in low-impact physical activity in keeping with national guidelines. Participants will also be encouraged to exercise an additional 2-3 times a week outside of the program. Descriptive statistics and Fisher's Exact test will be conducted on study data. Analysis of Variance will examine change in knowledge scores before and after participation in the education program. Results and conclusion: Collection is currently ongoing for this research project and will be complete by October 2015.

748 Relationship Between Depression, Anxiety, and Social Support in Older Family Practice Patients

Neil Dattani, MD, Toronto, ON; Bonnie Au, MSc, Toronto, ON; Katherine Stead, Toronto, ON;
Xiao Xiong Yu, Toronto, ON; Rahul Jain, MD, CCFP, Toronto, ON; Liisa Jaakkimainen, MD, MSc, CCFP, Toronto, ON;
Jocelyn Charles, MD, MScCH, CCFP, Toronto, ON

Description:

Context: The population of Canada is aging, with those over 65 expected to double over the next 25 years. Older patients who access healthcare frequently may be more likely to have depression, anxiety, and low social support. Depression and anxiety can be difficult to identify in older patients, and knowing which older patients are at increased risk for depression and anxiety will help family doctors identify these patients. Social support is an important determinant of health among older patients, and whether or not the association between social support and depression or anxiety differs based on frequency of visits to the family doctor is not known. Objective: To determine the relationships between depression and social support and between anxiety and social support among older patients of a family practice based on the frequency of their visits. Design: Cross-sectional descriptive study. Participants: Adults aged 65 years and older who are patients of the Sunnybrook Academic Family Health Team in Toronto, Ontario, Canada. We studied the top 5% and bottom 5% of users as determined by frequency of visits to the family doctor between July 1, 2013 to June 30, 2014. Instrument: Structured telephone-based questionnaire. Outcome measures: The Geriatric Depression Scale (GDS), Generalized Anxiety Disorder 7-item (GAD-7), and OARS Social Support Scale were performed on all patients. Spearman's correlation was used to assess the relationship between the variables. Results: We performed 39 interviews on 19 high frequency and 20 low frequency users. The association between depression and social support was -0.41641 ($p = 0.0762$) among high frequency users and -0.38717 ($p = 0.1015$) among low frequency users. The association between anxiety and social support was -0.45631 ($p = 0.0496$) among high frequency users and -0.07522 ($p = 0.7596$) among low frequency users. Conclusions: Among older patients who visit their family doctor frequently, social support may be a protective factor for anxiety, with less anxiety when there is higher social support. Therefore, screening for low social support during office visits with older patients who visit frequently may increase the recognition of anxiety disorders among these patients. Keywords: Geriatrics, primary care, depression, anxiety, social support.

749 Exploring Barriers to Measurement of Body Mass Index and Abdominal Circumference in Primary Care

Lucy Horvat, MD, MSc, Acton, ON; Graham Swanson, MD, MSc, CCFP, Burlington, ON

Description:

Context: The prevalence of obesity in Canada is rising. Multiple Canadian Clinical Practice Guidelines recommend measurement of body mass index (BMI) and abdominal circumference in overweight, obese, diabetic and or hypertensive patients to assess obesity-related health risks. Despite these recommendations, uptake in the primary care setting has been variable. Objectives: To evaluate performance in a community primary care setting with respect to measurement of BMI and abdominal circumference and to explore physician attitudes and identify perceived barriers to use in practice. Study Design & Methods: A mixed-methods study involving a cross-sectional analysis of electronic medical records and a survey of family physicians. Survey was administered online via SurveyGizmo and family physicians involved in postgraduate training at the McMaster Halton distributed medical education site were invited to participate. The study was submitted for review by the Hamilton Integrated Research Ethics Board. Results: Measurement of BMI was higher than that of abdominal circumference (45 percent (%) compared with 2%). Twelve of 18 physicians (66%) invited to complete the questionnaire responded. Most physicians were aware of the clinical practice guidelines' recommendations to measure BMI (92%) and abdominal circumference (75%). However, only 33% felt BMI measurement was important compared with 50% for abdominal circumference. The greatest perceived barrier to BMI measurement was the perception of limited value added (27%). Physicians reported more perceived barriers to measurement of abdominal circumference including: patient resistance (63%), time constraints (55%), limited value added (45%) and uncertainty with abdominal circumference measurement technique (36%). Conclusion: Despite multiple clinical practice guidelines recommending the measurement of BMI and abdominal circumference in primary care, adherence to these guidelines is poor. Perceived barriers of lack of time, patient resistance and limited value added need to be addressed if compliance is to improve.

STUDENT POSTERS / AFFICHES DES ÉTUDIANTS

NOVEMBER 13 NOVEMBRE

724 Family Physicians' Perceived Patient Satisfaction and Their Actual Satisfaction

Fariha Eshrat, Riyadh, Saudi Arabia, Baraa Alghalyini, MD, CCFP, MHSc, Riyadh, KSA; Emad Masuadi, PhD, Riyadh, KSA; Mazen Ferwana, MD, ABFM, JBFM, PhD, Riyadh, KSA

Description:

Introduction Literature has shown that patient doctor interaction has significant impact on the patient's satisfaction, and thus, their compliance. Therefore, effective doctor-patient communication is the bedrock for better patient health outcome. Consequently, the majority of malpractice allegations arise from communication errors. Objectives · Measure satisfaction of patients managed by family physicians in Saudi Arabia. · Measure the family physicians' self-perception of the quality of their patient care · Identify any gaps between the prior objectives, and the source of the gap Methodology A cross-sectional study, using questionnaires administered after a doctor-patient clinical interaction. Corresponding questionnaires were given to both the doctor and the patients. Results Both stake holders are satisfied with the appointment interactions, and there is no gap in between. Most patients reported high satisfaction with consultation time, high trust in doctor's diagnoses, and approachability in discussing concerns. Lack of continuity of care, adequate channels of communication with the doctors were the most common negative scores.

725 Impact of Comorbidities and Medications on Frequency of Primary Care Visits Among Older Patients

Tina Hu, MSc, Toronto, ON; Neil D. Dattani, MD; Bonnie Au, MSc; Leo Xu; Don Melady, MD; Liisa Jaakkimainen, MD; Rahul Jain, MD; Jocelyn Charles, MD

Description:

Context: The population of Canada is aging, with those over 65 expected to double over the next 25 years. In 2055 approximately one quarter of Canadians will be over 65. Data has suggested that older patients are more likely to access primary care and visit their family physician more often compared to younger patients. By understanding specific factors that influence the frequency of visits older patients make to their primary care physician, improvements can be made to provide more efficient and effective care for this age group. Objective: To determine if comorbidities and high risk medications impact the frequency of visits to a family physician among older patients. Design: Retrospective chart review. Participants: Among patients aged 65 and older seen at the Sunnybrook Academic Family Health Team between July 1, 2013 to June 30, 2014, the 5% that visited the family practice most frequently and the 5% that visited the family practice least frequently were selected for the study (N = 264). Instrument: Family practice electronic charts. Outcome measures: Charlson Comorbidity Index and age-adjusted Charlson Comorbidity Index were used to assess comorbidities. Beers criteria and the Anticholinergic Risk Scale (ARS) were used to identify high risk medications. We also abstracted the total number of medications patients were taking. Results: Charlson Comorbidity Index and age-adjusted Charlson comorbidity index were not associated with frequency of visits among older patients ($p > 0.05$). Total number of medications was significantly related to frequency of visits: for a one unit increase in total number of medications, the odds of being a high frequency user of primary healthcare services increased by a factor of 1.54 ($p < 0.001$). The number of Beers criteria medications and ARS score did not significantly impact frequency of visits. Conclusions: In general, total number of medications was a key factor among older patients in determining frequency of visits to family care physicians. Tools such as the Charlson Comorbidity Index, Beers criteria, and ARS were not able to independently predict the frequency of visits, indicating that predicting frequency is likely complex and there are multiple factors which lead to family physician visits.

726 Variations Among Spirometry Interpretation Algorithms: A push toward standardization

Florence Mok, Mississauga, ON; Amy Liao; Anthony D'Urzo, MD, CCFP, Toronto, ON

Description:

Context: Asthma and COPD are two of the most common respiratory illnesses encountered in primary care. Though patients often present with similar symptoms, it is important to distinguish between the two diseases because their pathophysiology and management is very different. Simple spirometry is an objective pulmonary function test that can support a diagnosis of asthma or COPD, but recent evidence has demonstrated that patients with moderate to very severe COPD also meet spirometric criteria for asthma diagnosis. Spirometry interpretation algorithms (SIA) should conform to diagnostic guidelines while acknowledging this overlap and prompting the clinician to consider further clinical assessment where such an overlap exists. Aim: To determine the variations in SIA that exist in the published literature and online sources. Method: Medline, Embase, and mainstream search engines were used to identify all SIA-related material dating back to 1990. Keywords used were "spirometry", "algorithm", "algorism", and "algorhythm". Results: 17 out of 27 SIA are unable to serve well as stand-alone documents. 24 SIA lack a logic string to post-bronchodilator FEV1/FVC ratio, potentially impeding COPD diagnosis. 10 SIA rely solely on post-bronchodilator improvement to definitively diagnose asthma. 23 SIA lack a prompt for bronchodilator challenge when FEV1/FVC is normal. 4 SIA unnecessarily recommend DLCO testing to confirm COPD diagnosis. Conclusion: 25 out of 27 SIA feature variations that may lead to disease misclassification. Further studies are needed to confirm whether or not these results have a real impact on disease diagnosis and treatment decisions. This study points to the need for minimizing SIA variability and the development of a standardized approach to asthma and COPD diagnosis.

727 How Function and Social Support Predict Frequency of Family Practice Visits Among Older Patients

Xiao Xiong Yu, Richmond Hill, ON; Neil D. Dattani; Bonnie Au; Katherine L. Stead; Rahul Jain; Liisa Jaakkimainen; Jocelyn Charles

Description:

Context: The population of Canada is aging, with those over 65 expected to double over the next 25 years. In 2055 approximately one quarter of Canadians will be over 65. Improvements in primary care delivery are necessary to more efficiently care for our aging population. Current literature shows a gap in understanding how level of function and social support influence the frequency of visits to the family doctor. Objective: To determine the relationship between level of function, level of social support, and frequency of visits to an urban academic family health team by elderly patients. Design: Cross-sectional descriptive study. Participants: Adults aged 65 years and older who are patients of the Sunnybrook Academic Family Health Team in Toronto, Ontario, Canada. We studied the top 5% and bottom 5% of users as determined by frequency of visits to the family doctor between July 1, 2013 to June 30, 2014. Instrument: Structured telephone-based questionnaire. Outcome measures: The Duke Social Support and Stress Scale (DUSOCS), the Older Americans Resources and Services (OARS) social support subscale, and OARS functional assessment were performed on all patients. T-test was performed to compare high frequency and low frequency users of the family practice. Spearman's correlation was performed to identify correlations between social support and level of function. Results: We performed 39 interviews with 19 high frequency and 20 low frequency users. The low frequency group had significantly higher level of function compared to the high frequency group ($p = 0.02$). There was no difference in social support using either the DUSOCS or OARS scores between the two groups. The only significant correlation was a positive correlation between stress and level of function in the high frequency group ($p = 0.02$). Conclusions: Low level of function was associated with increased frequency of visits, however low social support was not. This indicates that older patients may be more likely to visit their family doctor for physical complaints than for emotional complaints. Given the increased risk of depression and isolation among older patients, family doctors should more proactively elicit emotional concerns from these patients.

728 Barriers to and Facilitators of Medication Adherence From the Perspective of Inmates

Karolina Kowalewski, BHSc, MSc, Calgary, AB; Lauren Cuthbertson, BSc, Calgary, AB; Jennifer Edge, BHSc, MSc, Calgary, AB; Keith Courtney, DO, CCHP, Calgary, AB

Description:

Context: Effective medication delivery to inmates within correctional facilities is essential for managing symptoms, preventing relapse, slowing disease progression, and enabling recovery. Despite the importance of medications they are often refused by inmates. A number of studies have explored factors affecting medication adherence in the general population, however, few studies have explored this issue in the context of the prison-setting. Our study explores inmates' views of the barriers to and facilitators of medication adherence at the Calgary Remand Centre (CRC). Objective: To explore the individual and prison-setting factors that affect medication adherence from the perspective of inmates at CRC and to develop recommendations for medication administration in correctional facilities. Design: A mixed methods study using clinical records, structured questionnaires and qualitative interviews were used. Participants: CRC accommodates 704 remanded male and female inmates awaiting trial, transfer to appropriate provincial and federal institutions, and sentence inmates with further charges. All inmates at CRC are over 18 years and the majority are male. The eligibility criteria for our study include: inmates at CRC who are currently receiving prescription medications from the healthcare staff at the facility, and inmates that have had 1 or more incidents of medication non-adherence since their admission to CRC. Instrument: The instrument gathers information on participant demographics, general health information, medication information, prison-setting barriers/facilitators, and individual barriers/facilitators to medication adherence. Outcome Measure: The primary outcome measures are individual and institutional-level determinants of medication adherence. Findings: At the individual level, medication adherence is influenced by personal insight into disease and medication management, inmate social support, and medication side effects. At the institutional level, the rigid inmate schedule and the attitudes of healthcare providers towards inmates also affect medication adherence at the CRC. This combination of factors perpetuates the knowledge gap between physicians and vulnerable patients in the prison-setting, negatively affecting medication adherence. Conclusions: The findings of this study inform recommendations to improve disease management at the CRC and other correctional facilities. The results can be applied to other vulnerable populations outside of the prison-setting and could inform physicians working with similar populations in the community.

729 Chronic Insomnia: Time to change our behaviour?

Laila Jumma, Calgary, AB

Description:

Background: Chronic insomnia affects nearly 3.3 million Canadians. It is associated with increasing age. In Canada, the use of sleeping medication has nearly doubled from 2.9 million prescriptions to five million in 2011. During family medicine clerkship a dilemma presented when a 67-year-old woman asked my preceptor (her family doctor) to increase or change her sleeping medication- after 7 years of use, it was no longer effective. My preceptor was reluctant to change her medication, but the patient was adamant. My research question was-what is the evidence for non-pharmacological treatment of chronic insomnia? Objective: Participants will be able to evaluate the effectiveness of cognitive behavioural therapy (CBT) for chronic insomnia. Methods: My PICO question examined patients (>65 years) with chronic insomnia and compared use of CBT with hypnotic use for sleep improvement. I limited my PubMed search to randomized controlled trials, age (>65 years), published in the last ten years. Studies were restricted to similar patients encountered in family medicine. Study validity was appraised using JAMA evidence to include factors such as blinding, and concealment of patient allocation. Results: Over a thousand studies, narrowed to three randomized controlled trials ($n=209, 70, 46$). The first RCT concluded that at 3, 6, and 12 months, patients treated with CBT (6-8 sessions) showed overall improvement in their Pittsburgh sleep quality index scores, with reduced hypnotic drug use-33% report no use by 6 months. The second study determined that CBT allowed significant sleep diary improvement and reduced the time for patients to fall asleep. The third study demonstrated that zopiclone effects did not differ from placebo. In patients receiving CBT, their sleep efficiency improved from 81.4% to 90.1% post treatment. In contrast, patients' sleep efficiency decreased, when taking zopiclone alone. Conclusion: CBT is superior to hypnotic use in the treatment of chronic insomnia. As family doctors increasingly have access to behavioural consultants in the community, CBT should be considered as a viable option in the management of chronic insomnia.

730 Community Doctor Preferences for Hospital Discharge Medication Information

Jackie Mann, Drumheller, AB; Echo Enns, MD, CCFP, Calgary, AB

Description:

Objective: Learners will gain insight into how family doctors interpret the clarity, organization and usefulness of medication information found in hospitalists' discharge summaries and improvements they suggest. Background: Transition from hospital to home represents a vulnerable time for patient safety, particularly surrounding medication changes. As part of the hand-off to primary care, medication changed in hospital is disseminated to patients' receiving family doctors in the discharge summary, a one-way communication varying by author. As the Calgary Health Region works to implement a Required Organizational Practice (Accreditation Canada) to improve safety, we bring community doctors' insight into the process. Until now, hospitalists have never asked for feedback on the medication information relayed through these work intensive documents. QI Methods: We invited community family doctors whose patients are discharged from the Peter Lougheed Centre Hospital (PLC) in Calgary to evaluate discharge summaries they recently received. 6 doctors participated and 23 discharge summaries were analysed. Participants were asked to rate and comment on the clarity, organization, and completeness of the medication information. We asked how they determine what home medications a patient should take from the discharge summary and what improvements could be made. We presented the results to hospitalists who had authored the discharge summaries and were eager to learn the subsequent recommendations. Results: All community doctors found without home meds listed, the overall use of the discharge summary was reduced. 41% of the time, some home medications were not represented. Only 55% of the time, community doctors were confident they knew what changes to home medications were made in hospital. Why a dose or schedule of a home medication changed was clear 55% of the time and 83% of interviewed doctors wanted the reasoning behind changes. Perceived medication errors totalled a whopping 54. 69% of medication information evaluated was considered "organized" but there was no consensus how it should be structured. Conclusion: In addition to technological builds suggested, hospitalists were recommended to include 1) a full list of home medications 2) rationale behind medication changes to ensure it is clear what was known and what was intended.

731 Putting Communities First: The SHINE model for interdisciplinary, service-oriented medical education

Jennifer Edge, BHSc, MSc, Calgary, AB; Tammy Nighswander, MScPT, Calgary, AB; Karolina Kowalewski, MSc, Calgary, AB; Lauren Cuthbertson, Calgary, AB

Description:

Context: The CanMEDS Framework emphasizes leadership and advocacy as core competencies of the well-rounded physician. However, Canadian medical students often fail to receive adequate training in these crucial areas. Additionally, preventative health, inter-professional collaboration and "systems thinking" are often lacking in traditional medical education. The Students for Health Innovation and Education (SHINE) program at the University of Calgary was created to address these gaps. The SHINE model promotes interdisciplinary collaboration and unites the fields of medicine, population health and social policy by embedding students in service-oriented, longitudinal partnerships with community-based organizations (CBOs). Objective: To provide medical students with hands-on, longitudinal training in community development, leadership, and interdisciplinary collaboration. Design: Four students conducted mixed-methods research on inmate health at the Calgary Remand Centre in collaboration with site staff. Seven students partnered with the YMCA to design, implement and evaluate a Youth Wellness Program. All students organized monthly journal clubs and events featuring prominent leaders (e.g., in Prison and Aboriginal Health). Participants: 24 self-selected medical, public health, nutrition, and social work students were enrolled in the first two iterations of the SHINE program. Instrument: Survey evaluations were conducted at the end of each service cycle to assess the program's impact on students' professional development. Outcome Measures: Primary outcome measures addressed SHINE's impact on: 1) development of the CanMEDS Roles, 2) skills and knowledge acquisition to improve the health of vulnerable populations, and 3) professional development and career planning. Results: SHINE participants reported development across the majority of the CanMEDS Roles. On a 7-point Likert scale, the majority of students reported that they "Agreed"/"Strongly Agreed" that the program enhanced their skills and/or knowledge of working with vulnerable populations that would not otherwise be provided in the traditional curriculum. The majority also "Agreed"/"Strongly Agreed" that their involvement in SHINE influenced how they wanted to practice medicine in the future. Conclusions: The SHINE model demonstrates that student engagement in service-oriented, longitudinal community partnerships can advance individual development in each of the CanMEDS roles while supporting CBOs in achieving their goals. Similar models could be considered valuable complements to traditional medical curricula.

732 Disability Profiles in French-Canadians With Affective Symptomatology Surveyed in Primary Care Settings

Nina Nguyen, MD candidate, Montreal, QC; Pasquale Roberge, PhD, Sherbrooke, QC; Mathieu Philibert, PhD, Montreal, QC; Louise Fournier, PhD, Montreal, QC; Arnaud Duhoux, PhD, Montreal, QC; Annie Benoît, BA, Sherbrooke, QC

Description:

Context: Depression is associated with significant disability, but less is known about the contribution of anxiety symptoms to disability. Objective: To examine the disability profiles pertaining to depressive and/or anxious symptomatology (DAS). Design: Data were drawn from the Dialogue Project, an observational study conducted in 64 primary care clinics (Quebec, Canada). Participants: The sample of 14,833 adults was recruited in primary care clinics' waiting rooms when consulting a general practitioner for oneself. Instruments: The Hospital Anxiety and Depression Scale (HADS) was used to assess DAS. The World Health Organization Disability Schedule (WHODAS; short 12-item version) was used to assess disability in six domains: mobility, life activities, cognition, social participation, self-care and getting along. Outcome Measures: Respondents were divided in four groups according to their HADS score: anxious subjects (n=4667), depressive subjects (n=2304), anxious-depressive subjects (n=1785) and control subjects (n=9543). Results: Preliminary results indicate that depressive subjects, compared to anxious subjects, presented higher levels of disability for all six domains, and anxious-depressive subjects presented the worst loss of functionality. For the social participation domain, multiple logistic regression models showed that anxious subjects (OR = 4,10; CI=3,72-4,52), depressive subjects (OR = 7,50; CI=5,95-9,46) and anxious-depressive subjects (OR= 18,62; CI=15,76-22,01) were more likely to present disability than control subjects.

Conclusions: Depressive symptoms were associated with more disability than anxiety, but comorbid depressive-anxious symptomatology significantly increased disability levels in all domains. Anxious symptoms are also associated with a higher level of disability than the absence of DAS. Recognizing that any type of DAS likely causes disability will further the efforts to improve diagnosis and treatment of common mental disorders in primary care.

POSTERS / AFFICHES NOVEMBER 13 NOVEMBRE

710 **Procedural Skills During Residency: Introduction of a procedure clinic to improve technical competencies**

Jennifer Sy, MD, CCFP, Toronto, ON; Jessica Roy MD, CCFP, Toronto, ON; Diana Toubassi, MD, CCFP

Description:

The Canadian College of Family Physicians expects residents to be competent in several procedural skills by the end of their residencies, but there is currently no consensus on the best method to teach these skills. This study aimed at quantifying residents' exposure to standard office procedures, their confidence levels regarding execution, and whether introducing a dedicated Procedure Clinic to the residency curriculum would increase both these metrics. All first year Family Medicine residents at the Toronto Western Family Health Team were surveyed regarding their exposure to standard office procedures, as well as their confidence level in the execution of those procedures. A bi-monthly Procedure Clinic was then created for residents, with residents who participated in this clinic ultimately being compared to controls, who did not, on these same measures. Residents who participated in the Procedure Clinic were exposed to significantly more procedures than residents who did not, controlling for level of training (mean 6.6 vs 2.2, $p=0.005$). Furthermore, residents who participated in the Procedure Clinic felt generally more confident in their ability to perform procedures than residents who did not ($P<0.05$). Therefore, creating a dedicated Procedure Clinic increases residents' exposure to procedural skills training, as well as subjective confidence in executing these skills.

711 **Use of Public Health and Afrocentric Methods to Increase Cancer Screening in an Immigrant Population**

Onyenyechukwu Nnorom, MD, CCFP, MPH, FRCPC, Toronto, ON; Liben Gebremikael, MA, Toronto, ON; Nan Shi, PA, Toronto, ON; Abel Gebreyesus, MHI, Toronto, ON

Description:

Context: Numerous studies have demonstrated that immigrant populations are generally less likely to undergo cancer screening, compared to the Canadian-born population. TAIBU Community Health Centre serves the Black community in the Greater Toronto Area as well as the local, largely immigrant, populations of Scarborough. TAIBU's cancer screening rates were previously low but are improving steadily over time, by applying public health frameworks and integrating them with our organizational values (mainly Afrocentric) in order to improve our internal screening practices and ultimately, community outcomes. Objective: To increase breast, cervical and colorectal cancer screening rates at TAIBU CHC. Design: Quality Improvement Planning & Evaluation Participants: Patients at TAIBU CHC Intervention: A comprehensive quality improvement strategy was used to increase screening rates: (1) Establishment of a staff Preventive Taskforce; (2) Assessment of barriers and promising practices including: provider audits, education, a patient call-back system, identification of community partners to reduce transportation costs, informing patients of the availability of same-gender provider options for screening procedures; (3) Establishment of a Quality Improvement approach using the Plan-Do-Study-Act framework; (4) Provider and patient engagement using an Afrocentric "collective village" values-based approach. Outcome Measures: Breast, cervical and colorectal cancer screening indicators Results: Cancer screening indicators at TAIBU CHC were relatively low in the 2012/13 fiscal year (Breast: 24.84%; Cervical: 56.01%; Colorectal: 24.57%) and increased substantially in the 2014/15 fiscal year to 63.05%; 57.25%; and 64.79, respectively. Although CHC indicators are based on services offered, a cross-sectional chart review was also conducted to assess completion rates. Among the patients offered breast, cervical and colorectal cancer screening, 90.10%, 96.75% and 83.64% completed the screening tests, respectively. Conclusions: By establishing a Preventive Taskforce of TAIBU CHC staff who designed a comprehensive, evidence-informed cancer screening initiative grounded in organizational cultural values, we were able to almost triple breast and colorectal screening rates in an otherwise under-screened immigrant population.

712 **Dying to Learn: A scoping review of breast and cervical cancer studies focusing on African-Canadian women**

Onyenyechukwu Nnorom, MD, CCFP, MPH, FRCPC, Toronto, ON; Nakia K. Lee-Foon, MHSc, Toronto, ON; Ankur Jain, MD, Toronto, ON; Onye Nnorom, MD, CCFP, MPH, FRCPC, Toronto, ON; Carolyn P. Ziegler, MA, MSt, Toronto, ON; Fran E. Scott, MD, CCFP, FRCPC, MSc, Hamilton, ON; Aisha K. Lofters, MD, PhD, CCFP, Toronto, ON

Description:

Context: Cancer is the leading cause of death in Canada. Although the Canadian Cancer Registry does not collect information on race or ethnicity, international studies have demonstrated that African-American women have a 41% higher breast cancer death rate, and are nearly twice as likely to die from cervical cancer as white women, and that UK Black women had poorer breast cancer survival rates (aged 15-64 years) and were at higher risk of cervical cancer (65 years and over) compared to their white counterparts. In Canada, several studies have demonstrated that immigrant women are less likely to be up to date on cancer screening than Canadian-born residents. African Canadian women may be under-screened for cervical and breast cancer and may be predisposed to worse outcomes, however such information can be difficult to find. Objective: To identify common themes and gaps in the literature regarding cervical and breast cancer prevention and management in African Canadian women. Design: Scoping Review Participants: N/A Intervention: We searched Medline, Embase, EBM Reviews, CINAHL, PsycINFO, and Scopus databases (2003-2013), and conducted a grey literature search of Canadian cancer and public health agencies, community health websites and organizations dedicated to black healthcare. Relevant studies were selected, data was charted, and themes were extracted. Outcome measures: Themes were mapped based on pre-set criteria: screening; incidence; prevalence; mortality; barriers; promising practices; other Findings: A total of 1125 abstracts and 13 grey papers were identified through database and website searches; 19 studies were selected for detailed review. Among these, 12 matched our inclusion criteria. Themes: most studies focused

on cancer screening and generally showed lower screening rates for breast and cervical cancer among African-Canadian women. Further, most studies identified a lack of culturally specific programs and initiatives, inadequate awareness, low socio-economic status and unfamiliarity with services as barriers to seeking screening. Gaps: none of the papers reported incidence or mortality rates specific to the African-Canadian population. Conclusion: There is a paucity of health research on breast and cervical cancer specific to African-Canadian women. This review can provide guidance for future research which may improve health outcomes in this population.

713 **Bad Behaviour: Why are family physicians disciplined by professional colleges in Canada?**

Sabrina Akhtar, MD, CCFP, MHSc, Toronto, ON

Description:

Background: Family physicians are uniquely positioned amongst doctors to provide continuing care through repeated contacts as they build core patient-physician relationships. It is unclear whether family physicians are better able than other doctors to recognize when their own personal issues interfere with effective care, and are more cognizant of the power imbalance between doctors and patients and the potential for abuse of this power. If family physicians have an enhanced understanding and appreciation of the complexity of the patient-physician relationship, they might be expected to better avoid disciplinary action for offenses committed against patients as compared to non-family physicians. Aim: The aim of this study was to compare the characteristics of family physicians disciplined in Canada, and the frequency and nature of their offences committed against patients for the fourteen years from 2000 through 2014 to other physicians disciplined during that timeframe. Methods: Utilizing a retrospective cohort design, we constructed a database of all physicians disciplined by provincial licensing authorities in Canada for the ten years from 2000 through 2014. Demographic variables and information on type of misconduct violation and penalty imposed were also collected for each physician disciplined. We compared family physicians to non-family physicians for the various outcomes. Results: Results will be reported as the percentage of family physicians of total physicians disciplined in Canada in the fourteen years from 2000 through 2014. Of those disciplined family physicians, we will report the proportion of women compared to the national cohort, and whether a higher or lower proportion of family physicians were disciplined for sexual misconduct and unprofessional conduct towards patients. We will report the result of family physicians as having either greater or lower risk of having disciplinary penalties in categories of offenses in comparison to other physicians. Conclusion: Family physicians differ from non-family physician physicians in the prevalence of misconduct against patients. Understanding the ethical pitfalls encountered by family physicians in longitudinal patient-physician relationships is a step towards decreasing this medical misconduct. Initiatives to improve family physicians' appreciation of their unique role in the centrally important patient-physician relationship need to be conducted and systematically evaluated.

714 **Continuity of Care at NYGH: Taking stock and planning for the future**

Allyson Merbaum, MD, CCFP, FCFP, Toronto, ON; Vanessa Rambihar, MD, CCFP; Rebecca Stoller, MD, CCFP; David Eisen, MD, CCFP, FCFP; Risa Freeman, MD, MEd, CCFP, FCFP

Description:

Context: The College of Family Physicians of Canada (CFPC) identified "Continuity of education and patient care" as a key component of the Triple C Curriculum for Family Medicine residency training in 2011. The Family Medicine Postgraduate Program at North York General Hospital (NYGH), a large suburban community teaching hospital, has provided a preceptor-based training model since its inception in 1980. This model allows for continuity of education (supervision, learning environment, and curriculum) and for continuity of patient care whereby learners work with their preceptors to provide care in an immersion model. With the increase in distributed models of postgraduate training, it is imperative that we examine the factors that contribute to our residents' experience and their perceptions regarding the provision of continuity of care. Objective: To explore the factors that influence a resident's perception regarding the provision of continuity of care during their training program. Design: An extensive literature review and stakeholder consultations led to the development of an innovative model for the exploration of factors contributing to the resident's understanding of continuity of care. This model, the SRP, examines the issues that influence the learner's perception of their continuity of care experience through the lens of the System, the Resident's responsibilities, and the Preceptor. The SRP was applied to the existing training program at NYGH in order to identify key areas for further exploration. Results: The application of the SRP revealed many important factors for consideration at our site in our ongoing effort to enhance the continuity of care experience in our training program. Conclusions: As one of the pillars of the Triple C Curriculum, and central to the practice of Family Medicine, it is imperative that all training programs address and explore the continuity of care experience provided for their learners. The application of the SRP model provides a new and innovative way of looking at the resident's experience in this area. Future research will examine holistic interventions at each of the SRP levels to enhance the continuity of care experience and to determine how best to inculcate this construct into the identity of our future family physicians.

715 **Family Medicine and Public Health Together: Co-location as a structural support to collaboration**

Jessica Hopkins, MD, MHSc, CCFP, FRCPC, Hamilton, ON; Kely Hillier, MSc, Hamilton, ON; Cathy Risdon, MD, DMan, CCFP, FCFP, Hamilton, ON; Jessica Hopkins, MD, MHSc, CCFP, FRCPC, Hamilton, ON

Description:

Introduction: In May 2015, Hamilton Public Health Services and the Department of Family Medicine (DFM), McMaster University, including one of two sites of the McMaster Family Health Team (FHT) co-located in the same building. To our knowledge, this is the first organization-level co-location of a public health unit, DFM, and FHT. This poster will describe early observations on collaboration. Method: A narrative description of the process and outcomes to date will be provided. This will include an inventory of current collaborations between Public Health (PH) and Primary Care-Family Medicine (PC-FM) and a description of the process to develop collaborative goals. A reflective discussion of known strengths and constraints of the organizations will occur. Results: The inventory of collaborations demonstrates that much baseline work between PH and PC-FM is occurring, but that it is generally

not deliberate at an organization-level. Short-term collaborative goals included: 1) developing a committee to build knowledge of and relationships with the other organizations, 2) planning a shared continuing professional education agenda, and 3) planning to implement increased smoking cessation programming. Longer-term shared goals are under development and the results will be available in fall 2015. Lastly, known strengths and constraints of PH and PC-FM will be discussed. Early reflections show the strengths of PH to be population-based, strong background in health promotion, and mass media/public communications campaigns, but constrained by a formal organizational structure and high administrative processes burden. Comparatively, PC-FM has more distributed accountability for research and innovation, a strong background in secondary and tertiary prevention, strong individual-level relationships with patients, but is more limited than PH in reach (distinct patient population) and coordination of efforts at the organization-level (i.e., less clear priorities). Conclusion: PC-FM and PH collaborations support a larger continuum of care than either organization could individually. Much collaboration between PC-FM and PH exists in the normal course of work, but deliberate planning and resources can help to ensure these collaborations support organization-level goals and priorities. Acknowledgement of the uniqueness of each group within the larger group can build on organizational assets and minimize silos.

716 Not Every Low Back Pain is a Radiculopathy

Pankaj Bansal, MD, CCFP, Hamilton, ON; Laura Grennan, Hamilton, ON; E. Semenov, MD; Shanker Nesathurai, MD, MPH, FRCP(C), Hamilton, ON

Description:

A 66-year-old man with a history of chronic low back pain and three previous spine surgical procedures presented with new onset, acute, excruciating low back pain with dysesthesias radiating to the left leg, left leg weakness, and difficulty walking. There were no red flag signs. There was no focal weakness. The left ankle reflex was diminished. Sensation was decreased on the lateral foot, ankle, and lower leg. An acute left S1 radiculopathy was suspected. MRI did not reveal any changes from previous. Three weeks later, a diffuse vesicular rash appeared on his left leg. His examination remained unchanged with decreased sensation to S1-S3 dermatomes. He was diagnosed with acute herpes zoster complicated by lumbosacral postherpetic neuralgia (PHN). Over a period of 2.5 months, he was treated with oral acyclovir, tricyclic antidepressants (TCAs), oxycodone, gabapentin, physical therapy, and TENS (transcutaneous electrical nerve stimulation). His pain improved and he eventually returned to full function. Herpes zoster can manifest as low back pain and dysesthesias, despite initially suggesting a radiculitis. Reactivation commonly affects elderly and immunocompromised patients with an acute vesicular eruption distributed along adjacent dermatomes with severe pain and/or allodynia. [1] The most common neurologic complication is postherpetic neuralgia (abnormal sensations and severe, intractable pain or allodynia occurring one month after rash onset). [2] Early diagnosis and aggressive management of herpes zoster can alleviate symptoms and improve quality of life. All persons over 50 years of age and most persons under, should receive an oral antiviral within 72 hours of rash onset. [1,2] Adjunctive corticosteroids do not have any affect on quality of life or development of PHN. [3] The treatment of acute pain and PHN may include TCAs, gabapentin, carbamazepine, narcotics, topical anesthetics, transcutaneous electrical stimulation, acupuncture, regional sympathetic nerve blocks, intrathecal or epidural analgesia and lastly neurosurgical procedures. [1,4-7] Prevention with vaccination is recommended.[8]

718 Designing Better CPD in Emergency Medicine for Rural Family Physicians

Marianne Yeung, BSc, MD, CCFP(EM), FCFP, Ottawa, ON

Description:

Context: Rural family physicians often work solo, and identify higher needs for continuing professional development (CPD) in emergency medicine (EM) than their urban counterparts. The Community Emergency Medicine Outreach program (CEMO) aims to address these needs, and has been offered on-site at 12 rural hospitals in Eastern Ontario since 2009. Topics in adult EM are chosen by and tailored to the needs of each hospital's team of emergency health professionals, and discussed at half-day outreach sessions. Objective: To apply concepts learned during a Masters of Health Professions Education program to further develop the CEMO program. Intervention: The CEMO program director participated in the Masters program, supported by a CFPC Janus CPD Grant. New knowledge, skills and attitudes were applied to CEMO. Findings: Five important lessons learned, and their impacts on CEMO: Firstly, curriculum design is a dynamic and changing process; participants in CEMO now include many nurses, administrators, pharmacists, and junior learners as well as physicians. The content of each session is determined by each group to best serve their perceived and unperceived needs. Secondly, learning is most effective when it has high relevance to the local clinical context; CEMO's teaching strategies include case-based learning, interactive discussion and simulation. Fostering learning among interdisciplinary team members will promote translation of new knowledge into EM practice. Thirdly, it is more effective to integrate new technologies into a curriculum than to treat these as separate stand-alone educational endeavours. CEMO sessions include new presentation software, screencasts, procedural videos, and online audience response systems as tools to engage participants. Fourthly, participants may assess effectiveness of learning through reflection, multiple assessments over time, and multiple sources of assessment. CEMO encourages reflection during and after sessions, and considers participants' views on their new skills, knowledge and behaviours and their coworkers' reactions. Finally, program evaluation can take many forms, and begins with consideration of evaluation goals and questions. A program logic model has been developed for CEMO, and a combined process and outcome program evaluation is in progress. Conclusion: Applying important educational concepts can promote the design of effective emergency medicine CPD for rural family physicians.

719 Documentation de la lisibilité des documents d'information remis aux patients - Saguenay Lac St-Jean

Éva Marjorie Couture, MD, CCMF, Chicoutimi, QC; Maxime Dionne MD, Saguenay, QC; Dominic Cantin MD, Saguenay, QC; Benjamin Phaneuf MD, Alma, QC; Stéphanie Marceau MD, Saguenay, QC; Étienne Guillemette-Munger MD, Alma, QC; Catherine Potvin MD, MSc, Saguenay, QC; Mathieu Létourneau MD, Alma, QC; Marie-Ève Gaudreault-Villeneuve MD, Alma, QC; Mylène Lévesque MSc, Saguenay, QC; Mélissa Lavoie, MSc, Saguenay, QC

Description:

Contexte: Au Canada, le niveau moyen de littératie en santé est faible. Au Saguenay-Lac-Saint-Jean, 76 % de la population a un niveau de

littératie en santé insuffisant. La littératie englobe plusieurs concepts dont la capacité de lecture. Du point de vue des documents, la lisibilité sert, en partie, à évaluer le niveau de lecture nécessaire pour comprendre un document. Des données américaines suggèrent que les documents demandant de quatre à six ans de scolarité sont favorables à la compréhension par les patients. Objectif:

Documenter le score de lisibilité des documents d'information remis aux patients fréquentant les CSSS et UMF de Lac-Saint-Jean-Est et ceux de Chicoutimi. Plan : Étude descriptive Population cible: Les documents à visée éducative remis aux patients se présentant aux CSSS et UMF de Lac-Saint-Jean-Est et ceux de Chicoutimi. La taille d'échantillon est de 71 documents. Instruments : Les formules Simple Measure of Gobbledygook (SMOG) et Flesh-Kincaid ont été utilisées pour calculer le score de lisibilité. La formule SMOG est la plus adaptée au domaine de la santé et le Flesh-Kincaid est la plus utilisée. La formule SOL a par la suite été utilisée pour convertir le score du SMOG pour la langue française. Mesure des résultats : 71 textes ont été choisis aléatoirement et ont été analysés afin d'évaluer le niveau de scolarité nécessaire pour comprendre chaque document analysé. Un accord inter-juges (90%) a été réalisé au préalable. Résultats : Les textes analysés démontrent un score moyen de SOL de 8,7 (écart-type 1,4) et un score moyen de Flesch-Kincaid de 13,6 (écart-type 2,2) années de scolarité. 98,6 % des textes avaient un score SOL supérieur à quatre années de scolarité, comparativement à 100 % pour le Flesch-Kincaid. 97,2 % des textes avaient un score SOL supérieur à six années de scolarité, comparativement à 100 % pour le Flesch-Kincaid. Conclusion: Le niveau de lecture des textes analysés est supérieur au niveau de lisibilité recommandé pour la compréhension d'un document. Cela peut nuire à la compréhension des patients.

720 **Developing Quality Indicators for Collaborative Mental Health Care: A mixed-methods study**

Abbas Ghavam-Rassoul, MD, MHSc, CCFP, FCFP, Toronto, ON; Nadiya Sunderji, MD, FRCPC, Toronto, ON; Gwen Jansz, MD, PhD, CCFP, FCFP, Toronto, ON; Anjana Aery, MPH, Toronto, ON; Allyson Ion, MSc, Toronto, ON; Amanda Abate, MD, Toronto, ON

Description:

Collaborative mental health care is widely implemented in primary care settings, but often is not informed by evidence-based practices. This poster presents findings from an effort to develop quality indicators for collaborative care. We are conducting a mixed methods study to develop quality indicators for collaborative mental health care in primary care. Through a scoping review of peer-reviewed and grey literature we are identifying quality indicators and classifying them using the Institute of Medicine and Donabedian frameworks. We are purposively sampling mental health and primary care providers, and consumers, to participate in qualitative interviews, and thematically analyzing interview transcripts to identify indicators. Based upon the literature and qualitative phase, we will conduct a modified Delphi expert consensus process regarding the relevance of the identified metrics. Using the CIHR's Knowledge-to-Action framework, we are engaging an advisory group of primary care and mental health providers, people with lived experience of mental illness, and quality improvement experts to guide interpretation of the findings. Through a systematic search strategy we have identified 3762 literature sources to date, of which 202 met screening criteria. We have interviewed 13 healthcare providers. The work to date suggests that: a) co-location and adequate funding are integral to implementation, b) a tension exists between implementing evidence-based models versus adapting a model to the local context, c) team dynamics, relational skills, and physician buy-in may presage the functioning of a service, and d) high functioning teams may engage in multi-directional knowledge exchange, expanded scopes of practice and blurring of roles. Existing literature is heavily weighted toward evaluation of individual outcomes such as depression symptom severity, health status and level of function, whereas qualitative sources emphasized collaborative processes between clinicians, and facilitators and barriers to implementation. The research team and its advisory group have been able to incorporate overarching principles for collaborative care (e.g. equitability of access to care, meaningful choices available to consumers) and front-line perspectives on program operations (e.g. care management is available) The development of quality indicators will provide a consistent method by which to evaluate and improve the quality of collaborative mental health care in primary care.

721 **Advocacy in Action: Implementation of a Family Medicine Advocacy Project in the University of Toronto Longitudinal Integrated Clerkship**

Sharonie Valin, MD, CCFP, MHSc, Toronto, ON; Karen Weyman, MD, CCFP, Toronto, ON; Stacey Bernstein, MD, RCPSC, Toronto, ON; James Owen, MD, CCFP, Toronto, ON; Phiip Berger, MD, CFPC, Toronto, ON

Description:

Context: Advocacy is a CanMEDs core competency and it is something that we role model as Family Physician teachers regularly. However, it can be challenging to formally teach and evaluate. In 2014, the University of Toronto piloted a 51-week, longitudinal integrated clerkship (LinC) in an urban Academic Health Science Centre, with seven students. This provided an opportunity for innovation in advocacy teaching. Objective: To address this curricular competency, a formal advocacy project and evaluation tool was designed and implemented as part of the Family Medicine curriculum. Design: Students were instructed to identify a patient from their panel (a group of patients they follow longitudinally throughout the year), for whom social factors were significantly impacting their health and explore resources available to prepare an advocacy plan. Projects comprised of a presentation and abstract reflection were completed in five months, under the support of an identified faculty lead. The seven students were formally evaluated on a small group presentation and an abstract, which included a reflective component. A rubric was developed to evaluate: the advocacy issue, methodology, research and outcomes of their advocacy plan. This comprised 12% of their Family Medicine final evaluation. Findings: The students explored interventions regarding: medication access, housing, smoking cessation, and food security. Feedback from students revealed that they found the project feasible and meaningful. Unexpectedly, the project reinforced the value of the interprofessional team when advocating for a patient. A key finding post-project, was student self-report of continued application of advocacy skills in clinical care. Faculty found the project evaluation tool easy to use. Conclusions: The UofT LinC program successfully piloted a project that integrated advocacy training and evaluation of this core competency within the Family Medicine course. The project allowed students to explore ways of practicing and finding meaning in social responsibility. From an educator's perspective, we developed a project and tool that allowed for formal evaluation of an otherwise difficult skill to assess. This project will continue as part of the LinC program for next year. U of T is looking at integrating advocacy into the Block Family Medicine clerkship rotation.

722 Social Accountability Considerations for the Restructuring of a Family Medicine Residency Training Program

Danielle O'Keefe, MD, CCFP, MSc, St. John's, NL; Kristin Harris Walsh, PhD, St John's, NL

Description:

Context The Family Medicine residency training program at Memorial University in Newfoundland and Labrador trains residents for urban, rural and remote practice. With opportunities across Newfoundland and Labrador, New Brunswick and Nunavut, residents train in a variety of settings. Until recent years, residents completed short-term block training, resulting in little opportunity for integration into the clinic, hospital and community while requiring significant travel between training sites. In response to the CFPC Triple C curriculum changes as well as feedback from residents and preceptors, the residency training model was revised to reflect extended training opportunities in rural teaching sites across NL. Objectives • To learn how social accountability considerations led to a significant change in resident training opportunities in one Family Medicine program. • The early impact of residency training restructuring on the community. Design/Intervention In 2012, longitudinal integrated training opportunities were discussed at site visits and preceptors were asked to consider additional training options at their site. Based on this feedback, during the 2013-15 academic years a number of rural sites offered longitudinal integrated training to second year residents. The training increased from four months to six, eight, ten or thirteen training blocks depending on the site. As of 2014-2015, 49% of second year residents had the opportunity to complete longitudinal integrated training. Population Family Medicine residents and preceptors. Results Residents have stated a desire to "live in one place" and to "not move around" so often. Satisfaction with the rural Family Medicine rotation has increased over the past three years from 75% in 2011-2012 to 92% in 2013-2014. Preceptors reported satisfaction with the new training model. There has been recruitment success with this new model of training. Conclusion The longitudinal integrated training program has decreased resident travel and increased satisfaction of both residents and preceptors. We have begun to see improved recruitment to many of our rural sites and are thereby helping fulfill Memorial's social accountability.

723 Defining Priorities for the Assessment of Competence in Care of the Elderly by Family Physicians: The priority topics

Lesley Charles, BSc, MBChB, Edmonton, AB; Chris Frank, MD, FCFP, Kingston, ON; Marcel Arcand, MSc, MD, FCMF, Sherbrooke, QC; Sidney Feldman, MD, CCFP, Toronto, ON; Robert Lam, MSc, MD, CCFP, Toronto, ON; Prabin Mehta, MBChB, CCFP, Winnipeg, MB; Tim Allen, MD, CCFP(EM), FRCPC, Toronto, ON; Nadia Mangal, Toronto, ON; Tatiana Lozanovska, Toronto, ON

Description:

Context With Canada's senior population increasing, there is a greater demand for family physicians with enhanced skills and added competency in care of the elderly (COE). The College of Family Physicians Canada has introduced Certificates of Added Competence (CACs) in five domains, one being COE. CAC awards will be based on the demonstration of specific competencies. The first steps of defining these competencies are a determination of the priority topics. Objective To determine priority topics for the assessment of competence in COE. Design A modified Delphi technique was used with on-line surveys and face-to-face meetings. The Working Group (WG) of six physicians, with enhanced skills in COE, acted as the nominal group, and a larger group of randomly selected practitioners from across Canada acted as the Validation Group (VG) Intervention The WG, and then the VG, completed electronic write-in surveys that asked them to identify the priority topics. Responses were compiled, coded and tabulated to calculate the frequencies of selection of topics. The WG used face-to-face meetings and iterative discussion to decide on the final topics. Outcome A list of priority topics for the assessment of competence in COE, validated by correlating the input from the WG and the VG. Results There was a 19% response rate (41 of 212) from the VG. Most respondents from the VG are involved in teaching, and about one quarter are Program Directors. Half of them have more than 10 years of experience, and 45% have a focused practice. The correlation between the specific priority topic list identified by the VG and that identified by the WG is 0.68. The final list has 18 priority topics. There is an even higher correlation (0.89) for the generic skills of competence that were independently identified by the VG and the WG. Conclusion Defining the required competencies is a first step to establishing national standards in COE and these standards can be the basis for awarding CACs. The methodology used and the high correlation between the lists generated by the WG and the VG suggest that this priority topic list is valid for COE.

733 Potentially Avoidable Emergency Department Visits for Family Practice Sensitive Conditions

Geoff Paltser, PhD, Toronto, ON; Josh Fagbemi; Cheryl Gula

Description:

Context Canadians visit the emergency department (ED) frequently, at times for minor medical problems that might be more appropriately treated elsewhere. Many jurisdictions are evaluating strategies to reduce avoidable ED visits, and identifying and quantifying these visits can help efforts to improve appropriateness of care. Objective This study from the Canadian Institute for Health Information (CIHI) examines ED utilization to identify visits that may be more appropriately managed at a family physician's office or clinic, known as family practice sensitive conditions (FPSCs). Design ED visits for primarily low acuity reasons where patients were not admitted to inpatient beds were calculated and compared to rates of visits for other reasons. Possible explanatory factors including diagnosis and acuity, time of visit, length of stay, and patient age, SES, and rurality were examined. Target Population Included in the analysis are all unscheduled visits to EDs (excluding urgent care centres) in 2013-2014 where patients were discharged home. Instrument This study uses data from CIHI's National Ambulatory Care Reporting System (NACRS). The following jurisdictions submitted ED data with complete ICD-10-CA diagnoses in 2013-2014 and are included in the results: Ontario (all facilities); Alberta (all facilities); Nova Scotia (5 facilities); Saskatchewan (4 facilities); P.E.I. (1 facility); and Yukon (1 facility). Results Overall, 1 in 5 non-admitted ED visits were for FPSCs, totaling more than 1.4 million visits in 2013-2014. The most common reasons for these visits included upper respiratory infections (13%), antibiotic therapies (13%), sore throats (8%), ear infections (7%) and care following surgery such as dressing changes and removal of stitches (5%). More than one-third (35%) of non-admitted visits for children younger than age 5 were for FPSCs, compared with only 12% for patients age 85 and older. Additionally, 32% of non-admitted ED visits among rural-dwelling patients were for FPSCs versus 17% among urban-dwelling patients. Conclusions Providing care for patients presenting with FPSCs in settings such as doctors' offices and clinics may improve continuity of care and the patient experience, and allow ED resources to be focused on those who more appropriately require them.

734 Measuring the Patient Experience in Primary Care: Comparing email and waiting room survey delivery

Morgan Slater, PhD, Toronto, ON; Tara Kiran, MD, CCFP, MSc, Toronto, ON

Description:

Context: Measuring the patient experience is an integral step towards understanding and improving the quality of primary care. Finding the capacity to regularly survey patients can be challenging in a busy family practice and traditional methods can be costly and burdensome. Electronic surveys sent via email offer a low-cost alternative, however the method of data collection can influence survey responses. There is little literature to guide family practices on how patient characteristics and responses might differ when conducting patient experience surveys using different delivery methods. Objective: To compare the characteristics and responses of patients completing a patient experience survey accessed online after email notification or delivered in the waiting room via tablet computers. Design: Cross-sectional comparison of two methods of survey delivery Participants: Family health team patients aged 18+ who completed an email survey between January and June 2014 (n=587) or in the waiting room in July and August 2014 (n=592). Intervention: None. Outcome Measures: Comparison of respondent demographics and responses to questions related to access and patient-centredness. Results: Patients responding to the email survey were more likely to live in higher income neighbourhoods (p=0.0002) and had a different age (p=0.0147) and gender (p=0.0434) distribution than those responding to the waiting room survey; there were no significant differences in self-rated health. Patients responding by email were less likely to report being able to see a provider the same or next day when they were sick and needed care (53.3% email versus 60.2% waiting room, p=0.0265) but more likely to report their provider always or often spent enough time with them (89.2% versus 85.1%, p=0.0457); there were no differences in responses to other questions. Noted differences in responses disappeared after adjustment for patient demographics. Conclusions: Our findings suggest that responses may differ depending on the method of survey delivery but these differences can be explained by differences in the characteristics of the respondents. New methods of delivery that require electronic literacy may under-represent patients from low-income neighbourhoods.

735 Reach and Uptake of the Canadian Task Force on Preventive Health Care's Clinical Practice Guidelines

Nadia Bashir, PhD, Toronto, ON; Julia E. Moore, PhD, Toronto, ON; Charmalee Harris, BSc, Toronto, ON; Marcello Tonelli, MD, Calgary, AB; Sharon E. Straus, MD, Toronto, ON

Description:

Despite the large volume of published preventive health care research, many primary care practitioners (PCPs) routinely engage in practices that are not based on evidence. The Canadian Task Force on Preventive Health Care (CTFPHC) aims to minimize this knowledge-to-action gap by developing and disseminating evidence-based clinical practice guidelines for preventive care. Focusing on activities in 2014, we assessed the CTFPHC's success in accomplishing this goal by examining whether CTFPHC guidelines that recommend substantial changes in practice (i.e., breast [2011], cervical [2013], and prostate [2014] cancer screening) are reaching stakeholders and promoting practice changes. We measured reach by analyzing data on the CTFPHC's key dissemination activities (e.g., guideline and knowledge translation [KT] tool distribution). We also administered a survey to PCPs (N = 96) and conducted semi-structured interviews with them (N = 26) to assess self-reported current practices, awareness of CTFPHC guidelines and KT tools, and practice changes. Results revealed that the CTFPHC guidelines and KT tools have been viewed over 170,000 times and downloaded over 21,615 times. In addition, many survey and interview participants were aware of the guidelines and found them to be useful. Of these participants, 30-50% were aware of the KT tools and a similar proportion reported making practice changes based on the guidelines. When describing their current practices at the beginning of the survey or interview, however, most participants self-reported engaging in practices that were consistent with many of the CTFPHC's breast, cervical, and prostate cancer screening recommendations. Participants also provided several suggestions for increasing reach and uptake of the guidelines: (a) clarify differences between CTFPHC guidelines and other guidelines, (b) provide resources to support implementation, (c) disseminate guidelines and KT tools broadly, and (d) develop patient-focused resources. In sum, many Canadian PCPs are aware of the CTFPHC's breast, cervical, and prostate cancer screening guidelines and seem to be engaging in practices that are consistent with the guidelines. The results of this evaluation and the suggestions provided by participants identify ways in which the CTFPHC can improve its resources and activities aimed at supporting PCPs in delivering preventive care.

736 Women's Experiences of Contemporary Home Birth in Newfoundland and Labrador: A qualitative study

Kelly Monaghan, MD, PhD, St John's, NL; Patrick Fleming, MD, MSc, Toronto, ON

Description:

Background: Home birth is becoming increasingly common across Canada. In Newfoundland and Labrador (NL), approximately 12-15 women make this choice every year. Very little is known about the experiences of these women or home birth outcomes since they largely take place outside of the formal maternity care system. Methods: Using semi-structured individual interviews, this qualitative research project explores the experiences women who chose to home births in St John's, NL between 2011-2014. Participants were recruited through the province's sole practicing homebirth midwife. Interviews were transcribed and manually coded. We used thematic analysis to examine our data. Ethics approval was received from the local ethics board. Results: We included 11 women between the ages of 27-41 years who experienced 17 home births during the reference period. Participants tended to have higher levels of education and income than the general population with 81% having a university education and 64% exceeding the province's median household income. In our interviews, women discussed the reasons for their choice, outcomes of the experiences, some of the challenges they faced in arranging homebirth, and changes they would like to see to the formal maternity care system. Conclusions: Common reasons for choosing homebirth included the influence of peers, positive media representations, and prior unfavourable hospital experiences. Women reported satisfaction with the perceived comprehensiveness and family-centered nature of homebirth care. All participants expressed a desire for more choice in maternity care providers and seamless integration of legislated and publically funded midwifery services. This study addresses a significant knowledge gap on homebirths in Newfoundland and Labrador.

737 Development of Medical Imaging Pathways for Primary Care by Primary Care

Lilly Whitham, MSc, PMP, Toronto, ON; Jeff A. Bloom, MD, CCFP, FCFP, Toronto, ON; Karen Weiser, MBA, Toronto, ON; Ravi Menezes, PhD, Toronto, ON; Jisla Mathews, MBBS, MBA, Toronto, ON; Catherine Wang, Toronto, ON

Description:

Purpose: Medical imaging is a complex field, with rapidly advancing technology and variability in referral patterns. The provincial Diagnostic Imaging Appropriateness (DI-APP) Project was launched in 2014 by the Joint Department of Medical Imaging at the University Health Network to partner with primary care providers and build tools to assist with imaging referral decisions. The project aimed to develop robust, Ontario-specific, evidence-based pathways, framed in the primary care lens for common clinical scenarios, like headache and low back pain. Participants: The imaging pathways were developed collaboratively by multidisciplinary panels of over 50 members that included primary care providers, radiologists and relevant specialists from urban, suburban and rural practice settings. Primary care providers were placed in leadership positions to ensure applicability of the format and content to their practice. Methods: The pathway development methodology was informed by elements of the CAN-IMPLEMENT framework for guideline adaptation. Key steps involved guideline screening and summarization, assessment of recommendations via online surveys by clinician panels, meetings to resolve discordances and consensus building of the final pathway via modified Delphi technique. To develop an implementation strategy, a focus group was conducted to identify barriers and opportunities to pathway acceptance and adherence. Results: Using the consensus-based methodology, panel members successfully developed pathways for low back pain and headache and will continue with TIA/stroke and knee pain. The starting point of each pathway involves subcategories that combine specific symptoms and patient histories that should allow physicians to easily determine which management route to take. These subcategories are designed to reflect the initial assessment by primary care providers and align with current guidelines. Strong clinician engagement has been a key success factor and has been sustained over many months, ranging from 80-90% meeting attendance. Survey response rates have been consistently high as well, ranging from 70-80%. Conclusions: The imaging pathways are expected to be applicable to the local practice setting and accurately reflect patient presentation in primary care. Key to achieving widespread adoption will be integrating pathways into primary care providers' workflow and an implementation strategy that includes training and educational tools.

738 Innovative Practices in Primary Health Care for Alzheimer's Disease and Related Disorders

Isabelle Vedel, MD-MPH, PhD, Montreal, QC; Claire Godard-Sebillotte, MD, PhD (Cand); Geva Maimon, PhD; Geneviève Arsenaault-Lapierre, PhD; Mélanie Le Berre, MSc; Isabelle Vedel, MD-MPH, PhD; Liette Lapointe, PhD;

Introduction: According to the World Health Organization, Alzheimer's disease and related disorders (ADR) are "perhaps the 21st century's most serious health challenge" (WHO, 2012). Most primary healthcare (PHC) professionals are not prepared to deal with ADR patients, resulting in delayed diagnosis and late intervention. To increase PHC's capacity to cope with this population, new clinical and organizational practices must be implemented. This study investigates the impact of a report on ADR recently disseminated in Quebec. It aims to quantify quality of care, and identify organizational factors explaining performance. Methods: A convergent design, mixed methods study was conducted. Eight Family Medicine Groups (FMG) were studied. Retrospective chart reviews collected data on diagnosis and follow up procedures, before and after the report. A ranking scheme was developed to quantify the performance of the FMG based on these data. Semi-structured interviews with key actors made up the descriptive qualitative study, which sought to determine the factors that can explain the performance rankings. Results: High performing clinics had the following characteristics: 1) Highly motivated family physicians (FP) with the confidence and tools to make diagnoses and initiate treatment. 2) Nurses who collaborated with FP, and whose extended roles included both the initial assessment of patients and their follow-up. 3) There was one physician who took on the role of leader and championed the cause for change. 4) There was an ongoing communication between the FMG and specialists, who not only provided expert advice and training to the FP and nurses, but also worked with the champion to develop clinical tools. Varying degrees of these characteristics were observed for the lower ranking FMG. Conclusion: This paper suggests that, under specific circumstances, innovative interventions in PHC are indeed feasible, even in the case of passive diffusion of a report. Given that the implementation and diffusion of innovative interventions is challenging, it is essential to identify the key factors linked with better quality of care in order to customize the interventions and achieve promising results. Based on the results from this study, the Quebec Ministry of Health has further developed the Alzheimer plan.

739 Impact of Antidepressants on Blood Sugar Among Canadian Primary Care Patients With Type 2 Diabetes

Justin Gagnon, MA, Montreal, QC; Marine Hardouin, Marie-Thérèse Lussier, MD, BSc, MSc, FCMFC; Gillian Bartlett-Esquillant, PhD, MSc

Description:

Context: Depression is a common comorbidity in people with diabetes and is associated with increased risk of poor glycemic control compared with those without depression. While treatment of depression is expected to improve glycemic control, evidence suggests that certain antidepressants exacerbate glucose metabolism, further increasing the risk of poor control. Evidence on the effects of the majority of antidepressants on blood sugar among people with diabetes and depression, however, remains inconclusive. Objectives: The objectives of this study were to describe the antidepressant prescription practices among primary healthcare providers for patients with type 2 diabetes and depression, and to measure the impact of the top prescribed antidepressants on their blood sugar. Design: A population-based cohort study was undertaken. Participants: The study sample comprises diabetic patients seen in Canadian primary care practices between 2008 and 2014 and having been prescribed an antidepressant as treatment for depression. Instrument: Patient health data was obtained from the Canadian Primary Care Sentinel Surveillance Network (CPCSSN). The CPCSSN chronic disease database contains anonymized health information obtained from electronic medical records across Canada. Outcome measures: The principle outcome is the change in glycosylated hemoglobin (HbA1c) measured prior to and following an antidepressant prescription. A multi-linear regression model was computed to measure the extent to which HbA1c varies following exposure to one of the top prescribed antidepressants. Results: Tricyclic and tetracyclic antidepressants and monoamine oxidase inhibitors (which studies suggest cause weight gain and hinder glycemic control) are seldom prescribed by Canadian healthcare providers for people suffering from type 2 diabetes. Results on the impact of antidepressants on blood sugar will be presented at the conference.

740 Emailing Discharge Instructions: Does it click with patients?

Michael Heiber, MD, CCFP (EM), Scarborough, ON; Christine D. Connelly, PhD, Toronto, ON

Description:

Context: Patient education can influence disease management in certain medical conditions treated in the emergency department (ED) and in family practice. Traditionally, patient education has involved sending patients home with paper handouts or a web address jotted down on a sheet of paper. However new technology can more reliably connect patients with resources. Objective: The purpose of this study is to evaluate the utility of a computer program which send emails to patients with links to relevant patient education resources. Design: The study involves database and survey analysis. Participants: Participants include a convenience sample of 200 ED patients, including adults and children with a diagnosis corresponding to one of five specific topics (head injury/ concussion, asthma/COPD/bronchitis requiring an inhaler prescription, fractures, stitches and fever in children). Intervention: We selected five health topics commonly seen in the ED and created webpages for each one with relevant information culled from the Internet, which we reviewed. On discharge, patients were directed to a desktop computer in the ED running a software program we created. This program was accessible to emergency doctors, nurses, cast technicians and respiratory therapists. Consenting patients would type in their email address and answer three survey questions. The program would send each patient a personalized email with a link to a webpage pertaining to his/her health problem. Using click-tracking software, we collected data on whether patients opened this email message and accessed links on the provided webpage. Findings: In the first month of the study, preliminary findings showed that 11 out of 20 patients logged onto the website after discharge from the ED. Conclusions: Patient engagement with discharge instructions remains a challenge for clinicians. However, using a computer program to email patients tailored information is a promising approach to improving disease management which could be even more feasible in family practice than in the ED.

741 Exploring the Barriers to Depressed Family Medicine Residents Accessing Mental Health Services

Todd Hill, PhD, Calgary, AB; Kelsey MacLeod, MD, Calgary, AB; Todd Hill, PhD, Calgary, AB; Alex Kirvan, MD, Calgary, AB;

Kim Taylor, MD, Calgary, AB

Description:

Medical learning environments are stressful. Prolonged exposure to stress can negatively impact residents' performance academically as well as their physical and psychological well being, making them vulnerable to depression. Given that medical trainees are at an elevated risk of depression, access to mental health resources is important. Givens and Tjia (2002) looked at depressed medical students and found that only 22% of them were utilizing mental health counseling services. The most common perceived barriers were lack of time, lack of confidentiality, stigma, cost, fear of documentation on academic record, and fear of unwanted intervention. In the present study, the survey used by Givens & Tjia (2002) was given to 127 Family Medicine residents at the University of Calgary. Results indicate that 69.7% residents had below threshold symptoms of depression, 15.6% residents' scores were suggestive of mild depression, and 14.7% residents scores were suggestive of moderate to severe depression. When we looked at the residents who met criteria for moderate / severe depression (BDI - SF = 8 or higher), only 5 of the 16 residents (31.3%) reported seeing a counselor, and of those, only 1 was seeing a counselor provided by the university. The remaining 4 residents with moderate / severe depression reported receiving services outside of the institution. Similar to Givens & Tjia's results, the most common barrier identified to accessing mental health services was the lack of time to use services. The second most frequently identified barrier was fear of lack of confidentiality, followed by: fear of negative impact on career, fear of unwanted intervention, stigma, hard to find accesses / services, concern that no one will understand problems, cost, and fear of documentation on school record. The present results add to the work presented by Givens & Tjia indicating that time is a huge perceived barrier to accessing mental health services. Cohen and Patten (2005) found that time pressure was the leading factor in residency-related stress. These findings would suggest that time pressure is both a perceived cause of mental health problems and a barrier to accessing mental health services.

750 Health Care Provider Perceptions of the Identification of Adults With Suspected Mild Intellectual Disability

Meg Gemmill, MD, CCFP, Kingston, ON; Mary Martin, MSc; Nicole Bobbette, MSc; Elizabeth Grier, MD, CCFP; Ian Casson, MD, MSc, FCFP

Description:

Context: Adults living with intellectual and developmental disabilities (IDD) often experience complex physical and mental health issues, highlighting the importance of ongoing follow-up and management by family physicians and supportive allied health services. For adults with a previously undiagnosed IDD, a psychological assessment is recommended by the Canadian Consensus Guidelines for the Primary Care of Adults with Developmental Disabilities to confirm the diagnosis of IDD and prompt funding for community services. However, this is not easily adhered to, as the high cost is not subsidized by many health or social service systems. The purpose of this study is to explore the perceptions of family physicians (FP) and allied health providers (AHP) towards the need and potential use of an affordable, in-office IDD identification tool. Objectives: 1) exploring physician and allied health provider experiences with IDD diagnosis and assessment processes, 2) determining adherence to Canadian Consensus Guidelines, 3) determining perceived need and attitudes towards the use and usefulness of an identification tool designed for use in primary or allied healthcare settings. Design: To address objectives, we are carrying out a multi-method study. Here we present results of an online questionnaire that combines measures of agreement and free-text responses. Quantitative data will be analyzed using descriptive statistics and free-text responses through thematic analysis by two independent researchers using NVivo(10). Participants: Questionnaire will be distributed among currently practicing FP and AHP with past or present clients having diagnosed or undiagnosed IDD, working in Family Health Teams in south-eastern Ontario, Canada. Results: Data collection and analysis ongoing. We anticipate highly variable experience with identification processes and low adherence to Canadian Consensus Guidelines. Conclusions: Adults with undiagnosed IDD are a vulnerable population in need of enhanced primary care and allied healthcare support. This questionnaire will inform the development of an interview script with key stakeholders in community organizations to

gain an organizational perspective of the issue. Study results will support the future development of an in-office IDD identification tool.

751 Perceived Competence in Performing Procedures Among Urban and Rural Family Medicine Graduates

Payam Sazegar, MD, CCFP, Vancouver, BC; Payam Sazegar, MD, CCFP, Vancouver, BC;
Maureen Sharko, MD, CCFP (EM), Kelowna, BC

Description:

Context: Training family physicians to perform common outpatient procedures can increase job satisfaction, improve patient satisfaction, boost practice income and reduce health care costs. However, Residency programs in Family Medicine often do an inconsistent job providing adequate training in the Core Procedure Skills defined by the College of Family Physicians of Canada in 2005. Objective: The primary objective of this study was to perform a gap analysis to elucidate graduating Residents' perceived comfort performing the 65 core procedures and their intention to perform these in their future clinical practice. Design: survey research Participants: Surveys were circulated to residents at two different Family Practice training sites of the University of British Columbia– one urban and one rural site. Inclusion criteria were PGY-2 Family Practice residents graduating in June 2014 and those completing their training within 3 months of this cohort. Outcome measures: Perceived comfort performing procedures and intention to practice as measured by a 5-point modified Likert scale developed for this study. Results were analyzed for variance between the urban and rural training sites. Results: Surveys were collected from 9 urban respondents (10 circulated; 90% response rate) and 8 rural respondents (13 circulated; 62% response rate). Significant differences were observed between the 2 UBC training sites in the areas of Emergency, OBGYN and Musculoskeletal procedures with rural graduates having greater perceived comfort and competency in the aforementioned. Individual comments from respondents were also highlighted to support the quantitative analysis. Conclusions: In this study we review current procedural skills curriculum at two UBC Family Practice Residency programs, report survey results from our gap analysis, and make suggestions for enhancing training in core procedures based on professional practice gaps and best practices in medical education.

JANUS CPD POSTERS / AFFICHES JANUS DPC NOVEMBER 13 NOVEMBRE – FOYER MTCC

752 Masters in Education: Studying to Become a Better Teacher

Ann S. O. Lee, CCFP, Edmonton, AB

755 Designing Better CPD in Emergency Medicine for Rural Family Physicians

Marianne Yeung, CCFP(EM), FCFP, Ottawa, ON

S114835 A Binge-Eating Disorder, Obesity, and Primary Care: An intersection to improve patient care**06:45–07:45** Richard Ward, MD, CCFP, FCFP, Canmore, AB; Barry Simon, MD, CCFP, FRCPC, Toronto, ON**801AB MTCC****Learning Objectives:**

1. identify clinical situations where screening for binge-eating disorder would be appropriate
2. diagnose binge-eating disorder
3. describe evidence-based management options for binge-eating disorder

Description:

This session is meant to be an informal and interactive program that will raise awareness of binge eating-disorder in primary care. The format will be more conversational and casual between the two presenters, with an attempt to engage the audience in a dialogue.

Participants may claim an additional Mainpro-M1 credit for attending this session

S99587 Chronic Pain CPFM Networking Breakfast**07:00–08:00** Ruth Dubin, MD, CCFP, FCFP, Kingston, ON; Lydia Hatcher, MD, CCFP, FCFP, Ancaster, ON; Roman Jovey, MD, Mississauga, ON; Bruce Hollett, MD, CCFP, Conception Bay South, NL; Mark Ware, MD, Montreal, QC; Lori Montgomery, MD, CCFP, Calgary, AB; Greg Chernish, MD, Winnipeg, MB; Joel Bordman, MD, Toronto, ON**707 MTCC****Learning Objectives:**

1. connect with Canadian family physicians and residents who are interested in chronic pain
2. identify chronic pain issues relevant to colleagues across Canada
3. relate activities of the chronic pain CPFM committee in 2015

Description:

This networking breakfast for anyone interested in chronic pain will bring together the chronic pain community of practice in family medicine. The breakfast will provide networking opportunities for Canadian family physicians and learners. Members of the CPFM committee can update attendees on the activities of the committee and hope to hear from attendees about the issues that are of relevance to our members from across Canada. Sharing information on practical skills, educational initiatives, and regional barriers or successes in pain management will be our goal.

S102350 Substance Use and Pregnancy Networking Breakfast**07:00–08:00** Lisa Graves, MD, CCFP, FCFP, Ancaster, ON; Alice Ordean, MD, CCFP, FCFP, Toronto, ON; Suzanne Turner, MD, CCFP, Toronto, ON; Maya Nader, MD, CCFP, Toronto, ON; Mel Kahan, MD, CCFP, FCFP, Toronto, ON; Pat Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON**713A MTCC****Learning Objectives:**

1. identify current issues in substance use in pregnancy for family physicians
 2. share successes and challenges of caring for women with problematic substance use in pregnancy
 3. network with colleagues who share similar interests
-

S102783 Prison Health Breakfast Networking Session: What you need to know to become a prison physician**07:00–08:00** Josiane Cyr, MD, CCFP, Montreal, QC; Margaret (Peg) Robertson, MD, CCFP, Kingston, ON; Nader Sharifi, BSc, MD, CCFP, ABAM, CCHP, Surrey, BC; Fiona Kouyoumdjian, MD, CCFP, PhD, Hamilton, ON; Lori Kiefer, Medical Consultant, Ontario Provincial Corrections**715B MTCC****Learning Objectives:**

1. network with others who are interested in prison health
2. increase understanding of the steps involved in becoming a prison physician

Description:

During this informal breakfast networking session, prison physicians will share their personal narratives, in response to the following questions: What led me to become a prison physician? What steps did I take in order to become competent? How do I stay competent? How do I maintain my emotional resilience? Attendees of this networking session will be invited to share their own interest in and experiences of prison health, and to ask questions.

S102867 **Developmental Disabilities Community of Practice Networking Breakfast:
Genetic assessment in the workup of intellectual disability and autism spectrum disorders**
07:00–08:00 Elizabeth Grier, MD, CCFP, Kingston, ON
717A MTCC

Learning Objectives:

1. discuss new genetic testing techniques and their efficacy
2. describe the role of the family physician in assessment

S103724 **Cancer Care Networking Breakfast**
07:00–08:00 **715A MTCC**

Description:

Do you have a special connection to the care of cancer patients? You are invited to join the new Cancer Care CPF group at our networking breakfast! We'll meet each other, discuss ways that our new group can strengthen the work of FPs with a special commitment to cancer care, and be a better resource to our FP colleagues and to family medicine training programs. See you there!

S103752 **Dermatology Networking Breakfast**
07:00–08:00 **717B MTCC**

Description:

The Dermatology Networking Breakfast will offer a short didactic session: "The Top 10 Mistakes We Make When Treating Our Dermatology Patients", followed by a group discussion around future initiatives in dermatology primary care.

S103760 **Emergency Medicine Networking Breakfast**
07:00–08:00 **705 MTCC**

Description:

FMF Delegates are invited to share their knowledge and expertise in this specific area of interest at the Emergency medicine networking breakfast

S94708 **Teaching Procedural Skills in Your Office Based on the Triple C Curriculum**
08:30–09:30 Juan Garcia-Rodriguez, MD, CCFP, MSc (Med Edu), Dip Sports Med, Calgary, AB
707 MTCC

Learning Objectives:

1. recognize the importance of procedural teaching as a part of the Triple C curriculum
2. identify family medicine CanMed roles in procedural teaching
3. list the steps for teaching procedures

Description:

This is an interactive session to review the steps required for successfully imparting procedural skills instruction and to review a model to understand skill acquisition. Emphasis will be put on recognizing this teaching activity as a crucial part of the Triple C curriculum. At the end of the activity participants will practise skills reviewed during the session and will receive feedback on the simulated teaching.

S95094 **Approach to the Acutely Agitated Patient in the ED**
08:30–09:30 Vu Kiet Tran, MD, MHSc, MBA, CEUS, Richmond Hill, ON
714AB MTCC

Learning Objectives:

1. enumerate steps taken to de-escalate the agitation
2. enumerate precautions taken to prevent injury while performing physical restraints
3. enumerate most commonly used chemical restraints

Description:

In a busy emergency department where numerous things can happen at the same time and all of a sudden, knowing what to do is important. This is especially true when it comes to dealing with the irritated patient who has waited for a long time or with the psychiatric patient who has suddenly decompensated. What is an appropriate approach? How to do it safely (for all parties involved)? When are physical or chemical restraints appropriate or inappropriate? Learn which medication is effective and safe. Become more comfortable in dealing with the acute agitated patient in a chaotic environment like the emergency department.

S96388 **PMS: Pretty miserable syndrome**
08:30–09:30 Christiane Kuntz, MD, CCFP, FCFP, NCMP, Ottawa, ON
701A MTCC

Learning Objectives:

1. define "premenstrual syndrome" and examine the etiology/pathophysiology
2. describe the natural history across the life cycle and recognize the impact of PMS on health, wellness, and society
3. review clinical assessment tools for PMS, explore treatment options, and apply learning "pearls" through the review of cases

Description:

The session will begin with a definition of “premenstrual syndrome” and will continue with a description of the natural history of this disorder across the life cycle. The etiology and pathophysiology of PMS will be examined, recognizing the impact of PMS on health, wellness, and society. Clinical assessment tools for PMS will be discussed. This will be followed by an exploration of the hormonal, psychotropic, and alternative treatment options for PMS. Learning “pearls” will be applied through a review of real-life cases.

S99034 🎧**Identifying and Managing the “Can’t Miss” Headaches****08:30–09:30****Dépister et prendre en charge les céphalées à ne pas omettre**

Carolyn Rosenczweig, MD, CCFP, Surrey, BC

HALL F MTCC**Learning Objectives:**

1. use efficient tips and tricks to quickly and accurately identify a “can’t miss” headache
2. confidently manage the “can’t miss” headaches including identifying which patients need to be referred onwards for further tests and specialist care
3. learn which medications are potentially dangerous when dealing with patients suffering from headache—both acute and chronic

Description:

Headache is one of the most common presentations to a family practitioner’s office or emergency department. Sometimes these headaches are due to potentially dangerous conditions, which, if missed, can leave a patient permanently disabled (eg, blindness due to a missed temporal arteritis) or dead (eg, missing the sentinel bleed in an evolving subarachnoid hemorrhage). In this session, attendees will learn efficient tips and tricks in conducting a focused history and physical exam that ensures “can’t miss” headaches are caught. The “can’t miss” headaches will be reviewed individually using a case-based format. The management of these headaches will be reviewed using methods from the most up-to-date research. By the end of this session, attendees will feel confident in being able to efficiently identify and manage both benign (eg, migraine) and “can’t miss” (eg, subarachnoid hemorrhage) high-risk headaches. In addition, attendees will know which pitfalls to avoid when dealing with patients suffering from chronic recurring headaches (eg, avoiding oral contraceptives and triptans in patients with classic migraines due to their increased risk of stroke).

Objectifs d’apprentissage :

1. apprendre des trucs et conseils utiles pour dépister rapidement et avec précision une céphalée à ne pas omettre
2. prendre en charge les céphalées à ne pas omettre en toute confiance – y compris identifier les patients qui doivent être aiguillés pour recevoir plus de tests et des soins spécialisés
3. savoir quels médicaments sont potentiellement dangereux lors de la prise en charge d’un patient souffrant de céphalées, aiguës et chroniques

Description :

La céphalée est l’une des raisons les plus courantes pour lesquelles un patient consulte un médecin de famille ou se présente à l’urgence. Parfois, ces céphalées sont causées par une affection potentiellement dangereuse et, si elle nous échappe, peuvent handicaper un patient de manière permanente (p. ex., cécité causée par une artérite temporale non dépistée) ou causer son décès (p. ex., omettre le saignement sentinelle d’une hémorragie sous-arachnoïdienne évolutive). Durant cette séance, les délégués apprennent des trucs et conseils pratiques pour effectuer une anamnèse et un examen physique ciblés assurant le dépistage des céphalées à ne pas omettre. Les céphalées à ne pas omettre sont étudiées individuellement dans une formule basée sur des études de cas. La prise en charge de ces céphalées est examinée à l’aide de méthodes découlant de la recherche la plus récente. À la fin de la séance, les délégués pourront avoir confiance de pouvoir dépister efficacement et prendre en charge les céphalées bénignes (p. ex., migraine) et celles à risque élevé que l’on ne peut omettre (p. ex., hémorragie sous-arachnoïdienne). En outre, les délégués savent quels pièges éviter lorsqu’ils soignent des patients qui souffrent de céphalées chroniques récidivantes (p. ex., éviter les contraceptifs oraux et les triptans chez les patients souffrant de migraines classiques en raison du risque accru d’AVC).

S100369**From Notes to Reality: A songwriting workshop for (musical) medical professionals****08:30–09:30**

Ted Jablonski, MD, CCFP, FCFP, Calgary, AB


711 MTCC**Learning Objectives:**

1. understand the elements of a song and basic song structure
2. mine creativity, convert daily writing into lyrics, and find rhythms and melodies
3. complete a simple song by the end of the session

Description:

If you are a musician and always wanted to write a song, this will be the best workshop you ever attend. If you have written songs and want to take your craft to the next level, consider this a “master class.” An unusually high percentage of medical professionals have extensive musical backgrounds and a genuine passion for the arts. But how many can say they have ever written a song? For most, even with formal music backgrounds, this may seem like a daunting goal as the process seems difficult, poorly defined, and shrouded in mystery. We are a very focused hard-working group of over-achievers but sometimes our creativity has been beaten down by the challenges of our career, family responsibilities, and lack of time. Throughout our careers we can struggle with finding balance in our lives and we can lose our sense of fun and creativity. Our love of music becomes a “luxury” that we cannot afford due to all our other pressing commitments. We document information each and every day as a technical part of our jobs. Can this skill be translated into creative writing and a song? This practical, hands-on, interactive workshop is designed to help musical physicians write a complete song, even if they have never tried in the past. Ted “dr j” Jablonski is an award-winning multi-instrumentalist singer-songwriter and family practitioner in Calgary. He has written and published over a hundred songs, has released seven independent

CDs in blues/folk genre, and has had numerous television appearances and some radio play throughout Canada, USA, Europe, and Australia. He has successfully hosted songwriting workshops in a variety of settings, from homeless shelters to corporate offices.

S102824  **Primary Care Management of Celiac Disease**
08:30–09:30 **Prise en charge de la maladie coéliquie en contexte de soins primaires**

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

718AB MTCC

Learning Objectives

1. list the clinical situations where celiac disease should be suspected
2. distinguish between celiac disease and other kinds of gluten intolerance
3. test and refer appropriate patients for further evaluation, and provide advice on diet therapy and monitoring

Description:

Celiac disease is an under-recognized, common condition in primary care that is associated with several important conditions. As well, a growing number of patients present with self-declared “gluten intolerance.” This practical, interactive session—developed with input from family physicians, family physicians with celiac disease, a gastroenterologist, and patients—provides current evidence on celiac disease screening, investigation, and management principles.

Objectifs d'apprentissage :

1. de nommer les situations cliniques où la maladie coéliquie devrait être suspectée
2. de faire la distinction entre la maladie coéliquie et d'autres types d'intolérance au gluten
3. d'effectuer des analyses et orienter les cas appropriés pour une évaluation plus approfondie

Description:

La maladie coéliquie est une affection sous-diagnostiquée couramment rencontrée en soins primaires et associée à plusieurs affections importantes. En outre, le nombre de cas de soi-disant « intolérance au gluten » se multiplie. Cette séance pratique et interactive, élaborée en collaboration avec des médecins de famille, des médecins de famille atteints de la maladie coéliquie, des gastro-entérologues et des patients, traite des données probantes actuelles sur le dépistage, les tests et les principes de prise en charge de la maladie coéliquie.

S100473 **ABCs of Pediatric Dermatology**
08:30–09:30 Christie Freeman, MD, CCFP, MSc, DipPDerm, Peterborough, ON

HALL G MTCC

Learning Objectives:

1. recognize clinical presentations and utilize diagnostic tools to diagnose some common pediatric dermatology conditions seen in the office (eg, atopic dermatitis, perioral dermatitis, tinea capitis, skin infections, guttate psoriasis)
2. communicate with parents and patients effectively about treatments
3. prescribe appropriate therapy based on evidence and the speaker's experience

Description:

Family physicians encounter skin conditions in the pediatric population with great regularity. Having an approach to both diagnosis and treatment is important to provide timely relief to these children and to reassure parents. Most of the treatment of pediatric skin conditions will be the responsibility of the parents so having effective handouts and communication strategies are keys to good outcomes. This presentation will look at some common diagnoses, including atopic dermatitis, tinea capitis, perioral dermatitis, guttate psoriasis, pityriasis versicolor, and warts. Clinical photographs of these conditions and their complications will be shown along with a review of diagnostic procedures that can be done quickly in the office to aid with diagnosis. A review of treatments for these conditions, some evidence based and some pearls based on the speaker's experience, will be discussed.

S100561 **Opioid Tapering: Motivational interviewing through better listening**
08:30–09:30 Lori Montgomery, MD, CCFP, Calgary, AB; Todd Hill, PhD, RPsych, Calgary, AB;
 Chris Spanswick, MB, ChB, FRCA, FFPMRCA

701B MTCC

Learning Objectives:

1. use basic motivational techniques to introduce the idea of an opioid taper
2. practise motivational skills in helping a patient to plan a taper
3. troubleshoot potential barriers to a medication taper

Description:

We are all accustomed to hearing calls for caution when prescribing opioids, but what do you do when you inherit a patient on high doses of opioids, or a patient for whom you believe opioids have ceased to be useful? The prescription pad is sometimes the least important tool to help these patients. This workshop will outline motivational interviewing and other clinical tools to help patients make changes in the ways they use opioids.

S101471 Enhancing Patient Education in Your Practice

08:30–09:30 Jessica Dwyer, BSc, St. John's, NL; Cathy MacLean, MD, CCFP, FCFP, St John's, NL

713B MTCC**Learning Objectives:**

1. describe and address challenges encountered by family physicians in educating patients
2. employ patient education techniques to meet patient literacy needs
3. define strategies to enhance patient education encounters throughout the office environment and beyond

Description:

With a shift toward more patient-centred care and continuous advances in health technology, the extent of patients' knowledge and involvement in their own health care must increase for the purpose of self-management, informed consent, shared decision making, and patient engagement. With this evolution away from paternalism and toward patient-physician partnership, family physicians must depend on much more than printed patient education materials (PEMs) in their offices to convey additional information that cannot always be covered in a short office visit. Through researching health literacy and surveying the needs of patients in family practice clinics, this session will disseminate best practices related to patient education in the office setting. Through short case presentations, using brainstorming and small group work, we will address each of the three objectives. From a quality improvement project, the D-O-C-E-R-E method was developed to evaluate the PEMs currently used in practice. This method will be shared and participants will actively engage in using this approach to enhance their own practices. Using the D-O-C-E-R-E approach, participants of this session will be guided through the critical appraisal of various examples of PEMs currently in circulation. This demonstration will show participants how to assess health education tools—Display, Obtainability, Consistency, Effectiveness, Readability, and Explanation—to ensure their quality and appropriateness for their family practice. Empowering current and future family practitioners to be more cognizant of the challenges, techniques, and education strategies they employ with their patients may improve patient engagement and involvement in self-management. In small groups, chronic disease management cases will be used to demonstrate additional strategies for enhancing patient engagement, including the use of technology and community resources.

S101696 Adolescents en centres jeunesse : Comment évaluer la santé des vulnérables parmi les vulnérables?08:30–09:30 **Youth in Custodial Facilities: Vulnerables among vulnerables**

Yves Lambert, MD, CCMF, FCM, Longueuil, QC; Manon Duchesne, MD, CCMF, La Sarre, QC

713A MTCC — Small group interactive workshop – limited seating.**Objectifs d'apprentissage :**

1. décrire l'état de santé des jeunes hébergés en Centres jeunesse
2. présenter les caractéristiques particulières de cette clientèle ainsi que des indices de complexité/sévérité de leurs besoins en matière de santé ainsi que de leurs besoins en matière de services
3. s'approprier un outil d'évaluation adapté à cette clientèle hautement vulnérable

Description:

L'atelier est dérivé des résultats d'une recherche sur les problèmes de santé des adolescents hébergés en Centre de réadaptation (CR), sur leur prise en charge et les besoins de soins et services non-comblés. En 2012, 2791 adolescents étaient hébergés dans un CR, soit pour des troubles du comportement, négligence ou maltraitance. Ces problématiques sont associées à des atteintes psychologiques, physiques, sociales, développementales. De plus, ces adolescents cumulent plusieurs facteurs de risque pour la santé liés à leurs antécédents et mode de vie. Compte tenu de l'organisation du système de santé Québécois, on pouvait croire que les besoins de santé et l'utilisation des services seraient différents de ce qu'on retrouvait dans la littérature majoritairement américaine, en l'absence de données québécoises comparables. En 2003, l'ACJQ avait demandé au Regroupement des médecins en CR de produire un outil soutenant l'évaluation des problèmes de santé. De plus, pour les infirmières et le personnel psychosocial, il apparaissait important de pouvoir prioriser des situations, le soutien infirmier et davantage les effectifs médicaux étant fréquemment limités dans certaines régions. Nous proposons une grille d'évaluation qui repose sur les résultats de la recherche. À part les éléments communément retrouvés, nous mettrons en lumière les questions qui sont ressorties de la recherche, leur pertinence ainsi que leur valeur ajoutée. Certains éléments dont les variables construites sur les événements adverses et le sommeil, permettent d'établir, avant même l'entrevue médicale, le niveau de risque de maladies aiguës et chroniques, la « probabilité » de facteurs de risques, etc. Plusieurs sociétés savantes recommandent de faire une évaluation globale des jeunes à l'admission au CR. Notre étude en confirme la pertinence au bénéfice de la santé du jeune mais aussi du processus de réadaptation. De plus, notre étude pointe vers plusieurs dimensions qui souvent sont perçues de moindre importance dans le cadre d'une évaluation médicale usuelle. C'est sous la forme d'une interaction entre les participants et les présentateurs, mais aussi entre les données de la recherche et la grille d'évaluation, que nous proposons à la fois le questionnement sur les besoins de santé de ces jeunes très vulnérables, et l'appropriation des outils développés.

Learning Objectives:

1. describe the health of teenagers in youth custodial facilities
2. discuss the special characteristics of these youths and complexity/severity of their health needs as it relates to their services needs
3. discuss a grid especially developed for the health evaluation of these adolescents

Description :

The workshop is derived from the results of a study on the health problems of youth in custodial facilities, the management of these problems and unanswered health needs and services. In 2012, 2791 adolescents had been in custodial facilities in Quebec, mainly for behavior problems but also neglect and abuse: these are associated with physical, psychological, social and developmental problems. Moreover, these adolescents present many health risk factors in relation to their lifestyle and their own or family past history. Considering the organization of the Quebec health system, we could expect the health needs and use of services would have

been different from what the literature reports, especially from the US, although without comparable data from Quebec. In 2003, the ACJQ had asked the Association of MD in custodial facilities to develop a tool to support the evaluation of health problems. Also, for the nurses and psychosocial staff in those facilities, it was important to set priorities for some health situations, nursing support and worse, access to physicians, being often limited in some regions. We propose a health evaluation grid supported by the study results. Apart from commonly found items in such a grid, we will discuss items and questions that arise from the research, their pertinence and added value. Certain items like composite variables on adverse events or sleep problems, even before the health interview, establish the level of risky behaviors, and the chances of having acute or chronic diseases. Many professional societies recommend a global health evaluation of youth admitted in custodial facilities. Our study shows the benefit of such an evaluation as well as its benefit for the psychosocial readaptation process. Our study also highlights some dimensions and items often perceived as less important when performing a routine medical evaluation. The workshop proposes an interaction between participants and the animators, using the relation between study results and the evaluation grid, reflecting on the health needs of youth in custodial facilities and the appropriation of the evaluation tool.

S102116 How to Turn Your Quality Improvement Project Into Research

08:30–09:30 Christine Soong, MD, MSc, CCFP, Toronto, ON; Vandad Yousefi, MD, CCFP, Vancouver, BC
710 MTCC

Learning Objectives:

1. recognize the difference between quality improvement and research
2. use improvement science when designing quality improvement projects
3. apply research methodology to evaluate quality improvement projects

Description:

Family physicians are increasingly participating in quality improvement (QI) projects in the primary care setting. Designing a QI project with scientific rigour and evaluative design is necessary to determine efficacy of the intervention and to disseminate results within the scientific community. This session aims to describe the differences between QI and traditional research. Participants will learn how to design QI projects while incorporating evaluative design.

S102141 Don't Just Teach It – Share It: Teaching behaviour medicine using online resources

08:30–09:30 William Watson, MD, CCFP, FCFP, Toronto, ON; Allison Mullin, MA, Toronto, ON;
 Abbas Ghavam-Rassoul, MD, CCFP, FCFP, Toronto, ON
703 MTCC

Learning Objectives:

1. discover DFCM Open modules and other resources and how they can be used in teaching behaviour medicine
2. use the modules during the workshop
3. relate and discuss new ideas in using online resources that can applied to participants' own programs

Description:

Many family medicine residency programs struggle with teaching behaviour medicine, especially around common clinical psychosocial problems such as depression, anxiety disorders, chronic pain, suicide, and addiction. Despite the value of behaviour medicine in family practice, teachers of family medicine often wonder if and how to teach it within a curriculum that is already crowded. This workshop will focus on how to effectively combine didactic learning in behaviour medicine with an experiential component, with particular attention given to free Web-based learning modules available online. These modules are case-based, using real family-practice scenarios to pose questions to the readers, and are designed to be used in small group learning or self-learning. They include evidence-based information on specific topics dealing with some of the common psychosocial aspects of behaviour medicine in family practice. This workshop will be of particular interest to those involved in teaching behaviour medicine to family medicine residents. In the spirit of sharing information, participants will be invited to share resources and strategies that have worked in their own programs.

S102819 Prison Health Educational Opportunities for Medical Students and Residents

08:30–09:30 Margaret (Peg) Robertson, MD, CCFP, Kingston, ON; Josiane Cyr, MD, CCMF, Montreal, QC;
 Nader Sharifi, BSc, MD, CCFP, ABAM, CCHP, Surrey, BC; Fiona Kouyoumdjian, MD, CCFP, PhD, Hamilton, ON; Ruth Elwood Martin, MD, CCFP, FCFP, MPH, Vancouver, BC
715B MTCC— Small group interactive workshop – limited seating.

Learning Objectives:

1. review CanMED-FM competencies and roles that prison health educational opportunities can foster for learners
2. discuss the variety of prison health educational opportunities that are currently offered in undergraduate and postgraduate programs in Canada
3. network with others who are interested in fostering prison health educational opportunities

Description:

Incarcerated men and women represent an underserved and vulnerable population that suffers vast health inequities, when compared to the general population, with a high prevalence of mental illness and communicable disease. Therefore, Canadian prisons provide unique learning and invaluable service opportunities for medical students, residents, and physicians. We will describe varied undergraduate and postgraduate prison health educational programs in Canada. We will discuss the impacts of prison health experiences on learners, including the development of competencies in communication, health promotion, empathy, and reflective practice. Additionally, we will discuss ways

that prison health residency electives and prison clinical practice provide opportunities for personal and professional growth. We will also explore ways that workshop participants might consider initiating prison health educational programs in their local correctional institutions. This workshop will discuss health issues of the prison population, while also promoting opportunities for meaningful education, advocacy, and personal growth.

S102863 **Adults With Intellectual Delay in the Primary Care Physician's Office:
08:30–09:30** **Understanding intellectual delay**

Donna Lougheed, MD, FRCPC, Ottawa, ON; Meg Gemmill, MD, CCFP, Kingston, ON

501 MTCC

Learning Objectives:

1. identify and understand the four levels of intellectual delay and their associated cognitive impairment
2. recognize when to assess for capacity to consent or refuse treatment
3. use an identification tool for patients with suspected mild intellectual disability and arrange further assessments and community supports

Description:

How can a primary care physician identify adults with intellectual delay in the office? This session aims to give participants an understanding of functional impairment and simple office techniques for assessment. We review implications for the care of patients, including when to assess for capacity to consent, using case studies and videos. We will also present a new identification tool for patients with suspected mild intellectual disability, along with preliminary research on its use in primary care.

S120354 **So You Think You Can Research? Resident research projects**

08:30–10:15 Andrea Doxey, Manager, Continuing Professional Development, Ontario College of Family Physicians, Toronto, ON

716A MTCC

Learning Objectives:

1. examine current research in family medicine developed by top residents in Ontario
2. identify latest research from residents across Ontario and determine how to incorporate findings into everyday practice

Description:

This is a showcase of the most highly rated, practical research or scholarly projects developed by our future leaders in family medicine—the residents from the class of 2015. In this 90-minute session, each resident will be given 10 minutes to present his or her research, followed by a question-and-answer period. Come out and support your former residency program and support our future innovators as they present their award-winning projects. A winner among winners will be voted on following the session.

S100477 **12th EBM Teachers' Meeting**

08:30–10:45 Roland Grad, MD, MSc, FCFP, Montreal, QC; Cameron Ross, MD, CCFP, Chilliwack, BC;
David Chan, MD, CCFP, FCFP, Hamilton, ON; Inge Schabert, MB ChB, CCFP, Hamilton, ON

HUMBER ROOM – INTERCONTINENTAL HOTEL

Learning Objectives:

1. promote collaboration among EBM educators
2. raise awareness of individual successes with respect to education for evidence-based practice
3. share advances in instructional methods that can promote evidence-based practice

Description:

The objective of this meeting is to promote collaboration among EBM (evidence-based medicine) educators. In the past, this meeting of the EBM teachers group has been filled with presentations that provided a valuable starting point to realize this objective.

S101045 **Mindfulness in Medical Education**

08:30–10:45 Shirley Schipper, MD, CCFP, Edmonton, AB

709 MTCC

Learning Objectives:

1. describe mindfulness in the context of medical education from the perspective of a family doctor
2. understand the existing programs and curriculum innovations related to mindfulness practice
3. relate practising mindfulness to teaching, learning, and life as a family doctor

Description:

Mindfulness is a new buzzword for many educators of medical students and residents. It's not just reflective practice, or meditation. What is it? Why does it matter? Aren't I already doing this? If you're like most medical educators, more on the mindless side when it comes to this topic, come learn about this "new" thing. I'll delve into the evidence behind it, the use of mindfulness in medical programs, and the applications to teaching and learning during this session.

S102145 **Métasupervision entre collègues : L'intégrer à nos journées surchargées**
08:30–10:45 Lyne Ménard, MD, CCMF,FCMF, New Richmond QC; Sophie Galameau, MD, CCMF, Montreal, QC
705 MTCC

Objectifs d'apprentissage :

1. se familiariser avec le concept de métasupervision.
2. pratiquer la métasupervision à l'aide d'une grille/outil facilitant la rétroaction entre collègue.
3. discuter de son application concrète comme outil de développement professoral local et continu.

Description :

Cet atelier s'adresse tant aux médecins superviseurs qu'aux responsables locaux de développement professoral et aux directeurs locaux de programme. La métasupervision (ou supervision du superviseur) est une façon concrète et pratique de développer les compétences en supervision clinique autant pour les nouveaux enseignants que ceux d'expérience. Un outil (grille d'évaluation) pour faciliter la métasupervision vous sera proposé. Les différentes occasions de l'utiliser de façon informelle entre collègues ou lors d'une activité formelle de métasupervision seront discutées et l'expérience de métasupervision des animatrices sera présentée. L'utilisation de la grille sera pratiquée à l'aide de jeux de rôles en trios. Les commentaires et suggestions des participants pour améliorer cette grille seront les bienvenus.

S96520 **All Chronic Pain Is Not the Same: Making an accurate pain diagnosis**
09:45–10:15 Ruth Dubin, PhD, MD, CCFP, FCFP, DCAPM, DAAPM, Kingston, ON
701B MTCC

Learning Objectives:

1. formulate an accurate pain diagnosis (above and beyond "chronic non-cancer pain")
2. perform a focused chronic pain exam to detect myofascial, neuropathic, mixed, and widespread pain
3. provide patient education and treatment suggestions specific to the underlying pain condition

Description:

This presentation will cover aspects of one patient's chronic pain management over time. We will review the case of a 37-year-old construction worker with chronic low back pain as he is managed by his primary care provider. Elements of a pain-focused history and physical exam will be discussed and demonstrated. These skills will equip participants to make more accurate pain diagnoses. The role of central sensitization in the transition from regional to widespread pain will also be reviewed. Determining whether pain is myofascial, nociceptive, mixed, or neuropathic can potentially lead to more effective treatment options for many patients. This talk will reinforce why you, with your comprehensive and continuing understanding of this patient's bio-psycho-social milieu, are the most important health care provider for your patients who are living with chronic pain.

S96986 **Making It Real: Function and goal setting in a chronic pain patient**
10:15–10:45 Lydia Hatcher, MD, CCFP, FCFP, Ancaster, ON
701B MTCC

Learning Objectives:

1. identify the long-term consequences of chronic pain on patients physically, socially, and economically
2. describe the inherent issues and barriers associated with the effective management of chronic pain in primary care
3. provide patient education and treatment suggestions using functionality and goal orientation

Description:

This presentation will cover aspects of one patient's chronic pain management over time. We will review the case of a 37-year-old construction worker with chronic low back pain as he is managed by his primary care provider. You will gain comfort explaining that pain is best managed when the doctor and patient together understand what the goals for treatment are. You will learn new skills to be able to work with patients to improve their function. These skills will equip participants to better manage their pain patients. This talk will reinforce why you, with your comprehensive and continuing understanding of this patient's bio-psycho-social milieu, are the best equipped health care provider for your patients who are living with chronic pain.

S100869 **The Cancer Journey: What primary care providers need to know**
09:45–10:15 Edward Kucharski, MD, CCFP, Toronto, ON; Lisa Del Giudice, MD, CCFP, Toronto, ON
401 MTCC

Learning Objectives:

1. describe the cancer journey: prevention, screening, diagnosis, treatment, survivorship, and end-of-life
2. describe the role of primary care providers in the cancer journey
3. list the guidelines, programs, tools, and resources available to support primary care providers and their patients with a focus on Ontario-specific information

Description:

Primary care providers have a crucial role in cancer care as they support patients and families throughout the entire cancer journey. Two in five Canadians will be diagnosed with cancer in their lifetime and one in four will die of cancer (Canadian Cancer Society, 2013). Fortunately, more people are surviving and living longer with cancer. This interactive session will review the role of primary care providers in the cancer journey, including prevention, screening, diagnosis, treatment, survivorship, and end-of-life care. The emphasis will be on Ontario-specific guidelines and tools that are new, up-to-date, and relevant. The Cancer Journey presentation will focus on “pearls” and resources that primary care providers can use in their everyday interactions with patients and families. For example: Prevention: smoking cessation, tanning beds, HPV vaccine; Screening: Ontario-specific guidelines & appropriate follow-up, new programs such as the High Risk OBSP, and practical individualized tools for MDs, like the Screening Activity Reports (SARs); Diagnosis: focus on Diagnostic Assessment Programs (DAPs)—rapid access programs for patients with suspicious lung, colorectal, and breast findings and symptoms; Treatment: practical resources for primary care providers to support patients—CCO’s Symptom Management Guides (SMGs); End-of-Life Care—resources for both patients and practitioners including SMGs and advanced care planning; Recovery/Survivorship—tools to allow primary care providers the ability to follow up and care for patients who have survived cancer


S101338 **Moving Forward After Cancer: Cancer follow-up care for the family physician**
10:15–10:45 Jeff Sisler, MD, MClSc, CCFP, FCFP, Winnipeg, MB
401 MTCC

Learning Objectives:

1. define the survivorship phase of cancer, and empathize with the common concerns patients have in this phase
2. describe with examples the four domains of care that should be addressed by the FP in cancer follow-up care
3. list key activities in the follow-up care of breast and colorectal cancer survivors

Description:

Family doctors are being asked to play a larger role in the follow-up care of their cancer patients who have finished curative-intent therapy. For many patients, cancer and its aftermath constitutes a chronic disease, and FPs and their teams need an approach to this care that builds on their expertise in managing other chronic diseases. Like post-MI care, cancer follow-up is also an opportunity for the primary care team and patient to work together to enhance health and rehabilitation and reduce the risk of recurrent disease. This presentation will offer FPs a helpful framework for any follow-up cancer visit that builds on four domains of care: prevention of new and recurrent cancer through health promotion; surveillance for cancer recurrence and new cancers; intervention for consequences of cancer and its treatments; and coordination of care with other providers. In addition, more detailed information about follow-up care for breast and colorectal cancer patients will be presented.

S102176 
09:45–10:15**To Screen or Not to Screen for Prostate Cancer With the PSA Test:****Deciphering the evidence and exploring the controversy****Dépister ou ne pas dépister le cancer de la prostate à l'aide du test de l'APS : déchiffrer les données probantes et explorer la controverse**

Neil Bell, MD, SM, FCFP, Edmonton, AB; James Dickinson, MBBS, PHD, CCFP, FRACGP, Calgary AB

718AB MTCC**Learning Objectives:**

1. understand recent Canadian and US guideline recommendations on screening for prostate cancer with the PSA test
2. describe the natural history and epidemiology of prostate cancer and the potential benefits and harms of screening for prostate cancer
3. be able to engage in informed decision making with patients on screening for prostate cancer with the PSA test

Description:

Background: Prostate cancer (PCa) is the most commonly diagnosed non-skin cancer in men and the third-leading cause of cancer-related death among men in Canada. Screening for PCa with the PSA test remains controversial and primary care physicians have been provided conflicting recommendations on the benefits and harms of screening for PCa with the PSA test. Objectives: To develop sufficient understanding of the natural history/epidemiology of PCa and the potential harms and benefits of screening for PCa to undertake informed decision making with patients on screening for PCa with the PSA test. Audience: Practising family physicians, residents, and students. Session Description: 1) Review recent Canadian and US guideline recommendations on screening for PCa with the PSA test. 2) Understand the key points of PCa and PCa screening: a) The natural history/epidemiology of PCa including the incidence and prevalence of PCa, risk factors such as age, race, and family history. Discussion will also include the changes in the incidence and mortality of PCa after introduction of the PSA test in Canada and other countries. b) Review the PSA test including threshold levels, false positives, and overdiagnosis. 3) Explore the evidence and areas of controversy on the use of the PSA test in screening for PCa: a) Review the evidence from major RCTs and observational studies on benefits and harms of screening with the PSA test and discuss areas of controversy that have led to conflicting recommendations on screening with the PSA test. b) Consider how the positive PSA test can lead to further investigation and treatment. c) Consider how patient values and preferences would influence the decision to screen for PCa with the PSA test. 4) Talk to patients about PCa screening: a) Explore the available tools and resources that inform discussion with patients. b) Participant opportunity to model the discussion with patient on harms and benefits of PCa screening with the PSA test. Session Outcome: Attendees will have an increased understanding of the benefits and harms of screening for PCa with the PSA test and be better prepared to discuss PCa screening with their patients.

Objectifs d'apprentissage :

1. comprendre les récentes lignes directrices canadiennes et américaines sur le dépistage du cancer de la prostate par le test de l'APS
2. décrire l'histoire naturelle et l'épidémiologie du cancer de la prostate et les bienfaits et méfaits potentiels du dépistage du cancer de la prostate
3. pouvoir prendre des décisions éclairées avec les patients quant au dépistage du cancer de la prostate par le test de l'APS

Description :

Généralité : Le cancer de la prostate (CP) est le cancer non cutané le plus souvent diagnostiqué chez les hommes, et se classe au troisième rang des causes de décès lié au cancer chez les hommes au Canada. Le dépistage du CP par le test de l'APS demeure controversé et les recommandations à ce sujet sont contradictoires. Objectifs : Acquérir une compréhension suffisante de l'histoire naturelle/épidémiologie du CP et des méfaits et bienfaits potentiels du dépistage du CP afin de prendre des décisions éclairées avec les patients concernant le dépistage du CP par le test de l'APS. Auditoire : Médecins de famille en pratique, résidents et étudiants. Description de la séance : 1) Revoir les recommandations récentes des lignes directrices canadiennes et américaines sur le dépistage du CP par le test de l'APS. 2) Comprendre les principaux éléments du CP et du dépistage du CP : a) L'histoire naturelle/épidémiologie du CP y compris l'incidence et la prévalence des facteurs de risque tels que l'âge, la race et les antécédents familiaux. La discussion touchera aussi à la variation de l'incidence et de la mortalité liées au CP après l'introduction du test de l'APS au Canada et dans d'autres pays. b) Étudier le test de l'APS, y compris les valeurs seuils, les faux positifs et le surdiagnostic. 3) Explorer les données et les controverses quant au test de l'APS dans le dépistage du CP : a) Examiner les données tirées d'essais randomisés et contrôlés et d'études d'observation majeurs portant sur les bienfaits et les méfaits liés au dépistage par le test de l'APS et discuter de la controverse ayant donné lieu à des recommandations contradictoires à ce sujet. b) Réfléchir à la façon dont un test positif de l'APS peut entraîner d'autres investigations et traitements. c) Réfléchir à la façon dont les valeurs et préférences d'un patient influencent la décision quant au dépistage du CP par le test de l'APS. 4) Parler aux patients du dépistage du CP : a) Explorer les outils et ressources disponibles qui éclairent la discussion avec les patients. b) Les participants auront l'occasion de prendre part à la discussion avec un patient sur les méfaits et bienfaits du dépistage du CP par le test de l'APS. Résultats de la séance : Les participants comprendront mieux les bienfaits et méfaits associés au dépistage du CP par le test de l'APS et seront mieux préparés pour discuter du dépistage du cancer de la prostate avec leurs patients.

S102404 Optimizing Management of Pain in Correctional Facilities in Canada**09:45–10:15**

Fiona Kouyoumdjian, MD, MPH, PhD, CCFP, FRCPC, Hamilton, ON;
Ruth Dubin, MD, PhD, FCFP, DAAPM, DCAPM, Kingston, ON;
Nader Sharifi, BSc, MD, CCFP, ABAM, CCHP, Surrey, BC

715B MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. describe components of the assessment of patients who present with chronic pain in correctional facilities
2. identify key Canadian resources for opioid and chronic pain management
3. list best practices with respect to management of opioids in patients who are detained or incarcerated

Description:

Chronic pain and substance use disorders are common in persons in custody in jails and prisons in Canada. Challenges of managing pain for these patients while they are in custody include limited time for assessment, limited therapeutic and pharmacological treatment options, potential for abuse or diversion of medications, and the absence of continuity of care between the community and the custodial facility. This session is intended for primary care physicians who are working or planning to work in correctional facilities, or who frequently manage pain in persons after their release from custody. We will discuss key principles in pain management in this population, and then facilitate a discussion with participants regarding cases of interest and barriers to care. We will aim to identify opportunities to improve pain management in correctional facilities, which we will share with the Prison Health Community of Practice for advocacy purposes.

S101394 When Mom Goes to Prison: Prison health best practices for maternal and newborn care**10:15–10:45**

Lisa Graves, MD, CCFP, FCFP, Ancaster, ON; Ruth Martin, MD, CCFP, Vancouver, BC;
William Ehman, MD, CCFP, Nanaimo, BC; Katherine Rouleau, MD, CCFP, Toronto, ON;
Fiona Kouyoumdjian, MD, CCFP, Hamilton, ON; Janet Smylie, MD, CCFP, FCFP, Toronto, ON

715B MTCC— Small group interactive workshop – limited seating.

Learning Objectives:

1. review a prison clinical scenario based on real situation(s) that focus on maternity and newborn care and aboriginal health
2. identify evidence-based “best practice” responses, which are included in national guidelines for the implementation of mother-child units in Canadian correctional facilities
3. describe how Canadian health care providers can be health advocates for maternal and newborn care, both inside correctional facilities and in the outside community

Description:

Throughout the world, incarcerated women tend to be young and of childbearing age, often lacking financial resources and unable to access mainstream education systems. In 2003, an estimated 20,000 Canadian children were separated from their mothers because of incarceration. In 2013, a BC Court ruled that separating newborns from their incarcerated mothers violated the Canadian charter. This interactive workshop will review a prison health clinical scenario, based on real cases, to discuss evidence-based “best practices” in maternal and newborn care and aboriginal health. We will also explore ways that health care providers can engage in health advocacy for women and their children, both inside correctional centres and in the outside community. This workshop is designed for those with a special interest in prison health, but also for those who wish to understand better the impact of incarceration on women and their families.

S95441 Adolescent Sexual Health Update**09:45–10:45**

Aarti Kapoor, MD, CCFP, Toronto, ON

802AB MTCC

Learning Objectives:

1. use tips for speaking to youth, providing office environments that empower them with accurate knowledge to take control of their lives/bodies
2. recognize and employ knowledge of sex worker screening, sexual assault, post-abortion care, and intimate partner violence in discussions with youth presenting to the office
3. provide youth with knowledge on online dating/Internet safety, buying condoms online, anonymous/home HIV testing, and age of sexual consent

Description:

Recently, Canadian youth have been frequently featured in the news. Unfortunately, headlines vary from bullying-induced suicide, sexual assault, and intimate partner violence to a resurgence of syphilis, increased rates of new HIV cases, and antibiotic-resistant gonorrhea. It is becoming increasingly apparent that pre-teens, teenagers, and young adults experience many unique changes during the time of development known as “adolescence.” However, exposure to this population during medical training can be sparse. This lecture will aim to provide community practitioners with up-to-date information to meet the growing sexual health needs of youth in the community. Practitioners will leave feeling comfortable providing open office environments to empower youth with knowledge. They will learn to manage rarely taught sexual health topics relevant to youth in their communities such as LGBTQ/sex worker screening, sexual assault, post-abortion care, and an approach to intimate partner violence. Complementing Ontario’s proposed new sexual health school curriculum, practitioners will also be taught to provide youth with the most up-to-date knowledge on online dating/Internet safety, two-minute HIV testing, home oral HIV testing, and age of sexual consent. Session participants will leave having developed the ability to recognize and appropriately address sexual health issues specific to youth that present to their own practices, preventing the progression to chronic illness in the future.

S100005 Sex and Birth Control: Are they related?**09:45–10:45** Ellen Wiebe, MD, FCFP, Vancouver, BC**701A MTCC****Learning Objectives:**

1. name the possible sexual side effects of hormonal, intrauterine, and barrier contraception in order to help patients choose contraception that does not interfere with sexual pleasure
2. describe the different motivations to have sex and to have children in order to help patients avoid unintended pregnancies while enjoying sex
3. use good questions when asking about sexual side effects

Description:

This is an interactive session, using case histories with discussion as well as a presentation of evidence from the literature. Cases will involve sexual side effects of contraceptives, decreased motivation for sex being related to decreased motivation to contraception and unplanned pregnancy resulting from the conflict between the physiological drive to reproduce and logical life planning. The emphasis of this workshop will be practical aspects of family planning involving talking with our patients about sex and birth control. Although there is evidence that sexual side effects cause much of the discontinuation of hormonal contraception, this problem is infrequently discussed in family doctors' offices. In this session we will discuss problem solving these issues: finding contraception that does not interfere with sexual pleasure and helping our patients avoid unintended pregnancies while continuing to enjoy sex.

S101803 Mining for Data Gold: How to recycle imperfect EMR data into valuable and useful information**09:45–10:45** Michelle Greiver, MD, MSc, CCFP, FCFP, Toronto ON; Babak Aliarzadeh; Marjan Moeinedin**710 MTCC****Learning Objectives:**

1. learn to work with imperfect data: limitations and how to maximize the value of what is currently available
2. discover additional helpful tools and resources and how to access them
3. discuss what can be done today to improve the quality of their EMR data

Description:

EMR data are problematic. Quality can be poor and free text/unstandardized data are often difficult to query. However, many family physicians and primary care teams have already been able to derive significant value from currently existing data; these data can be used to measure, monitor, and improve care provided to patients. This can involve activities such as querying data in EMRs ("front end data"), supplementing EMR data with external information (e.g., Ontario's provincial Screening Activity Report, SAR), or participating in projects such as Canadian Primary Care Sentinel Surveillance Network (CPCSSN) where cleaned/standardized EMR data and reporting software are returned to groups of physicians. CPCSSN has now built a significant and growing library of algorithms to clean EMR data, tested across multiple EMRs in Canada. Our EMR data is full of golden nuggets that can be mined today. We will discuss several practical approaches to using what is currently available, and discuss requirements and activities that can improve and increase data usage in primary care.

S101873 "What Gets Measured Gets Treasured": Implementing clinical quality improvement initiatives that drive big results!**09:45–10:45**

Shauna Wilkinson, BMgt, Calgary, AB

714AB MTCC**Learning Objectives:**

1. discover how to establish a core team responsible for driving change and determine ongoing measurement, tools, and tactics for innovation
2. discover how to involve, motivate, and empower your people and to create excitement that will drive improved clinical outcomes and experiences for your patients
3. discover methods to sustain momentum and excitement and to continue to improve beyond your goals

Description:

Crowfoot Village Family Practice is a patient-centred medical home that has adopted a quality improvement method emphasizing empowerment, measurement, and supported change that drives clinical outcomes. This session will explore practical, recent examples of quality improvement initiatives that have resulted in achieving advanced access, reduced return visit rates, and reduced use of acute care services and which drive significant acute cost savings and enhanced patient and provider experiences. Our focus will be on the important components of change management and sustainability, no matter what the quality improvement initiative.

S102229 🎧 Emergency Medicine Top 10 Articles to Change Your Practice**09:45–10:45****Médecine d'urgence : Les 10 meilleurs articles qui changeront votre pratique**

Constance LeBlanc, MD, CCFP (EM), FCFP, MAEd, Halifax, NS;

Mark Mensour, MD, CCFP (EM), FCFP, Huntsville, ON; Janet MacIntyre, MD, FRCPC, Halifax, NS

HALL F MTCC**Learning Objectives:**

1. change practice in 10 areas based on the most up-to-date literature
2. translate the information into easy teaching bullets for teaching in the emergency department
3. effectively include cutting-edge literature, when applicable, to practice in the emergency setting

Description:

This session will include 10 six-minute reviews of recent, practice-changing articles from the emergency medicine literature. Five presenters will each present two articles. Implications, pitfalls, and legal issues, as well as the acceptability of not making these changes in emergency medicine practice, will be included for various clinical settings by each of the presenters. A template, developed by the primary presenter, will be used for all five presentations for that portion of this talk. This template provides structure for presenting articles from the literature efficiently and effectively. Presenters will also use the Katie Calculator Model from Dalhousie University CPD office (<http://katie.dal.ca>) in their presentations to provide both absolute and relative numbers in presenting the information to achieve balance. Discussion will include study bias, methods, results, NNT, NNH, and the application of this practice change in various settings. All speakers will remain available for informal discussion after the session.

Objectifs d'apprentissage :

1. changer la pratique dans 10 domaines, en fonction des publications les plus récentes
2. traduire l'information en points faciles à enseigner à l'urgence
3. inclure efficacement les publications d'avant-garde, le cas échéant, pour pratiquer dans un contexte d'urgence

Description :

Cette séance comprend 10 revues de six minutes d'articles récents tirés de publications sur la médecine d'urgence qui changeront votre pratique. Cinq conférenciers présenteront deux articles chacun adaptés à divers contextes cliniques. Chaque conférencier parlera des répercussions, des pièges et des enjeux juridiques, de même que de l'admissibilité de ne pas apporter ces changements dans la pratique de la médecine d'urgence. Un modèle créé par le conférencier principal sera appliqué aux cinq présentations de cette portion de la séance. Ce modèle permet de présenter de manière efficiente et efficace les articles des publications selon une même structure. Les conférenciers utiliseront aussi la calculatrice de signification clinique Katie (Katie Clinical Signification Calculator) mise au point par le bureau de DPC de l'Université Dalhousie (<http://katie.dal.ca>) pour présenter des chiffres absolus et relatifs afin d'équilibrer leur présentation. Les discussions traiteront de la partialité dans les études, des méthodologies, des résultats, du NPT, du NPN et de l'application de ces changements de la pratique dans divers contextes. Tous les conférenciers participeront à une discussion informelle après la séance.

S102520**Using EMR Tools to Improve the Primary Care of Adults With Developmental Disabilities****09:45–10:45**

Laurie Green, MD, CCFP (EM), Toronto, ON; Meg Gemmill, MD, CCFP, Kingston, ON;
Andrea Perry, OT, Toronto, ON; Abigail Scott, BA, CHIM, Kingston, ON

501 MTCC**Learning Objectives:**

1. create an electronic cohort of adult patients with developmental disabilities in a family medicine practice
2. use EMR tools to improve patient-centred delivery of health care to adults with developmental disabilities
3. use EMR tools in the delivery of guideline-recommended primary care to adults with developmental disabilities

Description:

Pilot projects in Ontario have implemented tools in EMRs to support clinicians, residents, and teachers and quality improvement researchers in assessing and improving care for adults with developmental disabilities. The Health Care Access and Research in Developmental Disabilities Research Program in Ontario has demonstrated positive attitudes among clinicians toward providing care for such patients but less confidence in knowledge or skills. EMR-based tools can provide both "just-in-time" support at clinical encounters and also measurable outcomes for quality improvement programs. Both goals are expected to make practices more efficient for family physicians and more effective for this group of patients known to experience barriers in access to health care. Family physicians and staff from two pilot projects will demonstrate the tools and encourage participants' questions. Participants will be provided with hard copies and links to resources as well as with approaches they can use to adapt their own EMRs and practices.

S102586 Innovations in Digital Health Technology: Can they change your practice?

09:45–10:45 Amanda Condon, MD, CCFP, Winnipeg, MB; Rashaad Bhyat, MD, CCFP, Toronto, ON

716B MTCC

Learning Objectives:

1. list new digital health technologies and how they are being used in family medicine offices
2. compare barriers and benefits to use of these solutions in your office
3. measure outcomes of using digital health technologies in the care of your patients

Description:

New digital health technologies are being developed every day; these innovations are marketed as tools that will change our practice or improve the health of our patients. Are they just gimmicks or do they actually work? This session will review new health technologies, profile actual users of these innovations, and describe their use in supporting the concept of the Patient's Medical Home and their impact on patients, office staff, and associated clinical outcomes. Some of the innovations include optimizing your EMR, implementing consumer health solutions (eg, electronic scheduling, e-visits), monitoring patients remotely, and using patient portals and integrated care plans.

S102751 Building Competencies in Care of the Elderly by Doing House Calls: How can we spread this?

09:45–10:45 Chase Everett McMurren, MD, CCFP, Toronto, ON; Sabrina Akhtar, MD, CCFP, Toronto, ON

703 MTCC

Learning Objectives:

1. identify three main competencies in care of the elderly with which family medicine learners struggle
2. outline resources available to family physicians for supporting the practice and teaching of home-based care
3. describe strategies for integrating home-based care into your family medicine teaching program

Description:

The need to develop innovative solutions to meet the growing demands of an aging population has been well established in the literature within both Canada and globally. Integrated home-based primary care (IHBPC) is a modern twist on the old-fashioned doctor's house call, and as a model of care is gaining attention of policy makers and providers as one way to meet increasingly complex health demands that are rendering a growing proportion of the population homebound. IHBPC is facilitated by interprofessional teams, which typically include family physicians alongside nursing, rehabilitation, pharmacy, and social work practitioners, who collaborate closely with community agencies. These home-based primary care programs have the following overall goals: to provide access to ongoing primary medical care; to maximize independence and function; to reduce emergency department and hospital admissions; to enhance patient safety and quality of life; and to link patients to supportive home-care services. IHBPC can improve patient and system outcomes, but the literature points to a lack of educational frameworks as one barrier to scaling up these programs across communities. Structured home-based primary care programs can increase family medicine trainees' exposure, skills, and positive attitudes towards doing house calls as future family physicians, and build competencies in care of the elderly. IHBPC for the frail elderly is a topic area rich with learning opportunities that stretch across family medicine educational competencies. Within several family medicine programs across the country, house calls are being integrated into family medicine teaching, and it would be beneficial for educators, teachers, and learners to share a consistent educational framework informed by evidence and best practices. In this workshop, we aim to review existent programs at work, and how skills in home-based primary care align with CanMEDs-FM objectives and competencies in care of the elderly, specifically the "harder to teach" competencies in health system navigation and advocacy.

S102855 Teaching Advocacy in Primary Care: Fostering social accountability in medical learners

09:45–12:15 Kathleen Doukas, MD, CCFP, Toronto, ON; Karen Weyman, MD, CCFP, Toronto, ON; Nasreen Ramji, MD, CCFP, Toronto, ON; James Owen, MD, CCFP, Toronto, ON

707 MTCC

Learning Objectives:

1. develop a framework for thinking about competency in advocacy and social responsibility
2. describe the impact of clinical experiences on advocacy
3. develop a practical curriculum design to teach advocacy to medical learners

Description:

Social accountability is an attribute we strive to foster in our medical trainees, and falls within the CanMEDS-Family Medicine (FM) Health Advocate Role. It can be difficult to teach and evaluate given its abstract nature and broad scope. The CanMEDS-FM Health Advocate must respond to individual and community needs, identify the specific social determinants of health of individuals and populations served, and promote health. Family medicine preceptors must foster an interest and participation in advocacy among trainees in order to achieve competency in the advocate role, while simultaneously recognizing that many values, attitudes, beliefs, and behaviour in medicine are learned via a "hidden curriculum," which must be explicitly addressed. Participants in this workshop will have an opportunity to discuss what it means to be an advocate and how this professional identity can be shaped by a variety of clinical experiences. Identifying marginalized populations within each participant's community of practice will be explored. A model of curriculum delivery exposing students to vulnerable patients and providing students with the opportunity to further develop their role as an advocate will be presented and discussed. The workshop will aim to develop a curriculum for advocacy within each participant's professional setting, using a case-based approach to identify specific opportunities to foster social advocacy within medical trainees. Family physicians should recognize the value of mentoring, role modeling, and reflection in teaching social accountability and advocacy. As family medicine provides care for a variety of individuals and groups throughout the life cycle, advocacy as a core competency can and should be embedded in teaching opportunities for our medical trainees.

S102882 Embodying Trust: Developing our senses for enhanced non-verbal communication in clinical practice
09:45–12:15 Martina Kelly, MBCh, MA, MICGP, FCRCP, CCFP, Calgary, AB; Lara Nixon, MD, CCFP, FCFP, Calgary, AB
711 MTCC

Learning Objectives:

1. discover a series of physical exercises to enhance awareness of visual interpretation, listening, movement, and touch
2. develop awareness of these dimensions of communication in clinical practice
3. relate these experiences to concepts of trust and relationship-building in family medical practice

Description:

Most human interaction is non-verbal. Non-verbal communication is complex, encompassing a range of interactions (eg, body language, touch, gaze, proximity, and use of the environment), which impact how we build trust and relate to one another in clinical practice. Traditionally the focus of communication skills training has been on verbal interaction. Less attention has been paid to our silent communication. This session aims to highlight the importance of non-verbal communication in day-to-day clinical practice by drawing on the concept of embodiment. Embodiment is the way individuals negotiate their everyday lives via their bodies and how they mediate, interpret, and interact with their physical and social environments, and will be demonstrated using theatre-based exercises to stimulate sensory awareness. This fun, interactive workshop begins with a brief overview of non-verbal modes of communication, stimulated by video clip analysis, followed by a series of theatre games and exercises designed to enhance listening skills, visual interpretation, and the use of touch to build trust in clinical interaction. After each exercise, participants will be asked to reflect on their learning from the activity and its relevance to clinical practice and medical education. We will consider how non-verbal messages can be encoded (generated) and decoded (interpreted). Throughout the workshop, collective themes will be charted and then summarized and fed back to the group for further discussion. We invite participants to attend ready for engagement (and recommend wearing comfortable clothing that allows movement), but participation in each exercise is optional.

S99546 Critical Drug Interactions That Family Doctors Should Know About
10:15–10:45 Suzanne Singh, BScPhm, PharmD, RPh, Toronto, ON
HALL G MTCC

Learning Objectives:

1. identify “high-alert” medications associated with clinically significant drug interactions in primary care
2. outline risk factors for the development of adverse effects from drug interactions
3. review strategies to avoid and manage common drug interactions in your practice

Description:

With so many medications available on the market, it is virtually impossible to remember every single drug interaction that may rear its ugly head. Help is on the way! This session will offer family doctors practical tips for how to identify, prevent, and manage drug interactions. Didactic presentation and interactive case discussion will be used to outline which drugs are on the “naughty list” (ie, medications that are the most notorious for clinically important drug interactions), and also illustrate which patients may be the most vulnerable for experiencing an adverse outcome from a drug interaction. Various strategies highlighting how to avert and handle common drug interactions encountered in primary care will be reviewed.

S101679 Therapeutic Applications of Botulinum Toxin Type A (Botox®): An introduction for the family physician
10:15–10:45 Samuel Hetz, MSc, MD, Ottawa, ON
713B MTCC

Learning Objectives:

1. screen for and diagnose chronic migraine and hyperhidrosis in your family medicine office
2. understand the evidence for onabotulinumtoxinA in chronic migraine and hyperhidrosis treatment, and discuss the potential benefits with patients
3. describe the safety profile of onabotulinumtoxinA for chronic migraine and hyperhidrosis, and discuss risks and side effects with patients

Description:

The therapeutic applications of botulinum toxin (onabotulinumtoxinA—Botox®) continue to grow. Chronic migraine (CM) prophylaxis and axillary hyperhidrosis (HH) are two common therapeutic applications pertinent to family physicians. These conditions have a profound impact on patients’ quality of life, productivity, and societal involvement. For example, studies have demonstrated that the disruptiveness of HH on daily activities is similar to that of rheumatoid arthritis and other chronic diseases. Managing CM and HH in the office setting can be challenging, yet treatment of these conditions using onabotulinumtoxinA is certainly within the scope of the family physician. Although not covered by provincial health plans, private health insurance usually funds onabotulinumtoxinA treatments if medically indicated. CM is defined by the International Classification of Headache Disorder (ICHD) criteria while a consensus panel defines HH. The specific diagnostic criteria for CM and HH, diagnostic tests, as well as diagnoses that must be excluded prior to making a diagnosis of CM and HH, will be discussed in detail. Indications for when treatment with onabotulinumtoxinA is indicated will be discussed in detail. Evidence for onabotulinumtoxinA for both of these conditions is quite robust. The PREEMPT study, published in *Headache* in 2010, demonstrated that onabotulinumtoxinA was safe and effective for treatment of CM. For axillary HH, sweat rate decreased by as much as 97.7 per cent following onabotulinumtoxinA injection. Although considered “off-label,” but widely accepted in medical practice, onabotulinumtoxinA is also used for both plantar and palmar hyperhidrosis. Detailed research will be presented during the session. Basic procedural technique for both CM and HH will be briefly discussed during the session. Potential risks and side effects of onabotulinumtoxinA treatment will be discussed

in detail. As well, common myths associated with onabotulinumtoxinA will be clarified. Participants will leave the session with a global understanding of onabotulinumtoxinA applications for CM and HH, which in turn will greatly benefit their patients.

S101360 Approach to Common Hand Injuries in the Family Practice and Emergency Room Setting

11:15–11:45 Sanjay Azad, MS, FRCSEd, FRCSEd (Plastic Surgery), Thunder Bay, ON

HALL G MTCC

Learning Objectives:

1. identify common hand injuries in the ER setting and family practice setting
2. evaluate and make appropriate and timely referrals of these common hand problems
3. effectively manage common hand injuries

Description:

Hand injuries are common in the family practice setting and in the emergency room environment. The injuries can range from simple to complex and timely management of these common problems is an issue. The presentation is aimed at primary physicians to facilitate better understanding of these problems including nail bed injuries, distal fractures, mallet fingers, common hand fractures such as boxer's fracture, and tendon injuries such as flexor and extensor tendons. Common operative approaches will be emphasized including use of Vicryl Rapide (dissolving sutures), long-lasting analgesia, and appropriate splintage with therapy. This would be extremely useful for remote rural settings and physicians working in ER.

S101948 Options, Options, Who Has the Options? Non-opioid treatments for chronic pain

11:15–11:45 Bruce Hollett, MD, CCFP, St. John's, NL

701B MTCC

Learning Objectives:

1. educate patients on evidence-based treatment modalities for chronic pain
2. prescribe non-pharmacological and non-opioid pharmacological therapies for chronic pain
3. tailor treatment for specific pain conditions such as myofascial, neuropathic, mixed, and widespread pain

Description:

This presentation will cover aspects of one patient's chronic pain management over time. We will review the case of a 37-year-old construction worker with chronic low back pain as he is managed by his primary care provider. The ideal treatment of chronic pain comprises non-pharmacological treatments (eg, physiotherapy, counseling, self-management, exercise, meditation) and pharmacological modalities. This talk will focus on non-opioid treatments for chronic pain, which should ideally be used before opioid prescribing is considered.

S102435 Chronic Pain: Optimizing opioids, reducing risks

11:45–12:15 Roman Jovey, MD, Mississauga, ON

701B MTCC

Learning Objectives:

1. assess and risk-stratify patients with chronic pain for opioid therapy
2. prescribe and monitor opioid therapy using universal precautions
3. document key outcome measures to demonstrate benefit

Description:

This presentation will cover aspects of one patient's chronic pain management over time. Various speakers will review the case of a 37-year-old construction worker with recurrent chronic low back pain as his primary care provider manages him. After a biopsychosocial assessment and an adequate trial of non-pharmacological and non-opioid medications, the primary care provider is considering a trial of long-term opioid therapy. This presentation will illustrate a practical, office-based process to optimize benefit and reduce risks, based on the Canadian Opioid Guidelines (2010). Topics will include how to assess and risk-stratify patients, starting and titrating opioids, managing common adverse effects, and structuring a follow-up strategy to document key outcomes of treatment.

S102792 Prison Health Best Practices: Palliative care and developmental disabilities

11:15–11:45 Ruth Martin, MD, MPH, CCFP, FCFP, Vancouver, BC; Paolo Mazzotta, MD, CCFP, Toronto, ON;

Liz Grier, MD, CCFP, Kingston, ON; Brian Hennen, MD, CCFP, FCFP, Dartmouth, NS;

Lori Kiefer, MD, CCFP, FRCPC, Toronto, ON

715B MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. discuss a prison clinical scenario focusing on palliative care and developmental disabilities, based on real situations that present in prison health
2. discuss evidence-based "best practice" responses recommended for health care providers in the community
3. explore ways to advocate for best-practice palliative care and developmental disability care for people during their incarceration and following their release

Description:

Incarcerated populations have a high prevalence of chronic conditions including developmental disabilities and cancer. In addition, incarcerated subgroups, such as the elderly, terminally ill, and those with developmental disabilities, have specific health concerns. Prison health practitioners often work in isolation without resources to guide their clinical decision making. This interactive workshop will review

a clinical scenario, based on real situations faced by prison health practitioners, such as intractable pain, terminal illness, and developmental disabilities, including fetal alcohol spectrum disorder. We will discuss community-based best practices for these conditions and the logistics of using equivalent best practices inside Canadian correctional facilities. This session will be certified for Mainpro CPD credits. Representatives from three Communities of Practice in Family Medicine (CPFM) will facilitate this workshop: Palliative Care, Developmental Disabilities, and Prison Health.

S100010 **Helping Your Patient Cope With an Unplanned Pregnancy**

11:15–12:15 Ellen Wiebe, MD, CCFP, FCFP, Vancouver, BC

716B MTCC

Learning Objectives:

1. help patients explore their options when faced with an unplanned pregnancy
2. give specific resources to patients dealing with the religious or relationship issues related to unplanned pregnancies
3. give accurate information about the risks of abortion compared to birth

Description:

We will share information about abortion in Canada so you can give the best information to your patients. We will then go through some typical cases of unplanned pregnancy in family practice. Doctors have professional and personal obligations as well as beliefs and facts. Patients arrive with personal and external issues. We will talk about good questions to ask women and their partners to help them clarify their issues and make the best decisions. We will share the best ways to address particular concerns such as risk of infertility and depression and the effect of an abortion or unplanned child on the relationship.

S101006 **A Clinical Algorithm for the Detection, Monitoring, and Management of Chronic Kidney Disease (CKD) in Primary Care**

11:15–12:15 Allan Grill, MD, CCFP, FCFP, Toronto, ON; Scott Brimble, MD, MSc, FRCP(C), Hamilton, ON

401 MTCC

Learning Objectives:

1. identify which patients in a typical family practice are at higher risk for chronic kidney disease (CKD)
2. clarify which investigations to order for patients at high risk for CKD and how to interpret the results
3. review and receive a practical clinical algorithm that outlines the role of the primary care practitioner in managing patients with CKD and the criteria for appropriate referral to nephrology

Description:

Chronic kidney disease (CKD) affects approximately two million Canadians and is a recognized risk factor for all-cause mortality. Patients that progress to end-stage renal disease experience significant morbidity and a reduced quality of life. Primary care providers (PCPs) can play an important role in the early detection and prevention of progression of CKD. The 2013 Kidney Disease Informing Global Outcomes (KDIGO), Canadian Hypertension Education Program (CHEP), and the Canadian Diabetes Association CKD guidelines were reviewed for relevant content to produce, through an iterative process, a clinical algorithm. The Ontario Renal Network (ORN) provides leadership and strategic direction to effectively deliver renal services in a coordinated manner. One of its key strategies is to improve early detection of CKD at the primary care level. It is anticipated that this algorithm will empower PCPs with confidence to become more aware of CKD management issues in a consistent evidence-informed manner. By the end of this talk, participants will be able to (1) identify which patients are at higher risk for CKD; (2) understand which investigations to order and how to interpret the results; (3) manage CKD and its associated cardiovascular comorbidities; and (4) appropriately select which patients need to be referred for nephrology consultation.

S101286 **Managing Attention Deficit Disorder in Adults in Your Office**

11:15–12:15 Nick Kates, MBBS, FRCPC, MCFP (Hon), Dundas, ON


713B MTCC

Learning Objectives:

1. recognize the presence of symptoms of ADHD during an office visit
2. understand the diagnostic criteria for ADHD in adults and its differential diagnosis
3. use the commonly prescribed medications for treating ADHD, and know their indications

Description:

Up to 5 per cent of all adults may have symptoms of attention deficit disorder but the majority of these problems remain undetected and untreated. Primary care remains the ideal and in many instances the only place for recognizing these problems and initiating treatment as most adults with ADHD will be seen in primary care, although rarely with attention or hyperactivity as the identified reason for a visit. This workshop reviews the prevalence of ADHD in primary care and the many different ways it can present including with other mental health or addiction problems. It outlines the diagnostic criteria for ADHD in adults and how to assess for its presence during an office visit, including the use of screening instruments. It then describes an integrated approach to management that includes education, support, providing structure, involving other family members, and medication. It summarizes the different kinds of short- and long-acting medications, their indications, side effects, and similarities and differences, and how to initiate treatment.

S101665  **Simplified Lipid Management: A truly primary care guideline**
11:15–12:15 **Gestion simplifiée des lipides : Une directive de soins vraiment primaire**
 Michael Allan, MD, CCFP, FCFP, Edmonton, AB
HALL F MTCC

Learning Objectives:

1. understand why to screen patients for cardiovascular risk rather than simple lipid levels
2. learn how to target therapy (lifestyle, statins, and others interventions) based on risk level and gain skills in how to discuss risks and benefits with patients
3. apply simple modifications to practice, like non-fasting lipids and reduced monitoring, to enhance compliance and ease for patients and care-providers

Description:

Family physician representation on clinical practice guidelines is sorely lacking and, in many cases, recommendations are not based on evidence or real application to primary care. The recently completed “Simplified Lipid Pathway for Primary Care” included a full evidence review, involved mostly family physicians, and had no industry, and the majority of participants had no conflict of interests. In this unique guideline, the focus has moved from lipid testing to risk assessment. We will review how we can reduce the frequency of lipid testing to every five years and, once a statin is started, perhaps never test again. Interventions like lifestyle and statins should be targeted at risk instead of surrogate markers. Simplified elements include using non-fasting lipids, reduced monitoring of lipids, removing lipid targets, removal of interventions with weak evidence, and little to no laboratory monitoring for CK/LFTs. Useful tools for discussion with patients will be presented and learners will be able to describe risk to patients as well as outline the benefits of treatment. These will include pamphlets from the guideline as well as risk estimation tools and examples of discussions with patients. In all cases, we will present the evidence to support these recommendations and outline the specific approach to certain subgroups like diabetics, the elderly, and those with renal impairment. We hope we can show how a family physician-run clinical practice guideline can both improve and simplify care while actively involving patients in true shared and informed decision-making.

Objectifs d'apprentissage :

1. comprendre comment dépister le risque cardiovasculaire plutôt que le simple taux de lipides chez les patients
2. apprendre comment cibler le traitement (mode de vie, statines et autres interventions) en fonction du niveau de risque et acquérir les compétences sur la façon de discuter des risques et bienfaits avec ses patients
3. appliquer des modifications simples de la pratique, telles que le taux de lipides non à jeun et la réduction de la surveillance afin d'améliorer l'observance du traitement et de faciliter la vie des patients et des fournisseurs de soins

Description :

L'absence de représentation des médecins de famille dans les comités de lignes directrices de pratique clinique est criante et dans certains cas, les recommandations ne sont pas fondées sur des données probantes ni sur l'application réelle en soins primaires. Le projet récemment terminé « Simplified Lipid Pathway for Primary Care » inclut une revue complète des données probantes, a fait participer surtout des médecins de famille, n'est pas commanditée par l'industrie et la majorité des participants étaient libres de tout conflit d'intérêts. Dans ces lignes directrices uniques, on passe des tests lipidiques à l'évaluation du risque. Nous examinons la façon dont on peut réduire la fréquence des tests lipidiques tous les 5 ans, et une fois qu'une statine est instaurée, peut-être ne jamais refaire le test. Les interventions telles que le mode de vie et les statines doivent cibler le risque plutôt que les marqueurs de substitution. Les éléments simplifiés sont : faire des tests lipidiques non à jeun, réduire la surveillance des lipides, éliminer les cibles lipidiques et les interventions fondées sur des données de faible qualité et peu, voire pas de surveillance en laboratoire de la créatinine kinase/tests de la fonction hépatique. Des outils utiles de discussion avec les patients sont présentés et les délégués pourront décrire le risque présenté par un patient de même que les bienfaits du traitement. Ils incluent des dépliants tirés des lignes directrices de même que des outils d'estimation du risque et des exemples de discussion avec les patients. Dans tous les cas, les données probantes étayent les recommandations et décrivent l'approche spécifique pour certains sous-groupes, comme les patients diabétiques, les personnes âgées et les patients atteints d'insuffisance rénale. Nous espérons pouvoir montrer comment des lignes directrices de pratique clinique formulées par des médecins de famille peuvent améliorer et simplifier les soins tout en faisant activement participer les patients dans la prise de décision vraiment partagée et éclairée.

S102019 **Approach to Anxiety Disorders in Primary Care**
11:15–12:15 Jon Davine, MD, CCFP, FRCPC, Hamilton, ON
801AB MTCC

Learning Objectives:

1. use screening questions to make rapid diagnoses of specific anxiety disorders
2. apply psychotherapeutic techniques to deal with anxiety disorders
3. describe psychopharmacologic treatments for the different anxiety disorders

Description:

In this workshop, we will present an overview of some of the DSM-V diagnoses for anxiety disorders, including panic disorder, agoraphobia, obsessive-compulsive disorder and related disorders, generalized anxiety disorder, and social phobia. We will discuss how to use specific screening questions to make the diagnosis. We will also discuss pharmacologic and psychotherapeutic strategies for each of these disorders. The pharmacologic data for this session will be based on the most recent 2014 guidelines for anxiety disorders.

S102129 Film in Medical Teaching: Refugee health care as a case study**11:15–12:15** Russell Dawe, MD, CCFP, St. John's, NL**709 MTCC****Learning Objectives:**

1. identify a concrete step-by-step process to create an original documentary film
2. recognize the strengths and weaknesses of film in medical teaching
3. recognize the application of these principles at an intellectual and emotional level, as experienced in the context of the film shown

Description:

This session will explore the role of film in medical teaching. *"Refugee Health Care In Newfoundland"*, the author's 16-minute film, will be presented and will serve as a basis for discussion to equip physicians, residents, and students to make appropriate use of film in their own settings and teaching programs. Narrative conveys not only one's conclusions on a topic, but also the process by which they are reached. Film as a medium lends itself naturally to teaching medical-social themes in a patient-centred manner. Physicians and residents involved in teaching, and those with an interest in qualitative research, will particularly benefit from this session. Physicians with an interest in refugee health care would also benefit from this session, though such interest is not necessary.

S102862 Using Data to Improve Care and Outcomes in Primary Health Care**11:15–12:15** Andrew Pinto, MD, CCFP, MSc, FRCPC, Toronto, ON**710 MTCC****Learning Objectives:**

1. identify common sources of data about a family medicine practice that can be accessed to characterize individuals and the patient population
2. discuss the concept of "shifting the curve" to reduce disease and of targeting interventions to reduce health inequities
3. understand basic ways of manipulating data in Excel to describe the distribution of disease in a family medicine practice

Description:

Family physicians have long cherished the principle that they are a resource to a defined practice population. The increased use of electronic medical records now provides rich data over many years on practice populations. However, many physicians find analyzing such data challenging. This workshop will begin with identifying common sources of data that are available to understand the health and determinants of health of individuals and a practice population. We will use such data to develop a practice health report, applying a population health approach to this assessment. We will then discuss the complementary concepts of "shifting the curve" and "hot spotting," and examine how they apply to primary care settings. We will work through a number of examples from the St Michael's Hospital Academic Family Health Team, using data to understand the health of diabetics, patients with HIV infection, and patients with multimorbidity. The workshop participants will then work through an exercise in small groups using data on cancer screening. We will conclude by examining data manipulation in Microsoft Excel, a widely available and familiar piece of software. It is important that all family physicians have some familiarity with conducting an assessment of the health of their practice population; this workshop aims to support such efforts.

S102865 The Modern Canadian House Call: Understanding the evolving role of house calls, from policy to practice**11:15–12:15** Samir Sinha, MD, DPhil, FRCPC, Toronto, ON; Mark Nowaczynski, MD, CCFP, Toronto, ON**716A MTCC****Learning Objectives:**

1. recognize the changing policy landscape that is encouraging a resurgence of house calls across Canada
2. discover the growing array of home-based primary and specialty care delivery models across Canada and the role technologies can play as an enabler
3. discover practical approaches to making both solo and collaborative house calls

Description:

Across Canada, primary care providers and geriatricians have long appreciated the inherent value of house calls in the provision of care for homebound patients. The way our modern health care system has been structured and financed has only led to an overall decline in the number of Canadian physicians providing house calls. The last few years have seen a growing number of jurisdictions recognizing the value of house calls and thus adapting health system policies and physician reimbursement models to encourage more house calls. Although provinces such as Ontario are now seeing a major resurgence in house calls, despite certain policy and funding barriers, another significant barrier remains: too few physicians have training or comfort in delivering house calls. This session brings together a primary care physician, who exclusively does home visits with the frail elderly, and a geriatrician, who works collaboratively with his team to deliver specialist consults. Together they will give an overview of the evolution of home care medicine in Canada, as well as provide participants with a practical approach to doing a variety of house calls on their own and with other health and social care providers/specialists. The first part of the session will present the underlying reasons why various jurisdictions are making house calls a priority and the variety of policy and funding mechanisms being employed to encourage their growth. This part of the session aims to help participants appreciate the specific considerations required to enable the advancement of house calls medicine, as well as the policy pitfalls that should be avoided whenever possible. A description of a variety of home-

based primary care models that are evolving across the country will be introduced. The second part of the session will give all participants the practicalities of what a house call should involve, from the perspective of experienced providers. Concepts such as what to take with you, and what exactly one can do in the home setting, including the intricacies of the "fridge biopsy," will be explored. Finally, tips on how to do collaborative home visits with a variety of professionals will be provided.

S102907 **SIM Start-up: Perspectives on creating a high-fidelity simulation curriculum at a community family medicine site**

11:15–12:15

Kim Cai, MD, CCFP, Toronto, ON; Harinee Surendra, MD, Markham, ON;
Jean Mok, MD, CCFP, Markham, ON; Seyon Sathiaseelan, BSc, MD, CCFP (EM), Markham, ON

703 MTCC

Learning Objectives:

1. discover how to solicit faculty buy-in, identify resources necessary for curriculum development, and avoid common pitfalls associated with simulation development and implementation
2. use evaluation tools to improve the quality of simulations and to evaluate knowledge acquisition in learners
3. discover and practise effective debriefing techniques learned as "evaluator" and "learner" in a hands-on simulated emergency scenario

Description:

This session will be of interest to family community doctors interested in developing simulations for continuing medical education or as teaching tools for learners. Perspectives from both evaluators and learners will be explored through a panel discussion. In addition, a hands-on simulation scenario will allow participants to practise evaluation and debriefing skills. The goal of the session is to empower community family doctors to create their own simulation curriculum within their distributed education sites.

S101391 **A Road Map for Family Physicians Treating Adolescent Depression**

11:15–12:15

Sanjeev Bhatla, MDCM, CCFP, FCFP, Calgary, AB

501 MTCC

Learning Objectives:

1. diagnose depression in adolescence
2. use systematic approach to counsel adolescents with depression
3. recognize when and how to initiate antidepressant medication

Description:

The greatest predictor of effective counseling lies in the quality of trust and respect between patient and therapist. This places family physicians in an ideal position for counseling and treating adolescents with mental health conditions. This presentation provides a road-mapped approach to counseling adolescents in the primary care setting. The goals of this presentation are for participants to develop the confidence to diagnose depression in adolescence, to engage in therapy, and to know when and how to initiate antidepressant medication.

S115049 **Making a Smooth Transition Into Practice**

11:15–12:15

Jaspreet Manganat, MD, Mississauga, ON; Emy Martineau, MD

705 MTCC

Learning Objectives:

1. discuss key issues involving transitioning from residency into practice, including licensing, financial concerns, location and relocation, and contracts

Description:

The path from residency to practice can take many directions, be direct or winding, and involve different practice settings and communities. A panel of family medicine graduates will individually relate their varied experiences, sharing pearls they acquired along the way, and invite participants' questions. Residents will come away with resources and tips to use in their own transitions.

S102868 **Frequent Emergency Department Patients: Improving care coordination in the ED**
Patients souvent vus à l'urgence : Amélioration de la coordination des soins à l'urgence

11:45–12:15

Jocelyn Charles, MD, CCFP, MScCH, Toronto, ON; Gayle Seddon, BScN, Toronto, ON;
Anne Moorhouse, RN, PhD, Toronto, ON

718AB MTCC

Learning Objectives:

1. recognize patients with complex care needs at higher risk of adverse events during transitions in care
2. define the role of the family physician in care transitions for complex patients
3. integrate the family physician's accumulated knowledge of the patient into collaborative care planning with other providers in the circle of care

Description:

Currently the top 5 per cent of complex patients consume 84 per cent of Ontario's hospital and home care costs. There is a critical need for a dynamic, person-centred care planning process for medically complex patients with real-time dialogue between primary care, emergency department (ED)/acute care, and community care providers at care transitions. A care pathway was developed in the emergency department using quality improvement methodology and care team collaboration. Medically complex patients with frequent ED use are now automatically flagged upon registration in the ED and an ED Care Coordination team is notified by secure email: geriatric emergency

management (GEM) nurse, ED Community Care Access Centre (CCAC) care coordinator, social worker, occupational therapist/physical therapist. The GEM nurse initiates a comprehensive patient assessment in the ED right after triage and the ED CCAC Care Coordinator initiates a teleconference with the patient's family physician and the community care coordinator, with the patient's consent. Usual physician assessment is preceded and followed by an interprofessional huddle (including the GEM nurse, ED CCAC care coordinator, and social worker, occupational therapist, physical therapist) to ensure the patient's needs, goals, and team recommendations are clear. These patients then have the opportunity to initiate a coordinated care plan and follow up with their family physician and community CCAC care coordinator to complete their care plan. Strategies to engage family physicians in coordinating care for complex patients will be described. Safety is enhanced through better communication between patients, their family physicians, ED providers and community care providers; a clearer understanding of the patient's priorities, goals, barriers, and social determinants of health; and proactive and anticipatory care planning to optimize self-management in the community. Outcome measures to be presented include initiation and completion of a coordinated care plan, patient satisfaction survey, provider satisfaction survey, completion of medication reconciliation, identification of reasons and avoidable factors for ED visit, follow-up with family physician, subsequent ED visits, readmissions, and length of stay.

Objectifs d'apprentissage :

1. reconnaître les patients qui requièrent des soins complexes et qui présentent un risque élevé d'événements indésirables durant la transition des soins
2. définir le rôle du médecin de famille durant les soins de transition pour les cas complexes
3. intégrer l'accumulation du savoir des médecins de famille à l'égard des patients dans la planification des soins coopératifs avec d'autres fournisseurs du cercle des soins

Description :

À l'heure actuelle, 84 % des coûts des soins hospitaliers et des soins à domicile en Ontario sont attribuables à la tranche supérieure de 5 % des cas complexes. Le besoin d'un processus dynamique de planification axé sur la personne pour les cas médicaux complexes est criant, de même qu'un dialogue en temps réel entre les fournisseurs de soins primaires, de soins d'urgence/soins aigus et de soins communautaires durant les soins de transition. Un cheminement des soins a été mis au point à l'urgence à l'aide d'une méthode d'amélioration de la qualité et de collaboration entre les membres de l'équipe de soins.

Les cas médicaux complexes qui reviennent souvent à l'urgence sont maintenant automatiquement signalés dès l'inscription à l'urgence et l'équipe de coordination des soins d'urgence est avisée par courriel sécurisé : infirmière en gestion des urgences gériatriques (GUG), coordonnateur des soins d'urgence du Centre d'accès aux soins communautaires (CASC), travailleur social, ergothérapeute/physiothérapeute. Avec l'accord du patient, l'infirmière en GUG amorce immédiatement après le triage une évaluation complète du patient se trouvant à l'urgence et le coordonnateur des soins du CASC communique avec le médecin de famille du patient par téléconférence avec le coordonnateur des soins communautaires. L'évaluation du médecin habituel est précédée et suivie d'un regroupement interprofessionnel (composé de l'infirmière en GUG, du coordonnateur des soins du CASC et du travailleur social, de l'ergothérapeute et du physiothérapeute) pour veiller à ce que les besoins du patient et les recommandations de l'équipe soient clairs. Ces patients ont alors la chance de mettre de l'avant un plan de soins coordonnés et de faire un suivi auprès de leur médecin de famille et du coordonnateur des soins du CASC pour compléter leur plan de soins. Les stratégies visant à mobiliser les médecins de famille à coordonner les soins pour les patients complexes seront décrites.

La sécurité est améliorée par l'intermédiaire d'une meilleure communication entre les patients, leur médecin de famille, les fournisseurs de soins d'urgence et les fournisseurs de soins communautaires; une meilleure compréhension des priorités, des objectifs, des obstacles et des déterminants sociaux de santé du patient, de même que la planification des soins anticipés vise à optimiser l'auto-prise en charge dans la communauté. Les paramètres d'évaluation qui seront présentés sont l'initiation et l'achèvement d'un plan de soins coordonnés, un sondage de satisfaction du patient, un sondage de satisfaction du fournisseur, un bilan comparatif de la prise de tous les médicaments, la détermination des motifs et des facteurs évitables de la visite à l'urgence, le suivi avec le médecin de famille, les visites subséquentes à l'urgence, les réadmissions et la durée du séjour.

S100482 What's New in Dermatology Therapy?

13:45–14:15 Hanna Nicolas, MD, CCFP, DipPDerm, Laval, QC

HALL G MTCC

Learning Objectives:

1. identify new treatment options for a variety of dermatologic conditions
2. evaluate the efficacy of these new treatments based on the available evidence
3. incorporate some of these new treatments into daily practice or be able to advise patients about their use by dermatologists

Description:

There are a number of new topical and systemic medications in the field of dermatology that have come to market in the past few years. With this changing landscape of treatment options it is difficult to know how these new treatments compare to current therapies and what the potential is to integrate these into our practices. This session will look at some new treatments for onychomycosis, genital warts, rosacea, dermatitis, and psoriasis. These conditions are commonly seen in the office. Evaluating the potential benefits and drawbacks of new therapies for our patients will be discussed.

S102854 CFPC Health Advocacy Regarding Segregation and Mental Health Inside Canadian Prisons

13:45–14:45 Nader Sharifi, BSc, MD, CCFP, ABAM, CCHP, Coquitlam, BC;
Ruth Elwood Martin, MD, MPH, CCFP, FCFP, Vancouver, BC; Marie Hayes, MD, CCFP, Sherbrooke, QC;
Josiane Cyr, MD, CCFP, Montreal, QC; Susan Crouse, MD, CCFP, St. Phillippe, NB
715B MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. summarize established international evidence regarding health impacts of segregation inside prisons
2. review current segregation practices within Canadian correctional facilities
3. discuss ways that CFPC health care providers might advocate for restricting segregation practices within Canadian correctional facilities

Description:

Thousands of incarcerated people worldwide are housed in segregation or solitary confinement. In addition, persons are sometimes punished with solitary confinement for behaviour resulting from their mental illness. Solitary confinement with isolation and sensory deprivation causes harm. Long-term segregation can cause mental health symptoms. In people with mental illness, solitary confinement will exacerbate the symptoms. Participants will review the policy statement regarding segregation and mental health, which is being written by the CFPC Prison Health and Mental Health Program Committees, and will discuss ways to advocate for restricting or abolishing solitary confinement practices within Canadian correctional facilities.

S101934 Cannabinoids and Chronic Pain

13:45–14:15 Mark Ware, MBBS, MRCP(UK), MSc, Montreal, QC
701B MTCC

Learning Objectives:

1. communicate in a patient-centred way with patients who are requesting a prescription for medical cannabis
2. recognize both cannabis use disorder and when medical cannabis might be a reasonable option for someone
3. use existing tools that assist with medical cannabis decision making (eg, the CFPC preliminary guidance document, and a checklist developed by the presenter)

Description:

Family physicians are increasingly being asked about medical cannabis by patients, for reasons ranging from curiosity to abject desperation. Many have already tried cannabis, and many physicians do not feel equipped to have a meaningful discussion with their patients on this topic. This session will touch on the language needed to communicate with patients regarding cannabis use, the framework needed to separate medical from problematic recreational use, and the tools available to make an informed shared decision.

S100480 Addiction in Chronic Pain: Part of CPM chronic pain group

14:15–14:45 Joel Bordman, MD, Toronto, ON
701B MTCC

Learning Objectives:

1. formulate the differential diagnosis of aberrant opioid behaviours in patients with chronic pain
2. communicate effectively with patients when a diagnosis of addiction is being considered
3. provide ongoing support to patients who require a referral for addiction treatment

Description:

Dr Bordman will review the differential diagnosis of addictive behaviour in a chronic pain patient. He will explore treatment options for the patient with addictive behaviour and chronic pain. It is hoped that at the end of the session, the audience will have an increased comfort in dealing with possible addiction in the chronic pain patient.

S103000 A Matter of Mind: Approach to delirium in the home setting

13:45–14:15 Andrea Moser, MD, MSc, CCFP, FCFP, CMD, Toronto, ON
715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. describe several ways to mitigate the risk of delirium and be able to educate seniors and caregivers
2. apply knowledge of common etiologies, non-pharmacological management strategies, and pharmacological strategies in a case study

Description:

A straightforward delirium is rarely the case in seniors where there are multifactorial etiologies. In the home setting, assessment is complex. In this session, we will review the CMAJ Choosing Wisely Canada's "Five Things to Know About ... Delirium" summary and discuss what investigations are available and how management can be accomplished at home. This short workshop will offer a review of ways to prevent delirium, examine key elements of the diagnosis of delirium, and focus on the unique challenge of an approach that is grounded in a patient's goals of care and current context. Using a case study, participants will apply the best practice that is unique to each individual patient (and family) within the local context and the resources available.

S95089 Managing Insomnia in Primary Care Office

13:45–14:45 Purti Papneja, MD, CCFP, Toronto, ON
803A MTCC

Learning Objectives:

1. develop an approach to insomnia
2. discuss diagnosis and management tips for initial insomnia, maintenance insomnia, and parasomnias
3. review strategies on weaning off sleeping aids

Description:

It's estimated that approximately 30–40% of adults suffer from occasional insomnia and 15–20% of adults have chronic insomnia. Poor sleep can cause significant behavioural and physiological changes in an individual. It also contributes to workplace errors and motor vehicle accidents. In this interactive workshop, participants will work through chief cases of sleep-related complaints that are commonly encountered in family practice/walk-in clinics. By the end of the session, participants will have a clear approach to insomnia and understand the role of sleep studies—when to order and how to interpret the results. We will review the advances in treatment of obstructive sleep apnea, including CPAP, dental devices, and Provent, and how to improve patients' adherence to these modalities. Participants will also learn how to help patients get off their benzodiazepines or other sleep aids safely.

S95449  **Commonly Missed Orthopedic X-rays in the ED**
13:45–14:45 **Radiographies orthopédiques souvent omises à l'urgence**

Vu Kiet Tran, MD, MHSc, MBA, CEUS, Richmond Hill, ON

718AB MTCC**Learning Objectives:**

1. enumerate which are the most commonly missed orthopedic X-rays
2. enumerate the specific radiographic signs of these commonly missed orthopedic injuries
3. elaborate tricks to mitigate these caveats

Description:

Missing an orthopedic injury or x-ray in the ED can bring significant morbidity and disability for the patient. Numerous factors in the emergency department can lead providers to be more at risk of missing these radiographic findings. One of them is the knowledge of these radiographic signs. Another is the constant distraction ER providers face on a minute-to-minute basis. What other factors come into play? Learn how you can mitigate against these risk factors and minimize the chances you will miss these injuries. Come and test your knowledge and find out what mistakes others have made so you don't make them!

Objectifs d'apprentissage :

1. nommer les radiographies orthopédiques les plus souvent omises
2. nommer les signes radiographiques spécifiques de ces blessures orthopédiques souvent omises
3. concevoir des astuces pour régler ce problème

Description :

L'omission d'une blessure orthopédique sur une radiographie à l'urgence peut entraîner morbidité et incapacité significatives pour le patient. À l'urgence, de nombreux facteurs peuvent accroître le risque que les urgentologues omettent ces constatations radiographiques. Un de ces facteurs est la connaissance des signes radiographiques. Un autre est les distractions constantes auxquelles les urgentologues doivent faire face à l'urgence d'une minute à l'autre. Quels sont les autres facteurs en jeu? Apprenez comment éliminer ces facteurs de risque et réduire au minimum les chances d'omettre ces blessures. Venez tester vos connaissances et découvrez quelles erreurs ont déjà été commises afin de les éviter!

S96045 **Smoking Cessation: Tools to make a difference in your practice****13:45–14:45** Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON; Elaheh Mousa Ahmadi, MD, Edmonton, AB**714AB MTCC****Learning Objectives:**

1. review the epidemiology of smoking in your practice
2. classify patients' readiness to make changes in their smoking
3. prescribe effective therapies and support to help promote this change using existing tools

Description:

Smoking is the leading cause of death in our patients, a scary thought. Patients know they should quit, but this is an addiction. We will review how to approach this common and frustrating condition in the office, and learn tools to allow real health change in your smokers, without getting you frustrated. Tools in your community will be reviewed.

S100268 **Approach to Depression in Primary Care****13:45–14:45** Jon Davine, MD, CCFP, FRCP(C), Hamilton, ON**801AB MTCC****Learning Objectives:**

1. describe the psychiatric differential of the "sad state"
2. describe the current treatment approaches to depression, both psychopharmacologic and psychotherapeutic
3. rule out organic factors in the assessment of the depressed patient

Description:

In this workshop, we present the psychiatric differential of the "sad state," and will comment on different treatments for the different diagnoses. We will then focus on the diagnosis and treatment of a major depressive episode. The use of psychotherapy will be

commented on. We will focus on the current literature of the psychopharmacologic treatment of depression. This will include optimal choices of antidepressants, based on the literature. We will then go on to discuss how to optimize the antidepressant dosing, commenting on starting dosages, and methods of increasing dosages. We then go on to discuss the use of augmenting techniques, as well as switching from an antidepressant to another. Dealing with the side effects of antidepressants will be addressed. Other issues such as the use of antidepressants in the pediatric population, the use of electroconvulsive therapy (ECT), and the use of transcranial magnetic stimulation (TMS) will be discussed. This will be an interactive seminar encouraging audience participation.

S101262 Buprenorphine/Naloxone: Office-based management of opioid dependence
13:45–14:45 Curtis Handford, MD, CCFP, MHSc, Toronto, ON; Dale Wiebe, MD, CCFP, Toronto, ON
717B MTCC

Learning Objectives:

1. elicit the clinical clues that suggest a diagnosis of opioid dependence that may be amenable to opioid maintenance treatment
2. describe the pharmaco-dynamics and kinetics of buprenorphine/naloxone and the resulting implications in terms of dosing, monitoring, and side effects.
3. outline the steps involved in achieving a safe and effective patient induction onto buprenorphine/naloxone in an office-based setting.

Description:

This workshop focuses on developing the skills of family physicians in diagnosing opioid dependence in their practices, identifying when it is appropriate to offer and initiate buprenorphine/naloxone treatment in their offices, and understanding basic principles of initiating and monitoring buprenorphine/naloxone treatment in the office. The workshop will be case based and interactive. Both the 2010 Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain and CAMH's 2011 Buprenorphine/Naloxone Clinical Practice Guidelines will be heavily utilized and referenced. Part of the workshop will be devoted to assisting providers in recognizing which patients receiving prescriptions for chronic opioid therapy have likely become addicted to opioids and would most likely benefit from opioid maintenance therapy, such as with buprenorphine/naloxone. The ultimate goal is for family physicians to leave the workshop with a foundational understanding of the core concepts of safe and effective use of buprenorphine/naloxone in their practices.

S101401 Intrapartum Skills: A refresher of specific skills
13:45–14:45 Lisa Graves, MD, CCFP, FCFP, Ancaster, ON; Anne Biringier, MD, CCFP, Toronto, ON;
 Shanna Fenton, MD, CCFP, FCFP, Saskatoon, SK; Kate Miller, MD, CCFP;
 Balbina Russillo, MD, CCFP, Mont-Royal, QC; Sudha Koppula, MD, CCFP, Edmonton, AB
717A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. perform hands-on intrapartum skills such as vacuum-assisted birth, release of shoulder dystocia, somersault maneuver for tight cords, and Foley catheter insertion for induction
2. manage postpartum hemorrhage

Description:

This interactive session will provide participants with an opportunity to develop further skills in intrapartum care. In small groups, participants will have the opportunity to review and practise crucial intrapartum skills such as vacuum-assisted birth, release of shoulder dystocia, pudendal block, and somersault maneuver for tight cords. Additional skills of placement of Foley catheter for induction and management of postpartum hemorrhage will be offered as part of this session.

S101660 What's New, True, and False, in 2015: Brief evidence updates for clinically relevant primary care topics
13:45–14:45 Michael Kolber, BSc, MD, CCFP, MSc, FCFP, Edmonton, AB; G.M. Allan, MD, CCFP, FCFP, Edmonton, AB
716A MTCC

Learning Objectives:

1. review numerous evidence updates relevant to primary care from the last year
2. recognize that clinical knowledge and practice continue to be challenged and updated to the benefit of patients

Description:

In clinical update for 2015: brief reviews of clinically relevant topics in primary care will be presented. Typically each topic / knowledge piece will be reviewed in two minutes, which allows for a breadth of clinical topics / knowledge pieces to be presented and discussed. These reviews, based on relevant evidence from the last year, include: new knowledge, eg. new therapy, diagnostic test, or use for existing medication—"new"; confirmation of current practice—"true"; refuting current practice / understanding—"poo". Examples of potential topics for 2015 include anti-viral therapy for influenza, fecal transplant for clostridium difficile, and electronic nicotine replacement systems.

S101771 **Reducing the Hidden Cost of Immunization: Management of immunization pain and fear across the lifespan**
13:45–14:45

C. Meghan McMurtry, PhD, C Psych, Guelph, ON; Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON; Anna Taddio, BScPhm, MSc, PhD, Toronto, ON

701A MTCC

Learning Objectives:

1. describe the importance of managing immunization-related pain and fear
2. identify the "Four Ps" (procedural, physical, pharmacological, psychological) of immunization-related pain and fear management
3. implement evidence-based pain and fear management strategies into clinical practice

Description:

Vaccines represent one of medicine's greatest achievements and are responsible for the reduction of a host of infectious diseases. Canadian children undergo well over two dozen vaccinations before the age of 18 years while adults may also receive yearly influenza vaccinations. Pain has been deemed an adverse effect of vaccines delivered by needles. There are evidence-based approaches to managing needle-related pain and distress but they are not being implemented in routine care. This is a problem because inadequate management of pain and fear related to immunizations has serious consequences that affect not only the recipient but also health care professionals, family members, and society at large. Short-term consequences include increased distress during the procedure and associated risk of injury (eg, fainting, flailing), longer procedure times, and a negative experience for the recipient, health care professional, and caregivers alike. Longer-term consequences include negative memories, increased fear of future procedures including development of needle phobia, and non-compliance with vaccination schedules, which may ultimately affect herd immunity. The Help Eliminate Pain in Kids Team created the first clinical practice guideline for immunization pain management in 2010; we have recently updated this guideline to provide guidance on the management of immunization-related pain and fear across the lifespan. This session will transform the cutting-edge results from a series of rigorous systematic reviews into accessible, clinically feasible pain and fear management techniques. Strategies will be grouped according to the "Four Ps" approach: 1) procedural (eg, no aspiration, most painful vaccine last), physical (eg, upright positioning, breastfeeding), pharmacological (eg, sweet-tasting solutions, topical anesthetics), and psychological (eg, music, video distraction). Brief videos and case studies will be used to familiarize the practitioners with how to apply these simple, best-practice techniques for their patients of various ages. Practitioner-focused resources will be provided.

S102111 **The Canadian Cardiovascular Society Heart Failure Companion: Bridging guidelines to your practice**
13:45–14:45

Jonathan Howlett, MD, CCFP, FRCPC, Calgary, AB, Adam Grzeslo, MD, CCFP, FCFP, Burlington, ON

716B MTCC

Learning Objectives:

1. apply the Canadian guidelines for identifying, targeting, and managing dyslipidemia
2. understand the role of non-statin drugs in cardiovascular risk
3. discuss new evidence and provide updated evidence-based care for patients living with and at risk of developing cardiovascular disease

Description:

Many serious cardiovascular events occur in individuals with no prior manifestation of cardiovascular disease (CVD), and these events can often result in death. Awareness of the contributions of various risk factors to the occurrence of CVD is growing. Asymptomatic individuals with multiple risk factors at low or moderate levels can be at greater risk for CVD than those with a single risk factor at a high level. Dyslipidemia is a risk factor that commonly coexists with other factors such as diabetes and hypertension and is modifiable through lifestyle changes and/or medications. There remains a lot of interest and questions in dyslipidemia management, given the 2013 American College of Cardiology (ACC)/American Heart Association (AHA) Dyslipidemia guidelines, as well as the new guidelines slated for release from the European Society of Cardiology in 2015. The Canadian guidelines will be updated in 2015. In this case-based presentation, members of the Canadian Cardiovascular Society Dyslipidemia Guidelines Panel will explain the latest evidence and recommendations needed to provide quality evidence-based care for patients living with and at risk of developing dyslipidemia.

S101711 **Sleeping for Two: Teaching moms and infants to sleep through the night**
13:45–14:45

Sanjeev Bhatla, MDCM, CCFP, FCFP, Calgary, AB; Lianne Tomfohr, PhD, R Psych, Calgary, AB

501 MTCC

Learning Objectives:

1. identify and apply effective treatment strategies for maternal insomnia (maternal sleep training)
2. describe easy and evidence-based approach for infant sleep training
3. review pharmacotherapy for refractory insomnia in pregnancy

Description:

Restorative sleep plays a critical role in maintaining health and well-being. Many pregnant and postpartum women suffer from chronic sleep deprivation, putting them at increased risk for depression, anxiety, and other health problems. This presentation describes an effective and brief cognitive behaviour treatment for insomnia that family physicians can deliver in office visits. A simple technique for sleep training infants is promoted, with evidence-based support. Safe pharmacotherapy for refractory insomnia in pregnancy will be reviewed.

S101455 Keeping Compassion in Family Practice: Lessons learned

13:45–15:30 Françoise Mathieu, MEd, CCC, Kingston, ON; Rupa Patel, MD, CCFP, Kingston, ON

711 MTCC

Learning Objectives:

1. identify the difference between burnout, compassion fatigue, secondary trauma, and moral distress
2. recall the most recent findings on effective management of burnout and compassion fatigue for physicians
3. acquire a compassion fatigue tool kit with five essential skills for best practice

Description:

This presentation was first offered at FMF 2014 and received extremely positive feedback. Participants asked us to consider returning to present at FMF 2015. Burnout and compassion fatigue may now be familiar terms to you, but how is that reflected in your daily practice? Family physicians are facing multiple pressures: a need to stay on top of new treatments; seeing increasing numbers of patients, often with high needs and complex issues; and increasing administrative work. Recognizing and managing compassion fatigue will help keep you able to do the work you used to love to do. Please join one of Canada's leading experts in compassion fatigue and a fellow family physician while they explore the newest findings on what it takes to be a healthy family physician in 2015. Handouts will be available in both English and French, and questions will be taken in both official languages. We will present "The compassion fatigue tool kit: 5 essentials for best practice."

S101448 Making Teams Work

13:45–16:00 Stephen Darcy, MD, CCFP, FCFP, Mount Pearl, NL; Lisa Bishop, PharmD, St John's, NL; Susan Avery, MD, CCFP, St John's, NL

709 MTCC

Learning Objectives:

1. identify the attributes of an effectively functioning team
2. appreciate the impact of team composition, leadership, and conflict on team effectiveness
3. develop the skills to promote team development and manage team conflict

Description:

Family doctors are more and more finding themselves as members of teams whether in the clinical setting or when involved in research. This workshop is geared for family physicians, residents, students, and other health care professionals who are part of a clinical or research team. The session will be largely interactive in nature and involve group exercises and discussion. The workshop will focus on the formation and maintenance of effective teams and will help the participant identify and appreciate the factors that influence effective team building while providing insight into some elements of team dynamics. The participant will also develop strategies to deal with conflicts that may arise in the team setting. Further, as a result of participation in the workshop, it is hoped that attitudes toward team participation may be more positive and confident.

S102283 Teaching Resiliency to Resident Doctors for a Rewarding and Sustainable Career

13:45–16:00 Christina Nowik, MD, Ottawa, ON; Nureen Sumar, MD, Calgary, AB; Simon Moore, MD, CCFP, Vancouver, BC

705 MTCC

Learning Objectives:

1. recognize the impact of distress on mental resiliency and the importance of early intervention
2. discover skills to manage shifts in mental resiliency
3. support the need for proactive and systematic implementation of resiliency training in medical education

Description:

Resiliency training is the development of skills to effectively identify, cope with, and recover from challenging experiences. Residency training is a particularly dynamic and stressful time for many trainees, who must balance educational and personal responsibilities with providing patient care, often making significantly life-altering decisions in emotionally charged situations. Over two-thirds of respondents to the 2013 CAIR National Resident Survey reported that work-related fatigue had an impact on their physical health (83.3%), on their relationships with family (79.8%) and friends (75.7%), and on their mental health (69.9%). Skills-based training to help mitigate stress can assist residents in overcoming adversity and provide them with the tools to better support their peers and patients, not only during their medical training but also over the course of their careers. Resident Doctors of Canada advocates strongly for the implementation of a formal resiliency curriculum, tailored to the needs of resident doctors, as a mandatory component of medical education. Resident Doctors of Canada has developed a skills-based resiliency curriculum with content support from the Department of National Defence's Road to Mental Readiness Program. It highlights the importance of promoting resident doctor mental resiliency by fostering supportive and positive learning environments and advocates for a systematic approach to understanding and addressing the anticipated stresses of residency. This session will include an interactive overview of the curriculum, including the demonstration and application of tools, such as the Mental Health Continuum, that will help resident doctors, clinical educators, allied health professionals, and support staff recognize early signs of varying levels of distress on mental resiliency, as well as apply effective evidence-based skills (known as the Big 4+) to help manage these stressors.

S123056 Role of the Resident Representative on Accreditation Visits

13:45–16:00 Keith Wycliffe-Jones, MD, CCFP, Calgary, AB; Shirley Schipper, MD, CCFP, Edmonton, AB; Steve Hawrylyshyn, MD, Toronto, ON

ROSEDALE ROOM – DELTA TORONTO HOTEL

Learning Objectives:

1. share and discuss the proposed major changes in both accreditation standards and accreditation processes for family medicine residency training

Description:

The College of Family Physicians of Canada (CFPC) accredits residency training programs in family medicine; family medicine/emergency medicine; and enhanced skills at all 17 medical schools in Canada. The purpose of accreditation is twofold: to attest to the educational quality of accredited programs and to ensure sufficient uniformity and portability to allow residents from across Canada to qualify for the CFPC examinations as residency-eligible candidates. The Accreditation Committee is responsible for setting standards for residency training. The role of the resident surveyor as a member of the Accreditation Survey Team is important: Learn why. Enrich your academic experience and increase your understanding of accreditation in medical education and as a quality assurance process. Volunteer opportunities exist to get involved and make a difference in family medicine programs across the country. This session is open to all family medicine residents.

S102575 Crossing Professional Boundaries: Pearls and pitfalls

13:45–16:00 Fiona Bergin, MD, CCFP, MEd, Halifax, NS; Stewart Cameron, MD, CCFP, FCFP, MAEd, Halifax, NS
707 MTCC

Learning Objectives:

1. identify and understand the significance of boundary transgressions in the medical educational setting
2. identify strategies for minimizing boundary transgressions
3. reflect on a personal approach to maintaining and promoting healthy boundaries with learners and colleagues in medical education settings

Description:

Professional boundaries delineate the area separating therapeutic attitudes and behaviours from potentially exploitative ones. In medicine, professional boundaries are most commonly discussed in the context of providing patient care and the concern is for the patient who might be harmed by the boundary transgression. Learners, like patients, are also in a relationship of unequal power with respect to their clinical or faculty supervisors, and can similarly be harmed when professional boundaries are not maintained with them or others in their learning environment. Yet boundary crossings are not uncommon and many would argue they are well-intentioned and might even be beneficial to the learner. The challenge is in identifying when the harms might outweigh the benefits and how to avoid the pitfalls inherent in boundary crossings. In this session, we will briefly review the literature on professional boundaries in the educational setting. In small groups, we will discuss several cases that illustrate boundary crossings and critique why and how they occurred. Finally, we will reflect on and share strategies to promote and maintain healthy professional boundaries in our educational settings.

S101935 New Strategies in the Management of Actinic Keratosis

14:15–14:45 Darshini Persaude, MBBS, CCFP, FCFP, Diploma in Practical Dermatology, Pickering, ON;
Trina Stewart, MD, CCFP, FCFP, Summerside, PE
401 MTCC

Learning Objectives:

1. identify patients with actinic keratosis and non-melanoma skin cancers and describe the progression from actinic keratosis to squamous cell cancer
2. recognize risk factors for the development of actinic keratosis and non-melanoma skin cancer and link them to prevention strategies
3. describe the current treatment approaches for actinic keratosis and review current guidelines for management

Description:

Actinic keratoses (AKs) are common skin lesions that can progress to squamous cell carcinoma. In fact, people with actinic keratoses have an increased risk for all types of skin cancer, including basal cell skin cancer, squamous cell skin cancer, and melanoma. Treatment and prevention of AKs in a timely manner is important in reducing the incidence of non-melanoma skin cancer. A wide array of treatment options are available to the family physician today. These include physician- and patient-administered therapies as well as targeted and field treatment approaches. This case-based interactive program will allow primary care providers to recognize the risk factors for AK and identify patients with AKs. They will be able to identify strategies to improve outcomes through prevention, early treatment, and timely follow-up. We will review an approach to treatment based on current guidelines and consensus expert opinion.

S109634 Exploring Requests to Hasten Death (2)

14:15–16:00 Monica Branigan, MD, MHSc (Bioethics), Toronto, ON; Doris Barwich, MD, CCFP, Delta, BC
713A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. describe the current literature regarding desire-to-die statements (DTDS) and requests to hasten death
2. explore evidence-based interventions in responding compassionately to DTDS, including dignity therapy principles and therapeutic communication principles
3. identify and respond to barriers to open conversation

Description:

Requests to hasten death are common in those with life-threatening illness or irremediable conditions. These requests can vary over time and with disease trajectory, symptom load, or perceived burden to others. Importantly, these statements and requests vary significantly regarding their underlying intention. Some patients are expressing a readiness to die; some, a plea to assist with living; and a small minority, a request for physician assistance in hastening death. With the anticipated change in legislation to allow for physician-assisted death, the options in how we might respond to these statements will change profoundly. As baby boomers who value control and autonomy approach aging, chronic illness, and death, these conversations will become more compelling. A compassionate exploration between patient and physician is necessary to help the patient clarify his or her intention, and to help the physician assess the nature of the request; consider interventions to mitigate suffering; or address questions, concerns, or fears. This exploration itself has the potential to be experienced as therapeutic by the patient. However, many barriers exist—in ourselves and in our institutions—that make these open conversations difficult. Fortunately, resources exist to support these conversations, as well as evidence-based interventions with which we can respond. In this workshop we will begin with a short didactic session, then view and discuss some videos and reflect on cases in small groups. We will brainstorm as a group about emerging best practice in responding to these requests, as well as ways to overcome common barriers to open conversations. This workshop will not focus on questions regarding possible participation in physician-assisted death but rather on the true exploration of a desire-to-die statement. Presenters will include facilitators from the Canadian Society of Palliative Care Physicians.

S101600 Oncological Emergencies

15:00–15:30 Anna Wilkinson, MSc, MD, CCFP, Ottawa, ON

401 MTCC

Learning Objectives:

1. identify the common oncological emergencies which may present to the family physician
2. recognize the presentation of common oncological emergencies
3. describe the appropriate management of oncological emergencies

Description:

As our population ages and the incidence of cancer continues to climb, cancer patients will constitute increasingly significant proportions of family practices. Family physicians must therefore be equipped to diagnose and manage common oncological emergencies that may present in patients with previously undiagnosed malignancies, patients on treatment, or palliative patients. This session will describe the diagnosis of common oncological emergencies that family physicians might see in the emergency room or their office. Oncological emergencies will be categorized as metabolic, structural, or side effects from chemotherapy; and corresponding topics such as hypercalcemia, superior vena cava syndrome, spinal cord compression, febrile neutropenia, and tumour lysis syndrome will be addressed. Management of these emergencies will be described, allowing family physicians to have greater confidence in caring for the oncology patients in their practices.

S102016  **Fracture Prevention Recommendations for Long-Term Care**
15:00–15:30 **Recommandations visant la prévention des fractures en soins prolongés**

Alexandra Papaioannou, BScN, MD, MSc, FRCPC, FACP, Hamilton, ON;

Sid Feldman, MD, CCFP, FCFP, Toronto, ON

718AB MTCC

Learning Objectives:

1. understand and have working knowledge of the recommendations surrounding osteoporosis and falls strategies and how to apply them in clinical practice
2. apply recommendations and resource tools for fracture prevention in frail older adults

Description:

Physicians caring for frail older adults at high risk for falls and fractures in long-term care (LTC) face multiple challenges, including multiple comorbidities, polypharmacy, and end-of-life care, while practice guidelines typically do not address this population. There is a clear need to integrate osteoporosis and falls strategies to reduce fracture. The goal of fracture prevention is to reduce pain, immobility, and transfers to hospital and to maximize opportunity for quality living among frail older adults. The implications of these guidelines for frail older adults are highly relevant.

Objectifs d'apprentissage :

1. comprendre et avoir une connaissance pratique des recommandations portant sur l'ostéoporose et les stratégies contre les chutes et la façon de les appliquer en pratique clinique
2. appliquer les recommandations et les outils de prévention des fractures chez les patients âgés fragiles

Description :

Les médecins qui soignent des patients âgés fragiles en soins prolongés présentant un risque élevé de chutes et de fractures font face à de nombreux défis, notamment les comorbidités multiples, la polypharmacie et les soins de fin de vie, alors que les lignes directrices restent coites sur cette population. Le besoin d'intégrer l'ostéoporose et les stratégies contre les chutes ne fait aucun doute pour réduire les fractures. La prévention des fractures vise à réduire la douleur, l'immobilité et les transferts dans les hôpitaux, et de maximiser les chances que les adultes âgés fragiles aient une bonne qualité de vie. Les répercussions de ces lignes directrices pour les adultes âgés fragiles sont très pertinentes.

S102485
15:00–15:30

Problem Gambling: Comorbidities and the impact on families

Daniela Lobo, MD, PhD, Toronto, ON; Toula Kourgiantakis, MSW, RSW, RMFT, Toronto, ON

701B MTCC

Learning Objectives:

1. screen quickly and efficiently for gambling problems and provide treatment referrals
2. understand the most common comorbidities present in problem gamblers
3. provide initial resources for families affected by problem gambling

Description

Problem gambling (PG) is a public health issue with adverse consequences for individuals and families. In Canada, 2.4 per cent of the population has a gambling problem and this rate is two to four times higher among youth. Problem gambling has high rates of comorbidity with other addictions and psychiatric disorders. A prevalence study (N = 49,093) found that 73 per cent of PG individuals had an alcohol use disorder, 38 per cent had a drug use disorder, 60 per cent had nicotine dependence, 50 per cent had mood disorders, 41 per cent had an anxiety disorder, and 61 per cent had a personality disorder. Problem gambling is also associated with high rates of trauma, suicidality, financial problems, and legal issues. Families are also greatly affected, with increased risks of child maltreatment, family violence, separation/divorce, and intergenerational transmission of PG. Despite the elevated risks for PG individuals and their families, research shows that only 3 to 6 per cent of those with a gambling problem seek treatment and 50 per cent drop out of treatment. These individuals often see physicians in primary care settings and present physical and mental health problems, but do not disclose problem gambling as a contributing factor. This presentation will describe the symptoms of problem and disordered gambling and discuss the most common comorbidities, as well as the impact of PG on families. We will also provide family physicians with information on screening, treatment, and referral consistent with evidence-based practices.

S102831

Acne Vulgaris in 2015

15:00–15:30

Jessica Hunter-Orange, MD, CCFP, DipPDerm, London, ON

714AB MTCC

Learning Objectives:

1. review the common types of acne and pathophysiology seen in day-to-day practice
2. recognize the need for ongoing follow-up due to the chronic nature of this disease
3. discuss the importance of the use of retinoids at all stages and describe combination therapies that have become available recently

Description:

This session will briefly review the different types and pathogenesis of acne. The concept of acne as a chronic disease of young adulthood will be highlighted. We will review the use of retinoids at all stages of the disease, as well as the use of combination therapy and the need to limit antibiotic resistance. We will also look at the three most recently available topical treatments and how best to use these in your practice. In addition, we will discuss the oral treatments available for severe acne and when referral might be necessary.

S102846

Clinical Framework for the Management of Hair Loss in Primary Care

15:30–16:00

Darshini Persaude, MD, CCFP, FCFP, Diploma in Practical Dermatology, Pickering, ON

714AB MTCC

Learning Objectives:

1. assess the patient who presents with hair loss and identify the type of hair loss
2. recognize patients that will need early intervention or referral to secondary care
3. select appropriate first- and second-line treatments, depending on the cause

Description:

Hair loss is a common problem in clinical practice and the effects are often devastating for patients. Early diagnosis and intervention can make a difference in the management and outcomes for these patients. This workshop aims to give primary care providers a clinical framework to use in the assessment and management of patients with hair loss

S96121

Can You Please Get Them to Stop Coughing?

15:00–16:00

Alan Kaplan, MD, CCFP(EM), FCFP, Richmond Hill, ON; Robert Hauptman, MD, St Albert, AB

716A MTCC

Learning Objectives:

1. differentiate between acute, subacute, and chronic cough
2. review the diagnostic approach and appropriate treatments
3. have fun with a number of challenging cases

Description:

A patient who is coughing suffers from reduced quality of life, fears, fatigue, and embarrassment. There are many causes of cough, ranging from mild to life-threatening. This case-based workshop will take us from acute causes of cough to chronic cough. We will review how to approach your patient and their cough in regards to diagnosis and treatment. We will move from the common to the uncommon; you will be on the hot seat to make the diagnosis and recommend treatments.

S101840 Integrating Preconception Health Promotion Into Primary Care

15:00–16:00 Patricia Mousmanis, MD, CCFP, FCFP, Richmond Hill, ON; Lisa Graves, MD, CCFP, FCFP, Ancaster, ON; Deanna Telner, MD, CCFP, FCFP, North York, ON

701A MTCC

Learning Objectives:

1. describe evidence-based recommendations for preconception health interventions
2. integrate clinical strategies into primary care practice for women and men of reproductive age, including LGBTQ populations
3. practise health promotion strategies to improve preconception and interconception health interventions in higher-risk clinical situations (abuse survivors, mental illness, and addictions)

Description:

This interactive, case-based workshop will look at the evidence for preconception interventions and how to integrate them into primary care practice environments. A new preconception tool developed by the Centre for Effective Practice and the new Ontario Public Health Association preconception health position paper "SHIFT: Enhancing the Health of Ontarians. A call to action for preconception health promotion and care" will be introduced as a framework to provide strategies that clinicians can use in everyday practice. Specific clinical pearls for interventions with youth, males, LGBTQ clients, and high-risk women (such as those who are abuse survivors or have addictions or mental illness) will be reviewed through the use of cases and small group discussion.

S102010 Mixing and Matching: Layering medications as family physicians

15:00–16:00 Jon Davine, MD, CCFP, FRCPC, Hamilton, ON

801AB MTCC

Learning Objectives:

1. identify scenarios of combining psychiatric medications that are pertinent to the primary care situation
2. combine medications to optimize antidepressant treatment response
3. combine medications to optimize sleeping

Description:

Often, psychopharmacologic treatment of psychiatric conditions involves combining medications in an appropriate manner. In this workshop, we will discuss a number of scenarios where this occurs, including augmenting a partial response to antidepressants, dealing with treatment-resistant depressions, treating acute manic conditions, dealing with insomnia, dealing with anxiety disorders, and dealing with schizoaffective disorder, among others. Participants will be encouraged to bring up some of their own cases where issues of "layering" occurred.

S102428 Making Patient Safety a Priority: Moving from a culture of blame to learning via narrative

15:00–16:00 Tejal Patel, MD, CCFP, Hamilton, ON; Joyce Zazulak, MD, CCFP, FCFP, Dundas, ON; Doug Oliver, MD, CCFP, FCFP, Dundas, ON

715A MTCC — Small group interactive workshop – limited seating.

Learning Objectives:

1. appreciate the components and benefits of a narrative-based patient safety program in a primary care setting
2. participate in an abbreviated patient safety "rounds"
3. implement similar programs within participant's own clinical settings to improve overall patient and clinician well-being

Description:

At McMaster Family Practice, we have adopted the practice of meeting regularly in a safe, non-blaming, and supportive environment to share our stories of near and actual misses, with the goal of improving patient safety. The purpose of this session is to demonstrate how, through the use of stories, we are able to explore the impact of medical error on both patients and caregivers, pass on knowledge and experience, and gain insights that can lead to effective change in practice or policies, in an environment that breaks down the medical "culture of blame" and traditional sense of hierarchy, to make patient safety a priority. All primary care clinicians, including allied health professionals and learners, would be welcome to attend. The workshop will be comprised of a short presentation to describe the key components of our program and the unique aspects of patient safety in a family practice setting, followed by an interactive mock "patient safety rounds," to allow participants the opportunity to share their stories and learn from one another in a setting where the process of storytelling and learning, rather than a need to lay blame or fix a problem, is the focus. We will close the session with some suggestions on how participants can begin to have open discussions and to foster an environment that is safer for both patients and caregivers in their own practices.

S102563 Office Management of Early Pregnancy Miscarriage and Termination

15:00–16:00 Ellen Wiebe, MD, CCFP, FCFP, Vancouver, BC

802AB MTCC

Learning Objectives:

1. choose appropriate medication protocols for women who have missed abortions (anembryonic/fetal demise)
2. describe the risks and side effects of medications used in early pregnancy termination: misoprostol, methotrexate, and mifepristone
3. safely select patients wanting pregnancy termination for use of misoprostol with either methotrexate or mifepristone

Description:

This one-hour session will focus on clarification of effective, safe medication use in early pregnancy for women who have a known miscarriage (anembryonic or demise), or who seek early pregnancy termination. We will discuss off-label use of misoprostol and methotrexate as well as the newly approved mifepristone. Clinical scenarios and review of recent research will allow the participant to feel confident in selecting appropriate medication protocols.

S100279 Caring for the Hepatitis B Carrier Patient: How can the primary care practitioner add value?**15:00–16:00** Vu Kiet Tran, MD, MHSC, MBA, Richmond Hill, ON**713B MTCC****Learning Objectives:**

1. list causes of hepatitis B transmission
2. enumerate monitoring strategies
3. enumerate criteria for referral to a hepatologist

Description:

With the growing numbers of new immigrants (especially from South-East Asia and China) to Canada, there is also a growing number of patients with chronic hepatitis B (carrier state). Unfortunately, many are not aware they are carriers of the virus. For the primary care practitioner, what is the most effective way to screen them? Then, what tests are necessary for monitoring? When to refer to our specialist colleagues? Who should be immunized? Come and learn how primary care can make a difference in these patients. Ultimately, we all want to prevent cirrhosis and liver malignancy for our patients.

S99190 Primary Health Care and Homeless Youth: A multidisciplinary approach**15:00–16:00** Naomi Thulien, NP-PHC, MN, PhD candidate, Oakville, ON; Karen Weyman, MD, MEd, CCFP, FCFP, Toronto ON; Eileen Murphy, RN, BScN, Toronto, ON**501 MTCC****Learning Objectives:**

1. identify common health-related concerns of homeless youth
2. confidently manage a “typical” office visit with homeless youth
3. describe how to effectively utilize a team approach to caring for homeless youth

Description:

Youth (aged 16–24 years) constitute the fastest-growing segment of the homeless population in Canada. One of the challenges in providing care to homeless youth is that even the most simple health matter is complicated by the fact that these youth are frequently struggling with issues related to mental illness and addiction, as well as attempting to heal from the emotional trauma experienced as a result of a chaotic childhood. In addition, the transient nature of youth homelessness means that the health care these youth typically receive is inconsistent and fragmented, punctuated by frequent visits to emergency rooms across Canada. A multidisciplinary team of health care providers from Covenant House Toronto—Canada’s largest shelter for homeless youth—will share their expertise in providing primary health care to this population. Common health-related concerns and clinical pearls are highlighted, as well as the opportunity to observe and participate in a “typical” clinical encounter.

S101339 Help, Doctor! My Face Is Red**15:30–16:00** Christine Rivet, MDCM, CCFP(EM), FCFP, MCISc, Ottawa, ON**803A MTCC****Learning Objectives:**

1. discuss the practical step-by-step approach to starting and following patients on oral retinoids
2. describe differences between acne and conditions with a similar appearance such as rosacea, perioral dermatitis, atopic dermatitis, and seborrheic dermatitis
3. give advice about what patients can expect from their skin condition and what they can expect from its treatment

Description:

This is a very interactive workshop that starts by discussing the objectives of the session, then giving a “warm-up quiz” of common patient “red-face” scenarios with multiple-choice answers. There are then about 10 cases of patients with different presentations of a red face. I use photos and a brief patient scenario for participants to discuss the diagnosis and management of each case for a few minutes in a small group of about four participants. Then the larger group discusses diagnosis and treatment of the patients. One example is a 13-year-old boy with a rash on his face that appears similar to acne but is keratosis pilaris. The differences between keratosis pilaris of the face and acne are discussed. Another example is a 15-year-old girl with severe acne and her management options. A third scenario is a 52-year-old woman with severe facial eczema who has tried several treatments. At the end I go back to the initial warm-up quiz to review the answers with the group. I have given this workshop to both residents and local colleagues and it has been very well received. As family physicians, up to 20 per cent of our practice includes skin problems and I have found that there is much enthusiasm to learn more about dermatology from a family physician’s perspective.

S101460**The Occasional HIV+ Patient****15:30–16:00**

James Owen, MD, CCFP, Toronto, ON; Kelly Anderson, MD, CCFP, Toronto, ON

716B MTCC**Learning Objectives:**

1. diagnose and perform an initial workup for HIV+ patients
2. independently monitor and manage stable HIV+ patients
3. appreciate that family physicians already have many of the competencies necessary for basic HIV care

Description:

HIV is an increasingly common diagnosis in both rural and urban family practice. In many regions, access to specialist HIV care is limited; however, as skilled managers of common chronic conditions such as diabetes and cardiovascular disease, family physicians have many of the necessary skills to competently manage stable HIV infection. This workshop, targeted at the generalist family physician, aims to increase your capacity to care for the occasional HIV+ patient. We will highlight the basic workup and management of HIV infection. We will also explore common preventive care recommendations for HIV+ patients, including cancer screening, immunizations, and the management of cardiovascular risk factors.