FMF

Family Medicine Forum
Forum en médecine familiale

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

PROGRAM
PROGRAMME

NOV 8-11 NOV

Palais des congrès de Montréal
Montréal, Québec

#MYFMF
#MONFMF

CREATE CRÉER | EDUCATE APPRENDRE | CELEBRATE CÉLÉBRER

fmf.cfpc.ca | familymedicineforum | @familymedforum | FMF 2017

A wonderful city ...
A great program!

Une ville merveilleuse...
Un programme épatant !

Celebrate Montreal's wealth of history and culture as well as its lively people, iconic places, and diverse neighbourhoods.

Venez profiter de toute la richesse du patrimoine historique et culturel de la métropole, de l'énergie de sa population, de ses endroits emblématiques et de ses quartiers diversifiés.

CREATE CRÉER	EDUCATE APPRENDRE	CELEBRATE CÉLÉBRER

The 2017 Family Medicine Forum Committee welcomes you to FMF!

Le Comité du Forum en médecine familiale 2017 vous souhaite la bienvenue au FMF !

Enjoy the conference, connect with colleagues, and renew your passion for family medicine.

Profitez bien de la conférence, créez des liens avec vos collègues et ravivez votre passion pour la médecine familiale.

Dr. Leslie Griffin
Co-chair, Nova Scotia
Coprésident, Nouvelle-Écosse

Dr. Stephen Hawrylyshyn
Co-chair, First Five years in Family Practice
Coprésident, Cinq premières années de pratique de la médecine familiale

Dr. Pierre-Paul Tellier
Past Chair
Président sortant

Dr. Jeanette Boyd
British Columbia
Colombie-Britannique

Dr. Katherine Burleigh
Prince Edward Island
Île-du-Prince-Édouard

Dr. Alex Chesley
Section of Residents
Section des résidents

Dr. Bill Eaton
Newfoundland and Labrador
Terre-Neuve-et-Labrador

Dr. Scott Garrison
Section of Researchers, Alberta
Section des chercheurs, Alberta

Dr. Moulay Jbala
Quebec
Québec

Winny Li
Section of Medical Students
Section des étudiants en médecine

Dr. Cathy MacLean
Section of Teachers
Section des enseignants

Dr. Ainslie Mihalchuk
Manitoba

Dr. Lori Teeple
Ontario

Missing from photos:
Dr. Natalie Cauchon, New Brunswick; Dr. Jason Hosain, Saskatchewan; and Dr. Benjamin Schiff, Section of Communities of Practice in Family Medicine

Membres ne figurant pas sur les photos : Dre Natalie Cauchon, Nouveau-Brunswick; Dr Jason Hosain, Saskatchewan; Dr Benjamin Schiff, Section des communautés de pratique en médecine familiale

Welcome to FMF 2017
Bienvenue au FMF 2017

Dear colleagues and esteemed guests,

On behalf of the College of Family Physicians of Canada, it is my pleasure to welcome you to FMF 2017. Our annual conference offers excellent opportunities to learn about new developments in family practice and celebrate great achievements in family medicine. The FMF Committee has done an outstanding job in curating this year's program. Your participation is an essential part of FMF's success, so thank you for joining us. I hope you enjoy your time in Montreal!

Francine Lemire, MD CM, CCFP, FCFP, CAE
Executive Director and Chief Executive Officer
College of Family Physicians of Canada

À nos collègues et à nos invités,

Au nom du Collège des médecins de famille du Canada, c'est un plaisir pour moi de vous accueillir au FMF 2017. Notre congrès annuel offre d'excellentes occasions de découvrir de nouvelles avancées dans la pratique de la médecine familiale et de célébrer les grandes réalisations de notre discipline. Cette année, le Comité du FMF a assuré une programmation remarquable.
Sans votre participation, le FMF ne pourrait connaitre un tel succès. Je vous remercie d'être des nôtres. J'espère que vous passerez un agréable séjour à Montréal !

Francine Lemire, MD CM, CCMF, FCMF, CAÉ
Directrice générale et chef de la direction
Le Collège des médecins de famille du Canada

What's new at FMF this year?
Quelles sont les nouveautés au FMF cette année ?

It's all about making your FMF experience easier so you have more time for learning and networking!

Nous avons apporté des changements pour rendre votre expérience au FMF plus conviviale afin de vous laisser davantage de temps pour apprendre et élargir votre réseau !

SCAN AND SKIP
SCANNEZ ET LE TOUR EST JOUÉ

Scanners and credit entry

Badge scanners will be used to track all sessions attended at FMF and add credits to your Mainpro+® account automatically!

Exception: 2 and 3 credit per hour certified Mainpro+ workshops

Scanneurs et saisie des crédits

Des scanneurs d'insigne seront utilisés pour garder le compte de toutes les séances auxquelles vous assistez au FMF ; les crédits seront automatiquement ajoutés à votre compte Mainpro+[MD] !

Exceptions : Ateliers certifiés Mainpro+ pour 2 et 3 crédits par heure

NEW APP-TITUDE
UNE APPLI FLAMBANT NEUVE

FMF Mobile App

Our new FMF Mobile App is available in the App Store and Google Play Store—just search "FMF 2017" and download.

This new and improved app offers some powerful and exciting new features!

- Access daily schedules at a glance
- View detailed course descriptions
- Find your favourite speakers
- Find the room numbers of all sessions and events
- Save your favourite events, speakers, and sessions
- Take notes on sessions, speakers, and exhibitors
- Review and rate your sessions
- Post photos and chat with other attendees
- Read about and locate exhibitors
- Access FMF floor plans and maps to local hotels

Application mobile du FMF

Notre nouvelle application mobile du FMF est offerte sur l'App Store et sur le Google Play Store : il suffit de rechercher « FMF 2017 » et de la télécharger.

Cette nouvelle application vous offre quelques nouveautés très remarquables !

- Consultez l'horaire quotidien en un coup d'œil
- Lisez les descriptions détaillées des séances
- Trouvez vos conférenciers préférés
- Trouvez les numéros de salle de toutes les séances et les activités
- Enregistrez vos favoris parmi les activités, les conférenciers et les séances
- Prenez des notes sur les séances, les conférenciers et les exposants
- Commentez et évaluez les séances auxquelles vous participez
- Publiez des photos et clavardez avec d'autres participants
- Lisez des renseignements sur les exposants et localisez-les
- Consultez les plans d'étage du FMF et des cartes indiquant les hôtels à proximité

NEW! CERTIFIED POSTER SESSIONS

We are piloting new certified poster session learning opportunities at FMF during two time slots in the FMF scientific program on Thursday, November 9th, at 3:00 p.m. and on Friday, November 10th, at 10:00 a.m. Meet in the keynote foyer at the Palais des congrès de Montréal (Level 5).

NOUVEAU ! PRÉSENTATION D'AFFICHES SCIENTIFIQUES CERTIFIÉES

Pour la première fois au FMF, nous organisons la présentation d'affiches scientifiques certifiées, offrant ainsi une nouvelle occasion d'apprentissage. Il y aura deux séances à l'horaire au cours du programme scientifique du FMF : le jeudi 9 novembre, à 15 h, et le vendredi 10 novembre, à 10 h. Le point de rencontre est le foyer où ont lieu les discours d'ouverture, au Palais des congrès de Montréal (niveau 5).

KEY LOCATIONS / ENDROITS CLÉS	ROOM / SALLE
Registration / Inscription	200 Viger Foyer
Exhibit Hall / Hall d'exposition	220CDE
Posters / Affiches scientifiques	Level 5 Foyer
Speakers Room / Salle des conférenciers	518A
Media Centre / Centre des médias	518B
Nursing Room / Salon d'allaitement	525A
Prayer Room / Salle de prière	525B
Wednesday / Mercredi	
Dr. Ian McWhinney Keynote Discours d'ouverture Dr Ian McWhinney	710
Teachers and Preceptors Knowledge Café and Lunch Déjeuner des enseignants et des superviseurs au *Café du savoir*	517A
Section of Researchers Business Meeting/Lunch Déjeuner et réunion de la Section des chercheurs	710
Thursday / Jeudi	
Keynote Address Discours d'ouverture	517BCD
CFPC Annual Meeting of Members Assemblée annuelle des membres du CMFC	710B
QCFP Networking Cocktail Reception CQMF Cocktail-Réseautage	Le Westin Montréal, Bar Reporter
FMF Welcome Reception Réception d'accueil au FMF	Level 5 Foyer
Friday / Vendredi	
President's Installation and Keynote Address Installation du président et discours d'ouverture	517BCD
First Five Years in Family Practice Luncheon Déjeuner pour les médecins de famille dans les cinq premières années de pratique	517A
Teachers and Preceptors Town Hall Assemblée générale des enseignants et superviseurs	710B
Saturday / Samedi	
Convocation photography and gown pickup Cueillette de la toge pour la collation des grades et photographie	517A
Convocation marshalling Défilé de la collation des grades	517A
FMF Celebration / Célébration du FMF	Level 5 Foyer
Convocation ceremony / Collation des grades	517BCD

This Group Learning program has been certified by the College of Family Physicians of Canada and the Quebec Chapter for up to **24** Mainpro+ credits.

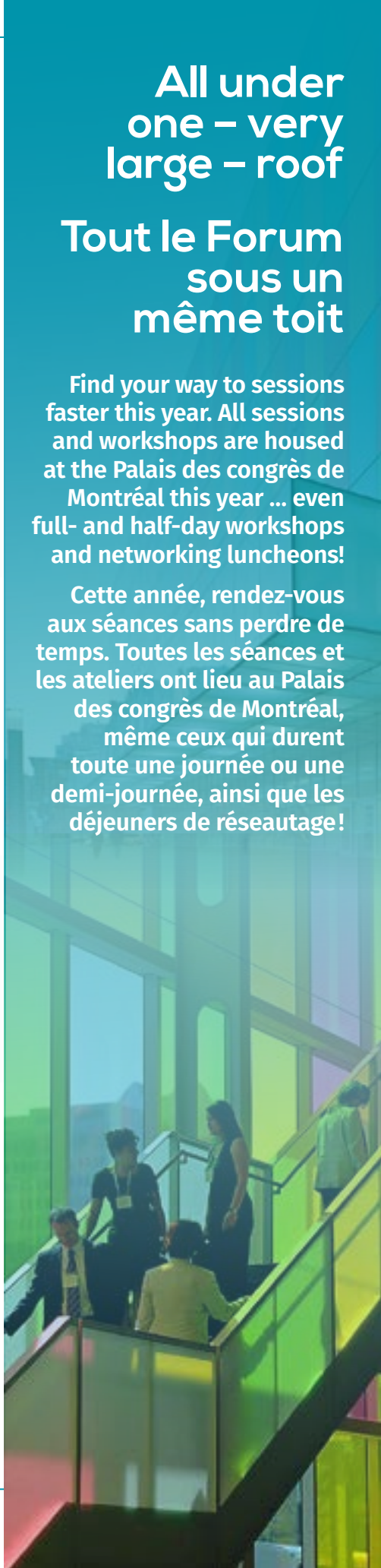
Ce programme d'apprentissage en groupe a reçu la certification du Collège des médecins de famille du Canada et de la section du Québec et donne droit jusqu'à **24** crédits Mainpro+.

All under one – very large – roof

Tout le Forum sous un même toit

Find your way to sessions faster this year. All sessions and workshops are housed at the Palais des congrès de Montréal this year ... even full- and half-day workshops and networking luncheons!

Cette année, rendez-vous aux séances sans perdre de temps. Toutes les séances et les ateliers ont lieu au Palais des congrès de Montréal, même ceux qui durent toute une journée ou une demi-journée, ainsi que les déjeuners de réseautage!



Wednesday / Mercredi
November 8 novembre

07:00 – 19:00	Registration open Ouverture des inscriptions
07:00 – 08:00	Breakfast / Petit-déjeuner
08:00 – 09:30	Dr. Ian McWhinney Keynote Address Discours d'ouverture Dr Ian McWhinney
09:30 – 10:00	Break and poster viewing Pause et exposition d'affiches
10:00 – 12:15	Sessions / Séances
12:15 – 13:30	Lunch
12:15 – 13:30	Section of Researchers Lunch and Business Meeting Déjeuner et réunion de la Section des chercheurs
12:15 – 13:30	Teachers and Preceptors Knowledge Café and Lunch Déjeuner des enseignants et des superviseurs au *Café du savoir*
13:30 – 14:30	Sessions / Séances
14:30 – 15:00	Break and poster viewing Pause et exposition d'affiches
15:00 – 17:00	Free-standing Paper Presentations / Présentations libres
15:00 – 17:15	Sessions / Séances
16:15 – 17:15	Fireside Chat / Discussion informelle

18:30 – 22:00

Section of Researchers Dinner
Souper de la Section des chercheurs
InterContinental Montreal / L'InterContinental Montréal
Sarah Bernhardt Ballroom / Salle de bal Sarah Bernhardt
Reception: 6:30 p.m. / Réception : 18 h 30
Dinner: 7:00 p.m. / Souper : 19 h

Join us for an evening of networking and celebration as the Section of Researchers honours those who have supported, shaped, and changed the field of family medicine research.

Soyez des nôtres lors d'une soirée de réseautage et de célébration, au cours de laquelle la Section des chercheurs rendra hommage à ceux et celles qui ont approfondi, étendu et transformé le domaine de la recherche en médecine familiale.

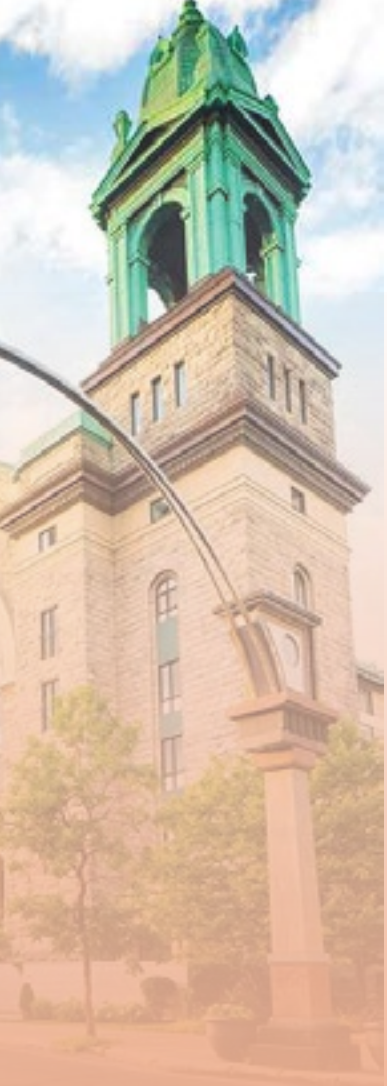
Dr. Gary Bloch

Are we ready for true generalism? Tackling the "social" in biopsychosocial approaches to care

Dr. Gary Bloch will propose a broader approach to generalism that attempts to fill a gap in our efforts to improve patients' health through individual and community interventions. He will describe an approach that focuses on multi-level, practical interventions for individual health providers and their teams that address the social determinants of health.

Sommes-nous prêts pour le vrai généralisme ? Agir sur les éléments « sociaux » dans les approches biopsychosociales des soins

Dr Gary Bloch proposera d'aborder le généralisme dans une optique plus large qui, au moyen d'interventions individuelles et communautaires, vise à pallier une lacune dans nos efforts pour améliorer la santé des patients. Il décrira une approche destinée aux professionnels de la santé et à leurs équipes, axée sur des interventions pratiques à plusieurs niveaux pour aider à agir sur les déterminants sociaux de la santé.



Thursday / Jeudi
November 9 novembre

06:30 – 17:30	Registration open / Ouverture des inscriptions
06:45 – 07:45	Ancillary sessions / Séances auxiliaires
07:00 – 17:00	Exhibit Hall open / Ouverture du Hall d'exposition
07:00 – 08:00	Breakfast and Networking Breakfasts Petit-déjeuner et petits-déjeuners de réseautage
08:00 – 09:30	Keynote Address / Discours d'ouverture
09:30 – 10:00	Break and poster viewing / Pause et exposition d'affiches
10:00 – 12:15	Sessions / Séances
12:15 – 13:30	Lunch
12:15 – 13:30	CFPC Annual Meeting of Members Assemblée annuelle des membres du CMFC
12:30 – 13:30	Ancillary sessions / Séances auxiliaires
13:30 – 14:30	Sessions / Séances
14:30 – 15:00	Break and poster viewing / Pause et exposition d'affiches
15:00 – 17:15	Sessions / Séances
17:00 – 19:00	CQMF Cocktail-Réseautage / QCFP Networking Cocktail Reception
17:30 – 18:30	FMF Welcome Reception / Réception d'accueil au FMF

18:00 – 22:00

Section of Teachers Dinner
Souper de la Section des enseignants
Le Westin Montréal
Montreal Ballroom / Salle de bal Montréal
Reception: 6:30 p.m. / Réception : 18 h 30
Dinner: 7:00 p.m. / Souper : 19 h

Honour educational leaders and the future of family medicine at the Section of Teachers Dinner, a night where we proudly say thank you to those who strive to meet the educational needs of the family medicine community.

Rendez hommage aux chefs de file en éducation et à l'avenir de la médecine familiale lors du Souper de la Section des enseignants. Il s'agit d'une occasion pour nous de remercier chaleureusement ceux et celles qui mettent tout en œuvre pour satisfaire les besoins pédagogiques de la communauté de la médecine familiale.

Dr. Joshua Tepper

Quality: Our fifth pillar
At the end of Dr. Joshua Tepper's keynote address the audience will have a shared definition of quality, understand the overall approach to quality improvement and improvement science, and be inspired to think about system- and practice-level strategies that can be used to create a culture of "quality first" and quality improvement.

La qualité : notre cinquième pilier
À l'issue du discours d'ouverture de Dr Joshua Tepper, l'auditoire aura obtenu une définition commune du concept de qualité, comprendra l'approche globale à l'amélioration de la qualité et au progrès scientifique et souhaitera pousser davantage la réflexion sur des stratégies au niveau du système et de la pratique pouvant servir à développer une culture qui accorde la priorité à la qualité et qui favorise son amélioration.

Friday / Vendredi
November 10 novembre

06:30 – 17:30	Registration open / Ouverture des inscriptions
06:45 – 07:45	Ancillary sessions / Séances auxiliaires
07:00 – 16:00	Exhibit Hall open / Ouverture du Hall d'exposition
07:00 – 08:00	Breakfast and Networking Breakfasts Petit-déjeuner et petits-déjeuners de réseautage
08:00 – 09:30	President's Installation and Keynote Address Installation du président et discours d'ouverture
09:30 – 10:00	Break and poster viewing / Pause et exposition d'affiches
10:00 – 12:15	Sessions / Séances
12:15 – 13:30	Lunch
12:30 – 13:30	Teachers and Preceptors Town Hall Assemblée générale des enseignants et superviseurs
12:30 – 13:30	Ancillary sessions / Séances auxiliaires
12:30 – 13:30	First Five Years in Family Practice Luncheon Déjeuner pour les médecins de famille dans les cinq premières années de pratique Registration required / Inscription requise
13:30 – 14:30	Sessions / Séances
14:30 – 15:00	Break and poster viewing / Pause et exposition d'affiches
15:00 – 17:15	Sessions / Séances

18:00 – 22:30 **CFPC Awards Gala / Gala de remise des prix du CMFC**
Hyatt Regency Montréal
Grand Salon Opera
Reception: 6:00 p.m. / Réception : 18 h
Dinner: 6:45 p.m. / Souper : 18 h 45

Dr. Alain Naud

Medical assistance in dying: A new option for end-of-life care demystified
Dr. Alain Naud is a family physician and family medicine teacher who has been involved in palliative care for 31 years. In his keynote address Dr. Naud will provide an overview of medical assistance in dying, describe how this type of care is integrated into end-of-life care, and discuss how this new area of care can make a difference for patients, their families, and their caregivers.

L'aide médicale à mourir : une nouvelle option de fin de vie et un soin à démystifier
Médecin de famille et enseignant en médecine familiale, Dr Alain Naud offre des soins palliatifs depuis 31 ans. Dans son discours d'ouverture, Dr Naud présentera une vue d'ensemble de l'aide médicale à mourir, décrira la manière dont ce soin s'intègre dans les soins de fin de vie et discutera de ce que ce domaine de soin apporte de nouveau ou de différent aux patients, aux proches et aux soignants.

Welcome to our 2017/18 CFPC President, Dr. Guillaume Charbonneau!

Bienvenue au président du CMFC pour 2017-2018, Dr Guillaume Charbonneau !

Saturday / Samedi
November 11 novembre

06:30 – 15:30	Registration open / Ouverture des inscriptions
07:00 – 13:45	Exhibit Hall open / Ouverture du Hall d'exposition
07:00 – 08:00	Breakfast / Petit-déjeuner
07:00 – 08:00	Canada's Walk With the Docs – Advancing Family Medicine Globally En Marche avec nos médecins – Faisons avancer la médecine familiale au Canada et ailleurs
08:30 – 09:30	Sessions / Séances
09:30 – 10:00	Break / Pause
10:00 – 12:15	Sessions / Séances
12:15 – 13:30	Lunch
12:30 – 13:30	Medical Student and Family Medicine Resident Networking Luncheon Déjeuner de réseautage des étudiants et des résidents en médecine familiale Registration required / Inscription requise
13:30 – 14:30	Sessions / Séances
14:30 – 15:00	Break / Pause
15:00 – 17:15	Sessions / Séances
15:30 – 16:30	FMF Celebration / Célébration du FMF
17:00 – 18:30	Convocation / Collation des grades

19:00 – 22:30 — **Student and Resident Social Evening**
Soirée sociale des étudiants et des résidents
Montreal Forum Sports Bar / Sports Bar du Forum de Montréal
6:45 p.m.: Buses depart from the Palais des congrès de Montréal
18 h 45 : Les autobus quittent le Palais des congrès de Montréal

LACE UP and join us for **Canada's Walk With the Docs – Advancing Family Medicine Globally.**

ENFILEZ VOS CHAUSSURES pour **En Marche avec nos médecins – Faisons avancer la médecine familiale au Canada et ailleurs**.

FMF Celebration and Convocation ceremony
Célébration du FMF et Collation des grades

All delegates and guests are welcome to attend the FMF Celebration and Convocation at the Palais des congrès de Montréal. Enjoy coffee and desserts at the Celebration followed by Convocation, the closing event of FMF at which we acknowledge family physicians who have achieved Certification in the College of Family Physicians and other notable accomplishments.

Tous les délégués et leurs invités sont les bienvenus à la Célébration du FMF et à la Cérémonie de collation des grades. L'événement se tiendra au Palais des congrès de Montréal. Dégustez café et desserts pour célébrer le FMF, puis assistez à l'événement de clôture où nous rendrons hommage aux médecins de famille qui ont obtenu la Certification du Collège des médecins de famille et ont accompli d'autres réalisations.

WEDNESDAY 8 MERCREDI

Family Medicine Innovations in Research and Education Day
Journée sur les innovations en recherche et éducation en médecine familiale

The Family Medicine Innovations in Research and Education Day is a full-day program hosted by the CFPC's Sections of Researchers and Teachers that highlights innovation and achievement in family medicine research and education.

Education sessions
Faculty development sessions will feature both novice and advanced-concept workshops for clinical preceptors, teachers outside the clinical setting, and educational leaders, along with a Teachers & Preceptors Knowledge Café featuring emerging topics.

Attendance to the keynote, education sessions, and research presentations, as well as breakfast, breaks, and lunch are included in your registration fee. There will also be ample opportunity to network with your colleagues.

La Journée sur les innovations en recherche et éducation en médecine familiale est organisée par les Sections des enseignants et des chercheurs du Collège des médecins de famille du Canada (CMFC). Cette activité d'une journée complète porte sur l'innovation et les réalisations dans ces domaines.

Séances de formation
Les séances de formation professorale incluront des ateliers qui portent tant sur des concepts de base que sur des concepts avancés, destinés aux enseignants en contexte clinique, aux enseignants hors du contexte clinique et aux leaders pédagogiques. Également à l'affiche : un Café du savoir où enseignants et superviseurs discuteront de sujets émergents.

Les frais d'inscription incluent le discours d'ouverture, les séances de formation et les présentations sur la recherche, de même que le petit-déjeuner, les collations et le dîner (lunch). Les participants auront également amplement d'occasions de réseauter avec leurs collègues.

W100 **Dr. Ian McWhinney Keynote Address: Are we ready for true generalism? Tackling the "social" in biopsychosocial approaches to care**

08:00–09:30 **Discours d'ouverture Dr Ian McWhinney : Sommes-nous prêts pour le vrai généralisme ? Agir sur les éléments « sociaux » dans les approches biopsychosociales des soins**

Gary Bloch, MD, CCFP, FCFP

ROOM / SALLE : 710AB

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. To outline our understanding of generalism to include a focus on addressing the social determinants of patients' health
2. To discuss practical approaches to, and challenges in, attempting to mitigate the negative impact of the social determinants of health
3. To describe, through examples, the opportunities and challenges for family physician researchers and teachers when focusing on interventions and scholarship into the social determinants of health

Description:
The specialty of family medicine has positioned itself as the only specialty capable of understanding and addressing the health needs of whole patients, their families, and their communities. While we have been very successful in developing a holistic approach to individuals' and families' physical and mental health, we have had a harder time defining our role in addressing the social contexts that have such a large impact on our patients' health.

Building on the work of Ian McWhinney among others, Gary Bloch will propose a broader approach to generalism that attempts to fill this gap in our efforts to improve patients' health through individual and community interventions. He will describe an approach that focuses on multi-level, practical interventions, for individual health providers and their teams into the social determinants of health. This approach will further enable our patients, their communities, and our society, to achieve optimal health. Drawing on

experiences from more than a decade of working on health and its social construction, Gary will share how educators, advocates, and researchers can learn from and draw upon the successes and challenges he and his collaborators have faced in attempting to develop this under-realized realm of family medicine practice.

Objectifs d'apprentissage :

1. Résumer notre définition de généralisme, en portant une attention particulière aux déterminants sociaux de la santé des patients
2. Discuter d'approches pratiques pour tenter de mitiger les effets négatifs des déterminants sociaux de la santé, et des défis connexes
3. Décrire au moyen d'exemples les occasions et les défis que rencontrent les chercheurs et les enseignants en médecine familiale lorsqu'ils se penchent sur les interventions et l'érudition sur les déterminants sociaux de la santé

Description :

La spécialité de médecine familiale s'est positionnée comme la seule spécialité en mesure de comprendre et d'aborder l'ensemble de besoins de santé des patients, de leurs familles, et de leurs communautés. Bien que nos efforts pour développer une approche holistique de la santé physique et mentale des personnes et des familles aient connu du succès, nous avons eu plus de mal à définir notre rôle dans des contextes sociaux qui ont une forte incidence sur la santé de nos patients.

En s'appuyant sur le travail de ses prédécesseurs, notamment d'Ian McWhinney, Gary Bloch proposera d'aborder le généralisme dans une optique plus large qui, au moyen d'interventions individuelles et communautaires, vise à pallier cette lacune dans nos efforts pour améliorer la santé des patients. Il décrira une approche destinée aux professionnels de la santé et à leurs équipes, axée sur des interventions pratiques à plusieurs niveaux pour aider à agir sur les déterminants sociaux de la santé. Cette approche permettra de promouvoir la santé optimale pour nos patients, leurs communautés ainsi que notre société. En s'appuyant sur plus d'une décennie d'expériences dans le domaine de la santé et sa construction sociale, Dr Bloch indiquera comment les éducateurs, les promoteurs des intérêts de la discipline et les chercheurs peuvent tirer parti des succès connus et des défis rencontrés — les leurs ou ceux de leurs collaborateurs — dans l'avancement de ce domaine sous-développé de la pratique de médecine familiale.

W172 TLC for LTC: Providing best care for your long-term care patients (Enhanced Clinical Session)

10:00–11:00 Eric Cadesky, MD CM, CCFP

ROOM / SALLE : 512ABEF

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Highlight the importance of continuous primary care and deprescribing for elderly residents
2. Review the investigation and treatment of urinary tract infections in the elderly
3. Evaluate behavioural and medication options in problem behaviour/dementia

Description:

Family physicians provide the majority of care to the 250,000 residents in Canadian long-term care (LTC) facilities. This interactive, bilingual workshop will help participants review best practices for assessing and treating possible urinary tract infections, behavioural problems of dementia, constipation, and polypharmacy. Come join the conversation with your LTC/residential care colleagues!

W221 A Full Wrist Exam for Your Busy Clinic (Enhanced Clinical Session)

10:00–11:00 Juan A. Garcia-Rodriguez, MD, MSc, CCFP (SEM), FCFP

ROOM / SALLE : 510B

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Develop a sequenced order to examine the wrist
2. Perform the special tests required to support common diagnoses in wrist pathology
3. Describe the relevant anatomy needed to understand wrist pathologies

Description:
In this interactive session participants will be able to review and practise the steps and the techniques needed to perform a comprehensive wrist examination. The examination will be carried out step by step while reviewing th functional tests to determine specific diagnoses. Participants will work in pairs to practise the learned concepts and skills.

W139 **The Delicate Art of Feedback: An evidence-based practical toolbox on providing learner-centred feedback**
10:00–12:15
Parisa Rezaiefar, MD, CCFP, FCFP; Vela Tadic
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 511E

Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Acquire skills related to forming strong coaching relationships
2. Assess a learner's specific needs
3. Develop and implement effective coaching strategies

Description:
Despite more than three decades of work on feedback in medical education and published literature on the importance of feedback during early training, there remains a gap in providing and receiving effective feedback. With the competing pressures of being attentive to learners, addressing work responsibilities, managing interruptions, and completing evaluation tools, it is difficult to have dedicated, thoughtful and intentional conversations with learners. The objective of this workshop is to explore some well-established perceived barriers to feedback (lack of a relationship with the learner, lack of vocabulary, fear of damaging the relationship with learner, lack of time, and lack of a safe environment) and develop strategies to overcome these barriers. Using this interactive workshop, we aim to enhance participants' skills in providing effective feedback in clinical practice using a strength-based feedback framework that focuses on the relationship with the learner. Using real case scenarios, video, role play, and small group discussions, participants will practise the application of context, goal setting, and collaborative approaches to engage the learner. Participants will acquire skills on how to create a safe environment in a busy workplace and provide time-efficient feedback. Participants will learn and implement specific feedback language to foster a trusting relationship, with the goal of improving learners' skills and maintaining their overall wellness.

W173 **The Opioid Epidemic: How emergency physicians can help (Enhanced Clinical Session)**
10:00–12:15
Yelena Chorny, MD, MSc, CCFP, DABAM; John Foote, MD, CCFP (EM); Aaron Orkin, MD, MSc, MPH, CCFP (EM)

ROOM / SALLE : 512CDGH

Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Manage opioid withdrawal and overdose risk with appropriate patient education and pharmacotherapy
2. Assess opioid-related harms
3. Balance patients' acute pain management needs with safer opioid prescribing practices

Description:
Canada is in the midst of an epidemic of opioid use, dependence, and resulting harms, including an increasing rate of deaths due to overdose. Emergency physicians regularly treat patients with opioid-related toxicity, withdrawal, or

related medical/psychiatric complications. They also treat patients with acute pain who may benefit from receiving prescribed opioids on discharge. Emergency physicians, therefore, are in a good position to mitigate some of the harms of the opioid epidemic and help prevent its continuation. This talk will review key interventions that can be provided in the emergency department to meet these goals. The initiation of buprenorphine/naloxone can control symptoms of opioid withdrawal, decrease other opioid use, and facilitate entrance to longer-term addiction treatment. Dispensing of injectable naloxone kits for home use can prevent overdose-related deaths. Conscientious management of acute pain and judicious prescription of opioids on discharge can help limit the misuse and diversion of these drugs. Participants will receive practical education on implementing these interventions. Evidence to support their use will be included and barriers to uptake will be explored.

W174 **Introduction to Office Based Surgical Instruments and Materials (Enhanced Clinical Session)**
10:00–12:15 Fred Janke, MD, MSc, CCFP, FCFP

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Become familar with the names and uses of basic instruments used in office based procedures
2. Understand the principles of suture and needle selection
3. Understand the basic principles of wound closure

Description:
The program will present a basic introduction into surgical instruments including, the naming, basic parts, and functions of basic office based surgical equipment. The differences between the basic uses of instruments, including selection of instrument and of scalpel blades will be addressed in the lecture. The lecture will discuss the different types of cutting, grasping, clamping, retracting and needle holding instruments. The second part of the lecture will focus on the principles of suture and needle selection, and basic principles of wound closure. The differences between absorbable, and non-absorbable sutures, the differences within suture types and the sizes of suture material, will be explored. Similarly the differences between the needle types, cutting, reverse cutting, tapered, traumatic and non traumatic needles will be discussed. The attendee will be given guidance as what factors should be considered when making the selection of material and needle. Finally the lecture will discuss the various suture patterns used in wound closure and the principles of suture placement and knot tying.

W298 **Quality Improvement Basics to Help You Teach Students and Residents**
10:00–12:15 Scott McKay, MD, CCFP (COE), FCFP
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 513CD
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Differentiate between quality improvement, scientific research, and quality assurance
2. Evaluate the completeness of an aim statement in a quality improvement project
3. Identify common challenges students and residents encounter in completing quality improvement projects

Description:
The importance of quality improvement (QI) concepts in health care are affecting both undergraduate and postgraduate curricula. Medical students and family medicine residents are increasingly being required to design, lead, and conduct QI projects. This session is designed for teachers who supervise the completion of these projects. QI basics including defining quality improvement, writing aim statements, developing project measures, using common QI tools, and developing Plan-Do-Study-Act cycles will be discussed. Ideas for generating project topics and guidelines for publication will be reviewed. The session will include case studies of actual student and resident projects to provide the opportunity to apply the concepts discussed.

W321 **Diagnostiquer l'étudiant/le résident en difficulté et faire des prescriptions pédagogiques adaptées**
10:00–12:15
Miriam Lacasse, MD, MSc, CCMF; Marie-Hélène Dufour, MD, CCMF; Johanne Théorêt, MD, MA, FCMF
Tous les enseignants sont les bienvenus.
Cette séance fait le point sur les concepts avancés pour les superviseurs cliniques.

ROOM / SALLE : 513AB
Crédits certifiés Mainpro+ d'apprentissage en groupe = 2

Objectifs d'apprentissage :
1. Identifier les difficultés d'un étudiant/résident pour poser un diagnostic pédagogique précis
2. À partir du répertoire proposé, sélectionner les interventions pertinentes pour aider le résident dans son cheminement
3. Proposer un plan d'appui à la réussite adapté aux difficultés de l'apprenant

Description :
Le plan d'appui à la réussite (plan de remédiation) est un outil qui vise à soutenir les résidents présentant des difficultés en proposant des interventions pour les surmonter. À partir d'une revue systématique de la littérature, nous avons développé un Répertoire de prescriptions pédagogiques visant à alimenter les plans d'appui à la réussite conçus par les cliniciens enseignants et les apprenants. Dans cet atelier, les participants apprendront comment tirer avantage de cet outil. Par la suite, à partir de scénarios d'enseignement, ils seront appelés à identifier les symptômes et signes de difficultés, à poser un diagnostic pédagogique et à sélectionner les interventions pertinentes pour compléter le plan d'appui à la réussite, en vue d'aider l'étudiant ou le résident dans son cheminement.

W396 **Managing Uncertainty in Medical Education and Practice: Teaching how to be a "good enough doctor"**
10:00–12:15
Katherine Larivière, MD, MSc, CCFP; Alison Eyre, MD CM, CCFP FCFP; Tetyana Rogalska, MD, MSc
All teachers welcome. Highlights advanced concepts for clinical preceptors.

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Define uncertainty in the context of science, family medicine, and medical education
2. Apply the "principle of good enough" to medical practice and medical education
3. Learn techniques to leverage the management of uncertainty to increase the resilience of learners and teachers in practice

Description:
In our current competency-based educational environment learners are required to gain a certain set of clinical skills. Often overlooked are the consultation skills required to synthesize history taking and information gathered during the physical exam, and to incorporate this with the broad variety of external factors in a therapeutic plan. Finding effective ways to help our learners manage uncertainty can assist with problems such as time management, selectivity, and early diagnostic closure. By broadening our teaching approaches to address thinking strategies we can broaden their cognitive apprenticeship, support their passage from novice to expert, and increase their confidence levels. In this session we will explore the concepts of diagnostic and therapeutic uncertainty, what it means to be a "good enough doctor," and how to apply this in both didactic and clinical teaching contexts. We will also explore possible effects on resilience during and after residency.

W414 **Teaching Residents to Teach: Developing distributed curricula for family medicine residents**
10:00–12:15
Tim Dubé, PhD; Evelyn Constantin, MD, MSc, FRCPC; Carlos Gomez-Garibello, PhD; Armand Aalamian, MD, CCFP, FCFP
All teachers welcome. Highlights novice concepts for educational leaders.

ROOM / SALLE : 511F

Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Describe distributed learning strategies used to teach family medicine residents how to become effective teachers
2. Discuss the drawbacks and possibilities with technology-enhanced learning
3. Apply practical strategies to develop curricula for teaching family medicine residents how to teach

Description:

Family medicine residents have important roles to play as both role models for and teachers of medical students, resident peers, and other health care professionals. Developing the knowledge and skills necessary to become an effective teacher also helps fulfill some of the requirements of the CanMEDS-FM competency framework, particularly the Scholar role. Although residents are expected to teach, only a few might have had any formal training on how to teach effectively. Residents often voice the need for some instructional approaches, particularly regarding their readiness for clinical teaching. Educational leaders must ensure there is a curriculum available to teach residents how to teach and provide them with opportunities to develop their teaching skills. Residents should also receive formal assessment of their clinical teaching to facilitate their achievement of the relevant competencies. There is no one-size-fits-all educational approach to teaching family medicine residents how to teach. The use of interactive instructional strategies such as distributed online modules should emphasize for residents the key concepts they need in their roles as teachers. This workshop will highlight how distributed educational strategies can bring new ideas to an old topic. Moreover, the educational principles used in developing curricula for teaching residents to teach can be used to address educational needs in designing curricula for other CanMEDS-FM roles. Participants are encouraged to bring questions and perspectives from their own work. Organization and method of presentation: Introduction (15 minutes); interactive practical application (75 minutes); and large group discussion and wrap-up (30 minutes). Target audience: Beginner and intermediate clinical teachers, program directors, residents, and others who are planning to develop, or are implementing, a curriculum to support family medicine residents in their role as teachers.

W480 **Adolescents and Adults with ASD: Ensuring access, managing common conditions, supporting transitions (Enhanced Clinical Session)**
10:00–12:15
Liz Grier, MD, CCFP; Diane Munz, MD, FRCPC, Pediatrician; Samantha Sacks, MD, CCFP

ROOM / SALLE : 510C

Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Describe anticipatory primary care, as well as accessible, patient-centred medical homes for transitional-age youth and adults with autism spectrum disorder (ASD)
2. Anticipate and manage common genetic, gastrointestinal, neurological, mental health, and women's health issues in ASD
3. Describe the family physician, caregiver, and patient roles in supporting transition from pediatric to adult health care

Description:

Autism spectrum disorders (ASD) are an important condition to recognize and manage in family practice, with prevalence reports as high as 1:160 individuals having this diagnosis. This session will review management of common physical comorbidities such as genetic conditions, developmental feeding disorder, gastroenterology issues, mental health issues, and epilepsy. Particular attention will be placed on women's health issues for individuals with ASD. Participants will be introduced to a new tool for anticipatory care for adult patients with ASD designed specifically for primary care providers as well as a helpful tools and processes for supporting transition from pediatric to adult health care. Preliminary research evidence on the use of coordinated care plans to support transition from children's treatment centres to the primary care medical home will be reviewed.

W521 **Tools for Teachers: The fundamental teaching activities resource repository**
10:00–12:15
Sudha Koppula, MD, MClSc, CCFP, FCFP; Viola Antao; Miriam Boillat; Vina Broderick; Paul Miron; Linda Snell; Marie-Claude Vanier; Allyn Walsh ; Cheri Bethune, MD, MClSc, CCFP, FCFP

All teachers welcome. Highlights advanced concepts for clinical preceptors.
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Understand the need for, and purpose of, a national repository of resources for family medicine teachers
2. Apply tools from the current faculty development resource repository
3. Discover additional tools that are useful in developing teaching competencies

Description:

The CFPC Section of Teachers' Faculty Development Education Committee has developed an online password-free repository of teaching tools resources to accompany the Fundamental Teaching Activities Framework. This interactive session is meant for teachers at all levels of experience working in diverse family medicine contexts. The session will begin with a plenary discussion on the utility of a national repository of resources for family physician teachers with participants using their own teaching experiences. The current online repository as it exists on the CFPC website will be presented, and participants will try using it to develop approaches to common teaching scenarios. Potential barriers to its use, and strategies to overcome them, will be discussed. Finally, participants will be invited to identify additional tools and resources that could be added to the repository by the committee.

W528 **CanMEDS-FM 2017 – Applying and using the Competency Framework across the continuum of learning**

10:00–12:15

Elizabeth Shaw, MD, CCFP, FCFP; CanMEDS-FM Review Working Group
All teachers welcome. Highlights advanced concepts for clinical preceptors.
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Validate the intended and potential uses of the CanMEDS-FM 2017 Competency Framework in various learning and practice contexts
2. Identify and assess the potential impact of the CanMEDS-FM 2017 Competency Framework on various roles of a family physician and on education across the continuum
3. Develop strategies for the dissemination and implementation of the CanMEDS-FM 2017 Framework within competency-based medical education and practice

Description:

At FMF 2016, participants had the opportunity to understand and provide feedback on the proposed changes to the CanMEDS-FM Competency Framework. In this year's interactive session, participants will learn how to use, and share strategies for using, CanMEDS-FM 2017 for its intended purpose and potential. The CanMEDS-FM 2017 Competency Framework has specifically been designed for family physicians, articulating a comprehensive definition of the abilities needed throughout the training and practice lifetime. It can be applied across the entire continuum of learning, from undergraduate through to continuing professional development. This workshop will explore the application of the framework to the various roles of a family physician—learner, teacher, practitioner, administrator, and leader. Based on multi-source feedback received over the past year, the framework has undergone significant revisions. A didactic presentation will describe the final framework, highlighting the Family Medicine Expert Role and the most significant changes from the original CanMEDS-FM Framework, and the intended and potential uses of the CanMEDS-FM Framework. The workshop will focus on small group discussion, providing further consultation and exploration of the use of the framework and its impact on the various roles of the family physician. In addition, suggestions for dissemination across the educational continuum, and overcoming any identified barriers to implementation with be discussed. Feedback from the workshop will assist the CanMEDS-FM Working Group in its communication and knowledge translation.

W532 **Foundations of Assessment in Residency Training**
10:00–12:15 Cheri Bethune, MD, MClSc, CCFP, FCFP; Theresa Van der Goes, MD, CCFP; Shelley Ross, PhD; Allyn Walsh, MD, FCFP
All teachers welcome. Highlights advanced concepts for educational leaders.
La séance sera présentée en anglais mais des animateurs francophones seront présents.

ROOM / SALLE : 516A
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe and explain the principles of assessment
2. Choose assessment tools and strategies that align with the purpose of assessment
3. Describe and explain educational leadership strategies to help address assessment challenges in your own program

Description:
Assessing learners is one of the greatest challenges for clinical preceptors. The difficulties arise due to the lack of understanding of the assessment role in both accelerating learning (coaching and feedback) and in ensuring that learners focus on those skills they have not yet mastered. The crux of assessment is the learner-teacher relationship whereby expert family physicians help learners achieve competence. The preceptor is the most important and effective assessment tool in authentic work-based learning. This course will use interactive plenaries and small group discussions to provide the fundamental theoretical concepts in assessment, enhance participants' understanding of the various tools for effective assessment, and facilitate the appropriate choice of tools depending on the assessment tasks. This course is designed specifically for those new to assessment and have educational leadership responsibilities to engage preceptors in effective assessment. This includes addressing and overcoming those barriers (both personal and institutional) to reliable assessment.

Presentations by the recipients of research awards • Présentations des récipiendaires des prix de recherche

W188 **Presentation by the recipients of the Research Awards for Family Medicine Residents - 1**
10:00–10:15 **Présentation par les récipiendaires du Prix de recherche pour les résidents en médecine familiale - 1**
Antepartum Vitamin D Levels as a Marker for Risk of Postpartum Depression: A systematic review of the literature
Ciaran McLoughlin, MD

ROOM / SALLE : 710AB
Mainpro+ Group Learning certified credits = 2

Background: Thirty-two percent of Canadians are vitamin D insufficient. This figure is particularly high in those of childbearing age, and pregnant women tend to be relatively vitamin D insufficient during the first trimester. Low levels of vitamin D have been linked with higher levels of depression, and vitamin D supplementation may have a therapeutic effect on depressive symptoms. **Research question(s):** We sought to answer the hypothesis that low levels of vitamin D in women in the antepartum period are associated with postpartum depression, and in doing so to assess the value of vitamin D screening in pregnancy and the value of supplementing vitamin D to prevent postpartum depression. **Methods/Methodology:** Systematic review of the literature yielded four cohort studies, of which three were fully published; two randomize controlled trials; and one case-control study. **Results:** Of the six fully published papers, three gave statistically significant results in favour of a link between vitamin D deficiency in pregnancy and postpartum depression. Analysis of vitamin D supplementation was possible in two papers, both of which demonstrated a statistically significant reduction in postpartum depressive scores in patients who received supplements of at least 1,200 IU daily. **Discussion:** Due to heterogeneity between the studies, a meta-analysis was not obtained. The studies were not representative of a typical cross-section of Canadian pregnant women in terms of demographics, but similar in terms of vitamin D exposure at baseline. Overall, the risk of bias in the studies was low. **Conclusions:** The balance of evidence neither supports nor refutes the initial hypothesis. There is some evidence that supplementation of vitamin D is protective against later development of postpartum depression. **Recommendations:** Further research is required to establish the presence and nature of the association between vitamin D deficiency and postpartum depression. Further experimental studies are required to reproduce the preventative effect of vitamin D supplementation in pregnancy.

W189 **Presentation by the recipients of the Research Awards for Family Medicine Residents - 2**
10:15–10:30 **Présentation par les récipiendaires du Prix de recherche pour les résidents en médecine familiale - 2**

Seasonality of Ankle Swelling: Population Symptom Reporting Using Google Trends

Fangwei Liu, MD; G. Michael Allan, MD, CCFP, FCFP; Christina Korownyk, MD, CCFP; Michael Kolber, MD, CCFP, FCFP; MSc; Nigel Flook, MD, CCFP COE, FCFP; Harvey Sternberg, MD, CCFP, FCFP; Scott Garrison, MD, CCFP, PhD

ROOM / SALLE : 710AB

Context: In our experience as primary care physicians, complaints of ankle swelling are more common in the summer, often patients with no obvious cardiovascular disease and do not go on to develop such disease. To our knowledge, this trend has never been reported in the literature. **Objective:** To determine if there is any seasonal pattern in the prevalence of ankle swelling. **Design:** Using the Google Trends search engine, we obtained data on search volume related to ankle swelling and similar terms from the United States between January 4, 2004 and August 16, 2015. We plotted the data as a time series and performed regressions with a seasonal model and a straight-line model (null hypothesis). We used a sum-of-squares F test to assess for statistically significant different in fit between the models. **Results:** The seasonal model was a significantly better fit than the straight-line model ($p < 0.0001$). Seasonality explained 85% of the variability in search volume ($R2 = 0.85$). Peak searches occurred in mid-June (mid-summer) and troughs occurred in mid-December (mid-winter). Conclusions: Internet searches for ankle swelling and related terms are highly seasonal, with interest peaking in mid-summer.

W187 **Presentation by the recipients of the *CFP* Best Original Research Article**
10:30–11:00 **Présentation par les récipiendaires du Prix du *MFC* pour le meilleur article de recherche originale**

Potential effects of rational prescribing on national health care spending: More than half a billion dollars in annual savings

Jordan Littman, MD, CCFP; Roland Halil, ACPR PharmD

ROOM / SALLE : 710AB

Objective: To estimate the cost savings that could result from implementation of a rational prescribing model for drug classes that are equivalent in terms of efficacy, toxicity, and convenience. **Design:** The top 10 drug classes based on annual spending were gathered from the Canadian Institute for Health Information. They were reviewed for potential inclusion in the study based on the ability to compare intraclass medications. When equivalence in efficacy, toxicity, and convenience was determined from a literature review, annual prescribing data were gathered from the National Prescription Drug Utilization Information Systems Database. The potential cost savings were then calculated by comparing current market shares with potential future market shares. **Setting:** Canada. Main outcome measures: Estimated differences in spending produced by a rational prescribing model. **Results:** Statins, proton pump inhibitors, angiotensin-converting enzyme inhibitors, and selective serotonin reuptake inhibitors were determined to have class equivalence for efficacy, toxicity, and convenience. Total current annual spending on these classes is $856 million through public drug programs, and an estimated $1.97 billion nationally. Through rational prescribing, annual savings could reach $222 million for public drug programs, and $521 million nationally. Conclusion: Most of the potential savings are derived from deprescribing the newest patent-protected medications in each class. Avoiding prescribing the newest intraclass drug, particularly in the absence of research to support its superiority in relevant clinical outcomes, could lead to considerable savings in health care expenditures and might push the pharmaceutical industry to innovate rather than imitate.
Can Fam Physician 2016; 62:235-44

W186 **Presentation by the recipient of the CFPC Outstanding Family Medicine Research Article**
11:00–11:30 **Présentation par le récipiendaire du Prix du CMFC pour un article exceptionnel de recherche en médecine familiale**

Building a Foundation to Reduce Health Inequities: Routine collection of sociodemographic data in primary care

Andrew D. Pinto, MD, CCFP, MSc; Gabriela Glattstein-Young, MD, MPH;

Anthony Mohamed, MES; Gary Bloch, MD, CCFP; Fok-Han Leung, MD, CCFP; Richard H. Glazier, MD, CCFP, MPH

ROOM / SALLE : 710AB

Introduction: Detailed data on social determinants of health can facilitate the identification of inequities in access to health care. We report on a sociodemographic data collection tool used in a family medicine clinic. **Methods:** Four major health organizations in Toronto collaborated to identify a set of 14 questions that covered a range of social determinants of health. These were translated into 13 languages. This survey was self-administered using an electronic tablet to a convenience sample of 407 patients in the waiting room of a primary care clinic. Data were uploaded directly to the electronic medical record. **Results:** The rate of valid responses provided for each question was high, ranging from 84% to 100%. The questions with the highest number of patients selecting "do not know" and "prefer not to answer" pertained to disabilities and income. Patients reported finding the process acceptable. In subsequent implementation across 5 clinics, 10,536 patients have been surveyed; only 724 (6.9%) declined to participate. **Conclusion:** Collecting data on social determinants of health through a self-administered survey, and linking them to a patient's chart, is feasible and acceptable. A modified survey is now administered to all patients. Such data are now being used to identify health inequities, develop novel interventions and evaluate their impact on health outcomes. JAM Board Fam Med 2016; 348-355

W190 **Presentation by the 2017 Family Medicine Researcher of the Year**
11:30–12:10 **Présentation par le récipiendaire du Prix du chercheur de l'année en médecine familiale pour 2017**
Information Outcomes: primary care clinicians' and patients' views
Pierre Pluye MD PhD

ROOM / SALLE : 710AB

Introduction: For clinicians and patients, the Internet constitutes a common source of information. However, no research has systematically examined health information outcomes, specifically how information is valuable from the users' perspective. This presentation will outline few key aspects and results of a 15-year research program on information outcomes in a primary care context. **Methodologies and methods:** This program is based on a theoretical model and the Information Assessment Method (IAM) that were developed and validated by our research group (integrating information studies and health sciences). We commonly use participatory research in partnership with governmental, professional and philanthropic organizations (synergy with existing interventions). Considering the complexity of human information interactions, we usually conduct systematic mixed studies reviews and mixed methods research. **Results:** The program includes studies with/for clinicians (information retrieval and delivery) and studies with/for patients. First, results of observational studies may encourage family physicians to search information more often. For example, they suggest the number of patients for whom medical information has to be retrieved by family physicians in order for one patient to benefit might be 14 (Number Needed to Benefit from Information: NNBI). Second, more than 15,000 Canadian pharmacists and physicians use the IAM to rate and comment educational emails (reflective learning activity), and earn continuing education credits. In turn, their feedback comments can contribute to improve informational content (two-way knowledge translation). Third, our results suggest easy-to-read credible information assisted with audio-ebook technology might benefit to patients with a low level of health literacy (60% of Canadian adults). **Conclusion:** Implications of these results will be outlined. Future projects are aimed to (i) provide family physicians at the point-of-care with the therapeutic recommendation that she/he has identified with IAM as beneficial for improving her/his practice, (ii) better detect clinically important drug interactions in the population aged 18-64 years, and (iii) assess a Patient Information Aid (PIA1) that might help patients to use information with professionals and prevent negative outcomes.

W287 **Canadian Armed Forces as a Patient's Medical Home Model for Occupational Medicine (Enhanced Clinical Session)**
11:15–12:15 Marc Bilodeau, MD, CCFP (EM), CCPE; Serge Blier, MD, MPH, CCFP, FCFP

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Demonstrate how the Canadian Armed Forces' primary health care delivery model aligns with the Patient's Medical Home pillars
2. Explain how useful the Patient's Medical Home model is in managing common occupational medicine issues
3. Identify areas for future development of the Patient's Medical Home concept in support of occupational medicine

Description:

The CFPC presented the Patient's Medical Home (PMH) vision in 2011 to provide a framework for the future of family practice in Canada. The goal of this initiative is for every family practice in each community across Canada to be able to offer comprehensive, coordinated, and continuing care to their populations through family physicians working with health care teams. Teams may involve, physically or virtually, several allied health care providers and specialists, depending on the needs of the patient community. The PMH is where patients can present and discuss their personal and family health concerns and receive a full spectrum of care. Relationships between patients and family physicians and other health care professionals are developed and strengthened over time, enabling the best possible health outcomes for each person, the practice population, and the community being served. In 2004 the Canadian Armed Forces (CAF) Health Services implemented a care delivery model in its Canada-wide network of primary care clinics. The presenters will demonstrate that this model aligns very well with the pillars of the PMH. Barriers to implementing such a model in the CAF will also be shared. This interactive session will explore the usefulness of the PMH model in the context of managing occupational medicine issues, particularly in challenging scenarios, and will be aimed at sharing best practices in addressing these challenges. Areas for future development will also be proposed for discussion by and feedback from participants. Participants will be invited to share their experiences and contribute to the discussion and possibly inform the future developments of the Patient's Medical Home concept in support of occupational medicine in an environment such as the CAF.

W464 Choosing Wisely in Long Term Care (Enhanced Clinical Session)

11:15–16:00 Andrea Moser, MD, MSc, CCFP (COE), FCFP; Jobin Varughese, MD, CCFP (COE), CMD, FAAFP

ROOM / SALLE : 512ABEF

Mainpro+ Group Learning certified credits = 3

Learning objectives:

1. Explore approaches to initiation of early palliative care in long-term care practice
2. Describe appropriate screening practices in long-term care practice
3. Apply practising wisely principles to practice in long-term care

Description:

This workshop will focus on the principles of practising wisely in long-term care (LTC). Care for individuals in LTC is becoming increasingly complex as patients are being admitted later in life and with more comorbidities. Prevalence of dementia in this clinical population is upwards of 70 per cent and, increasingly, people are admitted with a shortened life expectancy. It is estimated that average length of stay for new admissions to LTC is close to 18 months with a wide variation across this spectrum. That being said, residents and families are often unaware of this and far too often discussions about prognosis and clinical expectations have not been had. The workshop will start with an exploration of attitudes and awareness of the benefits of initiating of conversations about end-of-life care. Materials from Pallium Learning Essentials for Applied Palliative Care (LEAP) LTC focus on early adoption of a palliative approach to care. Case scenarios that focus on communicating with residents and families will be used to facilitate interactive discussions highlighting key issues challenging our approach to LTC. The second part of this workshop will focus on discussions around appropriate prescribing and use of investigations in the LTC setting. This will build upon the newly released Choosing Wisely Canada LTC recommendations developed by the Long Term Care Medical Directors Association of Canada, as well as recommendations and adaptation of materials developed for the popular workshops of Practising Wisely. We will present this in a case-based format to stimulate interactive discussion and practical challenges faced by clinicians in this setting. We hope to have education on a national stage by introducing this workshop at FMF, as LTC practices are not standard amongst the provinces.

12:15–13:30 **Teachers and Preceptors Knowledge Café and Lunch**
Déjeuner des enseignants et des superviseurs au Café du savoir

ROOM / SALLE : 517a

Join us for lunch at the Teachers and Preceptors Knowledge Café, where you'll have a chance to discuss emerging hot topics and network with colleagues at facilitated tables.

Partagez le repas du midi avec vos collègues enseignants et superviseurs dans le cadre du Café du savoir. Vous aurez l'occasion de participer à des discussions animées sur des sujets de l'heure et de réseauter avec vos collègues.

12:15–13:30 **Section of Researchers Lunch and Business Meeting**
Dîner et réunion de la Section des chercheurs

ROOM / SALLE : 710AB

W191 **Distinguished Papers**
13:30–14:30

ROOM / SALLE : 710AB

W618 **Documentation of Chaperone Use: What are family physicians doing and why?**
13:30-13:45 **(Distinguished papers continued)**
Maeve O'Beirne, MD, CCFP, FCFP, PhD; Juli Finlay, PhD; Sonya Lee, MD, CCFP, FCFP, MHSc

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:
1. Describe differences between physicians in the documentation of chaperone use
2. Describe how regulatory college guidance documents influence the use of chaperones by family physicians

Background: In Alberta, recommendations set out by the provincial regulatory college state that when a chaperone is used this should be documented in the patient's medical record. How family physicians are applying this guidance in their daily practice is unknown. **Objective:** To examine whether and how family physicians are documenting the use of chaperones, how aware family physicians are of provincial recommendations regarding chaperone use, and how provincial guidance influences family physicians' decisions on chaperone use. **Design:** Mixed methods design. Data on documentation practices and awareness of provincial recommendations were collected by cross-sectional survey, with analysis using SPSS statistical software. Data on influencing factors were collected through individual interviews that underwent thematic analysis by constant comparison method. **Participants:** Survey participants included 438 family physicians in Calgary. Interview participants included 17 family physicians in three academic, community-based Calgary teaching clinics. **Results:** There were 353 surveys used for analysis (30 per cent response rate) and 17 individual interviews were completed. Survey results showed that 67 per cent of respondents never/rarely documented the offer of a chaperone, and the majority of physicians never/rarely documented whether a chaperone was used. Gender differences were noted, with male physicians being more likely to document chaperone use ($P < 0.001$). Interview findings suggested physician reasoning around documentation was variable and included individual physician standard of practice, anticipation of concern, patient choice, and other patient factors. Survey results demonstrated that only 25 per cent of respondents were aware of provincial recommendations. This was supported by interview findings, which also showed that while many did not use the recommendations in determining chaperone use, others used them as a way to counsel patients that a chaperone was required. **Conclusion:** Documentation of chaperone use and application of provincial guidance are variable. Most physicians do not document chaperone use and physician gender may affect documentation practices.

W742 **The Normative Definition of Comprehensive Practice Across Three Generations of Alumni of**
13:45-14:00 **One Family Practice Program (Distinguished papers continued)**
Tom Freeman, MD, MClinSci, CCFP, FCFP; Leslie Boisvert, MA; Eric Wong, MD, MClinSci, FCFP; Stephen Wetmore, MD, MClinSci, CCFP, FCFP

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Compare the self-reported practice activities of three generations of graduates of one family medicine program

Objective: To determine the range of services and procedures offered by family physicians who define themselves as comprehensive practitioners and compare their responses across three generations of alumni of one family practice program. **Design:** Cross-sectional survey. **Setting:** One family medicine program in the province of Ontario. **Participants:** All graduates of one family medicine program between 1985 and 2012. **Main outcome measures:** Self-reported provision of care in office, care in-hospital, intrapartum obstetrics, house calls, palliative care, after hours care, nursing home care, minor surgery, emergency room, sport medicine, walk-in care. In addition, gender, training stream (urban or rural), size of community of practice, practice model, and satisfaction with practice were considered. **Results:** Participants practised in eight provinces across Canada, but principally in Ontario. A small number were located in the United States. There was a decline in the number of services across three generations of graduates, with newer graduates providing fewer services than the older graduates. Significant declines across the three groups were observed in the provision of house calls, palliative care, and nursing home care. Non-significant changes were seen in the provision of intrapartum obstetrics across the three alumni groups with an initial decline then an increase in reported activity. The average number of types of procedures offered declined from the oldest to the newest graduates. Most respondents were in a patient-enrolment practice model and those in such models reported offering significantly more services than those in either fee for service, Family Health Group, or salary models **Conclusion:** The normative definition of comprehensive care varies across three generations of graduates of this family medicine program, with newer physicians reporting fewer overall services and procedures than older graduates. A greater understanding of the forces that determine the meaning of comprehensive primary care is necessary if this foundational element of family medicine is to be preserved.

W819 **Adherence to Choosing Wisely Recommendations Within Primary Care**
14:00-14:15 **(Distinguished papers continued)**
Alexander Singer*, MB BAO BCh, CCFP; Leanne Kosowan, MSc; Lisa Lix, MSc, PhD, P.Stat; Kheria Jolin, MSc, MD, CCFP; Alan Katz, MBChB, MSc, CCFP, FCFP

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify and define Choosing Wisely Recommendations applicable to primary care
2. Recognize factors associated with adherence to the Choosing Wisely recommendations
3. Review an approach to evaluate adherence to the Choosing Wisely recommendations in primary care settings

Objective: To assess factors associated with adherence to four Choosing Wisely (CW) recommendations during patient encounters with a primary care clinician. **Design:** We conducted a retrospective review of electronic medical record data from the Manitoba Primary Care Research Network (MaPCReN). **Setting:** Data from 239 clinicians in 46 clinics representing 162,728 patients. **Population:** All patients with at least one encounter (2014 to 2016) from a participating MaPCReN primary care clinician. Data relating to the following CW recommendations: a) prescription of antibiotics for viral infections; b) prescription of antipsychotics in patients with dementia; c) vitamin D–level testing, or d) prostate-specific antigen (PSA) test. **Main outcome measures:** Adherence to each of the four CW recommendations. **Methods:** Descriptive statistics and multivariable logic models with generalized estimating equations assessed adherence to the CW recommendations and association with patient, provider, and practice characteristics. Odds ratios (ORs) and 95% confidence intervals (95% CIs) were reported. **Results:** There were 164,195 primary care encounters related to one of the four CW recommendations evaluated. Overall, 15.6 per cent (n = 25,629) of the encounters did not adhere to one of the investigated CW recommendations. The most common non-adherent CW encounter related to an antibiotic prescription for viral infection (65.4 per cent). The

remainder related to PSA screening (28.7 per cent), vitamin D tests (9 per cent), and antipsychotic prescriptions for patients diagnosed with dementia (0.7 per cent). Female patients had an increased odds of an encounter with an antibiotic prescription for viral infections (OR 1.18, 95% CI 1.1 to 1.3) or vitamin D test (OR 1.5, 95%CI 1.3 to 1.9). Salaried physicians, older patients, patients with more frequent office visits, and patients residing in rural areas had increased odds of non-adherence. **Conclusions:** There are patient-, provider-, and practice-related factors that affect adherence to CW recommendations. Understanding factors associated with adherence is essential to designing strategies to reduce unnecessary investigations and treatments.

W662 Experiences With Medical Assistance in Dying (MAID): Patient and loved ones' perspectives (Distinguished papers continued)

14:15-14:30

Ellen Wiebe*, MD, CCFP, FCFP; Jessica Shaw, MSW, PhD; Amelia Nuhn, MD; Sheila Holmes, MD

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Describe to patients what their experience with medical assistance in dying might be like
2. Describe to patients' loved ones what their experiences with medical assistance in dying might be like

Context: Canada passed its medical assistance in dying (MAID) law on June 17, 2016. **Objective:** To explore the experiences and perspectives of Canadians who requested and were eligible for MAID as well as the experiences of people supporting them. **Methods:** This was a qualitative study using semi-structured interviews and thematic analysis. Patients who had a consultation about MAID in a clinic in British Columbia and were found eligible were recruited for the study. Semi-structured interviews were conducted by two family practice residents with patients and the patients' support people to explore the wishes, fears, beliefs, and experiences as they pursued, prepared for, and in some cases reflected on MAID. Basic demographics were recorded for context. **Results:** Twenty-three patient experiences were explored in interviews with 11 patients and 18 support people. Most patients had a malignancy, neurological disorder, or organ failure. The major reason for requesting assisted death was a self-perceived unacceptable quality of life, most commonly due to the loss of autonomy, independence, physical function, and ability to communicate. Some patients expressed fear of future suffering and future disability. The support people included spouses, sons, daughters, and friends. All supported their loved one's decisions, although some were initially opposed and some found it very hard. All 11 support people who were interviewed after the MAID death said the death was peaceful. They valued that they could be present, prepared, and able to say some final words. **Discussion:** The reasons patients in our study requested assisted death were similar to the findings in other countries, namely loss of autonomy and the ability to do the things they enjoyed. Their loved ones supported their decisions and valued the chance to be prepared and present.

W307 Alcohol Withdrawal in the Emergency Department: Evidence-based assesment and treament (Enhanced Clinical Session)

13:30–14:30

John Foote, MD, CCFP (EM)

ROOM / SALLE :512CDGH

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Learn to assess the severity of alcohol withdrawal
2. Learn best practices for the medical management of alcohol withdrawal in the emergency department
3. Learn how and when to discharge patients in alcohol withdrawal safely

Description:

Alcohol withdrawal is a common and potentially life-threatening condition encountered in emergency departments across the country. There is a high degree of variability in the assessment and treatment of such patients. During this seminar participants will learn the current best practices involved in the safe assessment, treatment, and discharge of this vulnerable population. The treatment protocols discussed will stress a simple, non-invasive approach that can be used for the majority of patients in most emergency department settings.

W389 **Supporting Family Medicine Resident Research: How to facilitate high-quality, feasible, successful projects**
13:30–14:30
Braden O'Neill, MD, DPhil; Kim Lazare, MD, CCFP; Allyson Merbaum, MD, CCFP
All teachers welcome. Highlights novice concepts for educational leaders.

ROOM / SALLE : 516A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand feasibility in resident research and identify common pitfalls impeding the success of research projects
2. Appraise a resident research proposal for scientific rigour and originality
3. Develop a comprehensive plan to support a family medicine resident in completing a research project

Description:
Many Canadian family medicine residency programs require the completion of a scholarly project. In some programs this takes the form of a research project. Designing and completing a high-quality research project can be challenging in the course of a residency program. Time constraints and the process of learning research methods and study design are barriers in the context of busy clinical training programs. One of the most significant barriers residents encounter is the Research Ethics Board (REB) application process, which can be difficult particularly for those without prior research experience. Our team of family physicians at North York General Hospital, an academic community hospital in Toronto, Ontario, has instituted various initiatives and processes to support residents in doing research. We use the Feasible, Interesting, Novel, Ethical, and Relevant (FINER) framework when working with residents to develop and carry out projects. Our process for assisting residents in completing projects includes staff physician review, resident peer review, and deliberate engagement with the local REB to facilitate successful, expeditious reviews. We support residents in planning for a presentation or publication, rather than merely the completion of a rote requirement of the residency program. Our strategies have been successful and well received by residents and we think they are of value to the greater academic family medicine community. This session will provide family physicians in both academic and community settings involved with supporting resident research projects with practical strategies for success. Building on what we have learned we will discuss suggestions and tips for incorporating them into your setting for this purpose.

W392 **The Coaching Model: A novel approach for clinical teachers**
13:30–14:30
Jonel Miklea, MD, CCFP, FCFP; April Kam, MD, MScPH, FRCPC (PEM)
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Become familiar with the coaching model as it applies to the family medicine clinical preceptor
2. Learn how coaching techniques can be incorporated in the evaluation portfolio of our learners
3. Experiment with coaching tools to identify learner goals, including the Priority Wheel and the GROW model

Description:
Have you ever had the experience of working with a really good sports coach or music teacher? If so, you will probably remember how amazing it felt to have someone working with you to help you achieve at a level that was just not possible for you to do on your own. Research suggests that learning medicine is no different. We all know that a good coach needs to observe your performance in order to help, but that does not occur often enough in medicine. As medical education moves toward a more competency-based structure, direct observation, feedback, and the facilitation of deliberate practice are becoming essential teaching competencies for faculty and learners. The Doctor as Coach framework intentionally supports the implementation of contemporary concepts in medical education. Through this workshop attendees will learn practical techniques from the coaching model to apply to the learner in the family medicine setting. You will get a better understanding of how coaching can be applied to teaching and be able to apply the coaching tools in a hands-on manner to identify learners' goals and provide meaningful evaluations.

W495 **An Online Tool for Programmatic Assessment in Competency-Based Education: Presenting eCBAS 2.1**
13:30–14:30 Shelley Ross, PhD; Paul Humphries, MD, CCFP, FCFP; Shirley Schipper, MD, CCFP; Mirella Chiodo
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 511E
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the elements needed for managing the data associated with competency-based assessment
2. List advantages and disadvantages of paper versus online systems for competency-based assessment
3. Evaluate using a system like eCBAS 2.1 in your own program

Description:
Competency-based medical education became an undeniable fact of curriculum and assessment in family medicine residency programs across Canada in 2013, when the College of Family Physicians of Canada implemented the Triple C Competency-Based Curriculum. While individual programs across Canada have approached competency-based medical education in different ways, there have been some common challenges for many programs. One of those challenges has been how best to assess and track competence. The Working Group on Certification has provided guidance in the form of the Continuous Reflective Assessment for Training document. Individual programs have had to decide which actual tools and processes to use for assessment. Some programs have workable systems, but many are still struggling with how and what to do for competency-based assessment. Our program addressed the challenge of managing assessment information by developing an electronic portfolio, called the Electronic Competency-Based Achievement System (eCBAS). Regularly evaluating and monitoring eCBAS has proven to be an integral part of our change management strategy, allowing us to learn within the system, evolve, and continuously improve. In this session, we present the newest version, eCBAS 2.1, an online system for collecting and managing data generated during programmatic assessment. We will share evaluation data about the system. A system demonstration will be followed by the opportunity for participants to practise, using some of the tools in eCBAS. Table and group discussions will address issues of assessment centred around two case studies about residents—one progressing well and one encountering difficulty. This primarily interactive workshop is excellent for anyone with questions about how to implement workable competency-based assessment, and those who are already carrying out competency-based assessment and would like to share their experiences—positive and negative—with others.

W499 **Tales From the Program Director's Office: The learner in difficulty**
13:30–14:30 Daniel Grushka, MD, CCFP (EM); Jamie Wickett, MD, CCFP
All teachers welcome. Highlights novice concepts for educational leaders.

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe how to identify a learner in difficulty and the range of problems this term encompasses
2. Describe how to deal with these resident learning issues including the institution of learning, remediation, and probation plans
3. Understand the processes involved from remediation to appeal, and recognize the inherent challenges in finding solutions that work

Description:
As program directors, we are sometimes faced with supporting residents in difficulty. Having a robust tracking system to identify residents in trouble early is key. Following identification, proper procedures should take place to assist the resident and protect the program's interests as well. Designing an adequate learning program as well as remediation and probation plans are often challenging but should be done using an evidence-based rubric with input from multiple sources including the learner. Understanding the resident's and program's rights and responsibilities is of prime importance when navigating these murky waters. We will discuss the definition of a problem learner, the confounding issues in making this definition, and potential strategies that can be used to assist these learners in need. We will also present a tracking system and administrative structure that help identify

residents in distress, as well as discuss how to design adequate learning, remediation, and probation plans. Strong ties with the postgraduate medical education office helps in these situations, and having a working knowledge of the appeal process can help you design the plans. We will then present case scenarios that will be discussed in a workshop-based format.

W500 **Competency-Based Assessment for Family Medicine Enhanced Skills Programs**

13:30 –14:30 Connie Lebrun, MD CM, MPE, CCFP (SEM), Dip. Sport Med; Shelley Ross, PhD
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 511F

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe essential components of a competency-based assessment framework for an enhanced skills program
2. Explain the need for cumulative evidence of progress towards competence in the context of Certificates of Added Competence
3. Plan how to incorporate competency-based assessment into your own enhanced skills programs

Description:

Enhanced skills programs in Canada are currently facing two challenges: firstly, meeting the need to shift to competency-based education and assessment; and secondly, ensuring that programs are able to collect and provide adequate evidence for their graduates to receive Certificates of Added Competency (CAC). Two programs in Sport and Exercise Medicine (SEM) addressed these challenges by adapting the Competency-Based Achievement System (CBAS). CBAS is a competency-based assessment framework, developed by researchers in family medicine at the University of Alberta, that uses formative feedback to inform summative evaluation. CBAS offers a straightforward, learner-driven method to capture and document workplace observations of competency (FieldNotes), which provides immediate feedback, tracks learner progress, and allows for early identification of learners who are encountering difficulty. With CBAS, residents guide their learning using formative feedback. For preceptors and program directors, CBAS offers a way to document workplace observations and feedback, so that summative decisions are evidence-based and defensible. In this interactive workshop, an enhanced skills program director will present evidence of proof-of-concept for using CBAS via exploration of findings from a pilot study in the two SEM programs. Case studies will also be reviewed. Participants will gain some experience using CBAS tools through demonstration and group discussion. Applying the tools to unique cases within participants' programs will be emphasized. We will also discuss the value of the CBAS as a tool for collecting appropriate evidence to support applications for CACs. Participants will be encouraged to share their own experiences.

W522 **A Resident-led Initiative to Review and Improve Training in Advance Care Planning**

13:30–14:30 David Jerome, MD, MSc; Kiranpal Dillhon, MD; Yan Yu, MD, MPP, MBA; Rajiv Teeluck, MD; Graham Gaylord, MD, MHA
All teachers welcome. Highlights novice concepts for clinical preceptors.
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 513CD

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Review feedback from a national survey of residents on current teaching of advance care planning within family medicine residency
2. Review results from a literature review on best practices on teaching advance care planning to medical learners
3. Practise using a new clinical guide to performing advance care planning, developed by the CFPC Section of Residents

Description:

Each year, the CFPC's Section of Residents (SoR) reviews a specific aspect of Canadian family medicine residency training programs. The theme of the 2017 review is advance care planning (ACP). This workshop will: review

current ACP training within family medicine residency programs in Canada; review best practices and existing resources for teaching ACP to medical learners; and introduce a new guide to ACP developed by the SoR for use in a clinical environment. The SoR performed an online national survey of current family medicine residents in December 2016. The survey had a response rate of 267, representing approximately 20 per cent of all current Canadian family medicine residents. Eighteen per cent of responses were submitted in French. Responses were received from each of the 17 family medicine residency programs, and there was a proportional representation of residents at different stages of residency training. Two-thirds of respondents had not received didactic or clinical instruction about ACP in their residency training. Most respondents who were taught ACP rated the quality of the teaching they received as satisfactory or excellent. More than 77 per cent of respondents would like to see more ACP instruction in their residency training. Detailed results from this national survey, as well as the findings from literature searches on the topics of best practices in teaching ACP to medical learners and resources in teaching and performing ACP, will be reviewed in the workshop.

W523 **A How-to Guide for Teaching and Assessing Collaborator Competencies in Family Medicine**

13:30–14:30 Christie Newton, MD, CCFP, FCFP; Deborah Kopansky-Giles, DC, FCCS, MSc; Alison Eyre, MD CM, CCFP; Steve Balkou, MSc; Jose Silveira, MD, FRCPSC; Tanya Magee, BN, RN; Aleks Walczak; Ivy Oandasan, MD, CCFP, MHSc, FCFP
All teachers welcome. Highlights advanced concepts for clinical preceptors.
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 513AB

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe the collaborator role's key and enabling competencies and list strategies for teaching and assessing these competencies in family medicine
2. Review clinical teaching scenarios to identify opportunities to integrate the collaborator role and reflect on these examples in their contexts
3. Access and apply the CPFC How-to guide to support teaching and assessing the collaborator competencies

Description:

Globally, health systems are transitioning to integrated team-based care models. As such, collaborative practice education and assessment are now accreditation requirements for family medicine and most health professional programs. However, without common teaching and assessment tools, ensuring the acquisition of integrated person-centred practice competencies in training remains challenging. Family medicine preceptors need easily accessible tools to support them in their day-to-day roles of teaching and assessing the collaborative practice competencies of their learners. To address this need, the CFPC engaged an interprofessional group of educators to develop a how-to guide for teaching and assessing collaborator competencies. The guide has been purposefully designed to align with the CFPC Fundamental Teaching Activities Framework, and provides strategies applicable across a variety of educational settings—clinical preceptor, outside of the clinical setting, and educational leaders (e.g., curriculum designers, assessment leads, etc.) This interactive workshop is geared to family medicine educators (e.g., teachers, preceptors, program directors, health professional learners, etc.). The workshop will present the current state of teaching and assessment of the collaborator role in Canada, review some of the best practices identified, and give participants an opportunity to familiarize themselves with the how-to guide for teaching and assessing collaborative practice competencies. Through interactive scenarios, participants will be able to practice identifying teaching and assessment opportunities and applying some of the teaching and assessment strategies contained within the guide. Participants will be encouraged to reflect on the strategies and how they would apply in their own teaching contexts.

W531 **Selling Family Medicine: Further building the brand**

13:30–14:30 Amy Tan, MD, MSc, CCFP (PC), FCFP; Kathleen Horrey, MD, CCFP, FCFP
All teachers welcome. Highlights advanced concepts for clinical preceptors.

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Examine the myths about family medicine within the medical student population
2. Contemplate the information medical students are seeking about family medicine
3. Develop a message for medical students reflective of our changing discipline

Description:

Following 2008, when the number of students matching to family medicine was at its lowest, the CFPC undertook a number of strategies to overcome the barriers to students selecting a career in family medicine. Subsequently, attitudes towards family medicine began to shift. Our discipline has grown. The Undergraduate Medical Education Committee began a process to reconsider our messaging to medical students about our changing discipline. At FMF 2016, we heard new myths and barriers, as well as new ideas in considering this message. In the workshop we will explore the outcome of last year's workshop, along with the outcomes of additional surveys and focus groups, to craft a new message, overcoming these myths and barriers about our discipline, that will resonate with medical students of today.

W326 **Assessing and Understanding Challenging Behaviours in Patients with Cognitive Impairments: Tools and tips (Enhanced Clinical Session)**

13:30–16:00

Karen McNeil, MD, CCFP, FCFP; Donna Lee, MA; Jillian Achenbach, MD, CCFP

ROOM / SALLE : 510C

Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Identify the function of a patient's behaviour by using behavioural assessment tools
2. Apply key narratives to motivate the patient, caregivers, and family to engage in a behaviour management plan
3. Develop and implement a management plan to address these behaviours in collaboration with the patient, caregivers, and family

Description:

Patients with impaired cognition often communicate through behaviour. Understanding the functions of these behaviours allows us to hear our patients' voices and respond to their needs. Such behaviours can pose a risk to the patient, their families, and/or the community. Historically, the behaviour of people with impaired cognition has been misunderstood to be simply a symptom of the disability or an inappropriate effort to manipulate caregivers. However, these hypotheses can neglect the important information communicated by behaviour. Assessing and responding to the specific function of behaviour can lead to a greater understanding of the patient's health needs, improve emotional well-being, promote self-determination, and decrease the incidence of high-risk behaviours. Physicians providing primary care to individuals with impaired cognition frequently identify a need for education regarding challenging behaviours. This workshop will use a combination of didactic teaching and case-based discussion to introduce concepts and practical assessment tools behavioural specialists use when working with this population. Participants will be provided with a framework for establishing a behaviour management plan that can be implemented in collaboration with the patient, caregivers, family, and allied health professionals. Discussion will include resources for patients and caregivers and how to re-evaluate patients in follow-up.

W250 **Screening for Adverse Childhood Experiences to Build Resiliency and Improve Mental Health Outcomes (Enhanced Clinical Session)**

13:30 –17:15

Sanjeev Bhatla, MC CM, CCFP, FCFP; Sharon Cirone, MD, CCFP (EM), FCFP; Lydia Hatcher, MD, CCFP, FCFP, CHE; Maria Patriquin, MD, CCFP

ROOM / SALLE : 510D

Mainpro+ Group Learning certified credits = 3

Learning objectives:

1. Screen for adverse childhood experiences

2. Provide trauma-informed care to patients
3. Build healthy therapeutic boundaries with your patients

Description:

A large landmark study done by the Centers for Disease Control and Prevention and the HMO Kaiser Permanente confirmed that adverse childhood experiences (ACEs), such as exposure to violence, neglect, and abuse, are strongly associated with long-term poor mental health. In addition, the study revealed that these adverse events are associated with many other deleterious effects on health, such as increased rates of addiction, increased cardiovascular events, increased cancer rates, and earlier death. Screening for ACEs is an opportunity for family physicians to be better aware of a patient's risk factors for compromised health and an opportunity to intervene. At the end of this workshop participants will be able to use ACE screening and integrate it into everyday practice. Participants will learn how to use the insight of trauma-informed care to improve the health and well-being of patients. Participants will learn to use the power of empathy, compassion, and self-care to build resiliency in both patients and themselves. Experiences of current ACE screening pilot projects will be shared with the goal of developing a variety of ways to incorporate this tool into everyday family practice and measure outcomes of ACE screening.

W341 Preparedness for Your Practice: A discussion and simulation for family doctors in disasters (Enhanced Clinical Session)

13:30–17:15

Lynda Redwood-Campbell, MD, FCFP, DTMH, MPH; Videsh Kapoor, MD, CCFP; Lisa Schwartz, MA, PhD; Eric Juneau, MD; John Ascah, MD, FRCP, MPH; Gautham Krishnaraj; Raphael Nepomuceno, MD, DTMH, MPH; Clayton Dyck, MD, CCFP, FCFP; Videsh Kapoor, MD, CCFP; Carrie Bernard, MD, CCFP

ROOM / SALLE : 510A

Mainpro+ Group Learning certified credits = 3

Learning objectives:

1. Identify the various types of disasters and forms of humanitarian response and discuss ethical considerations for disaster response
2. Access resources that will help develop next steps for active contribution in their community for disaster preparedness
3. Define specific next steps and actions in the approach to disaster preparedness and response in their own Canadian community

Description:

This workshop is a novel and highly pertinent exercise for Canadian family physicians (FPs). As the complexity and diversity of disasters and emergencies continue to increase, FPs need to be prepared and understand our role in these contexts. This workshop is based on identified needs of family physicians in multiple contexts: hospital rounds, different departments of family medicine in Canada, a United Nations–funded meeting, and family medicine resident requests. Our three-stage workshop will be informed by existing literature and expert input on experiences in disaster contests. The first stage will be a discussion of foundational concepts that FPs should be able to engage in and understand. Participants will be asked to share their working definitions of terms such as disaster, humanitarian emergency, and the phases of disasters. They will be encouraged to draw on experiences within the Canadian context, including the Fort McMurray wildfire and Maritime ice storms. The second and main stage will be an interactive tabletop simulation. Participants will each be given a community "role" to play as groups navigate various disaster scenarios, unpacking the complexities of disaster response and working collaboratively to understand the processes. A team of circulating facilitators will introduce various ethical challenges and scenario-based content as the disaster event evolves. Participants will learn concepts of risk assessment and about the roles of different agencies and organizations involved in the response. The third stage will be a debrief and discussion about what each individual can do to move forward with this concept in their own communities/provinces in Canada. Participants will work in province-specific groups to develop their plans and will present this in five "regional" groups (North, West, Prairie, East, Maritime). Follow-up resources will be provided and may include webinars, evidenced-based ethical tools for disaster response, and appropriate publications.

W347 **Maternity and Newborn Enhanced Clinical Session: Important decisions and skills in intrapartum care (Enhanced Clinical Session)**

13:30–17:15 William Ehman, MD; Kate Miller, MD, CCFP, FCFP; Amanda Pendergast BSc (Hons), MD, CCFP, FCFP; Heather; Baxter, MD, CCFP, FCFP; Sudha Koppula, MD, CCFP, FCFP; Lisa Graves, MD, CCFP, FCFP

ROOM / SALLE : 510B

Mainpro+ Group Learning certified credits = 3

Learning objectives:

1. Interpret and respond to challenging intrapartum fetal surveillance; review intrauterine resuscitation and indications for emergency delivery
2. Manage intrapartum challenges and delivery complications and use under-utilized techniques for managing pain
3. Explore evidence-based third stage management and optimize skin-to-skin maternal child care in all environments

Description:

This clinically based session will focus on the difficult decisions encountered and the skills required in providing intrapartum care. Participants are encouraged to bring their own challenges for discussion. Faculty will facilitate small group discussions and practical, low-fidelity simulations with adequate time for interactive learning. This workshop will create an environment that allows participants to achieve increased competence and confidence in emergency procedures. All management strategies will involve teamwork and effective communication. Examples of scenarios are: interpreting and responding to abnormal intermittent auscultation and electronic fetal monitoring; managing occiput posterior fetal position; performing emergency vacuum-assisted delivery; using new ideas on delivery of the shoulders; managing shoulder dystocia; managing unplanned breech delivery; performing intradermal sterile water injections and pudendal block analgesia; and providing evidence-based third stage management and skin-to-skin maternal child care.

Free-standing paper presentations

Researchers will provide free-standing (oral) presentations of new research; the 2017 research award recipients are among the list of distinguished presenters.

Présentations libres

Des chercheurs livreront des présentations libres (orales) sur de nouveaux travaux de recherche ; les lauréats de 2017 des prix pour la recherche figurent au programme.

W766 **Impact of a Criterion-Based Competency Assessment Tool on Identification and Management of Residents in Difficulty**

15:00–15:15 Miriam Lacasse, MD, MSc, CCMF; Jean-Sébastien Renaud, PhD; Caroline Simard, MA

ROOM / SALLE : 511D

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Discuss the impact of a criterion-based competency assessment tool on the identification and management of residents in difficulty

Background: The family medicine residency program at Université Laval has developed and validated an innovative criterion-based competency assessment tool (CCAT) adapted to each rotation and training period. This computerized tool includes a decision support system suggesting educational diagnoses and prescriptions to support resident feedback and guide teachers in their judgment of competency achievement for each milestone. **Objective:** To determine the impact of a CCAT on the identification and management of residents in difficulty. **Methods:** Clinical teachers who had filled out at least one family medicine resident summative assessment in the previous three months participated in this study. They filled out a questionnaire before and after implementation of the CCAT to appraise Factors that Influence Reporting of Residents in Difficulty (Q-FIR-RID: 12 items, $\alpha = 0.81$) to assess four constructs on a Likert scale (1-5): documentation, knowledge of what to document, consequences for the evaluator,

and remediation options. Anonymized data about remediation rotations was obtained from the program promotion committee. **Results:** A total of 254 clinical teachers completed the questionnaire. The Q-FIR-RID score increased after implementation of the CCAT (mean change = 0.25). Three constructs improved after CCAT implementation: documentation ($P < 0.001$), knowledge of what to document ($P < 0.001$) and remediation options ($P < 0.01$). Residents in difficulty were identified earlier after implementation of the CCAT, and remediation rotations were offered earlier to residents (pre: 85 per cent of remediation rotations offered during PGY-1 and 15 as PGY-2; post: 100 per cent as PGY-1). **Conclusion:** This project suggests a criterion-based competency assessment tool that includes a decision support system improves the identification and management of residents in difficulty.

W803 **What's in an ITER?**
15:15–15:30 Gary Viner*, MD, CCFP, FCFP, MEd; Douglas Archibald, PhD; Eric Wooltorton, MD, CCFP, FCFP, MSc; Alison Eyre, MD CM, CCFP, FCFP

ROOM / SALLE : 511D
Mainpro+ Group Learning certified credits = 0.25

Learning objectives:
1. Describe rating behaviour by preceptors when assessing residents
2. Demonstrate the value of data analysis for program evaluation
3. Validate the approach of an action-oriented rating scale for competency attainment

Context: Since 2013 the University of Ottawa's family medicine (FM) in-training evaluation reports (ITERs) have used an "action-based" ITER evaluation scale having four parameters: "Not observed/applicable" (0); "Off trajectory for this benchmark (action required)" (1); "On trajectory for this benchmark (minimal/no action required)" (2); and "Attained this benchmark (no action required)" (3). The 29 PGY-1 and 32 PGY-2 stems of core FM ITERs are communicated as benchmarks that state expectations to be attained at completion of each training year. **Objective:** To explore how preceptors have completed ITERs since this rating system was implemented. **Design:** We retrospectively analyzed aggregated ITER data contained in our assessment system (one45 WebEval) from July 2013 to present. **Participants:** One hundred thirty-six preceptors completed 1,351 ITERs (666 PGY-1; 685 PGY-2). **Intervention:** ITER data in one45 were sorted by preceptor with sequenced FM rotations for five communication competencies. **Outcome measures:** Using descriptive statistics and frequencies and non-parametric tests we analyzed preceptors' use of FM ITERs. **Results:** Mean scores and standard deviations for PGY-1 ITERs were 2.26 (0.51) and 2.65 (0.48). Preceptors completed between one to 20 PGY-1 ITERs and one to 24 PGY-2 ITERs over more than three years. There was a statistically significant difference between PGY-1 ITERs completed at sequential FM rotations as determined by one-way ANOVA ($F[4,632] = 48.79$, $P < 0.001$) and for PYG-2 ITERs ($F[4,654] = 22.90$, $P < 0.001$). Post hoc tests revealed when the sequential changes in ITER scoring occurred. **Discussion:** Communication skills differ in PGY-1 and PGY-2 due to higher expectations. Supervisors should flag concerns and discern progression so residents can attain competencies required for graduatoin. We confirm that these ITERs reflect the preceptors' assessment of gradual development along the competency journey. **Conclusions:** Residents in a department of FM acquire communication competencies progressively. Analysis of preceptor ITER ratings allows normative feedback to preceptors on their patterns of scoring residents.

W841 **Capturing Resident Progression Toward Competence Using the Competency-Based Achievement System (CBAS)**
15:30–15:45 Chris Donoff, BSc; Shelley Ross, PhD; Shirley Schipper, MD, CCFP; Oksana Babenko, PhD; Paul Humphries, MD, CCFP, FCFP; Mike Donoff, MD, CCFP, FCFP

ROOM / SALLE : 511D
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Describe the feasibility of using the Competency-Based Achievement System to track resident progress to competence

Context: Competency-based assessment in medical education incorporates multiple constructs, including: "assessment for learning" or coaching, to promote guided self-assessment; and assessment of learning to

determine resident progress toward competence. In both cases the provision of continuous formative feedback is paramount for improving both the validity of summative assessments and the quality of coaching that residents receive. In our family medicine residency program we use the Competency-Based Achievement System (CBAS) as our assessment framework. The current study examined the effectiveness of CBAS in capturing evidence of resident progress from PGY-1 to PG-Y2. **Objective:** The objective of this study was to examine: 1) whether progress levels assigned by expert judges change to reflect the increased competence of residents from PGY-1 to PGY-2; and 2) if there were differences in progress level assignment between academic years, teaching sites, and mentor-learner relationship strength (advisors versus preceptors). **Design:** Secondary data analysis. **Participants:** FieldNotes (N = 6,664) spanning four academic years (2012, 2013, 2014, and 2015). Data came from residents (n = 156), preceptors (n = 451), academic advisors (n = 48) across four urban teaching sites. **Main outcome measures:** Between- and within-resident as well as between- and within-preceptor comparisons were made. **Results:** Overall, there was 14% increase in "Carry on, got it" from PGY-1 to PGY-2, irrespective of whether comparing between different residents or preceptors. One site maintained a high proportion of "Carry on, got it" between PGY-1 and PGY-2, indicative of ongoing implementation and buy in of the CBAS framework. No apparent differences in progress level assignment existed between preceptors and academic advisors when controlling for differences between residents. **Conclusions:** FieldNotes captured residents' increase in competence over time. Similarities between advisor- and preceptor-made notes support triangulation in formative assessment. Observed teaching site differences suggest further research is needed to examine reasons behind site discrepancies.

W824 A Realist Canada-Wide Audit of Triple C Implementation

15:45–16:00

Sonya Lee*, MD, CCFP, MHSc, FCFP; Rachel Ellaway, PhD; Maria Palacios-Mackay, DDS, PhD; Mariana Hofmeister, PhD; Juli Finlay, PhD

ROOM / SALLE : 511D

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Explain the different approaches to implementation of the Triple C curriculum and its impacts across Canadian family medicine residency programs

Context: The College of Family Physicians of Canada's Triple C (TC) initiative was one of the first national approaches to competency-based medical education. All family medicine residency programs at Canada's 17 medical schools have adopted TC, and program evaluation is ongoing. **Objective:** To examine the different approaches to implementation of TC and its impacts across Canadian family medicine residency programs. **Design:** A realist audit of the different approaches to the implementation of TC and its impacts was conducted. Realist analysis of the results was to identify the different contexts, mechanisms, and outcomes associated with implementing TC. Data were collected through individual interviews and focus groups that underwent thematic analysis by constant comparison method. **Participants:** Participants included program directors, department chairs, deans, administrators, preceptors, and residents at all 17 schools. **Outcome measures:** Outcomes included the identification of narrative themes related to TC implementation and its impact. **Results:** Every family medicine residency program had implemented some part of TC, in some way or form. Implementation was pragmatic, making use of opportunities where they arose. Some challenges in implementing TC were common to all schools, others were more localized. TC has been broadly successful, with earlier and more specific identification of struggling students being of particular value. Some programs struggled with renegotiating the role and presence of specialist physicians outside of family medicine in the training of family doctors. Implementing TC involved substantial administrative and resource costs. Schools that delayed the adoption of the TC curriculum learned from earlier adopters and many partially attribute their success to concurrent and new assessment programs. **Conclusion:** Despite many challenges, TC has been a driver for much quality improvement in programs and it has catalyzed the Canadian family medicine community to be much more engaged in and attentive to educational matters.

W644 R2C2 in Residency: Facilitating feedback implementation

15:00–15:15

Heather Armson, MD, MCE, CCFP, FCFP; Joan Sargeant, PhD; Jocelyn Lockyer, PhD; Marygrace Zetkulic, MD; Andrew Warren, MD, MSc, FRCPC

ROOM / SALLE : 511E

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Explore the effectiveness of the R2C2 feedback model in promoting feedback acceptance and use for improvement across varied disciplines and sites
2. Determine and explain factors that appeared to moderate the use and effectiveness of the model across sites
3. Examine implications for participants' teaching practices

Background: An evidence-based model (R2C2) was tested in residency education. The model focuses on: 1) building Relationships; 2) exploring Reactions to the feedback; 3) exploring understanding of feedback Content; and 4) Coaching for performance change. **Methods:** This was an international study of five residency programs using case study methodology and realist evaluation. Dyads of residents and their supervisors were recruited. Supervisors were trained and then asked to use the R2C2 model in two feedback sessions, three to six months apart. Feedback sessions and subsequent debrief interviews were recorded and transcribed. Content and template analysis were used within and across cases. Synthesis consisted of case and comparative analysis to identify the usefulness of each component and suggest revisions required to strengthen the R2C2 model. **Results:** Forty resident-preceptor dyads were recruited. The R2C2 model was effective in engaging residents in a reflective feedback conversation, although variability was noted across sites. The process appeared to enhance resident engagement and reflection, guided self-assessment, and encouraged active collaboration in the development of goals and outcomes. The model appeared to be useful with both excelling and struggling residents. Coaching for change was the most useful feature of the model, with the learning change plan an integral component to the coaching discussion. Factors influencing the use of the R2C2 model included supervisor and resident factors, such as the resident-supervisor relationship, and programmatic assessment approaches and contextual factors. **Conclusions and Significance:** The model can be effective in engaging residents in reviewing their performance assessment data, in reflecting and identifying opportunities for improvement, and in working with their supervisors to plan and implement improvements.

W802 **Barriers to Acquiring Minor Procedural Skills in Family Medicine Training at the University of Toronto**

15:15–15:30 Jeremy Rezmovitz, MD, CCFP*; Ian MacPhee, MD, CCFP, PhD; Risa Freeman, MD, CCFP, FCFP, MEd; John Maxted, MD, CCFP, FCFP, MBA; Anne Wideman, MD, CCFP; Sharon Domb, MD, CCFP, FCFP; Dimitrios Tsirigotis, MD, PhD; Tuhina Biswas MD, CCFP; Kulamakan (Mahan) Kulasegaram

ROOM / SALLE : 511E

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify barriers to acquiring procedural skills perceived by residents at the University of Toronto
2. Identify barriers to teaching procedural skills perceived by staff at the University of Toronto

Objective: To evaluate current barriers to minor procedural skills training in postgraduate family medicine at the University of Toronto in Toronto, Ontario. **Design:** This is a qualitative study that employed a grounded theory methodology. The data set is multi-sourced, including accreditation documents, one-on-one interviews, and surveys. Interviews were audio-recorded and transcribed verbatim. Documents, transcripts and survey responses were coded and categorized for common themes. **Setting:** This study took place during postgraduate residency training within the Department of Family and Community Medicine (DFCM). **Participants:** DFCM faculty physicians (11 from 10 sites), program directors (five), and PGY-1/PGY-2 family medicine residents who volunteered to participate (nine). **Main outcome measures:** The identification of barriers in teaching and acquiring minor procedural skills facilitates further inquiry to improve current standards of training in postgraduate family medicine. **Findings:** Family medicine sites employ a variety of approaches to deliver procedural skills training. Three are identified in family medicine: 1) routine clinical practice; 2) designated clinics; and 3) academic workshops. Each has its own barriers. Despite various strategies employed by sites, nearly all residents surveyed feel their current curricula are insufficient to develop procedural competence and confidence. Significant barriers identified include: insufficient volume of patients/case mix, infrequent procedural clinics spread among too many residents, and insufficient protected time to

pursue complementary training. Residents have difficulty obtaining procedure-rich electives within family medicine and experience tends to come disproportionately and inconsistently from external rotations. Teachers also identify underlying influences on training. In addition to an insufficient case mix, these include a perception of insufficient initiative among residents, an insufficient pool of experienced supervisors, and easy access to other specialists for procedural referrals in urban settings. **Conclusion:** Challenges to minor procedural training are multi-faceted; strategies to address this must also be multi-faceted. This study identifies minor procedural skills training needs at the University of Toronto with a view to improvement.

W728 **Training Doctors for Rural Generalist Practice: Memorial's pipelines to pathways approach**

15:30–15:45 James Rourke*, MD, CCFP (EM), MCISci, FCFP; Shabnam Asghari, MD, MPH, PhD; Oliver Hurley, MEnvSc; Mohamed Ravalia, CM, CCFP, FCFP; Michael Jong, MBBS, MRCP, CCFP, FCFP; Wanda Parsons, MD, CCFP, FCFP; Norah Duggan, MD, CCFP, FCFP

ROOM / SALLE : 511E

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Have a good understanding of the "pipeline" and "pathways" approach and what steps must be taken for its proper implementation

Objective: The objective of Memorial University of Newfoundland's "pathways to rural practice" approach is to produce rural family physicians to meet the rural health care needs of Newfoundland and Labrador and Canada. **Design:** The pathways to rural practice approach has led to a program made of four components: 1) a targeted pre-admission process (Indigenous initiative, MedQuest, geographic/minority selection); 2) medical school clinical placements (rural experiences); 3) vocational family medicine (FM) residency training (extended rural training experiences, deeper community integration); and (4) postgraduate (PG) training (opportunities for professional and faculty development). **Setting:** This study considers data from Atlantic Canada and Memorial University's school of medicine. **Participants:** This study included Memorial's medical school students and graduates from the classes of 2011 to 2019. **Intervention:** A survey and administrative data were used to collect student background data (address history, MD/PG placements, and practice location data). **Main outcome measures:** To evaluate Memorial's medical school curriculum we considered the percentage of placement weeks spent in rural locations for clinical placements and FM residencies. **Findings:** For the graduating classes of 2011 to 2019 (N = 617), 90 per cent of year 1 community health placement weeks took place in rural locations. Of the 537 students (classes of 2011 to 2018) who completed year 3 FM placements, 97 per cent of their placements were spent in a rural location (community or town). Of the students who graduated between 2011 and 2013 and went on to complete FM-PG training at Memorial (n = 49), 100 per cent completed rural training in some capacity. The same graduates (2011 to 2013, n = 49) spent 52 weeks (55 per cent) out of 95 weeks in rural areas while completing their FM training. **Conclusion:** The "pathways" approach has allowed Memorial to become one of the main producers of rural generalists for both Newfoundland and Labrador and Canada.

W659 **Lifelong Learning in Health Professions: Meta-analysis along the education and career continuum**

15:45–16:00 Oksana Babenko*, PhD; Lindsey Nadon; Sudha Koppula, MD, MClSc, CCFP, FCFP

ROOM / SALLE : 511E

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Describe the long-term trend in the orientation toward lifelong learning in health professions

Objective: Lifelong learning is an important aspect of health professionals' maintenance of competence. Several studies have examined the orientation toward lifelong learning at various stages of the education and career continuum; however, none has looked at changes throughout training and practice. The main objective of the present study was to determine whether there are differences in this orientation between groups defined by their places on the education and career continuum. Additionally, involvement in scholarly and research activities was considered for the influence on the orientation toward lifelong learning. **Design:** This was a group-level meta-

analysis of studies that used the 14-item Jefferson Scale of Physician Lifelong Learning or its variants. In total, 11 studies conducted with post-secondary health professions students, residents, and practising professionals met the inclusion criteria. Means and standard deviations of the total scores on the Jefferson Scale, together with sample sizes, were extracted from each study and used in the analysis. **Results:** Results of the meta-analysis indicated that the orientation toward lifelong learning in health professions tended to increase gradually further along the career continuum; however, substantial variability was observed within each group of studies with students, residents, and practising professionals. Significant differences in group means were found between trainees (students and residents) and practising professionals. Involvement in scholarly and research activities appeared to be associated with a greater orientation toward lifelong learning along the career continuum. **Conclusion:** The findings offer insights into the long-term trend in the orientation toward lifelong learning in health professions. Although the links between lifelong learning and its behavioural manifestations in health professions have been reported in the literature, much work in this area still needs to be done, including the examination of the impact of lifelong learning on patient care.

W719 **Does a Structured Curriculum Help Residents Diagnose and Treat Skin Cancer?**
15:00–15:15
Christine Rivet*, MD CM, CCFP (EM), FCFP, MClSc; Farhad Motamedi, MD, CCFP, FCFP; Douglas Archibald, PhD; Joseph Burns, MSc

ROOM / SALLE : 511F
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Be able to determine whether a longitudinal procedural curriculum could be implemented at their teaching site

Objective: To determine whether a biweekly procedure clinic and structured procedural curriculum throughout family medicine (FM) residency prepares residents to identify and manage skin cancers better than routine opportunistic teaching of skin procedures. **Design:** A survey and photo quiz. **Setting:** Family medicine training sites at the University of Ottawa. **Participants:** All incoming FM residents starting residency (N = 60). **Intervention:** All incoming FM residents were asked to fill out a survey and photo quiz at the beginning of their training to establish their level of experience with and knowledge of skin conditions. The photo quiz was validated by a dermatologist. FM residents at one site received training in the procedure clinic every two weeks along with a structured procedural curriculum focused on the diagnosis and management of skin cancer during eight months of FM training throughout the two years of residency. The other sites had routine opportunistic teaching on on the diagnosis and management of skin cancer. The procedure clinic is based on hands-on experience with direct supervision by the study authors. At the end of their first year and at the end of their training, all FM residents were asked to fill out a survey and photo quiz to verify their knowledge. **Results:** Twenty-five residents participated in the initial survey and photo quiz. The study participants and non-participants obtained a score of 61 per cent and 58 per cent, respectively, at the beginning of residency and 76 per cent and 57 per cent, respectively, at the end of residency. **Conclusion:** Our results indicate that a longitudinal curriculum helps FM residents identify and treat skin cancers, whereas opportunistic teaching showed no objective benefit.

W559 **Integrating a Medical Assistance in Dying Curriculum in a Family Medicine Residency Training Program**
15:15–15:30
SuSan MacDonald*, MD, MHSc, CCFP, FCFP; Sarah LeBlanc, MD, MSc, CCFP; Nancy Dalgarno, PhD, MEd, OCT; Karen Schultz, MD, CCFP, FCFP; Daniel Zimmerman, MD; Emily Johnston, MSc

ROOM / SALLE : 511F
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Be able to identify perceptions of MAID among family medicine faculty and residents

Objective: To determine family medicine (FM) resident and faculty perceptions of medical assistance in dying (MAID) in terms of interest in and knowledge of MAID, experiences with MAID, willingness and readiness to learn

and/or teach about MAID, anticipation of participating in MAID, and recommendations for curricular content for residents, faculty development, and continuing professional development (CPD). **Design:** An exploratory mixed method design was used to help inform the development of an integrated MAID curriculum. **Setting:** A Canadian FM residency program that included four distributed sites: one academic FM site and three community-based FM sites. **Participants:** Using purposive sampling, anonymous online surveys were distributed to FM physician preceptors (n = 158) and postgraduate year (PGY)-1 and PGY-2 FM residents (n = 193) associated with the FM program under study. **Results:** Survey response rates were 45 per cent for faculty and 33 per cent for residents. Faculty were significantly more confident, competent, and comfortable than residents in explaining and discussing MAID with colleagues and patients ($P < 0.05$). Residents, however, were more willing to participate in administering MAID than faculty ($P < 0.05$). Seventy-two per cent of respondents believe it is important to integrate MAID into the core curriculum, with faculty who were non-conscientious objectors being more likely to believe it should be included in the curriculum ($P < 0.05$). The curricular elements deemed most important included advance care/end-of-life planning (76 per cent), technical aspects (73 per cent), and regulations/ethical issues (56 per cent). **Conclusions:** Developing a MAID curriculum will bridge the competency gap self-identified by participants. Patients' access to compassionate end-of-life care can be improved through training that increases the comfort, confidence, and competence of both faculty and residents in the topic of MAID. Of importance is developing faculty development/CPD sessions to educate and support both conscientious objectors and non-conscientious objectors, allowing all residents to learn about the care of patients requesting MAID.

W759 — From Reactive to Proactive: Disease prevention and health promotion in undergraduate medical education

15:30–15:45

Richelle Schindler*, MD, MSc; Lauren Capozzi; Marianna Hofmeister, PhD; Kevin Busche, MD, PhD, FRCPC; Martina Kelly, MBBCh, MA, CCFP

ROOM / SALLE : 511F

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify a mixed methods approach to curriculum mapping
2. Describe data sources and methods that can be used to map disease prevention and health promotion in an undergraduate curriculum
3. Apply suggestions for the improvement in curriculum delivery of disease prevention and health promotion content

Objective: To evaluate the delivery of health promotion and disease prevention (HPDP) content in the curriculum at the University of Calgary medical school. **Design:** Mixed methods study. **Setting:** Cumming School of Medicine, Calgary, Alberta. **Participants:** Purposive sampling of 18 faculty from seven specialties. Eighteen student volunteers. **Intervention:** Using the Clinical Prevention and Population Health Curriculum Framework, data extraction was piloted, refined, and used to document HPDP content in the published curriculum. Students extracted quantitative and qualitative data on teaching activities. Two focus groups were conducted with year 1 and 2 learners. Faculty participated in semi-structured interviews. **Main outcome measures:** Quantitative data were analyzed using descriptive statistics to give the proportion of learning events with HPDP content and the proportion of content in each of the four key areas identified by the Framework. Qualitative data were analyzed thematically using the aforementioned theoretical framework. **Findings:** Of the 935 learning events identified, 88.8 per cent were available for analysis: 30.2 per cent of the learning events contained disease prevention content, while only 16.8 per cent contained health promotion content. The most frequently identified subject was Foundations of Population Health (75.6 per cent) and least frequent was Health Systems and Health Policy (9.45 per cent). Students in focus groups called for more integration of HPDP into existing content and suggested HPDP be included in communications cases. Faculty emphasized a need to address HPDP proactively by focusing on disease before it manifests, rather than concentrating on secondary and tertiary prevention. **Conclusion:** Health promotion and disease prevention content is well represented in the curriculum at the University of Calgary, but the experiences of students and faculty suggest the need for a HPDP approach that helps students better integrate and apply HPDP knowledge in clinical practice. This includes raising students' awareness of their own attitudes toward HPDP and providing opportunities for HPDP communication skills development in the undergraduate curriculum.

W578 **Understanding Curricular Messaging Surrounding Enhanced Skills Programs From the**
15:45–16:00 **Family Medicine Resident Perspective**
Lauren Payne*, MD, MPH; Azadeh Moaveni, MD, CCFP; Curtis Handford, MD, MHSc, CCFP

ROOM / SALLE : 511F

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Identify the main curricular messages surrounding enhanced skills fellowships from the resident perspective in one postgraduate family medicine program

Objective: To understand better the messages family medicine residents are receiving about enhanced skills fellowship programs throughout their training. **Design:** Phenomenologic approach using structured qualitative interviews. **Setting:** Postgraduate family medicine program in Ontario. **Participants:** Residents were recruited using both purposive and, subsequently, snowball sampling until data saturation was reached. Eleven family medicine residents (five PGY-1, six PGY-2) were interviewed from four separate training sites. **Methods:** Interviews were audiotaped and transcribed, and codes were developed by the study investigators. Themes arose from the data via immersion and crystallization techniques. **Findings:** Themes emerged in three categories: 1) perception of purpose; 2) sources of messaging; and 3) formal/informal versus hidden curricular messages. Residents viewed fellowship programs in terms of their personal and professional benefits. Residents learned about fellowship programs through word of mouth and role modelling. The formal curriculum remained neutral about fellowship training. The hidden curriculum highlighted a number of messages: 1) to maximize the chances of acceptance into some fellowship programs, one should focus most of their elective time in that clinical area; 2) many fellowships graduate subspecialists to the exclusion of family medicine; 3) a fellowship is required to practise in a large urban centre but not in rural communities; and 4) graduates without fellowship training are less well regarded. **Conclusion:** Residents both hear and perceive mixed messages regarding fellowship training. This may be an isolated phenomenon at a larger urban centre in Ontario. Decision making at the individual level in terms of career path seems to be affected and this may have implications at the larger system level.

W685 **Implantation de l'accès adapté en unités de médecine de famille : une recherche participative**
15:00–15:15
Mireille Luc, RD, MSc; Marie-Claude Beaulieu, MD; Isabelle Boulianne, RN MOrgM; Mylaine Breton, PhD; Louise Champagne, MD; Sandra Conway; Nick Côté, MD; Jean-François Deshaies, MD; Marylène Fillion, MEd; Philippe Villemure, MD; Catherine Hudon, MD, PhD

ROOM / SALLE : 513AB

Crédits certifiés Mainpro+ d'apprentissage en groupe = 0.25

Objectifs d'apprentissage :

1. Identifier des stratégies pour favoriser l'implantation et l'enseignement de l'accès adapté en UMF
2. Mieux comprendre l'utilité de la recherche participative en première ligne dans un contexte d'UMF

Objectifs : (1) Soutenir l'implantation de l'accès adapté (AA) dans les unités de médecine de famille (UMF) de l'Université de Sherbrooke et (2) identifier les défis et solutions à l'enseignement de l'AA aux résidents. **Méthodologie :** Une recherche participative a été menée de 2015 à 2017 avec la communauté de pratique des directeurs d'UMF, en utilisant une méthode qualitative descriptive. Un comité Accessibilité a été formé pour accompagner le processus d'implantation de l'AA. Le comité réunissait la directrice de la recherche, une coordonnatrice, deux directeurs d'UMF, un résident, une patiente partenaire, trois expertes (changement organisationnel, amélioration de la qualité et AA) et deux représentants du département. Les données ont été recueillies au moyen de six groupes de discussion traitant de différents aspects de l'implantation. Les résultats des analyses thématiques ont été validés avec la communauté de pratique. **Contexte :** Le projet a été réalisé dans 10 UMF de l'Université de Sherbrooke (province de Québec, CANADA). **Participants :** La communauté de pratique des directeurs d'UMF (n=18) représente les 110 superviseurs et 190 résidents des UMF. **Résultats :** Toutes les UMF ont adopté le modèle d'AA. La majorité (80 %) a implanté l'AA, tant pour les superviseurs que pour les résidents. Quatre défis à l'enseignement de l'AA aux résidents ont émergé : 1) définir la patientèle; 2)

assurer une continuité des soins; 3) adopter une approche de collaboration interprofessionnelle; et 4) formaliser l'enseignement de l'AA. La planification préalable de la patientèle, l'appariement des résidents, la clarification des rôles des professionnels et la formation initiale et continue de l'AA ont été identifiés comme des solutions pour faciliter l'enseignement de l'AA aux résidents. **Conclusion :** À la fin de cette présentation, le participant sera en mesure d'identifier des stratégies pour favoriser l'implantation et l'enseignement de l'AA en UMF et de mieux comprendre l'utilité de la recherche participative.

W786
15:15–15:30

Les courbes cognitives pour différencier un déclin normal relié à l'âge du développement d'une démence

Patrick J. Bernier*, MD, CCMF, PhD; Christian Gourdeau, MSc; Pierre-Hugues Carmichael, MSc; Jean-Pierre Beauchemin, MD; René Verreault, MD; Rémi W. Bouchard, MD, MSc; Edeltraut Kröger, PhD; Robert Laforce Jr, MD, PhD, FRCPC

ROOM / SALLE : 513AB

Crédits certifiés Mainpro+ d'apprentissage en groupe = 0.25

Objectif : Concevoir des courbes cognitives d'usage facile pour appuyer les cliniciens dans le suivi de leurs patients en utilisant uniquement des résultats du MMSE(*mini-mental state examination*) combinés à l'âge et à la scolarité. **Type d'étude :** Modélisation mathématique rétrospective. **Contexte :** Le MMSE demeure l'outil cognitif le plus utilisé dans le monde. Les performances au MMSE sont principalement influencées par l'âge et par la scolarité. La tâche demeure difficile en première ligne de faire la différence entre un déclin cognitif normal et l'apparition des premiers signes d'un processus dégénératif. **Participants :** La base de données de l'Étude sur la santé et le vieillissement au Canada (ESVC) qui regroupe 7 569 personnes âgées de ≥65 ans ayant complété le MMSE au départ, puis à 5 et à 10 ans. **Intervention :** La modélisation mathématique de la relation entre l'âge, la scolarité et le résultat du MMSE a permis de générer des courbes cognitives (CC) de percentiles selon la trajectoire normale attendue et basées sur les nouveaux concepts de quotient cognitif (QuoCo) et d'âge standardisé (AS). Une zone de seuil inférieur (*cut-off*) était intégrée. Les CC ont ensuite été validées à l'aide d'une base de données externe (NACC)**. Paramètres à l'étude :** Les sensibilités, les spécificités, les VPP, les VPN des CC et la stabilité de ces mesures.
Résultats : Le déclin d'un intervalle de percentile ou plus à partir de la mesure initiale suggère la présence d'une trajectoire cognitive anormale avec une sensibilité de 80 %, une spécificité de 89 % et une valeur prédictive négative de 99 %. **Conclusion :** À l'image des courbes de croissance pédiatriques, nous proposons ici un modèle innovateur de courbes cognitives qui tient compte du MMSE, de l'âge et de la scolarité pour déterminer si des patients âgés ont un déclin cognitif normal ou non. Les CC rendent possible un suivi longitudinal tout en intégrant un seuil ponctuel qui permet d'orienter précocement vers des investigations plus poussées.

W672
15:30–15:45

La télétraumatologie en milieux ruraux : une revue de littérature — travail en cours

Marie-Hélène Lavallée-Bourget, MSc*; Luc Lapointe, MA; Alexia Pichard-Jolicoeur; Jade Labrie; Richard Fleet, MD, PhD

ROOM / SALLE : 513AB

Crédits certifiés Mainpro+ d'apprentissage en groupe = 0.25

Contexte : Les traumatismes sont une cause importante de morbidité et de mortalité dans les milieux ruraux. Ces milieux ont cependant moins facilement accès à des médecins spécialistes en traumatologie que les milieux urbains, ce qui entraîne des délais de prise en charge et nécessite parfois des transferts sur de longues distances vers les centres hospitaliers spécialisés. Avec l'avènement des technologies de l'information, la télémédecine semble offrir des avenues prometteuses pour pallier ce problème. **Objectif :** Déterminer l'impact de la télémédecine sur la prise en charge des patients victimes de traumatismes en milieux ruraux.
Conception : Une revue systématique rapide de la littérature scientifique a été effectuée à partir des concepts suivants : « traumatology », « rural » et « telemedicine » ou « teletrauma ». La stratégie de recherche a été lancée dans 13 bases de données bibliographiques. Cette recherche a permis d'identifier 157 documents. Le tri des articles a été effectué par deux codeurs indépendants selon des critères d'inclusion prédéfinis. Uniquement les articles parus après 2010 ont été conservés pour l'analyse, réduisant le nombre d'articles à 19. Les bibliographies des documents retenus ont été ratissées, à la recherche de nouveaux articles pertinents. La question de recherche

étant de nature causale, seules les études expérimentales, quasi expérimentales et de cohorte ont été conservées. **Résultats :** Jusqu'à maintenant, neuf articles ont été sélectionnés pour extraction. Les résultats préliminaires suggèrent que l'utilisation de la télémédecine (téléphones intelligents, logiciels, réseaux privés virtuels, etc.) peut améliorer la prise en charge des patients. **Conclusions :** L'apport de la télémédecine semble donc avoir un impact positif sur la qualité des soins prodigués aux patients traumatisés en milieu rural. Les résultats préliminaires confirment l'intérêt de poursuivre la recherche de nouveaux articles, notamment en élargissant la période temporelle et en effectuant des recherches dans la littérature grise.

W692 **Améliorer les soins des patients ayant des besoins complexes en première ligne**
15:45–16:00
Catherine Hudon*, MD, PhD, CCMF; Maud-Christine Chouinard, inf. PhD; Marie-Dominique Beaulieu, MD, FCMF, MSc; Paul Morin, MSc, PhD; Danielle Bouliane, MA; Fatoumata Diadiou; Mireille Lambert, MA; Véronique Sabourin

ROOM / SALLE : 513AB
Crédits certifiés Mainpro+ d'apprentissage en groupe = 0.25

Objectifs d'apprentissage :
1. Comprendre les enjeux dans l'amélioration des services aux patients ayant de grands besoins en matière de soins de santé et services sociaux.
2. Identifier des pistes de solution pour améliorer les soins et les services des patients vulnérables ayant de grands besoins en matière de soins de santé et services sociaux.

Objectif : Identifier les enjeux et des pistes de solution pour améliorer les soins et les services aux patients ayant des besoins de santé complexes en groupes de médecine de famille (GMF). **Devis et méthode :** Approche de recherche participative dans le cadre d'un forum provincial utilisant des groupes de discussion mixtes d'acteurs-clés des milieux de la santé, des services sociaux, universitaires et communautaires ainsi que des patients partenaires, pour identifier les enjeux; puis des groupes de discussion disciplinaires pour identifier des pistes de solution. Une analyse thématique des données a été réalisée. **Organisations :** Les participants provenaient de centres intégrés et de centres intégrés universitaires de santé et de services sociaux (CISSS et CIUSSS), de GMF et d'organisations communautaires de 16 régions du Québec. **Participants** (n=160) **:** Gestionnaires (n=52), décideurs (n=15), chercheurs (n=23), pharmaciens (n=13), médecins (n= 9), infirmiers et infirmières praticiens spécialisés (n=18), patients partenaires (n=11), travailleurs sociaux (n=10), représentants d'organismes communautaires (n=6), psychologues (n=2) et kinésithérapeute (n=1). **Résultats :** Les enjeux identifiés portaient sur : 1) la conciliation des mandats des GMF, axés sur une population de patients inscrits, et des CIUSSS/CISSS, axés sur la population d'un territoire; 2) la méconnaissance mutuelle du réseau des GMF et du réseau des organismes communautaires; 3) une clientèle à risque hétérogène, qui passe souvent sous le radar; 4) le défi de structurer l'action collective de plusieurs professionnels et partenaires. Les pistes de solution suggéraient : 1) la conception de l'usager en tant qu'expert de sa complexité; 2) la conception des organismes communautaires comme partenaires de l'équipe GMF; 3) la création de nouveaux modèles professionnels; 4) la gestion du changement; 5) la contribution de la recherche axée sur le patient; 6) un financement qui favorise le travail interprofessionnel. **Conclusion :** Cette présentation permettra aux participants d'envisager de nouvelles pistes de solution pour l'amélioration des soins et des services aux patients ayant des besoins de santé complexes en GMF, et de comprendre les enjeux qui s'y rattachent.

W748 **Le Programme de sensibilisation à la santé cardiovasculaire pour les patients en liste d'attente pour obtenir un médecin de famille**
16:00–16:15
Marie-Thérèse Lussier, MD, MSc; Janusz Kaczorowski, PhD; Magali Girard*, PhD

ROOM / SALLE : 513AB
Crédits certifiés Mainpro+ d'apprentissage en groupe = 0.25

Objectifs d'apprentissage :
1. À la fin de cette présentation, le participant sera en mesure de déterminer les éléments essentiels du Programme de sensibilisation à la santé cardiovasculaire; de reconnaître l'importance d'adapter et d'offrir un programme de prévention et de promotion de la santé aux adultes qui n'ont pas de médecin de famille; et de

différencier le profil de santé de ces adultes de celui de la population générale.

Contexte : Le Québec affiche le pourcentage de patients orphelins le plus élevé au Canada. Par conséquent, des listes d'attente centralisées ont été mises sur pied dans le but de contrer les difficultés à obtenir un médecin de famille. Au moment de s'inscrire, les patients sont répartis selon des codes de priorité. En raison des délais d'attente et du caractère réduit des évaluations, il peut arriver que les codes de priorité ne soient plus à jour ou qu'ils soient erronés. Le Programme de sensibilisation à la santé cardiovasculaire (PSSC) pourrait permettre à des patients sur la liste d'attente de se voir accorder une nouvelle priorité et obtenir plus rapidement l'accès à un médecin de famille. Le BUT de ce projet pilote est de déterminer dans quelle mesure il serait réalisable et acceptable de mettre en place un programme comme le PSSC pour les patients adultes en attente d'un médecin de famille. **Méthode :** L'intervention était offerte à des patients adultes de 40 ans et plus inscrits sur la liste d'attente du guichet d'accès à un médecin de famille de Laval (Québec). Des séances PSSC ont été menées par des bénévoles formés, sous la supervision d'une infirmière. Leur déroulement comprenait notamment la prise de la pression artérielle, la mesure du tour de taille et de l'IMC, l'évaluation du risque cardiométabolique, la distribution de documentation éducative et d'information sur les ressources communautaires liées aux saines habitudes de vie, et la recommandation à un MF local pour les patients chez qui un risque de santé a été décelé. **Résultats :** Le projet a permis d'identifier les patients qui nécessitaient de l'aide médicale immédiate. En effet, plus de 40 % des participants ont été orientés vers des programmes de promotion de la santé offerts par des autorités sanitaires locales. La plupart des participants étaient sédentaires, ne consommaient pas suffisamment de fruits et légumes et souffraient d'embonpoint ou d'obésité. **Conclusion :** Les programmes communautaires de sensibilisation à la santé cardiométabolique, tels que le PSSC, peuvent présenter des avantages pour les évaluations des guichets d'accès : ils permettent d'identifier les participants qui nécessitent des soins immédiats et de leur attribuer un médecin, d'offrir de la documentation éducative sur les saines habitudes de vie et d'orienter les participants vers des ressources communautaires locales gratuites ou à prix abordable, qui souvent, sont inconnues des participants ou généralement sous-utilisées.

W752
16:15–16:30

Évaluation de l'état de préparation à la mise en place du Programme de sensibilisation à la santé cardiovasculaire dans les logements sociaux subventionnés du Québec

Janusz Kaczorowski, PhD; Marie-Thérèse Lussier, MD, MSc; Gina Agarwal, MD, PhD; Magali Girard, PhD

ROOM / SALLE : 513AB

Crédits certifiés Mainpro+ d'apprentissage en groupe = 0.25

Objectifs d'apprentissage :

1. À la fin de cette présentation, le participant sera en mesure de déterminer les éléments essentiels du Programme de sensibilisation à la santé cardiovasculaire, de comprendre les profils de santé et conditions de vie particuliers des adultes vivant dans un logement social subventionné et de comprendre à quel point les consultations avec les intervenants clés sont importantes pour adapter un programme communautaire afin de répondre aux besoins d'une population vulnérable.

Contexte : Les résidents des logements sociaux subventionnés constituent une tranche de la population vulnérable, à faible revenu, et reconnue comme étant en moins bonne santé que les locataires de logement privé ou les propriétaires. Le Programme de sensibilisation à la santé cardiovasculaire (PSSC) est un programme communautaire de prévention et de prise en charge des maladies chroniques. Son objectif consiste à réduire le fardeau associé aux maladies chroniques qui pèse sur le système de santé en s'attaquant aux facteurs de risques, en aidant les patients à obtenir des soins primaires et en améliorant les liens avec les ressources communautaires. Présenté sous forme d'évaluation des besoins et de l'état de préparation, ce projet a pour BUT, avant tout, d'évaluer les attitudes des principaux intervenants (disposés au changement), les conditions (le contexte, la structure) et les ressources (humaines, matérielles et financières) : en somme, tout ce qui est nécessaire à l'intégration d'un programme comme le PSSC dans les logements sociaux du Québec. **Méthode :** Ce projet propose d'adapter le PSSC aux besoins locaux en appliquant une approche intégrée de transfert du savoir qui repose sur la consultation de cliniciens, de participants, de gestionnaires du système de santé et d'édifice de logements sociaux, et d'ambulanciers. L'intervention comprend une série de groupes de discussion avec les principaux intervenants, et un sondage

ciblant les résidents des logements sociaux. **Milieu et participants :** Ce projet sera réalisé dans des cliniques et des logements sociaux situés dans les réseaux de recherche fondée sur la pratique de l'Université McGill et de l'Université de Montréal. **Résultats :** Les paramètres à l'étude compteront notamment un profil de l'état de santé des locataires de logements sociaux, ainsi qu'une analyse de leurs besoins en matière de soins de santé et de leur niveau de littératie en santé. Les groupes de discussion éclaireront les positions des intervenants, et mettront en valeur les conditions et les ressources qui entrent en jeu dans la mise en œuvre de programmes comme le PSSC pour les résidents des logements sociaux. **Conclusion :** Les résultats du sondage et des groupes de discussion seront indispensables pour formuler des recommandations et pour rédiger un guide d'implantation. On s'attend à ce qu'une part importante des résidents n'aient pas d'interactions régulières avec des fournisseurs de soins primaires et, probablement, que peu d'entre eux aient un médecin de famille. Un protocole de suivi sera ajouté au guide d'implantation une fois que les facteurs de risques seront identifiés.

W574 **Addressing Driving Retirement with Our Clients: A scoping review**
16:30–16:45
Julie Lapointe, erg., OT(C), OT Reg. (Ont.), PhD; Katelyn Bridge, OT Reg. (Ont.), Christopher C. Frank, MD, CCFP (COE), FCFP; Janet M. Craik*, MSc, OT(C), OT Reg. (Ont.)

ROOM / SALLE : 513AB
Mainpro+ Group Learning certified credits = 0.25

Objective: To review the existing literature on interventions supporting clients in their transition to driving retirement. **Design:** A scoping review was completed in September 2016. Articles were identified through PubMed, Embase, and the reference lists of relevant articles with key words that included "driving retirement intervention" and "driving cessation intervention." The selected articles had to be published in English and provide specific directions to support the transition to driving retirement. Articles strictly focused on the assessment of driving capacities were excluded. A thematic analysis was conducted to synthesize findings. **Findings:** Twenty articles were deemed relevant to informing professionals' interventions related to driving retirement. These articles fell into four themes: outcomes of driving retirement (n = 5), perceived barriers to driving retirement (n = 2), suggestions for driving retirement interventions (n = 3), and description and evaluation of existing programs (n = 10). Programs and interventions were often delivered in a group format by multidisciplinary teams including occupational therapists, physicians, nurses, and peer leaders and addressed both practical and emotional concerns associated with driving retirement. **Conclusions:** The results of this review will enable family physicians to identify and explore with clients the practical and emotional concerns linked to driving retirement. Family physicians will also be able to provide concrete and evidence-based strategies to their clients who need to transition to driving retirement. Finally, family physicians will be able to determine situations that would benefit from the input of an occupational therapist.

W603 **Overcoming Language Barriers Through the Training of Health Professional Students as Volunteer Interpreters**
15:00–15:15
Shiva Adel, MD, MSc; Belle Song, MD, CCFP; Eva Purkey, MD, CCFP, FCFP, MPH

ROOM / SALLE : 513CD
Mainpro+ Group Learning certified credits = 0.25

Background and Purpose: In recent years Kingston, Ontario, has seen an influx of new Canadians with limited English proficiency, most recently with the arrival of Syrian refugees. Currently, there are limited resources for medical interpretation at the Queen's Family Health Team (QFHT). Patients with limited English proficiency have significant health disparities, which can be improved through access to trained interpreters. **Objective:** To develop and evaluate a sustainable model to provide free interpreter services within primary care to patients with limited English proficiency at the QFHT. **Design:** Surveys, program evaluation, qualitative descriptive. **Setting:** Academic family health team in a medium-size city. **Participants:** Forty-four student volunteers from health sciences backgrounds, more than 50 patients with limited English proficiency, and health care providers at the QFHT. **Intervention:** Student volunteers underwent a training session regarding medical interpretation, confidentiality, and cultural competency. They were paired with patients with low English proficiency and attended medical intake and follow-up appointments at the QFHT to provide interpretation between patients and health care practitioners throughout the year. **Main outcome measures:** Surveys were distributed to volunteer interpreters prior

to the training session to assess interest, level of experience, and exposure to medical interpretation. A second survey was then administered several months later to collect feedback from volunteers, patients, and health care practitioners regarding the effectiveness of the program and potential improvements that could be implemented. **Results:** Volunteer interpreters attended two evenings of patient intake sessions and more than 40 follow-up appointments and urgent care visits. Preliminary feedback from volunteers and health care providers is positive and suggests that this provides a valuable service to underserved patients and health care providers at the QFHT. **Conclusions and Discussion:** Our program provides access to free interpreter services at the QFHT through health sciences students who have received informal training in interpretation, cultural competency, and confidentiality.

W681 **What Can We Learn From Action on Social Determinants of Health in Low-Resource Countries?**
15:15–15:30 Labib Girgis*, MD; Anne Andermann, MD, DPhil, CCFP, FRCPC

ROOM / SALLE : 513CD
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Understand the social challenges faced by patients in their countries of origin

Objectives: To explore how health care providers from low- and middle-income countries (LMICs) address the social challenges faced by their patients in their clinical practices. **Design:** A qualitative descriptive research methodology was used involving semi-structured in-depth interviews. All interviews were conducted in English (either in person or by phone), audio recorded, and transcribed verbatim. A conventional content analysis was used to analyze the data. **Setting:** The study was conducted at a large, university-affiliated family medicine centre in Montreal that serves one of the most ethnically diverse patient populations in Canada. **Participants:** Purposive sampling was used to recruit health workers with clinical experience in LMICs, specifically the Eastern Mediterranean region, as well a good understanding of the Canadian context. Recruitment of health workers trained in the Eastern Mediterranean region and who have since moved to Canada continued until data saturation was reached (N = 19). **Main outcomes:** Common social challenges, barriers, and facilitators for action in LMICs and South-North learning to help Canadian health workers identify and act on social challenges of the diverse patient populations they serve. **Findings:** The main social challenges of patients in LMICs include poverty, illiteracy, domestic violence, unstable families, and food insecurity. Health workers reported assisting vulnerable patients by increasing their access to health care services, helping them afford medications, and referring them to social supports, where available. Barriers included cultural and time constraints, unfamiliarity with social support resources, large patient loads, and inadequate numbers of family doctors. Participants suggested that both health workers and patients need to be educated on the importance of discussing and addressing social challenges during the clinical encounter. **Conclusions:** Many Canadian health care providers have socially and ethnically diverse practices. Understanding the social challenges faced by patients in their countries of origin can promote cultural competence to help health workers better address marginalization and inequity in the Canadian context.

W111 **Implementation of the OCFP Poverty Screening Tool in Primary Care and Pediatrics**
15:30–15:45 Michael P. Flavin, MBBCh; Eva Purkey, MD, MPH, CCFP, FCFP; Imaan Bayoumi, MD, MSc, CCFP, FCFP; Helen Coo, MSc; Andrew D. Pinto, MD, CCFP, FRCPC, MSc; Christina Klassen, MD; Shannon French, MD; Matti D. Allen, PhD; Ethan Toumishey, MD

ROOM / SALLE : 513CD
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Identify some of the barriers to universal poverty screening in primary care and pediatric settings

Objective: To evaluate the feasibility of universal screening for poverty in primary care and pediatric settings. **Design:** This study was an implementation evaluation of universal poverty screening. Health care providers were first trained using the Ontario College of Family Physicians' (OCFP's) "Treating Poverty" workshop and related Poverty Tool. They were instructed to perform universal poverty screening on their patients using the question "Do you have difficulty

making ends meet at the end of the month?" for the duration of the study (three months). Health care providers tracked the numbers of patients screened. Surveys were distributed to patients to assess the acceptability of being screened for poverty in a health care setting. Following the study period, health care providers were invited to focus groups to explore barriers to and facilitators of implementing universal screening with this tool. **Setting:** This study took place in six family medicine practices (community health centres, family health teams, an academic family health team, and private practice), as well as in in-patient and outpatient pediatric settings in Kingston and Napanee, Ontario. **Participants:** Twenty-two health care providers (family doctors, nurse practitioners, pediatricians). One hundred forty-eight patients completed the questionnaire about poverty screening. **Findings:** Despite the substantial motivation of the providers, only approximately 10 per cent of patients were screened during the study period. Most patients (72 per cent) either agreed or strongly agreed that screening was important. Lack of time and simply forgetting were some of the barriers encountered. Despite these barriers, most health care providers strongly supported normalizing the discussion of a patient's financial situation. **Conclusion:** For health providers to identify and intervene in cases of poverty, barriers need to be addressed to ensure that screening is universal.

W840 Health Outcomes and Family Physician Patient Volumes: Phase I results

15:45–16:00 Terrence McDonald, MD, MSc, CCFP (SEM), DipSport Med; Lee Green, MD, MPH

ROOM / SALLE : 513CD

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Understand the demographics and billing patterns of high-volume family physicians in Alberta
2. Understand the current labour supply of family physicians in Alberta

Primary care physician remuneration policies in Alberta are currently under review; at the moment it is a predominantly fee-for-service (FFS) system. Using blended capitation and capping FFS billings per day are being considered. Both would discourage high-volume (> 50 patients/day) practice, but little is known about high-volume practice in Alberta and its impact on patient outcomes. Using Alberta family physician (FP) billing and demographic data on all FFS FPs in the province (N = 3,465), we set out to improve our understanding of current physician patient volumes and billing practices in relation to associated provider demographics. Our first step was to characterize high-volume practice, including international medical graduate (IMG) status, geography, and billing patterns. Approximately 30 per cent of FPs currently working in Canada are IMGs. High-volume status was modelled on general practice billing data from 2011 to 2015, provider demographic characteristics, and geographic parameters in simple comparisons and in a logistic regression. Logistic regression analysis revealed that high-volume practitioners tended to avoid service codes representing time-intensive services, were typically older, were typically male, and tended to be located in the north of the province. IMGs were substantially more likely to be high-volume practitioners. Rurality was not associated with high-volume practice independently of location in the north. A large number of FPs do work not full-time. The results of this study serve to fill an important knowledge gap about high-volume practitioners and facilitate the next step in exploring the interaction between service volume and health outcomes. These results are important for policy-makers when considering the design of a payment system to optimize patient outcomes. Health outcomes data and analysis (Phase II) are also expected to be ready to present at the time of this presentation.

W837 Examining Family Medicine Residents' Self-Reported Perceptions of Their Specialty

16:00–16:15 Deena M. Hamza*, PhD; Shelley Ross, PhD; Ivy Oandasan, MD, CCFP, FCFP, MHSc

ROOM / SALLE : 513CD

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Explain how the Family Medicine Longitudinal Survey can be used to explore resident perceptions of their training and discipline
2. Describe family medicine residents' perceptions of how they and others value family medicine as a discipline
3. Identify ways in which perceptions of value of family medicine as a discipline may change over time in residency training

Context: Triple C is a competency-based medical education initiative that aims to ensure graduates from any family medicine residency program in Canada are prepared to provide comprehensive care to patients across their lifespan and meet the needs of the community. The Family Medicine Longitudinal Survey (FMLS), which began in 2012, is intended to evaluate Triple C. In this study, we used data from the FMLS to explore potential changes in perceptions about the discipline of family medicine pre- and post-residency. **Objective:** To explore resident responses on the FMLS responses from residents to: understand how residents perceive their medical specialty; identify aspects of the discipline that may need improvement; and show evidence of changes in perceptions pre- and post-residency. **Design:** Secondary data analysis. **Intervention (data sources):** De-identified FMLS responses from one cohort at entrance (T1) and exit (T2) of residency (N = 424). **Outcome measures:** Level of agreement with statements about family medicine as a discipline. **Results:** The majority of residents agreed with feeling proud to become a family physician; that patients recognize the value of the discipline; and that family physicians provide a valuable contribution that is different from other specialists and valuable beyond referrals. This high level of agreement was consistent at T1 and T2. Interestingly, a significant proportion of T2 respondents felt the government does not perceive family medicine as essential to the health care system, a notable reduction from T1 responses. This finding was not found to be correlated with practice intentions. **Discussion:** The FMLS has provided insight into resident perceptions of family medicine. While most perceptions about the discipline were positive at T1 and T2, more than 50 per cent of respondents indicated they perceived the government does not value the discipline. **Conclusions:** Surveying residents about their perceptions about family medicine has provided valuable insights into areas needing further examination.

W760 The Personal Health of Family Physicians: Barriers, gaps in care, and solutions

16:15–16:30

Mamta Gautam, MD, FRCPC, MBA; Caroline Gerin-Lajoie, MD, FRCPC; David Harel, MD; Bismil Ramprasad, MD, FRCPC, MBBS; Christopher Simon, PhD; Iuliia Oleksand Povieriena, MSc; Bridget McDonald

ROOM / SALLE : 513CD

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Recognize the barriers and gaps in the system preventing physicians from maintaining their personal health
2. Explore solutions within their work environment to build support and improve ease of access to resources

Objective: To determine the barriers and systemic gaps physicians encounter when seeking help, and suggest solutions to prevent physician burnout. **Design:** This qualitative study used grounded theory to uncover the recurrent themes identified in semi-structured discussion groups. **Setting:** This study was conducted in the setting of a conference on physician wellness. **Participants:** Convenience sampling, 57 participants, 51 per cent family physicians, 35 females, 22 males. **Intervention:** Following the testimonials of local physicians on themes of physician wellness and resilience, the participants were divided into 10 focus groups for discussion. **Main outcome measures:** Based on the recordings and scribe notes of the discussions, a spreadsheet of identified themes was created. These themes were then grouped into categories such as barriers, gaps, and solutions. The frequency of each theme being mentioned was tabulated and the most common themes were identified. **Findings:** Twenty-two themes related to barriers, nine themes on gaps, and 24 related to solutions were identified and their occurrence summarized. The most frequently mentioned barriers to seeking help were stigma, unsupportive work environment, and denial. The most commonly identified gap was lack of accessibility of existing services. This was especially true for family physicians in the community. The most frequently suggested solutions to barriers were creating a culture of support, providing continued mentorship, and improving awareness and accessibility of existing resources. **Conclusion:** The CanMEDS Framework for the role of Professional stipulates that the provision of optimal patient care requires physicians to take responsibility for their own health and well-being and that of their colleagues. The findings of this study indicate that for physicians to accomplish this, a culture of support, mentorship, and awareness must be created. Proposed solutions include improved communication and collaboration among colleagues to reduce stigma and remove the shame in seeking help.

W801 What Is the Link Between eConsult and CPD Programming?

16:30–16:45

Erin Keely, MD; Clare Liddy, MD, CCFP, FCFP; Douglas Green, MD; Julia Stratton, MD;

Christine Prudhoe; Douglas Archibald*, PhD

ROOM / SALLE : 513CD

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify learning opportunities that arise from eConsults
2. Compare clinical questions asked by primary care providers through eConsult to continuing professional development offerings

Objective: The objective of this study is to assess whether local annual refresher session offerings for primary care providers match their needs by coding and comparing session syllabi to clinical questions collected electronically through the Champlain Building Access to Specialists through eConsultation (BASE) service. **Design:** Retrospective review of eConsult clinical questions and continuing professional development (CPD) course offerings. **Participants:** Clinical questions posed by primary care providers through eConsult from July 2011 to January 2015. **Intervention:** Syllabi from 521 refresher CPD sessions offered to primary care providers in the eastern region of Ontario, Canada, over a three-year period (2012 to 2014). CPD session descriptions were coded using hybrid taxonomies derived from the International Classification of Primary Care Second edition (ICPC-2), *Journal of the American Medical Association* specialty classifications, and our eConsult specialty services experts. Of the 22,670 total CME minutes, 12,215 corresponded to the content offered through 12 eConsult specialty services. **Main outcome measure:** Percentage differences between CPD content and clinical questions posed through eConsult. **Results:** Congruence and dissonance between CPD content and clinical questions posed through eConsult varied significantly across the 12 specialty services. Within each specialty some topics were well covered while others were not. For example, psychiatry content such as depressive mood disorders, neurodevelopmental disorders, and substance-related and addictive disorders showed per cent differences ranging from 11.5 per cent to 26.3 per cent. Personality disorders, somatic system disorders, and trauma-related disorders showed strong congruence (1.5 per cent to 2.4 per cent difference). **Conclusion:** Differences between questions asked by primary care providers at the point of care through eConsults and the content of contemporaneous CPD refresher courses can be analyzed to identify gaps in offerings. This knowledge, if shared with CPD program offices and providers, could be used to develop CPD curricula and highlight areas of need for inclusion in primary care update activities.

W650 "Prisoner of measurement"—Kahlil Gibran

16:45–17:00 Robert Bernstein, PhD, MD CM, CCFP, FCFP

ROOM / SALLE : 513CD

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Understand longitudinality and comorbidity as key issues for family medicine research
2. Understand relevant measurements of quality of care
3. Understand how to use a structured electronic medical record for research

Recent trends in the measurement of quality seem almost irrelevant to the actual provision of care. Initiatives seem to focus on what is easily counted rather than what is important—the measurement of the irrelevant because it is available. Family medicine is the practice of general medicine for all ages in a context of low prevalence of disease, multiple accumulating comorbidities, and an ongoing doctor-patient relationship. The epidemiology of general practice is founded on treating the whole patient: treating all their diseases, providing prevention and screening, seeing patients over time, seeing symptoms evolve (either resolving or mutating into diseases), and managing multiple comorbidities for which evidence is scanty. Electronic medical records (EMRs) afford us the chance to analyze comorbidities and the longitudinal evolution of symptoms. To that end we need accurate, complete, and coded problem lists. We need new EMR recording paradigms to allow the analysis of episodic care. It is clear that the "episode of care" model will never be inculcated in Canadian EMRs and episodic care statistics have been obscured in billing diagnosis databases that suffer from being poorly coded and limited to one condition per visit. We need to teach our teachers and residents how to structure, manage, and use large EMR databases for the productive analysis of our practices. We should recognize comorbidity and longitudinality as

urgent areas of research in family medicine. It is this scientific approach that must be used to measure quality. We are not just patient-satisfaction oriented. We practise scientific generalism over time with a known, defined group of patients as a denominator. I will present unexpected comorbidity data from our EMR; for instance, our patients with diabetes are seven times more likely to have chronic back pain and GERD than expected, and our patients with asthma are 3.5 times more likely to be depressed.

W792 **Mental Health Impacts of Partnering Indigenous Elders Within Primary Care Teams:**
15:00–15:15 **A mixed methods prospective cohort study**

David Tu, MD, CCFP*; Elder Roberta Price; George Hadjipavlou, MD, FRCPC; Colleen Varcoe, RN, PhD; Jennifer Dehoney; Annette Brown, RN, PhD

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Understand the benefits Indigenous Elders have on patient care

Objective: To determine the mental health and broader impacts of patients connecting with Indigenous Elders as part of routine primary health care. **Design:** Mixed methods prospective cohort study with quantitative measures at baseline and after one, three, and six months; and in-depth qualitative interview at more than three months post intervention. **Setting:** A Western Canadian urban Indigenous primary care clinic. **Inclusion criteria:** Age > 18 years, self-identifying as Indigenous, and no prior contact with an Elders program. **Participants:** Forty-two patients were enrolled—four had incomplete follow-up and one died—allowing for complete quantitative data for 37 participants. Seventy per cent were female; the mean age was 51 years. Thirty-three per cent had attended residential school and 67 per cent had experience in the foster care system. **Intervention:** Participants connected with an Indigenous Elder as part of a one-on-one and/or group sessions. Follow-up visits were left to the discretion of the participant and the Elder. **Main outcome measures:** Quantitative depressive symptoms (PHQ9) and suicide risk (SQB-R) and qualitative descriptions of health impacts and harms. **Results:** Twenty-four participants at baseline had moderate/severe depression (PHQ9 > 10); of these there was a decrease in depressive symptoms (5 points) that was sustained over a six-month period ($P = 0.002$). Ten participants had an above-average suicide risk at baseline (SQB-R > 7); of these there was a decrease in suicide risk (2 points) that was sustained over a six-month period ($P = 0.008$). Twenty-nine participants completed qualitative interviews; 28/29 indicated a clear positive impact, 0/29 indicated harms. Common impacts were improved emotional regulation, adaptive behavioural changes, increased social connection, improved housing status, improved employment status, and less use of mood-altering substances. **Conclusions:** Connection with Indigenous Elders as part of routine primary care had a significant positive impact on depressive symptoms and suicide risk; it was also associated with beneficial mood, behavioural, and social outcomes and was not associated with identifiable harms.

W546 **Barriers and Facilitators in Primary Care Follow-Up Upon Hospital Discharge:**
15:15–15:30 **Patients' and caregivers' perspectives**

Soumia Meiyappan*, MSc; Benjamin Kaasa, MD, MScCH, CCFP; Hannah Sidrak, MBBS

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Identify a number of barriers and facilitators patients face in post-discharge follow-up care

Objective: To explore patient and caregiver experiences with how easy or difficult it was for patients to follow up with their primary care provider upon discharge from hospital. The transition period from an in-patient setting to an outpatient setting is a vulnerable time for patients. **Design:** Qualitative descriptive research design through the use of semi-structured individual interviews. **Setting:** The study took place at the Toronto Western Family Health Team (TWFHT) in Ontario. Interviews were held on-site or over the phone. **Participants:** Interviews were carried out with a total of 13 participants (11 patients and two caregivers). The purposive sampling technique was used to select patient participants who were: discharged home from the Family Inpatient Service unit of the TWFHT in the past 30 days;

had an identified primary care provider in Ontario at the time of discharge; suffered from one or more of chronic obstructive pulmonary disease exacerbations, congestive heart failure, gastrointestinal disorders, pneumonia, or acute myocardial infarction; and able to speak English, Portuguese, or Mandarin (interpretation was made available). **Findings:** Thematic analysis identified a number of barriers to follow-up by patient participants, including language barriers, lack of communication between the patient and their primary care provider and/or in-patient physician, and lack of communication between the primary care provider and in-patient physician. Among the main facilitators of follow-up identified were the availability and accessibility of a patient's primary care provider, a patient's proximity to the primary care provider, and accessible transportation to and from the primary care provider's office. **Conclusion:** Understanding patients' post-discharge experiences has the potential to aid in developing interventions to improve patient quality of life and care in the post-discharge transitional period. By including the experiences and perspectives of both the patient and their caregiver, our research team was able to gain broader critical insight into patients' post-discharge experiences and create recommendations on strategies to improve them.

W866
15:30–15:45

Reluctance to Discuss Advance Care Planning With Primary Care Providers Despite Prompting During Emergency Department Visits

Mandeep Pinky Gaidhu*, MD, PhD; Natasha Stribbell, MD; Kathryn Armstrong, MD, FRCP; Jaewoo Park

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Assess whether prompting at the emergency department would increase advance care planning discussions by patients with their primary care providers
2. Determine patient-perceived barriers to discussing advance care planning with their primary care providers

Context: Advance Care Planning (ACP) is important for patient-preferred care goals. Due to the complexity of ACP, discussions should occur with patients' primary care providers. However, ACP discussions often occur in the emergency department (ED) during acute clinical encounters; this is not a conducive setting for such discussions. **Objective:** To determine whether introducing the importance of ACP in the ED would promote discussions with primary care providers. **Participants and Setting:** Patients, 75 years or older, attending a community hospital ED for non-urgent medical conditions. **Interventions:** Patients who consented to participate were given a handout describing ACP and encouraged to pursue discussions with their primary care providers upon ED discharge. A follow-up telephone survey ensued at four to six weeks post-ED discharge to assess whether patients had initiated ACP discussions with their primary care providers. We also sought information regarding barriers to ACP discussions with their primary care providers. **Results:** Fifty-four handouts were offered during the ED visits, of which 50 were accepted. However, only 26 (52 per cent) patients agreed to participate in the post-discharge telephone survey. The post-discharge survey indicated only three of the 26 patients, all females, had initiated ACP discussion with their primary care providers. Of those who did not initiate ACP discussions with their primary care providers (23 of 26), 36 per cent stated it was not a priority, 27 per cent stated their physician-patient relationship was not open to such conversations, and 36 per cent felt it was a family matter not requiring discussions with the primary care provider. **Conclusions:** The intervention implemented at the ED to promote ACP discussion by patients with their primary care providers was not successful due to the patient-perceived barriers described above. Knowing these patient-perceived barriers would be important for primary care providers to initiate appropriate, targeted strategies to encourage ACP discussions, and to help alleviate the burden of such discussions at the ED during acute clinical encounters.

W724
16:00–16:15

Medical Assistance in Dying: Concern and optimism from palliative care physicians

Joshua Shadd, MD, MClSc, CCFP (PC); Marilyn Swinton, MSc; Cait O'Donnell, MBHL; Joseph Pellizzari, PhD; Kathleen Willison, MSc; Andrea Frolic, PhD; Anne Woods, MD, CCFP (PC), FCFP

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Understand palliative care physicians' perceptions of the anticipated impact of the legalization of medical assistance in dying

Objective: To understand palliative care physicians' perceptions of the anticipated impact of the legalization of medical assistance in dying (MAID) **Design:** Qualitative descriptive from in-depth interviews. **Setting:** Interviews were conducted in the time period between the 2015 Supreme Court ruling that decriminalized MAID in Canada and the implementation of federal legislation to govern the practice. **Participants:** Forty-four physicians (42 family physicians) practising primarily palliative care in southern Ontario. **Findings:** Participants articulated a wide spectrum of ideas regarding the nature and degree of anticipated impacts of the legalization of MAID. Participants anticipated impacts in multiple overlapping spheres affecting their patients, themselves, and their colleagues. Responses demonstrated complex and evolving ways of thinking about MAID that expressed a mixture of concern and optimism. **Conclusions:** Participants described the anticipated impact of the legalization of MAID primarily in relational terms. The principles of relational ethics were not a sensitizing concept for this study, but they provide a helpful lens through which to understand participants' perspectives.

W706 **Implications of Identifying Older Patients in Primary Health Care at Risk of Dying**

16:15–16:30 Robin Urquhart*, PhD; Jyoti Kotecha, MPA; Cynthia Kendell, MSc; Mary Martin, MSc; Han Han, PhD; Beverley Lawson, MSc; Cheryl Tschupruk, MSW; Emily Marshall, PhD; Carol Bennett, MSc; Fred Burge, MD, CCFP, FCFP, MSc

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Be able to identify the value and implications of practice-based end-of-life identification

Objective: To explore the acceptability and implications of using a primary health care (PHC)-based electronic medical record (EMR) algorithm to help providers identify patients in their practices at risk of declining health and dying. **Design:** Qualitative descriptive study using focus group methods (six in total). Participants were purposively sampled to gain maximum variation. Thematic analysis, using a constant comparative approach, was used to analyze data. **Setting:** PHC, palliative care, and geriatric care in Nova Scotia and Ontario. **Participants:** Twenty-nine health care providers and policy-makers in PHC, palliative care, and geriatrics. **Main outcome measures:** Knowledge of whether EMR identification algorithms are acceptable to health care providers and policy-makers, and informed views on the clinical, policy, and social implications of practice-level identification in PHC. **Findings:** PHC-based identification was viewed as acceptable and aligned with the values, aims, and positioning of PHC. Participants were less concerned about the identification algorithm itself and more concerned about what to do after identification. Participants felt PHC providers require additional training and supports to undertake conversations around a patient's values, wishes, and goals for future health care (i.e., advance care planning, ACP). Participants emphasized early identification and ACP conversations require an integrated team approach. They also noted early identification would not only trigger ACP discussions, but also prompt patients to reflect on and undertake life planning. Participants highlighted the need for a public health approach to early identification and that ACP is needed to optimize early identification and its impact. **Conclusion:** The research team has developed a validated algorithm using PHC EMR data to identify persons at risk of dying within 12 months. Understanding the implications of practice-level identification is critical to implementing EMR algorithms in ways that facilitate sensitive and responsive identification and care planning.

W661 **Reasons for Requesting Medical Assistance in Dying**

16:30–16:45 Ellen Wiebe* MD, CCFP, FCFP; Jessica Shaw, MSW, PhD; Stefanie Green MD; Michaela Kelly

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Describe the most important reasons Canadian patients give for requesting MAID

2. Describe some of the differences between the reasons given by patients with different diagnoses
3. Describe some of the differences between the reasons given by patients who had or did not have MAID

Background: Canadians have had the right to medical assistance in dying (MAID) nationally since June 2016. **Objectives:** The purpose of this study was to review charts of people who requested MAID to examine the reasons for their requests. **Method:** This was a retrospective chart survey of patients who requested an assisted death and were assessed by one of six physicians in British Columbia during 2016. **Results:** We have data on 270 assessments for MAID, with 132 assisted deaths, 14 natural deaths, and 124 others. The patients who had assisted deaths ranged in age from 26 to 102 years with a mean age of 74.2 years. The most common diagnoses were malignancies (61, 46.2 per cent), end-organ failure (29, 22.0 per cent), and neurological diseases (28, 21.2 per cent). For people who had assisted deaths, the reasons they gave as being the most important for their choice were disease-related symptoms (57, 43.2 per cent), loss of autonomy (32, 24.2 per cent), loss of the ability to enjoy activities (32, 24.2 per cent), and fear of future suffering (10, 7.6 per cent). There were significant differences in reasons given by people with different diagnoses; 66.7 per cent of patients with malignancies gave either disease-related symptoms or fear of future suffering as their most important reason while 66.7 per cent of people with neurological diseases gave either loss of autonomy or loss of the ability to do enjoyable or meaningful activities as their most important reason. ($P < 0.001$). **Conclusion:** This study shows that the reasons patients in British Columbia give for requesting an assisted death are somewhat different from those in other jurisdictions. Only 53.4 per cent of our patients listed loss of autonomy as the first or second most important reason for the request compared with 91.4 per cent of patients in Oregon. Loss of ability to enjoy activities was given as a reason by 53.4 per cent of our patients compared with 86.7 per cent of the Oregon patients.

W799 **Engaging Patients as Observers in Monitoring Hand Hygiene Compliance in Family Practice**

16:45–17:00

Chaitali Desai, Peng, MScHQ; Jeremy Rezmovitz*, MD, CCFP; Judith Manson, RN, NCMP; Sandra Callery, RN, MHSc, CIC; Mary Vearncombe, MD, FRCPC

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Identify a patient engagement strategy to monitor hand hygiene compliance in family practice

Objective: The objective of this quality improvement (QI) study was to assess the feasibility of engaging patients as observers to investigate hand hygiene compliance rates in our family practice clinic at Sunnybrook Hospital in Toronto, Ontario, and whether all four moments of hand hygiene were being met. **Design:** This QI study was conducted from 2013 to 2016. Each cycle occurred for a 2.5-week period. A convenience sampling strategy was used to obtain representative data by engaging a sample of participants presenting for scheduled appointments. **Setting:** The Sunnybrook Academic Family Health Team (SAFHT), which provides primary care services to patients and families. **Participants:** Participants included patients presenting to the SAFHT clinic. **Intervention:** Patients presenting to the clinic were asked if they would be willing to participate in observing and recording their health care providers' hand hygiene compliance. Patients agreeing to participate were given a one-page survey audit tool with instructions on which to record their observations. The surveys were collected from a drop box at the end of the observation period and responses were entered into a spreadsheet for analysis and reporting. **Main outcome measures:** Hand hygiene compliance rates. **Results:** This study demonstrated a hand hygiene compliance rate of 94 per cent in 2016 to 97 per cent in 2013, maintaining the target of 95 per cent for the clinic and exceeding the overall hospital target of 87 per cent. **Conclusion:** This study emphasized the importance of patient communication as a novel way to evaluate programs that have direct patient care implications. The success of this initiative has encouraged its expansion to other ambulatory areas of the hospital. The results must be considered in light of study limitations, such as reliance on volunteer resources and the Hawthorne effect.

W622 **False Positive Newborn Screening Results for Cystic Fibrosis: Impact on health service use**

15:00–15:15

June C. Carroll, MD, CCFP, FCFP; Robin Z. Hayeems, ScM, PhD; Fiona A. Miller, PhD; Marian Vermeulen, MHSc; Beth K. Potter, PhD; Pranesh Chakraborty, MD; Christine Davies, MSc; Felix Ratjen, MD, PhD; Astrid Guttmann, MD CM, MSc

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Assess the possible harms that may result from false positive newborn screening results

Objective: Evidence is mixed regarding the impact of false positive newborn screening results on health care use. Using cystic fibrosis (CF) as an example, we determined the association of false positive newborn screening results with health care use in infants and their mothers in Ontario, Canada. **Design:** Population-based cohort study **Setting and Participants**: All infants with false positive CF results (n = 1,564) and screen negative matched controls (n = 6,256) born between April 1, 2008, and November 30, 2012, using linked health administrative data sets. **Outcomes:** Maternal and infant physician and emergency department visits and inpatient hospitalizations from the infant's third to 15th month of age. Negative binomial regression tested associations of newborn screening status with outcomes, adjusting for infant (comorbidities, income quintile, rurality) and maternal (age, mental health history) characteristics. **Results:** A greater proportion of infants with false positive results had more than two outpatient specialist visits (16.2 per cent versus 13.2 per cent) and more than two hospital admissions (1.5 per cent versus 0.7 per cent) compared with controls; emergency department visits were not significantly different. Differences persisted after adjustment, with higher rates of specialist visits (RR 1.39, 95% CI 1.20 to 1.60) and hospital admissions (RR 1.70, 95%CI 1.24 to 2.34) for false positive infants. Stratified models indicated the effect of false positive status was greater among those whose primary care provider was a pediatrician compared with those whose primary care provider was a family physician. No differences in health care use among mothers were detected. **Conclusion:** Higher use of outpatient specialist services among false positive infants may relate to follow-up carrier testing or heightened perceptions of vulnerable infant health by parents or providers. However, increased rates of hospitalization might signal increased medicalization of these healthy infants. By understanding the downstream experience for patients and providers, newborn screening programs can better support them in navigating screening results. Specifically, counselling and education resources can be improved to ensure that parents and providers understand the benign nature of false positive CF screening results.

W755 Breastfeeding Discontinuation in the Cypress Health Region and Intrapartum Factors

15:15–15:30

Kristin Bonkowski, MD; Nicole Heintz, MD; Dalynne Peters, MD; Breanne Irving*, MBBS; Kevin Wasko*, MD, CCFP, MA; Kelechi Eguzo, MD, MPH

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Determine the relationship between intrapartum factors and breastfeeding discontinuation

Background: Previous research reveals that breastfeeding rates in the Cypress Health Region (CHR) dropped from 97 per cent at discharge to 36.1 per cent and 22.3 per cent at two and four months post-partum, respectively. There is limited information on the relationship between intrapartum factors and breastfeeding discontinuation in CHR. **Objective:** To determine the relationship between intrapartum factors and breastfeeding discontinuation in CHR. **Design and participants:** A cross-sectional retrospective chart audit of all women who delivered live infants at the Cypress Regional Hospital between January 1, 2014 and December 31, 2015 was performed. **Methods:** Intra-partum factors were included in analysis, including: duration of labor, route of delivery, skilled attendant at labor, Group B Strep (GBS) status, type of analgesia, presence of perineal tear and presence of postpartum hemorrhage (PPH). Demographic factors were also considered, including: maternal age, body mass index and gestational age at delivery. Outcomes considered were breastfeeding status at discharge, two and four months postpartum. Data was analyzed using descriptive statistics, t-test, chi-square test and logistics regression. **Results:** A total of 762 charts met the inclusion criteria, representing normal vaginal deliveries (65.5 per cent, 499/762), caesarean sections (27 per cent, 206/762), and operative vaginal deliveries (7.5 per cent, 57/762). 92 per cent (701/762) of mothers breastfed at discharge and were subsequently followed at two and four months post-partum. Of those breastfeeding women, the average patient age was 28.3 (±5) years and 40.3 per cent were primiparous. 72.7 per cent (336/462) and 57.5 per cent (267/464) who presented for follow up with public health at two and four months, respectively, were

breastfeeding. There was no significant independent relationship between breastfeeding at two and four months with presence of PPH, GBS status, perineal laceration or duration of labor. Women who had a normal vaginal delivery were more likely to breastfeed at discharge (OR=3.03, 95%CI (1.76-5.21) compared to other routes. Significant multivariate predictors of breastfeeding at two months were maternal age ($P < 0.002$), gestational age ($P < 0.034$), epidural analgesia ($P < 0.004$), and opioid analgesia ($P < 0.019$). Midwifery ($P < 0.014$) and specialist patients ($P < 0.0003$) were more likely to breastfeed at four months than those delivered by a family physician. **Conclusions:** Breastfeeding discontinuation rates in the CHR at two and four months postpartum are noteworthy. Intrapartum factors that may predict breastfeeding discontinuation are type of analgesia and provider involved in delivery. Significant demographic factors include both maternal and gestational age.

W775
15:30–15:45

Age-Related Decline in Social Connections: Does it affect loneliness and depression in the elderly?

Alanna Cluff, MD, CCFP (EM); Adam Rosanally, MD, CCFP; Matthew Orava, MD, MHSc, CCFP; Anwar Parbtani*, MD, CCFP, FCFP, PhD

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Assess age-related decline in social connections and its impact on loneliness and/or depression in the elderly

Objective: To explore whether an age-related decline in social connections/capital exists, and whether it has an impact on loneliness and/or depression in the elderly. **Design, setting, and participants:** A survey of patients, 55 to 85 years of age, was conducted at 10 primary care practices using a written questionnaire inquiring about employment and social and family connections via personal contact, telephone, the Internet, or social media. The questionnaire also inquired about living arrangement, loneliness, and depression. In addition, patients filled out a 15-question Geriatric Depression Scale (GDS). **Results:** One hundred one survey questionnaires were completed. These were divided into three age-groups (Group 1: 55 to 60 years, n = 32; Group 2: 61 to 70 years, n = 32; and Group 3: 71 to 85 years, n = 37) and analyzed using chi-square and *z* statistics. There was a significant age-related decline in employment-related connections (66 per cent versus 28 per cent versus 16 per cent, Groups 1 to 3, respectively; $P < 0.005$). There was no difference for connections with friends (53 per cent; 66 per cent; 65 per cent) or family (66 per cent; 66 per cent; 62 per cent, for Groups 1 to 3, respectively). Only a small number were living alone (13 per cent versus 25 per cent versus 19 per cent, Groups 1 to 3 respectively; NS). Depression was reported by 13 per cent, 25 per cent, and 16 per cent in Groups 1 to 3, respectively (NS). GDS score was similar in all three groups (8±3 versus 7±2 versus 7±2 in Groups 1 to 3, respectively). History of depression was lowest in Group 3 (19 per cent versus 41 per cent for Group 2 and 50 per cent for Group 1; $P < 0.02$). Loneliness was similar in all three groups (25 per cent, 19 per cent, and 22 per cent, respectively; NS). **Conclusions:** Other than an expected employment-related decline in social connection, there was no age-related decline in social capital. The oldest cohort (Group 3) did not show any greater loneliness and had a lower prevalence of depression than the other two cohorts. We conclude that the loss of social connections is not a major determinant for loneliness or depression in the elderly, warranting greater attention to parameters such as economic status and service accessibility.

W750
15:45–16:00

The Competency of Family Physicians in Adolescent Medicine: A mixed-methods systematic literature review

Diana Ramos, MD, MA; Pierre-Paul Tellier, MD, CCFP, FCFP; Julius Erdstein, MD, FRCP; Suzanne MacDonald, MD, FRCP; Charo Rodriguez, MD, PhD

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify the areas of concern in adolescent medicine and the challenges of providing optimal care to young adults
2. Be able to contrast current evidence with daily practice
3. Be able to propose recommendations to reinforce skill acquisition in adolescent medicine

Objective: To synthesize knowledge on family physicians' preparedness in adolescent medicine. **Design:** A systematic literature review of works on this topic in which authors used either qualitative, quantitative, or mixed methods research approaches, published in scholarly journals between 1996 and 2016. Analysis was based on narrative synthesis. **Setting:** Ovid MEDLINE, PsycINFO, Embase, Web of Science, CINALH, and ERIC were searched, combining these main concepts: family physicians, competence, and adolescent. **Article eligibility:** Eligible papers should: 1) be published in English, French, or Spanish; 2) report results of empirical investigations; 3) include medical care provided to 12- to 25-year-old individuals; 4) examine family doctors' competences; and 5) mention barriers to and/or facilitators of acquiring competency in adolescent medicine. **Intervention:** Relevant studies were selected following the PRISMA guidelines. Upon deduplication and application of a language filter, 1,905 articles were identified. Screening of the titles and abstracts yielded 692 articles. Full text reading resulted in 49 articles for analysis. A scoring system was used to assess the quality of studies. **Main outcome measures:** A narrative synthesis analytical approach was adopted, which included a thematic analysis and elaboration of a conceptual map with the main findings. **Findings:** Family doctors do not achieve the same level of competency in the areas of adolescent mental health, gynecology, and pharmacology as they do in adult medicine. Specifically, knowledge, communication, advocacy, and the application of guidelines are the main themes in need of improvement. More results will be presented. **Conclusion:** Although the literature regarding objective measures of competency remains scarce, this study reveals that family doctors need to respond to several issues in adolescent medicine, specifically the areas where training is insufficient. Also, it gives some recommendations on how to align competencies, population needs, and health care systems structure.

W817 — Are Direct Oral Anticoagulants Being Prescribed Appropriately in Canadian Primary Care Practices?

16:00–16:15

Alexander Singer*, MB BAO BCh, CCFP; Finlay McAlister, MD, MSc, FRCPC, FACP; Leanne Kosowan, MSc; Scott Garrison, MD, CCFP, PhD

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Recognize factors associated with inappropriate prescribing of direct oral anticoagulants
2. Identify and define direct oral anticoagulants prescribing patterns in Canada

Objective: To evaluate the appropriateness of direct oral anticoagulant (DOAC) prescribing patterns in Canada among patients with atrial fibrillation being managed in the outpatient setting by primary care providers and explore the impact of patient or provider factors. **Design:** Retrospective review of electronic medical record data from the Canadian Primary Care Sentinel Surveillance Network repository. **Population:** Data from 744 primary care clinicians in 137 clinics, with 6,854 patients prescribed a DOAC between 2010 and 2015. **Outcome measures:** Inappropriate DOAC prescribing, defined as under-dosing, overdosing, or not indicated based on comorbidity or CHADS2 score. **Methods:** We performed multivariate analysis using logistic regression considering inappropriate DOAC use as the outcome and patient, provider, and practice as independent variables. **Results/findings:** Of the 6,854 patients prescribed a DOAC (mean age 74.8 years, 55 per cent male), 12.3 per cent (n = 844) of patients had an inappropriate prescription. Of these, 59.1 per cent were prescribed too low a dose; 3.7 per cent were prescribed a dose too high given their age, weight, and eGFR; and 42.5 per cent had conditions for which DOACs are not indicated (i.e., valvular atrial fibrillation, low CHADS2 score). Nearly half of the patients prescribed a DOAC were also prescribed antiplatelet agents or NSAIDs. Inappropriate prescribing of a DOAC was associated with polypharmacy (AOR 1.3, 95%CI 1.1 to 1.6), female patients (AOR 1.3, 95%CI 1.1 to 1.6), and patients younger than 65 years (AOR 1.6, 95%CI 1.3 to 2.2). Patients with comorbid heart failure or dementia were significantly more likely to be prescribed inappropriate DOAC doses. Regarding provider characteristics, inappropriate DOAC prescribing was more common among younger physicians (AOR 1.3, 95%CI 1.1 to 1.5), rural physicians (AOR 1.9, 95%CI 1.6 to 2.3), and medium-size practices (600 to 1,000 patients) compared with smaller practices (fewer than 600 patients: AOR 2.7, 95%CI 1.9 to 3.8). **Conclusions:** These findings are similar to rates of inappropriate DOAC prescribing found in other registries (ORBIT-AF II) with predominantly cardiologist prescribers. Patient and provider factors should be considered when designing quality improvement efforts to improve care.

W740 **Who Still Uses Manual Blood Pressure Measurement in Routine Clinical Practice?**
16:15–16:30 **Results From a National Survey**
Claudio Del Grande, MSc; Janusz Kaczorowski, PhD, MCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Identify factors that are associated (or not) with using manual BP measurement in clinical practice

Objective: To explore whether sex of family physicians (FPs), age, type of patient population served, and province of practice are associated with routine use of manual blood pressure (BP) measurement for screening, diagnosing, and managing hypertension. **Design:** Web-based cross-sectional survey distributed by e-mail, conducted in 2016. **Setting:** Stratified random sample of FPs in Canada. **Participants:** FP members of the College of Family Physicians of Canada with valid e-mail addresses. **Main outcome measures:** FPs' self-reported routine use of manual BP measurement (mercury or aneroid device) for recording BP in their practices to screen for, diagnose, and manage hypertension. **Results:** A total of 774 valid responses was received (response rate: 16.2 per cent). Respondents were similar to nonrespondents except for underrepresentation of male physicians. Slightly more than half of Canadian FPs (54 per cent) reported using manual BP as their routine measurement method for hypertension screening; one out of five (21 per cent) did so for diagnosis; and two out of three (64 per cent) reported using manual BP measurement for management, generally along with other measurement methods. Following multivariate logistical regression analyses, province of practice was the most statistically significant factor related to using manual BP for hypertension screening, diagnosis, and management (adjusted ORs in the range of 0.2 to 2.8). FPs primarily serving rural or isolated/remote patient populations were less likely (adjusted OR 0.6) than those serving urban/suburban populations to report using manual BP measurement for hypertension diagnosis, although ambulatory BP monitoring was reported to be significantly less available to them, as well as to FPs in British Columbia, the Atlantic provinces, and Northern Canada. **Conclusion:** A sizable proportion of Canadian FPs routinely use manual BP measurement, counter to current national guidelines. Efforts to encourage FPs to adopt evidence-based BP measurement practices should reflect the uneven distribution of manual BP users among provincial jurisdictions, independent of FPs' individual characteristics.

W663 **Describing the Pause: A phenomenological study of physical examination in family practice**
16:30–16:45 Lisa Freeman*, MD, MPH, CCFP; Martina Kelly, MBBCh, MA, FRCGP, CCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objectives:
1. Interpret family physicians' experiences of physical examination
2. Investigate the association between diagnosis and communication during physical examination

Context: Physical examination is a cornerstone of family practice and serves not only to diagnose but also to communicate reassurance and care. However, with a shift to evidence-based medicine in the past few decades, physicians may be moving away from traditional aspects of touch and the use of physical examination to communicate with and reassure patients. **Objective:** This study was conducted to understand family physicians' experiences of physical examination. **Design:** Qualitative. In the tradition of phenomenology, a series of thick descriptions were sought through in-depth, semi-structured interviews with 16 family physicians recruited through purposive sampling to ensure participants included men and women, rural and urban family physicians, and individuals newer to practice and those more established in practice. Interviews were analyzed through template analysis starting with literature-informed a priori codes. **Findings:** Study participants described physical examination as core to their practice to diagnose, communicate, and validate patient and practitioner concerns. Participants described a pause, a slowing of time experienced while conducting physical examination, during which they were conscious of their bodies and their relation to time and space. This pause is a time when physicians experience affective, intellectual, and physical phenomena and integrate information to inform their behaviour, diagnosis, and management of the patient. The role of physical examination is therefore not only to

diagnosis in the context of the physician's role as an evidence-based medical expert, but also to act as a form of embodied, non-verbal communication to express care. **Conclusions:** This study describes and interprets family physicians' experiences of physical examination and demonstrates physicians' beliefs and attitudes toward physical examination. This includes the tension between the roles of physical examination in diagnosis and non-verbal communication. This understanding may inform the role of physical examination in practice and teaching as it reinforces the value of examination in patient-centred care.

W784 **Reducing Clinically Unnecessary Free Thyroid Indices in a Family Health Team**

16:45–17:00 Ji Hyeon Choi*, MD, MSc; Megan Tan*, MD; Karuna Gupta, MD, CCFP; John Maxted, MD, MBA, CCFP, FCFP; Pamela Tsao, MD, FRCPC; Muhammad Shuvra, MBBS, MPH, MSc (ECD)

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Be able to identify inappropriate indications for ordering free thyroid indices

Objective: To reduce clinically unnecessary ordering of free thyroid indices (fT3 and fT4) for patients at a family medicine teaching unit. If there is low suspicion for pituitary disease, fT3/fT4 are not required to investigate thyroid function or to monitor levothyroxine replacement when thyroid-stimulating hormone (TSH) is normal (0.5 to 5.0 mIU/L). **Design/setting:** This quality improvement project was initiated at the Health for All (HFA) Family Health Team in Markham, Ontario. All fT3s/fT4s, with their associated TSH values, were collected during a one-year period. **Participants:** From November 23, 2015, to November 23, 2016, 894 fT3/fT4s were ordered for adult patients (> 18 years old) at HFA. Of these, 646 (72.2 per cent) fT3s/fT4s were associated with a normal TSH, representing 487 patients. Ninety-seven charts (20 per cent) were randomly selected for review. **Intervention:** From the chart review, the most common reasons for ordering fT3s/fT4s despite a normal TSH were: to monitor levothyroxine dose in patients with known primary hypothyroidism (34.6 per cent), to investigate thyroid nodules (8.0 per cent), and to screen for primary hypothyroidism (6.5 per cent). A poster was created to educate providers at HFA not to order fT3s/fT4s for the reasons above. An accompanying survey quantified provider engagement. It was expected that the number of clinically unnecessary free thyroid indices ordered would decrease as the poster raised awareness about the largest contributors to the problem. **Main outcome measures:** Eighteen out of 34 providers at HFA received the poster. Data analysis one month after distribution revealed a reduced proportion of fT3s/fT4s associated with a normal TSH: 62 per cent (31 out of 50) compared with 72 per cent prior to the poster. **Conclusion:** By educating providers on the most common reasons for ordering clinically unnecessary fT3s/fT4s, we were able raise awareness and address the largest contributors to this problem. It is expected that continued data analyses will reflect a further reduction in the number of clinically unnecessary fT3s/fT4s ordered.

W613 **Home-Based Dialysis for Patients With End-Stage Kidney Disease: What does the evidence say?**

15:00–15:15 Eftyhia Helis, MSc; Alison Sinclair, MD, MSc, PhD; Bernice Tsoi, MSc, PhD; Tamara Rader, MLIS; Ken Bond, MA; Janet Crain; Kristen Moulton, MSc; Gino De Angelis, MSc

ROOM / SALLE : 515ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Compare current dialysis practices for managing end-stage kidney disease with the current evidence on the effectiveness of various dialysis modalities

Context: Some patients with chronic kidney disease (CKD) often progress to having end-stage kidney disease (ESKD), also known as kidney failure. When kidney transplantation is not an option, most patients living with ESKD are treated with dialysis, which is often a lifelong treatment. Even though several options for having dialysis treatment at home (e.g., home hemodialysis and peritoneal dialysis) are available to ESKD patients, traditional hemodialysis offered in a clinical setting remains the most frequently used modality in Canada. **Objective:** The presentation will provide an overview of the clinical effectiveness of home hemodialysis and peritoneal dialysis

as well as other considerations that may be important when planning for dialysis treatment. **Design:** A health technology assessment reviewed the evidence on clinical effectiveness, cost effectiveness, patient perspectives, ethical issues, and implementation considerations for home-based dialysis modalities. The review assessed the evidence based on the published literature and surveys relevant to Canadian dialysis stakeholders. An expert panel, which included family physicians, made recommendations on the use of home-based dialysis based on the reviewed evidence. **Target population:** Medical practitioners who need to provide care or consultation to patients with CKD or ESKD or their caregivers. **Findings:** Overall, compared with in-centre hemodialysis, home-based modalities appear to offer similar clinical benefits and are less costly for eligible patients. **Discussion/Conclusion:** The findings of the evidence review will be discussed in the context of how they may inform treatment decisions, particularly for patients living in areas with no easy access to treatment (i.e., patients in rural or remote areas) and patients with unique health and cultural profiles (e.g., Indigenous patients).

W614 **Predictors of Non-Adherence to Colorectal Cancer Screening Among Immigrants to Ontario**
15:15–15:30 Shixin (Cindy) Shen*, MD, MPH; Aisha Lofters, MD, PhD, CCFP; Richard H. Glazier, MD, MPH, CCFP, FCFP; Jill Tinmouth, MD, PhD, FRCPC; Lawrence Paszat, MD, MSc, FRCPC; Linda Rabeneck, MD, MPH, FRCPC

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Describe the prevalence of non-adherence to colorectal cancer screening among immigrants to Ontario

Objective: Though colorectal cancer (CRC) screening rates have increased over time, immigrants continue to have lower rates of screening. This study aims to examine the association between non-adherence to CRC screening and characteristics related to immigration, socio-demographics, health care use, and primary care physicians among immigrants to Ontario. **Design:** This is a population-based retrospective study with a cross-sectional design. **Setting:** This study used multiple health care administrative databases housed at the Institute for Clinical Evaluative Sciences and the Immigration, Refugees and Citizenship Canada database. **Participants:** Our cohort comprised immigrants between the ages of 60 to 74 years who had been eligible for the Ontario Health Insurance Plan for at least 10 years and who lived in Ontario on March 31, 2015. Those who had a history of CRC, inflammatory bowel disease, or total colectomy were excluded. The final cohort contained 182,949 individuals. **Main outcome measure:** The outcome was defined as not being up-to-date with any modality of CRC screening on March 31, 2015, which included fecal occult blood test in the previous two years, sigmoidoscopy in the previous five years, and colonoscopy in the previous 10 years. **Results:** Risk of non-adherence to CRC screening was higher among immigrants who were from low- or middle-income countries, refugees, unmarried, without post-secondary education, and non-English speaking, and among those who had immigrated more recently and lived in only one world region before landing in Canada. Compared with those from the United States, Australia, and New Zealand, immigrants from most other world regions had higher risks of non-adherence. Significant associations were also found between screening non-adherence and several socio-demographic, health care use, and provider factors, especially resource use, rostering status, and neighbourhood income quintile. **Conclusion:** Many immigration and non-immigration factors predicted the risk of non-adherence to CRC screening. These findings can be used in future efforts to improve the uptake of CRC screening among immigrants.

W580 **Impact of RADT on Antibiotic Prescription for Pharyngitis: A systematic review and meta-analysis**
15:30–15:45 Omar Anjum; Pil Joo, MD CM, CCFP

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Review the evidence exploring the impact of RADT in patients presenting with pharyngitis on the antibiotic prescribing behaviour of clinicians

Objective: To assess the impact of rapid antigen detection test (RADT) in patients presenting with acute group A

Streptococcus (GAS) pharyngitis on the antibiotic prescription rate and appropriateness of antibiotic management. **Design:** Systematic review and meta-analysis of prospective and retrospective cohort studies. **Setting:** Primary care clinics and emergency departments. **Participants:** Adult and pediatric population presenting with acute pharyngitis, excluding those with comorbidities such as altered mental status and immunosuppression. Ten out of 4,003 identified studies met the inclusion criteria (N = 10,859 participants, median age 31 years, 56.7 per cent female). **Intervention:** Studies were systematically searched using MEDLINE and Embase and selected according to a predefined PRISMA protocol. Data were extracted by two reviewers using DistillerSR. Study quality was assessed using the Cochrane Risk of Bias Tool and the Newcastle-Ottawa Scale. Studies were combined if there was low clinical and statistical heterogeneity ($I^2 < 30\%$). The bivariate Mantel-Haenszel random effects model was used to perform meta-analyses using SPSS 22 and RevMan 5. **Main outcome measures:** Dichotomous measure of antibiotic prescription, with or without RADT availability. **Results:** Mean antibiotic prescription rates in the RADT and control arms were 38.2 per cent (SD 15.6) and 55.9 per cent (SD 16.3), respectively. The use of RADT was associated with a lower antibiotic prescription rate in both adults (OR = 0.60, 95% CI 0.45 to 0.80, $I^2 = 8\%$, n = 1,407) and pediatrics (OR = 0.49, 95%CI 0.44 to 0.55, $I^2 = 5\%$, n = 976). There was no overall difference ($P = 0.3$) in antibiotic prescription rate among disease severity (Centor scores 1-4). The use of RADT did not significantly affect the appropriateness of antibiotic management (OR 1.15, 95%CI 0.94 to 1.5). **Conclusion:** The use of RADT is associated with reduced antibiotic prescription for patients with GAS pharyngitis without an increase in appropriate antibiotic use. Despite low prevalence of the disease, antibiotic prescription rates are still high. These findings suggest a great potential for antibiotic stewardship and re-evaluation of current guidelines for managing GAS pharyngitis.

W796
15:45–16:00

Follow-Up of COPD Patients at 14 or 30 Days Post-Discharge Affects Rebound to Emergency Department

Eric Traficante*, MD, CCFP; Mina Salama, MD, CCFP; Andre Bedard, MD, CCFP; Matthew Orava, MD, CCFP MHSc; Anwar Parbtani, MD, CCFP, FCFP, PhD

ROOM / SALLE : 515ABC

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Assess the impact of timely follow-up of COPD patients by primary care providers post hospital dicharge on emergency department rebound
2. Determine whether there is a difference on emergency department rebound if COPD patients are followed by a primary care provider either at 14 or 30 days post-discharge

Context: Acute exacerbation of chronic obstructive pulmonary disease (AECOPD) is associated with more hospitalization compared with other chronic diseases, with an estimated health care cost of approximately $1.5 billion annually. Timely follow-up in the community post-discharge from the hospital/emergency department (ED) has been shown to reduce ED rebound. However, optimal timing for the follow-up or distinction between specialist versus primary care provider follow-up is not clear. **Objective:** To assesses the impact of primary care provider follow-up of COPD patients upon ED/hospital discharge on ED rebound. **Design and outcome measures:** A retroactive chart review of COPD patients presenting at the ED at a community hospital over a three-year period (2013 to 2015) was conducted. We gathered data for no primary care provider follow-up, follow-up within 14 days, and follow-up 30 days post-discharge versus 90-day ED rebound. **Statistics:** Data were analyzed using chi-square analysis with Bonferroni corrections. **Results:** One hundred four ED visits (73 patients) were assessed. Forty-three visits (41 per cent) had no primary care provider follow-up within 30 days, 61 (59 per cent) had primary care provider follow-up within 30 days, and 37 (36 per cent) had primary care provider follow-up within 14 days of ED discharge. Ninety-day ED rebound was significantly lower for 30-day (20 per cent) and 14-day (19 per cent) post ED discharge with primary care provider follow-up versus no primary care provider follow-up (58 per cent; $P < 0.001$). **Conclusions:** Follow-up of COPD patients by a primary care provider within 14 days or 30 days post ED discharge significantly reduced 90-day ED rebound compared with those with no primary care provider follow-up. In the present study, 14-day primary care provider follow-up was not superior to 30-day primary care provider follow-up in reducing 90-day ED rebound. This study suggests there is ample time (at least up to 30 days) for post-discharge follow-up of COPD patients by primary care providers to optimize care and prevent hospital/ED rebound.

W558 **A Simple Clinical Prognosis Tool to Predict Mortality After a "First" Hospitalization for COPD**
16:00–16:15 Alain Vanasse*, MD, PhD; Josiane Courteau, PhD; Simon Couillard, MD; Marie-France Beauchesne, PharmD; Pierre Larivée, MD

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 0.25

Objective: To provide family physicians with a simple score sheet to estimate a one-year all-cause mortality risk for patients with chronic obstructive pulmonary disease (COPD) who are hospitalized for the "first" time. **Design:** Retrospective cohort study using linked administrative and clinical data. **Setting:** Hospitalized care. **Participants:** Patients with COPD between 40 and 84 years old hospitalized in a regional hospital (Sherbrooke, Quebec, Canada) between April 2006 and March 2013 and discharged alive. Patients with a previous COPD hospitalization within five years were excluded to retain only "first" COPD hospitalizations. **Main outcome measures:** One-year all-cause mortality after discharge was assessed and analyzed using multiple logistic regression on a derivation sample (backward elimination with P <0.01) and validated on a testing sample. **Results:** A total of 141 (12.5 per cent) of the 1,129 patients died within one year of discharge from their first hospitalization for COPD. Predictors of one-year mortality were: older age (OR 1.055, 95%CI 1.026 to 1.085), male gender (OR 1.474, 95%CI 0.921 to 2.358), having a severe COPD exacerbation during index hospitalization (OR 2.548, 95%CI 1.571 to 4.132), a higher index hospital length of stay (OR 1.024, 95%CI 0.996 to1.053), a higher Charlson Comorbidity Index score (OR 1.262, 95%CI 1.099 to 1.449), a diagnosis of cancer (OR 2.928, 95%CI 1.456 to 5.885), the number of prior all-cause hospitalizations (OR 1.323, 95%CI 1.097 to 1.595), and COPD duration exceeding three years (OR 1.710, 95%CI 1.058 to 2.763). Using estimates of the logistic model for these eight predictors, a simple clinical prognosis tool is proposed. The model shows good discrimination in both the derivation and validation cohorts (C statistic exceeding 0.78). **Conclusion**: One out of eight patients discharged alive from a first COPD hospitalization will die in the following year. It is thus important to identify high-risk patients to plan and manage appropriate treatments.

W555 **Breaking the Cycle of Survival Drinking: A peer-run managed alcohol program**
16:15–16:30 Bernie Pauly, RN, PhD; Vashti King, MD; Ashley Smith, MD; Sarah Tranquilli-Doherty*, MD; Christy Sutherland, MD, CCFP; Kate Vallance, MA

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Recognize managed alcohol programs in the therapeutic spectrum for individuals with severe alcohol use disorder and homelessness

Objective: Managed alcohol programs (MAPs) have been implemented in Canada to assist individuals with severe alcohol use disorder and homelessness by providing regularly dispensed standard-size drinks to prevent alcohol withdrawal symptoms and minimize non-beverage alcohol consumption. This study describes the individual experience of the members in a non-residential, peer-run MAP. **Design:** This project is part of a larger mixed methods study of five Canadian MAPs. Fourteen qualitative, semi-structured interviews were conducted using a previously developed and ethically approved set of questions from the National Study of Managed Alcohol Programs in Canada. **Setting:** A non-residential, peer-run MAP in a large urban setting, run by a non-governmental organization. **Participants:** MAP members were recruited by announcements at meetings, posters, and word of mouth. To be included participants had to have a minimum of 30 days in the program and speak English. Fourteen participants were eligible, and all were included. The mean age of participants was 42 years (range 29 to 61) and two were female. Eight participants identified as Indigenous or First Nations. **Findings:** This study describes the importance of community among individuals with chronic alcohol use disorder and homelessness. Prior to the program participants described injuries related to drinking, frequent hospitalizations, and overdoses as a result of concurrent illicit alcohol and drug use. While in the program participants noted decreased or discontinued illicit alcohol consumption and had fewer blackouts and withdrawal symptoms. Our findings suggest this non-residential, peer-run MAP was fundamental in participants' transition from daily survival drinking to meaningful engagement in their community. **Conclusion:** This non-residential, peer-run MAP played an integral role in the

lives of its participants, improving health, substance use patterns, relationships, and community connections. These benefits are consistent with the current literature on residential Canadian MAPs.

W780 **Assessment of Patient-Physician Communication in Primary Care Practices:**
16:30–16:45 **What is retained immediately post clinical encounter?**
Kyle Lee, MD, CCFP, MSc; Erzebet Kiss*, MD, CCFP; Matthew Orava, MD, CCFP, MHSc; Anwar Parbtani, MD, CCFP, FCFP, PhD

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objectives:
1. Assess physician-patient communication for three distinct types of clinical encounters in primary care practice
2. Assess what information is retained by patients immediately after clinical encounters in primary care practice
3. Assess concordance versus discordance between patients and physicians regarding the information relayed/understood at clinical encounters

Context: Effective communication is central to fostering shared decision making and empowering patient participation in their care plans. Numerous studies have identified gaps in patient-physician communication, but most are limited to single types of encounters or relate to specialty practices other than family medicine. Primary care physicians interact with patients for diverse conditions in a single day, hence assessing physician-patient communication for different types of clinical encounters is more relevant. **Objective:** To assess patient-physician communication in primary care practices for three different kinds of clinical encounters. To assess concordance versus discordance between physicians and patients for the information relayed and retained. **Design and setting:** A cross-sectional survey of patient-physician communication in eight primary care practices, for three types of clinical encounters; cholesterolemia, colon cancer screening, and smoking cessation. **Intervention:** Survey forms with five to seven identical questions for patients and physicians but on separate sheets, coded to allow comparisons, were employed. Each sheet had a standard overall question: for the physician, "Did you feel your patient understood the information discussed today?" and for the patient, "Did you understand the information discussed today?" **Result:** Fifty-eight completed surveys were obtained: 24 for cholesterolemia, 20 for colon cancer screening, and 14 for smoking cessation. The overall question about whether the information discussed was understood had 81 per cent concordance and 7 per cent discordance; 12 per cent were incomplete. Concordance for specific, encounter-related answers was high (85 per cent to 100 per cent), except for the importance of medications for cholesterolemia (54 per cent concordance) and referral for smoking cessation (66 per cent concordance); $P < 0.05$ for both, z statistics. **Conclusions:** This is a unique study assessing patient-physician communication in primary care settings for three distinct types of clinical encounters. The immediate post-encounter recall of communication between physicians and patients showed high concordance for the overall information, but there were gaps for details such as discussion of management/therapeutic approaches.

W800 **Family Physicians' Awareness of Charles Bonnet Syndrome: A Canadian national survey**
16:45–17:00
Tina Felfeli*; Keith D. Gordon, MSc, PhD

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 0.25

Learning objectives:
1. Distinguish Charles Bonnet syndrome from other causes of visual hallucinations
2. Recognize the challenges patients face with visual hallucinations following vision loss
3. Apply appropriate strategies for the management and referral of this patient population

Objective: To assess the awareness of Canadian family physicians (FPs) of Charles Bonnet syndrome (CBS). **Design:** National perception and practices survey. **Setting:** All provinces and territories across Canada. **Participants:** A total of 500 English- and French-speaking FPs across Canada were randomly selected. **Main outcome measures:** 1) The level of awareness of CBS among FPs. 2) The frequency of FPs' encounters with patients

who have visual hallucinations. 3) Management strategies and referral patterns for CBS patients presenting to FPs. **Results/findings:** A total of 499 respondents answered at least one question on the survey. Approximately 54.7 per cent of FPs indicated they were not at all aware, 19.7 per cent were only slightly aware, and 25.6 per cent were well aware of CBS. Among the respondents who were slightly or well aware of CBS, the most commonly reported sources of information included medical training (27.5 per cent), colleague(s) (18.4 per cent), conference(s) or continuing medical education (16 per cent), and patient(s) (14.3 per cent). With respect to the frequency of patient encounters with visual hallucinations, 5.3 per cent of physicians reported having encountered patients once a month, 18.9 per cent every six months, 13.4 per cent once a year, and 37 per cent less than once a year, while 25.4 per cent reported no encounters in their practice. The number of patients presenting to practice with visual hallucinations significantly predicted awareness of FPs about CBS ($\beta = 0.501$, $t(371) = 5.59$, $P < 0.001$). Of FPs who had previously encountered patients with visual hallucinations, 21.3 per cent reported having supported patients through pharmacological interventions and 31.6 per cent through non-pharmacological interventions, while 29.3 per cent FPs completed both and 17.8 per cent did neither. When speaking with patients who have visual hallucinations, 84.9 per cent of FPs do not discuss the possibility of developing CBS, while 7.9 per cent and 7.2 per cent discuss it always or sometimes, respectively. **Conclusion:** There is a lack of knowledge about CBS among FPs. Increased awareness of CBS is critical for the appropriate diagnosis, assessment, and management of biological and psychosocial manifestations of this condition.

W769 **Access to Primary Care for Persons Recently Released From Prison: An audit study**

15:00–15:15 Nahla Fahmy, MBBCH; Ruth Martin, MD, CCFP, FCFP; Fiona Kouyoumdjian, MD, CCFP, PhD; Stephen Hwang, MD, MPH; Sharif Fahmy, MBA; Carlos Magnas Neves; Jonathan Berkowitoz, PhD

ROOM / SALLE : 516A

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify barriers to accessing primary care for previously incarcerated individuals
2. Highlight the need for improved accessibility
3. Understand the need to address barriers to care

Objective: To determine whether a history of recent imprisonment affects the response a person receives when seeking a primary care appointment. **Design:** We conducted a controlled audit study in which we made unannounced telephone calls to the offices of family physicians (N = 339). Male and female researchers played the role of a patient seeking a physician and requested an initial appointment for primary care, according to one of four patient scenarios that were sequentially assigned to each physician office: 1) a male recently released from prison; 2) a female recently released from prison; 3) a male not recently released from prison; and 4) a female not recently released from prison. **Participants:** Family physicians who were listed as accepting new patients on the College of Physicians and Surgeons of British Columbia website. **Setting:** This study was conducted in British Columbia. **Main outcome:** Whether the caller was offered an initial appointment. **Results:** For physician offices that we contacted that were eligible for inclusion (n = 250), the proportion of calls resulting in an appointment being offered was significantly lower when the callers said they had recently been released from prison compared with controls (46.2 per cent of 122 versus 84.4 per cent of 128, $P = 0.001$). The odds of being offered an appointment was 7.3 times higher (95%CI 4.0 to 13.2) for controls compared with those who reported a recent release from prison. There was no significant difference based on the gender of the caller, with 48.3 per cent of 62 calls from a male and 37.1 per cent of 60 calls from a female ($P = 0.42$) resulting in an appointment. **Interpretation:** In a setting with a universal health insurance system, people who presented themselves as having recently been released from prison had poorer access to primary care. Efforts to improve access to primary care for this vulnerable population need to address barriers to care beyond health insurance.

W828 **Achieving Health Goals With Formerly Incarcerated Men**

15:15–15:30 Ruth Elwood Martin, MD, CCFP, FCFP, MPH; Catherine Latimer; Debra Hanberg; Larry Howett; Daniel Baufeld; Blake Stitilis, MPH; Kate Roth, MA; John Oliffe, PhD, RN; Jane Buxton, MBBS, MHSc, FRCPC; Nicole Myers, PhD; Carl Leggo, PhD; Wayne Taylor;

Naomi Dove, MD, MPH, FRCPC

ROOM / SALLE : 516A

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Determine health priorities with formerly incarcerated men
2. Reflect on factors that support incarcerated men in their integration into society
3. Understand barriers to navigating the health care system for formerly incarcerated men

Objective: To determine the immediate-, short-, and long-term health priorities of formerly incarcerated men leaving federal correctional facilities in the Lower Mainland of British Columbia. **Design:** A community-based participatory research approach using interpretive descriptive methods: survey data and focus group data. **Setting:** Two John Howard Society of the Lower Mainland of British Columbia halfway houses. **Participants:** Eighteen formerly incarcerated men participated in two focus groups. The first focus group (n = 10) included men released within three months from a federal correctional facility. The second focus group (n = 8), included men released from a federal correctional facility more than six months prior to the focus group. **Main outcome measures:** Focus group interviews yielded qualitative data regarding the formerly incarcerated men's health priorities and the factors that supported or prevented their self-health. Interview transcripts were coded and thematically analyzed by co-authors, including formerly incarcerated project assistants. The findings were member checked with some focus group participants (n = 6) to ensure validation of interpretation. **Findings:** The immediate- and short-term health priorities of recently released men related to acquiring personal identification and/or a medical card, refilling prescriptions, obtaining their medical records from prison, finding a family physician, learning how to navigate the health care system, and addressing mental health and substance use issues. As the men integrated into the community, their long-term health priorities focused on living healthy, building long-term relationships, maintaining ongoing medical care, addressing hepatitis C, and connecting to culture, spirituality, and volunteering. The focus group findings were primarily used to inform the design of the main research study. **Conclusion:** Men encountered significant individual and systemic barriers to achieving their health priorities as they transitioned from a federal correctional facility back into the community. All focus group participants reported post-release stressors as they adapted to community life.

W679 **I'm So Glad You Found Me! Caring for Patients With Multimorbidity Who Are Vulnerable**

15:30–15:45 Judith B. Brown*, PhD; Pauline Boeckxstaens, MD, PhD; Sonja M. Reichert, MD, MSc, CCFP; Luan Januzi, MSc; Moira Stewart, PhD; Martin Fortin, MD, CCFP, FCFP, MSc

ROOM / SALLE : 516A

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Identify factors that increase the vulnerability of patients with multimorbidity
2. Define and apply components of an innovative interdisciplinary primary health care team approach to their own practices to care for patients with multimorbidity who are vulnerable

Context: Patients with multimorbidity often require an interdisciplinary primary health care team approach. Within this population a subset of patients may be more vulnerable and require a tailored approach to address their complex needs. **Objectives:** To explore how a one-hour consultation outside of usual care, conducted by innovative interdisciplinary primary health care teams, addresses the needs of vulnerable patients with multimorbidity. **Design:** A descriptive qualitative study. A purposive sample was used to recruit participants for a 30- to 45-minute semi-structured interview. An iterative and interpretative process was conducted with both individual and team analysis to identify overarching themes and sub-themes. **Setting:** Ontario, Canada. **Participants:** Forty-eight interviews were conducted with 20 allied health care professionals (e.g., nurses, social workers, pharmacists), 10 non-family-physician specialists (e.g., psychiatrists, internal medicine specialists), nine decision makers, and nine family physicians who had made referrals to the primary health care consultation teams. **Results:** The collaborative nature of the team supported the sharing of ideas about how to overcome some

of the barriers patients experienced and facilitated the development of creative recommendations specifically designed to meet the needs of each patient. Participants paid specific attention to how and why certain patients with multimorbidity were vulnerable. Patients who were described as vulnerable were those who face major challenges in accessing and navigating the health care system and consequently "fall through the cracks." Mental health issues were a major contributor to patients being vulnerable and were often linked to common social determinants of health (e.g., poverty, homelessness, and social isolation). Cultural factors (e.g., language, values, and beliefs) were also identified as potentially causing patients to be vulnerable. **Conclusions:** These unique, one-time consultations go beyond the assessment of a patient's multimorbidity by including a psycho-social contextual understanding of their vulnerability within the primary health care setting. Findings may have important clinical and policy implications for supporting the spread of this innovative approach.

W680 **An Interdisciplinary Approach to Caring for Patients with Multimorbidity**

15:45–16:00 Judith B. Brown*, PhD; Pauline Boeckxstaens, MD, PhD; Sonja M. Reichert, MD, MSc, CCFP; Martin Fortin, MD, CCFP, FCFP, MSc; Moira Stewart, PhD

ROOM / SALLE : 516A

Mainpro+ Group Learning certified credits = 0.25

Learning objectives:

1. Understand how primary health care providers describe their teams' delivery of patient-centred care
2. Explain how an interdisciplinary primary health care team consultation approach provides patient-centred

Primary health care providers describe patient-centredness in a variety of ways; they are often relevant to the one-on-one relationship but rarely within the context of interdisciplinary team care. **Objective:** Reveal how providers describe their patient-centredness during a one-time telemedicine interdisciplinary consultation for patients with multimorbidity. **Design:** A descriptive qualitative study. A purposive sample was used to recruit participants for a 30- to 45-minute semi-structured interview. An iterative and imperative process was conducted with both individual and team analysis to identify overarching themes and sub-themes. **Setting:** Ontario, Canada. **Participants:** Thirty nine interviews were conducted with 20 allied health care professionals (e.g., social workers, nurses, pharmacists), 10 physician specialists (e.g., internal medicine specialists, psychiatrists), and nine decision makers. **Results:** Participants described a strong commitment to providing patient-centred care, starting at the outset of the consultation: "Make sure that it's patient-centred from the very beginning." They explored patients' perceptions of "how they would like to improve their quality of life and health" as well as the daily "struggles" they encountered in managing their multimorbidity. Participants explained their interest in "looking at the patient as a whole," hence going beyond the disease to understanding the person in context. Close attention was paid to identifying the patient's goals throughout the consultation: "What are the patient's goals?" As the team provided their concluding recommendations, they actively engaged the patient in the process: "Does this make sense to you? Would this be helpful?" Finally, patient-centredness was described as "coming up with a care plan that the patient would be able and willing to implement." **Conclusion:** These findings demonstrate how an interdisciplinary primary health care team consultation provides patient-centred care to a complex patient population with multimorbidity. This team approach to care is for a brief one-time consultation, yet the findings reflect how patient-centred care is achievable in this unique context.

W689 **Identifying Potentially Inappropriate Prescriptions in Ontario's Older Adult Population**

16:00–16:15 Lise M. Bjerre, MD, PhD, CCFP*; Timothy Ramsay, PhD; Catriona Cahir, HDip, PhD; Cristin Ryan, MPharm, PhD; Roland Halil, PharmD; Barbara Farrell, PharmD; Kednapa Thavorn, MPharm, PhD; Christina Catley, PhD; Steven Hawken, PhD; Ulrika Gillespie, MSc, PhD; Douglas G. Manuel, MD, MSc, FRCPC

ROOM / SALLE : 516A

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Be able to demonstrate how large health administrative databases can identify potentially inappropriate prescribing in large populations

Objectives: To describe the prevalence of potentially inappropriate prescriptions (PIPs) in Ontario's older adult population by applying criteria used in clinical settings to population-level health data. **Design:** Population-based retrospective cohort study. **Setting:** Ontario health administrative data set. **Participants:** Patients ≥ 66 years of age who were issued at least one prescription between April 2003 and March 2014 (N = 2,477,403). **Intervention:** Subsets of the 2014 STOPP/START criteria and of 2015 Beers criteria were selected as applicable to health administrative databases, codified using diagnostic and medication codes, and used to identify PIPs in the health administrative database among the patients selected. **Main outcome measures:** The incidence of a first PIP ever and the PIP prevalence for each criterion over the study period. **Results:** In this study, 95.5 per cent (84/88) of Beers criteria, 64.2 per cent (52/81) of STOPP criteria, and 26.5 per cent (9/34) of START criteria were identified as applicable to the health administrative database. The Beers criteria identified 51.1 per cent (1,265,295/2,477,403) of patients as having a first PIP ever, while 26.8 per cent of patients had more than one PIP and 2.56 per cent of patients had more than five PIPs ever. The STOPP/START criteria identified 69.2 per cent (1,714,311/2,477,403) of patients as having at least one PIP over the course of the cohort membership, 30.8 per cent of patients had more than 1 PIP, and 18.0 per cent of patients had more than five PIPs ever. The most common PIP criteria were diseaseB4, drugG3, drug-drug6 for Beers, and STOPP D12, STOPP D10, STOPP D6 for STOPP/START (excluding START 1—immunizations). **Conclusion:** Applying clinical criteria for identifying PIPs in Ontario's population age ≥ 66 years found that as many as 1.7 million older Ontarians who were issued a prescription between April 2003 and March 2014 had at least one PIP, and more than one in four had two or more. This likely underestimates the true prevalence of PIPs in this population, given the number of patients excluded due to limitations in the health administrative database.

W690 — Evaluating the Consistency of Medication Warnings Issued to Canadian, American, and British Prescribers

16:15–16:30

Lise Bjerre, MD, PhD, CCFP; Simon Parlow, MD; David De Launay; Matthew Hogel, PhD; Cody D. Black; Donald Mattison, MD; Carlos Rojas-Fernandez, PharmD; Jeremy Grimshaw, MD, PhD; Margaret Watson, PhD, MSc, MRPharmS

ROOM / SALLE : 516A

Mainpro+ Group Learning certified credits = 0.25

Learning objective:

1. Be able to evaluate differences in regulatory warnings issued to prescribers in three similar jurisdictions

Objective: To determine whether, and to what extent, there was consistency in the format, content, and timing of medication warnings issued by regulatory health authorities to prescribers in three similar jurisdictions. **Design:** Cross-sectional analysis. **Setting:** Online databases of health advisory letters (HALs) in Canada, the United States, and the United Kingdom. **Participants:** HALs issued by Health Canada, the US Food and Drug Administration (FDA), and the United Kingdom's Medicines and Healthcare products Regulatory Agency (MHRA) between January 1, 2010, and December 31, 2014, inclusive. **Intervention:** An abstraction tool, consisting of 21 clinically desirable HAL characteristics and developed by consensus of the research team, was created to facilitate identification and documentation of the presence or absence of these characteristics in each HAL selected. **Main outcome measures:** Jurisdictional overlap of the content, format, and timing of HALs. **Results:** A comparison of the HALs issued by Health Canada, the FDA, and the MHRA determined that of 245 unique letters issued between January 1, 2010, and December 31, 2014, inclusive, 227 (93 per cent) pertained to medications available in all three jurisdictions. Of these 227 letters, only 21 (9 per cent) were issued by all three jurisdictions; 40 (18 per cent) were issued by two; and 166 (73 per cent) were issued by only one. Only 13 of the letters published in all three jurisdictions were issued within six months of each other. While there was consistency in the basic format and content of the HALs across jurisdiction, there were differences in the way additional information was presented or emphasized. **Conclusions:** There is a lack of consistency in the format, content, and timing of medication warnings issued by authorities to prescribers in Canada, the United States, and the United Kingdom, raising important questions about how and when medication safety–related issues are identified and communicated to prescribers by the authorities in each jurisdiction.

W549 **Engaging Family Practice Physicians in System Change: Partnering with a health authority and communities**
16:30–16:45
David Snadden, MBChB, MClSc, MD, CCFP; Martha MacLeod, PhD, RN; Neil Hanlon, PhD; Trish Reay, PhD; Cathy Ulrich, MSc, RN

ROOM / SALLE : 516A
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Explain how a British Columbia Health Authority engaged and partnered with Divisions of Family Practice to support whole-system primary care change

Northern Health (NH), a British Columbia Health Authority, is leading a process of whole-system change in partnership with physicians and communities. **Objective:** To examine engagement with family physicians and how they have become partners in creating and scaling up NH–wide integrated, patient-centred primary health care. **Design:** Longitudinal, multiple case study. **Setting:** NH region and seven communities within it. **Participants:** A total of 236 participants, including 20 community physicians. **Approach:** Two hundred fifty semi-structured interviews were undertaken within the communities over three years. Data were analyzed by thematic analysis. **Intervention:** How NH had engaged physicians in the change process. **Findings:** Fundamental, transformative change that addresses the needs of people in communities, while meeting regional and provincial directions, takes longer than anticipated and physician engagement as true partners is critical to overall success. The Divisions of Family Practice in British Columbia have been instrumental in that engagement. In northern British Columbia this engagement has been facilitated by regular meetings between NH and five separate divisions, the development of shared strategic directions, and local flexibility in the development of the priorities of divisions. We also observed that over time, as personnel changed, there was a need to renegotiate the partnerships and orient new personnel on vision and priorities. Strong, flexible leadership from the divisions and NH was also important in building trust. Interim indicators of change are reflected in joint initiatives between the divisions and NH, positive quality improvement measures, and fewer unattached patients. **Conclusion:** An in-depth examination of processes of change illuminated the relationships, challenges, and approaches that are needed for services and structures to be reformed to serve the needs of patients and families better. This also demonstrated how the Divisions of Family Practice in British Columbia have facilitated physician engagement with NH. Partnerships allow for working through the inevitable tensions and barriers to fundamental, far-reaching system change.

W550 **Recruitment and Retention in Rural Practice in the Context of Generational Change**
16:45-17:00
David Snadden, MBChB, MClSc, MD, CCFP; Mark Kunzli, RPh, MBA

ROOM / SALLE : 516A
Mainpro+ Group Learning certified credits = 0.25

Learning objective:
1. Explore the impact on rural practice recruitment and retention of the aspirations of a younger generation of physicians

Objective: To examine the implications for rural practice of the changing aspirations of young practitioners. **Design:** Qualitative in-depth interviews and thematic interpretive analysis. Setting: Rural northwestern Canada. **Participants:** A purposefully diverse sample of 46 practitioners, mostly family physicians, but including some other specialists and nurses. The sample included early-, mid-, and late-career physicians. **Intervention:** The adaptation of practices to changing generational aspirations. **Methods:** A mixture of small group and one-on-one interviews. Data were analyzed thematically by both researchers independently and then a common coding framework and interpretation was developed. Initial findings were returned to respondents for validation. **Findings:** There were three main themes: scope of practice and generalism; the importance of connectivity and relationships; and sensitivity to generational change. These interact together to influence the ecosystem of practices and have major implications for the future recruitment and retention of young physicians in rural areas. Enablers are local mentorship and community support, supportive specialist networks, connectivity, flexibility of contract arrangements, the ability of communities to adapt to changing working preferences, teamwork, and collaboration. **Conclusions:** Those communities that adapt to the

aspirations of the next generation of physicians, who work hard but differently, may find it easier to recruit and retain young physicians. There may be potential implications in terms of educating patients and communities for care by teams, and in terms of how our professional associations negotiate on behalf of physicians.

W401 **Oncology Emergencies (Enhanced Clinical Session)**
15:00–16:00 Jock Murray, MD, CCFP (EM); Constance LeBlanc, CCFP (EM), FCFP, MAEd, CCPE

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Become aware of common oncology emergencies
2. Learn to treat common oncology emergencies
3. Learn to recognize rare oncology emergencies

Description:
Emergencies related to cancer and cancer treatment are common in the emergency department. This session will help participants recognize and treat these emergencies.

W428 **Integrating Family Medcine and Emergency Medcine Practice (Enhanced Clinical Session)**
16:15–17:15 Jock Murray, MD, CCFP (EM); Daniel Grushka, BSc, MSc, MD, CCFP (EM)

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the challenges of combining family medicine and emergency medicine practice
2. Understand the benefits of combining family medicine and emergency medicine practice
3. Learn strategies to combine family medicine and emergency medicine practice

Description:
It can be difficult to practise emergency medicine and family medicine. This session will explore the challenges and benefits of a combined family medicine/emergency medicine practice.

W874 **Fireside Chat**
16:15–17:15 Ian Scott, MSc, CCFP, FRCPC, FCFP; James Geortzen, MClSc, CCFP, FCFP; Ivy Oandasan, CCFP, MHSc, FCFP; Miriam Boillat, MDCM, CCFP, FCFP

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recommend family medicine teacher and preceptor initiatives and activities during the FMF
2. Identify strategies to support family medicine teachers and preceptors with their various roles
3. Appraise current FMF family medicine teacher and preceptor educational sessions and activities

Description:
Join Section of Teachers Chair, and Chair-Elect, Dr. Ian Scott and Dr. James Goertzen, along with CFPC Director of Education Dr. Ivy Oandasan, for a free flowing audience-directed discussion about how the College can best serve teachers and preceptors in their important roles.

TWO- AND THREE-CREDIT-PER-HOUR CERTIFIED MAINPRO+ WORKSHOPS
ATELIERS CERTIFIÉS MAINPRO+ POUR DEUX ET TROIS CRÉDITS PAR HEURE

W101 Airway Intervention and Management in Emergencies (AIME)

07:30–17:30 Sam Campbell, MD, CCFP (EM)

ROOM / SALLE : 516B

PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT

Learning objectives:

1. Be more confident and comfortable in making acute care airway management decisions
2. Acquire a practical, staged approach to airway management
3. Be able to choose the most appropriate method of airway management based on a variety of patient presentations

Description:

The Airway Intervention and Management in Emergencies (AIME) course has been providing valued and practical hands-on airway management learning experiences for clinicians around the world for more than 15 years. AIME educators are experienced (and entertaining) clinical instructors who understand the varied work environments of practising clinicians. Whether you work in a large, high-volume centre or a small, remote setting, AIME will provide a practical approach for airway management in emergencies. AIME program highlights include: case-based clinical decision making; new practical algorithms; when, why, and how to perform awake or rapid sequence intubation; a new textbook/manual based on the AIME program; unique, customized clinical videos; limited registration to ensure a clinician-to-instructor ratio of 5:1 or 6:1; clinician-to-simulator ratios of 2:1; reinforcement of core skills; an introduction to newer alternative devices (e.g., optical stylets, video laryngoscopes); and exposure to rescue devices (e.g., King laryngeal tubes, LMA Supreme).

W94 Management of Chronic Non-Cancer Pain: Assessment, treatment, and responsible prescribing

08:00–17:00 Robert Hauptman, MD, MCFP; Alan Kaplan, MD, CCFP (EM), FCFP

(2) credits per hour

ROOM / SALLE : 511A

PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 12 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:

1. Perform a complete assessment of a patient with chronic pain
2. Assess patient with chronic pain for addition risk
3. Prescribe appropriate therapy for a patient with chronic pain

Description:

Chronic pain affects 20 per cent of Canadians. The assessment and the management of chronic pain is now taught well in medical school. As well, there are ongoing controversies regarding chronic pain management, especially with opioids. This workshop will empower participants with the knowledge needed to assess patients with chronic pain, address risks for addiction, and manage chronic pain patients safely.

Topics will include pain assessment, review of addiction risks, non-pharmacological management of pain, and pharmacological management of pain.

This session will include both didactic and interactive components. Care is taken to engage the audience in a lively discussion regarding the management of this often challenging patient population.

W98 **IUD Update, Insertion, Troubleshooting, and Endometrial Biopsies**
10:00–12:15 Renee Hall, MD, CCFP; Ellen Wiebe, MD, CCFP, FCFP; Konia Trouton, MD, CCFP, FCFP; Darlana Mulzet, MD, CCFP
③ credits per hour

ROOM / SALLE : 511B
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Help patients choose from the 13 IUDs available
2. Perform IUD insertion and troubleshoot difficult IUD insertion
3. Perform endometrial biopsies

Description:
Now that copper and levonorgestrel IUDs are recommended for a much wider variety of women and conditions—such as for teens, for emergency contraception, and for treating dysfunctional uterine bleeding in peri-menopause—we can expect more challenges in inserting IUDs, particularly into tight cervices or into patients with uterine fibroids. There are 13 IUDs on the Canadian market today with which you will become familiar. This hands-on workshop will take advantage of plastic models, slides, and discussion and is suitable for clinicians with all ranges of experience with inserting IUDs. Participants are encouraged to bring up clinical scenarios they have found challenging. The facilitators are family doctors who run IUD clinics and insert thousands of IUDs per year. They will share their experiences with a range of clinical equipment and techniques, such as cervical anesthesia, to simplify challenging IUD insertions. All 13 IUDs currently available in Canada will be at the workshop. Any doctor who can insert an IUD can also do an endometrial biopsy. This will allow you to investigate your patients with suspicious peri-menopausal or post-menopausal bleeding and quickly rule out endometrial cancer.

W97 **Providing Medical Assistance in Dying (MAID)**
13:30–17:15 Ellen Wiebe, MD, CCFP, FCFP; Stefanie Green, MD, CCFP; Konia Trouton, MD, CCFP, FCFP; Ben Schiff, MD CM, CCFP
③ credits per hour

ROOM / SALLE : 511B
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 9 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Assess patients for eligibility for MAID
2. Prescribe and administer MAID drugs
3. Educate patients, their families, hospital staff, and others about MAID

Description:
The presenters are family physicians who have been providing medical assistance in dying (MAID) since Canadian law changed in 2016 and are members of the Canadian Association of MAID Assessors and Providers. The purpose of this session is to give clinicians the tools to be both assessors and providers of MAID. It will be suitable for clinicians who have already provided MAID as well as ones who are considering becoming assessors or assessors/providers in the future. We will spend about half of the time reviewing best practices in performing robust assessments for MAID, including interpreting the medical parameters of Bill C-14, and will use case discussion to explore the more challenging assessments of patients who have dementia or mental illness or are non-verbal. We will describe best practices in the provision of both IV and oral medications. We will discuss how to mitigate the risks and stress on ourselves and to do good self-care. Each province and institution has its own guidelines and we will ensure that each participant has access

to the local rules as well as an understanding of the federal law and best practices in providing MAID. There will be a pre-test and post-test as well as a reflection exercise and possible mentorship for new providers.

W253 **PAACT Anti-infective: 2017 update**
13:30–17:15 Peter Kuling, MD, CCFP, FCFP; Frank Martino, MD, CCFP (EM), FCFP
(3) credits per hour

ROOM / SALLE : 511C
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 9 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Review the principles of antibiotic resistance as well as what's new and how this affects antibiotic prescribing
2. Feel more comfortable investigating and managing common infectious diseases, including upper and lower respiratory tract infections and urinary tract infections
3. Acquire patient tools to help implement antibiotic stewardship in your practice

Description:
This is an independent educational program developed by family physicians based on the latest edition of the Anti-infective Guidelines for Community-acquired Infections. Cases are designed to highlight common infectious diseases, including upper and lower respiratory tract infections, skin infections, and urinary tract infections (including in long-term care). Materials: The 2017 Anti-infective Guidelines for Community-acquired Infections, participant manual, and viral prescription pads. Teaching method: Interactive, case-based, small group.

THURSDAY 9 JEUDI

T887 **At the Heart of It: A new look at Clinical Cardiovascular Disease (CVD) in diabetes (Ancillary Session)**
06:45–07:45 Ting-Yu Wang, MD

ROOM / SALLE : 710A

Learning objectives:
1. Review and interpret the CDA recommendations, including the November 20L6 updates, for vascular protection and diabetes management in patients with type 2 diabetes, with and without cardiovascular disease
2. Summarize available cardiovascular outcome data and discuss their relevance in the primary care setting
3. Compare and contrast among individual agents within the DPP-4 inhibitor, GLP-L receptor agonist, and SGLT2 inhibitor classes

Description:
Since 20L3, the CDA has recommended that healthcare providers individualize the choice of pharmacologic treatments according to patient and agent characteristics. In light of the availability of new cardiovascular outcome trial data, and their corresponding inclusion into the two 20L6 CDA Guidelines Interim Updates (March and November), this program aims to help healthcare providers navigate the wealth of treatment choices available to manage type 2 diabetes. Through case-directed learning, participants will address multiple considerations-in particular cardiovascular disease-associated with treating patients with diabetes today.

T382 **International Collaboration Promoting Scholarly Activity Among Family Physicians**
07:00–08:00 **Working in Latin America Networking Breakfast**
Kyle Hoedebecke, MD, MBA, MPA, FAAFP; Ray Mendez, MD; Rosanna D'Addosio, MD; Yasmin Cordova, MD; Elisabeth Sachs, MD; Anna Maria Pedro Pijoan, MD; Elena Klusova, MD

ROOM / SALLE : 510A
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Strategize to encourage international collaboration on scholarly activities that overcome geographical barriers
2. Demonstrate the importance of international partnerships to advancing family medicine as a specialty worldwide
3. Strengthen leadership among family physicians and continuous medical education

Description:
Scholarly activity, a residency requirement for most family medicine residents worldwide, encourages the acquisition of new knowledge within our field. One of the most exciting ways to enrich research in primary care is through collaborations with international colleagues. This interaction and teamwork empowers physicians from regions of the world in which research is limited or even nonexistent. These partnerships allow physicians from other regions to learn effective research methodology that facilitates dissemination and publication of their work in peer-reviewed medical journals. Several family medicine organizations such as WONCA, the American Academy of Family Physicians Center for Global Health Initiatives, the Society of Teachers of Family Medicine, and the Besrour Centre—among various other entities—exist to facilitate research and collaboration. Also, research highlights the role of the family physician in academic medicine within their region as well as the leadership skills needed to develop and consolidate projects in primary care that benefit the community and the individuals they serve. This round table discussion with colleagues from several Latin American countries will elucidate ideas for and methods of improving collaborations between these regions and Canada.

T530 **Researchers in Education Networking Breakfast**
07:00–08:00 Doug Archibald, PhD; Shelley Ross, PhD

ROOM / SALLE : 510B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Learn about research being undertaken by colleagues
2. Generate opportunities for collaborations
3. Discuss ideas for future research in education

Description:
This event is an informal networking opportunity to connect colleagues considering or conducting like-minded research and to provide a forum to discuss and share current and prospective research ideas.

T880 **Residency PBSG Networking Breakfast**
07:00–08:00

ROOM / SALLE : 510C
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

T884 **OCFP Networking Breakfast**
07:00–08:00

ROOM / SALLE : 510D
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

T200 **Keynote Address: Quality: Our fifth pillar**
08:00–09:30 **Discours d'ouverture : « La qualité : notre cinquième pilier »**
Joshua Tepper, MD, CCFP, FCFP

ROOM / SALLE : 517
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Have a shared definition of 'quality'
2. Understand the overall approach to Quality Improvement and Improvement Science
3. Think about system and practice level strategies to create a culture of 'quality first' and quality improvement

Objectifs d'apprentissage :
1. Obtenir une définition commune du concept de « qualité »
2. Comprendre l'approche globale à l'amélioration de la qualité et les principes qui s'y rattachent
3. Faire un retour sur des stratégies au niveau du système et de la pratique pour développer une culture qui accorde la priorité à la qualité et qui favorise son amélioration

---

T71 **Approach to Preventive Care in the Elderly**
10:00–11:00 Robert Lam, MD, MS, CCFP (COE), FCFP; Bachir Tazkarji, MD, CCFP (COE), ABFP

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe three helpful areas when considering a preventive health intervention
2. Have an approach for estimating remaining years of life in frail elderly patients
3. List key primary care preventive areas with a mnemonic, CCFP, short for cancer, cardiovascular disease, falls/osteoporosis, and preventive immunizations

Description:
Objective: To guide family physicians in creating preventive screening and treatment plans for their elderly patients. Sources of information: The MEDLINE database was searched for Canadian guidelines on primary health care and the elderly; guidelines, meta-analyses, practice guidelines, or systematic reviews related to mass screening in those

age 80 and older and the frail elderly, limited to between 2006 and July 2016; and articles on preventive health services for the elderly related to family practice or family physicians, limited to English-language publications between 2012 and July 2016. **Main message:** Estimating life expectancy is not an easy or precise science, but frailty is an emerging concept that can help with this. The Canadian Task Force on Preventive Health Care offers cancer screening guidelines, but they are less clear for patients older than 74 years and management plans need to be individualized. Estimating remaining years of life helps guide your recommendations for preventive screening and treatment plans. Risks often increase with an increase in frailty and comorbidity. Conversely, treatment benefits often diminish as life expectancy decreases. Preventive management plans should take into account the patient's perspective and be mutually agreed upon. A mnemonic device for key primary care preventive areas—CCFP, short for cancer, cardiovascular disease, falls and osteoporosis, and preventive immunizations—might be useful. **Conclusion:** Family physicians might find addressing the following areas helpful when considering a preventive health intervention: age, life expectancy (including the concept of frailty), comorbidities and functional status, risks and benefits of screening or treatment, and values and preferences of the patient.

T116 **Untangling The Helix 2017: Prenatal genetics for primary care providers**
10:00–11:00 June Carroll, MD, CCFP, FCFP; Shawna Morrison, MS, CGC

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Discuss options for prenatal genetic screening, including non-invasive prenatal testing, and ethnicity-based prenatal screening tests
2. Discuss the results of expanded carrier screening tests and management options related to results
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 prenatal genetic screening. Topics will include prenatal screening for aneuploidy, non-invasive prenatal testing, ethnicity-based screening, and expanded carrier screening. Participants will be introduced to the Genetics Education Canada - Knowledge Organization genomics resource website: www.geneticseducation.ca.

T119 **Chronic Airway Disease: Management of asthma, COPD, interstitial lung disease, and bronchiectasis in your office**
10:00–11:00 Suzanne Levitz, MD CM, CCFP; Alan Kaplan, MD, CCFP (EM), FCFP; Anthony Ciavarella, MD, CCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Apply current guidelines (CTS and GINA) to the management of asthma in the office setting
2. Identify and implement the use of bronchodilators for the COPD patient,including step-up and step-down therapy
3. Investigate unexplained dyspnea and organize the management of interstitial lung disease and bronchiectasis in the office

Description:
Many patients present to the office with shortness of breath, often of long duration. In this 60-minute session the learner will be taken through the investigation and management of this population. The talk will be divided into three 20-minute sessions in which the unique aspects of each disease will be explored (session 1: asthma; session2: COPD; and session 3: interstitial lung disease and bronchiectasis). Learn about new testing and medications, including where they fit into what we already do. The patient who does not clearly fit into a category will also be discussed. There will be time to ask questions and discuss management, even cases that have you stumped!

T122 **Returning Your Patient to Work**
10:00–11:00 Avram Whiteman, MD, MPH, CCFP, FCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the role of the family doctor in return to work
2. Identify barriers and solutions to return to work
3. Appreciate return to work as a therapeutic modality

Description:
Returning a patient to work can sometimes be a very difficult task 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 (e.g., doctor, patient, employer, insurance company, etc.)

T265 **Acne Therapy Demystified**
10:00–11:00 Dominik Nowak, MD

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Determine the optimal evidence-based acne therapy for any given patient based on lesion morphology and patient demographics
2. Confidently and safely prescribe a broad spectrum of targeted topical and systemic therapies, being mindful of pertinent risks and benefits
3. Distinguish between common acne mimickers

Description:
Acne is firmly within the competencies of the modern family doctor. After all, more than 85 per cent of adolescents will be affected by acne. Its sequelae in the psychosocial realm—by means of body image, social anxiety, and physical scarring—can be lifelong if not treated quickly and competently. Yet the choices among therapeutic modalities are often incredibly puzzling. In this interactive presentation we will provide an evidence-based, simplified, systematic approach to acne therapy. How do I assess a patient with facial erythema, papules, and/or pustules? What are the common mimickers? What basic skin care advice should I recommend to each patient? Which topical, where, how, and when? What is my armament of systemic therapies, and how effective are they? How can I confidently and safely prescribe isotretinoin? When should I refer? And, finally, what is fact and what is fiction in acne and its relation to diet, inflammatory bowel disease, and depression?

T267 **From the Arrival Gate Onward: Key issues in refugee health primary care**
10:00–11:00 Praseedha Janakiram, MD, CCFP; Vanessa Wright, NP; Vanessa Redditt, MD, CCFP

ROOM / SALLE : 524C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify key primary care priorities in refugee health including immunizations, infectious diseases, and chronic disease assessment/management
2. List early screening approaches and their relevance to the refugee population
3. Describe patient-centred approaches to care used at the Crossroads Clinic in Toronto, Ontario, that facilitate delivery of service

Description:
The world is experiencing an unprecedented refugee crisis. The UNHCR, the United Nations Refugee Agency, estimates there are 65 million people displaced worldwide. As refugees arrive in Canada, primary care providers are uniquely positioned to offer comprehensive, continuous care to support their migration process. Using evidence-based practices grounded in the Canadian Collaboration for Immigrant and Refugee Health guidelines, the Crossroads Clinic at Women's College Hospital in Toronto, Ontario, serves new refugees. This session will provide an overview of key primary care screening opportunities, immunization recommendations, tuberculosis screening, and prioritized infectious disease and chronic disease interventions. The session will actively engage participants in sharing their experiences regarding approaches to health care delivery and ways to overcome barriers to health care delivery in their settings.

T284 Couples in Distress: How family physicians can help

10:00–11:00 William Watson, MD, CCFP, FCFP; Lindsay Watson, MA, AAMFT; Tat Ying Wong, MD

ROOM / SALLE : 521ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize the causes of distress and contraindications to couple therapy
2. Apply evidence-based approaches and helpful strategies to working with couples in distress
3. Access and implement resources such as effective attachment-based couple relationship education programs in your practice

Description:
Marital and couple distress can cause considerable stress for our patients and their families and have a considerable impact on their health, both physical and psychological. These effects can cause chronic stress and medical problems, including physical symptoms, psychological concerns, sexual issues, addiction, parenting issues, and domestic violence, to name a few. Because these patients usually seek medical assistance, it is advantageous for family physicians to have basic knowledge and skills for dealing with couple relationship issues. Being able to work effectively with a couple is a critical skill for the family-oriented clinician. Individuals in a positive relationship tend to lead healthier lifestyles with more exercise, less smoking and alcohol use, and reduced stress. Children raised in well-adjusted and supportive families have better outcomes. Because of a lack of training in this area, most family physicians feel ill-equipped to deal with relationship stress in the context of an office visit, creating barriers to further counselling and care. Simple strategies such as active listening, intentional dialogue, psychoeducation, and facilitation of collaborative problem solving can easily be achieved by most physicians in the context of an office practice. Evidence-based approaches such as emotionally focused therapy and formal marital therapy provide more in-depth counselling. Using case-based scenarios and interactive audience participation, this presentation will focus on practical approaches, counselling strategies, and resources that will help family physicians support their patients who are experiencing marital or couple distress.

T294 Mainpro+ Credit Reporting: A practical demonstration

10:00–11:00 Melissa Lujan, M.Sc.

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Navigate the Mainpro+ dashboard effectively to assist in planning your continuing professional development learning goals
2. Define Mainpro+ credit categories and how they relate to continuing professional development activities
3. Track continuing professional development activities in your Mainpro+ dashboard with confidence

Description:
Join us for an informative and interactive session on Mainpro+. This session will cover changes to the Mainpro+

credit and activity categories. Participants can engage in a live demonstration on how to report various types of learning activities on the member dashboard. You will learn how to earn and report credits for practice activities you do on a daily basis. The CFPC is committed to providing high-quality continuing professional development to meet your evolving interests and learning needs.

T328 **Should I Perform a Digital Rectal Exam for Prostate Cancer Screening?**
10:00–11:00 Jason Profetto, MD, CCFP

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Appreciate the quality of evidence (or lack thereof) behind the use of the digital rectal exam in screening for prostate cancer
2. Understand the lack of inter-rater reliability in the accuracy of the digital rectal exam in diagnosing prostate cancer
3. Appreciate the challenges of screening for prostate cancer with the combination of prostate-specific antigen testing and digital rectal exam

Description:
Should we be performing the digital rectal exam (DRE) in primary care for the screening of prostate cancer? Traditionally, the DRE is commonly used as a clinical skill to screen for prostate cancer in primary care and other specialty (primarily urology) settings. Although the DRE is recommended as a screening tool in numerous guidelines for prostate cancer screening, it is neither a specific nor sensitive exam, with limited data to support its routine use in primary care. Our team performed a review to evaluate the effectiveness of the DRE in screening for prostate cancer, specifically in primary care. Pooled data on the accuracy of the DRE in primary care settings were analyzed using meta-analysis techniques. Pooled sensitivity of the DRE among primary care physicians was 0.51 (95%CI 0.36 to 0.67), with a large heterogeneity (I2 = 98.4%), and pooled specificity was 0.59 (95%CI 0.41 to 0.76; I2 = 99.4%). The pooled positive predictive value was 0.41 (95%CI 0.31 to 0.52; I2 = 97.2%), and the pooled negative predictive value was 0.64 (95%CI 0.58 to 0.70; I2 = 95.0%). This recent analysis supports previous studies that have shown overall low diagnostic accuracy of the DRE and demonstrates that this exam may have limited clinical utility in the primary care setting. The presenter aims to provide an overview of the literature review and meta-analysis while interacting with the participants. Interaction will provide a fruitful discussion and review of different practice patterns, as the use of the DRE in screening for prostate cancer is known to be quite variable across North America. The bulk of this session will focus on practice patterns, the application of evidence-based guidelines, and a further exploration of the psychology behind patient and physician decision making.

T361 **Medication-Assisted Treatment for Alcohol and Opioid Use Disorders: Lessons from META:PHI**
10:00–11:00 Meldon Kahan, MD, CCFP, FRCPC; Kate M.R. Hardy, MSW, RSW; Sarah Clarke, PhD

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize the indications for anti-craving medications (naltrexone, acamprosate, gabapentin, and disulfiram) and apply prescribing protocols
2. Explain and apply protocols for managing opioid use disorder in primary care: opioid tapering, buprenorphine prescribing, and take-home naloxone
3. Participate in ongoing education via materials developed by METAPHI, including a handbook, a pocket card, and online training modules

Description:
Medication-assisted management of alcohol and opioid use disorders has been shown to be safe and effective when used by family physicians in primary care settings, including anti-craving medications for alcohol use disorders (e.g., naltrexone, acamprosate) and buprenorphine for opioid use disorders. These Interventions provide

better long-term care than current treatment modalities, i.e., stand-alone psychosocial programs and methadone clinics. The family medicine setting offers several advantages over current treatments: It combines medication-assisted treatment with counselling; integrates addiction treatment with management of comorbid psychiatric and medical conditions; and offers flexible, easily accessible, and non-stigmatizing long-term care. Despite this, family doctors have traditionally been left out of the addiction care pathway. This creates an addiction treatment system that is overburdened, unsustainable, and ineffective. This session is intended to introduce family physicians to medication-assisted treatment. The session will consist of a didactic presentation and two short videos of office encounters with addicted patients. Increasing patient access to medication-assisted treatments was a primary objective of Project META:PHI (Mentoring, Education, and Clinical Tools for Addiction: Primary Care–Hospital Integration), a two-year program designed to create an integrated care pathway between the emergency department, hospital, community agencies, and primary care. META:PHI established rapid-access addiction medicine (RAAM) clinics in or near seven hospitals across Ontario, Canada. RAAM clinics provide immediate treatment access for patients in primary care and acute care settings, shared care with family physicians, and mentorship and training to health care providers. To date, 186 primary care physicians have participated in the care pathway across seven regions. The first 152 patients who attended the RAAM clinics experienced marked reductions in emergency department visits and hospitalizations.

T390 **What's New, True, and Poo: Evidence updates for clinically relevant primary care topics**
10:00–11:00 **Quoi de neuf, de vrai et de faux : Mises à jour des données probantes sur des sujets cliniquement pertinents en soins de première ligne**
Mike Kolber, MD, CCFP, MSc; Christina Korownyk, MD, CCFP; G. Michael Allan, MD, CCFP, FCFP

ROOM / SALLE : 517BC

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Review clinically relevant and practice-changing evidence from the preceding year
2. Encourage delegates to examine the evidence before adopting new diagnostic tests or medications
3. Review indirectly evidence-based medicine terms such as baseline risk, absolute and relative risk, and number needed to treat

Description:

In "What's New, True, and Poo" in 2017, we provide brief evidence updates pertaining to clinically relevant primary care topics. Typically each topic/knowledge piece will be reviewed in about two minutes, allowing for a breadth of clinical topics/knowledge pieces to be presented and discussed. We discuss patient-orientated and clinically relevant evidence pertaining to: 1) new therapies, new diagnostic tests, or new uses for existing medications (New); 2) the confirmation of current medical practice or prescribing (True); and 3) the refutation of practice or medical myths (Poo).

Objectifs d'apprentissage :

1. Revoir les données probantes pertinentes sur le plan clinique et ayant transformé la pratique de l'année précédente
2. Encourager les délégués à examiner les données probantes avant d'adopter de nouveaux tests diagnostiques et médicaments
3. Examiner indirectement les termes du programme EBM tels que risque initial, risque absolu et relatif et nombre de patients à traiter

Description :

En 2017, dans « Quoi de neuf, de vrai et de faux », nous fournissons une brève mise à jour des données probantes sur des sujets cliniquement pertinents en soins de première ligne. Habituellement, chaque sujet est revu pendant deux minutes pour permettre d'inclure une vaste gamme de sujets cliniques dans la présentation. Nous parlerons de données probantes axées sur les patients et pertinentes sur le plan clinique portant sur : 1. Nouveaux traitements, tests diagnostiques ou nouveaux emplois de médicaments existants (neuf) ; 2. Confirmer la pratique médicale actuelle ou la prescription (vrai) ; 3. Réfuter les mythes médicaux ou de la pratique (faux).

T399 Pediatric Emergency Medicine Update for the Family Doctor
10:00–11:00 **Nouveautés en médecine d'urgence pédiatrique pour les médecins de famille**

April Kam, MD, MScPH, FRCPC

ROOM / SALLE : 710B

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Learn the latest evidence for return to play following a concussion
2. Find out what is the latest in bronchiolitis management
3. Apply the take-home messages from the top articles in the field of pediatrics to your practice

Description:

Top practice-changing articles will be discussed from the field of pediatric emergency medicine. The latest updates about return to play in pediatric concussion will be interpreted. A quick overview of recent evidence behind the management of bronchiolitis and other common pediatric infections will be reviewed.

Objectifs d'apprentissage :

1. S'informer des toutes dernières données probantes concernant le retour au jeu après une commotion cérébrale
2. Découvrir ce qu'il y a de nouveau dans la prise en charge de la bronchiolite
3. Appliquer dans votre pratique les points essentiels des meilleurs articles du domaine de la pédiatrie

Description :

La discussion portera sur des articles susceptibles de changer la pratique, qui comptent parmi les meilleurs écrits dans le domaine de la médecine d'urgence pédiatrique. Ce sera aussi l'occasion d'interpréter les dernières nouvelles sur le retour au jeu après une commotion cérébrale pédiatrique. De plus, il y aura un aperçu des données récentes sur la prise en charge de la bronchiolite et d'autres infections courantes chez les enfants.

T469 Artificial Nutrition and Hydration: Exploring requests for initiating, continuing, or withdrawing treatment
10:00–11:00

Stephanie Connidis, MD, CFPC (PC) (COE), RACGP

ROOM / SALLE : 512ABEF

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe indications for artificial nutrition and hydration
2. Identify when discussions about continuation or discontinuation of therapy may be appropriate
3. Apply the legal principles of withholding and withdrawal of potentially life-saving treatment to this intervention

Description:

This presentation will use case studies to illustrate issues that family physicians, residents, and students engaged in delivering palliative care may encounter around requests for artificial nutrition and hydration. The rationale for and against initiating these interventions, the importance of re-assessing the goals of continued interventions over time with patients and their families, and understanding the legalities of withholding or withdrawing from this treatment will be highlighted. At the conclusion of the presentation participants will be able to apply factual information, and develop trigger points and strategies to guide decision making and conversations with patients and their families when oral intake and functional status declines.

T488 Women's Cardiovascular Health: What does a sex-specific cardiovascular risk assessment look like?
10:00–11:00 Karen Fleming, MD, MSc, CCFP, FCFP; Debbie Elman, MD, CCFP, FCFP; Shivani Bhat, MPH

ROOM / SALLE : 524A

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Interpret and integrate relevant evidence and clinical guidelines to identify and manage sex-specific cardiovascular disease risk factors
2. Devise strategies to identify at-risk women in your practice through electronic medical records or other mechanisms
3. Participate in case-based scenarios facilitating implementation of guidelines to practice

Description:

Cardiovascular disease (CVD) is the second-leading cause of death in women and in men in Canada. Despite marked sex-specific differences, many female-specific risk factors commonly go unnoticed, leading to increased female mortality. Women have unique risk factors for heart disease, such as pregnancy and hormone therapy, which need to be considered during primary treatment and management. For example, preliminary results from a patient recall survey conducted at Sunnybrook's Academic Family Health Team indicated that while two-thirds of the patients with CVD-related pregnancy complications were counselled on their future health risks by their family doctor during post-delivery visits, one-third were not. This represents a missed opportunity for primary CVD prevention. Recently, the Canadian Cardiovascular Society updated their screening criteria for dyslipidemia to include women with a history of hypertensive disorders of pregnancy as one of the at-risk populations for CVD—a positive step to improve current practice. This session will provide family physicians with updated evidence-based proficiencies to manage sex-specific CVD risk factors and deliver individualized care to their patients based on the updated Canadian Cardiovascular Society clinical guidelines. The session will be interactive, using clinical vignettes to address pregnancy-related complications, menopause, prior chest radiation, prior breast cancer (chemotherapy and radiation treatments), migraines (with aura), collagen vascular diseases, and traditional risk factors and CVD management. We will also address barriers to implementing sex-specific cardiovascular risk assessments in practice. All participants will be asked to complete a pre- and post-workshop survey to identify the impact of the workshop to their practice

---

T491 MedEd Research 101: An introduction to the basics of conducting medical education scholarship

10:00–11:00 Shelley Ross, PhD; Oksana Babenko, PhD; Douglas Archibald, PhD

ROOM / SALLE : 510D

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe medical education scholarship
2. Identify the factors that need to be considered when setting up a medical education scholarship project
3. Plan for a medical education scholarship project in your home program or clinic

Description:

Have you ever thought about conducting a medical education research project? Are you not sure how to start? This workshop is for you! Many clinical educators who teach students and residents, or who are involved in continuing professional development, develop a curiosity about some aspect of learning or assessment. It may be about the best way to deliver material, or whether their learners have really mastered the material, or perhaps whether a change in the way they teach has resulted in improved learning. Whatever makes a clinical educator start thinking about how to develop or evaluate an aspect of their clinical teaching, classroom teaching, or faculty development, there are common elements to consider and address when carrying out a research or scholarship project. Some of these elements—like developing a research question, choosing a research design and method, and looking at the need for ethics approval—are common to most projects. While they may seem intimidating if you are new to medical education research and scholarship, there are some tips and tricks to get you on your way. Through case examples and a review of resources, the presenters will walk participants through things to consider for medical education scholarship projects. In response to feedback from last year, this workshop will be more interactive, with didactics reduced and more resources provided for participants to look at in detail later. Working in small groups with shared interests, participants will work with the presenters as discussion facilitators. Participants will leave the workshop with a clear research question to begin planning a medical education scholarly project. This workshop is intended for those who are just beginning their journey in medical education scholarship.

T519 **#Milleducation: A guide to teaching millennial learners, by millennial medical educators**
10:00–11:00 Vanessa Rambihar, MD, CCFP
All teachers welcome. Highlights novice and advanced concepts for all teachers.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Characterize millennial learners and their unique learning styles based on current evidence in the education literature
2. Describe the learning needs of millennial learners in the context of the complex dynamic world of technology
3. Identify potential areas for greater effectiveness as an educator in teaching millennial learners

Description:
As millennials are now in the majority of students in medical schools and residency training programs across the world, medical educators must strive to adapt their teaching methods to meet the value system of this new generation of learners. As the literature on medical education of millennials has largely been written and reviewed from the perspective of non-millennials, this session offers a creative and novel perspective—it will be led by young medical educators and leaders who are millennials. Conference participants who are either interested or experienced in medical education at all levels and in various settings should attend in order to benefit from discourse and idea-sharing across generations, practice settings, and provinces. The presentation will focus on all of levels of medical education, with particular focus on undergraduate medical education, postgraduate residency training, and maintaining tenets of professionalism and CanMEDS-FM roles. Both millennial and non-millennial medical educators and learners are encouraged to participate in this workshop in order to stimulate a comprehensive discussion of this burgeoning topic. The session will be highly interactive, reflecting key characteristics of the technology-focused millennial generation, with a dynamic real-time approach to audience questions using a Prezi-based lecture, rather than traditional PowerPoint, and using tools like Twitter and Instagram for audience interaction. Small group collaboration will be used throughout the session to develop questions, share challenges, and create innovative solutions to share with the larger group. The intended outcome is to stimulate discourse amongst medical educators at all stages of practice, leadership experience, and teaching exposure, on the challenges in medical education based on the current generation of learners, with a focus on positive solutions and methods to engage this generation, facilitated by the unique perspectives offered by millennial staff family physicians and young innovative leaders in medical education.

T368 **Teaching Through a Generalist Lens**
10:00–12:15 Melissa Nutik, MD, MEd, CCFP, FCFP; Azadeh Moaveni, MD, CCFP; Ruby Alvi, MD, CCFP, MHSc; James Owen, MD, CCFP; Risa Freeman, MD, MEd, CCFP, FCFP
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe the key elements of generalism
2. Apply an evidence-informed generalism tool to teaching scenarios in curriculum development to assess them for evidence of generalist principles
3. Identify opportunities to teach generalism principles in daily practice

Description:
Generalism is believed to be a widely held fundamental value in medical education. The Faculty of Medicine at the University of Toronto is currently engaged in preclerkship curriculum renewal. The new curriculum is purported to be based on "generalist" principles. However, in the course of the curriculum review it became apparent that perspectives on generalism held by faculty and other stakeholders were varied and unclear. In response to this an environmental scan and literature review related to generalism were undertaken. From this, Department of Family and Community Medicine faculty developed an evidence-informed tool incorporating the key elements of generalism. This workshop will explore definitions and key elements of generalism in medicine and reflect

on its position within both the formal and the hidden curriculum. The evidence-informed Generalism Tool will be introduced and participants will have opportunities in small groups to apply the tool to curriculum scenarios to assess them for evidence of generalist principles and consider where this could be enhanced. This interactive workshop will include a discussion about opportunities to teach generalism principles in daily practice at both the undergraduate and postgraduate levels. This workshop will be of interest to clinical preceptors, teachers outside the clinic setting, and educational leaders wishing to reflect on their teaching and curricula through a generalist lens.

T454 **What Residents Want: The periodic review of progress**
10:00–12:15 Theresa van der Goes, MD, CCFP; Tom Laughlin, MD, CCFP; James Hudson, MD; Kiranpal Dhillon, MD
All teachers welcome. Highlights advanced concepts for clinical preceptors.
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 511C
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe the essential steps of a periodic review
2. Discuss key points that residents find support or detract from a periodic review
3. Integrate these key points to take back to their home programs to facilitate appropriate change and reinforce best practices

Description:
The periodic review of progress is a key element in family medicine residency training for effective resident continuity of development and assessment. When reviews are done well, residents are engaged, motivated, and reflective adult learners who are guided to develop and accomplish their learning plans over the length of their programs. Setting the stage and grasping a deeper understanding of what facilitates and what inhibits this critical process is vital to fostering excellence in this aspect of resident education. This workshop brings together foundational information and evidence about the periodic review along with the resident point of view—from both the Section of Residents 2017 GIFT document and a diverse and articulate panel of residents from across Canada. Participants will engage in a facilitated discussion and small group work to integrate this information as part of advocacy to improve periodic reviews at their residency programs.

T141 **It's Overgrown Toeskin, Not Ingrown Toenail**
11:15–12:15 Henry Chapeskie, MD, CCFP, FCFP, CAME

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explore evidence-based research demonstrating that there is no nail abnormality but rather an excessive amount of soft tissue
2. Gain confidence in this technical procedure that can be performed in the family physician's office
3. Gain confidence in an evidence-based rationale for the cessation of removing part or all of the toenail

Description:
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 the problem is due to an excessive amount of soft tissue, which can be excised. Removal of this tissue results in less bulging over the nail with weight bearing and eliminates the problem. The nail is not touched! The result is cosmetically excellent and the problem will never recur.

T271
11:15–12:15

Canadian Cardiovascular Society Atrial Fibrillation Guidelines: Management of AF for the family physician
Lignes directrices sur la fibrillation auriculaire de la Société canadienne de cardiologie : Prise en charge de la FA par le médecin de famille

Alan Bell, MD, CCFP; Laurent Macle, MD, FRCPC; Louise Pilote, MD, MPH, PhD

ROOM / SALLE : 517BC

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Examine the latest evidence on the management of concomitant anticoagulants and antiplatelet therapy in clinical practice
2. Discuss recommendations regarding the role of catheter ablation for the treatment of patients with atrial fibrillation
3. Update knowledge and decision making on screening patients for atrial fibrillation after cryptogenic stroke

Description:

Affecting approximately 350,000 Canadians, atrial fibrillation (AF) is the most common arrhythmia managed by physicians. As AF can lead to more serious medical problems such as stroke, heart failure, reduced quality of life, and additional heart rate and rhythm issues, the detection and management of AF in patients is important. Given the emergence of new evidence on AF, the Canadian Cardiovascular Society (CCS) Atrial Fibrillation Guidelines Panel periodically provides updated recommendations that address clinically important advances in the management and treatment of AF. In this workshop session, members of the CCS Atrial Fibrillation Guidelines Panel will present practical clinical strategies in the management of patients with AF. Members will use case examples to discuss: 1) emerging evidence on the management of concomitant anticoagulants and antiplatelet therapy in clinical practice; 2) the "who, when, and how" of catheter ablation; and 3) how and when to screen for atrial fibrillation after cryptogenic stroke.

Objectifs d'apprentissage :

1. Examiner les toutes dernières données probantes sur la gestion du traitement anticoagulant et antiplaquettaire concomitant en pratique clinique
2. Discuter des recommandations sur le rôle de l'ablation par cathéter dans le traitement de la fibrillation auriculaire
3. Actualiser les connaissances et la prise de décision sur le dépistage de la fibrillation auriculaire après un AVC cryptogénique

Description :

Touchant quelque 350 000 Canadiens, la fibrillation auriculaire (FA) est l'arythmie la plus souvent prise en charge par les médecins. Comme la FA peut entrainer des problèmes médicaux plus graves, comme l'AVC, l'insuffisance cardiaque, la réduction de la qualité de vie et d'autres problèmes liés à la fréquence et au rythme cardiaques, la FA doit être dépistée et prise en charge. Vu la publication de nouvelles données probantes sur la FA, les membres du comité de rédaction des Lignes directrices sur la fibrillation auriculaire de la Société canadienne de cardiologie (SCC) actualisent périodiquement ses recommandations afin d'intégrer les progrès cliniques importants dans la prise en charge et le traitement de la FA. Dans cet atelier, les membres du comité de rédaction des Lignes directrices sur la fibrillation auriculaire de la SCC présenteront des stratégies cliniques pratiques de prise en charge de la FA. Les membres du comité traiteront des sujets suivants par l'intermédiaire d'exemples de cas : 1) données émergentes sur la gestion du traitement anticoagulant et antiplaquettaire concomitant en pratique clinique ; 2) le « qui, quand et comment » de l'ablation par cathéter ; 3) quand et comment effectuer le dépistage de la fibrillation auriculaire après un AVC cryptogénique.

T316
11:15–12:15

Practical Tips for Managing ADHD in Your Office

Nick Kates, MBBS, FRCPC, MCFP

ROOM / SALLE : 517D

Mainpro+ Group Learning certified credits

Learning objectives:

1. Recognize clues of the presence of ADHD in patients in a practice
2. Be able to prescribe and adjust dosages of medications for ADHD in primary care
3. Be able to differentiate ADHD from other commonly occuring mental health problems

Description:

More than 60 per cent of children with attention-deficit/hyperactivity disorder (ADHD) will continue to have symptoms as adults, making it one of the most commonly encountered mental health problems in primary care but also one that is frequently overlooked. This workshop reviews the prevalence of ADHD in primary care and the different ways it can affect an individual's life. Using case examples the workshop describes ways ADHD can present in primary care and how to recognize when it may be a comorbid condition, often accompanying a mood or anxiety disorder. It outlines the specific criteria required to make a diagnosis of attention-deficit disorder with or without hyperactivity and screening tools available to detect its presence. It presents an overview of treatment approaches, including psychoeducation and support, the provision of structure and routine, family involvement, cognitive approaches, and the use of medication. It outlines the different medication options available and guidelines for their initiation, maintenance, and discontinuation and provides links to reading materials and resources that can be provided to patients.

T330 Acute Bronchitis, Pharyngitis, and Sinusitis: Mainly viral! But some physicians still using antibiotics?!

11:15–12:15 Jason Profetto, MD, CCFP

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Understand the unique pressures family physicians experience from patients for unnecessary antibiotics
2. Understand how patients, physicians, and the medical system all perpetuate the problem of inappropriate antibiotic prescribing
3. Appreciate the unique logical fallacies that both patients and physicians find themselves using when it comes to antibiotic prescribing

Description:

Many family physicians acknowledge that acute bronchitis, pharyngitis, and sinusitis are generally viral in nature and self-limiting illnesses, but then why do prescribing patterns still consistently show that physicians often give out antibiotics for these infections? Respiratory infections (specifically acute bronchitis, pharyngitis, and sinusitis) are common chief complaints presenting to a family doctor's office, yet there are growing data that show many cases of these infections are not being managed properly. It is estimated that up to 30 per cent of antibiotic prescriptions given in an outpatient setting in this context are unnecessary and often inappropriate. There is great risk to these prescribing patterns, including avoidable side effects and antibiotic resistance. One of the important predictors of antibiotic prescriptions can be patient expectations. Some studies suggest that 39 per cent to 75 per cent of patients presenting with any combination of runny nose, sinus pain, cough, ear pain, congestion, and sore throat had an expectation of receiving an antibiotic, despite a very strong likelihood that these infections are viral and self-limiting. Our team produced a paper after performing a literature search of the Cochrane library and PubMed for articles pertaining to antibiotic use in upper respiratory tract infections published between 1990 and 2016. Our search was limited to systematic reviews, meta-analyses, and randomized controlled trials. We found there is little evidence to support a clinically significant benefit of antibiotic therapy for symptom management and/or prevention of complications in acute bronchitis, pharyngitis, and acute sinusitis. The next critical step in this discussion will be to explore further the cognitive psychology and decision-making patterns of both patients and physicians to understand why these patterns of inappropriate prescribing continue to exist. This will be done largely through an interactive review of evidence and prescribing challenges that physicians continue to experience pertaining to acute bronchitis, pharyngitis, and sinusitis.

T355 The Many Faces of Adolescent Eating Disorders: Would you recognize them?

11:15–12:15 Karen Fleming, MD, MSc, CCFP, FCFP

ROOM / SALLE : 512CDGH

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe the updated DSM classification of eating disorders and their incidences in adolescence
2. Discuss barriers to implementing screening for eating disorders in primary care
3. Discuss the challenges inherent in the diagnosis and management of eating disorders in primary care

Description:

Disordered eating and eating disorders are common in adolescence. The chapter on Feeding and Eating Disorders was recently updated in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Statistics from the 2013 Youth Risk Behavior Surveillance System survey found 18.7 per cent of females and 7.7 per cent of males went without eating for more than 24 hours and 6.4 per cent and 3.2 per cent, respectively, took diet pills, powders, or liquids without the advice of a health care provider in an attempt to lose weight or avoid gaining weight. Eating disorders occur in all major ethnicities and socio-economic classes, with an increasing incidence in children younger than 12, and are the mental health diagnosis with the highest mortality and significant morbidity. Early intervention in adolescence is associated with improved long-term outcomes. Primary care providers should be aware that many adolescents do not want help with their eating disorders, so parents, schools, or coaches may be the ones to raise concerns. Adolescents may, however, present with bothersome eating disorder symptoms and the relationship with the family/teen provides an opportunity for screening and intervention. Referral by primary care providers is the most likely reason families/patients seek expert care. Primary care providers need to be aware of comorbidities associated with eating disorders and the identification and management of medical complications associated with various eating disorders. Outpatient care is the first line of treatment and primary care providers can assist families in understanding available treatments and accessing timely, specialty-based care and providing care while awaiting specialty care.

T357 Using Pharmacogenetics for Common Problems Managed in Family Practice

11:15–12:15 Martin Dawes, MBBS, MD, CCFP, FRCGP; Mark Gelfer, MD; Diana Dawes, CSP

ROOM / SALLE : 524A

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Use Stanford University's PharmGKB CPIC pharmacogenetic online free tool to look up clinically relevant genetic tests
2. Explain to patients how pharmacogenetic tests are performed, how DNA is analyzed, and what the results mean
3. Use a pharmacogenetic test result to identify drug options for a patient managed in primary care

Description:

Each year in Canada there are approximately 200,000 severe adverse drug events, claiming up to 22,000 lives. Physicians cannot predict whether a patient taking a drug for the first time will gain the desired benefit from that drug or experience harmful side effects. This is particularly relevant in primary care, where most prescriptions are written. Pharmacogenetic tests may reduce this uncertainty for many medications but the knowledge about these tests, their benefits, their quality, and their use in practice is not readily available for family physicians in Canada. This session will be interactive using a world-renowned pharmacogenetics platform called PharmGKB run by Stanford University. This tool works in two ways: It enables clinicians to look up drugs to see clinically relevant tests of variants and to look up genetic variant results patients may bring in to identify the drugs the variant may affect. Working in small groups, physicians will learn to navigate this system using information from prepared patient scenarios, and any real patient examples from the audience, to answer questions about whether patients might benefit from a test and what the pharmacogenetic test result means for them. The session will also include explanations of the technical aspects of pharmacogenetics with a demonstration of the whole process of genetic variant detection from swab to report. A primer on pharmacogenetics with a glossary of terms and a short description of tests will be provided. This includes the various laboratory techniques available, the terminology of

the test results, and a description of the resources available for further reading relevant to primary care.

T420 **Veteran Health: Life After Service Studies (LASS) and family practice**
11:15–12:15 Burton McCann, MD, JD, FCFP, FACOEM; Brent Wolfrom, MD, MSc, CCFP, FCFP

ROOM / SALLE : 524C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Examine the health status of Canadian veterans Including determinants of health from various well-being domains
2. Apply insights from the LASS program of research to veteran care in family ractice
3. Identify barriers and solutions to change in veteran health

Description:
Occupational medicine involves the effects of work on health and the effects of health on work. This includes these effects on our veterans. There are approximately 600,000 former Canadian Armed Forces (CAF) members living in Canada today who served after the Korean War. The well-being of recent CAF veterans across major areas of life, including health and disability, employment, finances, and social integration, has been described in more than two dozen publications from the Life After Service Studies (LASS). The LASS are nationally representative surveys of the well-being of former CAF members released since 1998 that were conducted in 2010, 2013, and 2016 in a collaboration between Veterans Affairs Canada, the Department of National Defence, and Statistics Canada. These findings have important implications for health care and disability mitigation in this important Canadian sub-population. This interactive session will explore participants' involvement in and understanding of veteran health. Original, cutting-edge Canadian research will be incorporated. Expected changes in veteran numbers and demographics will be explored. Reservist care and seven domains of veteran well-being will be examined in examples of barriers and solutions. The session will conclude with an interactive exchange on concrete action steps for Canadian family physicians caring for veteran patients.

T423 **Medically Unexplained Symptoms in the Family Physician's Office**
11:15–12:15 Angela Cooper, PhD

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Become aware how stress can manifest as physicial symptoms
2. Learn approaches to help patients with somatic symptoms related to psychological causes
3. Recognize when physical symptoms have orgins in stress and anxiety

Description:
Medically unexplained symptoms often are related to manifestations of stress. These symptom can be perplexing and frustrating. The participant will develop an approach to these patients in this session.

T436 **Clinical Application of the 2015 Long-Term Care Fracture Prevention Guidelines**
11:15–12:15 Sidney Feldman, MD, CCFP (COE), FCFP; Lynn Nash, MD, CCFP, FCFP

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify long-term care residents who are at high risk for fracture
2. Apply new LTC Fracture Prevention guideline recommendations
3. Stop pharmacotherapy when appropriate

Description:
Osteoporosis Canada's guideline, Recommendations for Preventing Fracture in Long-Term Care, is the first

guideline in Canada that focuses on preventing fractures among the frail and elderly in long-term care, in whom fractures are much more common than among community-dwelling seniors. Launched in 2015, the guideline is specifically designed to reduce immobility, pain, and hospital transfers and, most importantly, improve the quality of life of residents at these facilities. We will present valuable, practical information contained in the guideline, such as strategies to prevent fractures, that is useful to doctors, caregivers, and frail older adults at long-term care facilities and in the community.

T447 **How to Diagnose Motor Vehicle Accident Patients at Risk**
11:15–12:15 Richard Nahas, MD, CCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe risk factors, prognosis, diagnosis, and treatment of symptoms related to the polytrauma clinical triad
2. Perform a soft tissue examination to identify and treat muscle spasm and other triggers of brain dysfunction
3. Provide follow-up and self-care advice including prescription drugs , natural health products, and other non-drug interventions

Description:
More than 80 per cent of motor vehicle accident (MVA) victims sustain soft tissue injuries that appear to be minor. These patients are usually diagnosed with whiplash and managed with reassurance and a wait-and-see approach. One year later, up to 50 per cent will be on long-term disability benefits. Family physicians have an important role to play in the identification and evaluation of patients at greatest risk of disability. The polytrauma clinical triad (PCT) is an emerging syndrome that remains poorly understood by the average physician and under-diagnosed in primary care. It includes symptoms of chronic pain, post-concussion syndrome, and post-traumatic stress disorder. PCT has been described in military populations but is also seen in other patients after MVA and other traumatic injuries. This workshop will provide participants with an evidence-based review of these syndromes in the setting of MVA and related trauma. This will be supported by our clinical experience with patients referred to our community-based chronic pain management program.

T472 **First Five Years in Family Practice: Top five essentials for early career physicians**
11:15–12:15 Steve Hawrylyshyn, MD, MSc, CCFP

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Prepare for common challenges encountered by new physicians and gain confidence for approaching various clinical and patient-centric scenarios
2. Implement specific strategies to address practice management concerns for those new in practice or in early career
3. Apply the actionable methods and phrases discussed when similar situations arise in their own practice

Description:
This innovative session will focus on common areas of concern for early career physicians in five brief 10-minute presentations. The presenters will approach each topic by identifying a challenge commonly reported by many new family physicians and offering concrete tactics that can be employed by attendees in day-to-day practice. The topics will range from clinical questions, to practice management challenges, and to patient management situations. The strategies offered will be actionable and provide attendees with the confidence to tackle their most difficult situations as they begin practising family medicine. Over the course of an hour, established family physicians will share their top suggestions for managing the most common concerns that arise during the first five years of practice in a series of highly-informative, bite-sized sessions. Each bite-sized session will be followed by an opportunity to ask the speaker questions, with a longer question period at the conclusion of the session.

T516 **Patient-Partners in Primary Care Research: A physician's experience**
11:15–12:15 Fanny Hersson-Edery, MD CM; Jennifer Reoch, NP, MSc; Justin Gagnon, MSc; Arlene Abramovitch, SW; Stewart Jack

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the roles of a patient partner
2. Recognize the added value of including patient partners in primary care research
3. Explore ways to integrate patient partners into their current or future research projects

Description:
The goal of primary health care research is to improve quality of care for patients. By including patient partners in the research process, clinicians and researchers can develop health interventions that are patient-centred and address the needs of the population. Patient partners can help at all levels of research from helping identify relevant research questions, evaluating health programs, and helping develop novel health care interventions, to helping develop strategies for dissemination. The presenters will discuss their experience of including patient partners in the Diabetes Empowerment Group Program research team. Two examples will be discussed: the development of a knowledge translation plan, and the validation of a diabetes empowerment questionnaire. The patient partners will also provide their perspective on the clinician-patient-researcher collaboration. Participants will gain a better understanding of processes for working with patient partners and gain greater appreciation of the value that patient participants can bring to primary care research. Participants will be provided practical tips for integrating patient partners into their research projects.

T517 **Office-Based Use of Buprenorphine-Naloxone for Opioid Use Disorders**
11:15–12:15 Erin Knight, MD, CCFP; Nikki Bozinoff, MD, CCFP

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Compare methadone and buprenorphine-naloxone and evaluate which medication to prescribe for treating opioid use disorder
2. Explain the pharmacology and pharmacodynamics of buprenorphine-naloxone, and plan an office-based induction without precipitating opioid withdrawal
3. Explore provincial guidelines and identify how to obtain certification to prescribe buprenorphine-naloxone

Description:
Methadone has been used successfully for treating opioid use disorder since the 1960s, and remains the standard of care. While effective, methadone has several risks that require careful prescribing and dispensing practices that can be prohibitive for some patients. More recently, the combined medication buprenorphine/naloxone was approved for use in Canada, and has several advantages over methadone. In particular, it carries a much lower risk of overdose and adverse drug reactions, and is prescribed more liberally in other countries such as the United States. During this session, we will review the unique pharmacological and pharmacodynamic properties of buprenorphine-naloxone. Participants will be introduced to an office-based protocol for safe induction of buprenorphine-naloxone to prevent precipitated withdrawal. Furthermore, we will review the present provincial guidelines for the availability and use of buprenorphine-naloxone, and discuss how potential changes to these policies could result in safer, more effective treatment of opioid use disorder in a primary care setting.

12:15–13:30 **CFPC Annual Meeting of Members**
Assemblée annuelle des membres du CMFC

ROOM / SALLE : 710B

Description:
Why attend the Annual Meeting of Members (AMM)?

- Influence the direction of the CFPC.
- Interact with your Board Directors and the Executive Director/Chief Executive Officer. Do you have questions? Bring them!
- Meet your newly elected 2017–18 Board of Directors.

Lunch will be provided.

Description :

Pourquoi assister à l'Assemblée annuelle des membres (AAM) ?

- Influencer la direction du Collège.
- Échanger avec les membres de votre CA et avec la directrice générale et chef de la direction. Avez-vous des questions ? Posez-les.
- Rencontrer les membres du CA nouvellement élus pour 2017–2018.

Le lunch sera offert.

T881 **MDD - At work, but not really working (Ancillary Session)**
12:30–13:30 Valérie Tourjman, MD, FRCPC; Pratap Chokka, MD, FRCPC

ROOM / SALLE : 517A

La séance sera présentée en anglais mais des animateurs francophones seront présents.

Learning objectives:

1. Describe the prevalence of MDD in working individuals and the burden of the disorder in the workplace
2. Explain current management approaches to MDD to help improve workplace functioning and productivity
3. Apply data to the clinical context to help individuals living with MDD return to better functioning

Description:

One in five Canadians will experience a mental health issue in his or her life. This is of particular concern for working individuals – the largest proportion of people living with depression – and employers, as mental and behavioural health issues are the leading cause of short- and long-term disability in Canada. The impact depression can have on all areas of an individual's life is significant, and the related decline in work productivity is increasingly the subject of study. Like the other aspects of an individual's life, the effects of MDD on work functioning can be mediated by any of the broad spectrum of MDD symptoms – emotional, physical, and cognitive. This is an important consideration in that the 2016 CANMAT guidelines for the treatment of MDD state that a return to full functioning is the treatment goal in both the acute and maintenance phases of the disease, implying that a holistic view of symptoms and functional impairment is necessary for optimal disease management. In the context of real-life patient cases and recent study data, participants in this session will consider how the current management of depression affects the function of a patient with MDD, particularly in the workplace, and evaluate the potential correlation between improving some or all symptoms dimensions of MDD and improved workplace productivity.

T882 **Understand, Empower, Treat: Revolutionizing obesity care (Ancillary Session)**
12:30–13:30 Tina Kader, MD

ROOM / SALLE : 710A

Learning objectives:

1. Explore the multifactorial pathophysiology of obesity as a chronic disease and describe the rationale for its management
2. Compare currently available Canadian pharmacotherapy options for the management of obesity
3. Discuss practical approaches to the initiation and maintenance of obesity management in clinical practice

Description:

As knowledge and research in the area of obesity have advanced, so have the approaches to the management of patients living with obesity. Revolutionizing obesity care not only means incorporating a fundamental

understanding of the complex pathophysiology of obesity, but also assessing and building a patient's motivation for change and tailoring a management plan to the patient's needs.

Join us for an engaging session, where you will explore the key concepts of obesity, and review practical approaches to its assessment and management in clinical practice.

T505 **Implementation of a Diabetic Program in a Family Health Team**
13:30–14:30 Dominique Auger, MD, MSc, CCFP; Lyne Pître, MD, CCMF, FCMF, MMedEd

Mainpro+ Group Learning certified credits = 1.0

Learning objectives:
1. Describe the steps for creating a diabetes program in a family health team
2. Share the electronic tools used to track the rostered population
3. Adopt a new way to treat the diabetic population in a multidisciplinary approach

Description:
Implementing a diabetic program in a family health team (FHT): The goal of the diabetic program in our FHT was taking charge of a roster of patients, affected by diabetes, by a multidisciplinary team to improve on outcomes. According to the Canadian Diabetes Association, the best approach for care of diabetes and improving outcomes is to invest in a multidisciplinary approach. After creating a new FHT, the board was faced with the challenge of implementing a program that would organize, in a coordinated way, the care of all diabetic patients rostered in the FHT. A custom form was created in the electronic medical record and a computerized list of patients was used to track the results and visits. All clinical staff were solicited in the project. The outcomes of this new way of treating chronic disease are presented. The participants will be interested to learn about experiences implementing such a program.

T512 **Group Diabetes Care: An innovative way of providing chronic disease care**
14:00–14:30 Fanny Hersson-Edery, MD CM; Jennifer Reoch, NP, MSc

CANCELLED BY PRESENTER

T56 **Cannabis for Medical Purposes Update: The essentials for effective practice**
13:30–14:30 Alan Bell, MD, CCFP

ROOM / SALLE : 512ABEF

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Apply to clinical practice the CFPC's Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary guidance
2. Describe the role and function of the endocannabinoid system
3. Understand how to avoid misuse, diversion, and inappropriate authorization of cannabinoids

Description:
Using a case-based, interactive approach the learner will gain the knowledge needed to effectively authorize the use of cannabis for medical purposes. This will be in accordance with the CFPC document Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary guidance as well as Health Canada regulations. Topics to be covered include the role and function of the endocannabinoid system, evidence regarding the use of cannabis in neuropathic pain, multiple sclerosis and other conditions where benefit has been demonstrated, potential risks and benefits, regulations regarding authorization and avoidance of misuse, diversion and inappropriate prescribing. Clinical pearls will include how to identify the appropriate and inappropriate patient, how to adequately document initial and follow-up patient visits, use of the patient agreement and harm-reduction strategies. This session will provide an update to the FMF 2016 presentation.

T112 **Bone Density, Fractures, and the Evidence: Simplifying osteoporosis management**
13:30–14:30 Michael Allan, MD, CCFP; Tina Korownyk, MD, CCFP; Michael Kolber, MD, CCFP, MSc, FCFP

ROOM / SALLE : 517D

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Apply a simplified approach to osteoporosis screening and follow-up bone mineral density testing
2. Assess fracture risk and discuss with patient the risk and benefits of treatment options
3. Understand the uncertainty around therapy duration and follow-up testing but have a reasonable approach for each patient

Description:

The approach to the management of osteoporosis has been challenged by guideline recommendations that are frequently incongruent with evidence and unduly complex. In this session we will review a simplified approach to osteoporosis management that is evidence based and promotes shared decision making with the patient. We will describe a streamlined method, more reliable than those presently promoted, that can accurately select patients for bone mineral density testing. We will then discuss how to assess the risk of fracture in patients and how soon to repeat bone mineral density testing in those at low risk. For those with risk of fracture ≥ 10 per cent, we'll review how to present this information and explain to patients the potential benefits and harms of available therapies. Lastly, we'll review challenges in the evidence around monitoring bone mineral density to assess therapeutic success, and when or if treatment holidays can be considered. Although the evidence is imperfect, we'll discuss reasonable approaches for practical use in the office.

T192 **Lymphoma Diagnosis Workshop**
13:30–14:30 Mark Kristjanson, MD, CCFP

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe the various clinical presentations in which these malignancies should be included on the differential diagnosis
2. Explain when and how to expedite the diagnostic workup of aggressive forms of these malignancies
3. Examine the role of prostate-specific antigen in the workup of suspected prostate cancer and its limitations in screening for prostate cancer

Description:

To assist primary care providers, algorithms for the workup of suspected lymphoma and prostate cancer have been developed by a multidisciplinary group of Manitoba experts. That guidance is the basis for the content of these case-based, interactive, small-group workshops.

Unexplained lymphadenopathy, with or without other symptoms, is the most common presentation for lymphomas. However, the differential diagnosis of unexplained adenopathy is large and includes other malignancies, infectious diseases, and some connective tissue diseases. The primary care clinician needs to keep this broad differential diagnosis in mind when working up adenopathy.

In the case of neck adenopathy secondary to a primary squamous cell carcinoma of the head and neck, excisional biopsy of a pathologic node as part of the diagnostic workup, if performed prior to definitive treatment, can make subsequent surgery more technically challenging and can put the patient at higher risk of contralateral disease recurrence.

These case-based modules will discuss the diagnostic approach to unexplained adenopathy and suspected prostate cancer, with a particular view to expediting the diagnostic workup and navigating provincial cancer care systems to the benefit of the patient.

T195 **Besrour Center Narrative Working Group: Appreciative inquiry and storytelling for mutual understanding**
13:30–14:30

Christine Gibson, MD, FCFP, MMedEd, DTM&H; Bob Woollard, MD, CCFP, FCFP, LM; Russell Dawe, MD, CCFP; Clayton Dyck, MD, CCFP, FCFP

ROOM / SALLE : 524C

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Implement the use of appreciative inquiry and narrative for scholarly purposes
2. Develop research questions at multiple levels: micro, meso, macro
3. Integrate the use of storytelling for inquiry purposes in clinical practice and personally

Description:

Family physicians are inherently drawn to the narrative of the patient to understand the context of their illness experience. We learn the story of a community to define its priorities and the roles of the determinants of health. Stories enrich our mutual understanding and shape our values when we explore how another has lived, including the lessons they have learned and the meaning they have drawn from their experiences. The use of narrative is an important research tool. The Besrour Center of the CFPC aims to support the development of family medicine worldwide, and the Narrative Working Group formed in 2012 to gather stories of family medicine. Using multiple lenses, we will share and explore how to use narrative and an appreciative inquiry approach for research and mutual understanding. The "micro" level will be covered by the Besrour-WONCA Storybooth Project from Rio de Janeiro, Brazil, last fall, at which we gathered 136 stories from 55 countries, each describing the experience of physicians practising family medicine. At the "meso" level we describe a project in which we explored institutional narratives describing how a country or university relates enabling factors in the growth of our discipline. And the "macro" level we have the "pentagram partners" (i.e., policy-makers, health professionals, academic institutions, communities, and health administrators), those voices that are instrumental in ensuring we achieve social accountability and a sustainable relationship within our communities. This session presents these three levels of scholarly projects and invites audience members to learn more about how to use storytelling to deepen their understanding of their own discipline, both locally and globally.

T236 **The Top Five Problems in Competency Coaching**

13:30–14:30 Daniel Ince-Cushman, MD, CCFP, FCFP; Sanjay Aggarwal, MD, CCFP

All teachers welcome.

Highlights novice concepts for teachers outside the clinical setting.

ROOM / SALLE : 510B

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. State the purpose of competency coaching
2. Describe the components of a good academic goal
3. Describe two methods to motivate learners

Description:

Academic advising, or competency coaching, is a new and complex task for many preceptors. There are many parallels between competency coaching and patient-centred care. This presentation attempts to build on skills that academic advisers use in clinical practice. The five most common problems encountered by the presenter are: It is unclear what the goal of the process is; the resident doesn't buy into the process; data are scarce or incomplete; the resident is already performing well; or the resident is performing poorly and nothing seems to help. The presentation accomplishes this goal by reviewing some basic principles of qualitative data analysis, continuous quality improvement, feedback, and motivational interviewing. Some of these principles will then be applied to two cases: a resident who is doing well according to the sparse data available and a resident who is struggling despite multiple academic meetings. In both cases attendees will try to form specific, measurable, agreed-upon, realistic, and measurable goals that engage the resident.

T308 **Mifepristone Abortion and Family Physicians: CAPS online support is a click away**
13:30–14:30 Sheila Dunn, MD, MSc, CCFP (EM), FCFP; Wendy Norman, MD, CCFP, FCFP, MHSc

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify clinical and professional supports for physicians wishing to implement mifepristone abortion practice
2. Integrate knowledge and insights of experienced mifepristone abortion providers to prepare/improve your practice
3. Navigate the Canadian Abortion Providers Support (CAPS) online community of practice

Description:
Many family doctors may consider learning the new practice of medical abortion but be unaware of CFPC-approved resources available to support them in doing so. Mifepristone availability offers family doctors the opportunity to provide this common reproductive health service to women in their practices and communities. For regions without existing abortion services this will enable women to have abortions without leaving their communities and families to seek care. This session will introduce participants to the online Medical Abortion Training Program required for prescribing mifepristone and the Canadian Abortion Provider Support (CAPS) platform. CAPS is a secure website on which Canadian physicians who have completed the mifepristone training program can access tools for practice, discuss clinical challenges with expert providers, and share strategies discovered in their own practices to facilitate mifepristone abortion care. During this interactive session we will present practical tips for successful mifepristone abortion implementation identified by CAPS members and invite participants to bring questions about mifepristone abortion practice for discussion. The Medical Abortion Training Program and CAPS are supported by the College of Family Physicians of Canada and the Society of Obstetricians and Gynaecologists of Canada.

T365 **Top 10 Articles of the Year in Emergency Medicine**
13:30–14:30 **Les 10 meilleurs articles de l'année en médecine d'urgence**
Constance LeBlanc, CCFP (EM), FCFP, MAEd, CCPE; Jennifer Leverman, MD; Vukiet Tran, MD; Mark Mensour, MD, CCFP (EM) (FPA), FCFP; Jock Murray, MD, CCFP (EM)

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Review 10 great practice-changing articles of the year in emergency medicine
2. Apply the findings to emergency medicine practice in Canada
3. Address barriers to implementing the changes suggested by this literature

Description:
This fast-paced, high-level review of 10 practice-changing articles from the previous year in emergency medicine will provide critical appraisal, use both absolute and relative terms, and discuss clear risks and benefits at the end of each article. This is not a comprehensive review session; however, the review behind each article is done in depth to ensure appropriate conclusions are provided. Come see what's new and leave with a few evidence-based pearls for your emergency medicine practice. The format includes five presenters each reviewing two articles in 10 minutes for a fast-paced, just-the-facts approach with one minute per article for questions.

Objectifs d'apprentissage :
1. Revoir dix excellents articles qui ont changé la pratique en médecine d'urgence cette année
2. Appliquer les résultats à la pratique de la médecine d'urgence au Canada
3. Examiner les obstacles à la mise en œuvre des changements suggérés dans cette littérature

Description :
Cette revue rapide et de haut niveau de dix articles qui ont changé la pratique de la médecine d'urgence au cours de la dernière année donnera lieu à une lecture critique à l'aide de termes absolus et relatifs. Une discussion sur les risques et les bienfaits manifestes suivra chaque article. Bien que cette séance ne soit pas une étude approfondie,

chacune des revues a subi un examen de long en large, et en profondeur, afin de garantir la justesse des conclusions présentées. Venez découvrir les nouveautés et repartez avec quelques nouvelles perles fondées sur des données probantes pour enrichir votre pratique de la médecine d'urgence. Durant la séance, cinq présentateurs passeront en revue deux articles chacun en 10 minutes afin de privilégier une approche rapide, qui va droit aux faits. Pour chaque article, il y aura une période de questions d'une minute.

T394 **Authentic Engagement: Boot camp translation/workshop on participatory research and patient-oriented research**
13:30–14:30
Vivian Ramsden, RN, PhD, MCFP; Norma Rabbitskin, RN; Jon Salsberg, PhD; Ann Macaulay, MD CM, CCFP, FCFP; Danielle Rolfe, PhD; Kirk Kelly; Alain Pavilanis, MD, CCFP, FCFP; Maret Felzien, MA; Jack Westfall, MD, MPH

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the elements of participatory research
2. List the steps necessary for engaging in patient-oriented research
3. Reflect on how this could be used in clinical practice, quality improvement, and/or research

Description:
Purpose: Integration of the principles/values of engagement into research, evaluation, and knowledge translation. Methodology: Taking the lead from experiences in working with Indigenous communities, participatory, action-oriented approaches facilitate the integration of authentic engagement. Findings/Discussion: In Canada the framework for engaging patients, communities, or organizations is clearly outlined in Chapter 9 of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, which indicates that people and communities are to have a role in shaping/co-creating the research that affects them. Thus, these principles/values are being more broadly applied and as such have application to patient-oriented research funded by the Canadian Institutes of Health Research and the Patient-Centered Outcomes Research Institute. Rather than having the various elements of a research project designed by professional researchers, there needs to be engagement with patients and communities to find common ground while ensuring that the individuals/communities have a role in shaping/co-creating the research that affects them. Examples of research projects and processes that have been established over time will be shared by researchers and community members. As recently identified in the 2016 Council for International Organizations of Medical Sciences guidelines, there is an increased emphasis on the scientific and social value of research: the prospect of generating the knowledge and the means necessary to protect and promote health in and with individuals and communities. Proactive and sustained engagement with the communities from which individuals will be invited to participate demonstrates respect for them and for the traditions and norms they share. Community engagement is also valuable for knowledge translation of the results from the research by individuals and the communities into outcomes that are both clinically relevant and meaningful. Conclusions: The integration of principles/values of authentic engagement has the potential to change practice and research and build capacity in and with the communities.

T430 **Living the Best Till Last: Conversations for end-of-life planning**
13:30–14:30
Dale Guenter, MD, MPH, CCFP, FCFP; Doug Oliver MD, MSc, CCFP, FCFP

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the most important elements of any advance care plan for end-of-life care
2. Engage confidently in end-of-life planning conversations
3. Facilitate these conversations in varied formats including for patient/citizen groups, individuals, and families

Description:
Making a shift from acute/curative thinking to comfort/quality thinking is part of the palliative approach to care. Improving our ability to talk about the dying process, goals, and fears before serious illness occurs is the first step toward making this shift go well. At McMaster Family Health Team in Hamilton, Ontario, we have designed a workshop offered to anyone and everyone who wishes to delve into this conversation for themselves or for their loved ones. Most of those attending do not yet have a serious illness. They are interested in exploring their goals and priorities should serious illness occur, and understanding how to ensure that those are followed if they are unable to speak for themselves. We have found that this group approach to improving end-of-life conversations is highly effective, fun, and well received. Main aspects of the group process will be demonstrated. Skills for guiding this process will be highlighted and practised. Adapting this group approach to individual and family conversations at all stages of life will be explored. Preliminary evaluation data will be presented. This will be a lighthearted discussion on a very deep topic. This session is appropriate for individuals from any discipline, including general family practice, and especially for those working with people with all types of chronic disease. It is also relevant to those with a focus in palliative care. Prepare to befriend your own death.

T432 **Recent Research to Inform Rural and Family Physician Models of Obstetrical Care**
13:30–14:30 Kris Aubrey-Bassler, MD, MSc, CCFP (EM), FCFP; Russell Dawe, MD, MDiv, CCFP; Sayali Tadwalkar, MD, CCFP; Nancy Fitch, MD, CCFP

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Cite evidence comparing obstetrical outcomes between family physicians and obstetricians
2. Apply evidence to decisions about proceeding to Cesarean section
3. Use recent evidence to make decisions about obstetrical service level at rural hospitals of a given size and remoteness

Description:
We will review recent evidence comparing maternal and neonatal obstetrical outcomes and Cesarean-section rates between family physicians and obstetricians. We will also review Canadian evidence showing how obstetrical outcomes are affected by poor geographic access to obstetrical services and the impact of delivering at hospitals of different annual delivery volumes and levels of service. Finally, we will hear about successful models of rural obstetrical care and attempt to apply the evidence above to real-world health system decisions provided by members of the audience or from our own experience. If they wish to discuss cases, audience members should come with information about the obstetrical service level and volume at the hospital of interest as well as the next closest hospitals and the distance between these hospitals.

T438 **Quality Improvement Basics for Day-to-Day Practice**
13:30–14:30 Scott McKay, MD, CCFP (COE) FCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Differentiate between quality improvement, scientific research, and quality assurance
2. Write a SMART aim statement for a quality improvement project
3. Describe common quality improvement tools and project measures

Description:
Using the concepts of quality improvement (QI) in day-to-day practice can be challenging. This session will introduce participants to the basics of QI, including common vocabulary and concepts. Topics to be discussed include defining QI, developing QI ideas, writing aim statements, using common QI tools, determining QI project measures, developing change ideas, and understanding how to approach testing change ideas. Examples of actual QI projects will be used to deliver the content. This session is intended for clinicians who would like to start doing practice-level QI or improve their knowledge regarding QI that is already occurring in their practice.

T476 **Implementing the 2017 Canadian Guidelines for Primary Care of Adults With IDD**
13:30–14:30 Liz Grier, MD, CCFP; Bill Sullivan, MD, CCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify specific health issues of people with intellectual and developmental disabilities (IDD) that 2. are different from those of the general population
2. Apply this knowledge to conduct comprehensive preventive health assessments of people with IDD
3. Use adapted approaches to assessment, and care of health and behavioural disorders for people with cognitive and communication difficulties

Description:
This session highlights what is new in the 2017 Canadian Consensus Guidelines for the Primary Care of Adults with Intellectual and Developmental Disabilities (IDD), emphasizing how to apply its recommendations. Participants will also learn approaches to recognizing, assessing, and providing interventions for physical and mental health issues, as well as behaviours that challenge. Such approaches to care can be used not only to improve care of people with IDD but also other patients with cognitive impairments and communication difficulties.

T502 **Optimizing Family Medicine Team Function: Sharing well child care with primary care nurses**
13:30–14:30 Jolanda Turley, MD CM, MHSc, CCFP; Amy Clarke, RN

ROOM / SALLE : 513EF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Provide an overview of international evidence supporting nurse-provided well child care and the relevance to Canadian practice
2. Discuss the implementation steps of nurse-provided well child care in two primary care teams
3. Allow participants to imagine how to implement shared well child care in their own setting, anticipating possible challenges and resource needs

Description:
This session will focus on implementing shared well child care in family practices across the country. Many family medicine clinics now include nurses and other allied health care providers, and optimizing all providers' roles and functions is key to allowing everyone to work to their full scope of practice and abilities. Providing routine well child care is well within the scope of practice of primary care registered nurses. The speakers will describe their own experiences with establishing both shared and nurse-led well child care in their family practice units, including preparatory steps, implementation, and evaluation of outcomes. Participants will be allowed to work through imagined steps of implementing such a program in their own setting, anticipating challenges and barriers, and thinking through facilitating factors and solutions, using the speakers' personal experiences and examples from the literature. At the end of this session, participants should feel prepared to establish a program of shared or nurse-led well child care in their own family practice and be part of a community of practice innovating this new model of practice.

T504 **Coaching Conversations**
13:30–14:30 Shelly McEwen, MHS, RSW, CC
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explore the growing body of evidence behind coaching
2. Describe five communication skills of effective coaching conversations

3. Review practical application of coaching conversation skills

Description:
Preceptors require a myriad of skills to successfully assess and provide feedback to learners. One efficient and effective process for ongoing, positive, and effective adult learning that promotes reflectivity and supports competency-based assessment and feedback is coaching. As educational coaches, preceptors partner with learners in trusting, thought-provoking, and creative processes that offer reflective opportunities to maximize personal, educational, and professional potential. Coaching relationships involve having coaching conversations that are empowering and provide structure, accountability, expertise, and inspiration to enable residents (and faculty!) to learn and grow in professional and personal development. Effective coaching conversations require specific and defined communication skills. Come join an interactive session that will provide you with a solid introduction to the art and science of coaching conversations.

T529 **The Triple C Evaluation Project: Current results with question and answer session**
13:30–14:30 Shelley Ross, PhD; Ivy Oandasan, MD, CCFP, MHSc, FCFP; Nancy Fowler, MD, CCFP, FCFP; Lawrence Grierson, PhD; Alan Katz, MD, MBChB, MSc, CCFP; Kathy Lawrence, MD, CCFP, FCFP; Elaine Van Melle, PhD
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 511C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the Triple C Evaluation Project and the data that have been collected to date
2. Consider ways that data emerging from the project may be used for improving curricula design or conducting further research
3. Assess opportunities and challenges related to sharing data from the Triple C Evaluation project with stakeholders and end users

Description:
In 2010, after a five-year extensive consultation and review process, the CFPC introduced the Triple C Competency-based Curriculum (Triple C) for residency programs. While development of the Triple C was evidence-based, early concern was raised about lack of evidence about whether the Triple C will lead to better outcomes. With this in mind, the CFPC decided it was imperative to examine outcomes of Triple C. An evaluation plan was developed with a logic model highlighting the activities and expected short- and long-term outcomes. Both qualitative and quantitative methodologies were included to understand both the experience of implementing CBME as well as to measure outcomes experienced by learners and programs. Surveys of residents at residency program entry and exit began with a pilot group of six schools in 2012, and expanded to 16 of 17 schools in 2014. Cognizant that each residency program is different and implementation challenges are specific to context, a qualitative study was also conducted in 2016 to understand the experiences of residency programs implementing Triple C. Aggregate results from the Evaluation Plan Project will be available to family medicine training stakeholders and end users beginning in mid-2017. In this interactive workshop, we will first offer an overview of the methodologies used and data currently available from the Triple C Evaluation Plan project. The remaining time will be a question and answer discussion to allow stakeholders and end-users to better understand the project, and offer suggestions for future areas to explore.

T540 **The Best of Primary Care Research from NAPCRG 2016**
13:30–14:30 David Kaplan, MD, CCFP

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Synthesize clinically relevant research presented at the North American Primary Care Research Group

(NAPCRG) conference
2. Stimulate the interest of practising family physicians in primary care research
3. Understand how primary care clinicians can impact the research agenda

Description:
In a repeat of hugely successful presentations from the past two years, three outstanding speakers will present the best of clinically relevant, primary care research from among over 500 presentations 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.

T533 **Rural Educator's Forum**
13:30–17:15 Ruth Wilson, MD, CCFP, FCFP
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 510C
Mainpro+ Group Learning certified credits = 3

Learning objectives:
1. Review the recommendations developed by the Advancing Rural Family Medicine: The Canadian Collaborative Taskforce, presented in the Rural Road Map for Action
2. Apply the Rural Road Map for Action to various settings by identifying actions that can be undertaken in participants' individual roles
3. Identify and share examples and actions from across the country that support implementation of the Rural Road Map for Action

Description:
In this session, participants will have the opportunity to discuss the pan-Canadian Rural Road Map for Action, developed to support recruiting, retaining, and training the rural and remote family physician workforce. In addition, participants will be engaged in the application of the Rural Road Map for Action by discussing the implementation plan developed at the Rural Health Care Summit and identifying individual actions that can contribute to ensure comprehensive health services delivery for communities in rural Canada. Small and large group discussions will be used in the session to engage participants in these conversations.

T878 **Facilitated Poster Session**
15:00–16:00 During this session, five posters will be presented in 10-minute segments, followed by audience Q & A and a discussion.

ROOM / SALLE : Level 5 Foyer / Foyer du niveau 5
Mainpro+ Group Learning certified credits = 1

T715 **Deprescribing Bisphosphonates in Primary Care**
Ruben Hummelen* MD, PhD; Charnelle Carlos, MD; Olivier Saleh, MD

Objective: To identify and deprescribe bisphosphonates among patients who are at low or moderate risk for fragility fractures. **Design:** Chart review and individual risk assessments. **Setting:** This study took place in three academic family physician practices at McMaster Family Practice in Hamilton, totalling 942 patients of age ≥ 50 years. **Participants:** Chart reviews for 48 patients (five per cent) identified as receiving a prescription for a bisphosphonate between November 2014 and November 2015. After a thorough chart review of these 48 patients, 25 were excluded because they: were followed by a rheumatologist (n = 6); had stopped taking

their bisphosphonate (n = 6); were high risk or had a prior fragility fracture (n = 5); or other reasons (n = 8). **Intervention:** Assessment of patients' risk factors with a FRAX score calculation and counselling on their bisphosphonate use. **Results:** A total of 23 participants were assessed, of whom eight were low risk, 13 moderate risk, and two high risk according to FRAX. Duration of use was significantly longer among the low-risk group (median 10 years) than the intermediate- and high-risk group (median 7.5 years, $P = 0.05$). Among those in the low-risk group, six (75 per cent) chose to discontinue the use of their bisphosphonate after counselling. Among those in the moderate risk group, four (70 per cent) chose to discontinue the use of their bisphosphonate, while none in the high-risk group discontinued the use of their bisphosphonate. **Conclusion:** This study shows that a majority of patients in primary care may be eligible for a drug holiday or for discontinuing their bisphosphonate based on an absolute risk estimation. Periodic reassessment of bisphosphonate use using the FRAX can lead to better prescribing of these medications.

T561 Presentations and Outcomes of Necrotizing Soft Tissue Infections

Kuan-chin Jean Chen*, MD, CCFP (EM); Michelle Klingel, MSc; Shelley McLeod, MSc; Sean Mindra, MD; Victor Ng, MD, CCFP (EM)

Background: Necrotizing soft tissue infections (NSTIs) are aggressive infections associated with high mortality rates and significant morbidity, including amputation and organ failure. Much more common are non-necrotizing soft tissue infections, such as cellulitis, which present very similarly to NSTIs. The challenge in diagnosing NSTIs is the lack of signs or symptoms that reliably distinguish them from non-necrotizing infections. However, the rapid progression and significant risk of morbidity and mortality associated with NSTIs makes quick diagnosis and treatment critical. This study was conducted to determine the presentation of patients diagnosed with NSTIs, and their in-hospital outcomes. **Methods:** Retrospective review of adult patients with a discharge diagnosis of necrotizing fasciitis at London Health Sciences Centre (annual census 125,000) over a five-year period (April 2008 to March 2013). **Results:** Common comorbidities at presentation included immunocompromise (58.3 per cent), diabetes mellitus (41.7 per cent), vascular disease (45.0 per cent) and obesity (24.6 per cent). Initial presentations included swelling (91.7 per cent), erythema (86.7 per cent), bullae (28.3 per cent), petechiae (8.3 per cent), and bruising (45.0 per cent). Fifty patients (83.3 per cent) underwent surgery, with a median (IQR) time from initial presentation to surgery of 15.5 hours (7.8, 74.9). In-hospital mortality amongst those who had surgical intervention was 14.0 per cent, compared to in-hospital mortality of 60.0 per cent for those who did not (Δ 46%, 95%CI 14.8 to 70.2%). **Conclusions:** Diabetes mellitus, immune compromise, vascular disease, and obesity are common comorbidities of NSTIs. Survival is higher among patients who receive surgical treatment. Patients presenting with this clinical picture warrant a high degree of suspicion.

T729 Decision-making Capacity Assessment (DMCA) Training for Physicians

Lesley Charles, MBChB, CCFP (COE); Jasneet Parmar, MBBS, MCFP (COE)*; Bonnie Dobbs, PhD;-Suzette Brémault-Phillips, PhD; Oksana Babenko, PhD; Peter George Tian, MD, MPH

Context: Many physicians do not feel prepared to do decision-making capacity assessments (DMCAs). Therefore, we developed and administered an interactive DMCA workshop to familiarize physicians with concepts of capacity, a protocol, documents, and case studies. **Objective:** To determine the effect of the workshop on physicians' confidence and comfort with DCMAs. **Design:** Pre-test-post-test design. We administered a questionnaire before and after the workshop. The questionnaire asked participants to rate their agreement (four-point Likert-type scale) on 15 statements regarding awareness, confidence, and understanding of core concepts of capacity. Participants: A total of 137 physicians who attended workshops. Intervention: A three-hour DMCA workshop accredited by the College of Family Physicians Canada. **Outcome measures:** (1) Mean ratings on the questionnaire items; (2) demographic data (age, sex, years of practice, prior DMCA training). **Analysis:** Descriptive statistics (mean, SD); sign test to compare pre- and post-workshop ratings; ANOVA to determine differences in ratings across demographics. **Results:** There were 137 participants with an average age of 46 years: 55 per cent of the participants were female; 64 per cent of participants had ≥ 6 years of medical practice; and 54 per cent had no prior DMCA training. The post-workshop ratings were mostly agrees and strongly agrees (mean ratings, 3.09 to 4.27; range, 1 to 4). The highest positive differences were for problem solving techniques,

understanding a trigger, knowledge and skill set in regards to capacity assessments, standardized approach, and awareness of legislative acts. Among the participants, those without prior DMCA training exhibited the largest change in pre- versus post-workshop ratings ($P < 0.05$). **Conclusion:** This study has shown that a DMCA workshop was effective in training family physicians.

T671 Increased Cut-offs Improve the Sensitivity of the MMSE in Highly Educated Older Adults

Shannon Baker; Katie Kent; Matthew Greenacre*; Ayman Shahein;
Laszlo A. Erdodi, PhD, C.Psych.

At the conclusion of this activity, participants will be able to: 1) interpret the MMSE in highly educated older adults using multiple cut-offs; and 2) more accurately identify early cognitive decline in highly educated populations. **Context:** The Mini-Mental Status Exam (MMSE) is a widely-used screening test for early cognitive decline. Its comprehensiveness, short administration time, easy scoring, and straightforward clinical interpretation (intact/impaired) make it an attractive choice for a first-line assessment tool. However, the same diagnostic criterion may not be appropriate for all patients. Using a single cut-off may inflate false negatives in examinees with high premorbid functioning, as their cognitive reserve may mask the deleterious effects of neurodegenerative diseases. **Objective:** To determine whether increasing the cut-off would improve the MMSE's classification accuracy in highly educated older adults. **Design:** Prospective quasi-experimental design. **Participants:** Data were collected from 113 highly educated (M = 16.4 years) older adults (M = 72.4 years) from northern New England; 64 were classified as cognitively normal (intact), while 49 were classified as showing clinical signs of cognitive decline (impaired) by a panel of experts. **Instrument:** The MMSE at commonly used clinical cut-offs. **Results:** An MMSE score ≤ 25 had perfect specificity, but low sensitivity (.36). Raising the cut-off to ≤26 improved sensitivity (.53), at minimal cost to specificity (.95). Further increasing the cut-off to ≤27 achieved a reasonable balance between sensitivity (.86) and specificity (.88). An impaired participant was seven times more likely to score ≤27 than an intact participant. Conversely, an impaired participant was six times less likely to score >27 than an intact participant. **Conclusions:** Raising the standard cut-offs improved the overall classification accuracy with minimal loss in specificity, and appears to be a clinically justifiable trade-off. Results suggest that higher cut-offs may be warranted in examinees with high educational achievement.

T651 Implications of Guideline Change: Have Pap test guidelines impacted sexually transmitted infection screening in primary care?

Margaret Casson*, MD; Rebecca Zur, MD; Jackie Bellaire, MD, CCFP;
Mark Yudin, MD, MSc, FRCSC

Objective: In 2012, Cancer Care Ontario introduced new cervical cancer screening guidelines for women in Ontario. The goal of our research is to build on previous research and to examine how the cervical cancer screening guideline changes have impacted care of young female patients with respect to STI screening in the primary care setting. **Design:** A retrospective chart review analyzing the frequency of STI screening before and after the implementation of the cervical cancer screening guidelines in May 2012. **Setting:** Two family health teams in east Toronto. **Participants:** Female patients, aged 19 to 25 years, with at least one visit to their primary care physician. **Main outcome measures:** Number of Pap tests collected, the number of patients who had STI screening, and the number of visits during which they had STI screening. **Results:** There was a statistically significant difference in the number of visits with STI screening before the guideline implementation compared to after (mean number of visits with STI screening 1.21 before, 0.75 after, Mann-Whitney rank test $P = 0.010$). The difference in the number of Pap tests in the pre-guideline group (mean number of Pap tests 1.07) compared to the post guideline group (mean number of Pap tests 0.39; $P < 0.001$) was significant, and more cervical and vaginal screens used pre-guideline changes ($P < 0.001$ and $P = 0.002$ respectively) while more urine NATT was used in the post period ($P < 0.001$). **Conclusions:** Female patients aged 19 to 25 years had more visits to their primary care physicians that included STI screening in the three years before the guideline changes than the three years afterward. As expected, there was a difference in the number of Pap tests before the guideline implementation compared to after. In keeping with previous studies, there is a continued demonstration of a trend towards to non-invasive testing.

T65 **Dyspnea in Your Pregnant Patient: Does it make YOU short of breath?**
15:00–16:00 Alan Kaplan, MD, CCFP (EM), FCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the relevance of changes in respiratory physiology in pregnancy
2. Review the respiratory complications of and in pregnancy
3. Review the safety of investigations and treatments in pregnancy

Description:
Your pregnant patient presenting to you is actually two patients. She can get respiratory illness like anyone else, and there are specific respiratory complications that occur due to the pregnancy. This session will review the changes in the respiratory system that occur because of pregnancy and how they present clinically. Respiratory illnesses can present differently in pregnancy, and of course their treatments and investigations may need to be modified due to concerns regarding fetal safety. Similarly, there are specific respiratory risks to the mom due to being pregnant that need to be evaluated and treated.

T89 **Dangerous Ideas Soapbox**
15:00–16:00 **Tribune aux idées dangereuses**

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Acquire new perspectives on the scope of and approach to primary care practice, innovation, and research
2. Understand new, leading-edge, and unusual issues in family practice
3. Discuss ideas with national and international colleagues that touch on the breadth and scope of family practice and primary care

Description:
The Dangerous Ideas Soapbox has hosted enthusiastic audience debates about how best to improve patient care or the health care system since its debut at FMF 2013. This session offers a platform for four finalist family physician innovators to share an important idea that isn't being heard but needs to be heard in the family medicine community. A dangerous idea could be controversial, completely novel thinking or something that challenges current thinking. But it must also demonstrate a commitment to moving the idea forward to make a difference. Each speaker will have three minutes to explain the idea, then audience members have eight minutes to challenge and critique the presenters. The audience will vote to decide the most potent dangerous idea. All finalist ideas will be published in Canadian Family Physician.

Objectifs d'apprentissage :
1. Acquérir de nouvelles façons de percevoir la portée et l'approche de la pratique en soins primaires, de l'innovation et de la recherche
2. Comprendre les nouveaux enjeux de pointe et inhabituels en médecine familiale
3. Entretenir des discussions pour générer des idées entre collègues au Canada et dans le monde sur la portée de la pratique de la médecine familiale et des soins primaires

Description :
Depuis ses débuts au FMF 2013, la Tribune aux idées dangereuses a été la scène de débats passionnés avec l'auditoire quant à la meilleure façon d'améliorer les soins/le système de santé. Cette séance offre à quatre finalistes la possibilité de partager une idée importante qui passe inaperçue, mais qui devrait être répandue dans la communauté de médecine familiale. Une idée dangereuse peut prêter à controverse, être très créative et nouvelle, ou encore aller à l'encontre de la façon actuelle de penser. Il faut cependant qu'il y ait un engagement à aller de l'avant, à vouloir changer les choses. Chaque conférencier disposera de 3 minutes pour présenter son idée, puis

l'auditoire aura 8 minutes pour débattre et pour critiquer les présentations. L'auditoire votera ensuite pour déterminer l'idée dangereuse la plus puissante. Toutes les idées finalistes seront publiées dans *Le Médecin de famille canadien*.

T103 **Diabetes in the Hospitalized Patient**
15:00–16:00 Benjamin Schiff, MD CM, CCFP

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the target glucose for hospitalized patients
2. Recognize the impact of comorbidities on glucose control and choices of treatment
3. Prescribe sliding scales confidently

Description:
Recent years have seen the introduction of multiple new classes of agents for the treatment of diabetes. This poses particular challenges for the physician caring for diabetic patients when they are admitted to the hospital, whether it be for a primary diabetic complication or for another acute problem. Some specific issues include the impact of an acute illness on glucose levels (especially acute kidney injury and sepsis), the potential side effects of newer agents, and the safe and appropriate use of insulin sliding scales. For this presentation I will briefly review the classes of agents currently being used to treat diabetes, with particular emphasis on newer agents. I will discuss their mechanism(s) of action, metabolism, and potential side effects (including the risk of hypoglycemia). I will then discuss the appropriate goals of care for diabetic patients as it relates to glucose targets and blood pressure. Next I will present a rational approach to the (re)prescribing of the patient's current diabetic medications in the context of their acute medical and/or surgical problem(s),including kidney disease, infections, etc. I will then present an approach to the use of insulin sliding scales. Lastly I will present a couple of clinical vignettes illustrating some of the principles that have been discussed. At the conclusion of this talk you should confidently be able to care for your patients with diabetes admitted to the hospital.

T124 **Sex Med Update 2017: What's coming?**
15:00–16:00 Ted Jablonski, MD, CCFP, FCFP

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Define an approach to sexual medicine in primary care/family medicine
2. Manage key topics in female, male, and LGBTQ+ sexual health
3. Describe controversial sexual health issues of 2017

Description:
What is the place of Sexual Medicine in a busy family practice? When it comes to sexual health, what is "normal" for most men and women? What is the appropriate language when dealing with LGBTQ patients? In our rapidly changing, highly sexualized society there is still so much confusion about sex and we as family doctors are supposed to have all (if not most) of the answers. This interactive and entertaining "trouble shooting" session will provide a practical approach to sexual medicine in a busy family practice setting. It will focus on key topics in male, female and LGBTQ sexual health and will explore some of the controversies arising in 2017. Dr. Ted Jablonski is an award winning family physician based in Calgary. In addition to family medicine, Jablonski has done consultant work in sexual and transgender medicine for southern Alberta and central British Columbia for over a decade. Dr. Jablonski has a special interest in CME for physicians 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 musical entertainer, media spokesperson and public educator with many conference, radio, television and video credits.

T131 **Managing Patients with Opioid Use Disorder in the Emergency Department: Case studies**
15:00–16:00 Nitasha Puri, MD, CCFP; Rupinder Brar, MD, CCFP

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Use an acute pain management protocol to treat pain in opiate-tolerant patients in the emergency department
2. Manage opioid withdrawal in the emergency department in patients with opioid use disorder who are either on or off opiate replacement therapy
3. Explore the addicted patient's experience in the emergency department and generate some trauma-sensitive approaches to care and treatment

Description:
It's no secret that opioid use disorder is on the rise in Canada, as are opioid-related overdoses. Often, opioid users first present to the health care system via the emergency department requiring management of withdrawal and/or pain. This interactive session will guide you through common emergency department presentations of acute pain and withdrawal management in complex patients with opioid use disorder. In small groups, you and your colleagues will discuss specific cases, management plans, protocols, and common practices to better support vulnerable patients with opioid use disorder.

T133 **Back to the Future: The family physicians of today meet the family physicians of tomorrow**
15:00–16:00 Pierre-Paul Tellier, MD, CCFP, FCFP; Jennifer Hall, MD, CCFP(EM), FCFP

ROOM / SALLE : 522ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Provide valuable insights into a career as a family physician
2. Discuss opportunities in family medicine and ease the transition into practice for family medicine residents
3. Provide mentorship from the 2017 Family Physicians of the Year as well as peer support

Description:
In Back to the Future, the family physicians of today meet the family doctors of tomorrow. This session allows students and residents to speak with the recipients of the Reg L. Perkin Awards who are named as Canada's Family Physicians of the Year. This unique opportunity allows students and residents to ask questions regarding work/life balance and transitioning into family medicine practice, and to discuss the challenges and rewards they may face. This session also provides the opportunity for award winners to share their insights and experiences from when they were starting out in family medicine.

T332 **Return to Work Following Concussion: Is prolonged rest best?**
15:00–16:00 Ron Gorsche, MD, MMedSc,CCFP, FCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Determine which industries present the greatest risk of concussion
2. Use knowledge of the neurometabolic changes that accompany a concussive incident in treatment decisions
3. Implement evidence-based clinical guidelines to assist in assessment, treatment, and accommodation in the workplace

Description:
Although concussion receives substantial attention in sports, this discussion will centre on concussion in the workplace. Workers with mild to moderate concussion or mild traumatic brain injury form the largest brain-

injured group requiring treatment and accommodation in Canada. Understanding the neurometabolic changes related to concussions provides the treating physician with valuable guidance when prescribing rest and accommodation in the workplace. This presentation will concentrate on simplifying concussion assessment and treatment using evidence-based guidelines that will ideally improve our approach to return to work.

T412 **How the Future of e-Prescribing Will Affect Your Practice**
15:00–16:00 Rashaad Bhyat, MB BCh, BSc, CCFP; Amanda Condon, MD, CCFP; Alexander Singer, MB BAO BCh, CCFP

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Prepare for a future state in which family physicians will play an even more central role in medication management
2. Differentiate between different levels of electronic prescribing
3. Recognize the potential of true digital prescribing as a central tool for quality improvement in prescribing practices

Description:
Effectively using emerging e-health technologies has become important to family medicine. There is a growing body of evidence that suggests access to expanded data related to care delivery can be leveraged for quality improvement. Electronic medical records (EMRs) are used by more than 80 per cent of family physicians in many provinces and some also have access to provincial drug information (dispensing) systems via their EMRs. Family physicians already encounter a tremendous burden of chronic diseases that frequently necessitate several prescription medications; this burden will expand with an aging population. Access to digital health technology in the family physician's office can be used effectively to enable safe prescribing practices and optimal medication management. Data captured in prescriptions from digitally interoperable systems connecting physicians to pharmacists can facilitate quality improvement (QI) efforts targeted at optimal prescribing. Further, access to well-curated data, specifically related to the prescribing of controlled classes of medications, can assist with safer prescribing of these medications. Indeed, the federal government has identified electronic prescribing as a tool that can be used to address Canada's opioid crisis. Family physicians also play an important role in medication list management, as we are often custodians of a patient's most comprehensive medication profile. This session will provide an overview of how this role will become increasingly central as prescription data from EMRs, electronic health records, hospital information systems, and electronic prescription systems become increasingly accessible. Additionally, strategies that optimize the use of digital prescription data will be discussed. The evolution of e-prescribing will enable QI in prescribing practices, including standardizing prescription data, enhancing interprofessional communication and collaboration with community pharmacists, and facilitating medication reconciliation in the community. As the journey toward true e-prescribing progresses in Canada, it will be essential for family physicians to recognize and embrace our critical role in establishing quality in prescribing and expand leadership in medication management.

T494 **The Adult Periodic Health Examination: Screening and Prevention**
15:00–16:00 **Les examens médicaux périodiques des adultes : le dépistage et la prévention**
Susan Goldstein, MD, CCFP, FCFP, NCMP

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Provide an evidence-based periodic health exam to an adult patient
2. Order appropriate screening tests based on relevant patient demographics
3. Counsel patients on the use of appropriate resources and on health promotion

Description:
With the replacement of the annual physical with the new periodic health examination, physicians are struggling to adopt this new practice. Understanding the relevant recommendations and the evidence behind them, will aid in managing clinical practice and counselling patients. A comprehensive review of the most relevant and recent guidelines will be presented, with a focus on, but not limited to, the recommendations of the Canadian Task Force on Preventive Health Care and the Choosing Wisely Canada program.

Objectifs d'apprentissage :
1. Faire passer un examen médical périodique fondé sur les données probantes à un patient adulte
2. Prescrire des tests de dépistage appropriés selon des données démographiques pertinentes sur les patients
3. Conseiller le patient sur l'utilisation de ressources adéquates et sur la promotion de la santé

Description :
Depuis que « l'examen physique annuel » a été remplacé par le nouvel examen médical périodique, les médecins ont du mal à adopter cette nouvelle pratique. Avec une bonne compréhension des recommandations pertinentes et des données probantes à l'appui, il deviendra plus facile de gérer la pratique clinique et de conseiller les patients. Cette présentation consiste en une étude approfondie des lignes directrices les plus pertinentes publiées récemment. Sans toutefois s'y limiter, elle portera surtout sur les recommandations du Groupe d'étude canadien sur les soins de santé préventifs et du programme Choisir avec soin.

T511 La médecine de famille peut-elle contribuer à l'aide internationale du Canada ?

15:00–16:00 François Couturier, MD, MSc, CCMF; Katherine Rouleau, MD, CCMF

ROOM / SALLE : 515ABC

Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Décrire l'orientation des trois mémoires soumis au ministre responsable d'Affaires mondiales Canada (AMC)
2. Décrire les priorités d'AMC en développement international pour la santé
3. Expliquer la possible contribution de la médecine de famille canadienne aux soins de santé primaires dans les pays en développement

Description :
Les soins de santé primaires appuyés par une médecine de famille à l'écoute des besoins des populations améliorent la santé des individus et des communautés, et minimisent l'impact négatif des inégalités sociales. L'efficacité de ce principe a été démontrée dans les pays développés et dans les pays émergents qui l'ont appliqué. Il y a cependant moins de données concernant les pays en développement les plus pauvres. En effet, les grandes agences de développement international et de financement ont surtout centré leurs efforts sur des programmes verticaux, spécifiques à des maladies, à des médicaments ou à des technologies. Elles ont négligé le renforcement des systèmes de soins et la formation de professionnels de la santé prêts à répondre aux besoins des populations par une approche intégrée, centrée sur l'individu et la communauté. En juin 2016, le gouvernement canadien lançait une consultation publique sur l'examen de l'aide internationale du Canada et sur le cadre de financement de cette aide. Le Centre Besrour et les facultés de médecine de l'Université de Toronto et de l'Université de Sherbrooke ont répondu à cet appel. Les mémoires présentés insistaient sur l'importance de soutenir le développement de systèmes de soins de santé primaires robustes et professionnalisés, ancrés dans les communautés et répondant aux besoins des femmes, des filles et des enfants, notamment en termes de santé reproductive et sexuelle. Le but de cette séance est d'engager la communauté des médecins de famille du Canada dans une réflexion sur le rôle que pourrait jouer notre discipline pour améliorer la santé des individus et des populations dans les pays en développement. Elle s'adresse à ceux et celles dont les champs d'intérêt chevauchent l'amélioration de la médecine de famille et des soins primaires partout dans le monde, la responsabilité sociale et l'engagement du Canada, plus particulièrement en ce qui concerne le développement en santé.

T537 **Health Advocacy Regarding Solitary Confinement Inside Canadian Prisons**
15:00–16:00 Ruth Elwood Martin, MD, FCFP, MPH; Nader Sharifi, MD, CCFP, ABAM, CCHP; Fiona Kouyoumdjian, MD, CCFP, PhD; Josiane Cyr, MD, CCFP; Peg Robertson, MD, CCFP

ROOM / SALLE : 524C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand established evidence regarding health impacts of solitary confinement inside prisons
2. Review current solitary confinement practices within Canadian correctional facilities
3. Explore ways that health care providers might advocate to change solitary confinement practices within Canadian correctional facilities

Description:
Thousands of prisoners worldwide are housed in solitary confinement, which can lead to worsening of mental health. In addition, prisoners are sometimes punished with solitary confinement for behaviour that is a result of their mental illness. Solitary confinement can create barriers for individuals to access necessary medical and mental health care, with the risk that their health will worsen. Workshop participants will review the 2017 CFPC Position Statement on Solitary Confinement, which was developed by the CFPC Prison Health Program Committee. Participants will discuss ways that health care providers might advocate to address barriers to change regarding solitary confinement practices within Canadian correctional facilities.

T148 **Addressing Physician Boundary Violations: Education tools and strategies for students, residents, and physicians**
15:00–17:15 James Goertzen, MD, MClSc, CCFP, FCFP; Brent Kvern, MD, CCFP, FCFP; Miriam Boillat, MD, CCFP, FCFP; Teresa Cavett, MD, MEd, CCFP, FCFP
All teachers welcome. Highlights advanced concepts for clinical preceptors.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Discuss physician-patient boundary transgressions, including risk factors and prevention for both the learner and practising physician
2. Examine physician professional identify formation, including predictable transitions and their relevance to the teaching of physician-patient boundary issues
3. Apply tools and strategies for teaching about physician-patient boundary issues applicable to preceptor clinical settings or learner academic sessions

Description:
Maintaining clear professional boundaries is critical to the therapeutic relationship physicians have with patients. Although the physician-patient relationship is based on trust, the relationship is characterized by an imbalance of power in favour of the physician with the patient in a position of vulnerability. Therapeutic boundaries are important as they shape respective roles and expectations for both parties. Boundary transgressions vary from the subtle to the obvious and can be categorized into crossings or violations. Crossing are departures from usual practices that are not exploitive and can sometimes be helpful to the patient, while violations are exploitive and always harmful to the patient. Serious violations, including sexual contact between a physician and a patient, often develop as the final stage of a series of boundary crossings. Physician professional identity formation provides a useful framework for the teaching of both the therapeutic physician-patient relationship and boundary transgressions to both students and residents. Important principles to incorporate in the teaching of physician-patient boundary issues include: individual risk factors for learners and practising physicians; preventive strategies that incorporate self-care, , and support structures; and knowledge of provincial medical regulatory policies and reporting requirements. Discussions with learners should also include potential educational boundary transgressions that require familiarity with training program and institutional polices on harassment and intimidation. Teaching tools and strategies will be incorporated into the session that are relevant to the preceptor

in their personal clinical setting, learner academic session, or curriculum development responsibilities.

T333 **La prise de décisions interprofessionnelle partagée avec les patients aux besoins de soins complexes**
15:00–17:15 Mathieu Bujold, PhD, MA, MSc; Marie-Ève Poitras, inf., PhD

SALLE : 524A
Crédits certifiés Mainpro+ d'apprentissage en groupe = 2

Objectifs d'apprentissage :
1. Définir les patients aux besoins de soins complexes et leurs besoins décisionnels (situations où des options doivent être soupesées)
2. Identifier les besoins décisionnels prioritaires et les facteurs favorisant ou entravant la prise de décisions
3. Participer à la création d'un outil d'aide à la décision interprofessionnelle partagée

Description :
Les patients aux besoins de soins complexes souffrent d'une combinaison de maladies chroniques multiples, de problèmes de santé mentale, d'interactions médicamenteuses et de vulnérabilité sociale, pouvant conduire à une surutilisation ou une sous-utilisation des services de santé. Ces patients, leurs familles, leurs aidants naturels et leurs praticiens (ci-après les parties prenantes) font face à des conflits décisionnels reliés à des incertitudes et des désaccords quant aux options possibles. Le manque de connaissances sur les situations prioritaires où les options doivent être soupesées (besoins décisionnels clés) entrave l'application d'interventions efficaces pour favoriser une prise de décisions interprofessionnelle partagée avec les patients aux besoins de soins complexes. Une revue systématique financée par les IRSC et combinée à une étude qualitative appuyée par l'Unité SOUTIEN SRAP du Québec a permis de produire une liste de besoins décisionnels concernant les patients aux besoins de soins complexes et les grands utilisateurs de services. Cette évaluation des besoins décisionnels a permis d'identifier, selon la perspective des parties prenantes : (1) les types de décisions les plus difficiles à prendre; (2) les raisons des conflits décisionnels; (3) les obstacles à la prise de décisions interprofessionnelle partagée ; (4) les formats possibles d'outils d'aide à la décision pour les patients aux besoins de soins complexes. La première partie de l'atelier présentera les résultats de l'évaluation des besoins décisionnels des patients aux besoins de soins complexes et des grands utilisateurs des services. Dans la deuxième partie, les participants se réuniront en petits groupes pour classer ces besoins décisionnels en ordre de priorité. L'activité se conclura par une séance plénière où chaque équipe partagera ses réflexions. Les participants détermineront comment ces résultats peuvent informer la conception d'un outil de prise de décisions interprofessionnelle partagée avec les patients aux besoins de soins complexes et quelle forme cet outil pourrait prendre.

T358 **So You're Interested in Global Health? Taking the Next Steps**
15:00–17:15 Lawrence Loh, MD, CCFP; Cheyanne Vetter, MD; Ruth Wilson, MD, CCFP, FCFP; Kyle Hodebecke, MD, MPA, MBA, MS

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Explore the various pathways in global health and identify which activities meet their individual learning goals
2. Tackle effective global health projects and initiatives
3. Take the first steps to participate as CFPC members with WONCA Polaris and other international family medicine networks

Description:
The World Health Organization defines global health as "the area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide." This panel discussion will bring together leaders in global health to discuss their journeys in the field. Global health is diverse and involves everything from responding to crises as front-line health workers, to being leaders in health policy and research, to making health equity a priority in your own community. Learn from panelists about a variety of ways to get

involved and hear their suggestions about making global health a part of family practice.

T395 **CRAFTing The FTA: Enhancing teaching in a program of assessment**
15:00–17:15 Cheri Bethune, MD, MClSc, CCFP, FCFP; Sudha Koppula, MD, CCFP, FCFP; Theresa van der Goes, MD, CCFP; Mike Donoff, MD, CCFP, FCFP; Allyn Walsh, MD, CCFP, FCFP
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe the crucial role of the family medicine teacher as "the assessment tool" in competency-based education in family medicine
2. Explain Continuous Reflective Assessment For Training as an educational construct and strategy for acheiving training for competence
3. Use the Fundamental Teaching Activities Framework to explore the skills teachers need to use the Continuous Reflective Assessment For Training approach

Description:
Continuous Reflective Assessment For Training (CRAFT) is the descriptive process of how competency-based assessment can be achieved in our family medicine training programs. The Fundamental Teaching Activities (FTA) Framework describes the skills all teachers need to enhance family medicine training. The integration of these two models in this workshop will address the barriers family medicine teachers experience in learner assessment. Through an interactive format using facilitated discussion and role play, participants will gain an understanding of the components and process of assessment and identify the teaching skills all preceptors need. An action plan for teacher development will conclude this workshop so participants leave with concrete steps that can be used to enhance their own teaching and contribute to this development in their own programs.

T493 **MedEd Research 102: I have a research question, now what? Research design basics**
15:00–17:15 Oksana Babenko, PhD; Shelley Ross, PhD; Douglas Archibald, PhD

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe common medical education scholarship methodologies
2. Explain the importance of matching a specific research question to a research methodology
3. Plan a medical education scholarship project with appropriate methodology and analysis to match the research question

Description:
Do you already have a research question, but need a primer on methods to help you get started designing your education scholarship project? This workshop is for you, whether you want to explore if your innovation is having an effect on the learning and/or understanding of learners, or examine what is really happening in the minds of learners as they progress through a learning experience. The easiest part of medical education research and scholarship is deciding what interests you the most. Once that initial "I wonder" has been formulated as a research question, the next step is to design a project thoughtfully in order to get the most meaningful results. One of the biggest pitfalls that novice medical education researchers encounter is that they plan and carry out a study, only to discover that the results cannot be analyzed or interpreted in a way that gives the researcher the information they wanted to know. A bit of planning saves a lot of frustration. In this highly interactive workshop, participants will be given a whirlwind tour through the most common qualitative and quantitative research methodologies, with lots of resources for later viewing. As well, basic approaches to data analysis will be presented briefly. Participants will work with the presenters and with each other to determine which methodology is most appropriate to their research question. They will receive guidance about how to decide what data to collect, and what to consider regarding data analysis. Particular attention will be given

to the importance of matching the research question to an appropriate research method. 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.

T82 **Mood Disorders in Women During the Reproductive Years**
16:15–17:15 Christiane Kuntz, MD, CCFP, FCFP, NCMP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Review the impact of, manifestations of, diagnostic criteria for, and treatment options for mood disorders in reproductive-age women
2. Highlight specific mood disorders affected by hormonal fluctuation during the menstrual cycle, pregnancy, postpartum, and peri-menopause
3. Apply learning pearls through case material

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. Factors increasing suicidal risk will be reviewed. Specific mood disorders associated with or affected by hormonal fluctuation during the menstrual cycle, pregnancy, postpartum, and peri-menopause will be highlighted. A focus will be placed on premenstrual syndrome to define it, recognize its impact on health and society, review the etiology and pathophysiology, highlight clinical assessment tools, and explore treatment options. Learning pearls will be applied through case material.

T115 **Respiratory Medicine: Five top articles for 2017**
16:15–17:15 Alan Kaplan, MD, CCFP (EM), FCFP; Suzanne Levitz, MD, CCFP; Anthony Ciavarella, MD; John Li, MD

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Review five top articles in respiratory medicine relevant to your clinical practice
2. Learn how to apply new information to your practice
3. Learn new ideas in respiratory medicine

Description:
Executive of the Respiratory Medicine Program Committee of the Section of Communities of Practice in Family Medicine will review five top articles in respiratory medicine from this year. Learn what is new in the literature; we will make all the articles clinically relevant to you. We had a packed house the past two years; you do not want to miss this!

T225 **Les urgences oncologiques**
16:15–17:15 Michael O'Doherty, MD CCMF MU

ROOM / SALLE : 515ABC
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Décrire les urgences oncologiques les plus fréquentes
2. Réviser la prise en charge initiale des urgences oncologiques
3. Discuter de l'approche au sujet des niveaux d'intervention à la salle d'urgence

Description :
Au terme de la conférence, les membres de l'auditoire, qu'ils pratiquent en clinique, en milieu hospitalier ou à l'urgence, vont être en mesure d'identifier et de prendre en charge efficacement les urgences oncologiques les plus fréquentes. Les sujets couverts, notamment les métastases cérébrales, les compressions médullaires

métastatiques, les épanchements malins, le syndrome de la veine cave supérieure (et bien d'autres !) seront révisés. Les participants auront la chance d'intervenir pour approfondir leurs connaissances ou bien pour discuter d'interventions ciblées dans le contexte particulier de leur milieu de travail.

T248 **Weeding Through the Evidence for Medical Marijuana 2.0**
16:15–17:15 **Derrière la fumée 2.0 : Distinguer les données probantes concernant la marijuana médicale**
Lisa Graves, MD, CCFP, FCFP; Meldon Kahan, MD, CCFP, FCFP;
Sharon Cirone, MD (EM), CCFP, FCFP; Launette Rieb, MD, CCFP, FCFP; Lori Montgomery, MD, CCFP

ROOM / SALLE : 517BC

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Identify the evidence for the use of dried cannabis, including edibles, in the treatment of medical conditions
2. Determine key factors related to cannabis in specific populations, including children, adolescents, pregnant women, and people with mental health disorders
3. Use the guidance document for decision making, including requests for prescriptions, recommendations for driving, and identification of cannabis use disorders

Description:

This workshop continues from last year's well-attended "Weeding Through the Evidence for Medical Marijuana." During this case-based presentation, participants will continue to use the CFPC's Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance document to guide clinical decision making for authorizing cannabis use in chronic pain, particularly neuropathic pain. With the emergence of edible marijuana products, this workshop will also address the evidence and risks associated with these products. Specific attention will be paid to children, youth, pregnant and breastfeeding women, and individuals with comorbid mental health issues. Specific issues such as the identification and management of cannabis use disorder and driving will be addressed. Addressing challenges presented from requests for prescription cannabis will be discussed. Evidence from the preliminary guidance document as well as recent updates in the literature will be presented.

Objectifs d'apprentissage :

1. Identifier les données probantes sur l'utilisation du cannabis séché, y compris les produits comestibles, dans le traitement de troubles médicaux
2. Déterminer les facteurs clés reliés à la consommation de cannabis chez certaines populations, y compris les enfants, les adolescents, les femmes enceintes et les personnes souffrant de troubles de santé mentale
3. Utiliser le document d'orientation pour la prise de décision, y compris en ce qui concerne les demandes de prescription, les recommandations au sujet de la conduite automobile et le dépistage des troubles liés à la consommation de cannabis

Description :

Cette présentation fait suite à l'atelier très populaire de l'année dernière qui s'intitulait « Derrière la fumée : Distinguer les données probantes concernant la marijuana médicale ». Au cours de cette présentation basée sur des cas, les participants continueront d'utiliser le document d'orientation préliminaire pour guider leur prise de décision clinique en ce qui concerne l'autorisation de l'usage du cannabis pour le soulagement de la douleur chronique, particulièrement la douleur neuropathique. Avec l'émergence des produits comestibles, cet atelier portera également sur les données probantes et les risques qui leur sont associés. Une attention particulière sera portée sur les enfants, les jeunes, les femmes enceintes ou qui allaitent, ainsi que les personnes souffrant de troubles de santé mentale en comorbidité. En outre, nous aborderons des enjeux précis tels que le dépistage et la prise en charge de troubles liés à la consommation de cannabis, et la conduite automobile. La discussion portera également sur les défis que présentent les demandes de cannabis d'ordonnance. De plus, des données probantes tirées du document d'orientation préliminaire ainsi que les récentes nouveautés dans la littérature seront présentées.

T254
16:15–17:15

Identifying Potentially Harmful Medications When Prescribed Inappropriately in Patients With Chronic Kidney Disease

Allan Grill, MD, CCFP (COE), MPH, FCFP; Scott Brimble, MD, MSc, FRCPC

ROOM / SALLE : 524C

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Recognize the common causes of adverse drug reactions and implement steps within your practice to help prevent them
2. Identify a list of commonly prescribed, potentially harmful medications when used inappropriately for patients with chronic kidney disease
3. Determine which medications should be dose-adjusted or avoided in patients with decreased kidney function

Description:

Adverse drug reactions (ADRs) are a public health problem in Canada. Approximately 3 per cent to 6 per cent of hospital admissions are due to ADRs, resulting in significant costs to the health care system. Patients with chronic kidney disease (CKD) or end-stage renal disease (ESRD) are at increased risk for ADRs, including acute kidney injuries, due to the nephrotoxic effects of certain drugs. Inappropriate drug dosing, particularly for those drugs that rely on kidney function for elimination, also remains a challenge for this patient population as it often represents an older demographic with patients taking numerous medications for multiple comorbidities. It is difficult for primary care providers to access a list of commonly prescribed, potentially harmful medications in those patients with CKD or ESRD. The development of such a list would contribute to an effective strategy to reduce and prevent patient harm. The Ontario Renal Network, a provincial government agency, is responsible for overseeing and funding the delivery of kidney disease services across Ontario. It has committed to developing tools and resources for hospitals and primary care providers by 2019 to reduce the incidence of avoidable harm in people with, or at risk of, kidney disease. In the past year a literature review was conducted to identify commonly prescribed medications associated with harm to patients with CKD, followed by a modified Delphi method to generate a nationally accepted list of inappropriate medications and those requiring dose adjustment for patients with compromised renal function. The Delphi panel included representation from across Canada with participation from nephrologists, pharmacists, clinical pharmacologists, and family physicians. This lecture will use interactive case-based scenarios to provide an evidence-informed list of common medications prescribed by primary care providers that need to be used cautiously in patients with CKD. Office workflow strategies to prevent ADRs will also be presented.

T302
16:15–17:15

Canadian Cardiovascular Society Heart Failure Guidelines: Top five take-aways for the family physician

Adam Grzeslo, MD, CCFP, FCFP; Nadia Giannetti, MD, FRCPC

ROOM / SALLE : 710A

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Discuss advances in the diagnosis and prevention of heart failure by reviewing results of new trials
2. Update knowledge and decision making around risk assessment of patients and optimal pharmacological and nonpharmacological treatment options
3. Align heart failure prevention and treatment strategies to integrate the new 2017 Canadian Cardiovascular Society Heart Failure Guidelines into daily clinical practice

Description:

Heart failure remains a common diagnosis and continues to be associated with significant morbidity and mortality. It presents in many different guises and circumstances that require individualized therapy. In 2017 the Canadian Cardiovascular Society (CCS) Heart Failure Guideline Panel published a comprehensive update to consolidate 10 years of annual guideline updates. This comprehensive guideline forms the basis of high-quality care for patients with heart failure and underpins the development of best practices. In this presentation members of the CCS

Heart Failure Guideline Panel will present key messages from the 2017 heart failure update and highlight new evidence from a family physician perspective. Using cases to illustrate relevant clinical applications and guideline recommendations, presenters will discuss: 1) how heart failure is preventable, supported by evidence that treating cardiovascular risk factors and ventricular dysfunction leads to fewer patients developing heart failure; 2) the emerging role of biomarkers and risk scores; that natriuretic peptides have become the gold standard biomarkers in heart failure for diagnosis, prognosis, and monitoring disease activity; and that risk scores should be incorporated into practice and used to convey heart failure risk to patients; 3) how to titrate medications, including newly available heart failure treatment options with an emphasis on novel pharmacological approaches; 4) the role of implantable devices, the evidence supporting their recommendation, and how to choose the right option and time for referring your patient; and 5) advanced therapies and what you need to know about therapeutic options for patients with very advanced heart failure.

T311 Implications of Early Peanut Introduction in Family Medicine

16:15–17:15 Elissa Abrams, MD, FRCPC; Alexander Singer, MB, BAO, BCh, CCFP

ROOM / SALLE : 512ABEF

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Assess the current international guideline on early peanut introduction
2. Consider the implications for primary care of early introduction of allergenic foods in Canada
3. Explore emerging Canadian guidelines on food introduction and allergy prevention

Description:

In early 2017 an international guideline on peanut allergy prevention was released recommending early peanut introduction in high-risk infants. However, there remain practical issues that may affect the feasibility and tolerability of early peanut introduction in infants. For example, a study by the session's authors noted knowledge gaps nationally among pediatricians, family physicians, and allergists in the definition of a high-risk infant, the knowledge of which infants require evaluation prior to peanut introduction, and how to counsel parents about the introduction of other allergenic foods. In addition, there remain national issues (such as long wait-list times for allergist evaluation) identified in this survey that may affect successful implementation of this guideline. The goal of this session is to review the newly released guideline, explore the practical implications for family physicians in various practice settings, and attempt to provide practical recommendations for counselling on food introduction in infants. In addition, one of the session's authors is working on a Canadian Paediatric Society practice point about food introduction, which ideally will be released prior to FMF. The session will also review this practice point's recommendations. Particular attention will be placed on the potential care gaps revealed in our research and other literature. The session will provide a balanced approach to responding to this paradigm shift of early introduction with practical and realistic strategies.

T386 Office Emergencies

16:15–17:15 **Urgences à la clinique**

Jock Murray, MD, CCFP (EM); Constance LeBlanc, CCFP (EM), FCFP, MAEd, CCPE

ROOM / SALLE : 710B

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Learn how to prepare your office for emergencies
2. Learn an approach to common office emergencies, including anaphalaxis
3. Learn an approach to common office emergencies, including chest pain

Description:

Emergencies and potentially acutely ill patients occasionally present to our offices. This session will help participants prepare their offices for emergencies. In addition, participants will learn approaches to common office emergencies. These include chest pain and anaphylaxis.

Objectifs d'apprentissage :
1. Apprendre comment préparer leur clinique pour faire face aux urgences
2. Apprendre une approche pour faire face aux urgences courantes dans les cliniques, y compris les réactions anaphylactiques
3. Apprendre une approche pour répondre aux urgences dans les cliniques, y compris pour la douleur thoracique

Description :
Des cas urgents et des patients dans un état potentiellement aigu se présentent occasionnellement dans nos cliniques. Cette séance aide les participants à préparer leur clinique pour mieux réagir aux urgences. De plus, les participants apprendront diverses approches pour répondre aux urgences courantes dans les cliniques, y compris la douleur thoracique et les réactions anaphylactiques.

T474 An Online Guided Practice Assessment Tool to Support Individual Learning and Practice Improvement

16:15–17:15 Christie Newton, MD, CCFP, FCFP; Bruce Hobson, MD; Bob Bluman, MD

ROOM / SALLE : 521ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Access the online (e-COACH) self-assessment tool for practice improvement
2. List the steps involved in developing an individualized learning plan for practice improvement
3. Develop a personal context-relevant, practice improvement question to apply to the online e-coach self-assessment tool

Description:
It is broadly accepted that physicians are poor at self-assessment. As a result, it is difficult for practitioners to identify personal learning needs. In an era of practice improvement and physician enhancement programs, family physicians require support identifying and addressing knowledge and practice gaps. The University of British Columbia Continuing Professional Development Division and the BC College of Family Physicians collaborated to design and pilot an online guided self-assessment tool that walks family physicians through the process of identifying and addressing personal learning needs. This workshop will briefly review the evidence for supported self-assessment in practice improvement. It will engage participants in a discussion about current challenges with implementing and sustaining practice quality improvement initiatives. The main portion of the session will introduce participants to the newly developed online tool that guides the learner through identifying and defining a personal learning issue, often a clinical or practice-based question. Participants will work in small groups, using the tool, through the different steps of defining a practice query, formulating a researchable question, and collecting objective practice data to more accurately gauge the practice issue. Once the sources are identified (and reviewed) the learner is guided through outlining measurements of indicators for improvement and developing a practice improvement action plan. The table work will allow participants to use the tool and explore some of the embedded resources. The goal of the session is to not only introduce participants to the tool but to demonstrate how individual learning needs can be (more) objectively identified and how quality improvement can be done in active practice. The tool has been certified for three credits per hour, up to eight hours, and is expected to be open source.

T565 Mainpro+ Continuing Professional Development Program Certification - Repeat

16:15–17:15 Jessica Black, MEd

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the basic requirements for Mainpro+ certification
2. Define the minimum requirements for one-credit-, two-credit-, and three-credit-per-hour certification
3. Provide examples of activities that meet the definition of Group Learning, Self-Learning, and Assessment credit categories

Description:
This session will provide a high-level overview of the standards and processes for program certification in Mainpro+. The session will cover eligible topics, conflict of interest requirements, and submission requirements. We will review frequently asked questions related to Mainpro+ certification and program development. The intent of this session is to prepare continuing professional development program developers to complete and submit an application for Mainpro+ certification.

17:00–19:00 **CQMF Cocktail-Réseautage**
QCFP Networking Cocktail Reception
Le Westin Montréal, Bar Reporter (3rd Floor)

Le président du Collège québécois des médecins de famille (CQMF), le Dr Frédéric Turgeon, profite du passage du FMF à Montréal pour inviter les membres du Québec et d'ailleurs à venir échanger avec lui dans une ambiance décontractée lors d'un cocktail-réseautage, compliments du CQMF. Amenez-vous seul(e) ou entre amis(ies) et profitez de cette occasion pour faire une courte pause entre pairs, et ce, sans en ajouter aux engagements que vous procure le FMF.

The President of the Quebec College of Family Physicians (QCFP), Dr. Frédéric Turgeon, would like to take advantage of the FMF in Montréal to invite members from Quebec and elsewhere to come chat with him in a very laid-back ambiance during a networking cocktail, courtesy of the QCFP. Come alone or with your friends and enjoy some well-deserved down time with your peers that will not infringe on your FMF commitments.

17:30–18:30 **FMF Welcome Reception**
Réception d'accueil au FMF
Palais des congrès de Montréal, 517a

All delegates are invited to attend the annual FMF Welcome Reception.
Meet with friends and colleagues and make new acquaintances while enjoying beverages and appetizers.

Tous les délégués sont invités à la Réception d'accueil annuelle du FMF.
Rencontrez vos amis et vos collègues, et faites de nouvelles connaissances. Boissons et hors-d'œuvre servis.

TWO- AND THREE-CREDIT-PER-HOUR CERTIFIED MAINPRO+ WORKSHOPS
ATELIERS CERTIFIÉS MAINPRO+ POUR DEUX ET TROIS CRÉDITS PAR HEURE

T102 **Airway Intervention and Management in Emergencies (AIME) Repeat session**
07:30–17:30 Sam Campbell, MD, CCFP (EM)

ROOM / SALLE : 516B
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT

Learning objectives:
1. Be more confident and comfortable in making acute care airway management decisions
2. Acquire a practical staged approach to airway management
3. Be able to choose the most appropriate method of airway management based on a variety of patient presentations

Description:
The Airway Intervention and Management in Emergencies (AIME) course has been providing valued and practical hands-on airway management learning experiences for clinicians around the world for more than 15 years. AIME educators are experienced (and entertaining) clinical instructors who understand the varied work environments of practising clinicians. Whether you work in a large, high-volume centre or a small, remote setting, AIME will provide a practical approach for airway management in emergencies. AIME program highlights include: case-based clinical decision making; new practical algorithms; when, why, and how to perform awake

or rapid sequence intubation; a new textbook/manual based on the AIME program; unique, customized clinical videos; limited registration to ensure a clinician-to-instructor ratio of 5:1 or 6:1; clinician-to-simulator ratios of 2:1; reinforcement of core skills; an introduction to newer alternative devices (e.g., optical stylets, video laryngoscopes); and exposure to rescue devices (e.g., King laryngeal tubes, LMA Supreme).

T338 **Treating Poverty**
07:30–17:30 Gary Bloch, MD, CCFP
(3) credits per hour

ROOM / SALLE : 511F
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 18 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Intervene in poverty using the Poverty Tool and guide patients to relevant income benefit programs
2. Critically assess income benefit programs that require physician input
3. Build and empower a team to address poverty and social determinants of health and advocate for patients living in poverty

Description:
Poverty represents a significant and reversible risk factor for poor health. This practical, active learning workshop supports the development of relevant clinical skills, a deeper understanding of the federal and provincial income security systems, and other related resources including the Poverty Tool, which is now available for all provinces. Participants will explore key online resources during the workshop and are required to bring a laptop or tablet to fully participate. This workshop is a Signature Program of the Ontario College of Family Physicians and one of the first programs to achieve the 3-credit-per-hour status in Mainpro+. Participants receive 18 Group Learning credits plus additional Self Learning credits upon the completion of post course activities.

T450 **Learning Essential Approaches to Palliative Care (LEAP) Mini Course for Family Physicians in Community-Based Settings**
07:30–18:00 Sandy Buchman, MD, CCFP, FCFP
(2) credits per hour

ROOM / SALLE : 511E
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 16.5 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Identify patients who require a palliative care approach early and implement a generalist-level palliative care approach
2. Manage symptoms and psychosocial/spiritual needs at a generalist level
3. Undertake essential conversations

Description:
LEAP Mini is an intensive one-day course (total of 8.5 hours) geared toward health care professionals on the front lines of community-based care, including family physicians, nurses, social workers, and pharmacists working in community-based settings. It is highly interactive and uses different learning methods, including case-based learning and small group discussions. This particular LEAP course at this FMF is limited to 30 learners and will have two facilitators. LEAP Mini has been accredited by the College of Family Physicians of Canada for 16.5 certified Group Learning Mainpro+ credits. LEAP Mini consists of 9 modules: Taking Ownership (includes identifying patients who would benefit from

a palliative care approach); Advance Care Planning and Decision-Making; Nausea, Hydration and Nutrition; Pain; Delirium; Dyspnea; Psychosocial-spiritual Distress; Essential Conversations; and Last Days and Hours. Participants will do a short self-assessment of knowledge, comfort, and attitudes prior to the course and identify areas for quality improvement in their practices after the course. Participants will receive copies of The Pallium Pocketbook as a resource.

T256 **CASTED: Emergency - 1 Day hands-on orthopedics course**
07:30–18:30 Arun Sayal, MD, CCFP (EM)
(3) credits per hour

ROOM / SALLE : 520AD
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 27 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Discuss important orthopedic principles as they apply to caring for Emergency Department patients
2. Describe the ED assessment, diagnosis and management of acute extremity injuries that are common, commonly missed and commonly mismanaged
3. Perform fracture and dislocation reduction techniques with emphasis on proper splinting, moulding and positioning of various ED injuries

Description:
CASTED: Emergency is the 'hands-on' ED orthopedics course. It is a full-day, Mainpro+ and MOC accredited course, designed specifically for ED physicians and staff. Case-based lectures highlight ED orthopedic principles and clinical pearls while reviewing over 80 pediatric and adult extremity injuries. Focus is on the common, the commonly missed, and the commonly mismanaged. Over 4 hours of 'hands-on' time provides extensive demonstration and practice of reduction and casting/splinting techniques. Numerous tips are offered on splinting, moulding and reduction. Closely supervised 'hands-on' practice ensures you will have the confidence you are doing it right! By the end of the day, you will know 'red flags' to beware of; which patients need a reduction; how to properly reduce, immobilize and mould; which patients need follow-up; and how quickly they need to be seen. You are promised a day full of humour and numerous clinical pearls you will use on your next shift! Since 2008, CASTED has been presented over 200 times across the country. It has received numerous awards including the CFPC's Continuing Professional Development Award for providing 'an exceptional learning experience'.

T164 **ECGs for Family Docs: A comprehensive workshop**
10:00–17:00 Filip Gilic, MD, CCFP (EM)
(2) credits per hour

ROOM / SALLE : 511D
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 10 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Understand clinically relevant electrophysiology
2. Use electrophysiology to identify axis, hypertrophy, block, arrhythmias, and ST changes
3. Investigate and treat patients based on their ECG findings

Description:
This session will review the clinically relevant electrophysiology that will move participants beyond simple pattern recognition of ECG interpretation. Based on the physiology, participants will actively interpret groups of ECGs for axis, hypertrophy, block, arrhythmias, and ST changes in a progressive fashion. We will then use the ECG interpreation to disposition and investigate patients in an efficient and safe fashion.

T184 **Improving Quality/Safety in Family Practice: Learning and teaching from significant event analysis**
13:30–17:15
David Moores, MD, MSc, CCFP, FCFP; Mirella Chiodo
(2) credits per hour

ROOM / SALLE : 513AB
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Identify common characteristics and examples of significant events in family practice/primary care
2. Identify and use four core components of significant event analysis
3. Determine and examine the family practice/primary care implications of the death of a young Albertan, Greg Price

Description:
In 2017 more than 34,000 Canadians will die at the hands of the health system. It is estimated that one Canadian dies of a preventable error every 17 minutes. Unfortunately, little will be learned or acted on because of bureaucracies, a "name, blame, and shame" culture, and inappropriate attention to confidentiality. Learning from one another's mistakes and errors requires a willingness to discuss what happened; why it happened; what can be learned; and what to do to prevent this from happening again. Learning is essential to improving the quality and safety of Canada's health services systems. Since most health services error data are derived from the hospital sector, Canada is blind to the realities of non-hospital error and poor performance. Dr. Kerr White's seminal paper on the ecology of medical care suggests that for every hospital admission, approximately 28 interactions occur in the community (250:9). Family physicians have direct or indirect knowledge/responsibility concerning errors/mistakes/close calls contributing to an individual's death, adverse experience, or poor outcome, no matter where they occur within the system. While some countries mandate/support family practice/primary care documenting and analyzing these significant events through a national database, Canada has yet to consider/establish a family practice-led initiative. This workshop introduces participants to: the essentials of the University of Alberta Department of Family Medicine's Quality and Safety in Family Practice/Primary Care Program; the definition and documentation of significant events; the fundamentals of significant event analysis; and a family practice/primary care analysis of Greg Price's death. Greg Price, a young Albertan, died as the result of poor follow-up and a consultation/referral system that is a shambles. Canadian family physicians can no longer turn a blind eye to their own, their colleagues', and the system's poor performance. It's time to talk and share. It's time to make a difference.

T252 **PAACT: Men's health update 2017**
13:30–17:15
David Greenberg, MD, MCFP; John Pilla, MSc
(3) credits per hour

ROOM / SALLE : 511B
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 9 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Participate in small group case discussion pertaining to prevention and treatment of conditions specific to men
2. Introduce and review the 2017 Men's Health Guidelines for Family Medicine and other practice tools
3. Review practice pearls related to the diagnosis/treatment of urological and sexual health conditions and tools to incorporate into your practice

Description:
This sessions is an independent educational program developed by family physicians about the management of men's health issues in primary care. Cases to be discussed include issues in urological health, symptomatic late-onset hypogonadism, and sexual health. Teaching method: Small group, case-based, interactive. Materials: The 2017 Men's

Health Guidelines for Family Medicine, participant workbook with cases, and practice management tools.

T422
13:30–17:15

Behavioural and Psychological Symptoms of Dementia: Applying the P.I.E.C.E.S. framework for effective clinical management

Sidney Feldman, MD, CCFP (COE), FCFP; Andrea Moser, MD, MSc, CCFP, FCFP
(2) credits per hour

ROOM / SALLE : 511A
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:

1. Assess and interpret behavioural and psychosocial problems seen in patients affected by dementia living at home or in long-term care
2. Present the risks, benefits, and appropriate doses of medications that are currently recommended for BPSD
3. Support health-care team members in monitoring common side effects of drugs that may be used in the treatment of BPSD

Description:
Participants will access and interpret common behavioural and psychosocial problems seen in patients affected by dementia, whether they live at home in the community or in a long-term-care home. The presentation will focus on the risks, benefits, and appropriate dose ranges of medications that are currently recommended for BPSD. In addition it will support health care team members in the monitoring of common side effects of drugs that may be used in the treatment of BPSD. Furthermore, health-care team members will be knowledgeable in the utilization of the P.I.E.C.E.S. assessment framework and the application of principles outlined in U-FIRST for the implementation of non-pharmaceutical approaches. This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits and it is part of the CPD program of the Ontario College of Family Physicians.

FRIDAY 10 VENDREDI

F889 **Dietary Fats and Cardiovascular Disease (Ancillary Session)**
06:45-07:45 Andrew Samis, BSc(Hon), MSc, MD, PhD, FCCP, FRCSC, FACS

ROOM / SALLE : 710A
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Understand the history of dietary guidelines advising lowering total dietary fat and saturated fat
2. Review some of the evidence relating to specific dietary components and cardiovascular disease
3. Discuss what we should tell our patients about a healthy diet and cardiovascular risk from an evidence-based perspective

Description:
In today's world, one can find studies, guidelines, and popular press articles both espousing the benefits of reduced saturated fat as a means of reducing cardiovascular disease, as well as advocating that saturated fat in unrelated to heart attack and stroke or in some cases even beneficial in preventing these diseases.

It comes as no surprise that these strongly expressed opposing viewpoints create a sense of confusion. But what is the evidence? This presentation takes a step-by-step historical approach to review how the concept of reducing dietary fat became world-wide public policy, starting in the early 1900's until today.

With an evidence-based approach, the consumption of dietary fat and its relationship to cardiovascular disease is being reevaluated , as will specific dietary elements such as cholesterol, dairy saturated fat, butter, and eggs. Current food guidelines are reviewed, including the recent Heart and Stroke Foundation position statement on saturated fat which shifts away from an isolated macronutrient-restrictive approach towards a food-based paradigm.

F180 **Chronic Pain Program Committee Networking Breakfast**
07:00–08:00 Lori Montgomery, MD, CCFP

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
The Chronic Pain Program Committee of the Section of Communities of Practice in Family Medicine invites you to join them at their networking breakfast to discuss how they can best support you to care for people with pain in your day-to-day practice.

F193 **Global Health Committee Networking Breakfast**
07:00–08:00 Clayton Dyck, MD, CCFP, FCFP

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
This networking breakfast is hosted by members of the Global Health Committee of the Section of Communities of Practice in Family Medicine, a professional home for family physicians with special interests and focused practices within the CFPC. Participants will have an opportunity to network and share their personal experiences, challenges, and successes in the area of global health and to provide input into the Global Health Committee's activities for the coming year. Participants at all career stages are welcome to join.

F194 **Respiratory Medicine Program Committee Networking Breakfast**
07:00–08:00 Suzanne Levitz, MD CM, CCFP; Alan Kaplan, MD, CCFP (EM), FCFP; John Li, MD; Tony Ciavarella, MD; Chris Fotti, MD, CCFP; Alison McCallum, MD

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
The networking breakfast is hosted by members of the Respiratory Medicine Program Committee of the Section of Communities of Practice in Family Medicine, a professional home for family physicians with special interests and focused practices within the CFPC. Participants will have an opportunity to network with colleagues who have an interest in respiratory care and provide personal experiences, challenges, and successes. Participants at all career stages are welcome to join.

F198 **Palliative Care/Health Care of the Elderly Program Committees Networking Breakfast**
07:00–08:00 Chris Frank, MD, CCFP (COE), FCFP; Mireille Lecours, MD, CCFP (PC)

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
This networking breakfast is co-hosted by the Palliative Care and Health Care of the Elderly Program Committees of the Section of Communities of Practice in Family Medicine. End-of-life care in the nursing home is a topic of importance to these Communities of Practice. Although the average life expectancy after admission to long-term care is less than two years, there is still great variability in the type of palliative care provided. The majority of people living, and dying, in long-term care homes are elderly. We will discuss the challenges of and opportunities for caring for people in long-term care and share models that have been viewed positively by patients, family members, and staff. Participants will have an opportunity to network with colleagues and provide personal experiences, challenges, and successes. Participants at all career stages are welcome to join.

F202 **Enhanced Surgical Skills Program Committee Networking Breakfast**
07:00–08:00 Brian Geller, MD, MBA, FCFP, FRRMS; ESS Committee

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
This networking breakfast is hosted by members of the Enhanced Surgical Skills Program Committee of the Section of Communities of Practice in Family Medicine, a professional home for family physicians with special interests and focused practices within the CFPC. Participants will have an opportunity to network with colleagues who have an interest in enhanced surgical skills and provide personal experiences, challenges, and successes. Participants at all career stages are welcome to join.

F213 **Maternity and Newborn Care Program Committee Networking Breakfast**
07:00–08:00 William Ehman, MD; Kevin Desmarais, MD, CCFP; Amanda Loewy, MD, CCFP; Kate Miller MD, CCFP, FCFP; Sudha Koppula, MD, CCFP, FCFP; Amanda Pendergast, MD, CCFP, FCFP; Balbina Russillo, MD, CCFP, FCFP; Michelle Khalil Abou, MD; Heather Baxter, MD, CCFP, FCFP

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
This networking breakfast is hosted by members of the Maternity and Newborn Care Program Committee of the Section of Communities of Practice in Family Medicine. Participants will have an opportunity to network with colleagues who have an interest in maternity and newborn care and discuss relevant current issues. There will be an opportunity to share successes and challenges. Participants at all career stages are welcome to join.

F217 **Hospital Medicine Program Committee Networking Breakfast**
07:00–08:00 Ben Schiff, MD CM, CCFP

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Description:
This networking breakfast is hosted by members of the Hospital Medicine Program Committee of the Section of Communities of Practice in Family Medicine, a professional home for family physicians with special interests and focused practices within the CFPC. Participants will have an opportunity to network with colleagues who have an interest in hospital medicine care and provide personal experiences, challenges, and successes. Participants at all career stages are welcome to join.

F255 **What You Need to Know to Become a Prison Physician: Breakfast networking session**
07:00–08:00 Josiane Cyr, MD, CCMF; Ruth Elwood Martin, MD, CCFP, FCFP, MPH; Margaret (Peg) Robertson, MD, CCFP; Nader Sharifi, MD, CCFP, ABAM, CCHP; Fiona Kouyoumdjian, MD, CCFP, PhD; Vipul Parekh, MD, CCFP

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Network with others who are interested in health care in the prison system
2. Increase your understanding of the steps involved in becoming a prison physician
3. Become familiar with some Prison Health Program Committee activities

Description:
This networking breakfast is hosted by members of the Prison Health Program Committee of the Section of Communities of Practice in Family Medicine, a professional home for family physicians with special interests and focused practices within the CFPC. Participants will have an opportunity to network with colleagues who have an interest in prison health care and provide personal experiences, challenges, and successes. Participants at all career stages are welcome to join.

F293 **Addiction Medicine Program Committee Networking Breakfast**
07:00–08:00 Sharon Cirone, MD, CCFP (EM), FCFP

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Meet other members of the CFPC Addiction Medicine Program and the committee members
2. Share experiences of working with patients with alcohol and substance use disorders
3. Identify resources and relationships that support working with patients with alcohol and substance use disorders in comprehensive care

Description:
The CFPC Addiction Medicine Program represents a network of primary care and focused-practice physicians with

an interest in serving patients, families, and communities with alcohol and substance use disorders. The Addiction Medicine Program Committee is made of regional representatives from across the country who work together to address issues of interest and educational value to CFPC members with respect to alcohol and substance use disorders. Members of the committee will host the breakfast meeting to facilitate conversation and collaboration among attendees who are already Addiction Medicine Program members, who wish to become members, or who simply have an interest in the clinical area. The discussion will be open to any topics the attendees may wish to address. Clinical support and mentoring networks will be addressed. All are welcome!

F548 **Developmental Disabilities Networking Breakfast**
07:00–08:00

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

F876 **Emergency Medicine Networking Breakfast**
07:00–08:00

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

F877 **Mental Health Networking Breakfast**
07:00–08:00

ROOM / SALLE : 710B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

F323 **Interactive Introduction to North America's Young Doctors' Movement: WONCA Polaris – Networking Breakfast**
07:00–08:00
Kyle Hoedebecke, MD, MBA, MPA, FAAFP; Cheyanne Vetter, MSIII; Amber Wheatley, MSIII; Stephen Cashman, MD; Viviane Sachs, MD; Ray Mendez, MD; Steve Hawrylyshyn, MD, CCFP; Shastri Motilal, MD; Shakera Carroll, MD

ROOM / SALLE : 510A
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Understand WONCA Polaris's integration in the CFPC and the AAFP
2. Get involved with multiple ongoing global health, education, and leadership initiatives
3. Share family physician best practices with new and future family physicians worldwide

Description:
Since its inception WONCA has promoted various supportive environments for junior family medicine and general practice physicians. Such backing became even more evident with the introduction of the regional Young Doctors' Movements (YDMs), the first being the Vasco da Gama Movement in 2005. Each region then slowly but surely adopted its own version of the YDM—all regions except North America. At the 2013 WONCA World Conference in Prague, a renewed energy and desire for a North American YDM emerged. Furthermore, the timing for such a movement proved perfect, secondary to continued global interconnectivity and the need for improved health care systems, among many other factors. The generation of physicians entering the profession today reached maturity in an increasingly globalized world in which junior physicians more than ever want to "think globally and act locally." With key support from the Caribbean, American, and Canadian professional family physician associations and the WONCA North America Regional President, Dr. Ruth Wilson, the region launched its WONCA North America YDM in a strategic manner on May 19, 2014—World Family Doctor Day. The North America YDM's formal name is Polaris, representing one of the brightest stellar bodies in the celestial sky seen by those in the

northern hemisphere. This star has led travellers and seafarers during their journeys for centuries. Similarly, WONCA Polaris has shone through the creation of numerous innovations within family medicine and medical education over the past three years. Be it leadership, exchanges, research, or global health, Polaris has something to offer every interested individual.

F342 **Heath Humanities Across Canada Networking Breakfast**
07:00–08:00 Joyce Zazulak, MD, CCFP, FCFP

ROOM / SALLE : 510B
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Generate opportunities for future collaborations and idea generation with like-minded colleagues in the area of health humanities
2. Foster the development of a cross-Canada community in health humanities
3. Provide an opportunity for those interested in arts and humanities to learn about health humanities initiatives across Canada

Description:
The CFPC's History and Humanities in Family Medicine Committee invites those with a strong interest in health humanities to a Breakfast Networking Session. The arts and humanities provide valuable insights into how medicine takes place within both a cultural and social context and offer a historical perspective on medicine. The History and Humanities in Family Medicine Committee would like to create a space for colleagues with expertise in the humanities to showcase their various educational initiatives and for others with an interest to learn about the value of humanities-based initiatives that exist across the country.

F223 **Networking Breakfast for Teachers of International Medical Graduates**
07:00–08:00 Susan Phillips, MD, MSc, CCFP; Inge Schabort, MD, CCFP, FCFP

ROOM / SALLE : 510C
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Describe and critique international medical graduate training programs and their nuances across Canada
2. Connect with a community of Canadian family medicine teachers of international medical graduates
3. Assess such matters as the quality of international training, the Canadian Resident Matching Service, predictors of success, and ambiguous credentials (e.g., externships, observerships, clinical assistantships)

Description:
Applications to family medicine residency programs from international medical graduates (IMGs), whether physicians immigrating to Canada or, more likely, Canadians who went abroad to study medicine, continue to outnumber those from graduates who trained in Canada. IMGs spend thousands of dollars positioning themselves for acceptance into residency while programs grapple with determining which achievements predict the success of these candidates in becoming family physicians. At the same time, recent CCFPs are having increasing difficulty finding work as provinces restrain spending. We will briefly present recent information about programs, problems, and success stories in teaching IMGs to open discussion. This session is open to all who teach or supervise residents.

F886 **Déjeuner rencontre pour les membres des programmes de clinicien érudit du Québec**
07:00–08:00

ROOM / SALLE : 510D
Cette séance n'est pas certifiée par le CMFC. Elle pourrait donner droit à des crédits non certifiés.

Ce déjeuner est un moment d'échanges entre les membres des programmes de clinicien érudit du Québec.

Les résidents des différents programmes auront, entre autres, la chance de discuter entre eux de leurs projets respectifs et d'échanger avec les membres du groupe sur les différents aspects d'une carrière universitaire.

F300 **Medical Assistance in Dying: A New Option for End-of-Life Care Demystified**
08:00–09:30 **L'aide médicale à mourir : une nouvelle option de fin de vie et un soin à démystifier**
Alain Naud, MD, CMFC(F)

ROOM / SALLE : 517

Learning objectives:
1. Understand Medical Assistance in Dying (MAID) and deconstruct the myths that surround it.
2. Understand how this type of care is integrated into end-of-life care.
3. Know the eligibility criteria, evaluation and procedure.
4. Understand what this new type of care brings, and can make a difference for patients, their families and their caregivers.

Description:
After five years of rigorous, impartial work conducted by the Select Committee on Dying with Dignity, as well as overwhelming social consensus, Québec paved the way for MAID by adopting its own Act respecting end-of-life care in June 2014. In February 2015, the Supreme Court of Canada ruled unanimously in favour of the legitimacy and legality of this form of care in the case of Carter vs Canada. Nearly two years later, how have physicians succeeded in putting their compassion and scientific knowledge to work for patients; to listen to them without judgement, to understand them and, above all, to respect them?

By remembering that there is only one type of dignified and acceptable end-of-life care for a sick patient who is suffering and without hope, is mentally capable, and is well-informed: whatever they choose freely, legitimately, and out of respect for their own values, beliefs, and convictions.

Objectifs d'apprentissage :
1. Comprendre ce qu'est réellement l'aide médical à mourir (AMM) et déconstruire les mythes qui l'entourent.
2. Comprendre comment ce soin s'intègre dans les soins de fin de vie.
3. En connaître les critères d'admissibilité, l'évaluation et la procédure.
4. Connaître ce que ce soin apporte de nouveau ou différent aux malades, aux proches et aux soignants.

Description :
Après 5 ans de travail rigoureux et non-partisan de la commission spéciale Mourir dans la dignité et au terme d'un très large consensus de société, le Québec a pavé la voie à l'AMM en adoptant sa propre Loi sur les soins de fin de vie en juin 2014. La Cour Suprême du Canada a par la suite confirmé en février 2015 la légitimité et la légalité de ce soin dans un exceptionnel jugement unanime, l'Arrêt Carter. Presque deux ans plus tard, comment les médecins s'organisent-ils pour mettre leur humanité et leur science au service des malades, les écouter sans les juger, les comprendre et surtout les respecter ?

Il n'existe qu'une seule fin de vie digne et acceptable pour un malade souffrant et sans espoir, apte et bien informé : celle qu'il choisira librement, légitimement et en total respect de ses propres valeurs, croyances et convictions.

F879 **Facilitated Poster Session**
10:00–11:00 During this session, five posters will be presented in 10-minute segments, followed by audience Q & A and a discussion.

ROOM / SALLE : Level 5 foyer / Foyer du niveau 5
Mainpro+ Group Learning certified credits = 1

F601 COPD Self-Management Education Group: A program evaluation

D. Van Dam*, MD, CCFP; J. Hodgins, RRT, CR; E. Lortie, MHA; N. Snyder, RRT, CRE; G. Cimino, RPh; T. Kontio, RPh; G. Fish, OT Reg; N. Bowen-Smith, OT Reg; J. Withers, RN

Objective: Chronic obstructive pulmonary disease (COPD) is a leading cause of morbidity and mortality in Canada. However, research suggests that many individuals diagnosed with COPD have poor knowledge regarding the management of their condition. This study assessed whether providing patients with knowledge about COPD could improve their self-management of this disease. **Design:** Program evaluation. **Setting:** A rural family medicine clinic in Southwestern Ontario. **Participants:** Seventeen individuals with a diagnosis of COPD. **Intervention:** A program was designed and offered to improve self-management of COPD, and provided education about topics such as how to develop an exercise plan, breathing strategies, and how and when to take medications. Surveys were administered to participants before and after the program to assess self-reported knowledge/understanding of COPD and level of confidence in managing COPD. A program satisfaction survey was administered following the program. **Main outcome measures:** Participant knowledge of COPD, confidence in self-managing COPD, and satisfaction with the program. **Results:** Mean level of self-reported knowledge/ understanding of COPD and mean level of confidence in self-managing COPD significantly increased after the program (6.15 to 7.38, P = 0.02; 6.73 to 7.55, P = 0.01, respectively). The mean number of questions answered correctly, of 12 COPD knowledge questions, significantly increased following the program (7.71 to 9.71, p = 0.01). The mean participant rating of overall experience of the program was high (4.15 on a scale of 1 (poor) to 5 (superior)). Conclusion: Preliminary results of this study demonstrate that this COPD program had a positive impact upon patient knowledge of COPD and confidence in self-management. Improving patient self-management of COPD has been shown to reduce the severity and frequency of exacerbation and improve health-related quality of life. Further sessions are required to better evaluate this novel program.

F642 Physician Attitudes About Adult ADHD Diagnosis and Management in an Academic Primary Care Setting

Bahar Najafi*, MD; Peter Tzakas, MD, CCFP

Statement of purpose: To determine the residents' and staff's perceived comfort level in their current clinical setting with diagnosing and managing adult ADHD. **Methodology:** An online anonymous survey was designed and distributed via email to Toronto East Health Network family medicine residents and faculty. **Results:** The survey was completed by 47 people (30 residents and 17 staff physicians). Forty-two per cent of respondents reported using tools to diagnose adult ADHD. The most commonly reported obstacles to diagnosis were: lack of training and presence of comorbid psychiatric conditions; lack of time for full psychiatric assessment; and difficulty obtaining collateral history to confirm presence of symptoms in childhood. The most commonly reported obstacles to treating and managing adult ADHD were: concern about abuse or diversion of medications; uncertainty in correct choice of medication or dosage; lack of knowledge; and uncertainty about ADHD being the right diagnosis. **Conclusions:** Familiarizing oneself with one of these tools, such as CADDRA and increasing the frequency of their use could help standardize the diagnostic process. Given that time was also seen as significant obstacle, perhaps longer appointments could be arranged for full ADHD assessment.

F591 Pediatric Obesity: Are we using the right measurement?

Naghmi Shirin, MBBS; Sabrina Suleman, MD; Shahzana Shahzad, MBBS; Hammaan Khan

Context: The 2006 Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children recommends that primary care practitioners should calculate BMI according to age and gender, (A-BMI) using the World Health Organization (WHO) Growth Charts for Canada, in children and youth aged 2 to 17 years. Non A-BMI charts can overestimate or underestimate pediatric obesity. Pediatric obesity is a strong predictor of adult obesity and its comorbidities (e.g., CVD, diabetes, cancer) with increased morbidity and mortality. **Objective:** To determine if children aged 2 to 17 years were assessed with A-BMI. **Design:** A cross-sectional study. **Participants:** We identified 754 patients aged 2 to 17 years who visited HFHClinic, in Burlington, Ontario, between 2015–2017. They were divided according to age (2 to 17 years), gender, calculation of A-BMI, counselling for weight issues, and gender of primary care provider. **Intervention:** Analysis

of EMR data from HFHClinic. **Outcome measure:** Assessment of the A-BMI during visits and its association with weight related counselling. **Result:** Out of 754 pt(males=367, females=387),177/754(23.5%) did not have A-BMI calculated. No A-BMI calculated in males=121/367(33%) females=56/387(14.5%). No A-BMI calculated in age 2-13yrs=55/177(31%), in age 14-15yrs= 30/177(17%) and age 16-17yrs=88/177(50%). Pt who were counselled with calculated A-BMI were 44/56(78.5%) Pt who were counselled without A-BMI 12/56(21.4%). Male vs Female Physician's A-BMI calculation was comparable{(116/164)71% and (480/606)79% respectively}. **Conclusions:** According to Statistics Canada, 26 per cent of Canadian children aged 2 to 17 years are overweight or obese. Non A-BMI does not take in consideration normal growth velocity and fat-free mass. Despite the 2006 Canadian Clinical Practice Guidelines, the A-BMI was missed in 23 per cent of eligible patients (50 per cent in ages 16 to 17 years, and 17 per cent in ages 14 to 15 years). The A-BMI was missed twice as much in male patients versus female patients (33 per cent versus 14.5 per cent). There was an almost four-fold increase in counselling (with A-BMI, 78 per cent; without A-BMI, 21 per cent). Increasing physician awareness of current guidelines to use A-BMI through CMEs, medical journals, and so on, is required.

F669 Qualitative Evaluation of Pediatric Poverty Screening Techniques Used in Primary Care, and Barriers to Their Implementation

Sarah Gander, MD, FRCPC

Background: Childhood poverty is a significant public health concern in Canada; a disproportionate number of low-income individuals struggle with poor health. Health care professionals can help mitigate the effects of poverty, but evidence suggests that screening for poverty is not done frequently, and many providers feel they lack the tools to do so. **Objectives:** This study evaluated screening techniques for pediatric poverty in primary practice, including attitudes towards screening, and perceived barriers to screening. Additionally, where and how practitioners established their screening techniques was considered. **Design and setting:** A grounded theory approach was used. Interview questions were prepared and eight primary care practitioners were recruited from the area of interest, including family physicians, pediatricians, and a nurse practitioner. Participants completed a 30-minute interview; these were analyzed using thematic analysis. **Findings:** The pervasive themes indicated that many primary care practitioners lack a screening protocol, using clinical judgment and knowledge of the family to decide when to screen. Most find this inadequate, and would be interested in a standardized tool for all patients. The major barriers to effective screening were time and lack of comfort, education about the topic, and familiarity with services to support families. **Conclusion:** The results showed that improved education in medical training is essential to feeling comfortable talking to patients about poverty; this should consist of didactic sessions, and exposure to children living in poverty. Support and knowledge of resources throughout practitioners' careers is needed to maintain comfort in mitigating the social determinants of health. Finally, due to the system barriers inhibiting effective screening, options to better involve allied health care professionals in screening and intervention should be considered.

F790 Development of Family Practice Guidelines for Pain Management

M. Hamilton* MD, MPH; J. Pilla, MSc; L. Dunn, MSc

Background: Pain management is a common presentation in the primary care setting. There are currently no comprehensive, evidence-based, independent clinical practice guidelines available in Canada to assist in prescribing for this clinical entity. One outcome of a Canadian expert review panel on opioids convened by the Institute for Safe Medication Practices (ISMP) Canada was that the development of a pain management prescribing resource is a priority and that family physicians should play a pivotal role in the process. **Objective:** To develop a practical resource for pain management for family practice. **Methods:** A modified Delphi processwas used to develop the guideline. This process has been well documented in the literature and has beenused previously to develop other Canadian primary care guidelines in this series, such as the Anti-infectiveGuidelines for Community-acquired Infections ('Orange Book'). The preliminary draft was reviewed by theexpert review panel. The subsequent iterations underwent peer review by a national interdisciplinary panelcomprised of family physicians, specialists, other primary care providers, and patients. **Results:** The resultingdocument includes recommendations on management of commonly-seen presentations of both acute

andchronic pain, and includes specific dosing recommendations and available products. It also includes evidence- based, non-pharmacological recommendations for each diagnostic category, the role of opioids and appropriateprescribing of these agents, and a summary of the role of medical marijuana. Prescribing and patient informationtools are available in the appendices. Multidisciplinary guidelines developed by front line family physicians andother primary care providers resonate with the end users, ensuring widespread uptake. While the process is timeconsuming,the outcome is a robust, practical, and user-friendly guide to pain management. **Conclusions:** Basedon subsequent feedback from family physicians across Canada, the guideline is a useful resource in day-to-daypractice. Next steps include a more robust dissemination and implementation strategy.

F108 **Jeopardy: Rapid-fire pearls for common primary care presentations**
10:00–11:00 **Jeopardy : Perles en rafale sur des affections communes en soins primaires**
Tina Korownyk, MD, CCFP; Michael Kolber, MD, MSc, CCFP, FCFP; G. Michael Allan, MD, CCFP, FCFP

ROOM / SALLE : 517BC

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Discuss up-to-date evidence on a range of primary care topics
2. Incorporate best available evidence into the management of common primary care presentations
3. Use evidence in the context of physician experience and patient values to improve patient care

Description:

This is a rapid-fire presentation covering topics from all aspects of primary care. Most topics stem from the Tools for Practice library, although some are from other sources. Using the core feature of Tools for Practice (succinct, practical, and relevant evidence) we will present key research and bottom lines for a variety of clinical questions using a Jeopardy! game format. Audience participation and interaction is the theme of this session.

Objectifs d'apprentissage :

1. Discuter de données probantes actuelles sur une variété de sujets liés aux soins primaires
2. Incorporer les meilleures données probantes disponibles dans la prise en charge d'affections communes en soins primaires
3. Faire appel aux données probantes dans le contexte de l'expérience du médecin et des valeurs du patient afin d'améliorer les soins

Description :

Cette présentation éclair portera sur des sujets divers couvrant tous les aspects des soins primaires. La plupart des sujets proviennent du répertoire d'Outils de la pratique, hormis quelques-uns, tirés d'autres sources. À l'aide de l'élément fondamental d'Outils de la pratique (des données pertinentes, pratiques et concises), nous présenterons des recherches et des conclusions importantes répondant à une variété de questions cliniques, le tout en suivant le modèle du jeu Jeopardy. La participation de l'auditoire et l'interaction seront les thèmes de cette séance.

F120 **Respiratory Disease Vaccinations: Preventing influenza, pneumococcal pneumonia, and pertussis in adult patients**
10:00–11:00
Alan Kaplan, MD, CCFP (EM), FCFP

ROOM / SALLE : 515ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Explore the indications for and types of influenza vaccination and identify who should be vaccinated
2. Differentiate the roles of the two available pneumococcal vaccines in healthy and chronically ill adults
3. Examine the role of pertussis in patients with cough and implement pertussis vaccine into adult practice

Description:
There are many respiratory disease vaccines available now, and the choices of which to give and to whom are often confusing. In this one-hour session the roles of each class of vaccine will be reviewed, including current National Advisory Committee on Immunization guidelines. The science behind each vaccine will be reviewed as well as the indications and contraindications, using cases to illustrate scenarios learners face in their practices.

F137 Opioid Use for Chronic Non-Cancer Pain: The big picture

10:00–11:00 Henry Chapeskie, MD, CCFP, FCFP, CAME; Mark Dube, MD, CCFP (EM) (PC), FCFP, CISAM

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the social and historical contexts of opioids and evidence for using opioids to treat chronic non-cancer pain
2. Review narcotic-induced neurotoxicity and hyperalgesia, and the controversial role of marketing techniques in the use of opioids
3. Gain confidence in an evidence-based rationale for the cessation of opioids in the treatment of chronic non-cancer pain

Description:
Over the past 20 years the use of opioids for chronic non-cancer pain (CNCP) has increased dramatically along with associated morbidity and mortality. Physicians will gain an understanding of the history of opioids in society and medicine. With recent professional and public interest in the opioid crisis and controversial marketing practices, many physicians have begun to question the role of opioids in the treatment of CNCP. We will review the phenomena of narcotic neurotoxicity and narcotic-induced hyperalgesia. This presentation will provide physicians with the opportunity to identify and critically evaluate the role of opioids in the treatment of CNCP. Are opioids really safe and effective when compared with non-narcotic therapies?

F175 Introduction to System-Level Advocacy for Family Physicians

10:00–11:00 Samantha Green, MD, CCFP

ROOM / SALLE : 523AB

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Define advocacy and recognize its critical role in family medicine
2. Identify health inequities that require community- and system-level advocacy
3. Learn practical skills and discuss examples of addressing health inequities through system-level advocacy

Description:
It is well recognized that social determinants such as race, gender, gender identity, sexual orientation, income, ability, and housing are predominant drivers of health inequities. Family physicians are uniquely positioned to identify and respond to these inequities with a trusted voice through advocacy. Family physicians regularly act as health advocates for individual patients; yet this CanMEDS-FM role also bestows a responsibility to advocate for changes that will promote the health of communities and populations, especially those that are more vulnerable. Advocacy is foundational to family physicians' social accountability, which exists at the individual patient (micro), community and institutional (meso), and systemic (macro) levels. These broader advocacy efforts aimed at governments and systems can seem outside the scope of physician training, since medical school and residency curricula are inconsistent and often inadequate. In this session participants will explore the role of meso- and macro-level advocacy in family medicine using specific case examples. Participants will gain tangible tools for embarking on community- and system-level advocacy. Participants will leave with a framework for addressing health inequities in their communities.

F196 **Research Highlights from FMF's Family Medicine Innovations in Research and Education Day**
10:00–11:00 Baukje Miedema, RN, MA, PhD

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Showcase original research presented on Wednesday
2. Stimulate interest in primary care research
3. Learn about primary care research results

Description:
Please join us for this year's "Top Four Oral Abstracts" session at which the CFPC Section of Researchers and Section of Teachers highlight the best in primary care research from across Canada. A rigorous peer-review process is applied to these submissions and the top four–ranked oral abstracts are given the opportunity to present a second time for the general membership. Come out to challenge the presenters. Share your ideas on the clinical relevance of their work and give feedback on what questions they should pursue next time. Help us cheer on primary care researchers working to improve the care of all Canadians.

F272 **Changing the Course of Eating Disorders**
10:00–11:00 Ahmed Boachie, MD, DCH, MRCPsych, FRCPC; Karin Jasper, PhD, RP; Pierre-Paul Tellier, MD, CFPC

ROOM / SALLE : 524B
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the early symptoms of eating disorders in children and adolescents
2. Generate steps to determine differential diagnoses
3. Develop a management plan that includes collaboration with parents

Description:
Family physicians are in a unique position to identify eating disorders early because they are the first port of call for parents, who usually notice non-specific symptoms quickly. Children and adolescents who receive treatment within three years of becoming ill show better outcomes, particularly with family-based treatment. Early identification and treatment may also reduce lifetime disease burden. Early symptoms are non-specific and can masquerade as physical illnesses, but revisions made to the DSM-5—particularly the new diagnostic category known as Avoidant/Restrictive Food Intake Disorder—can help raise the indices of suspicion. Through this talk, clinicians will learn to identify the early symptoms of a developing eating disorder, how to determine a differential diagnosis, the benefits of working collaboratively with parents, and how to best manage patients waiting for specialized treatment. A national study, Involving Family Physicians in Early Identification of Eating Disorders, is in process.

F313 **Physical Health Monitoring in Psychiatry: It is time to work together**
10:00–11:00 **Baromètre de la santé physique en psychiatrie : L'heure de la collaboration est venue**
Gaurav Mehta, MD, DCP, PGDip (Diabetes), FRCPC

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Understand the physical health side effects of psychotropic medications
2. Understand the importance of physical health monitoring from a family doctor's perspective
3. Provide treatment for the side effects of psychotropic medications

Description:
Various psychotropic medications such as lithium and clozapine require special monitoring from a physical health perspective. Often high-dose antipsychotics are prescribed for the treatment for schizophrenia, bipolar disorders,

and other psychotic disorders, which puts patients at increased risk of mortality. Cardiovascular risk factors are the biggest cause of death in schizophrenia. With an increasing use of long-acting psychotics, rises in the incidences of metabolic syndrome and hyperprolactinemia are seen. Other challenges are QT interval prolongation and myocarditis, which are invariably seen with the use of clozapine and other antipsychotics. Lithium use requires monitoring of the heart, kidneys, and thyroid, in addition to monitoring serum lithium levels. It is important for psychiatrists and family doctors to come together to address the physical health issues in mental health. This session shall focus on how this could be achieved. We shall discuss challenges and solutions using practical examples and an evidence-based approach.

Objectifs d'apprentissage:

1. Comprendre les effets indésirables sur la santé physique des médicaments psychotropes
2. Comprendre l'importance de surveiller la santé physique du point de vue du médecin de famille
3. Traiter les effets indésirables des médicaments psychotropes

Description:

Divers médicaments psychotropes comme le lithium et la clozapine exigent une surveillance particulière du point de vue de la santé physique. Souvent, les antipsychotiques prescrits à fortes doses pour le traitement de la schizophrénie, du trouble bipolaire et des troubles psychotiques augmentent le risque de mortalité chez le patient. Les facteurs de risque cardiovasculaire sont la cause la plus importante de décès chez les patients schizophrènes. Avec l'emploi de plus en plus fréquent de psychotiques à action prolongée, on observe une hausse de l'incidence du syndrome métabolique et de l'hyperprolactinémie. L'allongement de l'intervalle QT et la myocardite sont d'autres problèmes invariablement présents à l'emploi de la clozapine et d'autres antipsychotiques. Le lithium exige de surveiller le cœur, les reins et la glande thyroïde, en plus des concentrations sériques de lithium.
Il importe que les psychiatres et médecins de famille se concertent pour traiter les problèmes physiques en santé mentale. Cette séance s'attarde sur la façon dont on peut y arriver. Nous allons parler des défis et des solutions, en donnant des exemples pratiques et en adoptant une approche factuelle, dans ce contexte.

F372 **Oral Isotretinoin for Acne Vulgaris: A primer for the family physician**
10:00–11:00 Vimal Prajapati, MD, FRCPC, DABD; Alim Devani, MD, FRCPC, DABD

ROOM / SALLE : 517D

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Identify the mechanism of action, formulation, dosage, administration, indications, contraindications, and adverse effects of oral isotretinoin
2. Implement effective counselling and monitoring of patients being treated with oral isotretinoin
3. Dispel common myths about oral isotretinoin

Description:

Acne vulgaris is a skin condition commonly encountered by family physicians. While the diagnosis remains straightforward in most cases, management can be challenging. Oral isotretinoin is a highly efficacious and cost-effective therapy that offers a cure for many patients. Regardless of their comfort level in prescribing oral isotretinoin for acne vulgaris, family physicians must be knowledgeable about this medication. Furthermore, recognizing which patients are appropriate candidates is imperative, as early treatment can prevent physical and emotional scarring. Herein, we provide an in-depth review and pearls on the use of oral isotretinoin for acne vulgaris.

F398 **Mainpro+ Continuing Professional Development Program Certification**
10:00–11:00 Jessica Black, MEd

ROOM / SALLE : 524A

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the basic requirements for Mainpro+ certification
2. Define the minimum requirements for one-credit-, two-credit-, and three-credit-per-hour certification
3. Provide examples of activities that meet the definition of Group Learning, Self-Learning, and Assessment credit categories

Description:
This session will provide a high-level overview of the standards and processes for program certification in Mainpro+. The session will cover eligible topics, conflict of interest requirements, and submission requirements. We will review frequently asked questions related to Mainpro+ certification and program development. The purpose of this session is to prepare continuing professional development program developers to complete and submit an application for Mainpro+ certification.

F431 Pediatic Ear, Nose, and Thorat Issues for the Family Physician

10:00–11:00 Jock Murray, MD, CCFP (EM)

ROOM / SALLE : 710A

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Learn to recognize common pediatric otolaryngology problems
2. Learn approaches to treating common otolaryngology presentations
3. Become aware of rare otolaryngology presentations

Description:
Otolaryngology presentations are common in the family medicine office. This session will allow participants to become more familiar with the diagnosis of and changing treatment patterns for these presentations.

F439 HPV Prevention in Adult Women: Effective communication about national guidelines

10:00–11:00 Marc Steben, MD

ROOM / SALLE : 516C

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Personalize communication about the burden of HPV in an era of social media
2. Communicate about the safety of the HPV vaccine and prevent communication gaps between health care professionals and their patients
3. Optimize adherence to Canadian guidelines about HPV vaccination in adult women

Description:
We will review the current recommendations with respect to HPV vaccination of adult women, then examine the results of a national survey of the beliefs, attitudes, and behaviours of Canadian women, family physicians, and obstetricians and gynecologists with respect to HPV vaccination. Opportunities to meet our patients' needs and expectations better are suggested by the results.

F466 Caring for Complex Patients: A tour across Canada

10:00–11:00 Amanda Condon, MD, CCFP; Paul Sawchuk, MD, CCFP, FCFP, MBA

ROOM / SALLE : 521ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify commonalities and differences among highlighted practices focused on care of complex patients
2. Describe measurement opportunities when caring for complex patients

3. Propose solutions for potential challenges identified for implementation of this type of work

Description:
The most complex, highest need members of our communities often require the most resources. Serving this patient population well in the community, with focused and targeted interventions, has the potential to impact and address all four components of the Institute of Healthcare Improvement's quadruple aim: improved patient experience, better health outcomes, lower cost, and a positive provider experience. The pillars of the Patient's Medical Home give us a framework to provide care to a population. However, typical family medicine practice addresses the needs of the patients who reach out, patients who make and attend appointments in the office. The most complex patients in our communities often have needs that extend beyond the office appointment and may even interfere with their ability to attend regular office-based appointments. What innovative approaches are being used to address the care needs of these patients in practices across Canada? How do these approaches fit within the Patient's Medical Home model? What role do family physicians play? How are patients identified? What is the role of home visits? What do the teams look like that care for these patients? What does improvement or success look like for these patients and for these teams? What are some of the challenges in implementing and maintaining this type of work? This presentation will highlight our initial findings from a cross Canada tour, identifying and describing practices that are working to innovatively address the care needs of this population.

F468 **Supportive Cardiology: Providing palliative care for patients with advanced heart failure**
10:00–11:00 Warren Lewin, MD, CCFP; A.M. Nina Horvath, MD, CCFP; Shana Haberman, MA; Archna Patel, RN, MN, CHPCN(C); Dorothy Sullivan, MBChB, MRCGP, MSc, CCFP

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the principal features of a comprehensive palliative care plan for patients with advanced heart failure
2. Recognize the value of the family physician's role in implementing a palliative approach alongside specialist colleagues and community partners
3. Identify key assessment and management strategies for end-of-life heart failure care

Description:
Heart failure (HF) is a chronic, life-limiting illness that progressively impacts health status and is a leading cause of hospital admissions. HF carries a poor prognosis and is associated with many unmet palliative care needs. Using a case study, we will describe the integration of a new model of early palliative care involvement into the routine cardiac care for patients with advanced HF. This innovative model of care led to collaboration between family physicians, cardiologists, and palliative care teams, resulting in increased advance care planning (documentation increased from 40 per cent to 100 per cent), reduced hospitalizations, and high satisfaction with care received. A referral tool was developed using evidence-based criteria to help identify patients with advanced HF who would benefit from upstream palliative care. We will highlight lessons learned in optimizing symptom assessment and management strategies for this patient group from both a generalist and specialist palliative care perspective. The overall aim of this presentation is to provide the family physician with a generalist-level HF palliative care skillset. This includes symptom management, initiating and managing conversations focusing on illness understanding, prognostic awareness, and goals of care that highlight patient and family values to optimize end-of-life care.

F478 **Building the Continuum: Establishing collaborations between undergraduate and postgraduate programs**
10:00–11:00 Karlyne Dufour, MD, CCFP, FCFP; Kathleen Horrey, MD, CCFP, FCFP; Nancy McCarther
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the benefits of collaboration between undergraduate and postgraduate educational programs
2. Examine the barriers and challenges of such collaborations
3. Explore potential solutions and opportunities for greater partnership

Description:
The concept of a continuum in learning is not new. Our Principles of Family Medicine highlight the importance of life-long learning. Functionally, however, undergraduate and postgraduate medical educational programs are often in silos, with few or infrequent opportunities for collaboration. Organizationally, the challenges for administrators are often similar, with undergraduate and postgraduate programs competing for the same set of precious resources, in particular our clinical teachers. While the specific objectives at the level of the learner differ, the skills needed by clinical teachers for instructing undergraduate and postgraduate learners often overlap. Addressing the transition of learners between undergraduate and postgraduate programs build upon this concept of the continuum to better address the learning needs of the individual. However, rarely have undergraduate and postgraduate educators engaged in those discussions jointly. During this workshop administrators, undergraduate and postgraduate educational leaders, and department heads/chairs will be invited to identify the benefits of building better collaborations between undergraduate and postgraduate medical education programs, to develop a better understanding of the barriers, to share examples of successful partnerships, and explore possible solutions in building collaborations.

F42 A Medical Educator Walks Into a Classroom: What cognitive psychology can teach us

10:00–12:15 Ian Scott, MD, CCFP, FRCPC
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe the basic principles of how learning works
2. Apply these learning principles to simulated learning settings
3. Explore how to apply these principles to one's current educational setting

Description:
This workshop will focus on the current scholarship and best practices from the field of cognitive psychology as related to teaching and learning. We will then move from this foundational understanding of best practices of teaching and learning to applying these principles in paper simulations. Small groups of workshop attendees will work through these scenarios and arrive at an educational answer to the teaching and learning problems presented in these simulations through discussion and consensus. We will then work in those same small groups and explore how we can apply these teaching and learning principles in our own educational settings while attending to practicality and contextual factors. Materials and resources will be handed out throughout the session as well as a summary document with key principles at the end of the session.

F70 Expanding the Primary Care Toolbox: Buprenorphine for opiate use disorder

10:00–12:15 Melissa Holowaty, MD, CCFP, PhD, CISAM

ROOM / SALLE : 512ABCF
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Recognize opiate use disorder in your practice
2. Initiate buprenorphine for treatment of opiate use disorder
3. Monitor treatment for this chronic disease using urine drug screening and integrate it seamlessly into generalist practice

Description:
Opiate addiction is present in everyone's practice. It can be difficult to recognize in your patients and to address and treat in a compassionate but clear manner. Using both real-world cases and didactic methods, you will learn how to recognize opiate use disorder in your practice, use and interpret urine drug screens, and use buprenorphine as part of your comprehensive treatment plan for this disorder. Addiction is a chronic disease, and for many patients their disease can be monitored and followed in the family practice office similar to non-complicated cases of diabetes and COPD.

F427 **Enhancing Acceptance and Application of Feedback: The R2C2 model**
10:00–12:15 Heather Armson, MD, MCE, CCFP, FCFP; Joan Sargeant; Jocelyn Lockyer; Marygrace Zetkulic, MD; Andrew Warren, MD, MSc, FRCPC
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Describe the four-stage R2C2 feedback model: building relationships, exploring reactions, exploring content, and coaching for change
2. Discuss the theory and evidence informing the model, which facilitates performance feedback collected by various assessment strategies
3. Discuss and critique the model and its potential applicability to the participants' programs

Description:
Recent studies have demonstrated that learners do not always readily accept or use performance feedback for improvement. Explanations for this include inconsistency of the feedback with self-assessment, concerns about data credibility, and perceived barriers to feedback use and change. In response, a four-stage model for facilitating the acceptance and use of formal feedback (the R2C2 model) was developed drawing on three bodies of theory and research: person-centred approaches to build trust and actively engage recipients in taking ownership of their feedback; informed self-assessment to enable the assimilation and use of external data; and coaching and behaviour change approaches to enable recipients to identify goals and plan for change. The four phases include building a relationship, exploring reactions to the data, focusing on the content of the data, and coaching the trainee for change using a learning change/action plan. In this model, the preceptor/coach is the mechanism that drives and energizes the learner through studying and understanding their performance data and engaging the learner in co-developing a plan for change while recognizing the contextual and organizational factors that will facilitate or hinder the necessary changes. The model has been tested with residents across five different residency programs in Canada, the United States, and the Netherlands and found to be feasible, adaptable, and useful in engaging learners in change and in monitoring progress on milestones and entrustable professional activities. Coaching for change was identified as the most useful feature of the model. A learning change plan was an integral component of the coaching discussion. The model appeared to be useful with both excelling and struggling residents.

F55 **Pearls in Thrombosis Update for Family Physicians: A case-based approach**
11:15–12:15 **Mise à jour des perles sur la thrombose pour les médecins de famille : Une approche fondée sur les cas**
Alan Bell, MD, CCFP

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Choose and select the appropriate dose of anticoagulants for atrial fibrillation and venous thromboembolsim
2. Diagnose and manage venous thromboembolic disorders, including deep vein thrombosis and pulmonary embolism
3. Determine the duration and perioperative management of anticoagulants

Description:
Upon completion of this session participants will better be able to manage patients presenting with diseases

requiring consideration of anticoagulation. A case-based, interactive approach will be used. Topics to be covered include appropriate dosing of anticoagulants in atrial fibrillation; diagnosis and management of venous thromboembolic disorders, including deep venous thrombosis and pulmonary embolism; duration of therapy in venous thromboembolism for secondary prevention; and reversal/perioperative/bleeding management of patients on anticoagulants. Current guidelines, including those of the Canadian Cardiovascular Society and the American College of Chest Physicians, are the standards on which this session is based. Participants will be provided with point-of-care clinical tools, developed and peer reviewed by Thrombosis Canada, to apply the principles of this presentation to their practices. This presentation will provide an update to the FMF 2016 session.

Objectifs d'apprentissage :

1. Bien choisir et doser les anticoagulants dans les cas de fibrillation auriculaire et de thromboembolie veineuse
2. Diagnostiquer et prendre en charge les troubles de thromboembolie veineuse (TEV), y compris la thrombose veineuse profonde et l'embolie pulmonaire
3. Déterminer la durée et la prise en charge peropératoire de l'anticoagulothérapie

Description :

À l'aide d'une approche interactive fondée sur les cas, les participants pourront mieux prendre en charge les patients atteints de maladies qui exigent d'envisager l'anticoagulation. Les sujets traités sont la posologie appropriée des anticoagulants dans les cas de fibrillation auriculaire, le diagnostic et la prise en charge des troubles de thromboembolie veineuse (TEV), y compris la thrombose veineuse profonde et l'embolie pulmonaire, la durée du traitement de la TEV en prévention secondaire et la prise en charge peropératoire, du renversement et des saignements chez les patients sous anticoagulothérapie. Les lignes directrices actuelles, y compris celles publiées par la Société canadienne de cardiologie et l'*American College of Chest Physicians*, sont la norme sur laquelle repose la séance. Les participants recevront des outils cliniques à utiliser lors des soins, mis au point et revus par les pairs de Thrombose Canada, afin d'appliquer les principes de cette présentation dans leur pratique. Cette présentation est une mise à jour de la séance de 2016.

F83 Too Busy to Relax?

11:15–12:15 Philippe Erhard, MD, CCFP, FCFP, Dip Sport Medicine

ROOM / SALLE : 524A

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Identify the causes of stress in medicine and its impact on physicians' lives
2. Implement steps to reduce stress in physicians' personal and professional lives
3. Learn three habits to increase resilience as well as methods to integrate those habits successfully into physicians' daily lives

Description:

Physicians often feel trapped by a demanding and busy lifestyle. Change, however, is possible, and does not have to be complicated or time consuming. Participants will learn about the importance of burnout in medical practice and how to prevent it. Essential professional and personal life modifications are presented as well as an introduction to three simple habits (the practice of deep breathing, mindfulness, and gratitude) that are easy to integrate into a busy schedule and are effective in relieving stress, increasing resilience, and improving life satisfaction.

F135 Benzodiazepine Deprescribing in the Elderly: A community family medicine approach

11:15–12:15 Joanne Laine-Gossin, MD, CCFP, FCFP; Tiffany Florindo, MD, CCFP

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Describe the risks and side effects of benzodiazepine use in elderly patients

2. Explore techniques for deprescribing that can be used effectively in a busy family practice setting
3. Explore various treatment modalities as alternatives to benzodiazepine use in elderly patients

Description:

Benzodiazepines have been used for years to treat chronic conditions such as anxiety and insomnia. However, we are now recognizing that they can be associated with significant risks and side effects, particularly in elderly patients. Risks include memory impairment, falls, fractures, and motor vehicle accidents. There are many misconceptions around the use of these medications, on the part of both patients and physicians, and many barriers to deprescribing. Patients like them because they work. Physicians find that educating patients about deprescribing can take considerable time and effort and often leaves patients dissatisfied. Newer tools that empower patients and adopt a patient-centred approach will be examined here. Patient education techniques, motivational interviewing, use of the EMPOWER brochure, cognitive behavioural therapy for insomnia, and a deprescribing timeline will be explored. Incorporating these various tools in a busy family practice without the aid of allied health professionals and other supports can be very challenging. Including computerized tools, Internet-delivered cognitive behavioural therapy, and online relaxation techniques can be helpful for the busy physician. Recognizing the difficulties and challenges in deprescribing, that patients' needs and expectations vary, and that no one technique works for all can help alleviate some of the frustrations in attempting deprescribing. Having the patient as a partner is crucial; this session is geared to giving busy physicians the tools to accomplish this.

F149 **Teaching Infants to Sleep Through the Night and Other Parenting Pearls**
11:15–12:15 Sanjeev Bhatla, MD CM, CCFP, FCFP

ROOM / SALLE : 524B

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Teach parents how to train their infant safely and effectively to sleep through the night
2. Teach patients how to apply key principles of child development to be more effective and happy parents
3. Provide patient handouts on parenting that reinforce parenting skills taught in the office

Description:

Parents seek and value guidance from their family physician for advice on how to train their infants to sleep thought the night and how to manage various parenting challenges. This workshop reviews evidence-based principles of child development to provide physicians confidence in teaching parenting skills. The workshop will demonstrate how to teach parents effective role-modelling skills and principles of age-appropriate discipline techniques. Case examples are used to teach parenting skills on sleep problems, mealtime challenges, temper tantrums, emotional dysregulation, perfectionism, anxiety, and depression. The workshop demonstrates how to provide parenting pearls in a way that takes five minutes or less and can be done effectively during a regular office visit. Participants will learn how to recognize opportune moments to teach parents in a way that is brief and high yield. There is an emphasis on teaching parents how to extrapolate a single parenting principle or technique for various situations. Participants will be provided one-page handouts that can be given to patients to reinforce the teaching that is done in the office visit. Interactive group discussion and role-playing is used to clarify concepts and to illustrate real-life applicability. Participants will be encouraged to reflect on how family physicians are ideally situated to teach parents because of the relationship of trust, respect, and continuity.

F232 **Dermatology Dilemmas: Ten missteps when treating skin diseases**
11:15–12:15 **Dilemmes de dermatologie : 10 faux pas du traitement des maladies de la peau**
Jessica Hunter-Orange, MD, CCFP

ROOM / SALLE : 517BC

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Identify some common diagnostic mimickers and characteristic features that allow discrimination between them
2. Explain the warnings attached to several therapeutic agents and interpret whether they are worthy of guiding

our treatment decisions
3. Widen the differential diagnosis for some common dermatology presentations and implement changes as to how these are investigated

Description:
Common dilemmas in dermatology such as the appropriate use of topical steroids, how to treat (or not treat) skin infections, adult acne, the ever-increasing burden of actinic keratoses, chronic red legs, and others will be discussed by looking at some common mistakes we make when treating dermatology patients. The evidence for treatment and diagnostic pearls will be shared to help us shrink the size of our own blooper reels in dermatology.

Objectifs d'apprentissage :
1. Identifier certaines imitations de diagnostics courants et nommer les caractéristiques qui permettent de les distinguer entre elles.
2. Expliquer les mises en garde de plusieurs agents thérapeutiques et interpréter si elles méritent de guider nos décisions thérapeutiques
3. Élargir le diagnostic différentiel de certaines présentations dermatologiques et changer la façon dont elles sont investiguées

Description :
Certains dilemmes dermatologiques courants, tels que l'emploi approprié de stéroïdes topiques, comment traiter (ou ne pas traiter) les infections de la peau, l'acné adulte, le fardeau toujours croissant des kératoses actiniques, les jambes chroniquement rouges, et autres, feront l'objet de discussions se penchant sur les erreurs courantes que nous commettons lors du traitement des patients en dermatologie. Les données probantes sur le traitement et les perles diagnostiques seront partagées afin de nous aider à réduire nos gaffes en dermatologie.

F234 Navigating the Prostate-Specific Antigen Recommendations

11:15–12:15 Fred Arthur, MD, CCFP (EM)

ROOM / SALLE : 512CDGH

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Summarize the existing literature on the use of the prostate-specific antigen test to screen for prostate cancer
2. Understand the recommendations provided by various organizations for the use of the prostate-specific antigen test in general practice
3. Attempt to develop an effective approach for advising your patients on screening for prostate cancer

Description:
The Canadian Task Force on Preventive Health Care recommends against screening for prostate cancer with the prostate-specific antigen test (strong recommendation; low-quality evidence). The Canadian Urological Association, the American Urological Association, and the European Association of Urology continue to advise the use of the test under certain circumstances, especially after shared decision-making. These differences of opinion place family physicians in some difficulty when discussing prostate screening with their patients. In this session we will review the existing scientific literature and the recommendations in detail. It appears that various advisory bodies have arrived at different conclusions after conducting evidence-based reviews of the same literature. We will attempt to review these recommendations from the perspective of the family physician. We will discuss what shared decision making might involve with our patients given our review of the literature.

F239 From Great to Outstanding: Take your medical presentations to the next level

11:15–12:15 Simon Moore, MD, CCFP
All teachers welcome. Highlights advanced concepts for teachers outside the clinical setting.

ROOM / SALLE : 510C

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the published literature on what makes an effective medical lecture and what improves learning outcomes
2. Define pearls and best practices for more effective visual aids (e.g., Prezi, PowerPoint), and overcome presentation pitfalls
3. Discuss presentation tips and pearls from other attendees and share your own

Description:
Over several years of giving highly rated conference presentations (including the well-attended FMF session "Simple Approach to the Red Eye: Evidence, pearls, and medico-legal pitfalls") and hosting multiple conferences and educational events, I have frequently been asked by attendees to give a talk on "how to give a talk." This presentation has been created in response to that request. I will discuss my experiences giving medical lectures and the top negative and positive feedback I (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 medical presentations and learn from others' techniques.

F275 **Supporting Families of Transgender and Gender Non-Conforming Youth:**
11:15–12:15 **The primary care team approach**
Thea Weisdorf, MD, CCFP, FCFP; Sue Hranilovic, NP-PHC; Giselle Bloch

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Increase awareness of gender dysphoria among Canadian youth
2. Explore the systemic, institutional, and individual barriers to accessing gender-safe health care for transgender and gender non-conforming youth
3. Identify the resources and research that validate the importance of family supports in promoting healthy outcomes

Description:
Gender dysphoria among youth has significant deleterious effects and is a challenging issue for family physicians to recognize and manage. Parents of these youth also require an enormous amount of support and do not know if they can turn to their health care providers for help. The entire family can face many obstacles and subsequent harmful and possible traumatic effects at a critical time in their lives. The Ontario government issued a new policy in March 2016 that changed the assessment process for gender-reaffirming surgery, which had required a specialist referral, to include the option of primary care assessments (including those provided by nurse practioners and social workers). This will likely result in more transgender and gender non-conforming (GNC) individuals seeking information and possible assessments from their primary care providers. This session uses a combination of didactic, experiential, and case-based teaching methods. A few of the "pearls of practice" participants obtain include: 1) understanding the three most common developmental periods during which youth are likely to experience gender dysphoria; 2) identifying the families' and caregivers' roles in the transgender and GNC youths' lives, and thus promoting a family-centred approach to their care; 3) identifying the numerous barriers to engaging and retaining transgender and GNC youth in primary care; and 4) gaining proficiency in accessing resources for these patients and their families/caregivers.

F350 **Common Questions and Problems Encountered in Pregnancy**
11:15–12:15 Balbina Russillo, MD, CCFP, FCFP; Lisa Merovitz, MD, FRCS

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Answer common questions pregnant patients ask
2. Identify common bothersome symptoms in pregnant patients and how to assess for serious health concerns
3. Manage common pregnancy symptoms effectively

Description:
This session will identify common questions and concerns during pregnancy. It will be presented in two parts. Part 1: "Will papaya put me into labour?" Snappy answers to strange questions we never learned in medical school. Part 2: Common problems in pregnancy and their management (e.g., dyspepsia, pruritus, headache, vaginal discharge, etc.).

F379 **Sleep Medicine Update: What's new in the world of sleep medicine**
11:15–12:15 Michael Curry, LLB/JD, CCFP (EM), FCLM, FCFP; Atul Khullar, MSc, FRCPC, DABPN, DABSM; Matthew Danchuk, DMD

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify symptoms and conditions that may warrant assessment for a sleep disorder
2. Recognize the role of sleep medicine specialists and how they can assist in managing patients with suspected sleep disorders
3. Distinguish between various treatment options for sleep medicine conditions

Description:
Sleep disorders are common and can often present with subtle and diverse symptoms. Fortunately, there is an array of diagnostic tests, sleep medicine specialists, and therapies that can help manage sleep disorders effectively and promote patient well-being. Sleep medicine covers a wide range of disorders, and while obstructive sleep apnea is an important sleep disorder it is only one of many sleep disorders. Similarly, CPAP therapy, while effective in compliant patients, is only one treatment option for patients with obstructive sleep apnea. Sleep medicine is also a rapidly advancing and dynamic area of medicine and recent developments in sleep medicine will be reviewed and analyzed. This interdisciplinary presentation will be hosted by a family physician and feature Dr. Atul Khullar, a sleep medicine psychiatrist who treats the full range of sleep medicine disorders, and Dr. Matthew Danchuk, a sleep medicine dentist who offers patients both diagnostic assessments and dental treatments that can effectively treat obstructive sleep apnea patients with mild to moderate disease or who are intolerant of CPAP therapy.

F463 **Ready, Steady, … Go! Besrour collaboration to develop mutually relevant research and QI-ready practices**
11:15–12:15 Katherine Rouleau, MD, CCFP, FCFP; Jose Pereira, MBChB, CCFP (PC), MSc, FCFP; Russell Dawe, MD, CCFP; David Ponka, MD, CCFP (EM), FCFP

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the CFPC's Research Ready Practice (RRP) and Quality Improvement (QI) programs
2. Analyze how RRP and QI programs can be applied in Canada and in other settings, such as the Global South
3. Reflect on the impact of RRP and QI programs and the necessary adaptations required for use in other settings

Description:
Family medicine researchers play an invaluable role in producing the evidence that supports effective clinical practice and helps promote the value of family medicine as a cornerstone of health care systems. One of the roles of the Besrour Centre—a hub of collaboration to advance family medicine as a pathway to health equity—is to enable the family medicine research community in the Global North and South to build and maintain connections through collaborative research, scholarship, and QI activities aimed at strengthening family medicine. Over the past five years, the Besrour community has continued to define the scope of family practice around the globe

and has continued to prepare for the dissemination of research skills to family medicine communities around the world. The time has now come for the Besrour Centre to seize the opportunity to harness the knowledge and richness of the Canadian family medicine research community to work towards advancing primary care globally. In this session, the Besrour Centre and members of the CFPC Research department will present the CFPC's emerging RRP and QI programs, while comparing these models to those used elsewhere (particularly the United Kingdom), highlighting both similarities and adaptations for the Canadian reality. Using the lessons garnered by these experiences, the presenters will engage the audience in what research-ready could mean in the Global South and reflect on the types of adaptations and resources that would be required to fit context-specific realities.

F477 **First Five Years of Family Practice: Efficiency and time management in early career**
11:15–12:15 Steve Hawrylyshyn, MD, MSc, CCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the primary factors contributing to inefficiency and poor time management for family physicians
2. Implement strategies to improve efficiency, time management, and personal well-being, beginning in the early stages of practice
3. Demonstrate methods to improve physician well-being and establish work-life balance in early career

Description:
The First Five Years in Family Practice Committee will present a session dedicated to improving practice efficiency and physician well-being, emphasizing early career physicians. The key factors contributing to inefficiency and poor time management of family physicians will be outlined, focusing on challenges facing those in the early stages of practice. Additionally, specific strategies to mitigate the role of these factors in day-to-day practice will be discussed and examined by the group, so attendees leave the session with actionable methods to implement in their own practice. The session will also feature an opportunity for attendees to ask questions and seek advice on specific concerns they experience in their practice.

F545 **La prescription d'exercice pour la prévention et le traitement des maladies chroniques**
11:15–12:15 Pierre Frémont, MD, PhD, FCFP (SEM)

ROOM / SALLE : 522ABC
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Identifier les personnes qui peuvent recevoir, de façon sécuritaire, des recommandations concernant la pratique d'activité physique
2. Effectuer des recommandations d'activité physique adaptées à l'état de santé et à la condition physique initiale des patients
3. Effectuer des recommandations sécuritaires à des personnes souhaitant commencer des activités physiques de haute intensité

Description :
Le participant à cette séance développera une bonne compréhension des données démontrant les bénéfices spectaculaires d'un mode de vie actif et la relation dose-effet observée entre l'exercice et ces bénéfices.
Nous discuterons des craintes, souvent injustifiées, concernant les complications potentielles de l'exercice chez les personnes à risque, une fréquente barrière à la prescription d'exercice par les médecins. Au terme de cette séance, le médecin de famille sera en mesure d'identifier les patients nécessitant une investigation préalable à une prescription d'activité physique. Finalement, le participant saura formuler des recommandations sécuritaires et bien adaptées à l'état de santé et à la condition physique initiale pour des patients souhaitant commencer des activités physiques.

F883 **Advancements in Basal Insulin: Tailoring treatment to patient needs (Ancillary Session)**
12:30–13:30 Jean-François Yale, MD

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize the role of basal insulin therapy in the T2DM treatment continuum
2. Identify and overcome barriers to insulin initiation and optimization from the patient and physician perspective, including hypoglycemia
3. Differentiate basal insulin options, with a focus on the newer basal insulins, and individualize basal insulin treatment based on patient characteristics and insulin profiles

Description:
Basal insulin remains one of the most effective treatments for type 2 diabetes, resulting from its high potency and lack of a dose ceiling. But, as patients and healthcare providers will affirm, it has long been a balancing act between the highs and lows.

Over the course of this session, participants will explore the key barriers to insulin therapy, the latest basal to insulin therapy, the latest basal insulin options, and strategies to individualize insulin therapy in type 2 diabetes. Furthermore, participants will use case-based discussion alongside a workbook to apply new knowledge, and reflect on how the latest insulin options can be integrated into clinical practice to improve patient care.

F106 **Say No to the Candyman and Yes to Non-Pharmacological Chronic Pain Management**
13:30–14:30 Ruth Dubin, PhD, MD, FCFP, DCAPM

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the roles of self-management, mindfulness, and exercise in chronic pain management
2. Access resources to locate or develop non-pharmacological pain programs in your community
3. Feel confident in promoting non-pharmacological modalities to your patients

Description:
Chronic pain is a common and disabling condition that requires holistic management. Overreliance on medications, particularly opioids, has contributed to Canada's crisis of opiate misuse, overdoses, and deaths. Pain patients often expect and receive passive treatment modalities such as medication or interventions. Evidence indicates that people who are actively involved in their treatment do better physically and mentally. The "three Ms" - mind, movement, and (self-)management often trump the other "M"—medication—by improving patient function and self efficacy and minimizing side effects. This presentation will describe the evidence for and benefits of the Stanford Chronic Pain Self-Management Program as well as mindfulness meditation for chronic pain. The role of exercise in reversing central sensitization syndromes (e.g., fibromyalgia, chronic low back pain) will be reviewed with an emphasis on both human and non-human animal studies. We will also review communication strategies to promote these approaches and provide information on the programs described.

F114 **Untangling the Helix 2017: Genomics for primary care providers**
13:30–14:30 June Carroll, MD, CCFP, FCFP; Shawna Morrison, MS, CGC

ROOM / SALLE : 524A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Discuss the opportunities and limitations of direct-to-consumer personal genomic testing as well as the meaning of the results of these tests

2. Understand the role of genetics in autism spectrum disorder
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. Topics will include personalized genomic medicine (direct-to-consumer genetic testing) and autism spectrum disorder. Participants will be introduced to the Genetics Education Canada - Knowledge Organization genomics resource (www.geneticseducation.ca). There will be time for a question-and-answer session, so bring your clinical genetics questions.

F146 **Approach to Depression in Primary Care**
13:30–14:30 **Approche à l'égard de la dépression en soins de première ligne**
Jon Davine, MD, CCFP, FRCPC

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Describe the psychiatric differential diagnosis of the "sad state"
2. Describe the psychopharmacological principles to treat depression optimally using the latest treatment algorithms
3. Describe methods to increase compliance with medications in patients with depression

Description:
In this workshop we will present the psychiatric differential of the "sad state" and comment on different treatments for the various diagnoses. We will then focus on the diagnosis and treatment of a major depressive episode. The use of psychotherapy will be discussed. We will focus on the current literature that deals with the psychopharmacologic treatment of depression. This will include optimal choices of antidepressants. We will discuss how to optimize antidepressant dosing, including starting dosages and methods of increasing dosages. We will discuss the use of augmenting techniques as well as switching from one 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, electroconvulsive therapy, and transcranial magnetic stimulation will be discussed. This will be an interactive session that encourages audience participation. I will take questions throughout the presentation to encourage interaction.

Objectifs d'apprentissage :
1. Décrire le diagnostic différentiel psychiatrique de « l'état de tristesse »
2. Décrire les principes psychopharmacologiques du traitement optimal de la dépression, à l'aide des tout derniers algorithmes thérapeutiques
3. Décrire les méthodes pour encourager l'observance du traitement médicamenteux dans la population de patients dépressifs

Description :
Dans cet atelier, nous présenterons le diagnostic différentiel psychiatrique de l'« état de tristesse », et commenterons les traitements de différents diagnostics. Nous allons ensuite nous arrêter au diagnostic et au traitement des épisodes de dépression majeure et commenter le recours à la psychothérapie. Nous examinerons les publications actuelles sur le traitement psychopharmacologique de la dépression, dont les choix optimaux. Nous poursuivrons avec la façon d'optimiser la posologie des antidépresseurs, en commençant par les doses initiales et les méthodes d'augmentation de la dose. Nous en profiterons alors pour discuter des techniques d'augmentation, de même que du passage d'un antidépresseur à un autre. Nous parlerons de la façon de composer avec les effets indésirables des antidépresseurs. D'autres problèmes comme le recours aux antidépresseurs en pédiatrie, à l'électroconvulsivothérapie (ECT) et à la stimulation magnétique transcrânienne (SMT) seront aussi abordés. La séance est interactive et encourage la participation de l'auditoire. Je poserai des questions durant la présentation afin d'encourager l'interaction.

F203 **Fundamentals of Caring for Adult Victims of Acute Sexual Assault**
13:30–14:30 Susan McNair, MD, MClSc (FM), CCFP, FCFP

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize key elements of the history as well as the body/anal/genital examination required in the assessment of sexual assault victims
2. Identify key elements of the forensic evidence collection, including the interpretation and documentation of blunt superficial trauma
3. Identify key elements of the medical and psychological management of victims of acute sexual assault

Description:
This session will explore the medical management and forensic assessment of adult victims of acute sexual assault. Key elements of the medical and sexual assault history will be highlighted as well as important aspects of the body, genital, and anal examination. Through the use of multiple photographs participants will gain a keen understanding of the blunt superficial trauma commonly found in sexual assault survivors, as well as helpful tips for the documentation of such trauma. Elements of the forensic collection, documentation, and preservation of evidence will be reviewed and their rationale highlighted. Key principles of the medical management will be reviewed, including the required sexually transmitted infection testing in the acute and follow-up settings, prophylactic antibiotics, use of the morning-after pill, and prophylaxis for hepatitis B and HIV. Case examples will be integrated throughout the presentation.

F219 **Pediatric Palliative Care: Pearls for primary care providers**
13:30–14:30 Christina Vadeboncoeur, MD, FRCPC

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe effective ways to support children and the families of children living with diseases with unknown prognoses who are expected to die during childhood
2. Identify issues that arise when young adults are transitioning from pediatric to adult services
3. Evaluate strategies for interactions with non-communicative children and choose tools to enhance the evaluation of symptoms such as pain

Description:
With the aging of the Canadian population, providers are becoming more comfortable with palliative approaches to care. In the pediatric population, advances in technology have led to a growing number of children who survive with complex medical needs. While much of the subspecialty care of these children takes place in tertiary care hospitals, the goal is always to have the child spend as much time as possible at home. Palliative care is often provided to these children alongside acute care to maximize the quality of life for the child and their family. Strengthening the connection between tertiary health care providers and the primary providers who care for the child at home improves the chances that when a decline of health is recognized the child can be supported better in the home environment. Through case examples, participants will learn strategies to support children living with life-limiting illnesses and their families throughout the disease process. The session will facilitate an increased understanding of the challenges to the child, the family, and the provider in dealing with an unknown prognosis. Sources of medication dosing (by weight) will be identified and validated tools to assess symptom evaluation will be discussed. There will also be discussion of the types of issues that arise when a child previously followed by multiple subspecialty services transitions to adult services.

F243 **Research From the Outports: What we've been up to**
13:30–14:30 Cheri Bethune, MD, MClSc, CCFP, FCFP; Tom Heeley, MASP; Shabnam Asghari, MD, PhD; Wendy Graham, MD, CCFP; Patti McCarthy, MSc

ROOM / SALLE : 510D

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the importance of research in rural family medicine
2. Use tips to overcome barriers to research engagement for rural family doctors
3. Identify the way forward with a research agenda

Description:
Background: 6for6 is a unique research skill training program that provides rural physicians from Newfoundland and Labrador, New Brunswick, and Nunavut with support to embark on a research agenda. Originally conceived as a three-year plan of decisive action to address the many barriers to rural physicians engaging in research, 6for6 has excelled and its participants are thriving. **The Workshop:** A small group of 6for6 participants will present a series of mini-presentations on the projects they have conceived as emerging researchers, their progress to date, and barriers they have surmounted along the way. The creators of 6for6 will expand on these, weaving important program perspectives between lectures to give a holistic sense of the scale of each journey. They will then initiate an open discussion with the audience and 6for6 participants on the importance and impacts of research conducted by rural doctors for rural communities. A speed-dating–like activity will follow in which 6for6 creators and participants will rotate among small groups of learners to provide first-hand advice on how to challenge their barriers and start their own research journeys. **Teaching method:** This workshop uses a series of mini-lectures presented by rural family physicians and enriched with small group and whole audience discussion activities.

F244 **Fire Over Ice: In the face of recalcitrant non-genital warts**
13:30–14:30 Lawrence Leung, MBBChir, FRACGP, FRCGP(UK), CCFP

ROOM / SALLE : 522ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the pathology of non-genital warts and reasons for recalcitrance
2. Review the options for treating non-genital warts and their evidence-based studies
3. Understand the mechanisms, indications, and benefits of hyfrecation as a treatment modality for recalcitrant non-genital warts

Description:
Non-genital warts are a common skin condition family physicians encounter in their daily practices. There are various options for treating non-genital warts, including folklore ones (duct tape, garlic) adopted by patients. What is the evidence behind all these treatment options? And when non-genital warts fail to respond to first-line topical treatments and repeated liquid nitrogen applications, what else is there to offer? This presentation will review the pathology of non-genital warts and the evidence for various treatment options, with a focus on hyfrecation as a cost-effective treatment for recalcitrant non-genital warts. Pictures and video from real cases will be presented. This presentation will adopt an interactive format.

F276 **Challenging Dyslipidemia Cases: Using Canadian Cardiovascular Society guidelines to solve common primary care dilemmas**
13:30–14:30 Richard Ward, MD, CCFP, FCFP; John Gregoire, MD, FRCPC, FACC

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Use the Canadian Cardiovascular Society's dyslipidemia guidelines to guide the identification and management of patients with lipid disorders
2. Incorporate a strategy for patients who are statin intolerant
3. Describe the evidence and indications for the use of new therapies to treat high-risk patients with lipid disorders

Description:
This interactive workshop will address common clinical problems demonstrated through real-life cases. Themes discussed will include: screening and risk stratification, lifestyle intervention, treating to target, statin intolerance, and the use of newer medical therapies. The 2016 Canadian Cardiovascular Society (CCS) Guidelines for the Management of Dyslipidemia for the Prevention of Cardiovascular Disease in the Adult will be used to navigate these clinic conundrums, supplemented by the wisdom of cardiology and family practice co-facilitators who are members of the CCS Dyslipidemia Guidelines Panel. Where relevant, differences between the "simplified lipid guidelines" for primary care and the CCS guidelines will be highlighted and discussed.

F296 **Wrestling With Osteoporosis: Challenging cases and controversies**
13:30–14:30 Sidney Feldman, MD, CCFP (COE), FCFP; Lynn Nash, MD, CCFP, FCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Decide on appropriate management for the patient at moderate risk of fracture
2. Choose which patients should consider an osteoporosis treatment drug holiday and which patients should not
3. Balance the risks and benefits of osteoporosis treatment

Description:
There continue to be many challenges and controversies in caring for patients with osteoporosis. In this evidence-based interactive workshop that uses a case-based approach, we will focus on challenging cases including what to do with the patient who is at moderate risk, when a drug holiday is appropriate (and when it is not), and what to do with the patient who has incurred a fracture while on osteoporosis treatment. Participants will be encouraged to raise their own challenging cases and controversies for group discussion.

F299 **PALS/NRP Update: Saving tiny lives in 2017**
13:30–14:30 Andre Jakubow, MD, CCFP (FPA)

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. State the initial steps to take when resuscitating critically ill children (Pediatric Advanced Life Support) and newborns (Neonatal Resuscitation Program)
2. Describe the main changes to Pediatric Advanced Life Support and Neonatal Resuscitation Program guidelines contained in this year's updates
3. Strengthen the use of good practices in resuscitation team dynamics and crew resource management

Description:
In this engaging, fast-paced session led by a family physician-anesthesiologist and certified Pediatric Advanced Life Support (PALS) instructor, we will review the latest changes in Neonatal Resuscitation Program and PALS resuscitation guidelines and invite the audience to reintegrate these best practices in resuscitating critically ill children and newborns into their heat-of-the-moment thoughts and actions. This session will be most useful for family and emergency physicians who want to be more confident in their assessment and treatment of critically ill children and newborns, for those curious about what has changed since their last update course, and for all health care providers who encounter kids with respiratory, circulatory, or combined emergencies.

F353 **Que faire lors de désaccords entre les perceptions d'un apprenant et d'un enseignant ?**
13:30–14:30 Bernard Martineau, MD, FCCMF, PhD; Gilles Girard, MPs; Steve Balkou, MPs
Tous les enseignants sont les bienvenus.
Cette séance fait le point sur les concepts avancés pour les superviseurs cliniques.

ROOM / SALLE : 510C

Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :

1. Expliquer la pertinence de mettre en évidence et corriger le cadre cognitif de l'apprenant pour gérer les désaccords
2. Utiliser une intervention ciblée pour gérer ce type de désaccord
3. Identifier des conditions gagnantes pour faciliter ce type d'intervention dans la relation enseignant-apprenant

Description :

Il s'agit d'un atelier interactif bâti sur mesure pour répondre à la question suivante : que faire faire lorsqu'il y a désaccord sur la performance d'un apprenant (p. ex., plainte, désaccord avec le feedback de l'enseignant ou d'un autre professionnel de l'équipe)? Ce questionnement est rencontré fréquemment par les enseignants qui enseignent la communication patient-médecin-famille dans divers milieux, allant de la formation initiale à la résidence. À l'aide d'un mode d'intervention proposé par les animateurs, les participants auront l'occasion de pratiquer la gestion de ce type de désaccord lors de jeux collectifs, au cours desquels les animateurs seront à la fois joueurs et coachs.

F405 Ophthalmology in the Family Physician's Office

13:30–14:30 Jennifer Leverman, MD, CCFP (EM)M)

ROOM / SALLE : 514ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Learn to recognize and treat common eye complaints
2. Learn to recognize rare but important eye complaints
3. Refine your eye exam

Description:

Eye complaints are common in the family medicine office. This session will help participants recognize and treat these complaints. The approach will be case-based with lots of pictures.

F415 Managing Oral Anti-Estrogen (Hormonal) Breast Cancer Therapy: A guide for family physicians

13:30–14:30 Mary DeCarolis, MD, MCFP, CFE

ROOM / SALLE : 512ABCF

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Discuss with a patient the benefits of anti-estrogen therapy and the indications for adjuvant bisphophonate therapy
2. Explain to a colleague when a selective estrogen receptor modulator (tamoxifen) or an aromatase inhibitor is used
3. Describe the common side effects of anti-estrogen therapies and their management

Description:

About 80 per cent of women with breast cancer are prescribed oral anti-estrogen (hormonal) therapy after their chemotherapy and/or radiation. With these patients increasingly being transferred back to their family physicians for follow-up, understanding the choices and issues around anti-estrogen therapy is important for family physicians. Should a patient receive five or ten years of therapy? Should a bisphosphonate be started? With the aid of a case-based approach, this presentation will highlight common issues faced by the family physician in supervising and troubleshooting this important part of breast cancer treatment.

F496 Want to Teach? A workshop focusing on teaching skills development for new teachers

13:30–14:30 Jamie Wickett, MD, CCFP; Daniel Grushka, MD, MSc, CCFP (EM)
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 510A

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand and use the One-Minute Preceptor model and SNAPPs with learners
2. Provide effective feedback to learners
3. Develop an approach to teaching procedures

Description:
Family physicians and family medicine residents are frequently involved in teaching medical students and residents. Therefore, understanding some core teaching concepts and techniques is essential. This workshop will provide new teachers in family medicine with some key skills to help them become effective teachers. The following will be covered during the session: the five microskills of the One-Minute Preceptor model; a review of SNAPPS; key elements of providing effective feedback; and an approach to teaching procedures. The workshop learning objectives will be met using a variety of techniques including interactive discussions with participants, reviewing AV vignettes, and a PowerPoint presentation.

F513 **Canadian Family Medicine Influence on Canada's International Assistance Policy**
13:30–14:30 François Couturier, MD, MSc, CCFP; Katherine Rouleau, MD, CCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the orientations of the three memoirs submitted to the Minister in charge of Global Affairs Canada
2. Describe Global Affairs Canada priorities in international development for health
3. Explore the possibilities for Canadian family medicine to assist the development of primary health care and family medicine in low-income countries

Description:
Health systems based on primary health care (PHC), supported by a family medicine specialty responsive to population needs, can improve individuals' and communities' health and reduce the negative impact of inequities on health. This has been observed in high- and middle-income countries committed to PHC and family medicine. It is not so clear in low-income countries where major international and global health agencies and funders mostly focused their attention on vertical programs centered on specific diseases and conditions, or specific medication and technology. Strengthening PHC-based health systems and training health professionals for a proficient, comprehensive system centred on patients and rooted into the communities have been neglected. In June 2016, the Canadian government launched a series of public consultations to renew Canada's international assistance policy and funding framework. The Besrour Centre and the faculties of medicine at the Toronto and Sherbrooke universities answered this call. Memoirs from the three institutions emphasized the importance of supporting the development of robust and professionalized PHC anchored in communities to respond to women, girls, and child needs, especially regarding sexual and reproductive rights. The purpose of this session is to engage the community of family physicians to reflect on the role our discipline can assume to improve population and individual health in low-income countries. This session also aimed at everyone interested in improving PHC and family medicine everywhere and to support the social accountability of the Canadian engagement.

F541 **Concussions: Implications of the new 2017 recommendations on your practice**
13:30–14:30 **Commotions cérébrales : Incidences des nouvelles recommandations de 2017 sur votre pratique**
Pierre Frémont, MD, PhD, CCFP (SEM), FCFP

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Apply the recommendations published in 2017 regarding concussions to the practice
2. Provide a medical recommendation about returning to an activity or sport at risk of concussion
3. Integrate practical tools that will facilitate concussion management in the practice

Description:
Whether or not concussion is a familiar area of practice for you, this session will present the main recommendations of the Berlin consensus meeting published in 2017 and will explain the practical implications that these recommendations should have on concussion management in a primary care practice. The practical implications of recommendations recently issued by the main concussion initiatives in Canada will also be presented. Finally, a practical tool that could facilitate the management of concussions by the family physician will be presented.

Objectifs d'apprentissage :
1. Appliquer à sa pratique les recommandations publiées en 2017 sur les commotions cérébrales
2. Faire une recommandation médicale concernant le retour à une activité ou à un sport comportant un risque de commotion cérébrale
3. Intégrer dans sa pratique des outils qui faciliteront la prise en charge des commotions cérébrales

Description :
Quel que soit votre niveau d'expérience clinique en ce qui a trait aux commotions cérébrales, cette séance vous présentera les principales recommandations émanant de la réunion de consensus de Berlin publiées en 2017. Elle expliquera les incidences pratiques que ces recommandations devraient avoir sur la prise en charge de la commotion cérébrale dans la pratique des soins primaires. Il sera également question des incidences pratiques des recommandations émises récemment dans le cadre des principales initiatives canadiennes liées à la commotion cérébrale. Enfin, un outil pratique qui pourrait aider les médecins de famille dans la prise en charge des cas de commotion cérébrale sera présenté.

F547 Family Medicine Resident and Medical Student Leadership Workshop

13:30–17:15 Louise Nasmith, CCFP, FCFP; Ian Scott, CCFP, FCFP

ROOM / SALLE : 513EF

Mainpro+ Group Learning certified credits = 3

By invitation only.

Learning objectives:
1. Develop leadership attributes and skills
2. Discuss models 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 is led by two of the College's most talented leaders and educators, Dr. Louise Nasmith and Dr. Ian Scott. The workshop is offered by invitation only.

F60 What is New in COPD: Times are changing!

15:00–16:00 Alan Kaplan, MD, CCFP (EM), FCFP

ROOM / SALLE : 517D

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Review how to diagnose COPD and assess severity
2. Review pharmacotherapies, both old and new
3. Review non-pharmacotherapeutic strategies for COPD patients, as these are often omitted

Description:
Chronic obstructive pulmonary disease (COPD) is the number two current cause of morbidity and number three cause of death. Early identification of the patient with COPD can make a difference to their long-term outcomes. Spirometry is the diagnostic test, but there are true barriers to its utility. Management includes non-pharmacologic therapies including

smoking cessation, rehabilitation, and vaccination, as well as the management of comorbidities. Pharmacotherapy options have exploded with many new meds in many new devices and, excitingly, the paradigms of therapy are changing. You need to learn these lessons to optimize therapy for these vulnerable patients in your practice.

F125 **Trans-forming Your Practice: An introduction to transgender medicine**
15:00–16:00 Ted Jablonski, MD, CCFP, FCFP; Ed Kucharski, MD, CCFP, FCFP; Rick Ward, MD, CCFP, FCFP

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the basics and challenges of transgender medicine
2. Manage patients before, during, and after medical transition with appropriate medical protocols
3. Describe the spectrum of transition-related surgeries

Description:
Transgender patients are now a part of many busy family practices and most primary care practitioners would like to be considered "trans-friendly" today. There are significant challenges in dealing with this often marginalized population, including unusual hormonal protocols, complex transition-related surgeries, and confusion regarding proper screening. These are all superimposed on language and terminology, which seems to perpetually change. Through live and video presentation in a question-and-answer format, this highly interactive session will provide a solid knowledge base to help you treat your transgender patients. This session will focus on the appropriate lexicon and nomenclature of the transgender world and will provide a practical and clinically based approach to the diagnosis and treatment of medical and surgical transition. Primary presenter, Dr. Ted Jablonski is an award winning family physician based in Calgary. Ted has a special interest in CHE for physicians, medical professionals and has been involved in the creation and delivery of a wide range of programs at provincial, national and international levels. In addition to family medicine, Dr Jablonski has done consultant work in sexual and transgender medicine for Southern Alberta and central British Columbia for over a decade. "dr j" is a sought after musical entertainer, trainer, media spokesperson and educator with many conference, radio, television and video credits. This program was developed for a national primary care audience by the non-profit group Alliance for Best Practices in Health Education, whose mission is to create outstanding evidence-based medical education.

F129 **Management of Common Chemotherapy Complications for the Family Physician**
15:00–16:00 Anna Wilkinson, MSc, MD, CCFP

ROOM / SALLE : 512ABCF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Learn the basics of chemotherapy
2. Demostrate an understanding of possible short-term side effects of chemotherapy and their appropriate management
3. Recognize remote effects of chemotherapy and appreciate appropriate managment

Description:
Family physicians are increasingly involved in the care of patients with cancer, both during and after treatment or on an ongoing palliative basis. Unfortunately, there is limited education for family physicians around oncology basics, specifically with respect to short- and long-term side effects of treatment. This talk will explore the management of acute side effects of chemotherapy, such as nausea, vomiting, and febrile neutropenia, as well as some of the lesser-known side effects of the newer biologic agents. Long-term side effects of treatment will also be explored, with an emphasis on cardiotoxicity, secondary malignancies, and ongoing side effects of hormonal therapies. This review of common chemotherapy complications is intended to increase the comfort level of family physicians caring for patients with cancer and cancer survivors in their practice.

F153 **Better Decision Making with Patients on the Harms and Benefits of Preventive Screening**
15:00–16:00 Neil Bell, MD, SM, CCFP, FCFP; Jim Dickenson, MBBS (Qld), CCFP, PhD; Roland Grad, MD, MS, FCFP; Brett Thombs, PhD

ROOM / SALLE : 522ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe and interpret the potential harms, benefits, and trade-offs associated with preventive screening
2. Explore and assess how patient values and preferences can influence decision making on preventive health screening
3. Demonstrate and implement shared decision making on preventive health screening with patients

Description:
Family physicians make frequent decisions on preventive screening with their patients. Many preventive screening activities provide clear benefits to patients. However, in others, such as screening for breast, prostate, or cervical cancer, there are potential trade-offs between the harms and benefits of screening. Patients may overestimate the benefits and underestimate the harms associated with preventive screening and physicians may have difficulty effectively communicating the risk of harms and benefits to patients. Patient preferences and values play an important role in considering the potential harms and benefits and could alter decisions on preventive screening. One strategy to improve decision making in preventive screening in circumstances when there is a trade-off between harms and benefits is shared decision making (SDM) between physicians and patients. SDM is a process whereby clinicians help patients reach value-congruent health decisions. SDM offers a structure for incorporating patient values and preferences in screening decisions. This workshop will help family physicians develop and implement SDM skills and the assessment of patient preferences and values in preventive screening with their patients. This will be undertaken through individual assessment of illustrative case examples, participation in SDM activities, and group discussion. Participants will develop skills in describing and interpreting the potential harms, benefits, and trade-offs associated with preventive screening. Participants will have an increased ability to assess and interpret outcome measures and harms such as false positives and overdiagnosis associated with preventive screening and examine approaches to better communicate risk of benefits and harms to patients. Participants will explore and participate in SDM activities and discuss how patient values and preferences could influence or alter the trade-offs in decision making by patients on preventive screening manoeuvres.

F163 **"Timber!": A common sense approach to syncope**
15:00–16:00 Filip Gilic, MD, CCFP (EM)

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the physiology underlying syncope
2. Identify high-risk features on history, physical, and ECG
3. Appropriately disposition and investigate syncope patients

Description:
This session wil review the clinically relevant physiology that enables adequate perfusion of the brain and the types of transient disruptions that can lead to syncope. Based on the physiology, participants will understand which history, physical, and ECG findings are important to elicit and review and, based on these findings and demographic factors, understand those that would allow them to disposition and investigate syncope patients efficiently and accurately.

F171 **Management of Hepatitis C in Primary Care: New treatments, tools, and practice pearls**
15:00–16:00 Vikky Qi, MD, CCFP

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Apply knowledge of new treatments for hepatitis C virus to identify and prepare patients considering treatment
2. Use practical guidelines to monitor chronic hepatitis C infection in practice before, during, and after treatment
3. Demonstrate an understanding of important management issues in end-stage liver disease/cirrhosis in primary care

Description:
Hepatitis C virus (HCV) is a preventable and treatable chronic disease and a major cause of end-stage liver disease in Canada. New treatments are evolving rapidly and offer many patients increased rates of cure. Family physicians are ideally placed to help patients prepare for treatment in the context of ongoing primary care and from within a chronic disease management framework. This interactive, case-based, and practical seminar will introduce participants to useful monitoring protocols for chronic HCV as well as pearls and management guidelines that can easily be incorporated into practice. The presenters are family physicians who have extensive experience in the management and treatment of HCV in the primary care context.

F245 **Approach to Psychosis in Primary Care**
15:00–16:00 Jon Davine, MD, CCFP, FRCPC

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Ask relevant questions to make the diagnosis of psychosis
2. Determine how to make a differential diagnosis in psychosis
3. Implement psychopharmacologic treatment of psychosis

Description:
Though psychosis represents a small percentage of what family doctors have to deal with, it is important that they have skills in diagnosing and treating these disorders. The learning objectives of this workshop involve understanding the definition of psychosis, learning how to ask the appropriate questions to make the diagnosis, and understanding the differential diagnosis of psychosis from both an organic and psychiatric viewpoint. A grid will be presented to help participants understand how asking about delusions, hallucinations, and "downward drift" will help the physician arrive at the correct psychiatric diagnosis for the psychotic patient. Finally, up-to-date psychopharmacologic approaches for the treatment of these disorders will be discussed. There will be an interactive didactic presentation and then participants will split into small groups to work on issues in psychosis from a prepared case. I will take questions throughout this presentation to encourage interaction. A large group discussion will follow.

F266 **Prenatal to Postpartum Care: Navigating evolving guidelines**
15:00–16:00 **Soins prénataux et post-partum : Naviguer les changements aux lignes directrices**
William Ehman, MD; Debra Boyce, MD, CCFP, FCFP

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Describe essential prenatal/postpartum care recommenations and the rationale for them
2. Develop strategies for incorporating the recommendations into routine perinatal care
3. Identify the purpose, content, and method of the new National Antenatal-Postpartum Collaborative Educational Program

Description:
This 60-minute presentation is provided in two parts. The first is a review of current evidence-based prenatal and postnatal maternity care. This will include how a standardized perinatal record can assist in the collection and documentation of care. The second part is a presentation of the new national Collaborative Prenatal and Post-Partum Care Educational Program that has been developed with contributions from the College of Family

Physicians of Canada, the Salus Global Corporation, the Canadian Association of Midwives, the Canadian Association of Perinatal and Women's Health Nurses, and the Society of Obstetricians and Gynaecologists of Canada. The purpose of this program is to identify gaps in existing educational and practice resources in antenatal/postnatal care and develop, implement, and maintain a program that will support all clinicians who provide antenatal/postnatal care.

Objectifs d'apprentissage :
1. Décrire les recommandations essentielles en soins prénataux et post-partum et leur justification
2. Formuler des stratégies pour incorporer les recommandations dans les soins périnataux de routine
3. Identifier l'objectif, le contenu et la méthode du nouveau programme national collaborateur d'éducation en soins prénataux et post-partum

Description :
Cette présentation de 60 minutes compte 2 volets. Le premier est un compte-rendu des données probantes actuelles sur les soins de maternité et prénataux. Cela inclut comment un dossier périnatal normalisé peut contribuer au recueil et à la documentation des soins. Le deuxième volet présente le nouveau programme national collaborateur d'éducation sur les soins prénataux et post-partum ayant été mis au point en collaboration avec le Collège des médecins de famille du Canada (CMFC), Salus Global Corporation (MOREOB), l'Association canadienne des sages-femmes (ACSF), l'Association canadienne des infirmières et infirmiers en périnatalité et en santé des femmes (CAPWHN) et la Société des obstétriciens et gynécologues du Canada (SOGC). Ce programme vise à reconnaître les lacunes des ressources existantes d'éducation et de pratique en soins de maternité et postnataux, et d'élaborer, de mettre en application et de maintenir un programme qui prête assistance à tous les cliniciens qui dispensent des soins de maternité et postnataux.

F285 **Trouver l'équilibre entre l'apprentissage des résidents et la sécurité des patients**
15:00–16:00 Gabrielle Trépanier, MD, CCMF(MU)
Tous les enseignants sont les bienvenus.
Cette séance fait le point sur certains concepts de base et avancés pour les superviseurs cliniques.

ROOM / SALLE : 510C
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Appliquer les critères juridiques de délégation d'actes médicaux dans leur pratique
2. Utiliser des stratégies pour diminuer les risques lors de la supervision des résidents
3. Sensibiliser les résidents à la culture de sécurité des patients

Description :
Dans les milieux universitaires, les médecins-patrons travaillent de façon quotidienne avec des résidents de différents niveaux de formation. Ces interactions routinières au chevet du patient soulèvent cependant de nombreuses questions d'ordre juridique. Comment un acte médical peut-il être délégué? Quel équilibre doit-on préconiser entre l'apprentissage de nos futurs médecins et la sécurité des patients? Qui assume la responsabilité lorsqu'un résident commet une faute? Comment transmettre la culture de sécurité des patients à nos résidents? Comment responsabiliser nos résidents vis-à-vis de l'obligation de suivi? Et finalement, comment diminuer les risques lors du travail quotidien avec les résidents? Cet atelier propose une approche par cas cliniques véridiques, avec la participation active de l'auditoire. Les participants pourront partager leurs expériences et les difficultés rencontrées lors de la supervision des résidents. Ils repartiront avec des outils cliniques pour améliorer la sécurité des patients lors du travail avec les résidents et diminueront du même coup les risques médicolégaux reliés au travail avec les résidents. La présentatrice est professeure adjointe au Département de médecine de famille et de médecine d'urgence de l'Université de Sherbrooke. Elle complète présentement une maitrise en droit et politiques de la santé à l'Université de Sherbrooke.
La professeure est également responsable du thème médicolégal du programme de doctorat en médecine de l'Université de Sherbrooke. Finalement, elle a fait la formation ASPIRE sur la sécurité des patients dans la formation des résidents.

F309 **Common Adolescent Problems: Sorted in the family doctor's office in 15 minutes**
15:00–16:00 Patricia Windrim, MD, CCFP, MHSc; Karen Weyman, MD, CCFP, FCFP; Sarah Chadwick

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the practical use of the HEADS tool to identify adolescent issues
2. Identify risk factors that require intervention in primary and secondary prevention
3. Explore appropriate multidisciplinary resources for the adolescent population

Description:
The health status of adolescents is typically good when measured by traditional outcome measures and their use of health care services is low compared with all other groups. Many of the problems facing adolescents, however, and the disability and mortality associated with them are related to preventable high-risk behaviours rather than disease. Nearly 60 per cent of adolescent deaths are due to accidents and homicides and another 18 per cent are due to suicide. Part of the risk-taking is based on the desire for peer acceptance, impulsivity, and a lack of experience. Adolescence is therefore a critical period for intervention and health promotion. It is a time when adolescents are making lifestyle choices and assuming responsibility for their own health. It is a period of great change, not only biological but also psychological and social. These changes inevitably provoke tensions and stress, not only for the individual adolescent but also for their family. This emphasizes the need to be aware of adolescent health issues, both medical and psychological, so they can be addressed in routine office visits . It also emphasizes the need to develop physician-adolescent communication skills and increase physician understanding of the problems faced by the adolescent and their family. Participants will learn to use the HEADS questionnaire, a validated tool, to identify these issues and mitigate some of these risks.

F325 **Assessing and Understanding Challenging Behaviours in Patients with Cognitive Impairments: Tools and tips**
15:00–16:00 Karen McNeil, MD, CCFP, FCFP; Donna Lee, MA; Jillian Achenbach, MD, CCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the function of a patient's behaviour by using behavioural assessment tools
2. Apply key narratives to motivate the patient, caregivers, and family to engage in a behaviour management plan
3. Develop and implement a management plan to address these behaviours in collaboration with the patient, caregivers, and family

Description:
Patients with impaired cognition often communicate through behaviour. Understanding the functions of these behaviours allows us to hear our patients' voices and respond to their needs. Such behaviours can pose a risk to the patient, their families, and/or the community. Historically, the behaviour of people with impaired cognition has been misunderstood to be simply a symptom of the disability or an inappropriate effort to manipulate caregivers. However, these hypotheses can neglect the important information communicated by behaviour. Assessing and responding to the specific function of behaviour can lead to a greater understanding of the patient's health needs, improve emotional well-being, promote self-determination, and decrease the incidence of high-risk behaviours. Physicians providing primary care to individuals with impaired cognition frequently identify a need for education regarding challenging behaviours. This workshop will use a combination of didactic teaching and case-based discussion to introduce concepts and practical assessment tools behavioural specialists use when working with this population. Participants will be provided with a framework for establishing a behaviour management plan that can be implemented in collaboration with the patient, caregivers, family, and allied health professionals. The discussion will include resources for patients and caregivers and how to re-evaluate patients in follow-up.

F371 **An Effective Dietary Intervention For Diabetes/Obesity: Fat is in and carbs are out!**
15:00–16:00 Dax Biondi, MD, CCFP, MSc

ROOM / SALLE : 524B
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Learn a one-minute intervention designed for your busy office that will help your patients lose weight easily
2. Describe the scientific evidence for why fat is in and carbs are out for weight loss and glycemic control
3. Appreciate results from my practice prescribing a low-carb, high-fat diet to my patients with insulin resistance

Description:
One in three Canadians is obese and prediabetic or diabetic. Front line health professionals have done little to curb this epidemic. We sincerely counsel our patients on calorie reduction and active lifestyle; when patients fail, we consider pharmacotherapy or even bariatric surgery. We have failed because we treat obesity as a behavioural problem. Obesity is actually a hormonal disease driven by insulin resistance. When counselled on carbohydrate restriction, patients lose weight effectively, safely, and sustainably. In an average of eight months in my family practice, 67 patients with a BMI greater that 30 lost an average of 24 lbs per person. Forty-five patients with diabetes lost an average of 22 lbs per person, with an average HbA1c reduction of 1.1 per cent, with a significant reduction in diabetes medication burden. Low carbohydrate, high/healthy fat diet counselling results in decreased triglycerides, increased HDL, equivocal LDL, decreased blood pressure, decreased central obesity, and weight loss. Whether you are curious, skeptical, or keen, you will walk out from this presentation ready to use this intervention.

F449 **What Do You Know About Delirium and Palliative Sedation at End of Life?**
15:00–16:00 Mireille Lecours, MD, CCFP (PC); Janet Baker, MD, CCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Be able to screen for and recognize delirium at end of life
2. Understand the place of palliative sedation therapy in the spectrum of end-of-life care
3. Understand the ethical and legal issues involved in the practice of palliative sedation therapy

Description:
This session will examine the spectrum of palliative care in relation to end-stage disease burden, in particular delirium. While reviewing possible treatments, including medical and nonmedical, we will discuss the use of palliative sedation therapy in this setting. At the end of this session each participant will be able to screen for and recognize delirium. Each participant will have an understanding of the impact of delirium on the patient, their caregivers, and the health system. Each participant will understand the place of palliative sedation therapy in the spectrum of end-of-life care. Each participant will have an understanding of the ethical and legal issues involved in the practice of palliative sedation therapy and will work through a sample palliative sedation therapy worksheet.

F455 **Skill-Based Reflective Practice Teaching: An innovative approach using the Procomp Tool Kit**
15:00–16:00 Patricia Seymour, MD, CCFP; Michael Gallea
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize an innovative method of reflective practice teaching currently used in the UBC Integrated Clerkship Program
2. Explore the use of Procomp flashcards in a small group mock reflective practice session
3. Reflect on how this method could be used in teaching reflective practice in other settings

Description:
The Professional Competencies (Procomp) Tool Kit is an applied, skill-based approach to teaching reflective practice to medical students. The Procomp Tool Kit is a set of 28 cards divided among six broad domains of professional competency. The purpose of the Procomp Tool Kit is to promote the development of reflective skills as an integral part of a student's clinical skills and knowledge acquisition in a manageable, bite-size, and habit-based fashion. The Took Kit was piloted at a small Integrated Community Clerkship (ICC) site on Vancouver Island, Canada, in 2012/2013, then rolled out to all six University of British Columbia (UBC) ICC sites in the 2013/2014 academic year. Each site has customized the delivery of the program to suit their setting while maintaining the overarching goals of the program. Although the program has been used to this point at UBC only at the clerkship level, we feel it could be a valuable tool to aid in teaching reflective practice and professionalism at a resident level and as a faculty development tool. Over the past five years the Procomp program has provided an effective way to take the broad domains of professional competency and ethics into the day-to-day experiences of our learners. Feedback from current and past students has been very positive, and the skills they learned have endured into residency and practice.

F507 **Challenges in Menopause Management**
15:00–16:00 **Défis liés à la prise en charge de la ménopause**
Susan Goldstein, MD, CCFP, FCFP, NCMP

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Take a structured approach to the assessment of the peri/menopausal patient
2. Make treatment recommendations for common symptoms associated with perimenopause/menopause
3. Address management challenges in treating perimenopausal and menopausal women

Description:
Over a decade following the Women's Health Initiative study, physicians are becoming comfortable once again in treating symptomatic menopausal women. However, the Initiative left a void in training physicians in menopausal management and many physicians struggle with the how to's of treatment. How to assess, treat, counsel, and manage treatment regimens and potential adverse events will be explored through the of use of patient cases.

Objectifs d'apprentissage :
1. Adopter une approche structurée d'évaluation des patientes en périménopause ou ménopausées
2. Émettre des recommandations thérapeutiques pour traiter les symptômes courants liés à la périménopause ou à la ménopause
3. Résoudre les problèmes liés au traitement des femmes en périménopause et ménopausées

Description :
Plus de dix ans après l'étude *Women's Health Initiative*, les médecins redeviennent à l'aise de traiter les femmes ménopausées qui présentent des symptômes. L'étude WHI est cependant restée muette en matière de formation des médecins sur la prise en charge de la ménopause et beaucoup de médecins avouent avoir de la difficulté avec « le comment » du traitement. Par l'intermédiaire de cas de patientes, la séance aborde comment évaluer, traiter, conseiller et prendre en charge les schémas thérapeutiques et les effets indésirables potentiels.

F123 **Teaching Professionalism: Incorporating concepts of professional identify formation,**
15:00–17:15 **patient safety, and collegial conversations**
James Goertzen, MD, MClSc, CCFP, FCFP
All teachers welcome. Highlights advanced concepts for clinical preceptors.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the impact of unprofessional or disruptive behaviour on patient safety
2. Demonstrate the relationship between professional identify formation and professionalism
3. Identify tools and strategies to address professional lapses and disruptive behaviour by both learners and colleagues

Description:
Professional lapses and unprofessional behaviour negatively affect learners, preceptors, individual practitioners, colleagues, and health care team members. Although learner unprofessional behaviour often results in preceptor angst, recent concepts on the relationship between health care professional identity formation and professionalism provide a framework for the development of relevant educational activities for teaching professionalism. Unprofessional behaviour or disruptive behaviour have also been shown to negatively affect both the delivery of quality health care and patient outcomes by eroding effective communication and collaboration. Thus, all members of the health care team, including both preceptors and learners, have a shared responsibility in addressing the unprofessional aspects of the hidden curriculum. In spite of professionalism being a core competency for medical students, residents, and practising physicians, teaching professionalism is often haphazard. Preceptors have a critical role in assisting learners with their professional development, including the support of key transitions in their professional identify formation. Lapses in professional behaviour by students and residents are common and to be expected as they integrate the principles of professionalism within the clinical setting. A lapse provides an opportunity to have a collegial conversation to better understand the learner's context and rational for their behaviour. Collegial conversations encourage reflection, assimilation of new professional behaviours, and the development of relevant future educational activities.

F291 Practice-Based Research for Beginners: Research redefined, simplified, demystified

15:00–17:15

Anwar Parbtani, MD, MSc, PhD, FCFP; Matthew Orava, MD, MHSc, CCFP; Deirdre Snelgrove, MA; José Pereira, MBChB, CCFP (PC), MSc, FCFP

ROOM / SALLE : 510D

Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Understand the basic concepts of research in the context of primary care practice
2. Learn to formulate, critique, and refine a research question and develop it into a proposal
3. Become familiar with the research-ready and QI programs implemented by the Research Department at the CFPC

Description:
Introduction: Family medicine is perpetually evolving as novel diagnostic/therapeutic modalities are envisaged and old dogmas are challenged. A family physician is expected to keep abreast of the shifting practice paradigm through systematic reviews of current practice modalities. This aligns with a component of the CanMEDS-FM curriculum, the "family physician as a Scholar," and is the crux of practice-based research, which melds with quality improvement (QI) initiatives. However, there is reluctance among family physicians to engage in research, which stems from the misperception that research is a complex exercise that is alien to clinical practice and a domain of academic institutions. To dispel this misperception the Research Department at the CFPC has embarked on implementing a research-ready and a QI program to encourage research and QI practices "in the trenches." Our workshop complements these initiatives. Objectives: To dispel misperceptions about research in primary care practices and enthuse participants to incorporate practice-based research and QI as parts of their clinical practices. Target audience: Family physicians, allied health care professionals, residents/trainees, new researchers. Methods: An interactive workshop with three parts: 1. Presentation by moderators defining "research" in the context of clinical practice and creating awareness of the CFPC's research-ready and QI initiatives (15 minutes); 2. Hands-on exercise with participants divided into three to four groups (60 minutes) to: a) formulate a research question by each group; b) refine one or two questions using FINER, SMART, and PICO processes and through inter-group discussions; and c) provide a briefing on methodology (proposals for research and "ethics" reviews, data collection and analysis, avoiding undue complexities); and 3. Wrap-up (15 minutes). Expectations: At the

end of this workshop session the participants will have an enhanced understanding of research/QI in context of primary care practice, and awareness of the CCFP's research-ready and QI initiatives. This workshop may also result in participants forging long-term collaborations.

F105 **Update on the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain**
16:15–17:15 **Mise à jour sur les Recommandations canadiennes 2017 sur l'utilisation des opioïdes pour le traitement de la douleur chronique non cancéreuse**
Lydia Hatcher, MD, CCFP, FCFP, CHE

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Incorporate the latest recommendations and best practices from the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
2. Use best practice tools based on evidence and expert opinion for opioid use according to the 2017 guideline
3. Describe side effects and risks of high-dose opioid use and techniques to safely taper or discontinue opioids

Description:
This session will provide an update on the newly released 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. There will be a discussion of best practice statements, specific practice tools, and the evidence-based recommendations to help you manage your chronic pain patients. These guidelines will help you deal with patients who are being considered for a trial of opioid therapy, a taper of therapy, or a discontinuation of opioid therapy.

Objectifs d'apprentissage :
1. Intégrer les pratiques exemplaires tirées des Recommandations canadiennes sur l'utilisation des opioïdes chez les patients souffrant de douleurs chroniques
2. Faire appel aux pratiques exemplaires appuyées par des données probantes et aux conseils d'experts pour l'utilisation des opioïdes, conformément aux recommandations 2017
3. Décrire les effets secondaires et les risques liés à une forte dose d'opioïdes ainsi que les techniques permettant de réduire graduellement ou de cesser leur utilisation sans danger

Description :
Cette séance présentera une mise à jour sur les nouvelles Reccomandations canadiennes 2017 sur les opioïdes. Elle donnera lieu à une discussion sur les énoncés de pratique, les outils particuliers pour la pratique et les recommandations axées sur les données probantes pour vous épauler dans la prise en charge de vos patients souffrant de douleurs chroniques. Ces recommandations vous aideront à soigner vos patients pour qui on envisage un essai du traitement par opioïdes, une réduction graduelle de la thérapie ou la fin d'un traitement par opioïdes.

F214 **Intrapartum Skills: A refresher of specific skills**
16:15–17:15 William Ehman, MD; Kevin Desmarais, MD, CCFP; Amanda Loewy, MD, CCFP; Kate Miller, MD, CCFP, FCFP; Sudha Koppula, MD, CCFP, FCFP; Amanda Pendergast, MD, CCFP, FCFP; Balbina Russillo, MD, CCFP, FCFP; Michelle Khalil Abou, MD; Heather Baxter, MD, CCFP, FCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Perform hands-on skills such as vacuum-assisted birth, management of shoulder dystocia, somersault manoeuvre for nuchal cords, unexpected breech, etc.
2. Perform Foley catheter cervical insertion for induction of labour
3. Manage postpartum hemorrhage

Description:
This interactive, hands-on session will provide participants with an opportunity to develop 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, and the somersault manoeuvre for a tight cord. Additional skills such as the placement of the Foley catheter for induction and the management of postpartum hemorrhage will be offered as part of this session.

F216 **Seniors Living With Frailty: Identification and management strategies in primary care**
16:15–17:15 Sheny Khera, MD, CCFP (COE), FCFP; Marjan Abbasi, MD, CCFP (COE); Neil Bell, MD, SM, CCFP, FCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the components of frailty and its impact on patients/families, health care providers, and the health care system
2. Practise using tools for frailty identification, assessment, and care planning
3. Describe the elements of successful practice change management

Description:
Canadian data have identified frailty and chronic complex conditions, which are both more common among seniors, as drivers of high health care utilization costs (e.g., emergency visits, hospital admission) and social costs (e.g., dependency, caregiver burden). Frailty is often described as a state of vulnerability that places individuals at increased risk for adverse health outcomes. Seniors are at particular risk for frailty due to factors such as medical complexity, physiologic changes, psychosocial isolation, and fragmentation of the health care system. The estimated number of frail elderly in Canada is 1.1 million and is expected to rise to more than 2 million by 2035. Family physicians have an integral role to play in health promotion and chronic disease management and provide the majority of care for seniors. With the anticipated aging population, rising burden of chronic diseases, and shortage of specialty-trained physicians in geriatrics, even more primary care physicians will be caring for frail seniors in the future. Primary care, with a trusted single most responsible provider, has the potential to become a central hub for seniors in the community to provide coordinated care and proactive, patient-centred interventions to combat frailty, but this requires innovative approaches. In this workshop participants will work through case presentations to identify components of frailty in community-dwelling seniors and gain current knowledge on frailty progression and the role of primary care interventions. Participants will practise using identification and assessment tools (e.g., Electronic Frailty Index, Frailty Assessment for Care Planning Tool) that can be brought back to their own practices. Presenters will discuss elements of successful practice management and their experiences with implementing a proactive, team-based model of care aimed to identify, assess, and manage vulnerable and frail seniors living in the community.

F264 **Your Adolescent Patient Has an Eating Disorder: Now what?**
16:15–17:15 Patricia Windrim, MD, CCFP, MHSc; Karen Weyman, MD, CCFP, FCFP; Priyanka Chowdhury, MD, CCFP; Joey Bonifacio, MD

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the features of eating disorders presenting in adolescence
2. Recognize the red flags that may require hospitalization or specialist intervention
3. Develop a therapeutic approach to managing eating disorders in family practice settings

Description:
Eight per cent of adolescents suffer from either anorexia nervosa or bulimia nervosa, making eating disorders the

third most common chronic health condition in this age group after obesity and asthma. Because of the lack of specialist resources in this area most adolescents with an eating disorder are managed in a family practice setting. Many family doctors feel ill-equipped to manage these patients. Participants in this session will learn how to recognize the presentation of an eating disorder in this population. They will be able to recognize red flags that may require hospitalization or intervention by another specialist. Participants will be encouraged to share the challenges they have encountered with these patients and a therapeutic approach to patient management can be developed using the principles of the set-point theory. Family doctors, with their longitudinal relationships with adolescent patients and their families, are also in a unique position to proactively prevent eating disorders by identifying risk factors and initiating timely intervention strategies. The evidence for these intervention strategies will be explored.

F274 **Teaching Procedural Skills: Lessons learned when introducing a new family medicine teaching program**
16:15–17:15 Juan A. Garcia-Rodriguez, MD, MSc (MEd), CCFP (SEM), FCFP
All teachers welcome. Highlights novice concepts for educational leaders.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Incorporate current evidence-based methods to teach procedures
2. Describe possible limitations for successful procedural skills training
3. Discuss strategies that can facilitate the development of effective procedural teaching activities

Description:
In this interactive session a summary of the steps taken in the implementation of a new procedural skills teaching program will be presented. Specific practical points to facilitate procedural teaching in office or in academic settings will be discussed and the participants will analyze the lessons learned from the experienced challenges that can be applied to other programs or settings.

F292 **Follow-Up Care of Breast Cancer Survivors: Evidence-based recommendations for primary care**
16:15–17:15 Genevieve Chaput, MD, MA Health Professions Education; Jeff Sisler, MD, CCFP, FCFP

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Integrate knowledge pertaining to the management of the long-term effects of breast cancer and its treatments into clinical care
2. Recognize the importance of healthy lifestyle promotion in the breast cancer survivor population
3. Implement evidence-based recommendations for cancer recurrence surveillance in patients with a breast cancer history

Description:
Breast cancer outcomes are improving, with survival rates of 88 per cent at five years. A strong shift to having family physicians (FPs) provide follow-up care has also been observed, driven by a shortage in supply of other specialists and by level I evidence demonstrating the effectiveness of post-treatment care by FPs. FPs have expressed the need for educational support and primary care guidelines to provide appropriate care to breast cancer survivors in their practices. This session will offer up-to-date survivorship follow-up care recommendations for breast cancer survivors summarized in four main categories: 1) surveillance for recurrence involving only annual mammography and screening for other cancers according to general population guidelines; 2) management of common late effects of breast cancer and its treatments, including chemotherapy-induced neuropathic pain, cancer-related fatigue, and side effects of tamoxifen and aromatase inhibitors, as well as longer-term concerns related to cardiac and bone health; 3) promotion of healthy lifestyles with particular attention to routine physical exercise; and 4) coordination of care among health providers with FPs as central providers to patients with a breast cancer history. The session's content will be based on a recently published review article

in Canadian Family Physician for which a MEDLINE literature search (2000 to 2016) and a review of selected guidelines published by recognized national cancer organizations were performed. Levels I to III evidence will be outlined. This learning activity will be delivered primarily in a didactic format and a self-directed learning format, and will include case-based presentations to engage participation and promote active learning. The focus will be on survivorship knowledge that can be incorporated into FPs' clinical practices.

F442 **Contraception in Canada: Where are we now and how can we improve?**
16:15–17:15 Amanda Black, MD

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand the current landscape of Canadian women's attitudes, knowledge, and beliefs about contraception
2. Adopt counselling techniques to explain sexual reproduction and contraceptive options that are currently available
3. Apply the most recent Canadian Contraception Consensus guideline to their everyday practices

Description:
In 2006 an online quantitative survey was fielded among sexually active Canadian women ages 15 to 50 to gain in-depth insights into their attitudes toward, knowledge of, and beliefs about sexual behaviour and contraception. The Society of Obstetricians and Gynaecologists of Canada decided to refield this study among sexually active Canadian women in 2016 to understand the current landscape and draw some comparisons, where possible, to the previous results from 2006. This session will be interactive, with touchpad technology, and will provide highlights of this survey and tips and tricks that can be used to educate patients about their sexual and reproductive health. This session will review the latest published Canadian guidelines on contraception.

F459 **Why Me? College Complaints and the Family Physician**
16:15–17:15 Gordon Giddings, MD, CCFP (PC), FCFP; John Ritchie, MD; Jean Langley, MD, CCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize common themes in clinical practice frequently identified in college complaints
2. Identify areas of potential concern in their own individual practices
3. Incorporate strategies into clinical practice that promote good patient care and enhance compliance with regulatory expectations

Description:
Professional self-regulation is a privilege, and inherent in that privilege is the legislated requirement for colleges to have a robust complaint evaluation process. Alberta statistics show that approximately 8.5 per cent of physicians receive a complaint in any given year, and most physicians can expect to receive at least one complaint in their career; simply put, it is not "if" you will receive a complaint but "when." Although this presentation is based on the Alberta experience, common themes are seen in complaints throughout the country, as is evidenced by the Canadian Medical Protective Association's general advice to physicians irrespective of their province or territory of practice. This session will outline some of the more common aspects of practice, both clinical and administrative, that are frequently identified as issues in college complaints. Strategies that promote both good patient care and compliance with regulatory expectations will be reviewed. In addition, participants will have an opportunity to discuss specific issues of concern relevant to their individual practices.

F462 **Come Meet the (Besrour) Family: The joys and challenges of global family life**
16:15–17:45 Katherine Rouleau, MD; Aboi Madaki, MD; Janie Giard, MD; Beatrice Godard, PhD; Ahmed Maherzi, MD; Adelson Guaraci Jantsch, MD

ROOM / SALLE : 521ABC

Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Describe activities through which Canadian and international Besrour Centre partners are learning from each other
2. Analyze how Besrour Centre activities might impact and engage the Canadian family medicine community
3. Discuss micro-, meso-, and macro-level strategies to improve global collaboration to advance family medicine

Description:

The Besrour Centre is an expression of the CFPC's commitment to social accountability and its identity as a world leader in family medicine. The Besrour Centre supports collaboration between Canadian departments of family medicine and partners from over 20 countries to support the development of family medicine in various settings as a pathway to health equity. The Besrour Centre's collaborative efforts to strengthen family medicine around the globe, the lessons learned, and the innovations generated provide opportunities to strengthen our ability to respond to the needs of our own patients and communities in Canada. In this session, international members of the Besrour community will present ways in which the Besrour process has influenced family medicine strengthening in their settings highlighting the contributions, joys, and challenges of our collaboration. Through guided group reflection and discussion, the group will explore the role of social accountability globally as an opportunity to inform and enhance the Besrour collaborative and engage in the richness of the Canadian family medicine community.

F564 Mainpro+ Credit Reporting: A practical demonstration (Session 2: Repeat)

16:15–17:15 Melissa Lujan, M.Sc.

ROOM / SALLE : 524A

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Navigate the Mainpro+ dashboard effectively to help plan your CPD learning goals
2. Define Mainpro+ credit categories and how they relate to CPD activities
3. Track CPD activities in your Mainpro+ dashboard with confidence

Description:

Join us for an informative and interactive session on Mainpro+. This session will cover the changes to the Mainpro+ credit and activity categories. Participants can engage in a live demonstration of reporting various types of learning activities right on the member dashboard. You will learn how to earn and report credits for practice activities you do on a daily basis. The CFPC is committed to providing quality CPD to meet your evolving interests and learning needs.

F501 The Occasional HIV+ Patient: Clinical pearls for primary care providers

16:15–17:15 James Owen, MD, CCFP; Kelly Anderson, MD, CCFP

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Recognize patients in your practice who are at risk of HIV and screen them accordingly
2. Monitor and manage stable HIV infection independently
3. Manage common comorbidities and preventive care needs for HIV-positive patients

Description:

As the prevalence of HIV increases in Canada, it is becoming increasingly common to see the occasional HIV+ patient in both rural and urban family practice. Despite this, we find that early access to specialist HIV care is still limited in many regions of the country. Advances in HIV care mean primary care providers can increasingly take a more prominent role in managing patients with chronic HIV infection. The initial workup of patients can be performed in the primary care provider's office and (following subsequent specialist support) the long-term follow-up of patients is also easily achievable in the primary care setting. This interactive, case-based workshop, targeted at the generalist primary care provider, aims to improve your capacity to diagnose and care for the occasional HIV+ patient. We will draw on

familiar primary care concepts such as chronic disease management, approaches to polypharmacy, care of the elderly, and preventive care. We will highlight the importance of screening patients for HIV infection and strategies for doing so. We will discuss the basic workup and management of HIV infection, review red flags for the "sicker" patient who may require additional specialist support, and discuss how to appropriately counsel patients and their partners about chronic HIV infection. We will also explore common preventive care recommendations for HIV+ patients, including cancer screening, immunizations, and the management of cardiovascular risk factors.

TWO- AND THREE-CREDIT-PER-HOUR CERTIFIED MAINPRO+ WORKSHOPS
ATELIERS CERTIFIÉS MAINPRO+ POUR DEUX ET TROIS CRÉDITS PAR HEURE

FS100 Emergency Medicine Review Act III (EMR III) (2-day course – Friday/Saturday)

07:30–17:30

Mark Mensour, MD, CCFP (EM) (FPA), FCFP; Eric Clark, MD, FRCPC; Constance LeBlanc, MD, CCFP (EM); Sarah Reid, MD, CCFP, FRCPC

(2) credits per hour

ROOM / SALLE : 516B

PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 32 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:

1. Incorporate up-to-date literature in the practice of emergency medicine
2. Discuss controversies in emergency medicine
3. Improve patient safety by developing an evidence-based approach to patient care

Description:

Emergency Medicine Review (EMR) is a robust program made up of concise, focused chapters with key concepts and core information served up in small bites so they are easy to digest! It provides a modern approach to continuing professional development using the flipped classroom technique. You receive 10 hours of EMR video to watch at your leisure prior to attending the course. While attending the two-day course you have an opportunity to discuss your clinical experiences in a small group. You get your questions addressed by the presenters and your peers.

F340 Practising Wisely: Reducing unnecessary testing and treatment

07:30–17:30

Peter Kuling, MD, CCFP, FCFP; Jobin Varughese, MD, CCFP (COE)

(3) credits per hour

ROOM / SALLE : 511C

PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 18 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:

1. Identify opportunities to reduce "too much medicine"
2. Access and assess reliable, renewing online resources and integrate relevant evidence into individual patient care
3. Communicate and build consensus with patients to reduce over-medicalization

Description:

Participants will identify opportunities to "practise wisely", with a focus on reducing over-prescribing, over-imaging, over-screening and over-monitoring using the latest evidence and tools from diverse sources. This workshop aligns closely with the Choosing Wisely Canada (CWC) campaign to implement good healthcare stewardship and avoid over-medicalization. The program centres on case studies and incorporates individual reflection and group work. It helps participants to build communication skills to guide their patients through the

shift from seeking sickness to enhancing health. Participants are required to bring a laptop or tablet to participate fully in the workshop. Upon the completion of post course activities participants receive up to 18 Mainpro+ certified Group Learning credits plus additional Self-Learning credits. This program is a Signature Program of the Ontario College of Family Physicians one of the first to receive three-credit-per-hour Mainpro+ certification.

F257 **CASTED: Primary Care - The hands-on orthopaedics course for family physicians**
07:30–18:30 Arun Sayal, MD, CCFP (EM)
3 credits per hour

ROOM / SALLE : 520BE
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 25.5 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Discuss orthopaedic principles as they apply to family medicine / primary care
2. Discuss and demonstrate the key clinical points in the assessment and diagnosis of various MSK/joint complaints
3. Practice joint injection techniques as they pertain to family medicine

Description:
CASTED: Primary Care is the 'hands-on' orthopaedics course for family physicians. This course is intended for family doctors and NPs to help manage the variety of MSK conditions that present to a primary care office.

CASTED: Primary Care combines practical, case-based lectures with 'hands-on' stations to review orthopedic principles and management in the context of a family doctor?s office. During this full-day course, you will learn keys to an efficient orthopedic history; 'high yield' physical exam tips, including a 'hands-on' exam review; MSK management principles; tips to identify 'red flag' patients; indications for further investigations and referral (How to 'choose wisely'); how to perform joint injections, including 'hands-on' practice with models; practical, office-based immobilization options. You are promised a day full of humour and numerous clinical pearls you will use on your next day in the clinic! The focus is on 'high-yield', practical, clinically relevant points that are immediately practice changing. Since 2008, CASTED has been presented over 225 times across the country. It has received numerous awards including the CFPC's Continuing Professional Development Award for providing 'an exceptional learning experience'.

F339 **MSK: Joint assessment made easy**
07:30–18:30 Janice Harvey, MD, CCFP, FRCP, Dip. Sport Med.;
Michelle Acorn, RN (EC), ENC (C), MN ACNP, GNC(C)
3 credits per hour

ROOM / SALLE : 511D
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 21 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Perform an organized and efficient physical exam of the major joints of the musculoskeletal system
2. Identify and differentiate between the various mechanisms of common musculoskeletal injuries
3. Interpret the findings from common physical exam tests to plan for the management of common musculoskeletal conditions

Description:
Musculoskeletal joint assessment and musculoskeletal examination are critical components of correctly diagnosing joint injury and managing disease. Health practitioners can be faced with a variety of presentations each day in

their practices. Keeping on top of the most current and advanced diagnostic techniques is critical to positive patient outcomes and timely recovery. Don't miss out on this comprehensive workshop, which will bring your diagnostic skills to the current state of practice. Assessments covered include ankle, back, shoulder, knee and hip. This is a hands on workshop and participants are asked to come wearing loose fitting/casual clothing. More information will be provided following registration. This program is part of the Ontario College of Family Physicians suite of CPD programs developed in collaboration with and for our members and their colleagues across Canada.

F869 **CASTED: Emergency - 1 Day Hands-On Orthopedics Course (Repeat)**
07:30–18:30 Arun Sayal, MD, CCFP (EM)
(3) credits per hour

ROOM / SALLE : 520AD
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 27 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Discuss important orthopedic principles as they apply to caring for Emergency Department patients
2. Describe the ED assessment, diagnosis and management of acute extremity injuries that are common, commonly missed and commonly mismanaged
3. Perform fracture and dislocation reduction techniques with emphasis on proper splinting, moulding and positioning of various ED injuries

Description:
CASTED: Emergency is the 'hands-on' ED orthopedics course. It is a full-day, Mainpro+ and MOC accredited course, designed specifically for ED physicians and staff. Case-based lectures highlight ED orthopedic principles and clinical pearls while reviewing over 80 pediatric and adult extremity injuries. Focus is on the common, the commonly missed, and the commonly mismanaged. Over 4 hours of 'hands-on' time provides extensive demonstration and practice of reduction and casting/splinting techniques. Numerous tips are offered on splinting, moulding and reduction. Closely supervised 'hands-on' practice ensures you will have the confidence you are doing it right! By the end of the day, you will know 'red flags' to beware of; which patients need a reduction; how to properly reduce, immobilize and mould; which patients need follow-up; and how quickly they need to be seen. You are promised a day full of humour and numerous clinical pearls you will use on your next shift! Since 2008, CASTED has been presented over 200 times across the country. It has received numerous awards including the CFPC's Continuing Professional Development Award for providing 'an exceptional learning experience'.

F437 **Les essentiels de l'approche palliative (LEAP Mini)**
07:30–18:00 Bruno Gagnon, MD, MSc
(2) crédits par heure

ROOM / SALLE : 511E
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
Ce programme d'apprentissage en groupe a reçu la certification du Collège des médecins de famille du Canada et donne droit jusqu'à 16,5 crédits Mainpro+ (Catégorie 1 pour les non membres du CMFC).

Objectifs d'apprentissage :
1. Acquérir l'essentiel des connaissances pratiques et des compétences nécessaires pour fournir des soins palliatifs
2. Gérer les symptômes et les besoins psychosociaux-spirituels à un niveau généraliste
3. Entreprendre des conversations essentielles

Description :
LEAP Mini est un cours de 8,5 heures adressé aux médecins de famille, infirmières, travailleurs sociaux et pharmaciens qui travaillent dans la communauté. Le cours a été conçu afin d'augmenter la capacité en soins

palliatifs de la communauté et de lier les participants aux ressources locales. Ce cours est offert sous forme d'ateliers avec une capacité maximale de 30 participants et un ratio apprenants-animateur n'excédant pas 15:1. LEAP Mini est un programme d'apprentissage en groupe certifié par le Collège des médecins de famille du Canada et donne droit jusqu'à 16,5 crédits Mainpro+. LEAP Mini comprend au total neuf modules dont le premier : « La prise en charge en soins palliatifs, vous avez un rôle à jouer », est élaboré de façon à encourager un changement de la perception culturelle des soins palliatifs et afin d'aider les participants à identifier les patients pouvant bénéficier d'une approche précoce des soins palliatifs. Les modules « Cadre concernant la prise de décision en soins palliatifs » et « Les derniers jours et les dernières heures » ciblent la prise de décision et les communications en lien avec la fin de vie. « Symptômes gastro-intestinaux, hydratation et nutrition en soins palliatifs », « Douleur », « Dyspnée », « Délirium » et « Détresse psychosociale/spirituelle » sont des modules qui présentent des compétences fonctionnelles nécessaires à la pratique quotidienne des soins palliatifs. Les activités d'apprentissage comprennent des vidéos (module « Les conversations essentielles »), des études de cas, et des discussions en petits et grands groupes. L'évaluation du cours est réalisée à partir de questionnaires remplis avant et après le cours : un pour l'évaluation des connaissances, un sur les attitudes en soins palliatifs et un autre sur le degré d'aise en soins palliatifs. Pour compléter le tout, un formulaire d'engagement à réaliser des changements doit être rempli immédiatement après le cours et 4 mois plus tard.

F76 Assessment of Decision-Making Capacity

13:30–17:15 Jasneet Parmar, MD, CCFP; Karen Chan, MD, CCFP (COE)
(2) credits per hour

ROOM / SALLE : 511B

PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:

1. Acquire knowledge of the guiding principles in assessment of capacity
2. Appraise a capacity assessment process
3. Review capacity assessment worksheets used in this process with case examples

Description:

As the life expectancy of Canadians and the prevalence of complex chronic health conditions continue to rise, the assessment of independent decision-making capacity emerges as an issue of increasing importance. To this end, the Decision-Making Capacity Assessment (DMCA) Model was developed to facilitate a process by which the least restrictive and intrusive means of support can be determined and offered to persons whose decision making has come into question. Many physicians do not feel prepared to assess capacity based on their residency training. Physicians play a key role in capacity assessment as they are able to declare persons incapable. Thus they often require additional training once in practice. An educational workshop has been developed on the DMCA process. This was based on an initial Capacity Assessment Professional Opinion Survey by Covenant Health (formerly Caritas) in Edmonton, Alberta, which identified this as an area that required interdisciplinary staff training in 2006. There were increased costs of poorly conducted capacity assessments. The study identified a lack of knowledge, skill set, standardized method/tools/guidelines, coordination, and role definition, plus the issue of resource allocation. A process was proposed with front-end screening/problem solving, a well-defined standardized assessment, and definition of team members' roles. A care map was developed based on this process. Documentation was developed consisting of a capacity assessment database and patient interview for formal capacity assessment. Interactive workshops, administered to familiarize staff with the model, include concepts of capacity, the protocol, documents, and case studies. This three-hour workshop is now being offered to physicians given their pivotal role in capacity assessment. This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for up to 6 certified Group Learning credits.

S497 **Navigating the "How" of Competency-Based Education and Assessment: Identifying and important issues addressing**
08:30–09:30
Mirella Chiodo; Shelley Ross, PhD; Paul Humphries, MD, CCFP, FCFP; Shirley Schipper, MD, CCFP, FCFP
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the issues that programs face implementing competency-based assessment
2. List the factors to consider in change management when transitioning to competency-based curriculum and assessment
3. Identify at least one change management strategy from the workshop to apply in your home program

Description:
Implementing competency-based education and assessment is a hot topic for program directors, assessment directors, department Chairs, and anyone else involved in residency education in Canada. The CFPC has provided general guidelines about expectations (such as the Triple C and CRAFT documents), but little in the way of a specific path for programs to follow as implementation progresses. This has been challenging for some programs as they grapple with how to implement competency-based education and assessment. "How" is not a singular issue. In addition to determining how best to assess competencies (tools and processes), programs must also decide how to inform residents and preceptors about new systems and procedures, administer new systems and processes, and evaluate and validate the data needed for making decisions about competence. In essence, there is more to the shift to competency-based education than just deciding competencies and selecting tools—change management must also be navigated successfully. In this session, we discuss the "how" of competency-based education and assessment from the perspective of a residency program that has been fully competency-based for seven years. While there will be a brief overview of how competencies are assessed in this program, most of the workshop will address the change management issues associated with moving from a traditional residency program to a competency-based approach. Issues such as implications for program policies, resources (human and monetary), and faculty development will be discussed through a lens of lessons learned. Large and small group discussions will address the various aspects of how, some prompted by case examples, some by participants' own experiences. Participants are strongly encouraged to provide input and share personal experiences.

S127 **Oncological Emergencies for Family Physicians**
08:30–09:30
Anna Wilkinson, MSc, MD, CCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the common oncological emergencies that 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 in 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.

S183 **Driving and Dementia: Practical tips for the family physician**
08:30–09:30 Linda Lee, MD, CCFP (COE), FCFP, MClSc (FM)

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. List findings in the cognitively impaired patient that may indicate fitness to drive is a concern
2. Explain office-based tests that can help identify 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 older than 65 suffering from either mild cognitive impairment or dementia, family physicians will be increasingly challenged with concerns about fitness to drive. In most provinces it is mandatory to report potentially medically unfit drivers to transportation authorities. This session will provide the busy family physician with practical tips for dealing with driving fitness in the older adult who is cognitively impaired.

S268 **Effective Teaming: A workshop to improve interprofessional primary care team functioning**
08:30–09:30 Thuy-Nga Pham, MD; Patricia O'Brien

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Define the concept of "teaming" and describe its relevance to interprofessional primary care team functioning in the Canadian context
2. Apply the attributes of high-functioning interprofessional primary care teams to your primary care context
3. Compare/contrast the leadership skills that improve effective, high-functioning interprofessional primary care teams with those present in your environment

Description:
Teaming refers to the actions associated with a team performing optimally. Contrasted with team effectiveness, which describes the capacity and capability of a team to achieve goals, teaming speaks to the functioning of the team and reflects the experience of being a team member. Employing interactive and innovative approaches to thinking about interprofessional primary care team function, this workshop will enable family physicians to learn about the attributes that support effective teaming and to reflect on improvement opportunities for their particular contexts. Focusing on the leadership aspect of interprofessional primary care teams, the concept of generative leadership will be explored as one of several skills for family physicians to apply to their role as team or organizational leaders.

S289 **From Theory to Table: Simplifying the message about healthy eating**
08:30–09:30 Michael Yan, MD, CCFP; Julia MacLaren, RD, CDE

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify common barriers to healthy eating
2. Discover evidence-based yet simple nutrition interventions for preventive health promotion
3. Implement readily available tools to promote healthy eating habits in a primary care practice

Description:
Healthy eating habits are fundamental to overall wellness. Many people actively search for guidance on providing healthy choices for themselves and their families. The media as well as a huge commercial nutrition industry stand poised to direct the public toward a range of dietary approaches that target specific goals such as rapid weight loss or sensationalized approaches that lack robust scientific evidence. These increasingly cause more harm than benefit to society's relationship with food. Family physicians share established, trusting relationships with individual patients and entire families. Thus, we are also well positioned as valuable sources of nutrition advice. Increasingly physicians work in collaboration with registered dietitians who contribute considerably greater expertise and knowledge than physicians alone could provide. Together, our influence on patients' lifestyle choices can be substantial. This workshop aims to summarize the best available evidence-based dietary recommendations for the promotion of healthy eating behaviour. The intention is to synthesize the evidence into simple and practical approaches and strategies that busy family physicians can, alone or with the collaboration of a primary care dietitian, quickly and easily champion during routine office visits.

S295 Management of Nausea and Vomiting in Palliative Care

08:30–09:30 Grace Ma, MD, CCFP (PC); Andrea Weiss, MD, MSc, CCFP (PC)

ROOM / SALLE : S295

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify common causes of nausea and vomiting in palliative care
2. Determine the receptor pathways based on the etiology of nausea and vomiting
3. Choose an effective anti-emetic confidently

Description:
Nausea and vomiting are common and distressing symptoms in palliative care. Controlling these symptoms can improve the quality of life of patients. Therapy for nausea and vomiting should be targeted to the underlying cause. We will describe a logical approach to identifying nausea receptor pathways. Together, we will work through clinical cases to determine nausea etiology and select anti-emetic treatments, both nonpharmacologic and pharmacologic. By the end of this session you will feel confident in your ability to assess and treat nausea and vomiting in a variety of clinical contexts.

S300 Derm DDx Stat Rounds

08:30–09:30 Dominik Nowak, MD

ROOM / SALLE : 517D

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Distinguish skin lesions accurately based on primary morphology
2. Describe a differential of the most common and the most worrisome diagnoses based on primary morphology
3. Identify some of the differentiating factors between morphologically similar lesions that often result in diagnostic blunders

Description:
Dermatology is ubiquitous in family medicine, yet the differentials are overwhelmingly broad. It's a rash—now what!? In this interactive presentation we will provide a simplified approach to dermatology based on primary morphology. We will then show, through rapid-fire audience engagement incorporating smartphone poll

technology, the broad and exciting differential available for each morphological pattern. We will also provide some clues for morphologically similar lesions that often result in diagnostic blunders. We will cover epidermal, pigmented, dermal, and subcutaneous growths; eczematous rashes; scaling papules, plaques, and patches; vesicles and bullae; inflammatory papules; pustules; generalized and specialized erythema; purpura; dermal induration; ulcers; hair disorders; mucous membrane disorders; and some signs of systemic disease.

S373 **The Sexual Assault Forensic Exam and Medicolegal Report for Family Physicians**
08:30–09:30 Tasha-Rachelle Maheu, MD, CCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Integrate the new standardized evidence collection kit into the forensic sexual assault exam
2. Provide patients with evidence-based treatment and a clear follow-up plan
3. Prepare a focused medicolegal report using appropriate terminology

Description:
In communities without sexual assault nurse examiners evidence collection may be left to general practitioners with minimal training in forensics and little experience in sexual assault care. Not surprisingly, the literature shows that evidence collected by a trained provider is more likely to be admissible in court and more likely to result in prosecution. At the conclusion of this session participants will be able to explain a patient's medicolegal options following a sexual assault, take an empathetic but objective history, provide patients with evidence-based treatment, and develop a clear follow-up plan. Participants will learn to maximize their evidentiary yield through demonstrations and discussion of the forensic principles necessary for evidence collection and preservation. Finally, we will discuss writing focused medicolegal reports.

S383 **Top 10 Family Medicine Articles That Should Change Your Practice**
08:30–09:30 **Les 10 meilleurs articles de médecine familiale qui pourraient changer votre pratique**
Jock Murray, MD, CCFP (EM); Mandi Irwin; Alethea Lacas; Jennifer Leverman

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Consider integrating three to five practice-changing concepts into the practice
2. Be aware of the influence of "spin" when interpreting new evidence
3. The participant will be made aware of the importance of caution when implementing guidelines

Description:
Ten articles with important, potentially practice-changing findings will be rapidly presented. Some of the articles will demonstrate that certain ones that are presented as practice changing should not be. Each article will be selected on the basis of relevance to family physicians practising in an office setting. The format will be a rapid review of the literature There will be one take-home point for each article. The articles will be selected to span the breadth of family medicine. Care will be taken to point out conflicts of interests in the selected articles.

Objectifs d'apprentissage :
1. Envisager d'intégrer à la pratique de trois à cinq concepts novateurs
2. Être conscient de l'influence de la « manipulation du message » lors de l'interprétation de nouvelles données
3. Être informé de l'importance de la vigilance dans l'application de lignes directrices

Description :

Dix articles renfermant des constatations importantes ayant le potentiel de changer votre pratique seront présentés brièvement. Certains articles démontreront que certains écrits prétendant changer la pratique ne le devraient en aucun cas. Chaque article sera choisi en fonction de sa pertinence pour les médecins de famille pratiquant en cabinet. La séance prendra la forme d'une étude rapide de la littérature, et des points à retenir seront soulignés pour chacun des articles. Les articles seront choisis afin de couvrir l'ensemble de la médecine familiale.
Les conflits d'intérêts décelés dans les articles sélectionnés seront indiqués avec soin.

S410 **EKG Workshop**
08:30–09:30 Laura Callaghan, MD, CCFP (EM); Caitlyn Wolfe, MD, CCFP (EM)

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Become familiar with an approach to reading electrocardiograms
2. Learn to recognize signs of acute coronary syndrome on electrocardiograms
3. Learn to recognize the signs of arrythymia on electrocardiograms

Description:
This session will be case-based with many electrocardiogram (EKG) examples. It will be directed more at the family physician who occasionally reads an EKG than at the practising emergency physician.

S503 **The Paradox of Opioids: Pain induced by use and withdrawal**
08:30–09:30 Launette Rieb, MD, MSc, FCFP, DABAM

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. List three pain phenomena associated with opioid use or cessation
2. Discuss possible mechanisms for opioids increasing pain with use and withdrawal
3. Identify potential mitigators of opioid associated pain that may be relevant for clinical practice

Description:
Opioids have been used for thousands of years to relieve both physical and emotional suffering. Yet exposure due to an opioid use disorder or through prescription use for chronic non-cancer pain can alter the nervous and immune systems, resulting in more pain sensitivity, called opioid-induced hyperalgesia (OIH). When opioids are stopped, the underlying pain sensitivity can be revealed, exacerbated by other withdrawal factors to produce even more pain, called withdrawal-induced hyperalgesia (WIH). Recently, the presenter and colleagues reported, in a mixed methods study, a novel opioid pain phenomenon involving the reactivation of old healed injury site pain during opioid withdrawal. This withdrawal-associated injury site pain (WISP) was shown to be a barrier to opioid detoxification and a risk factor for relapse. In this 60-minute session, the presenter will provide an overview of key studies on OIH, WIH, and WISP, including mechanisms and possible treatments. Then, cases from the author's research and clinical experience will be presented, including breaking research on WISP in people who inject drugs. Participants will be encouraged to share their own cases along with personal experiences to round out the interactive discussion. With the opioid crisis looming worldwide, it is important to understand problems related to opioid use and barriers to opioid detoxification, including the paradox of opioid-induced pain.

S61 **Smoking Cessation: Tools to make a difference in your practice**
08:30–11:00 **Abandon du tabac : Outils pour faire une différence dans votre pratique**
Alan Kaplan, MD, CCFP (EM), FCFP;

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

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

Description:
Lung cancer casuses more deaths than any other cancer in Canada, which is a scary thought. Patients know they should quit smoking, but this is an addiction; it is the most common addictive disorder in North America. We will review how to approach this condition in the office and learn tools to allow real health change in your patients who smoke, without getting you frustrated. The International Primary Care Respiratory Group has published a position paper on smoking and we will review smoking cessation in particular patient populations to help you personalize your advice to your patients.

Objectifs d'apprentissage :
1. Examiner l'épidémiologie du tabagisme dans votre pratique
2. Classifier la volonté des patients à apporter des changements à leur tabagisme
3. Prescrire les traitements et le soutien efficaces pour favoriser le changement

Description :
Le tabagisme est la cause principale de décès chez nos patients, ce qui est préoccupant. Les patients savent qu'ils devraient arrêter de fumer, mais nous avons affaire à une toxicomanie; le trouble de toxicomanie le plus répandu en Amérique du Nord. Nous allons examiner la façon d'aborder cette affection courante et frustrante en cabinet, et présenter des outils qui permettent d'apporter des changements réels à la santé des fumeurs, sans que vous vous arrachiez les cheveux! L'*International Primary Care Respiratory Group* a publié un énoncé de position sur le tabagisme et nous allons nous pencher sur l'abandon du tabac au sein de populations particulières pour vous aider à personnaliser les conseils que vous donnerez à vos patients.

S84 **Bloody Hell: Abnormal uterine bleeding**
10:00–11:00 Christiane Kuntz, MD, CCFP, FCFP, NCMP

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Define abnormal uterine bleeding during the pre-, peri-, and post-menopausal stages and explore etiology and pathophysiology
2. Review assessment tools and discuss treatment options
3. Apply learning pearls through clinical case scenarios

Description:
In this session abnormal uterine bleeding in the pre-, peri-, and post-menopausal woman will be defined. The etiology and pathophysiology for the condition will be explored. Assessment tools as well as treatment options for the condition will be discussed. Learning pearls will be highlighted using several clinical scenarios.

S121 **Borderline Personality Disorder: Effective management through therapeutic relationships of compassion, self-management, and resiliency**
10:00–11:00 James Goertzen, MD, MClSc, CCFP, FCFP

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe strategies to assist with the management of patient self-harm and self-mutilation behaviours
2. Demonstrate dialectical behavioural therapy principles applicable to the family physician's clinical settings
3. Encourage the development of physician compassion through their care of patients with borderline personality disorder

Description:
Borderline personality disorder (BPD) is chronic condition that is disabling for the patient and often seen as untreatable by health care practitioners. Patients with BPD struggle with instability of self-image, dysregulation of emotions, limited impulse control, and difficulty with interpersonal relationships. Frequent self-injury and testing of patient-physician boundaries can lead to physician heart sink, frustration, and/or burnout. There is growing evidence that with effective treatment most patients with BPD experience a significant reduction in symptoms and improvement in their lives. BPD is fundamentally a relationship disorder. Effective management strategies incorporate principles from dialectical behavioural therapy that can readily be embraced by family physicians, applied within their clinical settings, and used to support the development of resiliency. It is key to develop physician-patient relationships in which appropriate boundaries are defined, ongoing negotiation becomes a central feature, and mutual respect is a treatment goal. Nurturing compassion is possible through a better understanding of both the patient and their condition.

S128 **Le Guide Priorité Santé : outil et modèle de pratique collaborative en prévention clinique**
10:00–11:00 Claire Gagné, MD; Johanne Lessard, inf. ASI, DESS; Geneviève Thibault-Gervais, IPSPL

ROOM / SALLE : 512ABEF
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Utiliser le Guide Priorité Santé et ses outils clé en main
2. Explorer un modèle de pratique collaborative en prévention clinique et soins de santé primaires
3. Définir les conditions gagnantes pour la collaboration interprofessionnelle en première ligne

Description :
Le Guide Priorité Santé (GPS) est le premier guide de pratique destiné à soutenir les soins de santé primaires en pratique collaborative au Québec. Cette approche, reconnue par l'OMS, inclut la promotion de la santé et du bien-être, la prévention, l'habilitation en santé et l'utilisation efficace des ressources. Il permet à une infirmière bachelière d'évaluer les besoins de santé et de mettre en œuvre des mesures préventives ainsi que des interventions de soins ciblés auprès d'une clientèle adulte, et ce, en collaboration avec d'autres professionnels; c'est-à-dire, une infirmière praticienne spécialisée en soins de première ligne (IPSPL) et un médecin. Le guide comprend huit modules : les habitudes de vie, la santé cardiométabolique, le dépistage des cancers, l'immunisation, les chutes, les déficits sensoriels, la santé mentale et la santé sexuelle. Il recense les recommandations d'organisations expertes dans ces domaines et propose une intervention qui précise les rôles et responsabilités de l'infirmière, en plus de définir des balises claires d'orientation vers un médecin ou une IPSPL. L'Ordre des infirmières et infirmiers du Québec a demandé à ses membres de s'y conformer (normes de bonne pratique). De nombreux outils et algorithmes décisionnels viennent appuyer la démarche et sont utiles pour les professionnels, alors que d'autres sont destinés aux patients. Le GPS propose donc un modèle où la bonne intervention (qualité) est accessible au plus grand nombre (accès équitable), par l'entremise du bon professionnel (efficience). Largement connu et diffusé, le GPS est en voie d'implantation dans plusieurs milieux cliniques, dont le CIUSSS du Centre-Sud-de-l'Île-de-Montréal (unités de médecine familiale et groupes de médecine familiale). Les conditions gagnantes pour la collaboration interprofessionnelle seront discutées (dont la formation et le soutien) grâce à l'expérience de ces milieux participants.

S130 **It's Not Just About Getting High Anymore: Using psychedelic substances to improve mental health**
10:00–11:00 Nitasha Puri, MD, CCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the clinical context, patient population, and disease processes in which psychedelic medicine may be used as treatment
2. Interpret the preliminary literature on psychedelic medicine and critically assess its value for mental health and wellness
3. Explore how psychedelic medicine may become a part of family practice, primary care, treatment, and general wellness in the future

Description:
In the past 10 years there has been a resurgence in the evaluation of recreational psychedelic substances as possible adjuncts to psychotherapy for the treatment of substance use, mood, and anxiety disorders. Signals from preliminary studies are showing startling effects, causing researchers and clinicians to seriously consider the use of psychedelic substances in outpatient treatment. During this session we will examine the fundamental philosophy and clinical setting for the use of psychedelic medicines. We will then review properties of the more common psychedelic substances currently being studied and examine emerging evidence and other questions. Finally, we will conclude with a large group discussion on how the evidence may affect the future of mental health treatment and how we can use this knowledge in our practices as family physicians.

S281 **Seven Big Reasons to Get Briefed on Infectious Diseases**
10:00–11:00 **Sept grandes raisons de s'informer sur les maladies infectieuses**
Patricia Huston, MD, CCFP, MPH; Michel P. Deilgat, MD, MCFP

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Identify seven important new developments in infectious disease topics of direct relevance to family physicians
2. Summarize evidence-based recommendations, explore barriers to implementation, and identify the CanMED roles needed to incorporate these recommendations in practice
3. Provide an opportunity to advance competencies in infectious diseases and consider strategies to remain current on emerging issues

Description:
This will be a dynamic, interactive, info-packed workshop in which two well-known presenters will take turns covering seven key infectious disease topics of direct relevance to family physicians. Each topic will be presented in three to four minutes with a summary of up-to-date information and evidence-based recommendations. Each topic will end with a reflective question for a four- to five-minute discussion by the audience that will consider implications for practice, including how to address barriers to change. Topics covered will include: Zika virus and why it is recommended to discuss travel routinely with all women of child-bearing age; trends in antimicrobial-resistant gonorrhea and why combination therapy is the best defence against the increasing risk of totally drug-resistant gonorrhea; why ticks with Lyme disease continue to move northward and are now in a number of Canadian cities, and tips for early diagnosis and treatment of Lyme disease; what's new on vaccine hesitancy and three best practices to address it; news about the global elimination strategy for HIV/AIDS and how in Canada elimination depends on family physicians normalizing routine screening for HIV; why 40 per cent of hepatitis C patients in Canada remain undiagnosed and why high-risk screening is the best way to detect it; and why tuberculosis (TB) may show up in a shelter or an IV drug user near you, and the good news that a short, effective treatment for latent TB may soon be available. CanMED roles, such as Scholar, Advocate, Communicator, and Collaborator, will be explored by reflecting on how to integrate new learning into practice; how to assess the health needs of vulnerable populations; and how to incorporate screening, prevention, and early detection in clinical encounters.

Objectifs d'apprentissage :

1. Nommer 7 nouveaux développements importants sur des sujets liés aux maladies infectieuses qui sont directement pertinents pour les médecins de famille
2. Résumer les recommandations fondées sur les données probantes, explorer les obstacles à l'adoption et identifier des rôles CanMEDS qui sont nécessaires pour incorporer les recommandations dans la pratique
3. Se donner l'occasion de bonifier ses compétences sur les maladies infectieuses et d'envisager des stratégies pour se garder au fait des enjeux émergents

Description :

Il s'agit d'un atelier dynamique, interactif, qui déborde d'information durant lequel deux présentateurs bien connus couvriront à tour de rôle 7 sujets importants en matière de maladies infectieuses directement pertinents pour les médecins de famille. La présentation sur chaque sujet durera 3-4 minutes incluant un résumé de l'information à jour et des recommandations factuelles, et se terminera par une question visant à alimenter une discussion de 4-5 minutes avec l'auditoire sur les répercussions sur la pratique, y compris comment faire tomber les obstacles au changement. Les sujets traités seront : virus Zika et pourquoi il est recommandé de parler systématiquement de voyage avec toutes les femmes en âge de procréer ; évolution de la gonorrhée résistante aux antimicrobiens et pourquoi le traitement d'association est la meilleure arme contre le risque accru de gonorrhée entièrement résistante aux médicaments ; pourquoi les tiques porteuses de la maladie de Lyme continuent de progresser vers le nord et sont maintenant présentes dans certaines villes canadiennes — et conseils sur le diagnostic et le traitement précoces ; quoi de neuf sur l'hésitation vaccinale et trois pratiques exemplaires pour la faire tomber ; nouvelles sur la stratégie mondiale d'élimination du VIH/sida et comment l'élimination au Canada dépend de la normalisation du dépistage systématique du VIH par les médecins de famille ; pourquoi 40 % des cas d'hépatite C au Canada demeurent non diagnostiqués et pourquoi le dépistage chez les patients à risque élevé est la meilleure façon de les détecter ; pourquoi la tuberculose (TB) pourrait éclore dans un refuge ou chez un usager de drogue injectée près de chez vous et la bonne nouvelle voulant qu'un bref traitement de la TB latente puisse être offert sous peu. On se penchera sur les rôles CanMEDS, comme celui d'érudit, de promoteur de la santé, de communicateur et de collaborateur en réfléchissant sur la façon d'intégrer le nouvel apprentissage dans la pratique, l'évaluation des besoins en santé des populations vulnérables et l'incorporation du dépistage, de la prévention et du dépistage précoce dans les rencontres cliniques.

S306 **The Power of Critical Reflection in Enhancing Preceptors' Teaching Skills**
10:00–11:00 Mruna Shah, MD, CCFP, FCFP; Difat Jakubovicz, MSc, MD, CCFP
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 510C
Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Be able to define reflection and explore the principles behind doing reflective exercises
2. Examine the role of critical reflection as a tool for improving teaching skills
3. Be able to identify various activities/techniques that foster reflection

Description:

Critical reflection "is the process of analyzing, questioning, and reframing an experience in order to make an assessment of it for the purposes of learning (reflective learning) and/or to improve practice (reflective practice)," as Dr. Louise Aronson described it in Medical Teacher in 2010. We are all preceptors because we love teaching, but most of us are so busy with our day-to-day work that we rarely have the time to get the most out of the experience. Whether you are looking to improve as an educator or increase your enjoyment of the activity, reflection is a technique that brings you closer to the act of teaching. Reflection allows you to connect with your teaching experiences—the successes and the failures—and to see how you can better understand the values and actions that led to those outcomes. Studies have shown that the teaching effectiveness of clinical educators is improved by reflecting on their own teaching and the values that underlie it. Therefore, reflection can be a valuable tool in enhancing your teaching practice and it can help you be a better mentor for your students and peers. This introductory workshop will define reflective practice and review some of the fundamental concepts of

reflection. It will allow participants to discuss the applications of reflection in medical teaching. Participants will have the opportunity to try a reflective exercise and discuss the various activities that foster reflection.

S362 **Lean Management Principles: How can you apply them in your own practice?**
10:00–11:00 Marie-Renée B-Lajoie, MD, CCFP (EM), MPH, MBA

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand current trends in health care management and how they pertain to family medicine
2. Define lean health care management principles
3. Apply lean principles in their individual work and extrapolate them to their general practice environment

Description:
How can we learn from management principles to improve our effectiveness, efficiency, and overall well-being in family medicine? Our work is more than ever strained by increased patient complexity, shifting payment models, and patchy technological innovation integration. The goal of this session is to review, through a case-based approach, current trends in health care management and the evidence behind best practices. From there, we will deep dive on the principles of lean management. Participants will take away key tips on how to think in lean terms as they head back the following Monday to their clinical work with a skill set that helps them influence changes in their practice environments and innovations within their practices.

S366 **Managing the Complications and Problems of Obesity in the Emergency Department**
10:00–11:00 Constance LeBlanc, CCFP (EM), FCFP, MAEd, CCPE

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize the impact of morbid obesity on emergency department presentations
2. Use effective strategies to examine and assess the morbidly obese patient in the emergency department
3. Learn tips for emergency department procedures in the morbidly obese patient

Description:
Obesity is on the rise in Canada and morbid obesity, though uncommon, is also on the rise. Morbid obesity can provide a formidable challenge in some situations, and the effective diagnosis and management of these patients, from the exam through ancillary evaluation to therapy, can be tricky. In this session I will review some important data sets that relate to clinical presentations in the morbidly obese and provide tips for achieving a better physical examination. Therapeutic and procedural tips will also be discussed. After a short didactic segment at the outset, this session will be case-based to allow for the integration of cases from the audience to use the wisdom in the room effectively. Time will be left at the end to review barriers to change and strategies to mitigate them.

S441 **Publier en français dans *Le Médecin de famille canadien* (*MFC*)**
10:00–11:00 Roger Ladouceur, MD, MSc, CCMF(SP), FCMF ; Yves Lambert, MD, CCMF, FCMF ; Suzanne Gagnon, MD, MA, CCMF, FCMF

ROOM / SALLE : 510D
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Inciter à publier en français dans le *MFC*
2. Comprendre le processus de soumission et de révision

3. Aider à soumettre des textes en français au *MFC*

Description :
Vous avez un article que vous voulez publier ? Ou vous avez la fantaisie d'en publier un éventuellement ? Cet atelier vous permettra d'expérimenter la rédaction d'un résumé. Vous apprendrez à connaitre le processus et les conditions qui amélioreront vos chances d'être publié. Il vous permettra d'expérimenter la rédaction d'un titre accrocheur ; de rédiger un résumé qui réponde aux exigences du *MFC* ; d'évaluer à quel type d'article votre manuscrit correspond et comprendre les conditions spécifiques qui y sont associées ; et finalement, de comprendre le processus d'évaluation qui mène à la publication de votre article. Sous forme d'échange, avec le rédacteur adjoint et les membres francophones du comité consultatif éditorial, cet atelier vous guidera dans votre démarche.

S479 Things You Didn't Learn in Residency: Medical-legal tips for early career physicians

10:00–11:00 Marie-Pierre Carpentier, MD, CCFP(EM)

ROOM / SALLE : 522ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the key scenarios that place a physician at medical-legal risk in their early career
2. Implement methods to mitigate the potential for issues and prevent those that most commonly pose a risk for family physicians
3. Prepare for incidents that could potentially arise and integrate protection strategies against potential risks in practice

Description:
A representative of the Canadian Medical Protective Association will address physician risk management by highlighting the most prevalent incidents that pose medical-legal issues for physicians new to practice and the key methods that should be employed in order to mitigate those risks. The Canadian Medical Protective Association has been invited to speak to attendees in their first five years of practice to outline the key areas of concern for family physicians, offer insight and strategies to promote safe care, and help reduce medical-legal risk within their practice. The session will feature an overview of the most common medical-legal complaints against family physicians, including case studies, and will demonstrate methods of prevention to protect oneself and the course of action that should be taken in the event of a complaint. The session will conclude with an interactive portion, allowing attendees to ask questions and seek guidance on specific issues related to the medical-legal risks of practising family medicine.

S717 Social Accountability and Community Engagement: A confluence for leadership

10:00–11:00

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Create a definition of community engagement and social accountability
2. Describe the linkage of community engagement and social accountability
3. Delineate a level of commitment to community engagement and social accountability and give examples for furthering that commitment

Description:
In this provocative discussion, the frameworks of community engagement and social accountability will be brought together as the fundamental principles for leadership in health care. The literature demonstrates that our ongoing discussions are interfering with taking action and achieving outcomes. You will be challenged to continue your work as leaders beyond how and what, moving backwards to a passionate why.

S109 **Thinking of Retirement: The challenges for family physians and their patients**
10:00–12:15 Louise Nasmith, MD CM, MEd, CCFP, FCFP; Calvin Gutkin, MD, CCFP, FCFP, LM; Rod Crutcher, MD, CCFP, FCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Identify personal and professional goals to assist in career transition decision making near or at retirement to achieve personal well-being
2. Use an approach to guide making these decisions that can be applied to themselves as well as to patients
3. Learn from colleagues about potentially helpful practices and options

Description:
This 120-minute workshop is designed for family physicians who are considering or have made career transitions related to retirement or who are providing care and support for patients facing these same challenges. A brief presentation on issues related to decision making at this stage of an individual's career will be followed by participant discussion. An approach that outlines key questions and steps in the career transition process that take into account balancing patient and practice needs with personal health and well-being will be shared. Participants will then use the approach in individual and small group work focused on identifying personal and professional goals. Ideas, options, and helpful practices will be shared in dyads and then in the large group. Similar approaches will be useful in providing guidance to patients who are considering retirement. Each individual will leave the workshop with concrete ideas and approaches to assist in both their own and their patients' planning and adaptation to retirement.

S181 **Motivational Interviewing to Support Opioid Tapering**
10:00–12:15 Lori Montgomery, MD, CCFP; Todd Hill, PhD, RPsych

ROOM / SALLE : 515ABC
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Use basic motivational skills to introduce the idea of an opioid taper
2. Practise motivational skills in helping a patient plan a taper
3. Troubleshoot potential barriers to an opioid taper

Description:
Canadian family physicians have recently been provided a new guideline on opioid prescribing for non-cancer pain that encourages opioid tapering whenever possible for patients on high doses. But a conflict arises when some patients are more ready than others. How can you help a patient embrace the idea? Evidence suggests that one of the most effective tools to help patients make changes in behaviour is motivational interviewing. This experiential workshop will outline motivational interviewing and other clinical tools that are useful to help patients make changes in the ways they use opioids. Participants will have an opportunity to practise motivational interviewing skills and to craft a plan for an opioid taper.

S208 **To SEA Ourselves: Using significant event analysis to teach patient safety**
10:00–12:15 John Maxted, MD, MBA, CCFP, FCFP; Patricia O'Brien
All teachers welcome. Highlights advanced concepts for clinical preceptors.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 2

Learning objectives:

1. Teach significant event analysis (SEA) using a model adapted from the Patient Safety and Incident Management Toolkit
2. Evaluate the benefits of SEA in family medicine education from the experiences of the Markham Family Medicine Teaching Unit
3. Identify ways to integrate patient safety initiatives such as SEA into family medicine education

Description:

This is an interactive session for family medicine teachers and primary care practitioners who want to be more actively engaged in learning about and teaching patient safety. Significant event analysis (SEA) is a model used to assess a primary care incident to answer what happened and why did it happen, with the ultimate goal of prioritizing improvements in our systems of care to prevent it from happening again. SEA is a proactive response in patient safety that goes beyond reactive activities such as morbidity and mortality rounds or quality assurance. This session will focus on learning to use and teach SEA in family medicine education, including the application of methods to facilitate its use in improving patient safety. Participants will be invited to provide feedback about preliminary findings from the evaluation of the experiences of the Markham Family Medicine Teaching Unit over the past four years in performing and teaching SEA. This session will end by addressing the challenges in integrating patient safety into family medicine education, with reference to the experiences of the Quality Improvement Program of the University of Toronto Department of Family and Community Medicine. Ongoing efforts to engage family medicine teachers and primary care practitioners in patient safety through shared experiences and learning will be explored with participants, using opportunities for future collaboration to stimulate this discussion.

S79 **Community-Based Management of Cannabis Use Disorder in Adolescents**
11:15–12:15 **Prise en charge communautaire de l'usage de cannabis chez les adolescents**
Anthony Ocana, MD, CCFP, ABAM

ROOM / SALLE : 710B

Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:

1. Diagnose cannabis use disorder
2. Perform a comprehensive screen for co-occuring disorders (anxiety, bipolar, ADHD, trauma)
3. Create a treatment plan that integrates medical and other community-based resources

Description:

Overview: Attitudes toward, access to, and the legality of cannabis have changed dramatically in the past five years. During this period, 12-month and lifetime prevalence of DSM-5-defined cannabis use disorder (CUD) in 15- to 25-year-olds has increased to 2.5 per cent and 6.3 per cent, respectively. The annual socio-economic cost of CUD has been estimated at more than $1 billion and is associated with negative outcomes including school failure, social impairment, and lower employment achievement. Methods: The electronic medical record notes of 149 patients who smoked more than 20 days per month and met the criteria for CUD were exported and coded using quantitative narrative analysis software (NVivo 10). Results: The reoccurring themes were: First, CUD (304.3) is associated with comorbid diagnoses in more than 75 per cent of cases, the most common of which are: generalized anxiety disorder (300), major depressive disorder (311), and attention-deficit hyperactivity disorder (314). Second, adolescents endorse the use of two principal strains of cannabis, indica and sativa, each with distinct physiological and neuro-biological effects. Third, adolescents' choice of cannabis strain appears to be a purposeful form of self-medication. Specifically, sativa was associated with cognitive stimulation and improved productivity. Overuse was associated with anxiety and agitation, especially when combined with caffeine or psycho-stimulants. Indica was associated with improvements in sleep, appetite, and pain. Overuse was associated with lethargy, impaired cognition, and executive dysfunction. There was no statistically significant correlation between the strain of cannabis smoked and any particular comorbidity. Fourth, outpatient management of CUD with a combination of pharmacotherapy, group and individual psychotherapy, diet/fitness/sleep coaching, and mindfulness training was associated with improvement on the patient-rated Clinical Global Impressions scale, increases on the physician-rated Global Assessment of Functioning scale, and decreases in cannabis-using days

(25 versus eight; range 12 to zero). Anecdotally, asking about cannabis strain and discussing self-medication seemed to be a fruitful way to decrease barriers to change.

Objectifs d'apprentissage :

1. Poser un diagnostic de trouble de consommation du cannabis
2. Effectuer le dépistage complet des troubles concomitants (anxiété, bipolaire, TDAH, traumatisme)
3. Créer un plan de traitement qui intègre les ressources médicales aussi bien que communautaires

Description :

Survol : L'attitude à l'égard de l'accès et du caractère légal du cannabis a subi tout un revirement dans les 5 dernières années. Durant cette période, la prévalence à 12 mois et à vie du trouble d'usage abusif de cannabis tel que décrit dans le DSM-V s'est accrue de 2,5 et de 6,3 %, respectivement chez les 15-25 ans. Bon an, mal an, le fardeau socio-économique du trouble d'usage abusif de cannabis est estimé à plus de 1 milliard de dollars canadiens et est associé à des issues négatives, telles qu'échec scolaire, difficultés sociales et faible réalisation professionnelle. Méthodes : Les notes des ambulanciers sur 149 patients qui fumaient > 20 jours par mois et répondaient aux critères de trouble d'usage abusif de cannabis ont été exportées et codées, à l'aide du logiciel quantitatif *Narrative Analysis Software* (NVivo 10). Résultats : Les thèmes qui revenaient étaient les suivants : 1) Le trouble d'usage abusif de cannabis (304,3) est lié à un diagnostic de comorbidité dans plus de 75 % des cas. Les plus fréquents sont : trouble d'anxiété généralisé (300), trouble dépressif majeur (311) et trouble déficitaire de l'attention avec hyperactivité (314). 2) Les adolescents préfèrent deux principales souches de cannabis, soit *Indica* et *Sativa*, chacune dotée d'effets physiologiques et neurobiologiques distincts. 3) Le choix de la souche de cannabis par les adolescents semble être une forme intentionnelle d'auto-médication. Particulièrement, *Sativa* était liée à la stimulation cognitive et à une meilleure productivité. La surconsommation était associée à l'anxiété et à l'agitation, surtout lorsqu'elle était consommée en concomitance avec la caféine ou les stimulants. *Indica,* quant à elle, était liée à l'amélioration du sommeil, de l'appétit et au soulagement de la douleur. La surconsommation était liée à la léthargie, à un déficit cognitif et à la perturbation de la fonction exécutive. Il n'y avait pas de corrélation statistiquement significative entre la souche de cannabis fumée et une comorbidité en particulier. 4) La prise en charge ambulatoire du trouble d'usage abusif de cannabis par un amalgame de pharmacothérapie, de psychothérapie de groupe et individuelle, d'accompagnement en matière d'alimentation/de forme physique/de sommeil et de formation en pleine conscience était associée à une augmentation des scores à l'échelle GCI (*Clinical Global Improvement*) notée par le patient, et à l'échelle GAF (*Global Assessment of Function*) notée par le médecin, et par une baisse des jours de consommation de cannabis, pour les faire passer de 25 à 8 (intervalle : 12-0). Aussi, le fait de poser des questions sur la souche de cannabis et de parler de l'auto-médication a semblé faire tomber les obstacles au changement.

S95 Pulmonary Rehabilitation: What is it? Does my patient need it?

11:15–12:15 Suzanne Levitz, MD CM, CCFP

ROOM / SALLE : 523AB

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Define pulmonary rehabilitation and its target population
2. Identify patients who could benefit from this therapy at various stages of disease
3. Implement pulmonary rehabilitation principles in office practice

Description:

Pulmonary rehabilitation is a well-defined modality in the management of chronic lung disease (COPD and interstitial lung disease). It has shown superiority to inhaled bronchodilators and oral medications in the improvement of quality of life in affected populations; however, this information is not well known among family physicians. This session will review the principles of pulmonary rehabilitation programs and give learners simple techniques they can share with their patients to improve the management of this debilitating chronic condition.

S157 **Mixing and Matching: Layering psychopharmacological medications as family physicians**
11:15–12:15 Jon Davine, MD, CCFP, FRCPC

ROOM / SALLE : 517D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Use psychopharmacological augmenting techniques when dealing with partial responses to antidepressants
2. Describe the use of different combinations of hypnotics to treat insomnia
3. Describe using different combinations of drugs when treating anxiety disorders

Description:
Often, psychopharmacologic treatment of psychiatric conditions involves combining medications in an appropriate manner. In this workshop, we will discuss a number of scenarios in which this occurs. This will include augmenting a partial response to antidepressants, dealing with treatment-resistant depressions, treating acute manic conditions, dealing with insomnia, dealing with anxiety disorders and schizoaffective disorder, among others. Participants will be encouraged to bring up some of their own cases where issues of "layering" occurred. I will take questions throughout the presentation to encourage interaction.

S220 **Helping Your Patient Cope With an Unplanned Pregnancy**
11:15–12:15 Ellen Wiebe, MD, CCFP, FCFP; Darlana Mulzet, MD, CCFP
ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

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 with birth

Description:
We will give information about abortion in Canada so you can give the best information to your patients. We will then discuss 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 the risk of infertility and depression and the effect of an abortion or unplanned child on the relationship.

S240 **Simplified Approach to Red Eye: Evidence, pearls, and medico-legal pitfalls**
11:15–12:15 **Approche simplifiée de l'œil rouge : Données probantes, perles et pièges médicolégaux**
Simon Moore, MD, CCFP

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Differentiate various red eye diagnoses confidently and avoid common medico-legal pitfalls
2. Prescribe therapeutics for red eye, including antibiotics, safely according to recent evidence
3. Identify simplified red eye red flags requiring urgent referral

Description:
The focus of this lecture is not only to review the scientific content, but also to help the learner apply clinical, patient-is-in-front-of-you management. This lecture will help the learner confidently differentiate which red eye patients need urgent referral versus those who can safely be discharged home. The talk also emphasizes three

pearls that every family physician should know about red eye. This presentation is the updated version of a highly-rated 2014, 2015, & 2016 FMF presentation as well as a 2014 & 2016 OCFP ASA presentation. It incorporates updated recommendations and feedback from the previous presentations. Dr. Simon Moore has consistently received outstanding teaching evaluations at past conferences, and has also presented at FMF in 2011-2014 on "Starting Insulin in Type 2 Diabetes WITHOUT Losing Sleep at Night" as well as "I'm Not Injecting Poison Into My Child: How to confidently debunk your patients' anti-vaccination myths" and "From Great to Outstanding: Take your medical presentations to the next level" in 2015 & 2016

Objectifs d'apprentissage :

1. Différencier avec confiance les divers diagnostics des yeux rouges et éviter les pièges médicolégaux courants
2. Prescrire en toute sécurité un traitement contre l'œil rouge, y compris des antibiotiques, en fonction des données probantes récentes
3. Reconnaître rapidement les symptômes alarmants simplifiés de l'œil rouge qui exigent une consultation d'urgence

Description :

Cette présentation se concentre non seulement sur le contenu scientifique, mais aussi sur l'aide à l'apprenant pour mettre en application la prise en charge clinique du patient devant vous. À l'aide du logiciel de présentation innovateur et visuellement attrayant Prezi (plutôt que PowerPoint), cette présentation aidera l'apprenant à différencier avec confiance les cas de l'œil rouge qui doivent faire l'objet d'une consultation d'urgence de ceux qui peuvent être renvoyés à la maison en toute sécurité. La présentation présente trois perles que tout bon médecin de famille doit connaître sur l'œil rouge. Cette présentation est une version actualisée d'une présentation très populaire des FMF 2014, 2015 et 2016, de même que de la présentation à l'Assemblée scientifique annuelle du Collège des médecins de famille de l'Ontario de 2014 et 2016. Elle incorpore les nouvelles recommandations et les commentaires obtenus des présentations antérieures. Le Dr Simon Moore reçoit invariablement des évaluations d'enseignement exceptionnelles lors des conférences antérieures, et il a aussi présenté aux FMF de 2011 à 2014 sur « Commencer l'insulinothérapie dans le diabète de type 2 SANS s'empêcher de dormir » de même que « Je n'injecte pas du poison à mon enfant : Comment déboulonner avec confiance les mythes anti-vaccination entretenus par vos patients » et « De bonne à exceptionnelle : Faites passer vos présentations médicales au niveau supérieur » en 2015 et 2016.

S384 **Le préceptorat minute : pourquoi s'en servir au quotidien ?**

11:15–12:15 Manon Denis-LeBlanc, MD, CCMF; Lyne Pitre, MD, CCMF

Tous les enseignants sont les bienvenus.

Cette séance fait le point sur certains concepts de base pour les superviseurs cliniques

ROOM / SALLE : 510C

Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :

1. Décrire les étapes du préceptorat minute
2. Démontrer les avantages et les inconvénients du préceptorat minute
3. Encourager le développement du raisonnement clinique chez leurs apprenants

Description :

Tous les cliniciens sont à la recherche de méthodes pour améliorer l'efficacité de leur travail. Pourtant, nombreux sont ceux qui notent que l'enseignement ralentit considérablement leur boulot. De plus, peu se posent la question à savoir pourquoi une présentation de cas s'articule de la façon traditionnelle (soit raison de consultation, histoire de maladie actuelle, antécédents, etc.). Alors, pourquoi ne pas utiliser la présentation de cas comme tremplin pour encourager le raisonnement clinique, tout en l'évaluant ? La méthode du préceptorat minute, quoique non intuitive, est une façon inouïe d'approfondir son enseignement et de gagner du temps. Par contre, il faut l'approfondir, la comprendre, la tester. Et c'est cela que cet atelier propose de faire, de façon dynamique et interactive, par des exercices pratiques et l'utilisation de vidéos.

S456 **Dépistage et intervention psychologique : Meilleures pratiques pour les hommes post-événement cardiaque**
11:15–12:15
Jean Grenier, PhD, CPsych; Vanessa Tassé, candidate PsyD; Paul Greenman, PhD, CPsych; Marie Hélène Chomienne, MD, MSc, CCMF; Jalila Jbilou, MD, PhD

ROOM / SALLE : 521ABC
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Évaluer les symptômes de dépression, d'anxiété et de stress post-traumatique dans le contexte des maladies cardiaques à partir d'instruments validés
2. Reconnaitre la spécificité masculine en ce qui a trait à la présentation des symptômes psychologiques
3. Intervenir auprès des hommes ayant des maladies cardiaques en se servant d'informations psychoéducatives

Description :
L'activité sera bilingue. Elle débutera par une mise en contexte de la prévalence des troubles de l'humeur, troubles d'anxiété et de troubles de stress post- traumatique après un événement cardiaque et les implications sur la morbidité et la mortalité cardiaque si ces pathologies ne sont ni dépistées, ni traitées. Les particularités liées au genre (hommes) seront aussi présentées tant, quant à l'expérience des hommes qui ont des maladies cardiaques, que sur les manifestations spécifiques au genre de la détresse psychologique. Différents instruments permettant le dépistage et l'identification des troubles psychologiques chez les hommes seront présentés. Les participants seront instruits sur l'administration de questionnaires validés pour détecter la dépression, l'anxiété et le stress post-traumatique chez les hommes ayant des maladies cardiaques. Les auteurs pourront, à l'aide d'exemples concrets de leurs pratiques avec des hommes présentant une détresse psychologique, discuter des pistes d'intervention à partir des thérapies cognitives comportementales et axées sur l'émotion. Les participants seront informés des différents éléments essentiels de psychoéducation qu'ils peuvent utiliser dans un premier temps au bureau. Les participants seront aussi renseignés sur les spécificités des interventions cognitivo-comportementales dans un contexte d'événement cardiaque chez les hommes et de l'importance d'inclure les partenaires dans ces interventions; les auteurs présenteront aux participants comment et où ils pourraient orienter au mieux leurs patients afin d'obtenir des soins optimaux pour les hommes dans un contexte de maladie cardiaque. L'activité sera encadrée par un pré et post test, elle sera interactive, surtout dans le cadre de la démonstration du choix et de l'administration des instruments ainsi que pour l'interprétation des scores.

S460 **Canadian Choosing Wisely - Long Term Care: Uniquely Canadian**
11:15–12:15
Fred Mather, MD, CCFP; Serge Gingras, MD

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Provide background for the unique, Choosing Wisely Canada Long Term Care (CWC-LTC) recommendations
2. Present the six CWC-LTC recommendations
3. Highlight key references that support the recommendations

Description:
The Choosing Wisely Canada (CWC) campaign helps clinicians, patients, and families engage in conversations about clinical decision making. Smart and effective choices ensure a high quality of care. This includes avoiding unnecessary tests and treatments, which can expose the patient to harm; false positive results lead to more investigations. The Long Term Care Medical Directors Association of Canada established six key recommendations. These six recommendations are valid and relevant for Canadian patients and our health care system. The family physician in long-term care is part of an interdisciplinary team. At the conclusion of this interactive session, the clinician will use CWC-LTC as a guide to sound decision making. CWC-LTC is a useful

resource share with patients, their families, and other care providers on the team. The references provide further evidence to clinical decision making in long-term care. Visit the website, www.choosingwiselycanada.org/recommendations/long-term-care/ for more information.

S470 **First Five Years in Family Practice: Locums 101**
11:15–12:15 Steve Hawrylyshyn, MD, MSc, CCFP

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Evaluate locum opportunities and identify the essential questions that must be addressed to ensure successful locum coverage is provided
2. Prepare for contract negotiations and determine key areas where terms and expectations should be clearly defined
3. Recognize how successful locum coverage contributes to the continuity of care for patients

Description:
Locums are an essential part of family practice throughout Canada. This interactive session, facilitated by the First Five Years in Family Practice Committee, will provide a complete overview to providing locum coverage and will prepare attendees for each aspect of that process. A panel of family physicians who have extensive experience with locums will identify the essential information for those considering locum placements, through lessons learned from their personal experiences and their strategies for success that can be applied by attendees in their own locums. Topics will include what should be discussed during the initial contract negotiations, how to ensure the smoothest transition for coverage, key questions to ask of the host physician, and what to consider before accepting a locum—all of which ensure successful locums and maintain continuity of care for Canadian patients. The panelists will also demonstrate how locum experiences in early careers can be used to compare different types of family practices to assist with planning for one's own career and scope of practice. The session will conclude with an opportunity to ask questions to which panelists will respond and address any specific challenges or concerns raised by attendees.

S484 **Rethinking Research Mentorship Supports for Residents in Family Medicine**
11:15–12:15 Matthew Menear, PhD; Dominique Ansell, MD, CCFP (EM), MSc; Jordyn Lerner, MD

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the benefits of research mentorship and the characteristics of good mentors as described in the current literature
2. Explain the range of research mentorship supports available to residents in family medicine
3. Discuss strategies for improving research mentorship supports for residents, during and after their residency

Description:
Many family medicine residents are interested in scholarly and research activities but feel that they lack supports and guidance when taking on their scholarly projects or deciding how to include research as part of their practice as physicians. Difficulties accessing adequate mentorship can lead residents to have a negative perception of research during their residency and to them disengaging from research-related activities early in their careers as physicians. Therefore, connecting with helpful mentors is critical to helping residents appreciate their role as scholars and reflective learners that generate and apply knowledge to support evidence-informed practices. In this workshop, we will present the evidence for academic mentoring and the benefits it can have for mentees. Participants will learn about the qualities to look for in a research mentor. We will also share information about new ways that residents can access research mentorship, such as through practice-based research networks and SPOR networks. Finally, we will engage residents in a discussion about their own experiences around research

mentorship, the barriers they frequently encounter, and the strategies that the College can explore to improve connections between residents and mentors in family medicine research. These discussions will help shape new resources for residents as part of the College's research community of practice initiative.

S113 **Marriage and Medicine: Challenges and remedies**
12:30–13:30 Philippe Erhard, MD, CCFP, FCFP, Dip Sport Med

ROOM / SALLE : 510A
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Identify potential intimate relationship difficulties that are unique to physicians
2. Learn tips to nurture the relationship
3. Improve communication and listening skills

Description:
Our training and personalities may have brought success to our professional lives, but they may not be as effective in helping us develop intimate and harmonious relationships. In this session we will explore the different adaptations or maladaptations we've made as physicians and their potential negative effects in our intimate relationships. Change is possible and is our personal responsibility. Committing to the relationship, taking the time to nurture each other, and learning how to communicate and listen at an intimate level are crucial to a healthy relationship. Participants will review tips on how to implement these skills in their everyday lives.

S376 **The Art of Calypso for Public Health in Caribbean Culture**
12:30–13:30 Amber Wheatley, MD; Amber Wheatley, MD; Kyle Hoedebecke, MD, MBA, MPA, FAAFP; Shakera Carroll, MD; Shastri Motilal, MD; Vanita Jagai, MD

ROOM / SALLE : 511A
This session is not certified by the CFPC. This session may be eligible for non-certified credits.

Learning objectives:
1. Analyze the public health messages hidden in Caribbean calypso songs and stories
2. Assess the effectiveness of using calypso to carry public health messages
3. Write stories, poems, or songs of their own

Description:
Creative writing can be defined as "writing that expresses ideas and thoughts in an imaginative way [allowing] the writer ... to express feelings and emotions instead of just presenting the facts." Creative writing can take the form of stories, poems, or songs and is a well-recognized method of human expression and information sharing. Creative writing is heavily dependent on cultural context and often captures or reflects on the popular opinions of a society. A unique form of creative writing that developed in the Caribbean is calypso. Calypso is a type of folk music that originated in Trinidad and spread throughout the Caribbean in the 17th century. Slaves used calypso to tell stories and pass on information when communication was forbidden. In more modern times, calypso was used as a method of social commentary, often on topical issues of politics, relationships, and public health. This workshop seeks to introduce participants to the use of calypso to express public health concerns such as sexually transmitted infections, domestic violence, and drug abuse through three exercises. In the first exercise participants will be introduced to the musical structure and style of calypso. In the second exercise participants will be played two selected calypso songs and be invited to analyze the lyrics of the songs in small groups. The main theme of each song, the biases of the performer, and the intended audiences will be discussed. After the small group discussions participants will be invited to present their ideas to one other. The final exercise will involve participants writing their own lyrics about a public health topic that they feel most affects their community. A calypso melody will be provided and participants may write in groups or individually. Participants are welcomed to share their calypso songs at the end of the session.

S39 **Interventions We Should Abandon in the Emergency Department**
13:30–14:30 Vu Kiet Tran, MD, CCFP (EM), FCFP, MHSc

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize harmful procedures
2. Recognize wasteful procedures
3. Reduce unnecessary resource use

Description:
This lecture will be an immediate practice-changing educational event. We will discuss current legacy interventions we currently perform in the emergency department that are either harmful or wasteful. The learners will understand why these interventions should be abandoned and what interventions should replace them to achieve better outcomes.

S145 **Making Your Presentation More Interactive: The Better Way!**
13:30–14:30 Jon Davine, MD, CCFP, FRCPC
All teachers welcome. Highlights advanced concepts for teachers outside the clinical setting.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify the superiority of interactive group teaching versus the traditional didactic model in changing physician behaviour
2. Describe and participate in different activities that enhance interactive group teaching
3. Describe the use of commercial film clips to enhance group teaching

Description:
Educational literature has shown that traditional didactic presentations usually are not effective in changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop we look at methods to facilitate interactive discussions. It will have an interactive component that will involve participating in different group activities such as buzz groups, think-pair-share, and stand up and be counted. The use of commercial film to enhance educational presentations has been called "cinemeducation." We will discuss techniques to help use films as teaching tools and have an experiential component involving the direct viewing and discussion of a film clip. I will take questions throughout the presentation to encourage interaction.

S204 **An Exit Plan for Opioids: When, why, how?**
13:30–14:30 **Plan de sortie pour les opioïdes : Quand, pourquoi, comment ?**
Roman D Jovey, MD; Lori Montgomery, MD, CCFP

ROOM / SALLE : 517BC
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Define the reasons for considering tapering or discontinuing opioids for a patient with chronic non-cancer pain
2. Apply motivational interviewing techniques to initiate the discussion and facilitate the taper process
3. Identify options for tapering or discontinuing opioids in an outpatient setting

Description:
The use of opioid therapy to treat chronic non-cancer pain continues to generate controversy. In spite of the absence of published evidence demonstrating long-term benefit, clinicians report benefits for some patients with some types of pain for at least some period of time. Unfortunately, there is no current, validated method to predict who will benefit long term without a trial of therapy. However, when opioids do not provide adequate relief or the risks start outweighing the benefits in an individual patient, it can be difficult to taper or discontinue opioids because of the patient's fears and the clinician's beliefs regarding opioid withdrawal. During this presentation attendees will be introduced to how motivational interviewing techniques can be used to initiate this often-difficult discussion and support the patient through the opioid tapering process. Case scenarios will be used to illustrate the process of deciding when to taper opioids, how to do so in an outpatient setting, and how to mange patient fears and expectations, and some practical strategies to reduce the severity of withdrawal. The presentation will incorporate recommendations from the recently published 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain.

Objectifs d'apprentissage :
1. Définir les raisons pour envisager de réduire graduellement la dose d'opioïdes ou de mettre fin au traitement chez un patient qui souffre de douleur chronique non cancéreuse
2. Mettre en pratique les techniques d'entretien motivationnel pour lancer la discussion et faciliter le processus de réduction de la dose
3. Identifier les options pour réduire la dose d'opioïdes ou mettre fin au traitement en contexte ambulatoire

Description :
La controverse continue sur le recours aux opioïdes dans le traitement de la douleur chronique non cancéreuse. Malgré l'absence de données probantes publiées démontrant le bienfait à long terme, les cliniciens rapportent des bienfaits chez certains patients qui souffrent de certains types de douleur pendant du moins un certain temps. Malheureusement, il n'existe aucune méthode actuelle et validée pour prédire qui profitera à long terme, sans mettre le traitement à l'essai. Toutefois, lorsque les opioïdes ne soulagent pas suffisamment la douleur, ou lorsque le risque commence à surpasser les bienfaits chez un patient donné, il peut être difficile de réduire la dose d'opioïdes ou de mettre fin au traitement en raison des peurs entretenues par les patients et les croyances du médecin en matière de sevrage des opioïdes. Durant cette présentation, les participants apprendront les techniques d'entretien motivationnel pouvant être utilisées pour lancer une discussion souvent ardue et soutenir le patient durant le processus de sevrage de la dose d'opioïdes. Des scénarios de cas illustreront le processus décisionnel quant au moment de réduire la dose d'opioïdes, comment le faire en contexte ambulatoire, comment éliminer les craintes et les attentes du patient et certaines stratégies pratiques pour réduire la sévérité du sevrage. La présentation incorpore les recommandations des Lignes directrices canadiennes 2017 en matière d'opioïdes, récemment publiées.

S246 Odd and Scary: How to approach and manage unusual skin conditions

13:30–14:30 Lawrence Leung, MBBChir, FRACGP, FRCGP(UK), CCFP

ROOM / SALLE : 517D

Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Adopt an effective approach to skin conditions in family medicine
2. Be alert to odd and scary skin conditions
3. Derive differentials with the DERMAP approach leading to the most appropriate management

Description:
Dermatological conditions represent up to one in seven of all consultations in family medicine. When confronted with skin lesions that are odd or scary, practising family physicians often feel daunted when making a diagnosis, let alone managing them. This may lead to either unnecessary dermatological referrals or the inappropriate prescription of steroid creams in a reflex-arc manner. This presentation will give a structured view to those possible odd and scary skin conditions that can commonly be encountered. Attendees will be introduced to the DERMAP

flow chart approach to arrive at the best differentials and diagnoses for providing cost-effective management.

S249 **Scholarly Writing for Busy Clinicians: Why it matters and how to do it**
13:30–14:30 Cheri Bethune, MD, MClSc, CCFP, FCFP; Tom Heeley, MASP; Patti McCarthy, MSc; Shabnam Asghari, MD, PhD; Wendy Graham, MD, CCFP

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the fundamental principles of scholarly writing in clinical academia
2. Recognize opportunities, challenges, and best practices for scholarly writing in a clinical setting
3. Develop a conceptual framework for a scholarly writing project

Description:
Background: With the growing marriage between medicine and policy the ability of physicians to write in a scholarly way is more important than ever, but many physicians do not receive any formal training in this essential skill. The workshop: This workshop will detail key principles and best practices for scholarly writing in a clinical context, with an emphasis on why scholarly writing is an essential skill for rural physicians, and strategies physicians recommend to integrate it into your lifestyle as a busy clinician. Participants will experience multiple mini-presentations on important subjects in scholarly writing delivered by experts in scholarly writing, conceptualize a scholarly writing project using proven creative writing techniques, and embellish this draft through small group discussion. Teaching methods: This workshop will combine a traditional presentation interspersed with breakout small group activities. The traditional lecture will be broken into digestible five-minute mini-lectures on subjects including: 1) key concepts in scholarly writing; 2) why and how to write for publication; 3) scholarly writing frameworks; 4) identifying key elements of a scholarly writing project; and 5) creative techniques (mind mapping, free writing). The small group activities will challenge participants to apply the teachings from each mini-lecture to their own writing project to enhance their comprehension and retention.

S278 **Humanities Tool Kit: How reading, writing, art, and film can save your life**
13:30–14:30 Michael Roberts, MD, CCFP, FCFP; Deborah Adams, MA, MHSc, CHE; Jessica Munro, NP; Deborah Adams, MA

ROOM / SALLE : 521ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Experience how the humanities are an untapped resource for personal and professional wellness and resilience
2. Practise close reading and writing through the exercises “A Call to Stories” and “Writing Down the Bones”
3. Discover visual thinking strategies as a means to see art and film through fresh eyes

Description:
There is a growing body of research that suggests exposure to the humanities (including literature, film, poetry, and visual arts) fosters enhanced critical reflection and empathy in physician-patient encounters and prevents provider burnout. Furthermore, such exposure celebrates the subjective and emotional facets of adult learning alongside the more conventional scientific/evidence-based approaches. In this interactive, experiential workshop participants will be provided with opportunities to rediscover how the humanities can be an ongoing resource for wellness and resilience in their personal and professional health and well-being, patient care, and teaching of medical learners. In this session participants will work through an examination of prose, poetry, photography, and painting and participate in a hands-on writing exercise to determine how they can incorporate these modalities in their practices. This workshop will provide participants with a practical set of tools that they can implement in their practices with patients, use as a teaching tool with learners, and integrate into their self-care efforts. At the conclusion of this workshop participants will be able to use the humanities

to foster resilience in their personal and professional well-being; identify practical ways to integrate humanities into their approaches to patient care; and explore how the humanities could be applied to teaching and mentoring medical learners.

S280 **Leading Change in Climate Health**
13:30–14:30 Joe Vipond, MD, CCFP (EM), FCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the major current and future health impacts of climate change
2. Describe the three areas in which reducing greenhouse gas emissions has immediate health benefits: active transport, healthy energy, and low-carbon diets
3. Identify the means by which concerned physicians can become involved in advocacy for a healthy climate

Description:
The World Health Organization calls climate change the greatest global health threat of our time, and the Lancet says taking action on climate may represent our greatest health opportunity. Meanwhile, climate health is still not included in the curriculum at the vast majority of medical schools. Find out what the risks are—and how Canadian physicians are already having a major impact on local and national climate policy by addressing climate change through the lens of health and lending their input as part of multidisciplinary teams. A particular focus will be put on physician action in areas where decreasing greenhouse gas emissions improves health immediately. We will go through case studies from Montreal and elsewhere in which physician contributions helped revamp the approach to active transport (getting where you want to go under your own steam); look at successful efforts to minimize asthma-unfriendly air pollution through a phase-out of coal power; and explore new initiatives looking at the health benefits of moving toward a low-emission and heart-friendly "mostly plant" diet.

S322 **Balint 2.0: Engaging international and rural colleagues through digital Balint experiences**
13:30–14:30 Kyle Hoedebecke, MD, MBA, MPA, FAAFP; Ana Rochadel, MD; Kenneth Yakubu, MD; Maria Bakola, MD; Susanne Cording, MD; Lisdamys Morera, MD

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Understand how Balint implementation contributes to physician resiliency
2. Implement digital Balint platforms at their locations
3. Engage residents, rural physicians, and global health colleagues through this initiative

Description:
Background: A Balint group consists of approximately eight to 12 physicians who meet regularly to present clinical cases to understand clinician-patient relationships better. Rather than searching for "right" answers, these individuals focus on their ability to connect with and care for the patient, with outcomes showing improved resiliency and decreased burnout in participants. Traditionally these groups are performed in person; there are no published reports of physicians from around the world using audiovisual technology to create a Balint group. Methods: Balint 2.0 Ambassadors is a joint venture among a group of residents and young family doctors representing the seven regional Young Doctors' Movements (YDMs) of the World Organization of Family Doctors (WONCA) and the International Balint Federation. The "2.0" refers to the application of technology while "ambassadors" touches on the unique international nature of this Balint group. Contrary to traditional counterparts, this Balint group breaks down barriers by meeting online using social media and video-conferencing software. Using these means, the members of the group do not meet in a single place—instead meeting while thousands of miles apart and spread across the entire globe. Results and Conclusions: This two-year collaboration was completed in June 2017. The authors conclude this is a feasible solution for international and rural colleagues

as long as these individuals apply the lessons learned here. Balint 2.0 Ambassadors are a great example of young family physicians exploring new frontiers and creating a new era for medical learner and new physician collaborations that know no boundaries.

S336 **The Power of PrEP and PEP and the Future of HIV Prevention**
13:30–14:30 Charlie Guiang, MD, CCFP; Gordon Arbess, MD, CCFP; James Owen, MD, CCFP

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe HIV PrEP and how to integrate it into practice
2. Describe PEP regimens for use in high-risk HIV exposures
3. Review the future of HIV prevention startegies including TasP and injectibles

Description:
The number of people living with HIV in Canada continues to rise, but the number of new HIV infections is now declining. In 2014 it was estimated that 75,500 people in Canada were HIV infected. This represents a 9.7 per cent increase since 2011. With better care and medications, more people are living longer with HIV and dying less of AIDS and related conditions. However, the number of new HIV infections in 2014 declined to 2,044 compared with 2,290 in 2011. Prevention remains critical to keeping HIV infections in check. Family physicians are at the front line of prevention for many diseases, including HIV and other sexually transmitted infections. Understanding that testing for HIV, providing education, and providing counselling are paramount to HIV prevention, we aim to explore additional prevention methods in the form of chemoprophylaxis, which family physicians can use in everyday practice for their high-risk patients. In this session we will review: pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and the future of HIV prevention: TasP and injectables. The aim is for family physicians to have a better understanding of these HIV chemoprohylaxis methods, the evidence supporting their use, and practical pearls that will help with their confidence in prescribing PrEP and PEP, in addition to safer sex education and counselling, to decrease the risk of acquiring HIV infection.

S360 **Evidence-Based Practice Pearls in Well-Baby/Well-Child Care: Launching the 2017 Rourke Baby Record**
Perles de la pratique fondées sur les données probantes en puériculture : Lancement de l'édition 2017 du Relevé postnatal Rourke
13:30–14:30 Leslie Rourke, MD, CCFP, MClSc, FCFP; Patricia Li, MD, MSc, FRCPC, FAAP

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Apply preventive care information for comprehensive office-based care of children zero to five years of age
2. Interpret and apply new evidence related to social determinants of health, allergenic foods, and pediatric oral health
3. Implement the new 2017 Rourke Baby Record and its related resources and review the translation of research findings

Description:
"Is my young child healthy and growing and developing normally?" Preventive care and health supervision for infants and young children provide a unique opportunity to monitor and promote healthy child growth and development for optimal physical, mental, and emotional health throughout life. Recommendations for preventive care in infants and young children, including screening manoeuvres, anticipatory guidance, and specific interventions, should be based on the current best evidence. This interactive case-based session will launch the 2017 edition of the Rourke Baby Record. It will focus on current evidence for the well-child care of children ages one week to five years and will highlight new recommendations, including those related to allergenic foods, social determinants of health, and oral health. Pearls for practice will help participants answer parents' questions more

effectively and provide reliable resources to support the advice given. This session will appeal to family physicians, community pediatricians, primary health care providers, students/residents, medical teachers, and parents.

Objectifs d'apprentissage :

1. Mettre en application les renseignements en matière de soins préventifs en vue de dispenser des soins complets en cabinet aux enfants de 0-5 ans
2. Interpréter et mettre en application les nouvelles données probantes liées aux déterminants sociaux de la santé, aux aliments allergènes et à la santé buccale chez les enfants
3. Mettre en œuvre l'édition de 2017 du Relevé postnatal Rourke et des ressources connexes et revoir la traduction des résultats de la recherche

Description :

« Mon bébé est-il en bonne santé et est-ce qu'il grandit et se développe normalement ? » Les soins préventifs et la supervision de la santé chez les nourrissons et jeunes enfants sont l'occasion de surveiller et de favoriser la croissance et le développement normaux pour assurer une santé physique, mentale et émotionnelle optimale. Les recommandations en matière de soins préventifs chez les nourrissons et les jeunes enfants, y compris les manœuvres de dépistage, les conseils de prévention et les interventions précises, doivent s'appuyer sur les données probantes actuelles de la meilleure qualité. Cette séance interactive basée sur les soins lancera l'édition 2017 du Relevé postnatal Rourke. Elle se concentre sur les données actuelles en puériculture chez les enfants âgés d'une semaine à cinq ans et mettra en lumière les nouvelles recommandations, y compris celles liées aux aliments allergènes, aux déterminants sociaux de la santé et à la santé buccale. Les perles de la pratique aideront les participants à répondre plus efficacement aux questions posées par les parents, et à fournir des ressources fiables à l'appui des conseils prodigués. Cette séance intéressera les médecins de famille, les pédiatres communautaires, les fournisseurs de soins de première ligne, les étudiants/résidents, les enseignants en médecine et les parents.

S458 Medical Aid in Dying: Personal stories from across Canada

13:30–14:30 Benjamin Schiff, MD CM, CCFP

ROOM / SALLE : 522ABC

Mainpro+ Group Learning certified credits = 1

Learning objectives:

1. Learn more about medical assistance in dying from the perspective of family physicians from different backgrounds
2. Gain insights into the impact of the medical assistance in dying request on the physician, both professionally and personally
3. Appreciate what is involved in assessing and/or providing medical assistance in dying and its impact on the patient and family/caregiver unit

Description:

The legalization of medical assistance in dying (MAID) has brought with it opportunities and challenges for heath care providers, patients, and their families. In this workshop we will provide physicians with a forum in which to learn more about MAID from the perspective of family physicians from different backgrounds, in particular the opportunity to gain some insight into the impact of the MAID request on the physician both professionally and personally. As a group of physicians, we will share our stories. We will present patient encounters and elaborate on the circumstances that led to the request for MAID and reflect on the journey of the individual, whether or not they received MAID. We will also invite nursing colleagues to share their perspectives. The workshop will be interactive. Our goal is to provide advice, support, and encouragement to physicians. By the end of the workshop participants will have a better appreciation of what is involved in assessing and/or providing MAID to a patient and its impact on the patient and family/caregiver unit, as well as its impact on physicians and/or other health care providers.

S508 **Stand Up for Health! Learning the social determinants of health through simulation**
13:30–14:30 Latif Murji, MD
All teachers welcome. Highlights advanced concepts for educational leaders.

ROOM / SALLE : 510C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize and appreciate the effectiveness of experiential learning as a technique for teaching social determinants of health concepts
2. Appreciate the value of collaborative learning and the sharing of personal life experiences to bring context to the social determinants of health
3. Identify appropriate situations for using simulation learning for medical students, residents, and family physicians

Description:
The social determinants of health (SDOH) has long been a difficult concept to both teach and to truly grasp as a learner, due to its theoretical and abstract nature. In medical education, a didactic approach is often taken, with lectures accompanied by statistics, figures, and graphs. However, the SDOH is about people, and learners stand to benefit from a more human experience of learning, one that would bring these numbers to life. In line with this philosophy, Stand Up for Health was integrated into the Global Health, Family Medicine, and Primary Care course offered to family physicians and family medicine residents at University of Toronto, in 2017. Similarly, the simulation has been used for undergraduate medical education at both University of Toronto and Western University since 2015. Stand Up for Health is an immersive simulation that gives participants a better understanding and appreciation of the SDOH through experiential learning. Participants are placed in the role of a low-income Canadian and must interact, make choices, and overcome challenges within their given set of circumstances. Stand Up for Health concludes with a facilitated discussion about challenges faced by marginalized Canadians as well as about public policy that leads to a healthy and equitable society. This session begins with a discussion about the challenges related to teaching SDOH, making the material concrete, engaging, and relatable to learners. Research will be presented that shows the outcomes of the Stand Up for Health simulation played with family physicians, family medicine residents, and other medical learners. Attendees will have the unique opportunity to go through the entire simulation experience. Lastly, the presentation will reconvene with a facilitated discussion about the value of collaborative learning within a SDOH simulation, and identifying situations most appropriate for using experiential learning simulations.

S524 **Transitioning Into Practice: Advice for residents transitioning into practice**
13:30–14:30 Graham Gaylord, MD, MHA; Dave Jerome, MD, MSc
Facilitator credit: Dr. Graham Gaylord, Dr. Alex Chesley
Names of those to be included as they part of the panel discussion: Dr. Julia Rackal, Dr. Marie-Claude Moore, Dr. Nicole Stockley
All teachers welcome. Highlights novice concepts for clinical preceptors.
La séance sera présentée en anglais, mais des animateurs francophones seront présents.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Transition smoothly into practice after residency
2. Learn common errors of new physicians and how to overcome them
3. Gain insight into what practising physicians wish they knew when they started their practice

Description:
Learn from the experts, as a panel of newly graduated physicians discuss their experiences in their first five years of practice, common problems and pitfalls, and things they wish they knew! After a quick presentation about who

they are and their experiences, a question and answer session will follow. In response to feedback participants provided last year, the target audience for this session is family medicine residents although all are welcomed and encouraged to join us.

S542 **Les commotions cérébrales : Impact des nouvelles recommandations 2017 sur votre pratique**
13:30–14:30 Pierre Frémont, MD, PhD, FCFP (SEM)

ROOM / SALLE : 512CDGH
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Appliquer les recommandations publiées en 2017 concernant les commotions cérébrales dans le cadre de la pratique
2. Fournir une recommandation médicale concernant le retour à une activité à risque suite à une commotion cérébrale
3. Intégrer à la pratique des outils pertinents qui faciliteront la gestion des épisodes de commotion cérébrale

Description :
Quel que soit votre niveau d'expérience clinique en ce qui a trait aux commotions cérébrales, cette séance vous présentera les principales nouvelles recommandations du consensus de Berlin, publiées en 2017, et vous expliquera quels impacts concrets celles-ci devraient avoir sur notre prise en charge des épisodes de commotion cérébrale chez nos patients. Il sera également question des incidences pratiques de nouvelles recommandations émises par les principaux groupes canadiens dédiés à cette problématique. Finalement, des outils pratiques visant à faciliter la prise en charge des commotions cérébrales par le médecin de famille seront présentés.

S126 **L'intégration de patients-partenaires dans l'équipe d'une UMF : Repenser les soins ensemble**
15:00–16:00 Marie-Pierre Codsi, MD; Ghislaine Rouly, patiente-partenaire, UdeM; Antoine Boivin, MD, PhD; Philippe Karazivan

ROOM / SALLE : 510D
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Reconnaître comment l'intégration des patients au sein des comités correspond aux piliers du Centre de médecine de famille du CMFC
2. Présenter un exemple concret de partenariat avec les patients en médecine familiale, dans un comité d'amélioration continue
3. Comprendre comment le partenariat avec les patients peut aider à améliorer la gestion des laboratoires au sein des milieux de médecine de famille

Description :
Le milieu de la santé est en pleine transformation. En effet, le partenariat de soins avec les patients s'impose comme l'approche la plus apte à répondre aux défis de notre système de santé. En effet, l'intégration des patients dans les comités de gouvernance, d'amélioration continue et de recherche représente une révolution majeure. Dans ce contexte, un projet pilote unique de co-construction a débuté à l'UMF Notre-Dame, au Québec. Il s'agit d'un projet novateur visant l'intégration de patients-partenaires au sein d'un comité d'amélioration continue. Ce nouveau comité s'est penché sur l'amélioration de la gestion des tests et des laboratoires au sein des GMF-U (Groupes de médecine familiale et unités d'enseignement). En effet, actuellement, comme dans la plupart des cliniques au Québec, les patients ne sont pas informés de façon systématique des résultats de leurs tests, particulièrement lorsque ceux-ci s'avèrent normaux. Ceci crée, entre autres, des préoccupations et des sentiments d'inquiétude chez les patients. En plus de représenter un risque d'erreur médicale plus élevé, cette réalité ne soutient pas une vision de partenariat. Ce projet incarne la mission et les piliers du Centre de médecine de famille, lequel représente la vision pour l'avenir de la pratique de la médecine familiale au pays. Nous présenterons les différents apprentissages effectués durant ce projet afin que les différents milieux de première ligne du Canada puissent bénéficier de cette expérience.

S161 **"All Out of Breath": A common sense approach to shortness of breath**
15:00–16:00 **À bout de souffle : Une approche sensée sur l'essoufflement**
Filip Gilic, MD, CCFP (EM)

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Understand clinically relevant respiratory physiology
2. Identify the components of respiratory distress (oxygenation, ventilation, and effort)
3. Apply the universal treatment alghorithm in an escalating fashion

Description:
This session will go over clinically relevant respiratory physiology so participants can understand the difference between oxygen and carbon dioxide exchange (oxygenation and ventilation) and how to asses the patient for respiratory effort. These will form the apices of the respiratory assesment triangle; this will lead participants to the universal respiratory distress alghorithm, which will allow them to treat any patient with respiratory distress on an escalating continuum. Finally, the session will present the method of "following the oxygen molecule" to allow participants to identify the root cause of respiratory distress at the bedside in a rapid and accurate fashion.

Objectifs d'apprentissage :
1. Comprendre la physiologie respiratoire pertinente sur le plan clinique
2. Identifier les composants de la détresse respiratoire (oxygénation, ventilation et effort)
3. Appliquer l'algorithme universel du traitement sur un continuum qui s'intensifie

Description :
La séance présentera la physiologie respiratoire pertinente sur le plan clinique pour que les participants puissent comprendre la différence entre l'échange O_2-CO_2 (oxygénation et ventilation) de même que la façon d'évaluer l'effort respiratoire d'un patient. Cela forme les pointes du triangle d'évaluation respiratoire, qui les mène ensuite à l'algorithme universel de la détresse respiratoire, lequel leur permet de traiter tout patient en détresse respiratoire sur un continuum qui s'intensifie. Finalement, la séance présente la méthode du « suivi de la molécule d'O_2 » pour permettre aux participants d'identifier la cause de la détresse respiratoire au chevet du patient de façon rapide et juste.

S169 **Assessing and Remediating Clinical Reasoning: A practical workshop**
15:00–16:00 Parisa Rezaiefar, MD, CCFP, FCFP; Martha Holt, MD, CCFP; Marc Lebeau MD, CCFP, FCFP; Jay Mercer, ME, CCFP
All teachers welcome. Highlights novice concepts for clinical preceptors.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify common cognitive biases affecting clinical reasoning of learners in the family medicine environment
2. Implement a framework to assist learners in understanding critical thinking and clinical reasoning
3. Integrate the One-Minute Preceptor model to explore clinical reasoning when working with residents in busy practice settings

Description:
Clinical teachers are unique in that they often simultaneously provide patient care and teach clinical reasoning to learners. Given that cognitive biases occur in 74 per cent of diagnostic errors, clinical teachers must have skills for diagnosing learners' weaknesses in clinical reasoning while also diagnosing patients' conditions. Learners can accurately identify and analyze cognitive errors and intrinsic biases influencing their clinical reasoning, given the opportunity for reflection. Clinical teachers can learn to recognize when learners might benefit from a

diagnosis "time out" and the opportunity to enter reflective mode, wherein they slow down in order to recognize cognitive biases and correct them. In this interactive workshop we will explore principles of cognitive biases and their impact on the clinical reasoning of learners in the family medicine environment. During the first half of this interactive workshop we will introduce the "12 tips for teaching avoidance of diagnostic error" and the One-Minute Preceptor model as a framework for teaching clinical reasoning. Furthermore, we will explore critical thinking that requires the learner's ability to integrate knowledge and data gathering in the provision of clinical care. Remaining cognizant of the challenges of clinical supervision in the workplace, we will explore the implementation of a clinical reasoning framework that is respectful of the time pressures in a busy family practice setting. During the second half of the workshop, we will use role-playing to demonstrate strategies to help learners develop critical thinking and clinical reasoning. We will then facilitate small-group role-playing to allow participants to practise their acquired skills in identifying gaps in clinical reasoning and use the strategies mentioned above to teach critical thinking.

S215 **L'évaluation médicale périodique de l'adulte : comment intégrer l'examen annuel**
15:00–16:00 Carl Fournier, médecin de famille

ROOM / SALLE : 523AB
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Intégrer à la consultation et au suivi les éléments du questionnaire, de l'examen physique, de l'investigation et de la conduite
2. Appliquer les recommandations pertinentes aux pratiques cliniques préventives
3. Identifier les changements organisationnels nécessaires à la réalisation d'un suivi préventif optimal

Description :
Atelier interactif avec cas clinique qui permet de réviser les éléments clés du questionnaire et de l'examen physique de l'adulte afin d'évaluer ses facteurs de risques de santé et d'appliquer les notions de prévention en fonction des données probantes dans le contexte de soins actuels, où la place de l'examen annuel est remise en question, et ce, en fonction du nouveau mode organisationnel des médecins de famille.

S241 **Fostering Resiliency in Physicians to Avoid Burnout: Why are we failing?**
15:00–17:15 Keyna Bracken, MD, CCFP
All teachers welcome. Highlights novice concepts for educational leaders.

ROOM / SALLE : 510C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Define the terms burnout, resiliency, and professional identity through exploration of the current medical literature
2. Interpret the current medical literature on burnout and resiliency to recognize possible root causes and protective factors
3. Develop an action plan after discussion and review with colleagues to encourage and foster resiliency training

Description:
Burnout, mental health issues, and substance use affect physicians at a higher rate compared with the general population. The toll on struggling medical trainees in particular can be enormous, from the burdens of anxiety, depression, and substance use to avoidable critical adverse patient outcomes and the tragedy of suicide. How can we foster the development of resilient, humanistic physicians across the continuum of lifelong learning so they can avoid depersonalization and erosion of the spirit? This session briefly reviews adult learning theories and how they may contribute to the acquisition of the less tangible CanMEDS competencies, such as those of the Health Advocate and Collaborator Roles. Participants will explore the current medical literature to analyze how medical training emphasizing individual, autonomous medical expertise may undermine the social humanities, which

may be a major contributor to burnout. With this background we will break into small groups to develop possible ways to reduce stress and burnout and foster resiliency. Participants will be asked to reflect on their own work environments to identify barriers and anticipated resistance. Individual action plans will be developed for use in participants' home communities to help them advocate for change.

S329 **What's New in Newborn Care: 2017**
15:00–16:00 Kate Miller, MD, CCFP, FCFP

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe changes in neonatal resuscitation guidelines
2. Highlight and summarize newly released guidelines affecting newborn care
3. Provide newborn care in keeping with the latest pediatric guidelines

Description:
Having trouble keeping up with all the new guidelines? This session will give you an overview of new guidelines and recommendations published in the area of newborn care, including: changes to the Neonatal Resuscitation Program guidelines, oximetry screening for congenital heart disease, prevention of early-onset sepsis, and safe infant sleep environments.

S344 **Choosing Wisely for Children and Youth**
15:00–16:00 Roxanne MacKnight, MD, CCFP, FCFP; Fahamia Koudra, MD, CCFP

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the benefits and harms of several common testing and treatment options for children and youth
2. Decide what the best testing options would be for certain conditions
3. Apply the Choosing Wisely recommendations for children and youth to their practice settings

Description:
In this interactive presentation the audience will participate in a discussion of challenging questions and scenarios with a focus on choosing wisely when assessing, ordering tests for, and treating children and youth. There will be an emphasis on evidence-based medicine and expert opinion in making the most appropriate choices for the optimum care of children and youth.

S465 **Care Relationships and Technological Transformations in Family Medicine**
15:00–16:00 William Sullivan, MD, CCFP, PhD; Cathy MacLean, MD, MBA, CCFP, FCFP

ROOM / SALLE : 516C
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Identify and apply skills to improve the quality of shared decision making, assessment, and care through a relationship-focused family practice
2. Recognize and appreciate how recent technological transformations are affecting the relationship—good or bad—between care providers and seekers
3. Apply ethical criteria for evaluating the use of electronic technologies and artificial intelligence, with the emphasis on sustaining care relationships

Description:
Family medicine is undergoing many transformations that affect the relationship between care providers and care seekers, such as using electronic technologies and artificial intelligence, systems medicine, public health interventions, and the increasing commodification of health care. This workshop is offered by the CFPC Ethics Committee and the Patient Education Committee. It aims to highlight the merits and difficulties—clinical and ethical—of these transformations on care relationships that are integral to family medicine. Participants will learn to apply some ethical criteria, as well as practical skills and resources, for evaluating and partaking in these transformations to foster and sustain, rather than undermine, care relationships.

S485 Integrating Mental Health in Primary Care

15:00–16:00 Rajdeep Kandola, MD, CCFP; Kara Irwin, MSc ClinPsych

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Explain the model of integrated mental health in primary care used at the East Calgary Family Care Clinic
2. Assess the impact of the model so far, through case studies and a discussion of challenges
3. Explore future directions and areas of growth proposed for the future of the model

Description:
Much has been written about the need for collaborative practice among primary caregivers in various disciplines. However, achieving this in sustainable and efficacious ways has taken on many forms with varying success. The East Calgary Family Care Clinic is a specialized primary care setting designed to increase health care services for Albertans who are underserved and identified as having complex physical and/or mental health care needs. The clinic is located in the lowest-income neighbourhood in Alberta. A key tenet of the clinic is to act as a health home, providing a centralized home base for patients to seek care. The clinic has developed, and practises, a model of mental health whereby mental health services are integrated within the larger primary care health home. This integration ensures wraparound services, as opposed to parallel services, and is showing a great deal of promise. This presentation will discuss the model of integrated mental health care, specifics of implementation, challenges encountered, case studies, and goals moving forward into our third year in practice.

S514 Supporting First Nations Communities' Buprenorphine

15:00–16:00 Jennifer Wyman, MD, CCFP, DABAM, FCFP; Levi Sofea

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe the challenges inherent in implementing programs for opioid use disorder in remote First Nations communities
2. Identify the physician's role and responsibility in community-based buprenorphine and substance use treatment programs
3. Prepare for working collaboratively with buprenorphine programs in their local context

Description:
Prescription drug abuse and related harms have arisen as a distinct health and social issue among Indigenous populations in Canada. In northwestern Ontario, a region including 31 remote Anishinabe communities spread over 50,000 km, affected communities have implemented locally-driven treatment programs using buprenorphine. Each community has designed a program specific to its needs and resources using a combination of local skills (including counselling, traditional activities, and cultural healing) and outside medical support. Some physicians visit communities regularly, and others are in touch only through telemedicine. Physicians need to consider contextual logistics such as accessibility, communication with local dispensers and distant pharmacies, dose reassessments,

prescription renewals, carries, travel doses, and managing contracts as well as negotiating relationships with nursing, local leadership, and community values and priorities. The experience of supporting a community-based buprenorphine program can be both challenging and rewarding. Using examples of different models of community programs and physician roles, we will explore the opportunities for physicians to become involved with supporting and expanding community-based programs for the treatment of opioid use disorders in Indigenous communities.

S526
15:00–16:00

Transition to Residency: A medical student's guide to applying to and succeeding in family medicine residency programs

Graham Gaylord, MD; Dave Jerome, MD
Author credit: Dr. Graham Gaylord, Dr. Kiran Dhillon, Dr. Ashley Bhullar, Dr. Félix Bégin
All teachers welcome. Highlights novice concepts for teachers outside the clinical setting.

ROOM / SALLE : 510B
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Prepare for transitioning from being a medical student to a family medicine resident
2. Use other residents' tips and recommendations for 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:
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 current residents in family medicine, with participation from the CFPC's Section of Medical Students and the Section of Residents.

S262
15:00–17:15

MMM: Using misoprostol, mifepristone, and methotrexate for early pregnancy loss and termination

Ellen Wiebe, MD, CCFP, FCFP; Sheila Dunn, MD, CCFP

ROOM / SALLE : 522ABC
Mainpro+ Group Learning certified credits = 2

Learning objectives:
1. Choose appropriate spontaneous abortion patients for treatment with misoprostol
2. Describe the uses, risks, and side effects of mifepristone, misoprostol ,and methotrexate in spontaneous and induced abortions
3. Use protocols for treating early ectopic pregnancies with methotrexate safely

Description:
We will discuss cases involving missed abortion (blighted ovum), incomplete spontaneous abortion, ectopic pregnancy, and medical abortion and how to use the three M drugs, (mifepristone, misoprostol, and methotrexate) in your office to terminate these pregnancies. Many women with missed or incomplete spontaneous abortions can avoid surgical aspiration by using misoprostol. Early ectopic pregnancies may be treated safely by a family doctor using methotrexate. Mifepristone and misoprostol may be used to terminate unwanted pregnancies under 10 weeks' gestation. Note: To provide medical abortions with mifepristone it is also necessary to take the online course the Society of Obstetricians and Gynaecologists of Canada offers. The presenters are family doctors with experience providing medical abortions with methotrexate and mifepristone, providing completion of spontaneous abortions, and treating pregnancies of unknown location.

S40 **Stroke Mimics**
16:15–17:15 Vu Kiet Tran, MD, CCFP (EM), FCFP, MHSc

ROOM / SALLE : 514ABC
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Recognize stroke symptoms
2. List conditions that can present like a stroke
3. Perform an efficient investigation of a stroke-like presentation

Description:
This lecture will address the numerous conditions that can present like a stroke but are not a stroke and how to differentiate between them. This understanding is crucial for management and prognostication reasons. Learn how to approach these conditions efficiently.

S62 **Can You Please Get Them to Stop Coughing?**
16:15–17:15 Alan Kaplan, MD, CCFP (EM), FCFP

ROOM / SALLE : 710A
Mainpro+ Group Learning certified credits = 1

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 cases that will challenge you

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 terms of diagnosis and treatment. We will move from the common to the uncommon presentation; you will be on the hot seat to make the diagnosis and recommend treatments.

S81 **(Peri)Menopause Management: A case-based presentation**
16:15–17:15 Christiane Kuntz, MD, CCFP, FCFP, NCMP

ROOM / SALLE : 512CDGH
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Outline symptoms, signs, and issues arising in the peri- and post-menopausal time periods
2. Discuss management of issues including vasomotor menopausal symptoms; abnormal uterine bleeding; mood disorders; insomnia; genitourinary, bone, and cardiovascular health; migraine
3. List the peri- and post-menopausal hormonal prescription formulations in North America and briefly describe how they are used

Description:
This case-based session will outline the symptoms, signs, and issues arising in the peri-menopausal and early menopausal time period. Management of typical concerns, including vasomotor symptoms, abnormal uterine bleeding, mood disorders, insomnia, vaginal atrophy, bone and cardiovascular health, migraine, sexuality, and urinary concerns, will be reviewed. The peri- and post-menopausal hormonal treatment formulations in North America will be listed and how they are used will be described briefly.

S147 Approach to Anxiety Disorders in Primary Care
16:15–17:15 **Approche pour les troubles anxieux en soins de première ligne**
Jon Davine, MD, CCFP, FRCPC

ROOM / SALLE : 710B
Mainpro+ Group Learning certified credits / Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Learning objectives:
1. Apply the use of screening questions to make rapid diagnoses of specific anxiety disorders
2. Describe psychotherapeutic techniques to deal with anxiety disorders
3. Use psychopharmacologic treatments for the different anxiety disorders

Description:
In this session we will present an overview of some of the DSM-5 diagnoses for anxiety. This will include 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 facilitate making the different diagnoses in a time-efficient manner. Psychotherapy techniques that are applicable in the primary care sector will be presented. We will present principles for the psychopharmacological treatment of these disorders in primary care. The pharmacologic data for this session will be based on the most recent 2014 guidelines for anxiety disorders. I will take questions throughout the presentation to encourage interaction.

Objectifs d'apprentissage :
1. Appliquer les questions de dépistage permettant de diagnostiquer rapidement certains troubles anxieux
2. Décrire les techniques psychothérapeutiques pour composer avec les troubles anxieux
3. Utiliser les traitements psychopharmacologiques dans différents troubles anxieux

Description :
Durant cette séance, nous allons présenter certains diagnostics d'anxiété selon le DSM-V, dont le trouble panique, l'agoraphobie, le trouble obsessif-compulsif et autres troubles connexes, le trouble d'anxiété généralisé et la phobie sociale. Nous allons parler de la façon d'utiliser les questions de dépistage pour permettre de poser différents diagnostics de manière efficace. Les techniques de psychothérapie qui s'appliquent au secteur des soins de première ligne seront présentées. Nous présenterons ensuite les principes du traitement pharmacologique de ces troubles en soins de première ligne. Les données pharmacologiques utilisées dans cette séance se basent sur les plus récentes lignes directrices de 2014 sur le traitement des troubles anxieux. Je poserai des questions durant la présentation afin d'encourager l'interaction.

S150 Incorporating Mindfulness and Narrative Medicine Into Your Teaching
16:15–17:15 Millaray Sanchez Campos, MD, CCFP, FCFP; Lynn Bloom, MSW, RSW; Carol Gonsalves, MD, FRCP, MMEd; Heather MacLean MD, FRCP
All teachers welcome. Highlights novice and advanced concepts for clinical preceptors.

ROOM / SALLE : 510A
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Describe mindfulness and narrative medicine and their underlying principles
2. Explore how mindfulness and narrative medicine can enhance the clinical skills of our learners
3. Define how to incorporate mindfulness and narrative medicine in your teaching

Description:
Medical training and the practice of medicine are associated with high levels of depression and burnout compared with rates for the general population. Physician stress and burnout have been linked with medical error, suboptimal patient care, physician liability, and higher health care costs. Mindfulness practice—fostering an ability

to pay attention, in the present moment, with acceptance and compassion toward yourself and others—has been shown to reduce anxiety and depression and have a positive effect on empathy. Similarly, narrative medicine offers a means of expression, communication, and personal reflection through storytelling, and its practice has been associated with improved well-being and interpersonal connection. The addition of mindfulness and narrative medicine to the fundamental teaching activities of educators in family medicine offers a means of rethinking how we approach the individual learner in the context of their health and well-being. An approach that includes both mindfulness training and reflective writing has been shown to increase self- awareness and meaning-making among medical trainees, and to improve clinical efficacy and decrease burnout in primary care physicians. This interactive presentation will help educators learn how mindfulness and reflective writing can be incorporated as teaching activities. Participants will be guided in mindfulness exercises and in writing their own stories, followed by reflection in pairs and a group debrief at the conclusion. Guidelines for facilitating this type of combined mindfulness and narrative medicine writing session will be provided.

S247 **Quality Improvement in Family Medicine Made Easy: A beginners' workshop**
16:15–17:15 Sakina Walji, MD, CCFP; Michelle Naimer, MD, CCFP

ROOM / SALLE : 523AB
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Review and understand the model for improvement
2. Describe and understand the basic steps involved in completing a quality improvement project
3. Apply quality improvement principles to an issue within one's own health care setting

Description:
As we strive to improve the quality and efficiency of patient care there is increased emphasis on the need for quality improvement. The Ontario Ministry of Health and Long-Term Care has encouraged family doctors to integrate quality improvement processes within the everyday operations of their health care settings. There are various examples of how the successful implementation of quality improvement projects has led not only to more effective patient care, but also to considerable efficiencies of the system. In the family practice setting improving quality of care may relate to improved implementation of guideline-based medicine, better integration of care, or more effective care. The Institute for Healthcare Improvement's "Triple Aim" for optimizing health care system performance emphasizes the need for quality improvement work to improve the health of the population, enhance the patient experience, and reduce overall cost simultaneously. Studies in the family practice setting have demonstrated that incorporating quality improvement work in an office setting has led to more appropriate care, greater practice efficiency and safety, improved timeliness of care, improved patient and provider satisfaction, and cost savings. Despite increased pressure for health care providers to complete quality improvement work, many feel ill-equipped to do so. This is compounded by the fact that there is little in the way of formal quality improvement teaching. This workshop is aimed at individuals who are new to quality improvement work. During this workshop we will describe the different pillars of quality improvement and how they relate to work completed in the family practice setting. We will also describe the pertinent steps involved in completing a project. This workshop will allow participants to apply these principles to a project idea of their own with the hope that they may transfer these skills and perform quality improvement activities in their own setting with the goal of improving patient care.

S310 **Les arrêts de travail en santé mentale : une affaire d'équipe !**
16:15–17:15 Cynthia Cameron, MD, CCMF, professeure de clinique, directrice de l'UMF de Lévis, chef du service Alphonse Desjardins du département de médecine familiale du CISSS-CA ; Annie Plamondon, travailleuse sociale, psychothérapeute, professeure de clinique

ROOM / SALLE : 516C
Crédits certifiés Mainpro+ d'apprentissage en groupe = 1

Objectifs d'apprentissage :
1. Évaluer la pertinence de l'arrêt de travail et ses impacts
2. Optimiser l'arrêt de travail en visant le rétablissement de la santé mentale à l'aide d'interventions et d'outils ciblés
3. Identifier les partenaires et organiser la collaboration dans une optique de retour au travail efficace

Description :
Le participant pourra se familiariser avec les problématiques fréquentes en santé mentale causant les arrêts de travail en 2017 : trouble d'adaptation, épuisement, dépression. Grâce aux données probantes actuelles, il apprendra à reconnaître les facteurs de risque chez ses patients, et à comprendre l'évolution et les éléments influençant les arrêts de travail ainsi que le retour au travail. Par des discussions, il clarifiera les rôles des différents intervenants impliqués dans le dossier et découvrira des outils pouvant faciliter l'évaluation et le suivi des arrêts de travail en santé mentale. Le participant aura l'occasion de partager ses expériences personnelles et d'apprendre de l'expérience de ses collègues.

S335 **SIX on SEXually Transmitted Infections: Topics for today's primary care physician**
16:15–17:15 Charlie Guiang, MD, CCFP; Hannah Feiner, MD, CCFP

ROOM / SALLE : 512ABEF
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Review the importance of extragenital testing for sexually transmitted infections and understand when to perform a test of cure
2. Describe signs and symptoms of syphilis and interpret and manage test results
3. Review considerations for HIV testing and describe the Zika virus and sexually transmitted infection

Description:
The prevention, diagnosis, and treatment of sexually transmitted infections (STIs) is a core aspect of family medicine practice. In Canada the main causes of reportable STIs include chlamydia, gonorrhea, syphilis, HIV, and hepatitis. More recently we have heard of other micro-organisms, namely Zika virus, and their risk of sexual transmission. Given the rising rates of many STIs, family physicians must consider testing not only in genital sites, such as the urethra and cervix, but also in extragenital sites including the oropharynx and rectum. Consequences related to the positive detection in extragenital sites may bring up the question of adequate treatment as well as management, including the need for test of cure (TOC) in some cases. We will pay attention to extragential site testing of STIs and include when TOCs are required. Syphilis and HIV infection continue to be important concerns, and certain exposure categories, such as men who have sex with men, continue to have the highest rates of these STIs. The importance of recognizing the different manifestations of syphilis, beyond the classic genital chancre, is emphasized in this session, including later stages such as neurosyphilis that may include neurological symptoms. Testing for syphilis and interpreting results may be confusing for some, so we will review the accurate interpretation of syphilis tests using case-based examples and the types of tests being used and discuss their sensitivity and specificity. When to test for HIV, including repeat testing, is an important consideration that we will discuss. Finally, we will discuss the contemporary Zika virus, which has made headlines all over the world. We will review the sexual transmission of Zika virus and what you need to know as family physicians to counsel your patient on risks.

S369 **Improving the Appropriate Use of Proton Pump Inhibitors Using Choosing Wisely Recommendations**
16:15–17:15 Marwan Asalya, IMG. MHA; Karuna Gupta, MD, CCFP; David Makary, MD, CCFP

ROOM / SALLE : 510D
Mainpro+ Group Learning certified credits = 1

Learning objectives:
1. Apply evidence-based deprescribing algorithms for proton pump inhibitors

2. Identify and compare approaches and strategies used to reduce inappropriate long-term use of proton pump inhibitors
3. Evaluate the overall effectiveness of the intervention using appropriate process and outcome metrics

Description:
Inappropriate long-term use of proton pump inhibitors (PPIs) is associated with adverse events and can cause more harm than good. Deprescribing algorithms have been created to provide prescribers with guidelines and tools to help reduce or discontinue PPI use among select patient groups. As part of an ongoing two-year multi-site project, six Family Health Teams (FHTs) are working collaboratively to implement a Choosing Wisely PPI initiative. Five out of the six participating FHTs are academic sites affiliated with a collaborative of six large community hospitals within Ontario (Joint Centres). The project is in partnership with the Adopting Research to Improve Care (ARTIC) program and guided by Choosing Wisely Canada recommendations. The intervention comprises three components: education, engagement, and monitoring. Educational sessions were organized for staff physicians, residents, and pharmacists who also met regularly across the sites. Handouts on PPI initiation and deprescribing algorithms were made available in electronic medical records. Pharmacists began the process by conducting chart reviews and flagging charts of patients who had been taking PPIs for more than 12 months. A message would then be sent to primary care providers with a recommendation to review indications for PPI use. A custom encounter template was also used to track progress. Different approaches to patient education and engagement were used at the beginning of the project. Patients were offered educational materials, deprescribing appointments, and telephone consultations with four-week follow-ups. Early results show that among the 116,614 patients rostered with the six participating FHTs, 6.4 per cent (n = 7,461) of them were on PPIs for more than 12 months. Almost 60 per cent (n = 249) of identified eligible patients had either stopped or reduced PPI use after receiving the intervention. Results also indicate that opportunistic approaches are more effective in engaging patients on long-term PPIs than outreach alone.

TWO- AND THREE-CREDIT-PER-HOUR CERTIFIED MAINPRO+ WORKSHOPS
ATELIERS CERTIFIÉS MAINPRO+ POUR DEUX ET TROIS CRÉDITS PAR HEURE

S868 **Pour une pratique éclairée : une utilisation judicieuse des examens et des traitements**
07:30–17:30 Geneviève Bois, MD, CCFP
(3) crédits par heure

ROOM / SALLE : 511C
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
Ce programme d'apprentissage en groupe a reçu la certification du Collège des médecins de famille du Canada et donne droit jusqu'à 18 crédits Mainpro+ (Catégorie 1 pour les non membres du CMFC).

Objectifs d'apprentissage :
1. Repérer les occasions d'exercer une pratique éclairée afin de mettre un frein à la surmédicalisation
2. Consulter des ressources en ligne fiables et à jour et évaluer leur pertinence. Déterminer la conduite à tenir en fonction de données probantes pertinentes
3. Communiquer avec le patient à la recherche d'un consensus en vue de limiter la surmédicalisation

Description :
Les thèmes abordés afin d'examiner l'excès d'imagerie médicale incluent la lombalgie aiguë et les kystes ovariens. Des outils pratiques en lien avec la déprescription médicamenteuse (notamment en ce qui a trait aux inhibiteurs de la pompe à protons - IPP) sont présentés. Le surdiagnostic et la surmédicalisation sont principalement considérés en discutant du dépistage de différentes néoplasies (colon, prostate, sein). Tout au long de la formation, le médecin est appelé à réfléchir sur sa pratique et les pistes d'intervention concrètes pour contrer ces problématiques. Programme de formation de six (6) heures donnant droit à 3 crédits par heure. Ce programme d'apprentissage en groupe a reçu la certification du Collège des médecins de famille du Canada et du Collège québécois des médecins de famille et donne droit jusqu'à 18 crédits Mainpro+. Pour obtenir les crédits, les participants devront remplir un formulaire d'évaluation des connaissances avant et après la formation de même qu'une activité de suivi après la formation.

S258 **CASTED: Fracture Clinic - The hands-on follow-up orthopaedics course**
07:30–18:30 Arun Sayal, MD, CCFP (EM)
3 credits per hour

ROOM / SALLE : 520AD
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 25.5 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Describe those features of a fracture that make it safe for a family physician to manage
2. Describe how to clinically and radiographically confirm healing of fractures
3. Perform and practice cast application and an appropriate orthopedic physical exam for various acute injuries

Description:
CASTED: Fracture Clinic is the 'hands-on' follow-up orthopedics course. This course is intended for family doctors in smaller centres who follow-up patients with fractures and acute MSK injuries. The case-based lectures highlight practical and important management principles one needs to know in order to properly manage these patients. Numerous cases will be reviewed to show how these principles inform our approach. You will learn which patients are 'safe' to treat; which need closer attention; which are 'red flags' that warrant early specialist referral; when to follow-up when to x-ray, and when to discontinue immobilization. Understand when a fracture has healed, when to 'return to sports', which complications to watch out for along with strategies to manage them. For soft tissue injuries, the lectures review which patients need further imaging (U/S, MRI, CT, or bone scan), referral (to ortho and/or physio) or simply need some more time to heal. The 'hands-on' sessions focus on tips and tricks to properly apply and mould fiberglass casts. Cast removal is also practiced. The indications for removable splints are reviewed. Additionally, a detailed review of the MSK physical exam is invaluable in understanding how to 'put it all together'. By managing 'safe' fractures and injuries locally, you will significantly reduce both health care costs and patient inconvenience – while still ensuring your patient heals well. CASTED: Fracture Clinic covers adults and peds; upper extremity and lower; fractures and soft-tissue injuries. Numerous clinical pearls are offered; the results are increased understanding of MSK injuries and improved clinical confidence in managing these patients. The course will help you find the balance between over-casting and under-protecting! Since 2008, CASTED has been presented over 225 times across the country. It has received numerous awards including the CFPC's Continuing Professional Development Award for providing 'an exceptional learning experience'.

S870 **CASTED: Primary Care - The Hands-On Orthopaedics Course for Family Physicians (Repeat)**
07:30–18:30 Arun Sayal, MD, CCFP (EM)
3 credits per hour

ROOM / SALLE : 520BE
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 25.5 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Discuss orthopaedic principles as they apply to family medicine / primary care
2. Discuss and demonstrate the key clinical points in the assessment and diagnosis of various MSK/joint complaints
3. pPractice joint injection techniques as they pertain to family medicine

Description:
CASTED: Primary Care is the 'hands-on' orthopaedics course for family physicians. This course is intended for family doctors and NPs to help manage the variety of MSK conditions that present to a primary care office. CASTED: Primary Care combines practical, case-based lectures with 'hands-on' stations to review orthopedic principles and management in the context of a family doctor?s office. During this full-day course, you will learn keys to an efficient orthopedic

history; 'high yield' physical exam tips, including a 'hands-on' exam review; MSK management principles; tips to identify 'red flag' patients; indications for further investigations and referral (How to 'choose wisely'); how to perform joint injections, including 'hands-on' practice with models; practical, office-based immobilization options. You are promised a day full of humour and numerous clinical pearls you will use on your next day in the clinic! The focus is on 'high-yield', practical, clinically relevant points that are immediately practice changing. Since 2008, CASTED has been presented over 225 times across the country. It has received numerous awards including the CFPC's Continuing Professional Development Award for providing 'an exceptional learning experience'.

S273 **Challenging Cases in Opioid Use and Misuse**
08:30–17:15 Abhi Sud, MD, CCFP; Kate Hodgson, DVM, MHSc, CCMEP
(3) credits per hour

ROOM / SALLE : 511B
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 18 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Manage problematic situations with chronic pain patients
2. Develop approaches and practice tools to work with other health care professionals to manage complex patients
3. Effectively communicate with chronic pain patients

Description:
The Safe Opioid Prescribing workshop is designed to support physicians and other primary care providers to develop multi-modal approaches to complex chronic pain; initiate & manage safe & effective opioid therapy, prevent & address addiction to prescription opioids, and develop communication & collaboration practice skills to better manage opioid therapy for your chronic pain patients. During the small group problem based interactive workshop, participants will prepare to implement changes in practice. After discussing patient cases and through collegial interaction, participants will better manage problematic situations with chronic pain patients- including patients on high doses of opioids who are dysfunctional, but not addicted, patients at high risk of addiction, and patients using opioids illicitly. Participants will have an opportunity to role play and communicate about difficult subjects with chronic pain patients such as the necessity of tapering opioid dose, the diagnosis of addiction, and exploring addiction treatment options. Through extensive collegial collaboration on challenging case scenarios, participants develop the collaboration practice skills to manage challenges around opioid prescribing and addressing addiction with Pharmacists, Acute care physicians, and Pain and Addiction specialists. Using practice tools and enablers, participants will develop and apply an incremental approach to implement evidence-informed change and track the impact on their practice and patient care.

S370 **Spine Tools: An interprofessional approach to managing back and neck pain**
13:30–17:15 Julia Alleyne, MD, MScCH, CCFP (SEM), FCFP; Deborah Kopansky-Giles, DC, FCCS, MSc; Judith Peranson, MD, CCFP, MPH
(3) credits per hour

ROOM / SALLE : 511D
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 7 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Conduct an evidence-based, comprehensive assessment of patients presenting with neck and back pain using the CORE tools
2. Describe the roles, scopes and skill sets of other health professionals that deliver spine care within the primary care team

3. Develop and implement an interprofessional management plan for patients presenting with acute and chronic spine pain

Description:
According to the Global Burden of Disease report (2010), low back pain (LBP) and neck pain (NP) are the leading causes of disability worldwide [1]. There are numerous guidelines for primary care providers and good research based evidence evaluating best treatment for LBP and NP, yet, the management of these conditions within primary care remains inconsistent and leaves patients without a clear management plan. The purpose of this workshop is to provide an office based approach to the assessment and management of spine pain using clinical tools; i.e. CORE Back and Neck tools, to provide participants with an opportunity to sharpen their assessment skills. Participants will use case based learning to develop interprofessional management strategies for acute and chronic presentations of spine pain and gain confidence in supporting evidence-based treatment strategies. An inventory of relevant tools and resources from provincial Spine strategies across Canada will be integrated into discussions and demonstrations. The key messages will reinforce Choosing Wisely Canada's messaging on appropriate care for spine disorders and incorporate the clinical need for health promotion and prevention.

Workshop outline: 1) icebreaker: identification of current barriers in primary care when managing patients with spine complaints (15 minutes); 2) current guidelines for the management of LBP and NP including true/false interactive questions (30 minutes); 3) the CORE (Clinically Oriented Relevant Exam) Neck and Low Back Tools with video and patient demonstration (45 min); 4) approach to management of nonpharmacological and pharmacological strategies, integrating the IPCare Planning Tool (30 minutes); 5) small group sessions with cases portrayed by the instructors where participants apply new knowledge and practice skills (three cases, 30 minutes total); 6) presentation of the key learnings summary of the three cases (15 minutes); and 7) Integrating new learning into practice by sharing strategies and reflection for practice implementation in a large group discussion (15 minutes).

S417 **Ten-Minute CBT for Worry and Panic: A three-credit-per-hour workshop**
13:30–17:15 Greg Dubord, MD
(3) credits per hour

ROOM / SALLE : 513EF
PRE-REGISTERED DELEGATES ONLY / DÉLÉGUÉS PRÉINSCRITS SEULEMENT
This Group Learning program has been certified by the College of Family Physicians of Canada for up to 9 Mainpro+ credits (Category 1 for non-CFPC members)

Learning objectives:
1. Learn to pinpoint key anxiety-causing beliefs
2. Learn highly modular treatment protocols
3. Learn to match interventions to individual patients

Description:
A high percentage of patients present with anxiety, either as their primary diagnosis or secondary to whatever else they're suffering from. The evidence is clear that many can be helped non-pharmacologically, and leading clinical practice guidelines (e.g., Cochrane) recommend CBT as a first-line treatment. This highly-practical triple-credit (3:1) CME works through family practice case studies of two of the most common anxiety disorders: GAD and panic. The focus is on ten-minute techniques that can be effortlessly integrated into normal primary care appointments. Participants are encouraged to discuss real-life cases, and are shown how to work effective CBT techniques into their standard family practice routines. Head instructor Greg Dubord, MD is an Assistant Professor of Psychiatry at the University of Toronto, and the prime developer of medical CBT. He has presented over 400 workshops, including 50 for the College of Family Physicians of Canada, and is a University of Toronto CME Teacher of the Year. Workshop sponsor CBT Canada was recently awarded the National CME Program Award by the College of Family Physicians of Canada for the "exceptional learning experiences" of the Certificate in Medical CBT (CMCBT) program, and was Canada's first three-credit-per-hour certified organization. See www.cbt.ca for further details.

RESIDENT / RÉSIDENT

501 Physician Awareness and Action Regarding Postpartum Depression in Male Partners

Sarah Sloan*, MD; George Ko, MD; Ana Pesantez, MD; Richard Trawick, MD; Deirdre Ryan, MD, FRCP(C)

Objective: To evaluate the practice of physicians/residents pertaining to postpartum depression (PPD) in male partners. **Design:** Non-randomized cross-sectional survey. **Setting:** British Columbia, Canada. **Participants:** University of British Columbia (UBC) residents in family practice, pediatrics, and obstetrics and practising family physicians in British Columbia between 18 and 80 years old who expressed consent to participate. Excluded were physicians in other disciplines of medicine, allied health care professionals, those outside of British Columbia, those beyond the stated age range, or those who did not express, or who withdrew, consent to participate. There were 164 respondents; 130 identified with family medicine, 20 identified as staff physicians; mean age was 32.2 years, with 63.4 per cent female and 36.6 per cent male respondents. **Intervention:** An online survey was developed by the authors and distributed by email lists. Data were analyzed using IBM SPSS Statistics for Windows Version 22.0. **Main outcome measures:** The presence or absence of screening for PPD in male partners among primary care providers in British Columbia and assessment of the screening practices and follow-up among screening practitioners. **Results:** The data showed 95.3 per cent of respondents do not routinely screen for male partner PPD, 70.2 per cent do not screen for male partner PPD in the presence of maternal PPD, and 17.1 per cent offer no follow-up care if a male partner screens positive for PPD. Further, 97.7 per cent of respondents do not offer a dedicated visit for male partners of pregnant women and 59.1 per cent never screen the male partner for general health conditions when offering perinatal care. Only 35.3 per cent of participants reference the provincial screening guidelines for male partner PPD. **Conclusion:** Primary care residents and physicians in British Columbia are unfamiliar with PPD in male partners. Consequently, this condition is likely underscreened, underdiagnosed, and undertreated, leading to negative impacts on male partners, mothers, and children. Increased awareness, education, and resources to diagnose and support those affected by male PPD is required to improve these outcomes.

502 Educating Primary Care Providers Regarding Cancer Survivor Issues: Workshop results

Genevieve Chaput, MD, MA, CCFP (PC); Kristin Hendricks, MPH; Vinita D'Souza, MSc; Michael Shulha, PhD

Objective: To assess the educational benefit of a survivorship workshop (EW) targeting primary care providers in Montreal, Canada. **Design and Intervention:** A Mainpro+-accredited EW based on common survivorship issues was created and delivered to 167 primary care providers at six sites. Each EW was presented by the same physician and was approximately 50 minutes in duration. Brief matched pre-, post-, and three-month delayed post-surveys were designed (Likert-scale and short-answer questions), and completed on a voluntary basis. Data were analyzed with parametric (paired *t*-tests) and non-parametric (Wilcoxon Signed rank tests) comparisons, as appropriate. **Participants:** Inclusion criteria consisted of family physicians in active practice, postgraduate residents in family medicine, and nurse practitioners. Sample size was set at 100. **Main outcome measures:** Outcome measures targeted the first three levels of Kirkpatrick's learning model for adults: satisfaction, knowledge, and behaviour. **Results:** The pre- and post-survey response rate was 65.3 per cent and the three-month delayed post-survey response rate was 56.9 per cent. Immediately following the EW, participants were significantly more likely to be able to list standards of survivorship care, $t(108) = 10.50$, $P < 0.001$, and to name late-effects of cancer treatment, $t(108) = 5.52$, $P < 0.001$. High relevance and satisfaction of EW were reported (95 per cent), and 99 per cent expressed intent to incorporate survivorship information into practice. At three months post-intervention, confidence remained significantly higher than pre-intervention levels for both knowledge of "late physical effects" ($z = 6.08$, $P < 0.001$, n = 60) and "adverse psychosocial outcomes" of cancer and treatments ($z = 4.26$, $P < .001$, n = 62). **Conclusion:** Numerous studies have focused on identifying primary care provider barriers to survivorship care delivery, including suboptimal topic proficiency, but further initiatives are needed to close that knowledge gap. This EW increased primary care provider survivorship knowledge as well as confidence levels regarding cancer survivor issues.

503 Directions to Enable Safety, Health, and Well-being for Drivers With Musculoskeletal Conditions

Julie Lapointe*, erg OT(C), OT Reg. (Ont), PhD; Tamalea Stone, OT(C), OT Reg. (Ont); Janet M. Craik, MSc, OT(C), OT Reg. (Ont)

Objective: To present the results of the National Blueprint for Injury Prevention in Drivers with Arthritis, a strategic action plan addressing the multiple unmet needs of drivers with arthritis. **Design:** A scoping review was completed to garner the evidence and resources published in the past 25 years on the activity of driving a motor vehicle for people with musculoskeletal conditions and/or arthritis. A Delphi method was then used to collect the insights of a panel of 15 experts and stakeholders regarding the implications of this evidence, or lack thereof, in terms of knowledge, practice, professional training, and policies. Finally, the panelists met in-person to agree on guiding principles, priority goals, and directions for action. **Results:** A total of 111 publications focusing on drivers with musculoskeletal conditions and/or arthritis were identified. These publications addressed four aspects: "driving capacity and safety" (n = 45), "musculoskeletal health issues of professional drivers" (n = 37), "safe return to driving after a musculoskeletal surgery" (n = 21), and "ergonomic evaluation of vehicle equipment and seating posture" (n = 8). The panelists proposed a National Blueprint comprising nine guiding principles, six priority goals, and 16 concrete directions for action such as the need to equip professionals with evidence-based resources that can readily be provided to clients. **Conclusion:** The input of several professionals is instrumental in addressing the needs of this growing population of drivers. The National Blueprint for Injury Prevention in Drivers with Arthritis allowed the collection of valuable insights, which we hope will translate into collaborative actions to optimize the safety, health, and well-being of drivers with musculoskeletal conditions.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

504 Barriers and Facilitators Encountered by Family Physicians Prescribing Opioids for Chronic Non-Cancer Pain: A qualitative study

Joshua Goodwin*; Susan Kirkland, PhD

Objective: This qualitative study examined what family physicians in Nova Scotia feel are the barriers and facilitators to practising effective and safe opioid prescribing for chronic non-cancer pain (CNCP). **Design:** We conducted semi-structured interviews with family physicians in Nova Scotia to determine opioid prescribing patterns, what the participants feel are the core issues and challenges with respect to opioid prescribing for family physicians, and what kinds of supports would be helpful to them. The interviews were approximately 60 minutes in duration, and were audio-recorded and transcribed. The transcripts were then analyzed using a grounded theory approach in ATLAS.ti software. **Setting:** Participants were interviewed in their offices or another quiet setting of their choice. **Participants:** Participants were recruited using a snowball sampling technique and were screened for practice experience prescribing opioids for CNCP in Nova Scotia. Seven participants were interviewed. **Findings:** Family physicians identified a complex intersection of challenges in prescribing opioids for CNCP that stem from the complexity of chronic pain management; physician-patient relationships; concern for diversion of opioids; lack of training; and systemic issues such as wait lists for other specialists and the cost of pain medications. Education in chronic pain management enabled effective CNCP treatment for some family physicians. The complexity of the provider-patient relationship in treating chronic pain was also a focus of interest. Several prescriber tools such as opioid treatment agreements and prescribing guidelines were noted as being helpful in establishing an effective prescribing relationship. **Conclusion:** This study described the obstacles faced by family physicians in Nova Scotia in treating CNCP and identifies areas of focus for improving the safety and effectiveness of opioid prescribing in Nova Scotia.

505 Evaluation of Validated Clinical Tools in Pain Assessment and Screening for Substance Misuse

Liliana Romero, MD; Anne Marie Pinard, MD, FRCPC; Richard Côté, MD, FRCPC

Objective: To examine the feasibility and acceptability of family physician supervisors of medical residents in Quebec using validated clinical tools that are recognized by experts in pain assessment or in drug dependence. **Design:** Two complementary quantitative and qualitative methods were needed to meet the objectives of this project. The quantitative component is a cross-sectional analytical study and the qualitative component is an

exploratory study. **Setting:** The study was carried out in the family medicine units of the four faculties of medicine in Quebec. **Participants:** A total of 840 family physicians with clinical practices and duties that included supervising family medicine residents were targeted. **Intervention:** An online survey was carried out between February 16 and March 6, 2017. The questionnaire included 29 questions in order to obtain family physicians' opinions on six clinical tools previously selected by the experts. **Results:** The participation rate was 15 per cent. The proportion of insufficient knowledge among participants in relation to the clinical tools for pain impact assessment was between 28 per cent and 88 per cent, depending on the tool. For the tools related to screening for substance misuse, the proportions were 5 per cent (CAGE-AID) and 66 per cent (ORT).The reported percentage of usefulness of a clinical tool by the physician supervisors followed the same trend as the percentage of their recommendations for medical residents to master these same tools (in descending order): 86.51 per cent for CAGE-AID, 69.05 per cent for ORT, 48.41 per cent for Beck, 48.41 per cent for DN4, 42.86 per cent for BPI, and 32.54 per cent for PCS (chi-square test $P < 0.0001$). **Conclusion:** Quebec family physician supervisors need to improve their knowledge of the validated tools that are recommended by the national guidelines. This result emphasizes the need for training of family physician supervisors in family medicine units to strengthen their capacity to manage chronic pain and the risk of opioid drug misuse.

506 Risk Factors for Dementia in Canadian Primary Care Settings (work in progress)

Anh Pham, MSc; Boglarka Soos, MSc; Cliff Lindeman, MSc; Don Voaklander, PhD, MSc; Neil Drummond, PhD

Dementia is a long-term mental illness often resulting in loss of memory, loss in reasoning ability, and changes in personality. Progressive dementias are especially concerning as they have no effective treatment and prevention. Research has found that cardiovascular disease (CVD) risk factors increase the risk of developing dementia. In Canada there is little research into care for dementia in primary care settings. This is the first study to explore causation between CVD risk factors and dementia incidence among seniors in Canadian primary care settings; determine the incidence of dementia among community-dwelling Canadian seniors attending primary care; compare the risk of developing dementia in seniors with and without CVD risk factors; identify the association between an index diagnosis of dementia and physical health indicators; and recommend novel strategies in primary care for preventing and delaying the onset of dementia. A 10-year (2008 to 2017) retrospective cohort in patients age 65 or older, using electronic medical record data extracted by the Canadian Primary Care Sentinel Surveillance Network (CPCSSN). We require a sample of 3,945 incident dementia cases for 80 per cent power (95 per cent CI). In 2012, CPCSSN recorded 440,000 patients in total; 59,177 of those were age 65 and older, 4,552 (7.7 per cent) of whom were diagnosed with dementia. Currently, CPCSSN includes 1.5 million patients. In southern Alberta, 50 per cent of people with dementia have been recorded in CPCSSN for more than five years. Assuming that the proportions in 2017 remain the same, we expect a minimum of 8,000 dementia cases with at least five years of follow-up data in the 2017 CPCSSN data set. We expect to find an association between the incidence of dementia and exposure to modifiable CVD risk factors, including time-to-dementia and demographic and comorbidity covariates. Our findings should provide evidence to identify at least 23 per cent of new dementia cases in the Canadian community that could be prevented.

507 BETTER WISE: A comprehensive approach for wellness in primary care (work in progress)

Donna Manca*, MD, MCISc, FCFP; Carolina Aguilar, MA, MSc; Kris Aubrey-Bassler, MD, MSc, CCFP (EM); Denise Campbell-Scherer, MD, PhD, CCFP, FCFP; Aisha Lofters, MD, PhD, CCFP; Melissa Shea-Budgell, MSc; Nicolette Sopcak, PhD; Eva Grunfeld, MD, DPhil, FCFP

Objective: To determine whether patients randomized to receive an individualized prevention visit with a prevention practitioner have improved cancer surveillance and general prevention and screening outcomes at 12 months compared with patients receiving standard care in a wait-list control group. **Context:** Patients lack awareness of how lifestyle contributes to cancers and chronic disease. Cancer survivors and patients living in poverty achieve fewer prevention and screening goals. BETTER WISE (Building on Existing Tools to Improve Cancer and Chronic Disease Prevention and Screening in Primary Care for Wellness of Cancer Survivors and Patients) builds on the BETTER trial, which demonstrated the effectiveness of an integrated and comprehensive approach that targeted

patients to attend a personalized cancer and chronic disease prevention and screening (CCDPS) visit with a prevention practitioner. **Design:** A pragmatic, two-arm, cluster, randomized control trial. **Setting:** Sixteen primary care practices in rural, remote, and urban settings in Canada. **Participants:** Adults ages 40 to 65, including a subgroup of cancer survivors. **Intervention:** An allied health professional within the practice will be trained as a prevention practitioner and use the BETTER WISE tool kit, which includes cancer surveillance care paths for breast, colorectal, and prostate cancer survivors to meet with patients for a personalized prevention visit. **Main outcome measures:** A patient-level composite index, defined as the proportion of eligible CCDPS actions (determined at baseline), that is met (according to pre-defined targets) at 12 months follow-up. Qualitative and economic assessments will also be conducted. **Results:** BETTER WISE is a five-year project (2016 to 2021). It is expected that the prevention practitioner intervention group will have improved CCDPS outcomes at 12 months compared with wait-list controls, with maintenance at 24 months. **Conclusion:** The BETTER WISE approach addresses the CCDPS needs of patients, including cancer survivors, and involves screening for poverty. BETTER WISE provides a framework for an adaptable, comprehensive, and patient-centred approach grounded in evidence.

508 Screening for Nephropathy in Type 2 Diabetes: Does an abnormal urine ACR need to be repeated?

Divya Garg, MD, CCFP; Christopher Naugler, MD, CCFP, FCFP, FRCPC; Vishal Bhella*, MD, CCFP

Context: Canadian Diabetes Association guidelines recommend screening patients with type 2 diabetes for chronic kidney disease with a urine albumin to creatinine ratio (ACR) and then repeating an abnormal test twice over a three-month period. Two out of three positive results confirm microalbuminuria. Recent studies looking at first void samples have suggested that multiple samples may not be necessary at the screening stage for diagnosing microalbuminuria. **Objective:** To determine the positive predictive value of a single, random, abnormal measure of urine ACR compared with repeat samples in a patient with type 2 diabetes to diagnose microalbuminuria. **Design:** Retrospective, longitudinal, secondary data analysis using Calgary Lab Services data. **Participants:** Patients older than age 21 with a new diagnosis of diabetes in the study period from January 2008 to December 2015, and with first abnormal urine ACR followed by another measurement completed within 120 days were included in the study. **Outcome measures:** The positive predictive value of an abnormal urine ACR result to diagnose microalbuminuria was calculated. **Results:** Of 1,243 identified cases, results with macroalbuminuria (204) and with inadequate follow-up (444) were excluded. A total of 574 of the remaining 595 cases were true positives, resulting in a 96.4 per cent positive predictive value of the first abnormal urine ACR to diagnose microalbuminuria. The data were further assessed to exclude patients who were started on, or had a dose adjustment of, an angiotensin-converting enzyme inhibitor/angiotensin II receptor blocker medication around the time of ACR measurement in order to focus results on screening and not on treatment response. After exclusions, 306 out of 318 cases were identified as true positives, resulting in a 96.2 per cent positive predictive value. **Conclusions:** The first abnormal value of random urine ACR has good positive predictive value for the diagnosis of microalbuminuria in patients with type 2 diabetes. Further studies are required to evaluate the reproducibility of these results.

509 Screening for Chronic Kidney Disease in Primary Care Patients With Type 2 Diabetes: A longitudinal study

Divya Garg*, MD, CCFP; Amardeep Thind, MD, PhD; Heather Maddocks, PhD

Context: Canadian Diabetes Association (CDA) clinical practice guidelines recommend screening all patients with type 2 diabetes for diabetic nephropathy within the first year of diagnosis. Early detection and intervention can delay or prevent loss of renal function and progression to end-stage renal disease. **Objective:** To further knowledge of screening for chronic kidney disease in patients with type 2 diabetes in a subset of family medicine practices in Southwestern Ontario. **Design:** Retrospective longitudinal data analysis of a pre-existing database of a number of primary care practices. **Participants:** Patients with type 2 diabetes from 18 family medicine practices. **Outcome measures:** To determine if there is CDA guideline–compliant screening for chronic kidney disease in patients with diabetes. We explore the relation to patient age, gender, hypertension, and urban versus rural practice. **Results:** Out of 2,399 patients who met study criteria, 144 were screened for chronic kidney disease with both urine albumin to creatinine ratio (ACR) and estimated glomerular filtration rate (eGFR) completed within the first year of diagnosis. Holding other variables constant, the likelihood of screening using both urine ACR and eGFR increased with patient age. An abnormal ACR or eGFR test was 1.6 times more likely to be repeated in male patients and 1.4

times more likely to be repeated by urban physicians. Out of these 144 patients, only 69 had guideline-compliant care as defined by CDA, including adequate repeat testing for abnormal results. **Conclusion:** Overall rates of following the screening pathway as per Canadian Diabetes Association recommendations were low. Also, our study noted decreased compliance as the number of steps for screening increased, including follow up of abnormal results. Further studies are required to assess additional physician, patient, and system factors that affect guideline compliance and to improve the screening pathway for feasibility of screening.

510 CANCELLED / ANNULÉE

511 The Prevalence of Iron Deficiency in Children in Primary Care (study in progress)

Siwen Sun, MD CM, CCFP

Design: The present analysis is a cross-sectional study. Iron deficiency screening was offered to all participants. Sociodemographic data, breastfeeding duration, and laboratory results including hemoglobin, ferritin, and iron study (in cases of suspected inflammatory state) were collected through a retrospective chart review using Omnimed (electronic medical record). **Setting:** The study took place in a primary care clinic in Villeray–Saint-Michel–Parc-Extension, Montreal, Quebec. It is the second-most populated borough in Montreal, with 69 per cent of residents being either first- or second-generation immigrants. One-quarter of them are new immigrants from Haiti, Algeria, and Morocco. **Participants:** Healthy children ages six to 36 months who have had at least two scheduled pediatric follow-up visits in the primary care clinic with the same family physician between 2014-04-01 and 2016-04-01. Children with hemoglobinopathy, malabsorption syndrome (inflammatory bowel disease, celiac disease) or hemolytic disease were excluded from the study. **Results:** Pending. **Conclusion:** Pending.

512 Thyroid Testing for Patients Without Thyroid Disease in Canadian Primary Care (work in progress)

Michelle Greiver, MD, MSc, CCFP, FCFP; Kimberly Wintemute, MD, CCFP, FCFP; Warren McIsaac, MD, CCFP; Lisa Del Giudice, MD, CCFP; Frank Sullivan, FRSE, FRCP, FRCGP, MCFP; Babak Aliarzadeh, MD, MPH; Sumeet Kalia, MSc; Chris Meaney, MSc; Rahim Moineddin, PhD; Alex Singer, MD, CCFP

Objective: Choosing Wisely Canada does not recommend thyroid testing for asymptomatic patients. Using a preliminary analysis of electronic medical record data for 133,710 patients from UTOPIAN, the University of Toronto Practice Based Research Network's database, we found that 62 per cent of patients without thyroid disease and not on thyroid medications had at least one thyroid stimulating hormone (TSH) test recorded in their chart over a two-year period. Our objective is to describe TSH testing in Canadian primary care. **Design:** Cross-sectional and time trend data on TSH testing using electronic medical record data from CPCSSN. **Participants:** Data from all patients age 20 or older, with at least one encounter in the past two years. We will exclude patients with a diagnosis of thyroid issues or those prescribed thyroid replacement therapy. Patients with indications for thyroid testing (i.e., prescription for amiodarone or lithium, currently or recently pregnant, or investigated for infertility) will be excluded. While the data may not allow a complete differentiation between screening and case findings, we will report parameters commonly associated with case findings: obesity and depression. The prevalence of thyroid disorders is greater in the presence of autoimmune conditions; we will include the most common condition, rheumatoid arthritis, as a cofactor. We will also look for evidence of TSH test ordering being used as a screening test by measuring the prevalence of testing concurrent with blood tests that are commonly ordered for screening or disease management purposes (total cholesterol, HbA1c). **Main outcome measure:** Proportion of eligible adult patients with at least one TSH test performed in the past two years. **Results:** Based on preliminary data from UTOPIAN, we expect a significant proportion of adults have had TSH testing done in a two-year interval. **Conclusion:** If confirmed, these results could be used to support Choosing Wisely Canada initiatives intended to decrease thyroid testing.

513 Building a Proof-of-Concept National Diabetes Repository (work in progress)

Michelle Greiver, MD, MSc, CCFP, FCFP; Helena Medeiros, MSc; Frank Sullivan, FRSE, FRCP, FRCGP, MCFP; Neil Drummond, PhD; Donna Manca, MD, MCIS, FCFP; Marie-Therese Lussier, MD, MSc; Don Willison, ScD, MSc

Objective: To build a proof-of-concept diabetes repository that will support studies for Diabetes Action Canada (DAC). **Design:** DAC is a national Canadian Institutes of Health Research (CIHR)-funded chronic disease Strategy for Patient-Oriented Research (SPOR) initiative that aims to improve the care of patients with diabetes through a comprehensive program of research, quality improvement, and service. The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) extracts, de-identifies, and cleans primary care electronic medical record data, which is then entered into a structured national data set. CPCSSN has validated algorithms to identify primary care patients with diabetes. A proof-of-concept data repository for DAC could be formed using primary care data to enable an information technology foundation that can support DAC projects. **Setting:** The proof-of-concept repository will be housed within the CPCSSN data centre at Queen's University (Ontario) at the Centre for Advanced Computing. It will be managed and controlled by DAC and will include a virtual research environment to allow researchers to conduct their studies without giving them a copy of the dataset. **Participants:** Four CPCSSN Networks in Alberta, Ontario, and Quebec will be pooling their CPCSSN data relevant to patients with diabetes, representing 50,000 patients. **Results:** The proof-of-concept repository has been approved by DAC leadership and by CPCSSN's Steering Committee. Work has been undertaken to form the repository and set the stage for future expansion to include or link to other data: administrative data in several provinces, patient-reported outcomes, and experience data via smartphone apps or tablets. **Conclusions:** The proof-of-concept repository will be used for a variety of studies. Primary care electronic medical records can provide the data enabling a national repository for the study of diabetes in Canada.

RESIDENT / RÉSIDENT

514 Chronotype and Chronic Disease Prevalence in a Family Practice in the Greater Toronto Area (work in progress)

Carolyn Arbanas*, MD, MSc; Dennis Wong, MD, MSc; Muhammad Mizanur Rashid Shuvra, MB BS, MPH, MSc(ECD); Arsalan Monavvari, MD, MHSc, CCFP (PC), CHE; Michael Cardinal-Aucoin, PhD, MSc

Context: The circadian system orchestrates the temporal order in human physiology that is necessary for the maintenance of proper health. Chronotype, the genetically based preference in the timing of daily rest and activity, reflects individual differences in circadian biology. A handful of recent evidence suggests that differences in chronotype can influence one's risk of developing certain chronic diseases, including cancer, diabetes, and depression. An assessment of morbidity associated with chronotype will allow for future implementation of improved preventive measures, early intervention, and optimal disease management in the primary care setting. **Objective:** To evaluate the association between chronotype and prevalence of chronic disease morbidity within a representative sample population of family medicine patients. **Design:** Chronotype assessment and quantitative cross-sectional exploratory study. **Setting:** Family health team and family medicine teaching group. **Participants:** Approximately 500 primary care patients from the suburban community of Markham, Ontario, and the surrounding area, ages 18 to 65 years, who have not worked shift work in the past three months and who have never been diagnosed with a circadian sleep disorder. **Intervention:** Munich Chronotype Questionnaire. **Results:** The desynchrony of societally imposed daily sleep-wake schedules and individual chronotype can disrupt the circadian system. Individuals of a later chronotype experience greater desynchrony and so are subjected to a chronic state of circadian misalignment such that their endogenous physiological rhythms become internally inconsistent. It is anticipated that later chronotypes will have a higher prevalence of chronic disease including diabetes, cardiovascular disease, and depression compared with earlier chronotypes. **Conclusions:** This study provides an important preliminary examination and the basis for further investigations with larger data sets. Understanding the contribution of individual chronotype to the risk and development of chronic disease will lead to the design and implementation of personalized preventive plans and management protocols for use in primary care.

RESIDENT / RÉSIDENT

515 Human Circadian Biology and Family Medicine: A survey of physician awareness (work in progress)

Carolyn Arbanas, MD, MSc; Michael Cardinal-Aucoin, PhD, MSc

Context: Proper functioning of the circadian system is essential to human health, and its disruption (e.g., by shift work and jetlag) has been linked to a variety of chronic diseases, including depression, diabetes, and cancer. This is especially relevant in primary care since chronic conditions account for more than half of family physician consultations. **Objective:** To assess current awareness of family physicians regarding the circadian system, the role of circadian biology in health and disease, and the potential incorporation of chronobiological concepts into preventive practices and chronic disease treatment plans. **Design:** Survey of 30 family physicians in the Greater Toronto Area. **Setting:** Family health team and family medicine teaching unit. **Participants:** Family medicine residents and practising physicians. **Results:** Preliminary results indicate that of those family physicians who were surveyed thus far, most are well informed of effects of extreme chronotypes such as advanced phase sleep disorder and of some of the health consequences associated with acute disruption of the circadian system, as by jetlag and shift work. Few respondents were aware of the deleterious effects of long-term circadian disruption by light at night and social jetlag, or the critical importance of circadian health. All survey participants indicated they were uncertain how to assess the circadian health of patients and how to incorporate chronobiological strategies into patient care; several suggested the development of relevant guidelines. **Conclusions:** To develop and implement circadian strategies for primary health care it is important to evaluate current understanding and determine the needs and concerns of family physicians. There is a pressing need to translate the specialized knowledge of human circadian biology into primary care practice. Primary care can benefit from simple, safe, and non-invasive chronobiological interventions that can be incorporated into preventive care and chronic disease management, as well as from personalized medicine based on individual circadian phenotype.

516 Scarred for Life: Results from the Hidradenitis Suppurativa Patient Experience (HSPE) survey

Jennifer A. Pereira*, MSc, PhD; Susan Quach, MSc; Kathryn Andrews-Clay; Maria Goguen; Raed Alhusayen, MB BS, MSCE, FRCPC

Objective: To comprehensively describe the health care experiences of patients with hidradenitis suppurativa (HS), a devastating skin disease affecting more than 1 per cent of North Americans characterized by boils, lesional discharge, unpleasant odour, and pain. **Design:** In January 2017 we conducted an online survey of Canadians and Americans with HS. **Setting:** We engaged HS-related patient advocacy groups, physician groups, and social media groups to disseminate the survey. **Participants:** One hundred sixty-seven eligible respondents (living in Canada or the United States with a formal or self-diagnosis of HS) completed the survey. Thirty per cent were Canadians, the majority (96 per cent) of whom were female. Mean age was 36 years. **Main outcome measures:** Survey questions focused on the journey to diagnosis, health care encounters, costs of therapies to manage symptoms, and quality of life. **Results:** The average amount of time from symptom to diagnosis was nine years for Canadians, which included multiple health provider visits. During this period, 79 per cent of patients made at least four visits to family physicians for HS symptoms and 53 per cent visited 10 or more times. Additionally, 30 per cent made more than 10 emergency room visits. Respondents had three misdiagnoses on average, the most common being skin infection, ingrown hair, and sexually transmitted infection. The majority (69 per cent) were dissatisfied or extremely dissatisfied with their health care experience en route to diagnosis, but this number decreased to 36 per cent once HS was accurately diagnosed. Respondents turned to online support groups and websites (95 per cent) rather than to physicians (35 per cent) for information about HS. They struggle with many aspects of their disease, most commonly, the lack of awareness among physicians, and management of depression and anxiety. **Conclusions:** There is much room to improve the lives of those living with HS, including greater awareness of this condition among health care providers and support for the psychological impact of HS.

517 Palliative Care for Heart Failure: Characterizing the end-of-life experience of community heart failure clinic patients

Gregory Handrigan*, MD, PhD, CCFP; Jennifer Daly, MD, CCFP

Objective: To characterize the end-of-life experience of heart failure patients who attended the Central Okanagan Heart Function Clinic (COHFC), a community-based heart function clinic in Kelowna, British Columbia. **Design:** Retrospective chart review. **Setting:** Heart failure is a common, chronic illness characterized by significant patient symptom burden and heavy health care use at the end of life. A palliative care approach may improve both of these outcomes; however, patients with end-stage heart failure generally have limited access to palliative care due to an unpredictable disease trajectory and inadequate goals of care discussions. **Participants:** Patients of the COHFC who expired in 2015. **Outcome measures:** The patient population was characterized in terms of comorbidities, symptom profile, acute care usage patterns (i.e., emergency visits, admissions), use of opioids, documented discussions of goals of care, and involvement of palliative services. **Results:** Study patients had heavy symptom burden, with more than 90 per cent of patients experiencing dyspnea and fatigue. The same percentage of subjects reported functional impairment, and more than 70 per cent were designated as New York Heart Association class III-IV, experiencing symptoms with minimal activity or rest. On average, patients visited the emergency room four times and were admitted to hospital for 22.5 days in their final year of life; 68.9 per cent of hospital admissions were for heart failure sequelae. Two-thirds of patients ultimately died in hospital. Less than 40 per cent of subjects were referred to palliative care, often only days prior to death, and only 22.6 per cent used opiates for symptom control in their final year of life. This is despite 87 per cent of patients having end-of-life discussions that typically addressed issues beyond code status. **Conclusion:** COHFC patients had heavy symptom burden with associated functional impairment and frequent acute care usage in their final year of life. Early palliative service involvement should be considered to improve the end-of-life experience for patients and to mitigate health care costs.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

518 Understanding Challenges to the Delivery of Palliative Care in Rural Settings

Sara McDonald

Objective: Develop an understanding of how the delivery of palliative care in rural settings differs from that in larger urban centres, specifically considering challenges and barriers to providing care. **Introduction:** Approximately 0.5 per cent to 1 per cent of the Canadian population dies per year, according to Statistics Canada. Although many deaths are considered unexpected, a large proportion of deaths can be predicted. There has been an increased focus in research on the delivery of palliative care within medical communities; however, little is understood about the unique needs of rural communities. **Design:** Literature review. **Setting:** Rural communities. **Method:** A database search was initiated using PubMED, MEDLINE, and CINAHL. Key terms searched included palliative care, end-of-life care, terminal care, and rural. Articles found were screened for inclusion criteria. Work in developing countries was excluded. Only work completed in English was included. Articles must have included a discussion of challenges and barriers to palliative care delivery in rural settings. Fourteen articles met the inclusion criteria and were further reviewed, synthesized, and thematically analyzed. **Findings:** Similar barriers to the delivery of palliative care in rural settings were noted across the literature. Themes that emerged from the literature included costs, access to services, education and training, communication, symptom management, facility size, and coordination of care. Challenges associated with symptom management, education and training, and communication were the most prominent themes present in most articles reviewed. **Conclusion:** Although there is a small body of literature discussing the challenges and barriers to the delivery of palliative care in rural settings, much of the literature shares similar results. This knowledge could influence future practice to attempt to provide better access to quality palliative care in rural settings. Further research on specific interventions to address these challenges would be beneficial.

RESIDENT / RÉSIDENT

519 Multidisciplinary Instrument to Help Optimize End-of-Life Care in Nursing Home Setting (work in progress)

Catherine Richer, MD; Marie-Ève Rivard-Morissette, MD; Gabrielle Leclerc, MD; Juan Manual Villalpando Berumen, MD

To develop a multidisciplinary instrument for assessment, guiding treatment, and facilitating communication to help optimize end-of-life care in a nursing home setting. This was a qualitative study, using a three-rounds modified Delphi method questionnaire to assess the instrument's validity. After an extensive literature review, a unique instrument for end-of-life care in long-term nursing home care was developed. The instrument had 88 different items. It was submitted to experts in different disciplines related to end-of-life care of the elderly to each round using: 1) a questionnaire to mark (on a scale of 1 to 9) for the relevance of the item and its presentation; and 2) a form for general and specific comments about the items. In total 14 nurses and physicians, all experts in palliative care and/or geriatric long-term care participated in the study, divided according to their backgrounds: 10 had an academic background (were trainers or had publications in the field) and four had a clinical background with at least five years of experience in long-term care of the elderly. All the experts were working in the province of Quebec. At each of the three Delphi rounds expert consensus was reached on which items should be included and on how the items should be presented. The questionnaire has been administrated twice so far and the instrument had been modified based on whether complete consensus was made for each item. For the first questionnaire, complete consensus was obtained for 58 out of 88 items. With the different commentaries, modifications were made for 20 items, one item was removed, and seven items were added. For the second questionnaire, 26 more items made consensus. Three of the last four items have been removed and the last item needs to be submitted for a third round. It is clear that this validated multidisciplinary instrument could contribute to improved end-of-life care in the nursing home setting.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

520 Do Injury Rates in Playgrounds Outweigh Benefits of Play? A systematic rapid review

Nicolas Bergeron*; Catherine Bergeron; Luc Lapointe, MA; Dean Kriellaars, PhD; Patrice Aubertin; Brandy Tanenbaum; Richard Fleet, MD, PhD, CCMF (MU)

Objective: Collate statistics on injuries to assess whether the benefits of play on playgrounds outweigh the consequences of potential injury. **Design:** A literature review was conducted from June to July 2016. A search strategy was built around the question "Does playing in a playground represent an increased injury risk activity compared to other activities?" and revolved around the main concepts of "child," "playground," and "injury." The search strategy was applied in three databases (PubMed, Embase, and Cochrane) and was limited to articles published in the past five years. Inclusion and exclusion criteria were systematically applied to the retrieved references. **Results:** Of the 167 unique articles found, 22 respected the criteria and were retained for data extraction and analysis. Most of the injuries that occur on playgrounds are minor. Injuries requiring first aid accounted for 75 per cent of total playground injuries, and 90 per cent of all children who actually consulted a medical professional for their injuries were released without further investigation. Fractures, brain injuries, and other traumatic injuries accounted for less than 20 per cent of all playground injuries. Fractures occurring on playgrounds were generally less frequent than fractures caused by other sports and other types of falls. Playground falls rarely caused brain injury, accounting for 2 per cent to 9 per cent of all minor head injuries. **Conclusions:** Playgrounds do not seem to account for a significant proportion of injuries in children. Many sports, leisure activities, and even other types of falls cause more traumas than playground falls. By taking into account the psychological, social, physical, and intellectual benefits that this kind of risky play provides to children, potential risks of injury do not seem to be sufficient grounds for encouraging parents to keep their children away from playgrounds.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

521 Les blessures dans les arts du cirque, une revue de la littérature

Isabelle Lavallée-Bourget*; Luc Lapointe, MA; Patrice Aubertin; Richard Fleet, MD, PhD, CCMF (MU)

Contexte : Les médecins de famille sont souvent confrontés aux blessures issues d'activités sportives. Chaque sport engendre des risques de blessures particuliers et il convient d'offrir des soins adaptés en fonction de la discipline sportive pratiquée. Depuis les années 1980, le cirque québécois a connu un véritable essor. Plusieurs compagnies et écoles de cirque ont vu le jour. Il s'agit d'un milieu très effervescent et il devient donc de plus en plus pertinent, pour les omnipraticiens, de mieux comprendre les types de blessures fréquemment rencontrés dans cette discipline. Ainsi, nous avons conduit une revue systématique rapide de la littérature pour répondre à la question : « quelles sont les blessures musculo-squelettiques des artistes de cirque ? » **Méthode :** La stratégie de recherche de la revue de littérature, basée sur les concepts : « blessures musculo-squelettiques » et « cirque », a été lancée dans 17 bases de données bibliographiques incluant notamment SPORTDiscus et MEDLINE. La stratégie a identifié 36 articles, dont 16 répondaient aux critères d'inclusion et ont subi l'étape de l'extraction des données. **Résultats :** Les résultats suggèrent que 2/3 des blessures sont de nature traumatique, le 1/3 restant résulte généralement de surutilisation. Les entorses et les élongations musculaires sont les blessures les plus fréquentes, représentant près de 30% de toutes les blessures. Les fractures et les luxations sont moins courantes (4 % et 2 % respectivement). Les chevilles sont le site le plus susceptible aux blessures aiguës, alors que les blessures à évolution graduelle touchent plus souvent les épaules. Certaines disciplines prédisposent à des problèmes spécifiques, tels que la fracture de stress de la fibula chez le trapéziste. **Conclusion :** En tenant compte des blessures fréquemment rencontrées chez les artistes de cirque, l'omnipraticien pourra offrir des soins médicaux adaptés en fonction des besoins particuliers de cette clientèle spécifique en croissance.

522 Chaperone Use During Intimate Examinations: What we do and what we teach

Sonya Lee*, MD, MHSc, CCFP, FCFP; Juli Finlay, PhD; Maeve O'Beirne, MD, PhD, FCFP

Context: Recommendations from the College of Physicians and Surgeons of Alberta (CPSA) state that physicians should use chaperones when conducting intimate examinations of patients. Despite this recommendation, there are no published data on the use of chaperones in Alberta, and there is an overall paucity of research in Canada and in family medicine. **Objective:** To identify family physicians' use of chaperones during adult intimate examinations and their teaching practices. **Design:** This project was a questionnaire-based study with data collected using the anonymous, online FluidSurveys™ platform. SPSS® statistical software was used for statistical analysis. **Participants:** The study population included 1,154 practising family physicians in the Department of Family Medicine in Calgary. **Outcomes measures:** Outcomes included the frequency of self-reported chaperone use by physicians with adult patients and their teaching practices. **Results:** The total number of responses used for analysis was 353 (30 per cent response rate). Physicians do not routinely use chaperones when examining male patients, and there were no significant differences between male and female physicians across all exam types ($P = 0.073$ to $P = 0.636$). Male physicians use chaperones significantly more than female physicians when examining female patients across all types of exams ($P < 0.001$). Less than 10 per cent of physicians teach male learners to use chaperones with male patients, with no difference noted in physician gender ($P = 0.177$ to $P = 0.873$). Ten per cent of physicians teach female learners to use chaperones with female patients, with male physicians more likely to teach chaperone use across all exam types ($P = 0.012$ to $P = 0.035$). In general, female learners are less likely to be taught to use chaperones and male physicians are more likely to teach chaperone use. **Conclusions:** Despite CPSA recommendations, not all physicians routinely use chaperones during intimate examinations. Both patient and physician gender influence chaperone use. These results confirm previous international and Canadian research findings. This is the first study to address teaching practices around chaperone use, and results demonstrate that the gender of the learner, patient, and physician influence teaching practices.

523 Does the Use of Dialectical Behaviour Therapy (DBT) Improve Anxiety and Depression Symptoms?

Nicole Bennett*, MN, NP; Jeff Korchoski, MA

Learning objective: The learner attending this poster will learn that the use of DBT as an adjuvant in treating patients in the primary care setting with anxiety and depression will improve pre and post PHQ9/ GAD7 measurements. **Design:** Patients completed a four week DBT group facilitated by a Nurse Practitioner and Shared Care Counsellor focusing on Core Mindfulness skills, Interpersonal Effectiveness Skills, Emotional Regulation Skills, and Distress Tolerance Skills. GAD7 and PHQ9 were administered pre and post. **Setting:** The DBT course was offered in the Primary Care clinic two hours a week for four weeks, and was offered monthly. **Participants:** Patients with a diagnosis of depression and or anxiety were referred from primary care clinics within the community by their Nurse Practitioner, Family Physician or shared care counsellor and voluntarily attended the four week program. **Intervention:** DBT group was facilitated using a course adapted from the Fulton State Hospital (Missouri Dept. of Mental Health). **Main outcome measures:** A total of 31 people participated in the group with 12 successfully completing both the pre and post PHQ9 and GAD7 measures. Data were compared pre and post for both the PHQ9 scores and the GAD7 scores using a paired *t*-test with confidence interval set at 95 per cent. **Results:** There is strong evidence ($t = 3.24$, $P = 0.004$) that the addition of a four week DBT program significantly improves the PHQ9 scores of participants. There is also strong evidence ($t = 2.81$, $P = 0.008$) that the addition of a four week DBT program significantly improves GAD7 scores in participants. **Conclusion:** Use of a DBT group can significantly improve anxiety and depression symptoms in primary care patients. In the past DBT was commonly used for borderline personality but should also be considered in the treatment of anxiety and depression.

524 Mindfulness-Based Interventions in Clinical Samples of Youth With Internalizing Disorders: A systematic review

Sara Ahola Kohut*, PhD, CPsych; Ahlexxi Jelen, CCRP; Danielle Ruskin, PhD, CPsych; Jennifer Stinson, RN, PhD

Background: Mindfulness-based interventions (MBIs) have emerged as a promising strategy for individuals with chronic health conditions, given their versatility in targeting both physical and mental health outcomes. However, research to date has focused on adult or community-based populations. Yet, a recent meta-analysis revealed that MBIs are three times more impactful for clinical versus non-clinical pediatric populations and are particularly helpful for internalizing symptoms (e.g., depression, anxiety). **Objective:** To summarize and critically appraise the available literature on the feasibility and effectiveness of MBIs for clinical samples of youth diagnosed with internalizing disorders (e.g., anxiety, depression, post-traumatic stress). **Design:** A systematic review of the literature with electronic searches conducted by a library information specialist familiar with the field using Embase, PsycINFO, MEDLINE, CINAHL, Web of Science, and EBM Reviews databases. Two reviewers independently selected articles for review and extracted data. **Results:** Of a total of 4,710 articles, five articles met inclusion criteria. Study designs were primarily randomized controlled trials with one prospective pre-post intervention study. Sample sizes varied across studies from 24 to 102 participants. No studies included in-patient participants or participants with comorbid internalizing and physical disorders. MBIs included in this review were primarily group-based and did not offer remote or online options. All MBIs were feasible and studies consistently found that following MBI completion, youth reported significant improvements in internalizing symptoms (e.g., anxiety, depression, post-traumatic stress). **Conclusions:** MBIs are a promising approach to coping with internalizing symptoms in youth. Clinical populations of youth are an essential sample to target for future work in mindfulness due to the significant impairment to quality of life and function related to living with mental illness. Future research with rigorous study designs is warranted to determine definitive treatment effectiveness of MBIs for internalizing symptoms. Research methodology and clinical implications will be discussed.

525 Continuity of Care in Postgraduate Training: Context and mechanisms to enable learning

Rebecca Stoller*, MD, CCFP, FCFP; Kulamakan Kulasegaram, PhD; Allyson Merbaum, MD, CCFP, FCFP; Risa Freeman, MD, CCFP, FCFP, MEd

Context: Continuity of care is integral to the practice of comprehensive family medicine. To date, research in

the area of continuity of care in residency training programs has examined the effect of structural programmatic changes and the impact of such changes on residents' continuity of care experiences. The mechanisms and enablers that facilitate the learning of continuity of care have not been well established. **Design:** We have undertaken a two-year mixed-methods comparative study to understand how residents experience their learning of continuity of care and the effectiveness of a complex educational intervention targeted to integrating continuity of care into residents' identities at multiple levels of the postgraduate curriculum. **Participants:** The population for this study consists of one cohort of family medicine residents in the Department of Family and Community Medicine at the University of Toronto in Ontario, their clinical preceptors, and a control group at a comparable community-based teaching site in Toronto. **Intervention:** We will describe a System Resident Preceptor (SRP) intervention that has been delivered to one cohort of residents and preceptors, which includes structural initiatives to enhance learning of continuity of care (e.g., remote electronic medical record access), an orientation workshop for trainees, and faculty development sessions. Additionally, this intervention has introduced two novel formative assessment tools. **Findings:** Early findings over the two-year interventions point to contextual issues at the level of the system (such as electronic medical record access), the resident (such as career trajectory), and the preceptor (such as role modelling). These themes identify the critical mechanisms in our context for integrating continuity of care into emerging identity of physicians. **Conclusion:** While curriculum design and assessment standards are important components of providing a structured approach to teaching continuity of care in the postgraduate curriculum, other factors such as evolution of skill and experience over the course of training, system of practice, and preceptor influence are crucial mechanisms.

526 Role Modelling of Professionalism in Family Medicine Residency (work in progress)

Stephen Marisette*, MD, CCFP; Muhammad Shuvra, MB BS, MPH, MSc;
Jeremy Rezmovitz, MD, MSc, CCFP; Joanna Sale, PhD, MSc; John Maxted, MD, MBA, CCFP, FCFP;
Donatus Mutasingwa, MD, MPhil, PhD, CCFP; Shiphra Ginsburg, MD, MEd, FRCPC

Objective: This study explores how family medicine residents experience role modelling of professionalism by family medicine preceptors. **Design:** This is a qualitative study that employs a phenomenological methodology. The research assistant is conducting one-on-one, semi-structured interviews with participants. Interviews are audio-recorded and transcribed verbatim. Transcripts are being coded and analyzed for developing themes. **Setting:** We are completing interviews with family medicine residents at two University of Toronto teaching units. **Participants:** We have conducted 10 interviews to date and aim to complete a total of 16 interviews of first- and second-year family medicine residents. **Main outcome measures:** A better understanding of residents' experiences with role modelling of professionalism will be useful in the design of family medicine professionalism curriculum and in the creation of faculty development initiatives. **Results/Findings:** Analysis to date indicates that residents look for role models who are intentional, self-reflective, empathic, supportive, and respectful of others. Residents describe experiences with role modelling of varying aspects of professionalism including ethical practice, high standards of personal behaviour (especially respect), and self-reflection. Residents appear to have difficulty identifying role modelling of self-care. Some residents describe a lack of shared patient encounters in which they experience role modelling of professionalism by their family medicine preceptors. They attribute this paucity of role modelling in clinical settings to the fact that residents seldom observe their preceptors interacting with their own patients. **Conclusion:** Family medicine residents experience role modelling of professionalism and are able to identify positive role models, especially with respect to ethical practice, high standards of personal behaviour, and self-reflection. As family medicine preceptors, we need to recognize the importance of self-care and then find ways to model this aspect of professionalism. Furthermore, it is important for preceptors to identify opportunities to model professionalism in clinical settings.

RESIDENT / RÉSIDENT

527 Canada Student Loan Forgiveness as a Financial Incentivization Policy: Interest and matches into family medicine residency programs

Conrad Tsang*, MD, MPH

Objective: To evaluate whether the 2012 implementation of the Canada Student Loan Forgiveness for Family Doctors program increased the interest and matches to family medicine residency programs. **Design:** Quasi-experimental interrupted time series with weighted synthetic control methods to match for pre-intervention trends. **Setting:** National data from 2000 to 2016. **Participants:** All Canadian medical graduates participating in the Canadian Resident Matching Service (CaRMS) first iteration match. **Intervention:** Financial incentivization policy providing $8,000 federal loan forgiveness for family medicine residents and physicians working 400 hours in underserved or remote communities per year. All residency programs with mandatory rural rotations meet requirements. **Main outcome measures:** Immediate change after policy implementation and longitudinal trend changes in the number of first-choice applicants to family medicine, with a priori stratification by sex, and match results. **Results/Findings:** A total of 339 applicants in 2010 ranked family medicine as their first-choice discipline, which increased to 1,050 in 2016, similar to the control group with 373 in 2010 and 940 in 2016. Although there were no significant changes in the total number of first-choice applicants immediately or longitudinally when compared with the control group, in the year following policy implementation there was a statistically significant increase of 71 female first-choice applicants (95%CI 0.4 to 141.9; $P = 0.049$) and 74 female first-choice matches to family medicine (95%CI 5.6 to 141.5; $P = 0.035$), with unchanged trends. First-choice male applicants had a statistically significant longitudinal trend increase of 11 matches per year (95%CI 0.9 to 21.8; $P = 0.034$). Among all applicants, regardless of discipline ranking, there was a statistically significant increase of 112 matches to family medicine in the year following policy implementation (95%CI 18.5 to 204.9; $P = 0.021$) with a maintained modest trend increase. **Conclusion:** Significant benefits were already seen at five years after policy implementation for interest and matches to family medicine. Financial incentivization programs should consider characteristics of income sensitivity between sexes.

RESIDENT / RÉSIDENT

528 CANCELLED / ANNULÉE

RESIDENT / RÉSIDENT

529 **Preceptors' Assessment of a Pre-clerkship Longitudinal Family Medicine Experience (LFME) at McGill University**

Karen A. Willoughby*, MD CM, PhD; Leonora Lalla, MD; Miriam Boillat, MD; Marion Dove, MD; Peter Nugus, PhD; Yvonne Steinert, PhD; Charo Rodriguez, MD, PhD

Objective: To examine preceptors' views on a Longitudinal Family Medicine Experience (LFME) course for first-year medical students at McGill University following its first year of implementation. **Design:** This study is part of a larger project assessing students' and preceptors' views of LFME using surveys and focus groups. A 54-item survey using seven-point Likert scales was developed to assess preceptors' views on various aspects of the LFME (e.g., course logistics, motivation for becoming a preceptor, mentoring role, etc.). Fourteen items were identical to the students' survey (N = 120; published in 2016) and mean scores from these items were compared across the two groups. **Setting:** Surveys were available online via fluidsurveys.com from June to August 2014. **Participants:** Ninety-nine LFME preceptors (57 per cent participation rate; 54 per cent female) completed the survey. **Results:** Preceptors had more positive ratings regarding their role and the benefits of the LFME course than did students. For example, preceptors were more likely to report that students were given sufficient opportunity to practise clinic skills, received sufficient feedback from preceptors, felt more prepared for clerkship, had a better understanding of the work performed by family physicians, and were more likely to pursue family medicine as a result of the LFME ($P < 0.01$). Younger preceptors were more likely to report they had a challenging time balancing LFME teaching with maintaining their practice, were motivated to join LFME for remuneration, felt challenged as a role model, and felt the LFME would encourage students to pursue family medicine ($P < 0.01$) compared with older preceptors. Female preceptors were more likely to report having a challenging time balancing LFME with their practice and were less likely to feel confident in their teaching ability ($P < 0.01$) compared with male preceptors. **Conclusion:** Both preceptors and students were very satisfied with the LFME course; however, preceptors had more positive reviews than students.

530 Examining Follow-up of Residents in Difficulty in a Competency-Based Assessment Framework

Natalia Binczyk; Shelley Ross, PhD; Oksana Babenko, PhD; Shirley Schipper*, MD, CCFP

Context: Residents in difficulty are expensive for residency training programs in both human capital and financial resources. Detection and support of residents in difficulty has been challenging. Our program implemented competency-based assessment in 2009. While we have heard anecdotally that there has been an improvement in the follow-up of residents who encounter difficulty, we wished to explore this question empirically. **Objective:** To determine the extent to which the Competency-Based Achievement System (CBAS) results in better follow-up of residents identified as encountering difficulty. **Design:** Secondary data analysis of archived resident files. **Setting:** University of Alberta Family Medicine Residency Program. **Participants:** Archived files for urban family medicine residents who commenced and completed residency training in 2006 to 2016 (N = 517). **Interventions:** Introduction of CBAS as the main assessment tool in University of Alberta's family medicine residency training program. **Main outcome measures:** Resident files were analyzed for evidence of difficulty in the form of professionalism flags or performance flags. It was recorded whether the files contained documentation indicating that the flags were addressed by the residency training program. **Results:** Post-CBAS implementation: There was a decrease in the proportion of flagged residents whose difficulties were not documented as recognized and addressed, with 48.0 per cent of such residents pre-CBAS (95%CI 39.0 to 57.5) and 16.9 per cent of such residents post-CBAS (95%CI: 8.5 to 25.3). Pre-CBAS residents were 2.0 times (95%CI: 1.2 to 3.4) more likely to encounter difficulty, residents older than 30 years were 2.3 times (95%CI: 1.2 to 4.1) more likely to encounter difficulty, and non-transfer residents were 9.0 times (95%CI: 1.2 to 68.4) more likely to encounter difficulty than their respective counterparts. **Conclusion:** CBAS is effective in identifying residents in difficulty and ensuring that difficulties are addressed. Addressing difficulties appears to result in a decrease in the proportion of learners who continue to encounter difficulty during training. Some characteristics may increase likelihood that a resident may encounter difficulty.

531 Exploring the Relationship Between Competency-Based Assessment and Applications to PGY-3 Enhanced Skills Programs

Natalia Binczyk; Oksana Babenko, PhD; Shirley Schipper, MD, CCFP; Shelley Ross*, PhD

Context: In Canada many family medicine residency programs offer Enhanced Skills (PGY-3) programs that allow family physicians to obtain extra training in areas such as Care of the Elderly, Emergency Medicine, and others. There has been a steady increase in applications to these programs, which is becoming a controversial topic. There is some speculation that residency program graduates pursue PGY-3 training because they do not yet feel ready for independent practice. In this study we explored the relationship between the implementation of a competency-based assessment framework and application to PGY-3 programs. **Objectives:** To what extent is there a relationship between competency-based assessment and the proportion of graduates from the program who apply to PGY-3 programs? To what extent are there trends in the characteristics of residents applying to PGY-3 programs? **Design:** Secondary data analysis of archived resident files. **Setting:** University of Alberta family medicine residency program. **Participants:** Archived files for urban family medicine residents who commenced and completed residency training in 2006 to 2016 (N = 517). **Interventions:** Introduction of the Competency-Based Achievement System (CBAS). **Main outcome measure:** Application to PGY-3 programs. **Results:** Residents trained pre-CBAS implementation were 1.69 times (95%CI 1.01 to 2.82) more likely to apply to PGY-3 programs than their post-CBAS implementation counterparts. Male residents were 2.21 times (95%CI 1.32 to 3.68) more likely to apply to PGY-3 programs than female residents. Residents > 30 years old were 2.13 times (95%CI 1.22 to 3.70) more likely to apply to PGY-3 programs than younger residents. Canadian medical graduates were 2.72 times (95%CI 1.35 to 4.47) more likely to apply to PGY-3 programs than international medical graduates. **Conclusion:** The implementation of CBAS may have contributed to a decrease in the proportion of residents pursuing PGY-3 training. Male, older, and Canadian medical graduate students may be facing unique circumstances contributing to an increased likelihood of applying to PGY-3 programs.

532 Examining Relationships Between Residents' Interest and Achievement on the Family Medicine In-Training Examination

Oksana Babenko*, PhD; Shirley Schipper, MD, CCFP; Shelley Ross, PhD;

Denise Campbell-Scherer, MD, PhD, CCFP, FCFP; John Chmelicek, MD, CCFP, FCFP, FAAFP

Objective: Interest, as a form of motivation, has been shown to facilitate learning and stimulate effort and personal involvement; however, interest in a particular area/subject can also jeopardize individuals' achievement and learning in other areas/subjects. The objective of this study was to examine the associations between residents' interests in specific areas of family medicine and their performance on the In-Training Examination (ITE), a standardized measure of medical knowledge and clinical reasoning. **Design:** This was a cross-sectional study employing survey methodology and 2016 ITE data. **Setting:** In the fall, all residents (N = 151) in their first (PGY-1) and second (PGY-2) years took the ITE (computer-based, 240 multiple-choice questions). **Participants:** Immediately before the ITE, all residents were invited to indicate which area of family medicine they were especially interested in. Response rate was 60 per cent (n = 87). **Main outcome measures:** Residents' performance on each of the eight areas on the ITE: adult medicine; care of surgical patients; care of the elderly; maternity care; care of female patients; care of children; emergent care; and mental health. **Analyses:** Multivariate linear regressions, with year of residency (PGY-1/PGY-2) and interest in a specific area (Yes/No) were entered as predictors of residents' performance in each domain. **Results:** Fifty-four per cent of responding residents were PGY-1; 58 per cent were female residents. Residents had on average the highest scores on emergent care and the lowest scores on maternity care. Significant differences in performance were observed between PGY-1 and PGY-2 residents on adult medicine, care of the elderly, care of children, emergent care, and mental health. Interest was a significant predictor of residents' performance on maternity care and emergent care (both βs = 0.22; $P < 0.05$) only. **Conclusion:** Given the broad spectrum of family practice, it is reassuring that residents' performance on specific areas was largely comparable and independent of residents' interest for the majority of the areas of care in family medicine.

533 Family Medicine Residents' Perceptions and Experiences in Teaching

Lillian Au, MD, CCFP, FCFP; Oksana Babenko, PhD; Sudha Koppula, MD, CCFP, FCFP MClSc; Olga Szafran, MHSA

Context: Teaching is one of the best ways to be engaged in lifelong professional development. Previous involvement and experience in teaching contribute to perceptions that individuals have about the importance and value of teaching with respect to professional development. **Objective:** To examine family medicine residents' perceptions of the importance and value of teaching, as well as their enjoyment and interest in teaching in light of their previous teaching experience and training in teaching. **Design:** Survey study. **Participants:** Family medicine residents at a Canadian university at the midpoint of their training. **Outcome measures:** Residents completed a questionnaire with measures of perceptions of the importance/value of teaching, enjoyment/interest in teaching, and previous teaching experience/training in teaching (scale 1 to 10). A descriptive data analysis was conducted. **Results:** In total, 52 (67 per cent) residents completed the survey (53 per cent were female, 65 per cent were in the urban stream, and the mean age was 28.8 (standard deviation [SD] = 3.2; range = 24 to 38) years). A total of 92 per cent of residents reported having taught medical students (77 per cent), patients (72 per cent), school students (53 per cent), university students (34 per cent), and other health care professionals (30 per cent). Eighty-seven per cent of residents taught one-on-one, 75 per cent taught small groups, and 53 per cent had classroom teaching experience. Only 36 per cent of residents had any training in teaching. Overall, residents reported a high level of teaching enjoyment (mean = 8.7; SD = 1.5), considered teaching an important skill for physicians to have (mean = 9.4; SD = 0.9) and to develop (mean = 9.3; SD = 0.9), and viewed teaching as part of lifelong learning (mean = 9.3; SD = 1.0). Residents felt a professional duty to teach (mean = 8.6; SD = 1.4), were interested in teaching medical students (mean = 8.5; SD = 1.7) and residents (mean = 8.3; SD = 1.6), and would choose to include clinical teaching as part of their careers (mean = 8.8; SD = 1.5). **Conclusion:** Family medicine residents are highly interested in teaching. To encourage the development of future teachers, residency programs should consider early formal processes in training residents to foster teaching in clinical settings.

534 Resident Ice Cream Rounds to Support Well-being and Prevent Burnout: A work in progress

Kelly Howse*, MD, CCFP; Nancy Dalgarno, PhD; Emily Johnston, MSc

Background: Physician and resident stressors negatively affect the quality of our health care system and patient care.

Most studies conducted on resident wellness focus on identifying stressors and wellness strategies. There is a dearth of literature guiding effective curricular support for residents. **Objective:** The purpose of this study is to evaluate an innovative, voluntary, resident-facilitated, discussion-based curricular learning initiative in one family medicine training program, called Resident Ice Cream Rounds (RICR). **Design:** This evaluation uses a mixed-method design. Quantitative data were collected from confidential participant exit surveys following 11 RICR that addressed stress level, well-being, influence of RICR on stress, and likelihood to attend RICR again or recommend RICR to a colleague. Data collection will also include a final survey and semi-structured interviews with five RICR participants, five non-participants, and the two resident facilitators, which will be completed by June 2017. Thematic analysis and descriptive and inferential statistics will assist in analyzing the data. **Participants/Setting:** Postgraduate year 1 residents (n = 46) and resident facilitators (n = 2) in a medium-size Canadian family medicine training program are involved in this research. **Results:** To date, there have been eight RICR totalling 80 completed exit surveys. There were on average 10 residents per session, ranging from three to 22 residents. Preliminary data showed that 77 per cent of residents experienced moderately to extremely stressful days two weeks prior to completing the surveys. The RICR were well received, with 96 per cent of residents reporting that they would likely/very likely attend another session and 87 per cent reporting that they would likely/very likely recommend RICR to others. **Conclusion:** The preliminary results demonstrate that residents attending RICR are experiencing high levels of stress, and these facilitated small-group discussions improve their well-being. RICR is an effective form of curricular support for resident wellness.

535 Collège des médecins du Québec : rôle et responsabilités de l'apprenant et du superviseur.

Louise Samson, MD, FRCPC; Yves Gervais, MD; Josée Dubois, MD; Ève-Reine Gagné, MD; Kenneth Doyle, MD; Sylvie Bélanger, MD; François Caron, MD; Serge Keverian, MD; Julie Lalancette, MD; Mario Deschênes, MD; Anne Marie MacLellan, MD

Introduction : La formation médicale est de grande qualité au Québec et les nombreux référentiels qui encadrent cette formation y jouent un rôle fondamental. Toutefois, il persiste certaines ambiguïtés dans la perception des apprenants et des superviseurs quant à leur rôle et à leurs responsabilités respectifs**.** Ce guide vise une standardisation des messages quant au rôle et aux responsabilités de l'apprenant et du superviseur**.** La préoccupation centrale est d'assurer la sécurité des soins. L'objectif de cette affiche est d'amener le participant à se familiariser avec certains énoncés du guide et à envisager les manières dont il peut être utilisé au quotidien. **Méthode :** Le guide est écrit en fonction de cinq principales interactions de l'apprenant ou du superviseur avec leur environnement, soit le patient, les milieux de formation, les équipes soignantes, le CMQ ainsi que la profession et la discipline, et enfin envers soi-même. Pour cette affiche, certains énoncés ont été sélectionnés parmi les cent énoncés du guide afin d'aider le participant à saisir la portée du guide et à voir comment transposer les différents messages dans la réalité de son milieu de formation**. Conclusion :** Ce guide se veut un document succinct et facile à consulter dans le but d'offrir des balises claires et concrètes qui définissent le rôle et les responsabilités de l'apprenant et de son superviseur. Les énoncés décrits dans ce guide reflètent la préoccupation centrale d'assurer le respect de la mission du CMQ, qui vise pour l'essentiel la protection du public par une médecine de qualité.

536 Family Medicine Residents' Appreciation of Home Care in a Non-Urban Training Setting

Nancy McLaughlin, MD, PhD, CCFP, FRCSC; Émilie Audy, MSc; Marie-Thérèse Lussier, MD, CCFP, FCFP; François Aubry, PhD; Johanne Gauthier, MD, CCFP; Serge Dumont, MD, CCFP

Objective: To describe family medicine residents' appreciation of home care in a non-urban training setting and identify factors influencing their opinion. **Design:** Qualitative study using individual semi-structured interviews with participating residents. **Setting:** The study was conducted between January 2015 and July 2016 at the Trois-Rivières Family Medicine Teaching Unit (FMTU), a non-urban centre affiliated with the University of Montreal in Quebec. **Participants:** Among the 22 residents completing their residency at the Trois-Rivières FMTU, 15 agreed to participate in the study. Ten were in their first year of residency and five were in their second year of residency. Participant age ranged from 24 to 38 years, with a female predominance (11/15). The majority of participants completed their undergraduate studies in a non-urban training setting. **Intervention:** Interviews were record-

ed and transcribed integrally by a research professional. Following codification of the transcriptions, a transversal analysis was performed by study themes, enabling a descriptive analysis of interview content. **Findings:** Residents' appreciation of home care was favourable for three residents, unfavourable for three residents, and nuanced for nine others. Residents' opinions regarding home care are influenced by its bad press among residents and other factors perceived as either favourable (e.g., supplementary information obtained during home visits, benefits for patients, distinct nature of patient-physician relationship) or unfavourable (e.g., uncertainty regarding home care practice, patient population targeted by home care, travel). For the majority of residents (nine of 15) there was no association between their appreciation of home care and their openness to delivering home care in their future practices. Almost half (seven of 15) expressed, with no hesitancy, their willingness to integrate home care in their future practices. **Conclusion:** Residents trained in a non-urban setting do not express a spontaneously unfavourable appreciation regarding home care. Their opinion is nuanced and is influenced by various aspects specific to this practice, which are perceived positively by residents, resulting in an important proportion of residents with an openness to home care in their future practices.

537 How Family Medicine Residents Learn: Understanding the role of cues in self-regulated learning

Jane Griffiths, MD, CCFP, FCFP; Han Han, PhD; Nancy Dalgarno*, MEd, PhD, OCT; Jessica Rich, MEd; Karen Schultz, MD, CCFP, FCFP; Geoffrey Hodgetts, MD, CCFP, FCFP; Elaine Van Melle, PhD

Objective: To identify cues that drive family medicine residents' self-regulated learning and to determine the effectiveness of the cues. **Design:** A qualitative descriptive design was adopted. Information was collected from family medicine residents' natural learning behaviours in their training program. Over a one-month period, participants used their smartphones to audio record a series of 120 voice notes about their in-training experiences and learning processes. The recordings were transcribed verbatim and pseudonyms replaced all identifiable data. Data analysis employed a thematic design. **Setting:** The study took place in one medium-size department of family medicine located in an urban postgraduate medical education institution in Canada. **Participants:** Using purposive sampling, postgraduate year (PGY)-1 (n = 6) and PGY-2 (n = 6) family medicine residents participated in the study. **Findings:** The residents reported major sources of uncertainty that drove learning: prescribing or explaining medications, diagnosing complicated presentations, ordering further clinical investigations, handling patients' non-clinical demands, and managing differing opinions. These uncertainties prompted searching for information during clinical encounters. External resources included websites and published guidelines and consultation with preceptors, advisers, senior staff, or allied health professionals. Obstacles to learning were not enough time to learn during clinic, inability to find specific guidelines, and the perception that preceptors were unable to provide clear and sufficient information. **Conclusion:** Residents are prompted to learn from uncertainties arising in clinical work. They enact self-regulated learning though accessing both internal and external resources to alleviate their uncertainty, regardless of the challenges they face to resolve the uncertainties. This study expands our understanding of the cues and processes that family medicine residents use to engage in self-regulated learning. Evidence of the range of cues prompting residents to feel uncertain will help us design innovations and supports to promote self-regulated learning purposefully in practice.

538 Program Evaluation of a Simulation-Based Obstetrical Skills Workshop for Family Medicine Residents

Kelsey Klages*, MSc; Adrienne Wakabayashi, MSc; Laura Lyons, MD, CCFP; Jamie Wickett, MD, CCFP; Jo-Anne Hammond, MD, CCFP

Objective: To enhance family medicine residents' knowledge and skills in intrapartum care through participation in a simulation-based Obstetrics Skills Day workshop designed and implemented within a postgraduate program in family medicine. **Design:** Program evaluation. **Setting:** Western University in London, Ontario. **Participants:** First-year family medicine residents in 2014, 2015, and 2016. **Intervention:** A hands-on, low- to medium-fidelity simulation-based workshop was developed according to objectives identified by a family medicine faculty member who practised obstetrics. Objectives for the workshop included nine low-risk obstetric activities: assessment of cervical dilation, assessment of vertex and breech presentation, artificial rupture of membranes, normal vaginal birth, shoulder dystocia, postpartum hemorrhage, scalp clip application, knot tying, and perineal repair. The workshop took place over the course of three hours, beginning with a 30-minute introduction including videos

of normal vaginal birth and perineal repair. Following this the residents had two hours and 25 minutes to rotate through four quadrants (approximately 35 minutes each) with various simulations. The workshop concluded with a 10-minute wrap-up. **Main outcome measures:** Pre-test evaluation questions focused on demographic questions, along with questions regarding experience and competence in the objectives of the workshop. Post-test evaluation questions focused on competence in the objectives after the session and workshop improvement questions. **Results:** In total, 185 residents completed pre- and post-evaluations over the three years (response rate was 81.5 per cent). Self-reported competence in all nine objectives significantly increased after the session in all three years, according to a paired-samples *t*-test with a *P* value of 0.05. The feedback received regarding the workshop was extremely positive. **Conclusion:** Obstetrics Skills Day appears to have improved self-reported competence in managing low-risk intrapartum experiences in family medicine. The program capitalizes on successes of the workshop and continual improvements are made each year.

539 Family Medicine Resident Training in Abdominal Aortic Aneurysm Ultrasound Screening: A pilot study

Martin Badowski, MD; Joseph Newbigging, MD, CCFP (EM)

Objective: To determine family medicine residents' uptake, confidence, knowledge, and barriers to abdominal aortic aneurysm (AAA) ultrasound screening in an academic family health team following a structured AAA ultrasound screening teaching program. **Design:** Prospective observational study. **Setting:** Queen's University academic family health team. **Participants:** Fourteen postgraduate, year one family medicine residents with no formal ultrasound training. **Interventions:** The structured AAA ultrasound screening teaching program included a 45-minute video followed by supervised ultrasound scans by ultrasound educators from the Queen's Department of Emergency Medicine. Family medicine residents completed questionnaires before and six months after the teaching intervention assessing for confidence using five-point Likert items, and knowledge using multiple-choice questions. Barriers to AAA ultrasound screening in an academic family health team were assessed using three-point Likert items. **Main outcome measures:** The primary outcomes of the study included family medicine residents' confidence, knowledge, perceived barriers to AAA ultrasound scanning in an academic family health team, and the number of AAA ultrasound screening scans performed pre- to post-training session. **Results:** Fourteen family medicine residents performed a median of eleven supervised scans. Post-training, overall confidence in ruling out an AAA increased (mean difference: -3.8, W value: 0, $P \leq 0.05$) and proportion of correct knowledge responses increased from 58 per cent to 91 per cent (mean difference = -6.3, $z = -3.62$, $P < 0.05$). Major barriers identified by family medicine residents both pre- and post-training were time limits in clinic and lack of faculty supervision and commitment to AAA ultrasound screening. The number of AAA ultrasound screening scans performed by residents following the six-month AAA teaching intervention increased from zero to 81 scans ($t = 2.94$, $P \leq 0.05$). **Conclusion:** Family medicine residents experienced increased knowledge and confidence following a structured AAA ultrasound screening teaching program. Its implementation in academic family health teams may be successful if accompanied by faculty development, awareness of time limitations, and patient education regarding its utility.

RESIDENT / RÉSIDENT

540 A Quantitative Evaluation of the Resiliency Website (OttawaResiliency.org) as a Resource for Improving Resident Wellness

Yu Shan (Wendy) Zhang, MD; Annelise Miller, MD CM

Introduction: Resiliency is the capacity of an individual to endure, overcome, and recover from hardship or challenges. In the past few years, family medicine residents at the University of Ottawa (U of O), Ontario have identified resiliency training as a gap in their program. The Family Medicine Resiliency Committee has undertaken several projects to address this issue. One project is a resiliency website (OttawaResiliency.Org): a tool designed by residents for residents to promote wellness by providing relevant and easily accessible information and resources for coping with the stresses of residency training. **Objectives:** To obtain feedback from U of O family medicine residents about the content and utility of the resiliency website. **Methods:** A short, 10-question, anonymous online survey was emailed to all current family medicine residents at U of O. Website traffic data were also analyzed using Google Analytics. **Results:** Since its creation in June 2016, the resiliency website had 177 visitors, accounting

for 709 page views. Of approximately 150 residents, 33 responded to the survey (22 per cent). A total of 84.8 per cent of respondents were interested in a website that provided resources for resident wellness and resiliency, 97 per cent were aware of the Ottawa Resiliency website, and 78.8 per cent had visited the website. On a five-point rating scale, the website scored an average of 3.31 for usefulness, 3.32 for comprehensiveness, and 4.07 for ease of use. The web pages residents found most helpful were resources for living in Ottawa and wellness resources. Twenty-one residents provided specific suggestions for website improvements. **Conclusions:** The OttawaResiliency.Org website was positively received by the family medicine resident community. The website was found to have a very user-friendly platform, but has room to improve on the comprehensiveness of its content. The results of this study allow the Resiliency Committee to improve its resident wellness curriculum.

541 Caring for Those in Long-Term Care: Results from a training program for family medicine residents

Alethea Lacas, MD, CCFP (COE); Christy Nickerson Rak, MA

Care of the elderly is a growing area of practice within primary care. Training for family medicine physicians needs to incorporate exposure to, and skill development for, practice with elderly patients and those living in long-term care (LTC) facilities. LTC training can provide an important opportunity for family medicine residents to engage in interprofessional practice with other LTC staff, families, and patients. The Dalhousie Department of Family Medicine launched a three-month LTC rotation as part of postgraduate training for Halifax site residents in 2010. Results from pre- and post-rotation surveys completed by 26 first-year residents from the 2013 and 2014 academic years show that 50 per cent of residents had an increased interest to practise in LTC following the rotation. More than two-thirds of the residents indicated an increased comfort in managing safe prescribing, constipation, chronic pain, and wounds. More than three-quarters had increased comfort in conducting medication reviews and comprehensive geriatric assessments. Feedback from these residents shows that exposure to LTC practice as part of their postgraduate training can have a positive impact on their comfort in managing issues for this population. The exposure to interprofessional practice and working with families was valued by the residents.

542 Transition to Residency: A first-year family medicine resident perspective

Britta Camilla Claire Laslo*, MD, CCFP; Judith Belle Brown, PhD; Thomas Freeman, MD, MClSc, CCFP, FCFP

Objective: To explore the feelings and experiences of first-year family medicine residents regarding the transition to first-year family medicine residency. **Design:** Descriptive qualitative study consisting of nine semi-structured, in-depth interviews with family medicine residents. Data were independently transcribed and then reviewed by three investigators to identify emerging themes. The data analysis was both iterative and interpretative. Credibility of findings was enhanced through field notes, questioning of the data, concurrent analysis of data with ongoing data collection, and by employing reflexivity. **Setting:** The Department of Family Medicine at Western University, in London, Ontario. **Participants:** Participants had to be enrolled in their first year of family medicine residency training at Western University and had to have completed their undergraduate medical school training at a Canadian medical school. The final sample included nine first-year family medicine residents. **Findings:** Family medicine residents described this transition as complex as they experienced evolving, and often competing, positive and negative feelings during this transition. Family medicine residents articulated an important professional transition that occurs as a first-year resident as well as personal, intrinsic attributes (i.e., personality traits, attributes, or habits) and a multitude of extrinsic factors (e.g., geographical moves, residency rotation schedule, prior experiences with transition) that affect this transition. Importantly, family medicine residents consistently noted a perceived lack of connection to their family medicine resident peers, their family medicine preceptors, and their family medicine postgraduate program, which often left them feeling disengaged. **Conclusion:** The findings increase our understanding of this complex transition in medical education. The findings support recommendations to improve the transition from final-year medical student to first-year family medicine resident through a training environment with increased connectivity to the department of family medicine, early family medicine rotations, and fewer transitions between services.

543 Memorial University's Integrated Pathways to Rural Family Practice

James Rourke, MD, CCFP (EM), FCFP, MCISci; Shabnam Asghari, MD, PhD, MPH; Oliver Hurley, MEnvSc;

Danielle O'Keefe, MD, CCFP; Mohamed Ravalia, MD CM, CCFP, FCFP; Scott Moffatt, MD, CCFP, FCFP; Wanda Parsons, MD, CCFP, FCFP; Norah Duggan, MD, CCFP, FCFP

Objective: To assess the national and provincial impact of Memorial University of Newfoundland's pathways approach to producing rural family physicians. **Design:** This is a retrospective cohort study that used data from three sources, which included national, provincial, and university databases. **Setting:** This study uses georeferenced practice location and student background data from Newfoundland and Labrador and Canada. **Participants:** We considered graduates from Memorial's family medicine postgraduate program who graduated between 2004 and 2013 at the national level and Memorial MD graduates practising in Newfoundland and Labrador as of January 2015 at the provincial level. **Intervention:** We used data from three sources: 1) Canadian Post MD Education Registry (2004 to 2013); 2) College of Physicians and Surgeons of Newfoundland and Labrador database (as of January 2015); and 3) Learners and Locations database (2007 to 2015). We georeferenced the practice and background locations of Memorial graduates and classified locations based on a standard Canadian geographic definition. **Main outcome measures:** Our main outcome measures are the proportion of graduates practising in a rural location in Canada and Newfoundland and Labrador. National level analysis compared Memorial postgraduates practising in rural Canada with all other Canadian medical schools. Descriptive and bivariate analyses were performed. **Results:** For Memorial family medicine graduates who were practising in Canada two years after completing their postgraduate training (2004 to 2013), 26.9 per cent were practising in a rural location compared with the national average of 13.3 per cent. We found 305 Memorial MD graduates were practising in Newfoundland and Labrador, of whom 36 per cent were practising in a rural location. For Memorial family medicine postgraduates, 41.9 per cent were practising in rural Canada and 73 per cent were practising in Newfoundland and Labrador (50 per cent of those practising in Newfoundland and Labrador were rural). **Conclusion:** The integrated pathways approach has allowed Memorial to meet its targets with regard to providing rural generalists for rural Newfoundland and Labrador and Canada.

544 Developing, Implementing, and Evaluating a CPD Intervention for MPN and MDS Cancers

Francesca Luconi*, PhD; Leonora Lalla, MD CM, CCFP; Bettina Habib, MSc, MScPH

Objectives: Chronic myeloproliferative neoplasms (MPN) and myelodysplastic syndromes (MDS) are unknown to many health care professionals. This study aimed to develop and implement a theory-driven MPN/MDS continuing professional development (CPD) intervention; assess the feasibility of delivering this intervention to its target audience; and determine its impact on the outcomes of participation, satisfaction, knowledge, reported performance, and perceived patient health. **Design:** We conducted a longitudinal, exploratory case study in which we employed mixed methods to collect data on the delivery, quality, and impact of the CPD intervention. The design was informed by the Knowledge-to-Action Cycle, the Expanded Outcome-Based Evaluation Framework, and the CPD "push" model. **Setting:** Continuing professional development for Canadian health care practitioners. **Participants:** We used purposeful convenience sampling to select eligible Canadian health care practitioners. A total of 124 practitioners participated, among whom 60 per cent were family physicians and 46 per cent primarily served urban/suburban populations. **Intervention:** Recommendations on the screening, diagnosis, treatment, and management of MPN/MDS, delivered both synchronously and asynchronously as part of a free, online, three-module CPD course. **Main outcome measures:** Data were collected using a registration form (participation outcome), an evaluation form (satisfaction outcome), pre- and post-tests (knowledge outcome), and the Information Assessment Method (IAM) and My MPN/MDS Portfolio (MMMP) questionnaires (perceived impact on practice and patient outcomes). **Results:** Of 124 participants, 94 per cent stated that the intervention met their expectations (satisfaction outcome). Significant differences between pre- and post-tests ($P < 0.001$) indicated that knowledge had been gained. In addition, participants reported positive impact of the course on their practice regarding knowledge acquisition (86 per cent) and the application (81 per cent) and confirmation (75 per cent) of practice. In analyzing reported patient outcomes, IAM results will be triangulated with those of the MMMP. **Conclusion:** Preliminary results indicate that this multifaceted MPN-MDS CPD intervention is a feasible and effective knowledge translation strategy that addresses health care professionals' perceived and unperceived needs.

545 Assessing Communicator, Collaborator, and Professional Skill Levels of Faculty of Northern Ontario (work in progress)

Deborah Smith*, MD, CCFP, FCFP; Jacques Abourbih, MD CM, FRCS(C); Marion Maar, PhD;

Diana Urajnik, PhD; Clare Cook, PhD; Janice Willett, MD, FRCSC

Objective: To identify perceived and unperceived learning needs of Northern Ontario health care providers in three CanMEDS Roles beyond Medical Expert—Communicator, Collaborator, and Professional; and to elicit perceptions of and attitudes toward these needs and identify barriers to change. **Design:** We are using a mixed methods multi-layered approach to obtain diverse information. An environmental scan of the College of Physicians and Surgeons of Ontario, the Canadian Medical Protective Association, and other regulatory colleges' data identifies deficiencies in skills that may result in formal complaints. A validated electronic survey of health care providers provides information on self-assessed skill level. A validated telephone survey of patients gives the patients' assessment of the skill level of their health care professional. Finally, focus groups gather data about the attitudes and barriers health care professionals face in accessing continuing profession development on the identified topics, as well as their perceived preferences and facilitators for accessing the training. **Participants:** A total of 367 faculty of the Northern Ontario School of Medicine, representative of key demographics, participated in the health care provider survey. To date, more than 270 patients across Northern Ontario, crossing a range of demographic and geographic features, have participated in the telephone survey. **Results/Findings:** The quantitative portion is complete and is being analyzed. These lines of evidence will then be compared and contrasted to analyze and identify gaps. Preliminary converging results from our mixed methods indicate that the unperceived needs of faculty in Communicator, Collaborator, and Professional Roles are greater than their perceived needs. Patient handover has emerged as a particularly relevant issue. **Conclusion:** Triangulation of data from multiple sources and methods provides an innovative evidence-based methodology for assessing perceived and unperceived needs of practising health care providers.

546 Factors Influencing Faculty Engagement With Canadian Medical Schools

George Kim, MD, MClSc (FM), CCFP, FCFP; Leslie Boisvert, MPA; Melissa Cookson

Objective: The primary aim of this study is to assess faculty engagement in Canadian medical schools and identify potential barriers and facilitators to engagement. **Design:** Semi-structured interviews. **Setting:** A qualitative phenomenological study using semi-structured interviews to examine facilitators and barriers to faculty engagement. **Participants:** Twenty-two faculty/staff involved in distributed medical education within Canadian medical schools. **Intervention:** Semi-structured interviews were conducted. Audio-recorded interviews were transcribed verbatim and analyzed using an iterative and interpretive process. **Main outcome measures:** Barriers and facilitators of faculty engagement. **Findings:** The findings revealed engagement occurred within three areas: administration, teaching, and faculty development. Faculty identified relationships as being an important element of engagement. Relationships with their clinical team, students, administration, and community were all important factors of engagement; however, they also proved to be barriers in some ways. Lack of recognition from administration, as well as a feeling of a lack of personal skills and training for their roles as clinical teachers, contributed to a feeling of disengagement. Suggestions for improved learning activities included distributed medical education–focused faculty development, hands-on teaching sessions, and conferences being made available to address personal and professional barriers to engagement. **Conclusion:** Faculty engagement occurs across many levels. Improved communication between faculty, administration, and clinical teams would lead to increased levels of engagement. Recognition and feedback plays an integral role in the satisfaction of faculty with their roles as faculty within a distributed medical education system.

547 What's Your IQ in QI? Building a faculty development program in quality improvement

Ed Seale, MD, CCFP (EM), FCFP; Elizabeth Muggah, MD, MPH; Doug Archibald, PhD

Objective: To determine the effectiveness of a quality improvement (QI) faculty development program for family medicine faculty at the University of Ottawa. **Design:** Cohort study. **Setting:** Department of Family Medicine, University of Ottawa, Ontario, Canada. **Participants:** Family medicine faculty. **Intervention:** Faculty participated in an interactive one-day faculty development session. The session covered key concepts in QI including physician engagement, use of the electronic health record for QI, and measurement in QI. **Main outcome measures:** Participant knowledge of 11 QI domains was assessed using a survey with a six-point Likert scale (no knowledge, awareness, skilled, deep knowledge, understanding, and wisdom). We dichotomized the scale at three to some

skill (three and below) and deep knowledge (four and above). This survey is used by our department to assess resident knowledge acquisition in QI. We will assess behaviour change by tracking engagement in QI activities at three and six months post session. **Results:** Fourteen of 21 (67 per cent response rate) faculty completed the survey pre session. The post survey was completed immediately after the session by 16 participants (80 per cent response rate). Gains in deep knowledge were seen in 10 of 11 QI domains. The biggest increases in deep knowledge were found with the following QI domains: identification of improvement projects (33 per cent before the session versus 64.3 per cent after the session), collaboration with interprofessional team to achieve QI goals (25 per cent versus 57 per cent), and engagement of stakeholders (25 per cent versus 57 per cent). There was a decrease in deep knowledge in only one domain: the identification of root cause of a gap in care (41.7 per cent versus 28.6 per cent). **Conclusion:** A one-day faculty development session resulted in a measurable increase in participant knowledge across 10 of 11 QI domains. We will follow this cohort to determine whether gains are maintained and engagement in QI activities improves.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

548 "We Are The Little Person": A qualitative study of refugee experiences with primary care

Elizabeth Munn*; Matthew To; Mandi Irwin, MD; Emily Gard-Marshall, MSc, PhD

Objective: To characterize the experiences of refugees with primary care services and determine barriers to and facilitators of access. **Design:** Four focus groups were conducted following a semi-structured interview guide. Groups were organized by gender and language. Interview data were coded independently by two research team members and analyzed using a thematic analysis approach. **Setting:** Halifax, Nova Scotia. **Participants:** Government-assisted refugees living in the Halifax region were recruited through purposive sampling. Individuals were recruited from the Arabic- and Nepali-speaking communities, which represent the major language groups of refugees resettled to Nova Scotia. Participants accessed care at walk-in clinics, family practices, emergency departments, and/or a specialized refugee health clinic. **Findings:** The individuals in this study described significant challenges in accessing primary care, vision/dental care, and specialist services. Barriers were personal (e.g., language, financial) and structural (e.g., wait times, bureaucracy). Individuals expressed different concerns based on their location of primary care. Perspectives were influenced by pre-migration experiences. Facilitators included having an English speaker at home and support from the local resettlement agency. **Conclusion:** Refugees face personal and structural barriers to accessing primary care and other health services. Access to interpretation and consideration of income are examples of measures that could improve the quality and accessibility of primary care for this population. The findings have public health and service provision implications, particularly as refugees are increasingly integrated into the mainstream primary care system.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

549 Research-Based Theatre as a Method of Enhancing Patient-Centred Primary Care for Marginalized Populations

Natalie Ramsay; Michael Milo; Mo Moore; Rahat Hossain*

Objective: To determine whether research-based theatre as knowledge translation can enhance physician advocacy and attitudes toward homeless health care access and quality. **Design:** Quasi-experimental, two-armed, non-randomized trial. **Setting:** The study was conducted in St. Catharines, Ontario. **Participants:** Eligibility criteria included that participants identify as health care providers who have had or who may have clinical encounters with homeless individuals. Study participants (N = 21) included the following disciplines: nursing (n = 2), medicine (n = 12), social work/psychology (n = 3), and other (n = 4). **Intervention:** A 20-minute ethnodrama about barriers and facilitators to care encountered by homeless individuals in the region. This research-based theatre production was developed from a qualitative interview study with individuals who had health care interactions while homeless. **Main outcome measures:** The Health Professionals Attitudes Towards the Homeless Inventory (HPATHI), a 19-item Likert scale, and Legislative Theatre Questionnaire (LTQ), a five-item Likert scale, were used to evaluate attitudes of personal advocacy, social advocacy, and cynicism toward the homeless and perceptions of research-based

theatre as a tool for knowledge translation. **Results:** Paired *t*-tests on HPATHI demonstrated significant ($P < 0.05$) pre/post changes on the following items: greater agreement with "Homeless people are victims of circumstance," "Homelessness is a major problem in our society," "Health-care dollars should be directed toward serving the poor and homeless," and "I believe social justice is an important part of health care." The LTQ was analyzed descriptively. Participants reported increased insight about patients who struggle with housing, agreement regarding the positive impact of theatre on interactions with marginalized patients, and agreement regarding theatre's positive effects on learning. **Conclusion:** Research-based theatre may promote empathy for the social circumstances of homelessness and promote personal and social advocacy. Enhancing these attitudes in clinicians, including family physicians, can advance the cause of equity for marginalized patients seeking primary health care.

550 Evaluating a Community Paramedicine Health Promotion Program in Seniors in Social Housing Buildings: A cluster randomized trial

Gina Agarwal, MB BS, PhD, MRCGP, FCFP; Ricardo Angeles, PhD; Melissa Pirrie, MA; Brent McLeod, MPH; Francine Marzanek; Jenna Parascandalo

Background: Community paramedicine is a new field in which paramedics provide health care services outside of the traditional model of emergency response. Community Paramedicine at Clinic (CP@clinic) is a community-based health promotion and disease prevention program intended to prevent diabetes, cardiovascular disease, and falls among seniors with low socio-economic status living in subsidized housing. **Methods:** This was an open-label pragmatic cluster randomized controlled trial with parallel intervention and control groups in seniors' apartment buildings in Hamilton, Ontario, Canada. Six buildings were randomly allocated to intervention (CP@clinic for one year) or control (usual care) via block randomization. **Participants:** Residents 55 years and older. The primary outcome was building-level ambulance call rate and secondary outcomes were individual-level changes in blood pressure, health-risk behaviours, diabetes risk, and health-related quality of life (HRQoL) measured via EuroQol 5 Dimensions (EQ-5D). Data were analyzed using *t*-tests, chi-square tests, and regression modelling (linear regression, hierarchical linear modelling). **Findings:** The total resident population was 455 in the three intervention buildings and 637 in the three control buildings. The CP@clinic participation rate in intervention buildings was 35.6 per cent (n = 171). The rate of ambulance calls in the intervention buildings (mean = 3.1/100/month units; SD = 1.6) was significantly lower than in control buildings (mean = 3.9/100 units/month; SD = 1.7; $p = 0.02$) leading to a net capacity gain of $115,843. Higher participation rates in CP@clinic were significantly predictive of a decrease in ambulance calls (B=-2.482, P=0.03). Among seniors in buildings with the CP@clinic drop-in sessions, mean systolic and diastolic blood pressure decreased after the second visit (5 mmHg and 3 mmHg, respectively). Intervention participants demonstrated significant improvement compared with the control group in diabetes risk, HRQoL (self-care and usual activities), and quality-adjusted life-years. **Interpretation:** The CP@clinic intervention improved individual-level risk factors and HRQoL that led to building-level changes in ambulance call rates and resource gains.

551 Interventions to Reduce Social Isolation Among the Elderly: A scoping literature review

Shamiel McFarlane, MB BS; Anne Andermann, MD, DPhil, CCFP, FRCPC

Context: Social inclusion of elderly individuals is essential for improving access to care and, ultimately, health outcomes in this rapidly growing segment of the population. The number of people worldwide age 60 years and older is expected to rise from its current 740 million to one billion by the end of the decade. Estimates of social isolation within the elderly population range from 5 per cent to 40 per cent, depending on the country under investigation, making this an important emerging public health challenge. **Objective:** To identify effective interventions proposed in the scientific literature to reduce social exclusion and improve access to services and health outcomes of isolated elderly persons, and to explore how these approaches could apply to a lower-middle income country context of Jamaica. **Design:** We conducted a scoping review of the scientific literature using the Ovid MEDLINE database with keyword searches. Abstracts were scanned for relevance according to predefined inclusion/exclusion criteria, and the retrieved articles were analyzed using a pre-established template. **Results:** Several individual and group interventions have been developed to increase social inclusion among the elderly, ranging from reminiscence therapy to facilitating transportation. However, the few trials that have evaluated the impact of such interventions on improv-

ing social participation and loneliness among the elderly show inconsistent results. Interventions that promote active rather than passive interactions are more likely to have a positive meaningful impact on health and quality of life (e.g., community-based music and art therapy programs). **Conclusion:** As this is still a novel area of inquiry, there is, as yet, very little literature on the issue of socially isolated elderly, especially in low-resource settings. More research is needed on the role of health workers in helping to better support patients and reduce exclusion and on the role of advocates for effective community-based interventions to promote inclusion.

552 The Writing Club: An interprofessional peer-support writing group in an academic family health team

Nicholas Pimlott*, MD, CCFP; Susan Hum, MSc; Lisa Fernandes; Viola Antao, MD, CCFP; Sheryl Spithoff, MD, CCFP; Janet Probst, RN; Sheila Dunn, MD, CCFP, MSc; Melissa Desouza, MD, CCFP, MHSc, MSc; Helen Batty, MD, CCFP, MEd, FCFP

Context: Academic family physicians and other health professional educators receive promotions based on their research and scholarly productivity. However, they face many challenges in writing for publication. Barriers to successful writing and publishing can be overcome through peer support. **Objectives:** To describe the processes, experiences, and evaluative outcomes of an ongoing, bimonthly, (90-minute) interprofessional peer-support writing group that was established in January 2012. **Design:** The peer-support writing group was evaluated using a mixed-methods approach: an anonymized online survey in 2013 and 2016 and a focus group discussion in June 2016 to corroborate the quantitative findings. **Setting:** An academic family health team in Toronto, Ontario. **Participants:** Academic family physicians and their interprofessional colleagues. **Main outcome measures:** Impact on writing skills, confidence, and academic and scholarly work productivity. **Results/Findings:** From September 2012 to June 2016 the peer-supprt writing group met bimonthly, a total of 76 times. Meetings were 90 minutes long and were held at the beginning of the work day. Attendance ranged from three to nine participants. Group members liked the "hands-on" working meeting format and the group review process. Most participants felt supported/understood by both the facilitator and their peers in sharing their drafts for feedback/discussion. The peer-support writing group enhanced participants' writing confidence, skills, and productivity; stimulated rich discussions; and inspired creative thinking and new writing project ideas. **Conclusion:** Our peer-support writing group is unique because it is interprofessional and is grounded in family practice. It encourages/supports a variety of writing projects ranging from research to education scholarship, to reflective practice. This peer-support writing group has been sustainable over many years due to the supportive, non-judgmental, and collegial environment of our working meetings. Future work will determine whether our group review process can be implemented in other academic family health teams using distance education models and facilitator-training workshops.

553 Capacity and Practice Features of Downtown Vancouver Primary Care (work in progress)

Rita McCracken, MD, CCFP (COE); Nardia Strydom*, MB ChB; Kasra Hassani, PhD, MPH; Gurkirat Randhawa; Melanie Catacutan; So Eyun Park; Sujin Im; Ravi Parhar; Stephanie Chan; Mary Sue Fairbarn; Setareh Banihosseini, MD, PhD

Objectives: The aim of this study was to assess various features of primary care in downtown Vancouver, British Columbia, including its capacity, availability, and accessibility. This comprehensive description is intended to guide the development of new policies and primary care structures to meet the health care needs of the downtown Vancouver community. **Design:** This observational cross-sectional study is a part of the Models and Access Atlas of Primary Care at Providence Health Care (MAAP-PHC) project. Survey tools are modelled after a pioneering study in Nova Scotia (MAAP-NS). A Working Hours survey measured practice style, features, and capacity (response rate 84 per cent), while an After-Hours survey studied availability of after-hours care by studying clinics' voice messages (response rate 100 per cent). **Setting:** The surveys were completed by telephone or fax from March to November 2016. **Participants:** An initial inventory of all clinics in the downtown area was created by searching three sources: the College of Physicians and Surgeons of British Columbia website, the Yellow Pages, and Google Maps. Based on the collected information, each clinic was classified as one of the following: family practice (FP), walk-in (WI), family practice and walk-in (FPWI), special, or excluded. Excluded clinics were either closed or not providing primary care. **Results/Findings:** From a total of 70 locations identified, 32 were verified to be clinics where at least one family physician regularly saw patients. These included 14 FPs, four WIs, nine FPWIs and five special clinics. Thirty-eight clinics

were excluded. In all, 103 family physicians were working in 44.6 full-time (five days/week) positions. An estimated 83,000 to 123,000 patients are attached to these clinics. Most clinics provide same-day appointments, but maternity care and after-hours care are limited. **Conclusion:** Using the clinic, rather than a specific family doctor, as a unit of planning and measure for attachment may be more relevant to future primary care planning.

554 The Five Types of Urban Family Doctors in Vancouver (work in progress)

Rita McCracken, MD, CCFP (COE); Nardia Strydom*, MB ChB; Kasra Hassani, PhD, MPH; Gurkirat Randhawa; Melanie Catacutan; Setareh Banihosseini, MD, PhD

Objectives: There are approximately 1,000 family doctors working in Vancouver (as per the College of Physicians and Surgeons of British Columbia); however, few details are known about their practice styles. The purpose of this study was to describe the practice scopes and styles of a subgroup of family doctors in Vancouver. **Design:** The survey tools used in this study were modelled after a pioneering MAAP-NS study in Nova Scotia, but were adjusted to match the differences in local practice patterns. The survey explored features including personal and practice location characteristics, hospital and teaching work, payment, and appointment characteristics. **Setting:** The study is a part of the Models and Access Atlas of Primary Care at Providence Health Care (MAAP-PHC) project. **Participants:** The survey was distributed to all members of the PHC Department of Family and Community Medicine in spring 2016. **Results/Findings:** Response rate was 254/295 (86 per cent). Survey participants identified their practice style as one of "continuous community-based primary care" (CCBPC; 75 per cent), "hospital or facility-based care" (18 per cent), or "locum only" (7 per cent). We further divided the CCBPC category into three groups based on their self-reported patient panel size: Focused-Practice with <500 patients (37 per cent, Smaller-Practice with 500-1000 patients (21 per cent), and Classic GP with >1000 patients (41 per cent). Overall, we found diversity in the practice scopes and styles of the surveyed Vancouver family physicians. However, the medians of self-reported weekly work hours of all groups were similar regardless of practice style. We also found that the newer family physicians (12 years or less away from medical school graduation) are more likely to work at multiple locations, including specialty clinics, and are likely to be engaged in clinical supervision and teaching. **Conclusion:** Urban family doctors have diverse scopes and styles of practice. Given this diversity and dynamism, our findings suggest that human resource planning for primary care policy and service delivery may need to evolve and respond to the variety of actual work patterns.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

555 Impact of a Patient Rostering Model on Continuity of Care and Coordination of Specialized Care

Jatinderpreet Singh*, MASc; Simone Dahrouge, PhD; Monica Taljaard, PhD; Michael Green, MD, MPH CCFP, FCFP

Although patient rostering is widely considered to be a cornerstone of a high-performing primary care system and is believed to improve continuity and coordination of specialized care, few studies have examined these relationships. **Objective:** Examine the impact of a patient rostering enhanced fee-for-service (eFFS) model on continuity of care and coordination of specialized care. **Design:** Population-based longitudinal study using health administrative data. **Setting:** Urban family practices in Ontario, Canada. **Participants:** Family physicians who transitioned from traditional FFS (tFFS) to eFFS between 2004 and 2013 were followed over time. Physicians providing comprehensive primary care who had at least four years of pre-transition and two years of post-transition data were eligible. Patients were attributed to study physicians on an annual basis by determining the provider who billed the largest dollar amount of primary care services over a two-year period. **Outcome measures:** 1) Continuity (usual provider of care index [UPC]); and 2) coordination of specialized care (referral index [RI]: per cent of total primary care referrals for a physician's roster made by main provider). **Analysis:** Mixed-effects segmented linear regression was used to examine changes in outcomes from before to after the transition while controlling for patient and provider contextual factors. **Results:** Prior to transition, the UPC was decreasing at a rate of 0.27 per cent/year (95%CI -0.34 to -0.21, $P < 0.0001$). Following the transition, the UPC began decreasing by an additional 0.59 per cent/year (95%CI -0.69 to -0.49, $P < 0.0001$) compared with the pre-transition rate. RI decreased by an additional 0.34 per

cent/year (95%CI -0.43 to -0.24, $P < 0.0001$) relative to the pre-transition period, during which it had been stable. **Conclusion:** Continuity and coordination of specialized care decreased upon transition from tFFS to eFFS. This is possibly due to the increase in after-hours care across practices adopting these new models, which gave patients more care options aside from their main provider.

556 Scaling Up Chronic Disease Management in Alberta

S. Foss, RN; K. Kidd Wagner, MSc; J. Lester, CPF; S. Peters, MClSc; B. McCaffrey, Dip Ed; L. deBoer, RN; J. Cooper, RN; A. Atkins, MBA; J. Austin, RN; K. Remington; S. Hannay; E. Patterson, MCE, PMP; M. Watt, RN; T. Barber, MA; L.A. Green*, MD, MPH

Setting: Effective chronic disease management (CDM) can achieve significant clinical improvements quickly and across large populations. In Alberta, providing the right tools and supports for practices engaging in CDM requires more than replicating what works for leading teams; it requires understanding how different teams conceptualize CDM and perform day-to-day work. **Objective:** To understand how different physicians and team members (individually and collectively) manage their patients living with chronic diseases to develop strategies and supports scalable across Alberta. **Design:** We used cognitive task analysis (CTA), a family of qualitative methods. CTA is effective in eliciting tacit knowledge; the information and processes (known as "macrocognition") are so automatic that the methods and reasons behind them go unnoticed or are misperceived. Analysis was iterative. Data were coded independently by at least two CTA-trained facilitators for macrocognitive processes/functions; this was followed by group analysis meetings to review coding and develop mental models of how teams approach CDM. **Participants:** Purposive sampling was used to recruit participants representing teams successful with CDM and teams newly engaging in CDM. A total of eight practice teams (a physician and key team member, e.g., registered nurse, medical office assistant) were interviewed from a variety of practices (e.g., urban/rural, small/large). **Main outcome measures:** Rich descriptions of team macrocognitive processes and mental models. **Results:** Effective teams delivering CDM distribute the macrocognition functions across all team members, are "flatter" versus hierarchical in organizational structure, engage deliberately in high-trust activities and meaningful use of their electronic medical record, and have a higher degree of connectivity (formal and informal interaction). **Conclusions:** We are sharing our findings with policy-makers, leaders in medicine, and other stakeholders to develop evidence-informed approaches to take the implementation of team-based initiatives (new and existing) in our province to an impactful scale.

557 My Health eSnapshot: A local strategy for improving preconception health through innovation and technology

Nicola Mercer, MOH & CEO, WDGPH; Liz Robson, MPH; Cynthia Montanaro, BScN, RN; Lyn Lacey, BScN, RN; Amy Estill, MSc; Sonja Vukovic, MPH

Objective: This research study examined whether the use of My Health eSnapshot (MHeS) during primary care visits increased preconception health knowledge and behaviour change among women of reproductive age. **Design:** Wellington-Dufferin-Guelph Public Health (WDGPH) in Ontario conducted a cohort study. A mixed method approach was used to include both quantitative and qualitative data. **Setting:** MHeS was studied in 2016 across seven primary care sites within four family heath teams in the Wellington-Dufferin-Guelph (WDG) area. **Participants:** Three hundred participants were recruited. **Eligibility criteria:** Female, ages 15 to 49, not pregnant, no hysterectomy, able to read/write English, comfortable using a tablet, had an email address, and were WDG residents. **Intervention:** In partnership with Boston University Medical Centre, WDGPH developed a patient-driven, electronic, evidence-based preconception health risk assessment tool called MHeS. Participants completed MHeS prior to a visit with their family practitioners. Results were automatically integrated into the participants' electronic medical records; family practitioners discussed the results and provided a customized handout generated by MHeS. To evaluate impact, WDGPH collected data from participants (risk assessment and two online follow-up surveys) and primary care sites (key informant interviews). **Main outcome measures:** Most prevalent risk factors, improvements in knowledge, and changes in behaviour. **Results/Findings:** All 300 participants completed a MHeS, 188 completed a one-week survey, and 144 completed a two-month survey. Preliminary analysis identified the most prevalent risk factors as nutrition, ethnicity, caffeine, unprotected sex, and stress. Most participants reported that completing MHeS prior to their family practitioner appointment made it easier to have a conversation with

their family practitioners, and they were motivated to make positive changes to their health. **Conclusion:** Preliminary research findings support MHeS for use during primary care visits. Future analysis will further identify effects on knowledge and behaviour. Based on the findings, improvements will be made to MHeS and the delivery model for further research and/or implementation.

558 In Primary Health Care, What Are the Outcomes of Using Internet-Based Consumer Health Information?

Reem El Sherif, MSc, MBBCh; Pierre Pluye, MD, PhD; Christine Thoër, PhD; Vera Granikov, MLIS; Maria Cristiane Barbosa Galvao, PhD; Quan Nha Hong, MSc; Isabelle Marie Vedel, MD, PhD; Francesca Frati, MLIS; Sophie Desroches, RD, PhD; Jo-Anne Hutsul; Carol Repchinsky; Benoit Rihoux, PhD; France Légaré, MD, CCFP, FCFP, PhD; Burnand Bernard, MD, MPH; Mathieu Bujold, PhD; Roland Grad, MD CM, FCFP, MSc

Objective: The Internet is the most frequently accessed source of consumer health information. Our objective was to identify the outcomes associated with Internet-based Consumer Health Information (IBCHI) in primary health care. **Design and Participants:** A systematic mixed studies review, followed by a two-stage interpretive qualitative study. A search strategy developed by four specialized librarians used in six information sources, followed by selection and critical appraisal by two independent reviewers. **Framework synthesis:** Deductive-inductive qualitative thematic analysis was followed by a disambiguation and harmonization of themes, and evidence was coded against an initial framework. We interviewed a purposeful sample of 19 IBCHI users and a convenient sample of 10 key informants: three family physicians, two nurses, two pharmacists, and three health librarians. Thematic analysis was performed by three qualitative researchers on transcribed verbatim text, assisted by specialized software. **Main outcomes:** Outcomes associated with IBCHI from the perspective of consumers were identified. In the qualitative study we also identified strategies to prevent negative outcomes. **Findings:** Out of 4,322 unique records identified, 65 eligible studies were included in the analysis. Our initial framework was revised and types of patient outcomes and influencing factors were identified and described. In the qualitative study we found that negative outcomes may occur along three dimensions of IBCHI tensions: internal (anxiety), interpersonal (worsening of patient-physician relationship), and service-related (excessive emergency room visits). Three main preventive strategies are providing reliable IBCHI sources, teaching consumers how to evaluate IBCHI sources, and encouraging consumers to discuss the information. **Conclusion:** We propose a revised conceptual framework of the outcomes of the use of IBCHI in primary health care. Whereas there are ongoing initiatives to be included in the curriculum and continuing professional development of health professionals, further support should be provided to practitioners to help them discuss IBCHI presented by patients during a clinical visit.

MEDICAL STUDENT / ÉTUDIANT EN MÉDECINE

559 "It's the Difference Between Life and Death": Professional medical interpreters and patient safety

Margaret Wu, Shail Rawal, MD, MPH, FRCPC

Objective: Patients with limited English proficiency (LEP) experience poorer quality of care and more adverse events when compared with their English-proficient counterparts. Consequently, there is interest in understanding the role of medical interpreters in efforts to improve patient safety. The objective of this study is to explore the views of professional medical interpreters on their role in patient safety. **Design:** We conducted a qualitative analysis of in-depth interviews with professional medical interpreters. Interviews were audiotaped and transcribed verbatim. Participants' views on their role in patient safety were analyzed and organized into themes. **Setting:** The study took place in Toronto, Ontario, Canada. **Participants:** Fifteen professional medical interpreters affiliated with the Healthcare Interpretation Network in Toronto were interviewed. **Results:** Professional medical interpreters described being uniquely situated to identify and prevent adverse events involving patients with LEP by: 1) facilitating communication between patients and health care providers; 2) enhancing patients' comprehension; 3) giving voice to the patient; and 4) speaking up when they had safety concerns. Medical interpreters highlighted challenges in fulfilling these functions, including the hierarchical structure of health care teams, the ill-defined role of interpreters within such teams, and the ethical imperative for interpreters to remain impartial when facilitating communication between patients and health care providers. **Conclusions:** Our study found that professional

medical interpreters view their work as integral to the delivery of safe and high-quality care to patients with LEP. Interpreters and health care providers require a mutual understanding of their roles to engage in patient safety efforts together effectively. Importantly, the benefits of partnering with interpreters can be realized only when health care providers consistently use their services. However, there remain tensions between an expanded role for interpreters that includes speaking up about patient safety concerns and the need for interpreters to remain impartial.

560 The "6W" Model of Care Trajectories for Patients With Chronic Ambulatory Care Sensitive Conditions

Alain Vanasse, MD, PhD, FCMF; Mireille Courteau, MSc; Jean-François Éthier, MD CM, PhD

Background: Reducing hospital readmission rates for ambulatory care sensitive conditions (ACSCs) is essential since these events are common and could potentially be avoided through effective processes of care. Thus, observational studies on care trajectories based on secondary analysis of existing data should provide valuable information on rehospitalization risk factors at the health care level. However, published studies assessing care trajectories as sets of predictive variables are very sparse, while other approaches related to the process of care are fragmented, often overlapping, and confusing. It is time to synthesize that research into a comprehensive scheme. **Purpose:** The aim of this paper is twofold: first, to describe, analyze, and synthesize published concepts related to processes of care; and second, to integrate these concepts into a comprehensive model of care trajectories, enabling cohesive, replicable studies on rehospitalization for ACSCs and its associated factors. **Research design:** Conceptual modelling supported by a literature review. **Findings and conclusions:** The most relevant concepts and approaches for the assessment of predictive factors of readmissions related to the process of care use generic terms such as continuity, pathway, episode, and trajectory. However, those concepts, taken separately, will provide incomplete information. Using their common denominators, those concepts were integrated into the 6W multidimensional model of care trajectories, which is based on six dimensions. Considering the patients' attributes and illness course ("who" and "why"), the 6W model better reflects their journey through the health care system across care providers ("which"), care units ("where"), and treatments ("what") for specific periods of time ("when"). This comprehensive model gathers most of the potential factors associated with rehospitalization for ACSCs and provides a logical framework for further research.

561 Characteristics Associated With Inner-City Primary Care Continuity (work in progress)

Ginetta Salvalaggio, MD, MSc, CCFP; Lara Nixon, MD, CCFP; Karine Lavergne, PhD; Elaine Hyshka, PhD; T. Cameron Wild, PhD; Judith Krajnak, PhD; Jane Leske; Klaudia Dmitrienko, MSc; Stacy Lockerbie, PhD; Kathryn Dong, MD, FRCP(C)

Objective: To determine the demographic, social, and substance use patterns associated with high versus low primary care continuity for an inner-city patient population. **Design:** Secondary analysis of baseline-linked quantitative data from an ongoing controlled patient outcomes evaluation of an acute care–embedded multidisciplinary team intervention. Data sources include researcher-administered quantitative surveys and administrative health, income support, and housing records. Bivariate analyses of relationships were conducted between survey variables of interest and the main continuity measure, using *t*-tests for continuous variables and chi-square tests for categorical variables. **Setting:** Inner-city Edmonton and Calgary, Alberta. **Participants:** Patients were recruited from one of three urban acute care facilities and endorsed active excessive alcohol/drug use, unstable income, and/or unstable housing. **Main outcome measure:** Usual provider continuity ratio (number of visits with most frequent primary care provider/number of visits with any primary care provider over the previous six months); high continuity is ≥ 0.8. **Results:** A total of 95 per cent (n = 545) of enrolled participants consented to the retrieval of administrative health services data. Of those, 167 (31 per cent) demonstrated high baseline continuity with their usual care provider, 277 demonstrated low continuity (51 per cent), and 101 had no primary care visits (18 per cent). Compared with patients with low continuity or no primary care visits, patients with high continuity reported longer duration of residence locally ($P < 0.05$), and were less likely to report transitory sleeping ($P = 0.001$), homelessness ($P = 0.001$), opioid use ($P < 0.05$), and stimulant use ($P < 0.01$). Age, gender, ethnicity, income, employment, valid identification documents, HIV/hepatitis C seropositivity, mental illness, medication need, heavy alcohol consumption, and injection drug use did not vary by level of continuity. **Conclusion:** Inner-city primary care continuity is associated with housing stability and abstinence from opioid and stimulant use.

POSTER PRESENTATIONS / PRÉSENTATIONS D'AFFICHES
NOVEMBER 9 NOVEMBRE

601 Implications of Guideline Change: Have Pap test guidelines impacted sexually transmitted infection screening in primary care?

Margaret Casson*, MD; Rebecca Zur, MD; Jackie Bellaire, MD, CCFP; Mark Yudin, MD, MSc, FRCSC

Objective: In 2012, Cancer Care Ontario introduced new cervical cancer screening guidelines for women in Ontario. The goal of our research is to build on previous research and to examine how the cervical cancer screening guideline changes have impacted the care of young female patients with respect to STI screening in the primary care setting. **Design:** A retrospective chart review analyzing the frequency of STI screening before and after the implementation of the cervical cancer screening guidelines in May 2012. **Setting:** Two family health teams in east Toronto. **Participants:** Female patients, aged 19 to 25 years, with at least one visit to their primary care physician. **Main outcome measures:** Number of Pap tests collected, the number of patients who had STI screening, and the number of visits during which they had STI screening. **Results:** There was a statistically significant difference in the number of visits with STI screening before the guideline implementation compared to after (mean number of visits with STI screening 1.21 before, 0.75 after, Mann-Whitney rank test $P = 0.010$). The difference in the number of Pap tests in the pre-guideline group (mean number of Pap tests 1.07) compared to the post guideline group (mean number of Pap tests 0.39; $P < 0.001$) was significant, and more cervical and vaginal screens used pre-guideline changes ($P < 0.001$ and $P = 0.002$ respectively) while more urine NATT was used in the post period ($P < 0.001$). **Conclusions:** Female patients aged 19 to 25 years had more visits to their primary care physicians that included STI screening in the three years before the guideline changes than the three years afterward. As expected, there was a difference in the number of Pap tests before the guideline implementation compared to after. In keeping with previous studies, there is a continued demonstration of a trend towards to non-invasive testing.

602 Presentations and Outcomes of Necrotizing Soft Tissue Infections

Kuan-chin Jean Chen*, MD, CCFP (EM); Michelle Klingel, MSc; Shelley McLeod, MSc; Sean Mindra, MD; Victor Ng, MD, CCFP (EM)

Background: Necrotizing soft tissue infections (NSTIs) are aggressive infections associated with high mortality rates and significant morbidity, including amputation and organ failure. Much more common are non-necrotizing soft tissue infections, such as cellulitis, which present very similarly to NSTIs. The challenge in diagnosing NSTIs is the lack of signs or symptoms that reliably distinguish them from non-necrotizing infections. However, the rapid progression and significant risk of morbidity and mortality associated with NSTIs makes quick diagnosis and treatment critical. This study was conducted to determine the presentation of patients diagnosed with NSTIs, and their in-hospital outcomes. **Methods:** Retrospective review of adult patients with a discharge diagnosis of necrotizing fasciitis at London Health Sciences Centre (annual census 125,000) over a five-year period (April 2008 to March 2013). **Results:** Common comorbidities at presentation included immunocompromise (58.3 per cent), diabetes mellitus (41.7 per cent), vascular disease (45.0 per cent) and obesity (24.6 per cent). Initial presentations included swelling (91.7 per cent), erythema (86.7 per cent), bullae (28.3 per cent), petechiae (8.3 per cent), and bruising (45.0 per cent). Fifty patients (83.3 per cent) underwent surgery, with a median (IQR) time from initial presentation to surgery of 15.5 hours (7.8, 74.9). In-hospital mortality amongst those who had surgical intervention was 14.0 per cent, compared to in-hospital mortality of 60.0 per cent for those who did not (Δ 46%, 95%CI 14.8 to 70.2%). **Conclusions:** Diabetes mellitus, immune compromise, vascular disease, and obesity are common comorbidities of NSTIs. Survival is higher among patients who receive surgical treatment. Patients presenting with this clinical picture warrant a high degree of suspicion.

603 Increased Cut-offs Improve the Sensitivity of the MMSE in Highly Educated Older Adults

Shannon Baker; Katie Kent; Matthew Greenacre*; Ayman Shahein; Laszlo A. Erdodi, PhD, C.Psych.

At the conclusion of this activity, participants will be able to: 1) interpret the MMSE in highly educated older adults using multiple cut-offs; and 2) more accurately identify early cognitive decline in highly educated popula-

tions. **Context:** The Mini-Mental Status Exam (MMSE) is a widely-used screening test for early cognitive decline. Its comprehensiveness, short administration time, easy scoring, and straightforward clinical interpretation (intact/impaired) make it an attractive choice for a first-line assessment tool. However, the same diagnostic criterion may not be appropriate for all patients. Using a single cut-off may inflate false negatives in examinees with high premorbid functioning, as their cognitive reserve may mask the deleterious effects of neurodegenerative diseases. **Objective:** To determine whether increasing the cut-off would improve the MMSE's classification accuracy in highly educated older adults. **Design:** Prospective quasi-experimental design. **Participants:** Data were collected from 113 highly educated (M = 16.4 years) older adults (M = 72.4 years) from northern New England; 64 were classified as cognitively normal (intact), while 49 were classified as showing clinical signs of cognitive decline (impaired) by a panel of experts. **Instrument:** The MMSE at commonly used clinical cut-offs. **Results:** An MMSE score ≤ 25 had perfect specificity, but low sensitivity (.36). Raising the cut-off to ≤26 improved sensitivity (.53), at minimal cost to specificity (.95). Further increasing the cut-off to ≤27 achieved a reasonable balance between sensitivity (.86) and specificity (.88). An impaired participant was seven times more likely to score ≤27 than an intact participant. Conversely, an impaired participant was six times less likely to score >27 than an intact participant. **Conclusions:** Raising the standard cut-offs improved the overall classification accuracy with minimal loss in specificity, and appears to be a clinically justifiable trade-off. Results suggest that higher cut-offs may be warranted in examinees with high educational achievement.

604 Deprescribing Bisphosphonates in Primary Care

Ruben Hummelen*, MD, PhD; Charnelle Carlos, MD; Olivier Saleh, MD

Objective: To identify and deprescribe bisphosphonates among patients who are at low or moderate risk for fragility fractures. **Design:** Chart review and individual risk assessments. **Setting:** This study took place in three academic family physician practices at McMaster Family Practice in Hamilton, totalling 942 patients of age ≥ 50 years. **Participants:** Chart reviews for 48 patients (five per cent) identified as receiving a prescription for a bisphosphonate between November 2014 and November 2015. After a thorough chart review of these 48 patients, 25 were excluded because they: were followed by a rheumatologist (n = 6); had stopped taking their bisphosphonate (n = 6); were high risk or had a prior fragility fracture (n = 5); or other reasons (n = 8). **Intervention:** Assessment of patients' risk factors with a FRAX score calculation and counselling on their bisphosphonate use. **Results:** A total of 23 participants were assessed, of whom eight were low risk, 13 moderate risk, and two high risk according to FRAX. Duration of use was significantly longer among the low-risk group (median 10 years) than the intermediate- and high-risk group (median 7.5 years, P = 0.05). Among those in the low-risk group, six (75 per cent) chose to discontinue the use of their bisphosphonate after counselling. Among those in the moderate risk group, four (70 per cent) chose to discontinue the use of their bisphosphonate, while none in the high-risk group discontinued the use of their bisphosphonate. **Conclusion:** This study shows that a majority of patients in primary care may be eligible for a drug holiday or for discontinuing their bisphosphonate based on an absolute risk estimation. Periodic reassessment of bisphosphonate use using the FRAX can lead to better prescribing of these medications.

605 Decision-Making Capacity Assessment (DMCA) Training for Physicians

Lesley Charles, MBChB, CCFP (COE); Jasneet Parmar*, MBBS, MCFP (COE); Bonnie Dobbs, PhD; Suzette Brémault-Phillips, PhD; Oksana Babenko, PhD; Peter George Tian, MD, MPH

Context: Many physicians do not feel prepared to do decision-making capacity assessments (DMCAs). Therefore, we developed and administered an interactive DMCA workshop to familiarize physicians with concepts of capacity, a protocol, documents, and case studies. **Objective:** To determine the effect of the workshop on physicians' confidence and comfort with DCMAs. **Design:** Pre-test-post-test design. We administered a questionnaire before and after the workshop. The questionnaire asked participants to rate their agreement (four-point Likert-type scale) on 15 statements regarding awareness, confidence, and understanding of core concepts of capacity. **Participants:** A total of 137 physicians who attended workshops. **Intervention:** A three-hour DMCA workshop accredited by the College of Family Physicians Canada. **Outcome measures:** (1) Mean ratings on the questionnaire items; (2) demographic data (age, sex, years of practice, prior DMCA training). **Analysis:** Descriptive statistics (mean, SD); sign test to compare pre- and post-workshop ratings; ANOVA to determine differences in ratings across demographics. **Results:** There were 137 participants with an average age of 46 years: 55 per cent of the participants were female;

64 per cent of participants had ≥ 6 years of medical practice; and 54 per cent had no prior DMCA training. The post-workshop ratings were mostly agrees and strongly agrees (mean ratings, 3.09 to 4.27; range, 1 to 4). The highest positive differences were for problem solving techniques, understanding a trigger, knowledge and skill set in regards to capacity assessments, standardized approach, and awareness of legislative acts. Among the participants, those without prior DMCA training exhibited the largest change in pre- versus post-workshop ratings ($P < 0.05$). **Conclusion:** This study has shown that a DMCA workshop was effective in training family physicians.

610 Interventions visant à réduire l'utilisation de médicaments inappropriés chez les personnes âgées

Benoît Cossette, BPharm, PhD, pharmacien au CIUSSS de l'Estrie-CHUS; Jean-François Éthier, MD CM, PhD; Thomas Joly-Mischlich, BPharm, MSc; Nicole Dubuc, PhD; Martine Grondin, BPharm, MSc; Catherine Hudon, MD, PhD, CCMF; Mitchell Levine MD, MSc, FRCPC, FISPE, FACP; Mireille Luc, DtP, MSc; Hélène Payette, PhD; Geneviève Ricard, MD; Jacynthe Roy-Petit, BPharm, MSc; Thibault, BPharm, MSc; Alain Vanasse; Marie-Pier Villemure*, MD

La prescription de médicaments est l'un des défis complexes auxquels font face les cliniciens qui soignent des personnes âgées. En effet, l'interaction de nombreux facteurs peuvent augmenter l'incidence des événements indésirables médicamenteux. Des critères existent pour aider les cliniciens à prescrire les médicaments appropriés aux patients âgés, tels que les critères de Beers et les critères START/STOPP. Peu de données canadiennes sur la prescription de MPI sont disponibles. Dans les dernières années, notre groupe de recherche a implanté un modèle de transfert de connaissances qui a mené à une réduction de l'utilisation de MPI dans le contexte hospitalier. Ce modèle de transfert de connaissances inclut notamment des interventions pharmacien-médecin à partir d'alertes d'un Système d'alertes informatisées (SAI). Nous avons déjà démontré la pertinence clinique de telles alertes dans un contexte hospitalier. Dans la présente étude, nous faisons l'hypothèse que le modèle d'interventions pharmacien-médecin à partir des alertes du SAI permettra de réduire l'utilisation de MPI par les patients suivis en communauté, plus précisément en contexte GMF/UMF. L'objectif principal est d'évaluer l'impact d'un modèle d'intervention interdisciplinaire pharmacien-médecin sur le taux de changement des médicaments. Dans les objectifs secondaires, nous souhaitons évaluer la pertinence clinique des alertes du SAI. Nous visons aussi à déterminer les conditions favorables et l'organisation optimale pour la mise en œuvre d'un modèle d'intervention pharmacien-médecin visant la réduction de l'utilisation de MPI par les personnes âgées suivies en GMF/UMF.

611 A Strategy for Transferring Anticoagulation Follow-Up to Community Pharmacies (work in progress)

Charles-André Bray*, PharmD, MSc; Daniel Murphy; François Lehmann; Samah Elsadi; Odette Pomerleau; Tu Dung Huynh; Nadia Salois

Objective: Evaluate the efficiency of a strategy designed to transfer anticoagulation follow-up to community pharmacists. **Design:** Pre-experimental, one-shot case study design. **Setting:** Since the adoption of Loi 41 in Quebec, pharmacists may adjust anticoagulation therapy more independently with the patient's physician directives. The study took place at the Clinique universitaire de Médecine familiale – Groupe de Médecine familiale de Verdun from September 2016 to September 2017. **Participants:** Patients age 18 years and older on warfarin, whose dose is adjusted by nurses using a protocol. **Intervention:** Pharmacists from the clinic developed a strategy to conveniently transfer patients to their community pharmacy. It included different stages, such as seeking consent from doctors and consulting community pharmacists for feasibility. Patients were selected based on adherence (blood tests done on time) and stability of their international normalised ratio (INR). The best performing patients were included in the first of two waves of transfers. The second wave consisted of patients with a less stable INR. **Main outcome measures:** The number of patients transferred to community pharmacies and to direct oral anticoagulants (DOACs) was evaluated. Obstacles to transfers and reasons for non-transfer were also documented and assessed. A secondary outcome was the time liberated for nurses after the transfers. **Results/findings:** During the first wave, between September 2016 and March 2017, 35 of 87 patients were transferred to their community pharmacists. Another six of the remaining 52 patients were switched to a DOAC. Prior to the switch, 3 to 19 per cent of nursing activities per month was spent monitoring and adjusting patients' INR. Post-transfer analysis is ongoing. **Conclusion:** The strategy led us to transfer almost half of the patients. Other studies are needed to evaluate the clinical impact.

612 Practice Profile of a Primary Care Physician Assistant in a Community Health Centre

Angela Cassell*, MPAS, CCPA; Laura Muldoon, MD, MPH, CCFP, FCFP

Objective: To describe the types and volumes of patients seen and the interventions performed by a physician assistant (PA) in an interprofessional community health centre (CHC). **Design:** Cross-sectional retrospective electronic extraction of data from an electronic medical record. **Setting:** Somerset West Community Health Centre (SWCHC), a large interprofessional primary health care setting in central Ottawa. **Participants:** All patients with an electronic visit record (encounter) initiated by the PA from February 1, 2013, to July 31, 2016. The PA must always work under the supervision of a physician, so all patients were ongoing primary care patients of physicians at SWCHC. **Main outcome measures:** Patient age and sex; postal code (to provide surrogate income data); date of visit; health issues addressed at each visit (through data entered at each visit using the coding system Encode FM). Was a prescription written at the visit? (Y/N) Was an internal referral made at the visit? (Y/N) Was an external referral made at the visit? (Y/N). **Results:** The PA saw 1,377 unique patients at 8,095 visits over 42 months. The average number of visits per patient was 5.9 (range 1 to 68). Sixty-four per cent of patients were female, 35 per cent male. The PA wrote prescriptions at 18 per cent of visits. The three most common diagnoses were diabetes mellitus, prenatal care (routine), and hypertension. Chronic conditions accounted for the majority of visits. Patient socioeconomic status will be described. **Conclusions:** Working collaboratively with physicians and other members of the interprofessional team, the PA provided a considerable amount of care for chronic and acute conditions in a large number of individual patients, likely expanding the team's capacity to care for larger numbers of patients.

613 Iron Deficiency and the Risk of Depression During Pregnancy

Manish Dama*; Ryan Van Lieshout, MD, PhD, FRCPC; Gabriella Mattina; Meir Steiner, MD, PhD, FRCPC

Objective: To examine the association between iron deficiency and maternal depression at mid- to late-pregnancy. **Design:** A retrospective cross-sectional design. **Setting:** The Women's Health Concerns Clinic at St. Joseph's Healthcare in Hamilton, Ontario, between 2009 and 2016. **Participants:** Pregnant women with serum ferritin data during mid- to late-pregnancy (more than 20 weeks gestation; N = 142) were categorized as either iron deficient (ferritin < 12 µg/L) or iron sufficient (ferritin ≥ 12 µg/L). **Main outcome measures:** Edinburgh Postnatal Depression Scale (EPDS) scores were compared between the two groups using t-tests, and the odds of developing significant levels of depressive symptoms (EPDS ≥ 12) was conducted using logistic regression while adjusting for a history of depressive and/or anxiety disorders, pre-pregnancy overweight/obesity, and multiparity. **Results:** Forty-four participants were iron deficient and 98 participants were iron sufficient. Samples of serum ferritin were taken at 31 weeks gestation (30.51 ± 4.49). Iron deficient pregnant women scored significantly higher on the EPDS (10.14 ± 5.69 versus 7.87 vs ± 5.75; P = 0.03) compared to those who were not. The odds of developing significant levels of depressive symptoms were two and a half times higher among iron deficient women (adjusted OR: 2.53, 95%CI 1.15 to 5.55). **Conclusion:** These findings suggest that iron deficiency at mid- to late-pregnancy may be associated with a significant risk of depression. Future research with larger samples that are followed prospectively will help to determine if widespread screening of antenatal ferritin can be recommended as a means for detecting the risk of maternal depression during pregnancy.

614 Development and Evaluation of www.whatsnextforme.ca, a Mobile Website to Support Decision Making for Emergency Contraception

Sheila Dunn*, MD, MSc, CCFP (EM), FCFP; Payal Agarwal, MD, CCFP; Dilzayn Panjwani, MSc; Erika Feuerstein, MD, CCFP; Bill Kapralos, PhD; Arlene Chan, MD, CCFP; Lisa McCarthy, PharmD, MSc; Sarah Warden, MD, CCFP; Joyce Nyhof-Young, MSc, PhD; Caitlin MacLeod, MI

Background: Three methods of emergency contraception (EC) are available in Canada: two types of EC pills, and insertion of a copper IUD. Few women are aware of all three options and accessing the prescription EC pill or the IUD can be a challenge. The aim of this project was to address this gap. **Objective:** To create and evaluate a mobile website that provides the public with accurate information and links to clinics where all EC methods can be accessed. **Setting:** Toronto, Canada. **Participants:** Young women aged 18 to 30 years. **Method:** Website content and design were targeted to young women. Content was based on current evidence. Input was collected from two focus groups with young women about essential content, language, and design of the website. Website

design was co-created by the design team and the second focus group. Pop-up questions on the new website collected data about how users learned about it and their satisfaction with the information. Website traffic was collected using Google Informatics. **Findings:** Focus group participants wanted a reassuring, non-judgmental tone and non-gendered language. Desired information included effectiveness, cost, side effects, safety, how to access, and after care. Ensuring user privacy was seen as important. Inclusion of quizzes and knowledge questions was not favoured. Connection with a hospital or health care organization fostered trust. The website www.whatsnext-forme.ca launched in March 2016, with subsequent promotion through Women's College Hospital, health clinics, pharmacies, and health websites. Over the first 12 months, 2,221 individuals had 2,875 sessions on the site. Users spent an average of 99 seconds and viewed an average of 2.1 pages on the site. About 70 per cent of users were from the Toronto area. **Next steps:** Over the next, year we will expand the site's network of clinics, market/promote the site more broadly, and incorporate user feedback to improve content and usability.

615 Developing a Healthy Lifestyles Program: Moving patient-centred care from rhetoric to practice

Elizabeth Alvarez*, MD, MPH, PhD, CMCBT

Background and gaps identified: Rates of overweight/obesity and chronic diseases are increasing throughout Canada and internationally. These chronic conditions, on their own and combined, significantly impact the quality and quantity of people's lives. The current acute care system is failing our patients with chronic conditions. General mental health is rarely addressed in the context of chronic disease management due to time limitations, payment schemes, and lack of training. Behaviour change is difficult yet this lies at the crux of patient self-management in clinical medicine and of health promotion in public health. Initiatives at the provincial level in Ontario are focusing on integrating primary care and public health and developing patient-centred care. However, innovative methods are needed to achieve patient-centred care and true sustainable improvements in health. **Intervention:** A new year-long program to be piloted in Hamilton, Ontario, supports patients in developing and prioritizing health goals, identifying barriers and facilitators to lifestyle changes, and creating sustainable action plans for health. The program includes doctor's visits, consultations with a physical therapist and dietician, support groups, education sessions, smoking cessation, and motivational techniques, and is informed by theories of health behaviour, cognitive behavioural therapy, and executive function skills, among others. Patients not only lead in determining their health priorities, but they also shape the future design of the program. This presentation will showcase components of the program, and highlight preliminary implementation considerations and findings. **Evaluation:** A pragmatic mixed methods approach is used to evaluate the program. Multiple aspects of a person's health are measured, including physical and mental well-being, to evaluate how effective the program is in helping patients achieve their goals and the influence that has on other health indicators. Matched controls will help determine effects of the program. Cost-effectiveness will also be evaluated.

616 Implementing and Evaluating Quality Indicators for Collaborative Mental Health Care (work in progress)

Abbas Ghavam-Rassoul*, MD, MHSc, CCFP, FCFP; Priya Vasa, MD, MSc, CCFP; Nadiya Sunderji, MD, MPH, FRCPC; Allyson Ion, MSc; Marni Lifshen, MA

Objective: Guided by a systematic review, qualitative interviews with primary care providers and mental health clients, and an expert consensus process, we developed a quality framework to guide quality measurement and improvement in the implementation of collaborative mental health care in primary care settings. We are now validating the framework by examining two family health teams' (FHTs) experience using quality measures developed based on the framework to support quality improvement (QI) initiatives. **Design:** We use a case study research design and are informed by the Consolidated Framework for Implementation Research (CFIR). We concurrently collect and analyze data from documents and correspondence, in-depth individual qualitative interviews, quantitative surveys, and field notes of the researchers' observations of the QI teams in action. **Participants:** Health care providers and administrators comprising the QI teams at two FHTs in Toronto. **Intervention:** The FHTs will conduct quality measurement over a 12-month period. **Main outcome measures:** Perceived importance, relevance, validity, feasibility, resource requirements, acceptability, and actionability of each measure implemented; impact, if any, on QI in primary mental health care. **Results/findings:** In this poster, we share the early experiences of the teams

with selection and implementation of measures from the Quality Framework for Collaborative Mental Health Care including successes and challenges. Mental health appears to compete with other areas of health to be on the quality agenda. Teams seem to select measures based on strategic alignment with existing QI initiatives, perceived opportunities for improvement, and feasibility to measure. **Conclusion:** The Quality Framework for Collaborative Mental Health Care has been received positively by early adopters and may be transferable to other teams wishing to measure and improve their collaborative mental health programs.

617 Maternal Depression in the Prenatal Period and School Readiness in Siblings (work in progress)

Marta Karpinski*; Gabriella Mattina; Alison Fleming, PhD; Roberto Sassi, MD, PhD; Meir Steiner, MD, MSc, PhD, FRCPC

Objective: To determine if prenatal maternal depression affects school readiness in offspring. **Design:** A within-family design was used to examine if differential maternal mental health status during two consecutive pregnancies predicts differences in school readiness between siblings. This design was chosen because current literature is limited by between-family design studies that compare cognitive development in children of different mothers. These studies fail to control for family characteristics of the pre- and postnatal environment, which influence cognitive development of the offspring, thus introducing bias. **Participants:** Data from 34 mother-sibling trios enrolled in the Hamilton cohort of the prospective Maternal Adversity, Vulnerability and Neurodevelopment (MAVAN) study were used. **Outcome measures:** Maternal depression was measured with the Montgomery-Asberg Depression Rating Scale (MADRS), and Edinburgh Postnatal Depression Scale (EPDS). These measurements were taken during both the second and third trimester of pregnancy. School readiness at age four years in the offspring was assessed with the Lollipop test. A first differences model was used to determine if change in MADRS and EPDS scores between the first and second pregnancies predict change in Lollipop score between the first and second siblings. **Results:** Change in EPDS second trimester scores between the first and second pregnancies was a significant predictor for change in Lollipop scores between siblings ($P = 0.049$, $R2 = 0.2$). EPDS third trimester scores and MADRS scores were not significant predictors of school readiness. Future analysis will use structural equations models to elucidate whether this association is due to direct effects of maternal mental health on school readiness, or an indirect effect by which maternal mental health modifies the postnatal environment in which the child is raised. **Conclusions:** Higher EPDS scores in the second trimester predict poorer performance on the Lollipop test. The child born following a more severely depressed pregnancy may be at a disadvantage upon starting school, compared to their sibling.

618 Burnout and Suicide Prevention Among University of British Columbia Family Practice Residents: Cross-sectional survey

Jani Laramée*, MD CM, CCFP; David Kuhl, MD, MHSc, PhD

Objective: In 2009, British Columbia lost a family practice resident to suicide. Residents are at high risk for burnout and suicide. The goals of this study completed in 2011 were to determine the extent to which burnout and suicidal ideation existed among the University of British Columbia (UBC) family practice residents in 2010, and to compare the identified rates to other similar studies. **Design:** Web-based survey (phpESP). The survey included evaluation of burnout (Maslach Burnout Inventory), and evaluation of suicide risk (inventory developed by Meehan and colleagues), both using a validated scale. A univariate descriptive analysis and a bivariate analysis were used to determine the prevalence of burnout and suicidal ideation, and to define relationships with demographic variables. **Setting/participants:** In 2010, a total of 109 first- and second-year family practice residents from UBC participated completely, anonymously, and electively to the online survey (46.6 per cent response rate). **Main outcome measures:** The identified prevalence of burnout was similar to another study previously conducted in the United States, but the identified prevalence of suicidal ideation was significantly higher than the prevalence identified by other US and European studies. **Results:** The prevalence of burnout during residency was identified at 73.5 per cent, and was represented by a perceived lack of personal accomplishment. The rate of suicidal ideation during residency was 33.3 per cent, the rate of suicidal ideation with a plan during residency was 18.1 per cent, and the rate of suicide attempt during residency was 2.9 per cent. **Conclusion:** This study identified a high rate

of resident psychological suffering. It recommended further research to improve prevention, identification, and support of residents in distress. The author of this study is planning to conduct a large-scale, follow-up analysis of suicidal ideation among Canadian residents in 2017.

619 Exploration and Assessment of a unique model of care in a Psychiatry Unit

Rose Zacharias*, MD; Shawna Belcher, RN, MN (IP), CPMHN (C); Marissa Rodway-Norman, MD, FRCP; Dmitry Guller, MD, FRCP; Anjana Chawla, MD, FRCP; Phil Hough, RN, Med; Gary Smith, MD, FRCP FAAP, MHSc

Purpose: To explore, document, and assess a unique model of care for patients admitted to a secondary level schedule 1 adult psychiatry unit. **Background:** At the opening of the Regional Schedule 1 Adult Mental Health Unit in Orillia Soldiers Memorial Hospital (OSMH) in 2006, a unique model of primary care psychiatric hospitalist was established. Literature from 2008 indicated that a model involving family physicians in the medical care of in-patients improved length of stay, decreased rate of medical specialists referrals, and improved staff satisfaction. The Orillia model is distinctly different from those described in the literature. The model established at OSMH involves family physicians as the most responsible physician. They act as admission gatekeeper for all unattached patients who are admitted to the psychiatry in-patient unit. Throughout the admission, the psychiatric hospitalist maintains clinical responsibility for all medical issues and provides concurrent/supportive care for the patient's psychiatric issues. However, the psychiatrist drives the psychiatric management. **Method:** A PubMed, EBSCO, Ovid MEDLINE, Embase, CINAHL, and Web of Science database review of the last 10 years (2006–2016) was undertaken. A satisfaction survey was undertaken using a five-option Lickert scale to determine satisfaction of allied health personnel, physicians, and patients with the primary care psychiatric hospitalist program. **Outcomes:** The literature review found additional articles indicating that family physicians who had access to collaborative care with mental health services were significantly more satisfied with mental health services reporting greater knowledge, skills, and comfort level.

620 Role of Functional Abilities Assessments in the Diagnosis of Dementia in Primary Care

Linda Lee*, MD, MClSc (FM), CCFP (COE), FCFP; Laura Turner, MScOT, OT Reg. (Ont.); Sarah Pritchard, MScOT, OT Reg. (Ont.); Loretta M. Hillier, MA

Context: In primary care, establishing the progression of Mild Cognitive Impairment (MCI) to dementia allows for timely dementia diagnosis and interventions to reduce suffering and maintain quality of life. Dementia diagnosis requires identifying functional impairment due to cognitive decline. While corroborated history is helpful, at times reported history from the patient or caregiver may be inaccurate or difficult to obtain. Performance-based functional abilities assessments may provide additional information about presence of functional impairment. **Objective:** To explore the contribution of Occupational Therapist (OT) home functional abilities assessments in persons diagnosed with MCI in a Primary Care Collaborative Memory Clinic (PCCMC) setting. These persons have impaired cognitive testing but no functional impairment identified on corroborated history obtained by a skilled multidisciplinary team in primary care. **Design:** Uncontrolled before and after. Setting: Community. **Participants:** Thirty-one older patients diagnosed with MCI within a PCCMC. **Intervention:** Following comprehensive assessment in which a diagnosis of MCI was made, an OT conducted an in-home assessment that included the Texas Functional Living Scale (TFLS), a validated performance-based measure of instrumental activities of daily living. **Outcome measures:** TFLS scores; number of patients for whom TFLS scores prompted a diagnosis review or management change. **Results:** The average participant age was 78.2 years (range = 60 to 92); 61 per cent of the participants were female. TFLS scores ranged from 28 to 50; average = 41.3 (higher scores reflect no functional impairment); impairments were identified in all subscales, the greatest being communication (average = 23.8/28). For 24 patients (77 per cent), identification of functional impairment resulted in management changes such as medication review and recommendations for community supports, and in 15 patients (48 per cent), findings of functional impairment resulted in physician review for consideration of diagnosis of dementia. **Conclusions:** OT home functional abilities assessments can provide additional information that can help primary care clinicians to distinguish between MCI and dementia, and may alter care management.

621 Interprofessional Outreach Team for High Risk Patients: Who is served?

Linda Lee*, MD, MClSc (FM), CCFP (COE), FCFP; Loretta M. Hillier, MA; Kelly Niall, CCPA; Maria Bohem, MSc; Kay Weber, MTS, MA RMFT; Jillian Bauer, Pharm

Context: To better serve individuals who frequently use health system resources (e.g., greater than four emergency department visits per year, frequent home care service users, etc.) an interprofessional outreach team (physician assistant, nurse practitioner, social worker, pharmacist, and community service case manager) was created to conduct home assessments and tailor interventions according to risk level. **Objective:** To better understand the patient population served by this outreach team. **Design:** Chart audit. **Setting:** Community. **Participants:** Fifty consecutively served patients. **Intervention:** Using a case management approach, screening with standardized measures was conducted to identify risk for psychosocial conditions and complex medical conditions. **Outcome measures:** Demographic information included age, gender, available family physician and caregiver, living situation, financial security, available transportation, personal safety. Health information collected included incidence of frailty, dementia, heart failure, COPD, falls, depression, anxiety, substance abuse, social isolation. **Results:** Mean patient age = 66.5 years (range = 21 to 99); 68 per cent were female. The majority (88 per cent) did not have a family physician and 26 per cent lived alone. Although 76 per cent had a reliable source of food, fewer had financial stability (52 per cent), stable community transportation (32 per cent), or very safe personal security (30 per cent). The average number of comorbid health conditions was 7.7; 24 per cent were cognitively impaired, 8 per cent had heart failure, 46 per cent smoked and 22 per cent had COPD, 50 per cent were identified as high falls risk, 52 per cent had a history of depression, 30 per cent had a history of anxiety 26 per cent a history of substance abuse, and 37 per cent were identified as frail based on gait speed. There were significant age differences in frailty, dementia, COPD, and substance abuse. **Conclusion:** Patients deemed high risk for acute care are complex and many do not have access to consistent primary care. Information on the social determinants of health provides insights into the challenges experienced by this population.

622 Patient Education to Reduce Excess Use of Vitamin B12 Injections: A Program evaluation

Daniel Léger*, MD, CCFP; Jessica Howard, MD, CCFP, DipPDerm; Darren Van Dam, MD, CCFP; Michael Craig, MD, CCFP; Amy Elizabeth Taylor, RN

Objective: Research suggests that B12 injections may be overused in some primary care practices and confirms the efficacy of oral supplements in treating B12 deficiency for patients without pernicious anemia, malabsorption conditions, or prior gastric surgery. The purpose of this study was to evaluate a program developed to reduce the excess use of B12 injections in a rural primary care clinic. **Design:** A program evaluation was conducted to determine: 1) How successful was the intervention in affecting participant decisions to switch to oral B12?; 2) Were B12 levels negatively affected by switching to oral B12?; and 3) What were some of the barriers that prevented participants from switching to oral B12? **Setting:** The Middlesex Centre Family Medicine Clinic. **Participants:** All patients receiving B12 injections at the Middlesex centre (N = 66). Patients with a diagnosis of pernicious anemia, malabsorption conditions, or prior gastric surgery, or without a B12 lab result since 2008, were excluded from the study. **Intervention:** Potential participants were identified via chart review. Participants were contacted by phone and asked to participate in short educational discussions regarding their B12 treatment options. Participant responses were documented on a tracking sheet. **Main outcome measures:** The number of participants willing to switch from B12 injections to oral supplements, B12 lab results, participant responses. **Results:** Of the 66 patients receiving B12 injections, 35 (53 per cent) were willing to switch to oral B12 following educational discussions. B12 levels were all within the normal range (M = 523.9 pg/mL) following the change. Barriers preventing participants from switching were related to preference, habits, and personal health beliefs. **Conclusion:** In general, participants appreciated the information regarding their treatment options. Switching patients from B12 injections to oral supplements reduces frequent clinic visits, mobility concerns, and painful injections. A cost analysis shows clinic savings of $1,671.60 per year by switching 35 patients to oral B12 therapy.

623 Patient and Manager Perceptions of Patient Experiences in Family Medicine Teaching Units: A qualitative study

Andréa Lessard*, MD, MSc, CCMF; Éva Marjorie Couture, MD, MSc, CCMF; Martin Lemieux, MD, CCMF; Mathieu Bisson, MSc; Mylène Lévesque, MSc; Josiane Boily, MD; Raphaëlle Cardinal, MD;

Kitsidikiti Muzinga, MD; Julia Picard, MD; Jean-Dominic Rivard, MD; Maud-Christine Chouinard, Inf PhD; Esther Jones

Context: Collecting information about patient experiences when consulting in family medicine teaching units (FMTU) is essential to improve care. Actual instruments are not adapted to FMTU and are difficult to interpret. **Objectives:** To collect perceptions of patients and managers regarding dimensions of patient experiences in FMTU in order to develop a questionnaire. **Design:** Descriptive qualitative study. **Participants:** Patients of one FMTU in Quebec. Administrators and directors of a FMTU affiliated with the Université de Sherbrooke, Quebec, Canada. **Intervention:** Individual semi-structured interviews and focus groups. Interview guides were developed following a literature review and were divided into seven main dimensions: access, space and equipment, communication, continuity and coordination, understanding of care, trust and impact of care. Questions specifically addressed the impact of the academic mandate of FMTU on patient experiences and the desired characteristics of a future questionnaire. Data saturation was used to cease recruitment. A patient as research partner, family medicine (FM) residents and clinicians participated at each step of the study. **Main outcome measures:** Thematic analysis of written transcriptions (NVIVO) **Findings:** Ten patients participated in individual semi-structured interviews. Two focus groups of four and three patients were conducted. Six administrators participated in individual semi-structured interviews and directors of the ten FMTU participated in a focus group. The seven major dimensions were still present at the end of the process and more than one hundred sub-dimensions emerged. FMTU-specific features related to FM residents were identified, such as availability, appointment duration, patient-physician relationship and continuity, trust and impact of care. Expected questionnaire characteristics were identified, such as: short to answer, simple, educational, easy to interpret and useful. **Conclusion:** This study exposes the point of view of patients and managers regarding dimensions and sub-dimensions that characterizes patient experiences in FMTU as well as characteristics expected from a future questionnaire.

624 Management of Osteoporosis Through an Evidence-Based Quality Improvement Program

Saif Matti*; Cathy Faulds, MD, CCFP (PC), FCFP

Objective: The aim of the program is to improve outcomes for patients with osteoporosis through patient-centred interventions in addition to early detection of those at risk. **Design:** This is a quality improvement program, involving collection and analysis of patient data. **Setting:** This was incorporated into family medicine practice, but can be applied to other primary care settings. **Participants:** Rosters were screened for patients aged 65 years and older, in addition to patients younger than 65 years with related risk factors. The target population consisted of 296 patients, 131 of which were diagnosed as moderate or high risk. **Intervention:** EMR tools and resources were developed to track outcome measures. Data were collected initially to establish a baseline, then was collected on a monthly basis. Data were reviewed monthly and program modifications were made accordingly to ensure care plans were patient-centred. **Outcome measures:** The program measured the percentage of patients sent for a BMD, and the percentage seen for osteoporosis-related visits (or sent a letter regarding their status) within their appropriate intervals. BMD T-score improvement among moderate/high risk patients was also tracked. **Results:** Over five years, the percentage of patients sent for a BMD increased from 15.7 per cent to 77.7 per cent and the percentage of patients seen for osteoporosis-related visits (or sent a letter regarding their status) increased from 52.1 per cent to 68.7 per cent. When comparing most recent BMDs with the previous, T-scores were maintained/improved in 60.2 per cent and 37.4 per cent of patients for lumbar spine and femoral neck respectively. **Conclusion:** As demonstrated, quality improvement programs can significantly enhance osteoporosis management by translating evidence-based medicine into practice. This emphasizes proactive care where intervention is prioritized over simply managing symptoms as they appear. The impact of such programs can help patients maintain independence and keep as healthy as possible while potentially reducing downstream costs within the health care system.

625 Discovery Toolkit for Family Caregivers of Seniors: Facilitating conversations and scholarship

Jasneet Parmar*, MBBS, MCFP (COE); Lesley Charles, MBChB, CCFP (COE); Suzette Brémault-Phillips, PhD; Bonnie Dobbs, PhD; Peter George Tian, MD, MPH; Melissa Johnson, MSc

Introduction: Family caregivers are an integral, yet increasingly overburdened, part of the health care system. In

Canada, there are an estimated 3.8 million family caregivers caring for seniors. We successfully held a CIHR-funded conference in 2014, Supporting Family Caregivers of Seniors. Knowledge users and researchers from Alberta and across Canada discussed the state of family caregiver support and initiated research plans. We developed a discovery toolkit from learnings and resources in the conference. **Methods:** 1) Each speaker's slide deck was presented in a page containing six representative slides and a hyperlink to the full slide deck. (2) Evidence summaries were shortened to a page. (3) Notes from discussions were subjected to thematic analysis and summarized. (4) A caregiver's account was presented as a personal communication to a government official. (5) Relevant articles, webpages, and organizations were collated and listed. **Results:** The toolkit is 44 pages long and designed for online viewing. It contains an executive summary and five parts: (1) Supporting Family Caregivers of Seniors with Complex Needs; (2) Voices of Family Caregivers: A Window into their Experiences; (3) Online Support for Caregivers of Seniors; (4) Support for Caregivers in End-of-Life Care; and (5) Research and Resources. **Discussion:** We will disseminate the toolkit to family caregivers, seniors, health care providers, researchers, health care organizations and community organizations, and other stakeholders. Also, we will use parts of the toolkit to create an academic module for family physicians, health care providers, and trainees. **Conclusion:** This toolkit is a timely resource for family caregivers.

626 Facilitating Resident and Family Engagement in Alberta Continuing Care Facilities

Jasneet Parmar*, MBBS, MCFP (COE); Kathy Classen; Julie-Ann Babiuk, MSc, PMP

Background: The Covenant Health Network of Excellence in Seniors' Health and Wellness (the Network) is focused on enabling seniors to live to the fullness of their capacity in their communities. The Network works with seniors, their families, and experts to design and test innovative approaches to seniors' care and services. Resident and family councils (RFCs) are mechanisms for families to share their ideas, and for operators to proactively share information and to develop plans in cooperation with families. Implementing effective RFCs in continuing care facilities will help ensure that families and residents are active partners in care. The Network will enhance and expand the value and use of RFCs in continuing care settings. **Purpose:** The goal of this project is to positively affect and support effective RFCs based on evidence of best practice adjusted to the Alberta environment. **Methods:** An advisory and planning committee—comprised of researchers, rural and urban continuing care administrators, patient relations staff, Alberta Health Services (AHS), and family members and residents—is working to: (1) conduct a literature review of best practices for RFCs; (2) conduct an environmental scan of current RFC practices for in Alberta continuing care centres; and (3) develop, implement, and evaluate a toolkit for effective RFCs based on literature review, environmental scan, and expert input. **Anticipated results:** Findings from the pilot projects for implementing the RFC toolkits will be broadly disseminated through the Network's' communications mechanisms. Recommendations will be sent to AHS and Covenant Health for consideration and follow-through.

627 Primary Thromboprophylaxis in Non-Cancer Patients Admitted to a Geriatric Palliative Care Unit

Giulia-Anna Perri*, MD, CCFP (COE) (PC); Adam Gurau, MD, CCFP; Jurgis Karuza, PhD; Anna Berall, RN

Objectives: Patients with end-stage, non-cancer disease are increasing in prevalence on palliative care units (PCU). The aim of this study was to compare venous thromboembolism (VTE) prophylaxis in elderly patients with non-cancer diagnoses to those with advanced cancer on a dedicated PCU. **Methods:** This was a retrospective chart review for all patients admitted to and discharged from the Baycrest Health Sciences PCU in 2015. We measured the association between demographic data and admission palliative performance scale, admission source, and length of stay in patients with cancer and non-cancer diagnoses. **Results:** Of the 316 patients included in the final analysis, 56 (17.7 per cent) had a non-cancer diagnosis. On admission, VTE prophylaxis was administered in 31.8 per cent of the cancer patients and 26.8 per cent of the non-cancer patients ($P = 0.285$). Patients admitted from hospital were more likely to receive VTE prophylaxis (39.8 per cent versus 13.7 per cent; $P < 0.05$). Mean admission PPS score was 31.43 for non-cancer patients and 36.04 for cancer patients ($P < 0.05$). Length of stay was shorter for patients with a PPS < 30 (18.64 versus 33.62 days; $P < 0.05$). The rate of VTE prophylaxis in bed-bound patients was similar to that in ambulatory patients (29.8 per cent versus 32.2 per cent; $P = 0.363$). **Conclusion:** Approximately one-third of all patients admitted to the Baycrest PCU, regardless of cancer or non-cancer diagnosis, were given VTE prophylaxis. Patients with non-cancer diagnoses were significantly younger, and had a lower PPS

and shorter length of stay compared to cancer patients. Further research would help to better guide VTE prophylaxis decisions and minimize suffering for patients at the end of life.

628 **Vaccine Answers: The development of an online tool to reduce parental vaccine hesitancy**

Jen Potter*, MD, CCFP; S. Michelle Driedger, PhD; Andrea Bunt, PhD; Salah Mahmud, MD, PhD, FRCPC; Ryan Maier, MA; Volodymyr Dziubak, MSc

Our objective was to develop and refine a novel, interactive website to provide evidence-based, plain-language information to help parents make informed decisions about childhood vaccination. Content is based on current risk-communication best practices, with the goal of providing timely, evidence-based information to parents in an engaging way. The novel parts of this website are its interactive components (an active blog and an "ask a question" section, managed by qualified moderators). Expectant and new parents were recruited to use the initial version of the website and provide qualitative feedback, in a focus group session or in individual interviews, focusing at this stage on design and content. This led to significant refinement of the website's organization and layout. After using the revised version, a second focus group session or individual interview was held with the same group of participants to assess the ease of navigation and functionality of the website, including identification of technical bugs. General impressions of the website content for helping participants make decisions about vaccinating their children were also explored. Feedback suggested that users liked the website's Canadian focus, plain language, and transparency around sources used. Improvements suggested and implemented included a mobile-friendly design, explicit information about user confidentiality and moderator credentials, and organization/layout preferences. Feedback received after these changes were implemented was overwhelmingly positive with regards to credibility, design, and usability. Users identified the website, particularly the ask a question feature, as an easier source for timely information than busy visits with their health care providers. The result is a website that incorporates end-user needs and preferences in a vaccine information resource. The website needs further testing to evaluate its effectiveness and impact on parental vaccine hesitancy, and as a communication tool or supplementary resource for physicians during clinic visits.

629 **Creating a Physician Governance Model That Enhances the Patient-centred Medical Home**

Shauna Wilkinson*; Wendy Stefanek, MD, CCFP; Richard Ward, MD, CCFP, FCFP; Chris Bockmuehl, MD, CCFP; Ted Jablonski, MD, CCFP, FCFP; Katharine Johns, MD, CCFP (EM), FCFP; Michelle Klassen, MD, PhD, MCFP; Reid McLean Wiest, MD, CCFP; Karyn Richardson, MD, CCFP; Karen Seigel, MD, MSc, CCFP

Physician leadership is crucial in the delivery of innovative patient-centred care in a medical home. Crowfoot Village Family Practice (CVFP) will discuss our experience developing a physician governance model that supports leadership development, clinical care innovation, timely access to care, health team development, quality improvement, improved health outcomes, and reduced system-wide costs (which is evaluated and measured). We will further explore the role of patients in guiding the service delivery and experience in their medical home. We will review the impact of a collaborative, goal-oriented business strategy that engages all physicians and supports both individual and clinic-wide growth and development. This includes physician leadership roles, methods (meetings, communication), evaluation, measurement, and tactics. CVFP's physician governance model supports improved outcomes that include: 1. CVFP patients are seen in the emergency department 10 per cent less often than the average Calgarian. 2. CVFP patients' length of stay is 40 per cent shorter than the average Calgarian. 3. Sustained same day/next day access. 4. On-going quality improvement projects including health screening, proactive care, and population management (COPD). 5. Core teaching facility for R1 and R2 residents. 6. Business development and sustainability planning. 7. Supported professional development (clinical and leadership) for physician team members.

630 **Enriching the Patient-Centred Medical Home Through Secure e-Communication**

Shauna Wilkinson*; Wendy Stefanek, MD, CCFP; Richard Ward, MD, CCFP, FCFP; Chris Bockmuehl, MD, CCFP; Ted Jablonski, MD, CCFP, FCFP; Katharine Johns, MD, CCFP (EM), FCFP; Michelle Klassen, MD, PhD, MCFP; Reid McLean Wiest, MD, CCFP; Karyn Richardson, MD, CCFP;

Karen Seigel, MD, MSc, CCFP

Many providers and patients are looking to technology to enhance communication and the patient journey in the health system. Crowfoot Village Family Practice has implemented a secure messaging system to allow patients to communicate safely and securely with their primary provider and health team. We will explore the implementation process, which includes change management, process mapping, patient engagement, system configuration, and internal training. We use secure mail to: 1. Enable the primary provider and health team to offer advice on non-urgent concerns. 2. Schedule appointments and send reminders. 3. Follow up with treatment plan reminders and notify patients of changes. 4. Follow on the effectiveness of treatment. 5. Send requisitions, appointment instructions, educational material, and test results. We will discuss outcomes and evaluation, which includes enhanced in-office access for patient appointments, reduced volume of incoming phone calls, improved workflow efficiencies, and cost reductions related to support staff, patient empowerment, and satisfaction.

631 Effectiveness of Mobile Health Technology Used by Patients for Promoting Activity and Weight Loss

Michael Brokop*, MD; Sharon Johnston, MD, LLM, CCFP; Cleo Mavriplis, MD, CCFP, FCFP

Over two-thirds of Canadian men and more than half of Canadian women are overweight or obese. The 2015 Canadian Task Force on Preventive Health Care guidelines recommend that practitioners offer or refer these patients to structured behavioural interventions aimed at weight loss. There can be many barriers to an intervention being implemented such as accessibility, distance, and convenience. Mobile health technology, such as smartphone apps and mobility trackers, may provide a practical alternative. The objective of this project was to review and synthesize the existing research about the effectiveness of mobile health technology used by patients in promoting physical activity and weight loss in order to derive lessons for primary care providers working with patients. A systematic review of the literature was conducted to address the project question and the PubMed database was searched for articles. As numerous systematic reviews covered the project question, the synthesis was limited to a review of reviews. A descriptive synthesis of the results describing the state of knowledge was conducted. Ten systematic reviews, which included a total of 221 individual studies, were analyzed and the results were consistent. Nine of the 10 systematic reviews concluded that interventions that incorporated mobile health technology had a significant impact on outcomes such as weight loss, BMI, and physical activity, compared with interventions that had no technology or minimal intervention. However, due to the rapid advancement of technology, as well as wide variety of technologies studied, no specific recommendations can be made regarding what interventions are necessary for effective outcomes. There are promising results and in general, technologies that incorporate self-monitoring or monitoring devices (such as accelerometers) could be suggested to patients. Further studies incorporating the latest technology, or perhaps comparative studies replicating real-world practise with factors such as time constraints and cost-effectiveness, could provide valuable future information.

632 CANCELLED / ANNULÉE

633 Community Palliative Care Clinical Nurse Specialist: An anchor for family physicians providing end-of-life care in the home

Karen Weisz*, MD, CCFP; Tina Parassakis, RN, MN; A.M. Nina Horvath, MD; Daryl Roitman, MD; Shana Haberman, MA

Patients living with advanced cancer often wish to receive end-of-life care at home. Challenges to providing high-quality care in this setting include: symptom management, caregiver support and education, and seamless around-the-clock support. The Freeman Centre for the Advancement of Palliative Care strives to meet the complex needs of these patients through a multidisciplinary approach to care that optimizes the patient and family experience with a goal of improving quality of life. The Freeman Outreach program enables adults living with advanced cancer, whose wish is to die at home or remain living at home as long as possible, to receive in-home care from a clinical nurse specialist (CNS) with the support of a Freeman Outreach physician and other community care providers. We aim to describe the Freeman Outreach model in which the CNS acts as an anchor to Freeman Outreach physicians. Further, the model helps support community family physicians who wish to provide palli-

ative care at home for their own patients. A key feature of this model is providing care 24/7. The CNS acts as the primary contact for patients and families, manages symptoms, provides patient and caregiver support, and leads coordination of care with all community care providers. We will share Freeman Outreach data that highlight the CNS role in providing end-of-life care in the home including: referrals to outreach programs from hospital or community service providers; independent home visits; telephone triage; deaths at home; direct admission from home to North York General Hospital's oncology unit; and direct admission from home to a palliative care unit. This outreach model of care is likely associated with significant cost savings, representing a high-value-based program while simultaneously providing exemplary patient- and family-centred care in the home. We will also highlight opportunities for, and challenges to, future growth.

634 Influenza Vaccination Rates in Diabetic Patients in an Academic Family Health Team

Marcin Badowski, MD, CCFP; Stephen Bathe, MD, CCFP; Stephanie Brass, MD, CCFP; Jason Murray, MD, CCFP; Sarah Wilkinson, MD, CCFP; Shannon Winterburn*, MD, CCFP

Context: Patients with diabetes are at high risk for influenza-related hospitalization, morbidity, and mortality. Influenza immunization is associated with a 40 per cent reduction in mortality in this population. The Canadian Diabetes Association recommends annual vaccinations. **Objective:** To determine influenza vaccination rates during the 2014–2015 flu season among diabetic patients at the Queen's Family Health Team (QFHT), evaluate existing quality improvement measures, and identify the main barriers to influenza vaccination uptake. **Design:** Quality improvement initiative. **Target population:** All patients aged > 6 months with a diagnosis of type 1 or type 2 diabetes, excluding patients with gestational diabetes. Flu shot status must have been recorded in the preventions module on OSCAR EMR. **Instrument:** All patient data were mined from the OSCAR EMR database. Our cross-sectional online survey was sent to health care providers at QFHT. **Outcome measures:** Uptake of influenza vaccination in patients with diabetes at QFHT, with comparisons to that of other high-risk groups, and a sub-group analysis of vaccination rates divided by clinic areas and supervising physicians. Survey design included scale ratings and text entry. **Results:** Sample included 917 patients, aged 3 to 97 years. The overall vaccination rate for patients with diabetes at QFHT was 70 per cent, exceeding that of pregnant patients (45 per cent), asthma/COPD patients (45per cent) and total patients at QFHT (32 per cent). Barriers to vaccination cited by QFHT staff included lack of patient education, poor attendance at medical appointments, fear of needles or vaccines, and time constraints. **Conclusions:** The percentage of this population that obtains vaccinations is greater than that of overall QFHT patients, as well as that of other high-risk groups. The health care provider has a small effect on the vaccination rate. Future quality improvement initiatives could be aimed at better patient education resources, encouraging medical appointment attendance, and increasing access to immunizations outside the clinic setting.

635 Addressing Women's Health Care in a Canadian Remand Centre: Catalyst for improved health?

Jonathan Besney*; Cybele Angel, RN, MA; Diane Pyne, RN; Rebecca Martell, CACII, RCS; Louanne Keenan, PhD; Rabia Ahmed, MD

Objective: Incarcerated women have a disproportionate burden of infectious and chronic disease, substance use disorders, and mental health illness. This study explored women's health and whether a women's health clinic improved care within this vulnerable population. **Design:** A retrospective chart review and focus groups were conducted. **Setting:** A large Canadian maximum security remand centre. **Participants:** Female inmates who expressed interest in and participated in a women's health clinic. **Intervention:** A women's health clinic was established to address gaps in gender-specific care and to provide comprehensive care supported by on-site access to multidisciplinary services including social work, mental health, addictions, infectious diseases and STI services, primary care practitioners, and pharmacists. **Findings:** Poor access to care in the community was described due to competing social needs. Barriers during incarceration included lack of comprehensive gender-specific services, mistrust of providers, and fragmentation. **Results:** Of 109 women, high rates of mental health, partner violence, substance use, STIs and irregular Pap testing was observed. Pap (15 per cent to 54 per cent; $P < 0.001$) and STI (17 per cent to 89 per cent; $P < 0.001$) testing rates increased. **Conclusion:** Fragmentation of health care remained at transition points and further work is needed to improve access within corrections and the community. There are many benefits in implementing a women's health clinic in short-term incarceration facilities in order to address health care

needs and improve health outcomes in this vulnerable female inmate population.

636 **Priority Solutions Proposed by Quebec Emergency Physicians to Enhance Rural Emergency Care**
Jonathan Audet*; Luc Lapointe, MA; Marie-Pierre Renaud, MA; Catherine Turgeon-Pelchat, MA; Richard Fleet, PhD

Learning objectives: At the conclusion of this activity, participants will be able to identify and list challenges faced by Quebec's rural emergency departments (EDs). **Introduction:** In Quebec, roughly 20 per cent of the population live in rural areas. Rural EDs face different challenges than their urban counterparts. Yet, few studies have sought to understand these challenges. **Objectives:** This study aims to survey Quebec's emergency physicians to identify problems and solutions specific to rural EDs ,and rank solutions in order of priority. **Design:** During the 2016 annual conference of the Quebec Emergency Physicians' Association, we asked physicians and residents (including those from urban EDs), to complete a survey about the challenges faced by rural EDs. The survey contained two sections: open-ended questions in which respondents could write three challenges about accessibility and quality of care in rural EDs and three solutions to address them. The second section listed 11 potential solutions identified in our previous studies. Participants had to rank them by priority level on a five-point Likert scale ranged from "not a priority" to "an absolute priority." **Results:** Ninety-one physicians out of the 417 completed the survey: 58 per cent came from urban EDs and 42 per cent from rural EDs. Open-ended questions suggest that access to specialists and interfacility transfers are the principal challenges faced by rural EDs. The top five solutions identified as the highest priorities were care protocols, improvement of interfacility transfers, training with simulators, targeted ultrasound, and implementation of staff retention and recruitment strategies. **Conclusions:** Roughly a quarter of attendants at the conference spontaneously volunteered to help identify and prioritize solutions to foster the accessibility and quality of care in rural EDs. Furthermore, these conclusions will be triangulated with those of Urgences Rurales 360, our recently-launched, wide-scope study that aims to explore problems and solutions faced by the 27 rural EDs in Quebec.

637 **The Patient Experience of After-hours Care in St. John's, Newfoundland and Labrador**
Ian Gallant*, MClSc; Sandra Parsons, MPSc, MER; Cathy MacLean, MD, MCISc, CCFP, FCFP; Michelle Levy, MD, CCFP, FCFP

Objective: Newfoundland and Labrador has an emergency department (ED) use rate twice the national average. Over half of ED visits across Canada are for less-urgent or non-urgent health conditions, most which could be effectively managed by a family physician. Poor access to a family physician after regular business hours and on weekends is one reason patients decide to visit an ED for non-acute issues. The objective of this project is to determine how residents of St. John's, Newfoundland and Labrador currently access after-hours (AHC) care, how satisfied they are with their options, how likely they would be to use an AHC clinic if available, and what factors would be most influential in their decision. **Design:** Survey research. **Setting:** An urban centre (St. John's). **Participants:** Surveys were mailed to 3,604 households in St. John's using Canada Post's Unaddressed Admail Service. **Intervention:** A 26-item questionnaire was developed by the researchers in consultation with a project steering committee composed of key stakeholders. **Main outcome measures:** How residents are accessing AHC, satisfaction with current options, likelihood of using a coordinated AHC clinic if one were available, and what factors would be most influential in their decision. **Results:** A total of 666 surveys were completed and returned. Analysis of the results indicate that 66 per cent of respondents went to the ED the last time they needed AHC. If available, 85 per cent would use an AHC clinic, with 91 per cent of respondents preferring this option to the ED. The most commonly cited explanation was long ED wait times. The most important factor related to using an AHC clinic is the ability to access same-day care. **Conclusion:** Results suggest that a coordinated AHC clinic would meet the needs of St. John's residents. The priorities of patients seeking AHC outside of an ED are for same-day access and reasonable wait times.

638 **Barriers and Facilitators to Accessing Health Care for Homeless Individuals in Niagara, Canada**
Michael Milo; Natalie Ramsay; Mo Moore; Rahat Hossain*

Objective: To identify the barriers and facilitators to accessing and navigating the health care system as an individual struggling with homelessness and housing in the Niagara region of Ontario, Canada. **Design:** Face-to-face, semi-structured interviews using qualitative methodology with a phenomenological approach. Thematic analysis was used to identify the common barriers and facilitators across interviews. Convenience sampling conducted through partnership with community organizations. **Setting:** Study interviews were conducted at the following sites: Start Me Up Niagara in St. Catharines, ON; The Hope Centre in Welland, ON; and Nightlight Youth Services and Shelter in Niagara Falls, ON. **Participants:** Eligible individuals (n = 16) had to self-identify as homeless and residing in the Niagara region, be aged 18 years or older, and have interacted with a health care provider during the time they were homeless. Individuals under the age of 18, with no interactions with health care providers while homeless, or those unable to give informed consent were excluded. **Findings:** Nine barriers and eight facilitators to accessing health care were identified. The key barriers were: affordability, challenge finding a family physician, inadequacy of the psychiatric model of care, inappropriate management, loss/lack of trust in health care system/health care providers, poor therapeutic relationships, systemic issues, and transportation and accessibility. The key facilitators were: accessibility of services, community health care outreach, positive relationships, and shelters coordinating health care. **Conclusion:** Our findings support that effective communication, empathetic listening, and non-judgmental attitudes foster positive relationships and improve health care experiences for homeless patients. For family physicians, greater attention to the subjective experience and concerns of homeless patients, and inclusion of their opinions in decision making, appears to be an important prerequisite to effective therapeutic relationships that facilitate access to care. Based on evidence supporting family physicians as facilitators for health care, policies should be in place to ensure homeless individuals are able to find a primary care provider.

639 CHIUS: Examining the impact of student-run clinics on interprofessional health care students (work in progress)

Kelly Huang*; Mona Maleki; Heather McEwen, MD, CCFP

Objective: To evaluate the impact of the student-run clinic (SRC) at the Community Health Initiative by University Students (CHIUS) on student participants. **Participants:** University of British Columbia (UBC) students from pharmacy, medicine, nursing, social work and occupational therapy. **Method:** Twenty-three participants in the CHIUS SRC at the UBC took part in two focus group interviews: a 10-minute focus group on their first or second clinic day, and a 20-minute focus group on their final clinic day. A combination of open-ended and specific interview questions were used to explore the participants' learning from the SRC. Using the Grounded Theory approach, transcribed interviews were iteratively analyzed and questions were adjusted for subsequent focus groups as the analysis revealed certain themes. Three investigators coded the data individually, consolidated the themes, and developed explanation models for each theme. **Findings:** Five themes emerged from the focus groups: (1) Students derived value in the SRC's opportunity to manage real patients with complex medical conditions, which provided them with holistic learning about patients' perspective unique from case-based learning or didactic lectures. (2) Early patient exposure in students' education gives them confidence and motivation. (3) Managing patients with an interprofessional team allowed the students to understand each profession's scopes of practice and expertise. (4) The SRC experience encouraged students to analyze their definition of illness and disease, specifically in relation to chronic illness and marginalization. (5) The students demonstrated a sense of unease regarding whether the SRC provides benefit to the patients. **Conclusions:** The study currently has demonstrated the value of interprofessional learning and exposure to real complex patients for health care students early in their training.

640 Lenient Scoring of the Spatial Orientation Items on the MMSE Lowers Sensitivity

Katrina Kent*; Matthew Greenacre; Shannon Baker; Laszlo Erdodi, PhD, C.Psych

Objective: This study was designed to examine the effect of lenient scoring of the spatial orientation items (SOI) on the classification accuracy of the MMSE. Lenient scoring occurs when the examiner gives patients with incorrect responses on SOIs a second chance by asking the name of their city, county, and state of residence. Correct answers are recorded as full points on the original SOIs. This practice is problematic, as the cognitive demands are significantly reduced in the second round of questions. **Design and setting:** A retrospective chart review was conducted based on a consecutive case series of older adults referred for neuropsychological evaluation at an

academic centre in the northeast US. Inclusion criteria were adults aged ≥ 60 years and a full administration of the MMSE. **Participants:** A total of 103 charts met inclusion criteria. Mean age was 70.48 (SD = 7.03). Mean level of education was 14.34 (SD = 3.24). Patients were classified into cognitively intact (n = 46) and impaired (n = 57) using an a priori algorithm based on a combination of neuropsychological tests. **Main outcome measures:** The main outcome measures were base rate of lenient scoring of MMSE SOIs, and the resulting change in classification accuracy (AUC, sensitivity, specificity) along common cut-offs (25, 26, 27). **Results:** Fifty-three patients had ≥ 1 leniently-scored SOI. MMSE scores were re-computed by reversing lenient scoring (i.e., applying standard scoring rules). Classification accuracy was recalculated. Lenient scoring resulted in a small decrease in AUC (two to five per cent) and modest loss in sensitivity (7 to 18 per cent) across all three cu-toffs. **Conclusion:** Lenient scoring of SOIs on the MMSE is common, and it attenuates diagnostic accuracy. Although the loss in sensitivity was modest, the high cost of false negatives during such a critical period of a potential neurodegenerative disease process warrants a re-examination of scoring practices on the MMSE.

641 The Physical Environment in a Palliative Care Unit: What matters most to patients?

Shiraz Malik, MD, CCFP; Sarah Ollier*; Lauren Siegel, MSc; Leslie Boisvert, MPA

Objective: The physical environment is a significant contributor to quality of life for patients with advanced, terminal illness. The purpose of this study was to determine what specific environmental factors matter most to patients receiving care in an acute palliative care unit (PCU) and their level of satisfaction with those factors. **Design:** Cross-sectional survey. **Setting:** Fourteen-bed PCU in a 508-bed tertiary care hospital. Participants: Patients met eligibility criteria if they had an admission of five days, spoke English, and were without cognitive deficits; 17 participants met the criteria. **Intervention:** Surveys were conducted during which participants rated the importance of, as well as their satisfaction with, 26 environmental factors on a four-point Likert scale. Two open-ended questions assessed what environmental factors patients value and what recommendations they might have for improvements. **Main outcome measures:** Quantitative—mean importance and satisfaction score for each of the 26 care elements. Qualitative—open-ended responses were coded for thematic analysis. **Results/findings:** Elements with the five highest mean rating scores included: staff attitude, adequate communication regarding care, staff availability, overall appearance/cleanliness of the room, and environmental support for patients. Participants reported high satisfaction with these factors with satisfaction scores ranging from 2.6 to 2.9 (maximum score of 3). Factors that were least important to participants included: room décor, quietness for meditation/prayer, availability of a private room, interaction with other patients, and availability of spiritual resources. Areas that participants expressed dissatisfaction with included access to the natural world, a home-like environment, and meals. **Conclusion:** Friendly, available staff is of utmost importance to patients admitted to an acute PCU. In regards to the physical environment, having a clean, home-like space with access to the natural world is more important than having a private space. These results can help guide the future design of acute PCUs.

642 Influential Factors for a Medical Student Ranking Their Home Institutions Family Medicine Residency Program

Christopher Russell*; Kay-Anne Haykal, MD, OD, CCFP; Lina Shoppoff, MD, CCFP

Background: Understanding the factors that influence medical students' self-rank order of residency programs is of great interest to these programs. Ottawa's Family Medicine Postgraduate training program has observed fluctuation in the number of medical students choosing to pursue family medicine at Ottawa in recent years (14 to 20 students, cohort 2013 to 2016). **Methods:** To assess whether fluctuations were due to modifiable program factors, a survey was distributed to the class of 2017. Survey development was based on influential factors from the literature, assessing these factors' impact on where Ottawa was placed on student's rank list. **Results:** Forty-two students completed the survey. Fifty-five per cent reported basing rankings primarily (45 per cent) or completely (10 per cent) on location. The top two positively influential factors were the desirability of Ottawa as a city (lifestyle, factors not related to personal relationships; n = 33), and quality of clinical sites (n = 26). The top two negatively influential factors were the proximity to the home town (n = 15), and the location of spouse/partner (n = 14). Eight-three per cent of applicants applied to the academic sites (14 per cent academic, 45 per cent academic and community, 24 per cent academic, community, and rural), 31 per cent had applied to rural sites (5 per cent community and rural, 2 per cent rural). **Discussion:** The most positively influential factors are split between non-modifiable factors (Ottawa as a city) and semi-modifiable factors (quality of clinical sites). The most nega-

tively influential factors (proximity to hometown, location of spouse/partner) are non-modifiable by the program. Location of program is a key determinant in students' rank orders. **Conclusion:** Ottawa medical students are in a unique position regarding their opinion of the family medicine residency program, due to their exposure to family medicine-related programs and initiatives over their four years of undergraduate training, and interactions with family medicine residents on clinical rotations. Programs can gain valuable insight into student perception of the postgraduate programs by surveying students from their institution.

643 Surveying University of British Columbia Medical Trainees on Their Understanding of Resource Stewardship and High-Value Care

Ahmad Sidiqi*, MSc; Noren Khamis; Malcolm Maclure, Sc.D; Geoffrey Blair, MD, FRCSC

Objective: To determine the insight and interest current medical students at the University of British Columbia (UBC) have with regards to resource stewardship and high-value care, to help guide medical curriculum adjustments. **Design:** A 21-item, research-ethics approved online survey was designed and piloted with 43 medical students from medical schools across Canada who had previously shown an interest in resource stewardship. The validated REDCap-generated survey was distributed to all medical students (1,146 students) at UBC. **Setting:** The survey was distributed online via an electronic mailing list and all survey responses were collected online. **Participants:** The survey was distributed to all medical students at UBC, and 88 students provided completed responses. **Intervention:** Students were asked to complete a 21-item survey. **Main outcome measures:** Not applicable. All items on the survey were analyzed. **Findings:** The majority of students (93 per cent) agreed or strongly agreed on the importance of resource stewardship and high-value care in clinical decision making. However, all respondents felt that their training has inadequately prepared them on this topic, and only 28 per cent felt comfortable discussing costs of care and over-treatment with patients. Furthermore, a vast majority of participants (85 per cent) believe that training in resource stewardship and appropriate care needs to begin in the first two years of medical school. **Conclusion:** UBC medical students value resource stewardship education, but their lack of adequate training inhibits them from advocating for appropriate patient care and resource allocation. Increased emphasis on resource stewardship and high-value care in the undergraduate medical curriculum, especially in the first two years of medical school, may help trainees make safe and cost-effective health care decisions.

POSTER PRESENTATIONS / PRÉSENTATIONS D'AFFICHES
NOVEMBER 10 NOVEMBRE

701 Development of Family Practice Guidelines for Pain Management

M. Hamilton*, MD; J. Pilla, MSc; L. Dunn, MSc

Background: Pain management is a common presentation in the primary care setting. There are currently no comprehensive, evidence-based, independent clinical practice guidelines available in Canada to assist in prescribing for this clinical entity. One outcome of a Canadian expert review panel on opioids convened by the Institute for Safe Medication Practices (ISMP) Canada was that the development of a pain management prescribing resource is a priority and that family physicians should play a pivotal role in the process. **Objective:** To develop a practical resource for pain management for family practice. **Methods:** A modified Delphi process was used to develop the guideline. This process has been well documented in the literature and has been used previously to develop other Canadian primary care guidelines in this series, such as the Anti-infective Guidelines for Community-acquired Infections ('Orange Book'). The preliminary draft was reviewed by the expert review panel. The subsequent iterations underwent peer review by a national interdisciplinary panel comprised of family physicians, specialists, other primary care providers, and patients. **Results:** The resulting document includes recommendations on management of commonly-seen presentations of both acute and chronic pain, and includes specific dosing recommendations and available products. It also includes evidence-based, non-pharmacological recommendations for each diagnostic category, the role of opioids and appropriate prescribing of these agents, and a summary of the role of medical marijuana. Prescribing and patient information tools are available in the appendices. Multidisciplinary guidelines developed by front line family physicians and other primary care providers resonate with the end users, ensuring widespread uptake. While the process is time-consuming, the outcome is a robust, practical, and user-friendly guide to pain management. **Conclusions:** Based on subsequent feedback from family physicians across Canada, the guideline is a useful resource in day-to-day practice. Next steps include a more robust dissemination and implementation strategy.

702 Qualitative Evaluation of Pediatric Poverty Screening Techniques Used in Primary Care, and Barriers to Their Implementation

Laura Kerr*; Sarah Gander, MD, FRCPC

Background: Childhood poverty is a significant public health concern in Canada; a disproportionate number of low-income individuals struggle with poor health. Health care professionals can help mitigate the effects of poverty, but evidence suggests that screening for poverty is not done frequently, and many providers feel they lack the tools to do so. **Objectives:** This study evaluated screening techniques for pediatric poverty in primary practice, including attitudes towards screening, and perceived barriers to screening. Additionally, where and how practitioners established their screening techniques was considered. **Design and setting:** A grounded theory approach was used. Interview questions were prepared and eight primary care practitioners were recruited from the area of interest, including family physicians, pediatricians, and a nurse practitioner. Participants completed a 30-minute interview; these were analyzed using thematic analysis. **Findings:** The pervasive themes indicated that many primary care practitioners lack a screening protocol, using clinical judgment and knowledge of the family to decide when to screen. Most find this inadequate, and would be interested in a standardized tool for all patients. The major barriers to effective screening were time and lack of comfort, education about the topic, and familiarity with services to support families. **Conclusion:** The results showed that improved education in medical training is essential to feeling comfortable talking to patients about poverty; this should consist of didactic sessions, and exposure to children living in poverty. Support and knowledge of resources throughout practitioners' careers is needed to maintain comfort in mitigating the social determinants of health. Finally, due to the system barriers inhibiting effective screening, options to better involve allied health care professionals in screening and intervention should be considered.

703 Physician Attitudes About Adult ADHD Diagnosis and Management in an Academic Primary Care Setting

Bahar Najafi*, MD; Peter Tzakas, MD, CCFP

Statement of purpose: To determine the residents' and staff's perceived comfort level in their current clinical set-

ting with diagnosing and managing adult ADHD. **Methodology:** An online anonymous survey was designed and distributed via email to Toronto East Health Network family medicine residents and faculty. **Results:** The survey was completed by 47 people (30 residents and 17 staff physicians). Forty-two per cent of respondents reported using tools to diagnose adult ADHD. The most commonly reported obstacles to diagnosis were: lack of training and presence of comorbid psychiatric conditions; lack of time for full psychiatric assessment; and difficulty obtaining collateral history to confirm presence of symptoms in childhood. The most commonly reported obstacles to treating and managing adult ADHD were: concern about abuse or diversion of medications; uncertainty in correct choice of medication or dosage; lack of knowledge; and uncertainty about ADHD being the right diagnosis. **Conclusions:** Familiarizing oneself with one of these tools, such as CADDRA and increasing the frequency of their use could help standardize the diagnostic process. Given that time was also seen as significant obstacle, perhaps longer appointments could be arranged for full ADHD assessment.

704 Pediatric Obesity: Are we using the right measurement?

Huma Numair*, MD, CCFP; Naghmi Shirin, MBBS; Sabrina Suleman, MD; Shahzana Shahzad, MBBS; Hammaan Khan

Context: The 2006 Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children recommends that primary care practitioners should calculate BMI according to age and gender, (A-BMI) using the World Health Organization (WHO) Growth Charts for Canada, in children and youth aged 2 to 17 years. Non A-BMI charts can overestimate or underestimate pediatric obesity. Pediatric obesity is a strong predictor of adult obesity and its comorbidities (e.g., CVD, diabetes, cancer) with increased morbidity and mortality. **Objective:** To determine if children aged 2 to 17 years were assessed with A-BMI. Design: A cross-sectional study. **Participants:** We identified 754 patients aged 2 to 17 years who visited HFHClinic, in Burlington, Ontario, between 2015–2017. They were divided according to age (2 to 17 years), gender, calculation of A-BMI, counselling for weight issues, and gender of primary care provider. **Intervention:** Analysis of EMR data from HFHClinic. **Outcome measure:** Assessment of the A-BMI during visits and its association with weight related counselling. **Result:** Out of 754 pt(males=367, females=387),177/754(23.5%) did not have A-BMI calculated. No A-BMI calculated in males=121/367(33%) females=56/387(14.5%). No A-BMI calculated in age 2-13yrs=55/177(31%), in age 14-15yrs= 30/177(17%) and age 16-17yrs=88/177(50%). Pt who were counselled with calculated A-BMI were 44/56(78.5%) Pt who were counselled without A-BMI 12/56(21.4%). Male vs Female Physician's A-BMI calculation was comparable{(116/164)71% and (480/606)79% respectively}. **Conclusions:** According to Statistics Canada, 26 per cent of Canadian children aged 2 to 17 years are overweight or obese. Non A-BMI does not take in consideration normal growth velocity and fat-free mass. Despite the 2006 Canadian Clinical Practice Guidelines, the A-BMI was missed in 23 per cent of eligible patients (50 per cent in ages 16 to 17 years, and 17 per cent in ages 14 to 15 years). The A-BMI was missed twice as much in male patients versus female patients (33 per cent versus 14.5 per cent). There was an almost four-fold increase in counselling (with A-BMI, 78 per cent; without A-BMI, 21 per cent). Increasing physician awareness of current guidelines to use A-BMI through CMEs, medical journals, and so on, is required.

705 COPD self-management education group: A program evaluation

Darren Van Dam*, MD, CCFP; J. Hodgins, RRT, CR; E. Lortie, MHA; N. Snyder, RRT, CRE; G. Cimino, RPh; T. Kontio, RPh; G. Fish, OT Reg; N. Bowen-Smith, OT Reg; J. Withers, RN

Objective: Chronic obstructive pulmonary disease (COPD) is a leading cause of morbidity and mortality in Canada. However, research suggests that many individuals diagnosed with COPD have poor knowledge regarding the management of their condition. This study assessed whether providing patients with knowledge about COPD could improve their self-management of this disease. **Design:** Program evaluation. **Setting:** A rural family medicine clinic in Southwestern Ontario. **Participants:** Seventeen individuals with a diagnosis of COPD. **Intervention:** A program was designed and offered to improve self-management of COPD, and provided education about topics such as how to develop an exercise plan, breathing strategies, and how and when to take medications. Surveys were administered to participants before and after the program to assess self-reported knowledge/understanding of COPD and level of confidence in managing COPD. A program satisfaction survey was administered following the program. **Main outcome measures:** Participant knowledge of COPD, confidence in self-managing COPD, and satisfaction with the program. **Results:** Mean level of self-reported knowledge/understanding of COPD and mean

level of confidence in self-managing COPD significantly increased after the program (6.15 to 7.38, P = 0.02; 6.73 to 7.55, P = 0.01, respectively). The mean number of questions answered correctly, of 12 COPD knowledge questions, significantly increased following the program (7.71 to 9.71, p = 0.01). The mean participant rating of overall experience of the program was high (4.15 on a scale of 1 (poor) to 5 (superior)). **Conclusion:** Preliminary results of this study demonstrate that this COPD program had a positive impact upon patient knowledge of COPD and confidence in self-management. Improving patient self-management of COPD has been shown to reduce the severity and frequency of exacerbation and improve health-related quality of life. Further sessions are required to better evaluate this novel program.

710 Transitions in Care

Lesley Charles*, MBChB, CCFP (COE); Lisa Jensen, RD; Claire Johnson, RN

Background: There has been much research about how to smooth the transition to home from hospital by identifying patients at high risk for readmission and coordinating discharge with community supports. **Method:** Phase 1 used expert consensus from the Covenant Transition Steering and Working Groups and literature review to design a risk assessment tool, to determine which patients would benefit from this intervention, and the components of a scripted telephone call. A pilot was undertaken, June 2016, to validate the efficacy of the risk assessment tool. Phase 2 includes the intervention of the risk assessment tool and follow-up telephone calls 48 hours after discharge, which includes support as needed from the research coordinator (with nursing/transition coordinator background) to bridge any gaps identified in the telephone calls. **Results:** The pilot used a modified LACE tool; N = 40. Using 19 as a cut-off, it identified 16 patients as high risk. The original LACE, with a cut-off of 13, identified 13 patients as high risk. Therefore, the added length of the modified LACE did not yield much and the decision was made to use the original LACE in Phase 2 for patients discharged home from the medicine/geriatric and stroke units. The scripted telephone call focuses on whether the patient: understands the discharge instructions; picked up medications; if referred for equipment, picks up the equipment; and, if referred to home care, has heard from the provider. The study has partnered with home care, the local PCN, and primary care physicians (PCP), as well as a pharmacy to support the patients. Data and decision support supplements the evaluation framework, which will focus on outcomes, including emergency visits and readmission rates. **Conclusion:** Phase 1 of this study has helped inform the risk assessment tool and telephone call/supports needed to facilitate smooth discharge home for high risk patients.

711 What do Residents and Faculty Think of Practice-Based Small-Group Learning?

Risa Bordman*, MD, CCFP (PC), FCFP; Linda Mayhew, MA; Upe Mehan, MD, CCFP; Jacqueline Wakefield, MD, CCFP, FCFP; Heather Armson, MD, MCE, CFPC, FCFP; Elizabeth Shaw, MD, CCFP, FCFP; Tom Elmslie, MD, MSc, FCFP, FRCPC

Objective: To understand the educational value of residency practice-based small-group (PBSG) learning through the experience of residents and faculty participants. **Design:** Web-based survey of residents and faculty. Quantitative and qualitative responses were collected asking about group function, PBSG process, modules, facilitators, what they liked/disliked about the program, and suggested changes. Setting: All English language family medicine residency programs in Canada. **Participants:** All residents (2,458) and faculty (336) involved in the PBSG program. A total of 867 responses were received, for a response rate of 31 per cent. **Main outcome measures:** PBSG qualities and comparison to other learning modalities, facilitator factors. **Results:** Resident responses were received from every university, with equal numbers of PGY1s and PGY2s. Faculty responses were received from all but one university. On average, over 80 per cent of the residents and 90 per cent of the faculty rated the learning experience, group interaction, and quality of the modules as good or excellent. Eighty-five per cent of residents reported that a facilitator led their group. Fifty-nine per cent of residents had a resident or resident/faculty combination as their facilitator. Eighty-seven per cent rated their facilitator as good or excellent. Resident's overall experience was enhanced when resident and faculty co-facilitated. Themes from the qualitative data included concerns about the use of out-of-date modules, suggested module adaptations, challenges with group process, and the limited clinical experience of residents. Fifty-nine per cent of residents and faculty said the PBSG program was superior to other learning modalities. **Conclusions:** Overall, the program is highly regarded and well received. There was a high rate of resident facilitators, which helps to promote true peer learning. The most common criticism was using out-of-date modules. Ideas to address this issue include encouraging universities to use current modules, enhancing the website to more

readily identify out-of-date modules, and adapting and continuously updating some modules for residents.

712 SPOT-CCSE clinique communautaire de santé et d'enseignement : innover en formation et soins auprès de personnes marginalisées.

Josette Castel*, MD, MSc, CCMF, FCMF; Maxime Amar; Geneviève Perry; Nathalie Bouchard; Annie Bérubé; Christopher Fletcher; Shelley-Rose Hyppolite; Geneviève Olivier d'Avignon; Sophie Turmel; Camille Rodrigue; Maude Rodrigue, Clinique SPOT-CCSE

Contexte : En 2011, la Faculté de médecine de l'Université Laval lançait l'idée d'une clinique communautaire étudiante de santé. Les étudiants des sciences de la santé et des sciences sociales exprimaient le besoin d'être exposés plus rapidement aux réalités sociales et communautaires pendant leur formation. Les populations en situation de vulnérabilité à Québec aspiraient à plus de services de santé. En 2014, SPOT-CCSE a été fondée, puis a accueilli ses premiers étudiants dès janvier 2015. **Objectifs visés :** SPOT a pour mission d'améliorer l'état de santé des populations marginalisées, désaffiliées, en situation de vulnérabilité sociosanitaire, non rejointes par l'offre de soins et services existante, et de former une relève professionnelle sensibilisée aux enjeux sociaux et aux besoins de santé de ces personnes. SPOT offre un milieu de formation pratique axé sur une vision de santé globale et de collaboration interprofessionnelle. **Méthodes utilisées :** Les étudiants s'intègrent à une équipe interdisciplinaire dans les 5 points de services situés en milieu communautaire. Au cœur de l'équipe se retrouve l'infirmière clinicienne en rôle clinique élargi, aidée par un pair. Par un processus d'accompagnement, structuré et réflexif, l'étudiant peut développer les compétences requises. **Résultats :** Trente étudiants par an provenant des Facultés de médecine, sciences infirmières, pharmacie et des Écoles de nutrition et de psychologie effectuent des stages à SPOT. Chaque programme de formation, dont celui de résidence en médecine familiale, définit les compétences à développer pour ses stagiaires et les modalités de stages. Un questionnaire pré et post stage documente des indices d'impact de ces stages notamment les préjugés ou la compréhension des déterminants sociaux de la santé. **Conclusion :** La clinique SPOT atteint et poursuit son mandat de formation et d'intervention pour et avec les personnes rejointes. Une démarche de recherche-évaluation continue soutient l'équipe de soins et d'enseignement.

713 On the Cutting Edge of Shared Care: A combined family medicine and surgery community skin cancer clinic

Nelson Chan*, MD, LLB; Kathryn Roth MD; Leslie Boisvert

Objective: The aim is to evaluate the effectiveness of an interdisciplinary skin cancer clinic where residents are supervised by a surgeon, in a family medicine clinic. Procedural skills proficiency and increasing residents' participation in skin cancer-related procedures after graduation will also be assessed. **Learning objective:** Demonstrate the feasibility of teaching family medicine residents skin procedural skills in an interdisciplinary setting. **Design:** Controlled trial design with second-year family medicine residents at an Ontario family medicine program. **Participants:** Seventy residents are eligible to participate per year. **Intervention:** A case-based teaching session on skin cancer is presented to all residents. Rural residents received only this session and act as a control group. The urban group received an additional hands-on session, and rotated through the clinic, performing a minimum 6 procedures with one-to-one surgeon instruction. **Outcome measures:** Pre- and post-skin knowledge tests after receiving the intervention. Skill acquisition was assessed by one procedure being videotaped and then evaluated using a validated scale. A 12-month post-intervention test and a survey relating to skin-related procedural participation after graduation will be administered. **Findings:** Our preliminary results show that procedural practice linked to live patients promotes skill development, retention, and confidence. We are currently collecting 12-month post-intervention tests and surveys from the first graduated cohorts. **Conclusions:** While rural residents have more exposure to procedural opportunities in their training, preliminary data show that urban residents who rotated through the clinic acquired additional skills and knowledge that may be carried over to their independent practice. We hope to show that residents trained in both settings will have similar procedural practice patterns post-graduation. Our education innovation offers a unique and successful example of postgraduate family medicine surgical training, providing a benchmark for achieving competency in skin procedural skills.

714 Caring for Immigrants and Refugees: Health professionals' knowledge and experience, a qualitative study in Saskatchewan

Razawa Maroof, MD, CCFP, FCFP; Mamata Pandey, PhD; Rejina Kamrul*, MD, CCFP; Clara Rocha Michaels, MD, CCFP; Samra Sahlu

Context: Saskatchewan immigrant population has increased over the years, so has the need for culturally sensitive services. Given the importance of social context in help-seeking behaviours and expectations, knowledge of specific local patterns is imperative to shaping a responsive health care system. **Objective:** Identification of potential barriers to health care provision for immigrant and refugee population as perceived by different health care professionals in Regina, Saskatchewan. **Design:** Following a qualitative research design, 23 interdisciplinary heath care professionals were interviewed. **Setting:** Regina, Saskatchewan. **Participants:** The participants included: family physician, psychiatrist, pediatrician, cardiologist, registered nurse, nurse practitioner, dietitian, social worker, settlement worker, lab technician, X-ray technician, exercise specialist, pharmacist, health record technician, and the executive director of the Regina community clinic. **Results:** Thematic analysis of the interview data indicated that all health care providers cared for patients from diverse cultural, economic, and educational backgrounds, varying age groups, and varying English language abilities. Lack of adequate training to work with vulnerable populations, inadequate time for consultation with patients, insufficient knowledge about trauma and other environmental factors immigrants and refugees were exposed to prior to coming to Canada hindered the health care providers' ability to optimize care. Further, inadequate knowledge about availability of services, lack of child care, transportation, socioeconomic factors, inadequate access to interpreters, confidentiality issues when interpreters are involved, cultural norms and belief about health influenced an individual's ability to seek health care in a timely manner. Language barriers hindered health information sharing between health care provider and recipient, causing problems with sample collection and diagnostic procedures. **Conclusions:** Treatment planning and non-adherence were common areas of concerns. Communicating procedures for sample collection was a common challenge, even with the use of interpreters. Additionally, differing conceptualizations of chronic disease contribute to poorer outcomes. Our findings have important implications for health care providers and will affect future program development to improve immigrant and refugee care in Canada.

715 Childhood Obesity Prevention In Primary Care: Current practices and future directions

Ekta Lakhani*, MD, MSc, CCFP; Aditi Lakhani, MD, CCFP; Cleo Mavriplis, MD, CCFP, FCFP; Sharon Johnson, MD, LLM, CCFP

Objective: To investigate barriers and facilitators for obesity prevention for children ≤ 2 years old in primary care. **Design:** This two-phase, mixed-methods study included an audit of charts from two clinics to identify best practices and recurrent gaps in care. Ten semi-structured interviews were conducted with primary care providers. Thematic analysis was done to identify common themes, contrasting ideas, and areas for further investigation. **Setting:** Two urban, academic, interprofessional primary care practices, one in Ottawa and one in Toronto. **Participants:** Chart audit across both practices of 40 randomly selected healthy infants aged 24 to 36 months who had a minimum of four well-baby visits at their clinic since ≤ 2 months of age. Interviews were conducted with a purposive sample of 10 primary care providers from both sites (including MDs, RNs, and NPs) who regularly saw infants and counselled families during well baby visits. **Findings:** Most providers discussed breastfeeding at least until the six-month well-baby visit, and counselled regarding appropriate food choices starting at the four-month well-baby visit. However, few discussed screen time, avoidance of sweetened beverages, and physical activity at any visit. Many interviewees prioritized obesity prevention discussion only if they identified concerns on the child's growth curve. The most common barrier identified for addressing childhood obesity was lack of time, with others being deficient public and provider knowledge. Strategies to overcome these barriers included addressing childhood obesity at the public health level, using a multi-disciplinary approach, and empowering patients by providing resources. **Conclusions:** Our findings demonstrate that despite evidence-based recommendations for obesity prevention in very young children, gaps in practice exist.

716 Dementia Care Training for Family Medicine Residents: The memory clinic experience

Linda Lee*, MD, MClSc (FM), CCFP (COE), FCFP; W. Wayne Weston, MD, CCFP, FCFP; Loretta M. Hillier, MA

Context: Family physicians often find themselves ill-prepared to manage dementia. Primary Care Collaborative Memory Clinics (PCCMCs), which provide comprehensive dementia assessment and management, may provide an optimal learning environment for family medicine residents. **Objective:** To explore residents' and faculty members' perceptions of the impact of PCCMC training experiences on learning and confidence. **Setting:** PCCMCs in Ontario. **Design:** Surveys completed by residents following PCCMC and interviews with faculty members. **Participants:** Ninety-eight family medicine residents (two residency programs) and the seven family physicians who teach them, across seven PCCMCs. **Intervention:** The PCCMC resident training program includes a three-hour online tutorial and two half-days of supervised practical experience. A teaching guide and related materials were developed for faculty. **Outcome measures:** Rating scales (five-point: not at all to extremely) were used to rate the helpfulness of the tutorial, learning resources (brain map, clinical reasoning approach, dementia medication dose titration chart, selected readings) and learning within an interprofessional team. Perceived knowledge, skill acquisition, and confidence were rated using post-pre intervention comparisons. Faculty members were asked questions about their perceptions of the tutorial and PCCMC learning opportunity. **Results:** Mean ratings of helpfulness reflect that the tutorial (M = 4.0), learning resources (M = 3.6 – 4.0) and learning within an interprofessional team (M = 4.2) were very helpful. As a result of this training, the majority of residents reported knowing more about dementia assessment (96 per cent) and management (94 per cent) and being better able and more confident to assess and manage (98 per cent, 97 per cent, and 92 per cent, respectively). Faculty valued the teaching supports received, structured learning approach, and tutorial as significant learning and confidence building opportunities for residents. **Conclusion:** It is critically important to prepare family physicians for optimal dementia care through improvements to training programs aimed at both residents and faculty. PCCMC training provides a significant opportunity for residents to learn about quality dementia care.

717 Introduction of a Multi-disciplinary Program to Deprescribe Sedative Hypnotics

Maria Muraca*, MD, MSc, CCFP; E. Lui, MSc, PharmD; E. Bartlett, MSW, RSW; H. Rambharack, MSW, RSW; N. Maraj, MSW, RSW; Kimberly Wintemute, MD, CCFP

Choosing Wisely Canada has recommended against using benzodiazepines or other sedative hypnotics (SH) in older adults as first choice for insomnia, agitation, or delirium. NYFHT has created a multidisciplinary program to deprescribe SH. Patients were referred to either a pharmacist alone, the Cognitive Behavioural Therapy-Insomnia (CBT-I) program (or an individual social worker for CBT-I), or both. Pharmacists provided an initial assessment, recommendations, and follow up. The CBT-I program ran over seven weeks and was led by a social worker, with a one-hour presentation each from the pharmacist and dietician. The pharmacists evaluated pre- and post-SH use. The CBT-I program evaluated pre- and post-measures for depression (PHQ-9), anxiety (GAD-7), and sleep quality (Insomnia Severity Index; ISI). Preliminary data were assessed over the last 12 months. Among 16 patients who met with the pharmacist, 15 attempted to wean or stop SH; 11 (73 per cent) either reduced their usage (8) or completely abstained (3). Among the 14 patients older than age 65 who attended the CBT-I program, 11 patients (78.5 per cent) reported an improvement in mood (62 per cent decrease in PHQ-9 scores), and 10 patients (71 per cent) reported a reduction in anxiety (54.8 per cent decrease in GAD-7 scores). Using the ISI, 11 patients (78.5 per cent) reported an improvement in sleep quality (55 per cent decrease in ISI score). Interestingly, none of the 16 patients who met with our pharmacist also attended the CBT-I program. Two met with our social worker for individual counselling for insomnia. These resources provided to patients appear to help introduce the idea of deprescribing SH and in turn may reduce their usage. Data measuring potential benefits of the CBT-I program in deprescribing SH are required. We have found this approach to deprescribing SH an innovative and collaborative pathway to address the use of these drugs among older adults in our community, which may ultimately improve patient safety.

718 The Impact of a Rural Site Visit Program on Preceptor and Resident Satisfaction

Danielle O'Keefe*, MD, CCFP; Kristin Harris Walsh, PhD; Marshall Godwin, MD, CCFP, FCFP; James Rourke, MD, CCFP (EM), FCFP; Shannon Fisher, MSc

Introduction: The family medicine residency program at Memorial University of Newfoundland has increased and

extended its rural training in order to meet the Triple C Competency-based curriculum mandate and to accommodate an increase in residency numbers. The program supports rural preceptors and residents by conducting site visits. **Objectives:** To solicit opinions about the role of the site visit, to discover opinions relevant to site visits, to develop a survey based on the results, to administer the survey to preceptors and residents, and to determine satisfaction. **Design and intervention:** A sequential exploratory model was used. Phase 1 involved interviewing site visitors, preceptors, and residents to determine opinions of site visits. A program logic model was developed based on the original program. Phase 2 involved developing the survey and distributing it to rural preceptors and residents. Results were brought to the residency program and the logic model was updated. **Participants:** Rural preceptors and family medicine residents. **Results/findings:** Thirty-one preceptors responded. Preceptors indicated the importance of reviewing educational goals (77.4 per cent), meeting and supporting preceptors (51.6 per cent), addressing concerns (54.8 per cent), and reviewing site infrastructure and resident housing (61.3 per cent). Preceptors suggested having the agenda prior to the visit, including faculty development, reviewing site feedback, having more time, and increasing the frequency of visits as ways to improve. Finding the time and arranging the time were noted as the biggest challenges. Overall, 70.4 per cent of preceptors indicated satisfaction. Thirteen residents completed the survey. All reported satisfaction and they appreciated the opportunity to discuss potential concerns and to review their training. **Conclusions:** The mixed-methods approach enabled preceptors and residents to voice concerns. The program responded to the results by shifting the program structure, reviewing the site visit program, creating means for better communication, and subsequently improving the ability to address the needs of preceptors and residents.

719 Are We Having an Impact? The Toronto International Program In Strengthening Family Medicine and Primary Care (TIP-FM)

Katherine Rouleau*, MD CM, CCFP, MHSc; Paula Godoy-Ruiz, MA, PhD; Jamie Rodas, MPH; Kenneth Yakubu, MD

In the wake of calls by the WHO for countries to organise health systems according to the needs of people and communities, with an emphasis on integrated people-centred primary care (WHO 2008; WHO 2016), countries around the world are striving to strengthen primary health care in their respective jurisdictions. An important element of this thrust is to build capacity in the delivery of primary care including the development of locally congruent models of family medicine. In 2013, the Department of Family & Community Medicine (DFCM) at the University of Toronto launched the Toronto International Program in Strengthening Family Medicine and Primary Care (TIP-FM) with the goal of enhancing leadership capacity in family medicine and primary care globally. TIP-FM is a two-week program, delivered in Toronto, and is aimed at international leaders in policy, academia, or health care delivery who are engaged in strengthening family medicine in their settings. The program has graduated 40 individuals from 11 countries, since 2013. Through a mixed-methods, approach this study examines the quality and impact of TIP-FM on the learners. In the first phase, an online questionnaire is used to assess the program's quality through relevance (did it meet learner needs) and applicability (were learners able to transform knowledge and apply it to their setting). In the second phase, semi-structured interviews are applied to examine the perceived impact of TIP-FM on the learners themselves, their organisations, and/or the communities they serve. This research project contributes to the scholarship on international educational experiences in medicine and fills a gap in literature specifically exploring global health education in family medicine and primary care. This project also informs future research examining the transformative efficacy and models of cultural congruency in international health education.

720 Continuing Professional Development and Self-Directed Learning in a Digital Age: Implications for health professional adult learners

Vernon Curran,PhD; Lisa Fleet, MA; Diana Gustafson, PHd; Lauren Matthews, B.Sc., Mohamed Ravalia, MD, FCFP, Karla Simmons, MA; Pamela Snow*, MD, FCFP; Lyle Wetsch, MBA

Background: Self-directed learning activities are a recognized type of informal adult learning across many CPD systems. Adult learners report a number of barriers to SDL, including concerns with their access to information (i.e.,the Internet) and the ability to use systems effectively to search and locate relevant information. The latter is particularly important given the increasing use of digital technologies such as the Internet and social media. While the use of

social media and mobile technologies in adult learning is growing, its value in supporting life-long learning is not well understood. **Methods:** Scoping review; semi-structured interviews with a purposive sample of health professional adult learners. **Results:** One hundred and thirty (N=125) articles were reviewed in Round 1 of the scoping review. The majority were commentaries (45.6%) or focused on level one satisfaction outcomes (49.6%). Forty-nine percent (50.4%) of the articles focused on the medical profession. Preliminary themes identified include: use of digital, social and mobile technologies as learning tools; key considerations for use; and successes of best practices. NL interview respondents (N=12) identified triggers for SDL (i.e. patients/scope of practice), methods for undertaking SDL (electronic resources/paper-based), and barriers to SDL (time, cost, access) as key themes.
Discussion/Conclusions: There are limited models describing the SDL habits of adult learners in a digital age and there is limited evidence surrounding the use of social media and mobile technologies in mandatory CPD delivery systems. Further, little research has explored the unique contexts of health professional adult learners working in rural and remote areas, their patterns and habits of SDL and the effect of barriers to SDL on feelings of professional isolation. The study findings have implications for informing post-secondary and adult education to improve the SDL skills of adult learners and enhancing CPD systems to better integrate SDL in a digital age.

721 Addressing Primary Health Care Services Gaps for Transition-Aged Youth

Erin Brandon*, MN, RN(EC), NP Pediatrics; Marilyn Ballantyne, PhD, RN(EC); Melanie Penner, MD, PhD; Andrea Lauzon, RN(EC)

Objective: Youth with childhood-onset disabilities experience challenges with accessing age-appropriate primary health care (PHC) services as they transition from pediatric to adult care. As a consequence, these individuals often experience a negative impact on their health with associated social concerns, disease complications, and increased use of emergency services. This is particularly challenging for youth with cerebral palsy (CP) due to the complexity of their medical needs. Furthermore, PHC services are not tailored to support their complex needs. The aim of this study was to gain an understanding of the experiences of youth, parents, and physicians (e.g., PHC physicians and pediatricians) and identify the enablers and barriers of accessing PHC services for transition-aged youth with CP. **Design:** This study used qualitative descriptive methodology to explore the experiences of physicians, young adults with CP GMFCS IV/V, and parents on accessing primary care services as adults. One-on-one interviews were conducted using a semi-structured interview guide. Interviews were audio-recorded and transcribed verbatim. Data were analyzed using content analysis. **Setting and participants:** Study participants were recruited using purposeful sampling. A total sample size of 16 participants; four participants from each group: PHC physicians, pediatricians, parents, and young adults with CP GMFCS IV-V (ages 18 to 35 years) in the Greater Toronto Area (GTA). **Results:** PHC physicians and pediatricians experience multiple barriers from lack of expertise to funding models. Parents and young adults experienced a number of barriers with accessing needed resources, accessibility of services and lack of expertise in disabilities by providers. **Conclusion:** The findings raise awareness of needed improvements in transition services for PHC. Collaborations established with provincial advocacy groups will be leveraged to improve access. The research conducted along with the collaborations of the stakeholders will impact clients and families by helping to improve access to PHC services and ultimately outcomes for transition-aged youth with CP.

722 Incorporating e-Learning in Quality Improvement (QI) Curriculum: Design and development considerations

Patricia O'Brien*, RN; Philip Ellison, MD, MBA, CCFP, FCFP; Brian DaSilva

The decision to incorporate e-learning in the family medicine resident quality improvement (QI) curriculum for 2016–2017 was guided by the knowledge that a successful QI curriculum must be learner-focused, emphasizing application of knowledge. With the goal of improving the QI curriculum learning experience and impact for first year family medicine residents, the opportunity to augment in-class sessions was the reason for considering e-learning at the Department of Family and Community Medicine (DFCM), University of Toronto. The process to incorporate e-learning in the QI curriculum included: reflection on feedback and evaluation from learners; discussion and agreement on requirements with the QI Program Director and the Quality Program Committee; consultation with the DFCM eLearning Design and Development (eDD) Analyst; creation of a timeline, budget, and work plan to frame the design and development period; and evaluation of the design/development process feedback from family medicine resident learners about their e-module experience. This poster will display the QI curricu-

lum design and development process for e-learning elements including the curriculum map and related content details. Lessons learned and reflections from the faculty, residents and staff who participated will be included from the perspective of how the e-learning curriculum elements support the process of learning QI.

723 Celebrating Five Years of Quality Improvement: A descriptive analysis of resident quality improvement projects, 2011 to 2016

Patricia O'Brien*, RN, MScCH; Philip Ellison, MD, MBA, CFPC, FRCP; Lorri Zagar, MSc

Delivering quality improvement (QI) curriculum for first year family medicine residents marked a five year anniversary in June, 2016. To date, more than 490 academic QI projects have been completed by interprofessional primary care teams led by family medicine residents and facilitated by academic site family physician faculty. The QI projects were reviewed in November, 2016, to perform a descriptive analysis of the projects. The analysis included an assessment of the extent to which the QI concepts included in the curriculum have been applied in a methodologically appropriate manner. In support of the analysis, a timeline was developed to highlight internal and external factors relating to the evolving QI landscape such as curriculum redesign, faculty QI capacity building, primary care QI plan requirement and enhanced access to data to support QI activity. The descriptive analysis has provided evidence of the QI curriculum's ability to realize its goal of preparing family medicine residents and interprofessional care team colleagues for practice in an environmental culture of continuous quality improvement and accountability. This curriculum goal has been realized through the use of the behaviours of a reflective practitioner to identify opportunities for improvement in practice environments; the teaching of the knowledge and skills of continuous quality improvement; and the application of learning in a project practicum.

724 The Core of the Patient-centred Medical Home: Vision, mission, and values

Shauna Wilkinson*; Wendy Stefanek, MD, CCFP; Richard Ward, MD, CCFP, FCFP; Chris Bockmuehl, MD, CCFP; Ted Jablonski, MD, CCFP, FCFP; Katharine Johns, MD, CCFP (EM), FCFP; Michelle Klassen, MD, PhD, MCFP; Reid McLean Wiest, MD, CCFP; Karyn Richardson, MD, CCFP; Karen Seigel, MSc, MD, CCFP

At Crowfoot Village Family Practice (CVFP) we recognize that fostering a team-based culture—which includes aligned leadership and commitment to a vision—is at the core of a patient-centred medical home. In 2014, our team came together to review and refine our vision, mission, and values: **Vision:** Optimal health for people and communities; **Mission:** To provide outstanding care in a patient-centred health home; **Values:** Integrity, excellence, relationships, and innovation. Definition and alignment are important but a commitment to the values is crucial to achieving the vision. Our work included implementing tactics that enabled the use of values in our business strategy, goals, behaviour, organizational norms, and decision-making process. This includes communication of real-life values stories, regular internal messaging in our clinic communication platform, and a portable tool that outlines the values-based decision-making process and steps. We will discuss the six-step values-based decision-making process and include examples of its application in daily clinic life. This work has unified our leadership and health team in delivering care. It provides a platform to support creativity, curiosity, innovation, continuous improvement, and demonstrated improved health outcomes: 1. CVFP patients are seen by their family physician 10 per cent less frequently than patients within northwest Calgary*. 2. CVFP patients are seen in specialty care 14 per cent more frequently than patients within northwest Calgary*. 3. CVFP patients are seen in urgent care 12 per cent less frequently than patients of northwest Calgary*. 4. When admitted, CVFP patients' length of stay is 42 per cent shorter than the provincial average*. *Health Quality Council of Alberta

725 Imaging in Low Back Pain: Is the Queen's Family Health Team choosing wisely?

Scott Shallow, MD; Ariel Isackson, MD; Lindsay Bowthorpe*, MD; Humaira Saeed, MD; Katherine Soucie, MD

Objective: Evaluate the adherence to the Choosing Wisely guidelines for imaging in patients with low back pain (LBP) at Queen's Family Health Team (QFHT). **Design:** Quality improvement study: chart review and qualitative surveys. **Setting:** Family Health Team in Kingston, Ontario, with 22 physicians and 50 residents caring for 15,000

patients. **Methods:** Chart review of a random sample of 55 visits where imaging was ordered for LBP between October 1st, 2015, and October 1st, 2016. Qualitative survey was completed by 17 physicians and 42 residents (77 per cent and 84 per cent response rate, respectively). The survey evaluated knowledge of and perceived barriers to following the Choosing Wisely guidelines. **Outcome measurements:** Chart review assessed for red flags (RF) as the indication for imaging LBP. **Primary outcomes:** The presence of RFs, and was the correct imaging modality ordered. Primary outcome measures of the survey: Self-reported rates of ordering imaging in the absence of RF; justification for ordering imaging in the absence of RFs; and perceived barriers to ordering the correct imaging modality. **Findings:** Chart review indicates 62 per cent of imaging requested in this sample was done in the absence of RFs. Furthermore, 45 per cent of the imaging was a suboptimal modality. We found the majority of physicians and residents know the RFs for LBP imaging. However, a significant number did not know that MRI was the preferred imaging modality. Those who ordered imaging in the absence of RFs had difficulties convincing patients imaging was not required. Lastly, barriers existed to providers accessing MRI when RFs were present. **Conclusion:** The QFHT is currently not choosing wisely when it comes to imaging in LBP. Many staff and resident physicians within QFHT continue to order imaging for LBP in the absence of RFs. Barriers and external influences contribute to the lack of adherence to these guidelines.

726 Facilitating Advance Care Planning Discussions in a Primary Care Setting: A quality assurance project

Nisha Arora*, MD; Samantha Reaume, MD, CCFP; Stacey Snider, MD, CCFP, FCFP

Context: Advance care planning (ACP) discussions are significantly beneficial. Patients are more satisfied with their care, are more likely to use hospice services, and have fewer life-sustaining treatments at the end of life. Family members of patients whose treatment is intensified at the end of life tend to have poorer psychological outcomes. Unfortunately, few Canadian patients have discussed their end-of-life wishes with their family physician. **Objective:** Our project aimed to increase the number of patients over the age of 80 at our family health team's clinic (n = 308) with a documented ACP discussion from 10.4 per cent to 30 per cent over a four-month period. **Methods:** We performed four PDSA cycles to test various techniques to improve ACP. We implemented reminders in PSSuite, provided patient education materials, and developed a standardized approach using an ACP Toolbar in PSSuite to document discussions in a manner reflective of the Level of Care forms at the local hospital. A SpeakUp poster was placed in the waiting room. Over the course of four PDSA cycles, the toolbar was modified for ease of use and educational materials were reduced to a booklet. We searched PSSuite to count how many patients over 80 years old have an ACP discussion form completed in their chart. **Results:** Over the four-month period, we increased the number of patients older than 80 years with an ACP discussion to 22.4 per cent, of whom 62 per cent had a completed ACP. **Conclusion:** We were able to use the EMR to facilitate ACP discussions with patients older than 80 years of age. Results may be underestimated, as the initial sample size of 308 patients was not reassessed, while patients deceased, turned 80, or were in nursing home. The primary challenge was having sufficient appointment time to conduct planning discussions. Future directions to overcome these challenges are proposed.

727 Trans-identified Individuals' Experiences in Primary Care

Justin Bell*, MD; Eva Purkey, MD, MPH, CCFP, FCFP

Context: The provision of health care for trans individuals has historically been relegated to specialist clinics in tertiary care centres. Recent provincial health policy changes have shifted significant responsibility to care for these patients to family physicians. This population has well documented mental and physical health disparities when compared to cisgender Canadians, and family physicians need to be prepared to provide for their specific health needs. **Objective:** Explore past experiences and describe the expectations of members of the trans community regarding the delivery of primary care by their family physicians. **Design:** Qualitative phenomenological approach. Semi-structured interviews were recorded, transcribed verbatim, and thematic analysis of transcripts carried out using NVivo by two independent researchers. **Setting:** Urban centre in Kingston, Ontario, with a population of 123,000. **Participants:** Convenience sample of 11 individuals over the age of 18 years who self-identified as trans, recruited through community agencies and family medicine clinics. **Results:** Eleven interviews took place between September and November 2016; five individuals identified as trans men, five as trans women, and one as gender non-conforming. Themes identified included poor physician awareness of trans health needs, physician discomfort

with caring for trans individuals, and interventions needed to improve clinic environments to meet trans needs. The expected role of the family physician for trans patients included hormone assessment and prescription, as well as referrals for gender affirming surgeries. **Conclusions:** The trans community has several physical and mental health needs that are not being met by the current health care system. Family physicians need to be empowered to provide services such as hormone initiation and gender affirming surgery referrals. Although specialists may have a role for some patients, most trans people expect care to be delivered by family physicians whenever possible.

728 Screening for Mental Illness in Cancer Survivors in Primary Care (work in progress)

Mary-Kathryn Blackbyrne*, MB, MSc; Aisha Lofters, MD, PhD, CCFP; Carolina Aguilar, MA, MSc; Donna Manca, MD, MClSc, FCFP

Context: Following the completion of cancer treatment, cancer survivors return to their family doctor for their primary health care. Survivors have a higher prevalence of mental illness compared to the general population. Should family doctors screen this population for poor mental health and if so, how? The National Comprehensive Cancer Network Distress Thermometer (DT), validated in cancer patients and survivors, offers a simple way to quantify the level of distress experienced. Other validated quick screening measures include the two-item Generalized Anxiety Disorder scale (GAD-2) and two-question Patient Health Questionnaire (PHQ-2) for depression. **Objectives:** To examine whether cancer survivors seen in family practice have higher levels of distress, anxiety and depression than the general population and determine factors associated with this. Secondly, to explore the relationship between the DT, GAD-2, and PHQ-2 in survivors and the general population. **Design:** Cross-sectional. **Setting:** Sixteen family medicine clinics in Alberta (8), Ontario (4), and Newfoundland and Labrador (4). Participants: Approximately 1,280 consenting adults aged 40 to 65 years (320 survivors of breast, colorectal, or prostate cancer who are no longer on active treatment, and 960 without those cancers), who have accessible medical records, and are able to attend a prevention visit as part of the BETTER WISE Project (a pragmatic cluster randomized controlled trial). **Intervention:** Self-reported questionnaire, adapted from that used previously in the BETTER and BETTER- 2 Trials. **Main outcome measures:** Positive screen for distress, anxiety, and depression using the DT, GAD-2, and PHQ-9. **Results:** The results will determine whether there are significant differences in levels of distress, anxiety, and depression in cancer survivors versus the general population. We will examine factors associated with these outcomes including socioeconomic, and preventive and comorbid health factors. We will also explore how the DT relates to the GAD-2 and PHQ-2 in both the survivor and general health population.

729 Prevalence of Chronic Pain in High Frequency Users of the Emergency Department

Joshua Burley*, MD; Samantha Biggs, MD; Bayley Ostenfeldt, MPH; Chris Mushquash, MA, PhD, C.Psych; Catherine Smyth, MD, MSc, FRCPC; Yaad Shergill, DC; Patricia Poulin, C.Psych; David Savage, MD, MScF, PhD, CCFP; Bryan MacLeod, MD, CCFP

Objective: The number of visits to emergency departments (ED) across Ontario continues to increase, resulting in long wait times. Many of these patients could be better served in a different setting, as evidenced by the correlation between timely access to a family physician and decreased ED use. In particular, patients with chronic pain are better served outside of the ED. To our knowledge there has been no quantification of the burden of chronic pain in the ED in northern Ontario. **Design:** An audit will be performed of all patients over one fiscal year who meet the local health integration network (LHIN) definition for high-frequency user (HFU) of eight or more visits per year. From this population, 268 charts will be randomly selected for review. Two abstractors will be trained to use a standardized data abstraction tool by the Primary Investigator. Five per cent of the charts will be reviewed by both abstractors in order to calculate inter-rater reliability at two checkpoints—after reviewing 100 charts and at the end of the study. **Setting:** The ED at a single regional tertiary care teaching hospital in northern Ontario, which services more than 100,000 patients per year. **Participants:** A total of 268 patients will be randomly selected from all patients who presented to the ED eight or more times between April 2015 and March 2016.
Main outcome measures: The primary outcome of this study is prevalence of chronic pain in HFUs of the ED. Secondary outcomes will compare HFUs with chronic pain and all other HFUs in such metrics as length of stay and access to a family physician. Also, we will examine the practice pattern relating to opiate prescription in this population. **Results/conclusion:** This study seeks to address gaps in our knowledge of chronic pain in the ED in northern Ontario.

730 Physician Remuneration Systems: Assessment and recommendations for action

Shelly Chopra*, MD, MHA; David Ostrow, MD, FRCPC, MA

Objective: The primary objective of the study was to assess physician remuneration systems—including fee-for-service, salary, capitation, pay-for-performance, and bundled payment—using an evaluative framework focused on cost and quality of care. **Design:** The study consisted of several steps to achieve the intended objective: descriptive data analysis of physician remuneration expenditures and care performance indicators in British Columbia and Canada; evidence-based development and application of an evaluative framework to five selected systems of remuneration; and modelling of costs and outcomes using a case patient. **Findings:** Data from the Canadian Institute for Health Information National Physician Database and National Health Expenditure Trends demonstrated inconsistent performance in care with evidence of increasing physician remuneration costs in British Columbia. The proposed evaluative framework involved assessment of each remuneration system on measures in three categories: a) patient-centredness, defined by accessibility, acceptability, and appropriateness of care; b) physician performance, defined by efficiency, continuity, and complexity of care, and research, education, and innovation; and c) system operation defined by efficiency and administrative resource use. Evidence review supported that bundled payment incentivizes more components of the evaluative framework than the remaining systems studied. Modelling costs and outcomes using a case patient demonstrated differences between primary care and specialist physicians for each remuneration system with the exception of bundled payment, where providers have shared interests in a patient's care cycle. **Conclusion:** Bundled payment is a physician remuneration option that British Columbia and other Canadian provinces should consider to improve the patient experience of care, optimize physician performance, and reduce costs associated with over-service, avoidable complications, and delays in service provision.

731 Exercice physique durant la grossesse : votre médecin de famille vous donne-t-il l'heure juste ?

Catherine Drouin*, MD, PhD ; Stéphanie-May Ruchat, PhD ; Magali Brousseau-Foley, MD, PhD

Malgré les bienfaits reconnus de l'activité physique prénatale sur la santé maternelle et fœtale, et l'existence de recommandations en matière d'activité physique chez la femme enceinte, seulement 15 % des femmes enceintes atteignent le niveau d'activité physique recommandé. En première ligne, le médecin de famille, peu importe son type de pratique, peut donc représenter une source d'information fiable auprès des femmes lors de rencontres pré-conception ou tout au long de la grossesse. Toutefois, est-ce que les médecins de famille émettent des recommandations adéquates à leurs patientes enceintes ? Sur quelles bases fondent-ils leurs recommandations ? Une enquête réalisée auprès des membres de la SOGC en 2015 a conclu que seulement 55,5 % des répondants basaient leurs recommandations sur les lignes directrices actuelles. Il est pertinent de se questionner sur ce qui en est en médecine familiale. À l'aide d'un questionnaire électronique, ce projet de recherche vise donc à dresser le portrait des connaissances des médecins de famille et résidents en médecine familiale du Québec sur les recommandations en matière d'activité physique durant la grossesse. Les résultats auront une portée clinique indéniable puisqu'ils permettront d'identifier les besoins en formation des médecins de famille en matière d'activité physique pendant la grossesse. Il sera alors possible de cibler les documents devant faire l'objet d'une plus grande diffusion (résumé des lignes directrices canadiennes, outil X-AAP). Selon les résultats, des recommandations sur la formation durant la résidence ou en cours de pratique pourront être formulées.

732 Development of a Medical Abortion Service at an Academic Family Medicine Team (work in progress)

Inna Genkin*, MD; Sheila Dunn, MD, MSc, CCFP (EM), FCFP ; Yee Lee, RN; Jordana Sheps MD, CCFP; Melissa de Souza, MD, CCFP; Jessica Bawden, NP

Background: Approximately one-third of Canadian women seek abortion care during their lifetime. The recent approval of mifepristone in Canada presents an opportunity for primary care practitioners to extend their reproductive health services to include medical abortion care. There is an association between reproductive health training during residency and subsequent intention to provide services. **Objective:** To develop a medical abortion service at Women's College Hospital Family Practice Health Centre (WCH-FPHC), in order to meet patient needs and expose resident physicians to medical abortion care. **Setting:** Based on the practice demographics of WCH-FPHC—an academic family health team in Toronto, Ontario—and Canadian abortion rates, an estimated 70 pa-

tients per year have therapeutic abortions. **Design:** Since January 2017, a multidisciplinary working group, led by a second-year resident and an experienced medical abortion provider, has met monthly to develop a care pathway and resources. The team developed a care pathway so that all primary care providers could screen for eligibility, provide preliminary counselling, and work-up women seeking medical abortion. Ten physicians and three nurses completed the Medical Abortion Training Program, which is required to prescribe mifepristone. Subsequently, patients would be seen by a Medical Abortion Trained provider for further counselling and mifepristone prescription. Informational resources for patients, informed consent form, procedure checklist, and follow-up forms were developed for inclusion into the electronic medical record. A system for emergency on-call phone access was developed. Residents will complete the Medical Abortion Training Program during an academic teaching day and integrate it into the care process. **Main outcome measures:** Number of medical abortions, number of residents with clinical exposure, and an assessment of residents' intention to provide medical abortion care in their practice will be considered as process outcomes. **Results:** Preliminary results will be reported after a six-month implementation of the medical abortion service.

733 Exploring the Trends and Impact of Clinic Non-Attendance (No-shows) at a Canadian Academic Family Medicine Clinic

Robert Weitemeyer; Jade Goliath*; William Baldwin; Sarah Liskowich, MD, CCFP; Kelechi Eguzo, MD, MPH

In the Canadian health care system, issues about resource allocation, efficiency, and wait times attract a attention because improvements in these areas result in better health for all. A significant feature of waste in the system is underutilization due to missed appointments, known colloquially as no-shows. Patients who miss primary care appointments have been shown to attend emergency departments and be hospitalized more frequently. This has implications for both patient safety and health care resources. Research from a universal health care system in the United Kingdom, which is similar to the Canadian model, has shown a primary care no-show rate of about seven per cent. A variety of interventions have been proposed to minimize the impact of missed appointments. The choice to invest in any intervention would be based on the missed appointment rate having significance to justify the spending. To provide guidance we performed a cross-sectional, sequential mixed methods study of a primary care clinic. Quantitative data were collected from established electronic medical records on clinic appointment use between January 1, 2014, and January 1, 2017. The data analyzed include: demographics (age, sex, three-digit postal code, existing chronic condition), date of missed appointment, duration from booking to appointment, and provider with whom appointment was made (resident, attending, nurse/nurse practitioner).

734 Queen's Family Medicine Resident Teaching Nights (FM-RTNs)

Paige Hacking, MD

Objective: The Queen's Family Medicine Resident Teaching Night (FM-RTN) project has the following objectives: (1) enhance medical students' interests in family medicine; (2) help students develop approaches to common presentations; (3) provide a unique opportunity for students to interact with and develop mentorships with residents; and (4) provide valuable teaching opportunities for family medicine residents. **Design:** Residents invited students to attend sessions, where residents led students through small group case-based discussions and mentorship topics. Anonymous pre- and post-session evaluations were collected from participants. Themes were identified from the survey data for program evaluation using Likert-scale response analysis and constant comparison methodology. **Setting:** Four FM-RTN sessions were held during 2016 at Queen's Department of Family Medicine. **Participants:** A total of 99 non-unique first- and second-year medical students and 27 non-unique family medicine residents attended the sessions on a self-selection basis. **Main outcome measures:** General outcome measures studied included the residents' interests in teaching, students' interests in family medicine, multiple session attendance, level of participant satisfaction with the program, and factors contributing to participant satisfaction. **Findings:** Overall, 100 per cent of residents agreed that Queen's FM-RTNs are an effective venue for developing their teaching skills and were interested in attending another session with a post-session response rate of 95 per cent. As for the students, 100 per cent agreed that family medicine residents are effect teachers and 90 per cent were interested in attending another session with a 62 per cent post-session survey response rate. **Conclusion:** Queen's FM-RTN pilot project is an effective venue for residents to experiment with their teaching styles, students

to learn approaches to useful presentations and gain insight into the profession, and learners interested in family medicine to interact in a meaningful way via a peer network mentorship model. These findings provide strong support for further development of this project and translation into other specialties.

735 Use of Video Conferencing for Clinical Encounters With Patients in an Academic Family Practice

Jatin Kaicker*, MD, CCFP; Shahrose Malik, MD, CCFP; Gina Agarwal, MD, CCFP

Introduction: Telemedicine is exchanging medical information through video conferencing to improve patients' health. It can be used as an adjunct to clinic visits for select primary care patients. The objective of this study was to assess clinicians'/residents' understanding of telemedicine, patient suitability, platform selection, and integration into the clinical workday. Our pilot project assessed patient understanding of telemedicine before and after an online clinical encounter. **Methods:** Twenty-one clinicians/residents at McMaster Family Practice were surveyed about their understanding of telemedicine and its suitability for integration at an academic practice. Ten patients over age 18 with mobility difficulties were recruited into an observational, prospective survey investigation. A pre- and post-intervention survey was administered about understanding and comfort with video conferencing and perceived benefits and/or drawbacks. After a short video encounter using the TeamViewer platform, a post-intervention survey was administered. **Results:** Most residents/clinicians felt video conferencing encounters would be useful, especially for patients with mobility difficulties. There was a lack of consensus about the time of day to use the technology. Pre- and post-intervention surveys revealed improvement in patients' understanding of telemedicine, belief it would not deter from effective clinical care, acknowledgement of the importance of privacy/confidentiality, and a consensus that it would save time/money. **Conclusion:** Clinicians agree that a select group of patients would benefit from telemedicine with appropriate platform selection. However, there was a lack of consensus about the time of day to use the technology. Patient responses demonstrated excitement about telemedicine, comfort discussing sensitive issues, and improvement in knowledge/understanding about the use of telemedicine after our clinical video encounters.

736 Deprescribing Benzodiazepines in Patients Aged 65 Years and Older Within an Academic Family Health Team

Stephanie Klein*, MD; Dana Mayer, MD; Kimberly Wintemute, MD, CCFP, FCFP

Background: Older adults on benzodiazepines have an increased risk of falls, cognitive impairment, and motor vehicle accidents, which is costly to the patient, society, and health care system. Emerging evidence shows that education empowers patients to reduce these medications. **Objective:** To reduce the benzodiazepine dose in 10 per cent of patients aged 65 years and older within a family health team. **Design:** This quality improvement project began with a targeted EMR search and chart review to identify eligible patients. A multiprofessional team was educated on benzodiazepine harms and tapering regimen. Patient interventions included phone call counselling, clinic visits to review the Tanenbaum patient education empowerment handout, pharmacist consultation, and social work-led cognitive behavioural therapy for insomnia (CBTi). **Setting:** Four practices within the North York Family Health Team. **Inclusion criteria:** Adults aged 65 years and older, on benzodiazepines for more than three months. **Exclusion criteria:** Benzodiazepine use for medical issues other than insomnia or anxiety. **Quality measures:** Safety, patient-centredness, effectiveness. **Main outcomes:** Percentage of patients who discontinue or reduce their dose of benzodiazepines, resources, and iterations required to deprescribe benzodiazepines. **Results to date:** The initial EMR search identified 93 patients aged 65 years and older with a benzodiazepine listed in their chart. After chart review, 24 patients were eligible for the study. Seventeen patients received a phone call inviting them to discuss the benzodiazepine deprescribing tool in clinic, and seven patients were counselled at their next visit. Eighteen patients reviewed the deprescribing tool and were interested in deprescribing. Three patients engaged in pharmacist-led tapering, two patients saw a social worker, and five were referred for CBTi. **Conclusion:** Preliminary data suggest that a multiprofessional team in combination with a deprescribing empowerment tool encourages patient willingness to deprescribe. Future steps include follow-up and additional counselling to determine how many patients were successful in reducing benzodiazepine use.

737 Improving Smoking Cessation Program Referral Rates by Residents at Health For All's Family Health Team

Elbert Manalo* MD, MSc; Ehsan Samiee MD; Yali Gao; Zhanying Shi; Caroline Jackson;

Karuna Gupta, MD, CCFP, ABFP

Objective: To determine whether health care professionals using EMR stamp/custom forms when trying to assess patients' readiness for smoking cessation can improve referral rates to smoking cessation programs at family health teams (FHTs). **Design:** Quality improvement model using Plan-Do-Study-Act (PDSA) cycles. The first PDSA cycle examined the current smoking status documentation rate in the FHT's EMR. The second cycle involved creating the Smoking Cessation Readiness Assessment EMR custom form. The third cycle increased awareness of the custom form through a reminder graphic placed on all FHT computer desktop wallpaper backgrounds. The fourth PDSA cycle educated residents about how to use the custom form. **Setting:** Health for All Family Health Team. **Participants:** Family medicine residents. **Intervention:** Use of EMR stamp/custom form, Smoking Cessation Readiness Assessment. **Outcome measures:** Number of referrals to a smoking cessation program and smoking status documentation rate. **Process measures:** Number of Smoking Cessation Readiness Assessment EMR custom forms. **Results/findings:** There was a 40 per cent increase in the number of successful referrals to the smoking cessation program in the two months after implementation of the Smoking Cessation Readiness Assessment EMR custom form (seven referrals) compared to the two months preceding (five referrals). The smoking status documentation rate for Health for All FHT was 77.4 per cent. The Smoking Cessation Readiness Assessment EMR custom form was used a total of six times in the two months after its implementation. **Conclusion:** Using EMR stamps/custom forms to guide health care professionals' assessments of smokers' readiness to quit smoking can lead to an increase in the number of referrals to smoking cessation programs and subsequently an improvement in smoking cessation.

738 Referrals to the Emergency Department From the Outpatient Setting (work in progress)

Sarah Nitoslawski*, MD CM; Audrey Marcotte; Keith Todd, MD, PhD

Objective: To perform a qualitative analysis of outpatient clinic (Herzl and CRIU) referrals to the emergency department (ED), looking at reasons for referral and ED outcomes. **Design:** Using EMR tracking of emergency consultations, we will identify patients who have been referred to the ED from outpatient clinics. These patients' medical records will be reviewed and sorted by chief complaint. Then we will review charts in order to determine the ED outcome. **Participants:** Chart review of 756 patients who were referred to the ED from the outpatient setting (walk-in clinic or family medicine clinic) in a 12-month span. **Study limitations:** There is a possibility that consults made to the ED using freehand typing into the consultation box may not be able to be read via our EMR system of consultation tracking, leading to missed referrals. **Expected outcome:** The findings of this study have the potential to provide insight into why these ED referrals are made, and may lead to cost-saving measures and more efficient patient care. Hopefully, we may be able to implement strategies to avoid ED consultation: for example, faster access to specialist outpatient clinics or radiology. **Results:** Thus far, we have noted multiple referrals that could have been managed in the outpatient setting. We will provide these as case examples, and provide the appropriate resource options to avoid unnecessary ED referrals. **Conclusion:** Primary care physicians occasionally refer to the ED for various reasons, which range from need for rapid access to imaging to need for rapid specialist consultation. However, there are tools and strategies that may be implemented to facilitate the outpatient management of certain patient presentations in order to avoid ED referral and therefore ED overcrowding.

739 Family Medicine Residents' Personal Health Practices: What are the barriers, and how does this affect patient care?

Esther Rosenthal*, MD; Paul Das, MD, CCFP (EM), MSc; Charlie Guiang, MD, CCFP

Research shows that residents leading healthy lifestyles are less likely to experience burnout and more likely to counsel patients on these behaviours. This study aims to determine what proportion of University of Toronto family medicine residents achieve the Canadian recommendations for aerobic exercise, muscle and bone strengthening activities, nutrition, low-risk alcohol limits, and sleep. It also examines the relationship between residents' habits and their likelihood to counsel patients. Furthermore, this study aims to identify common barriers for residents to have healthy lifestyles as well as ways that the residency program could help encourage these wellness recommendations. A quantitative and qualitative survey was sent electronically through the listserv to all University

of Toronto family medicine residents. Descriptive statistics as well as chi-squared tests were used. Qualitative results regarding barriers and suggestions for residency programs to address these barriers were obtained. Results revealed that 21 percent of residents achieved Canadian recommendations for cardiovascular exercise, while between 2.8 and 61.2 percent met recommendations for each of the Canada Food Guide food groups. More than half (58.2 percent) of residents reported sleeping for an adequate number of hours per night. Residents who were under Canada's low-risk alcohol weekly and daily maximum guidelines and did not report themselves as binge drinkers were found to be significantly more likely to counsel patients on alcohol consumption than residents who were above the guidelines or reported binge drinking. Many residents identified a lack of time and control over their schedule as barriers, and believed that the program could help improve these outcomes. We suggest that programs could help residents improve their lifestyle by providing healthier food options at hospitals, dedicated time for exercise and grocery shopping, and education on alcohol and healthy behaviours, with the ultimate goals of preventing burnout and encouraging patient counselling on these important topics.

741 Willowbridge Transitional Housing Life Skills Sessions: A reflective educational experience

Aaron Sobkowicz*, MD; Timothy Walters, MD; Henry Gerelle, MD

Objectives: To take part in a community-based learning experience and examine the benefits of such on both the student learners and session participants. **Design:** As part of the University of British Columbia MD Doctor Patient and Society course, three medical students engaged in a community service learning opportunity at Willowbridge Transitional Housing. A literature review was conducted to determine the potential benefits to participants engaging in life skills sessions. Based on this review, the students designed and facilitated weekly life skills sessions from fall 2014 to spring 2015, focusing on topics requested by the group participants. Following each session, the students spent time reflecting on how their experiential learning opportunity affected their preparation for medical practice. **Setting:** Willowbridge Transitional Housing is a facility run by the Canadian Mental Health Association to help individuals recently affected by homelessness transition into independent living. **Participants:** Six to eight residents of Willowbridge that voluntarily attended the weekly sessions, all of whom had recently been homeless and many who had experience with mental health and addictions issues. **Results:** Benefits to participants included learning about basic life skills important for independent living, establishing healthy interpersonal relationships, and having positive interactions with future health care professionals—potentially reducing future hesitancy in accessing health care. Benefits to student facilitators included valuable insight into many issues faced by the homeless, an opportunity to face and dispel biases, and garner a better understanding of the advocacy needs of a marginalized population. **Conclusion:** Community service learning can be an excellent opportunity for students to engage in their local community, confront their biases, and make a practical difference in the lives of marginalized populations.

742 Do Primary Care Physicians Adhere to Physical Activity Guidelines for Patients with Diabetes?

Annie St-Yves*, MD, MSc; David Grenier, MD; Isabelle Germain, MD; Tatiana Sirbu, MD; Irvin Klibansky Revilla, MD; Stéphane Turcotte, MSc; Hubert Robitaille, PhD; France Légaré, MD, PhD, CCFP, FCFP

Objective: To assess family physicians' adherence to the Canadian Diabetes Association (CDA) clinical practice guidelines with regards to physical activity for patients with type 2 diabetes mellitus (T2DM). **Design:** We conducted a retrospective audit and feedback study. **Setting:** One family medicine teaching unit (FMTU). **Participants:** Using electronic medical files, we identified patients ages 50 to 69 years with glycated hemoglobin (HbA1c) $\geq$ 6 per cent between July 1st, 2015 and June 30th, 2016. **Exclusion criteria:** HbA1c value assessed for reason other than office follow-up, absence of T2DM diagnosis, and absolute contraindication for physical activity. We randomly selected 42 files and 39 were included. Mean age was 61 $\pm$ 5.3 years and mean HbA1c was 7.6 $\pm$ 1.2 per cent. **Main outcome measures:** Adherence to the CDA clinical practice guidelines for physical activity were divided into three recommendations for audit and feedback: 1) assessment of patient's physical activity level (active/sedentary) by physician (yes/no); 2) physical activity counselling (yes/no); and 3) referral to another professional (yes/no for nurse, exercise specialist, and/or dietician). Physicians' adherence to at least one of the recommendations was considered acceptable. **Results:** One-third of the participants were considered sedentary. Seventy-five percent were followed by physicians while the others were followed by family medicine residents. Family physicians ad-

herence to CDA guidelines on physical activity was as follows: 1) 77 per cent assessed physical activity; 2) 67 per cent counselled physical activity; and 3) 85 per cent referred to another professional. Overall, physicians adhered to all recommendations in 23 per cent of cases and adhered to at least one of the three recommendations in 85 per cent of cases. **Conclusion:** Although limited by a small sample in one FMTU, our results suggest adequate or acceptable adherence by family physicians to the CDA clinical practice guidelines with regards to physical activity for T2DM patients. However, it is not clear if this is sufficient for improving patient outcomes.

743 Améliorer la gestion des laboratoires en GMF-U : Repenser les soins en partenariat avec les patients

Marie-Pierre Codsi*, MD, MSc (en voie de complétion); Antoine Boivin, MD, PhD; Philippe Karazivan, MD, MSc; Ghislaine Rouly, patiente-partenaire

Cette année, l'UMF Notre-Dame a décidé de se lancer dans un projet innovant de co-construction en partenariat de soins et services sociaux afin de travailler sur l'amélioration de l'expérience des patients au sein de la clinique. Ce projet pilote unique de co-construction interdisciplinaire et en partenariat avec les patients débutera à l'UMF Notre-Dame (unité d'enseignement de médecine familiale) cette année. Il s'agit d'un projet novateur qui visera à implanter un comité d'amélioration continue interdisciplinaire incluant, pour la première fois, des patients-partenaires. Ce nouveau comité d'amélioration continue se penchera sur les problématiques entourant le contexte de la « péri-consultation ». Plus particulièrement, comme premier mandat, le comité travaillera à l'amélioration de la gestion des tests et des laboratoires au sein des GMF-U (Groupes de médecine familiale et unités d'enseignement). En effet, actuellement, comme dans la plupart des cliniques au Québec, les patients ne sont pas informés de façon systématique des résultats de leurs tests, particulièrement lorsque ceux-ci s'avèrent normaux. Ceci crée, entre autres, des préoccupations et des sentiments d'inquiétude chez les patients. En plus de représenter un risque d'erreur médicale plus élevé, cette réalité ne soutient pas une vision centrée sur le patient. C'est pourquoi la clinique Notre-Dame, déjà reconnue comme un leader en matière de collaboration interdisciplinaire et pour ses innovations dans le domaine de l'enseignement en médecine familiale, a décidé d'en faire le premier projet de son nouveau comité. Celui-ci sera formé de différents professionnels de la santé (médecin, infirmier(ère), secrétaire, résident, pharmacien, etc.), ainsi que de patients-partenaires recrutés à même la clinique Notre-Dame. Ce projet sera une expérience exceptionnelle de co-construction et de collaboration interdisciplinaire en partenariat avec les patients.

744 Coordinating Care for Adults With Developmental Disabilities and Complex Health (work in progress)

Meg Gemmill*, MD, CCFP; Ian Casson, MD, MSc, FCFP; Elizabeth Grier, MD, CCFP; Mary Martin, MSc; Janet Durbin, PhD; Yona Lunsky, PhD, C.Psych

Objectives: People with intellectual/developmental disabilities (IDD) are a complex population that would benefit from improved coordination across health and social care sectors. This pilot introduces a novel, enhanced model of care coordination that is patient-centred to improve outcomes for complex patients with IDD in our region. To better inform the implementation, a midway analysis examines baseline participant data to better understand their challenges and ensure the target population is being reached. **Design:** Analysis of pre-intervention health care satisfaction surveys with primary caregivers (family or professional) using descriptive statistics, qualitative analysis (using NVivo) of pre-intervention interviews with patients, and 12-month retrospective hospital and primary care chart review. **Setting:** The Kingston Health Link, an organization embedded in primary care and located in the South-East Local Health Integration Network (LHIN) in Kingston, Ontario. **Participants:** Primary caregivers of (up to) 30 adults (age 18 years and older) with IDD and complex health (i.e., multiple conditions, frequent hospital/emergency department use) as well as patient participants with the ability to recall and verbally recount details of past health care experiences. **Instrument:** Survey tool consisting of 26 questions modified from validated Canadian health care satisfaction surveys and tested for face validity prior to administration. Additionally, patient charts at two local hospitals and the patient's primary care home. **Main outcome measures:** Participant characteristics, past service use, satisfaction with past health care experiences. **Results:** Data collection in progress. Patient profiles are consistent with aim of intervention to treat more medically complex individuals. However, patient participation is lower than expected, so a review of the recruitment process in ongoing. **Conclusion:** The ultimate goal of the intervention is to deliver coordinated, patient-centred care to vulnerable and complex patients in keeping with the

Four Principles of Family Medicine as outlined by the CFPC. This midway analysis will ensure the target population is being reached and help inform study completion.

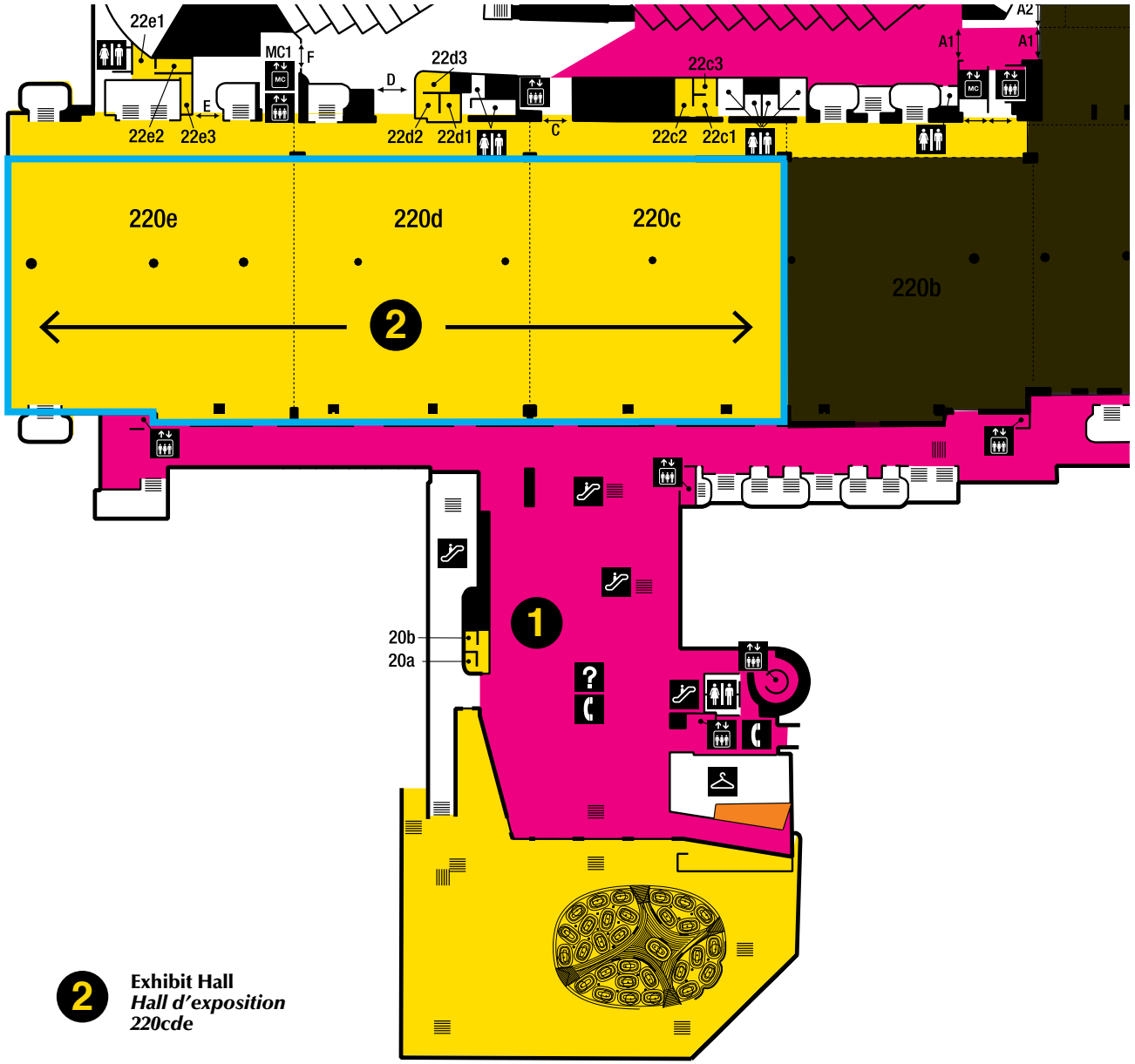
JANUS CPD POSTERS / AFFICHES JANUS DPC
NOVEMBER 10 NOVEMBRE

745 **Simulation-based Training for Family Physician to Increase Preparedness in Managing Medical Emergencies**
Rajani Vairavanathan, MD, CCFP (EM)

746 **Microprogramme universitaire de deuxième cycle de soins palliatifs et de fin de vie**
Stéfane Gaudry, MD, CCMF

747 **Intégration de concepts reliés à la responsabilité sociale des médecins : formation des étudiants et des professeurs**
Eric Lachance, MD, CCMF

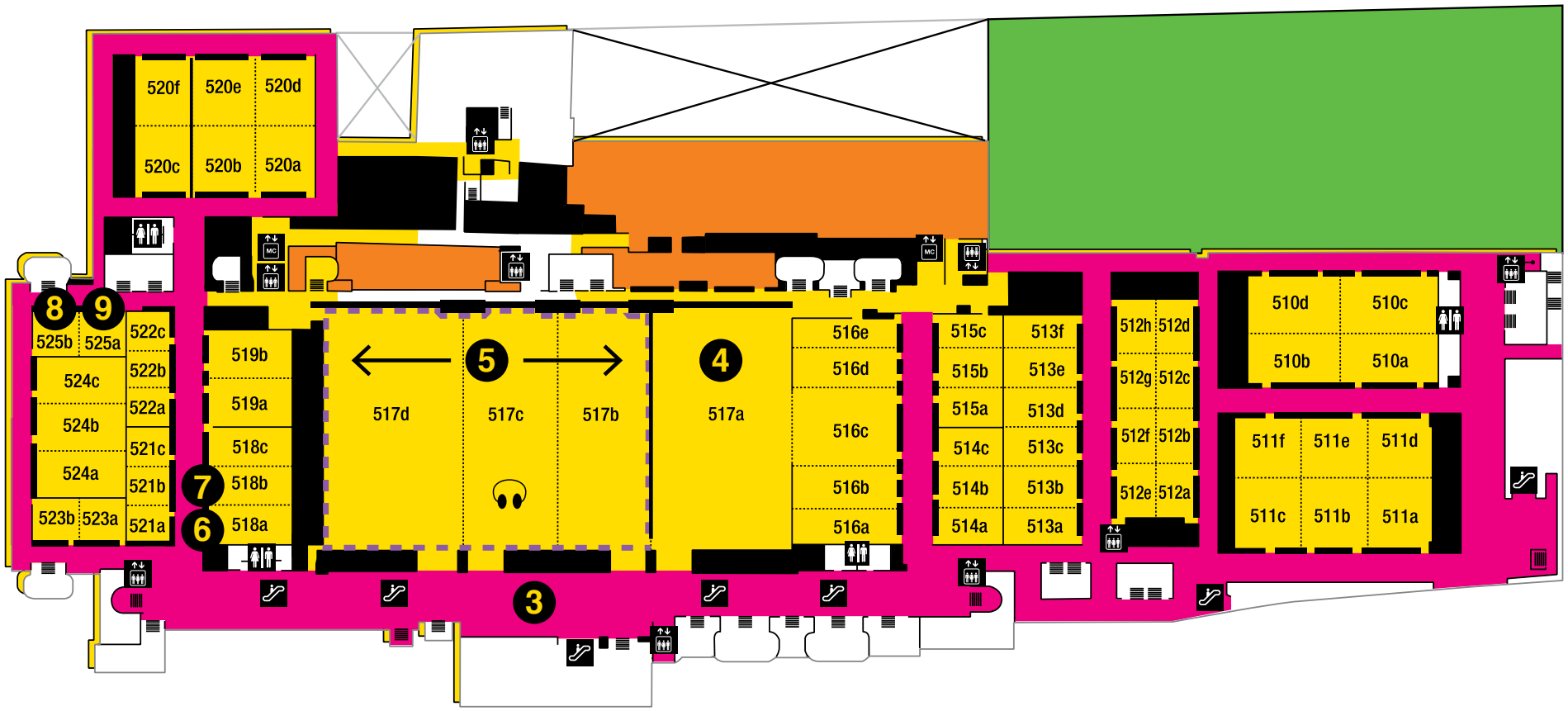
Level 2 Viger Foyer / Foyer Viger - niveau 2



1 **Registration**
Inscription
Information
Information

2 **Exhibit Hall**
Hall d'exposition
220cde

Level 5 Foyer / Foyer - niveau 5



3 **Scientific Posters -** Wednesday, Thursday, Friday
FMF Celebration - Saturday
***Affiches scientifiques* -** mercredi, jeudi, vendredi
***Célébration du FMF* -** samedi

4 **Teachers and Preceptors Knowledge Café / Lunch -** Wednesday
***Déjeuner des enseignants et des superviseurs au Café du savoir* -** mercredi

Ancillary Session - Thursday
***Séance auxiliaire* -** jeudi

FMF Welcome Reception - Thursday
***Réception d'accueil au FMF* -** jeudi

First Five Years in Family Practice Luncheon - Friday
***Déjeuner pour les médecins de famille dans les cinq premières années de pratique* -** vendredi

Convocation Photography, Gowning and Gown Pickup - Saturday
***Cueillette de la toge pour la collation des grades et photographie* -** samedi

Convocation Marshalling - Saturday
***Défilé de la collation des grades* -** samedi

5 **Family Medicine Plenary -** Thursday
***Plénière en médecine familiale* -** jeudi

Keynote Address and President's Installation - Friday
***Discours d'ouverture et installation du président* -** vendredi

Convocation Ceremony - Saturday
***Collation des grades* -** samedi

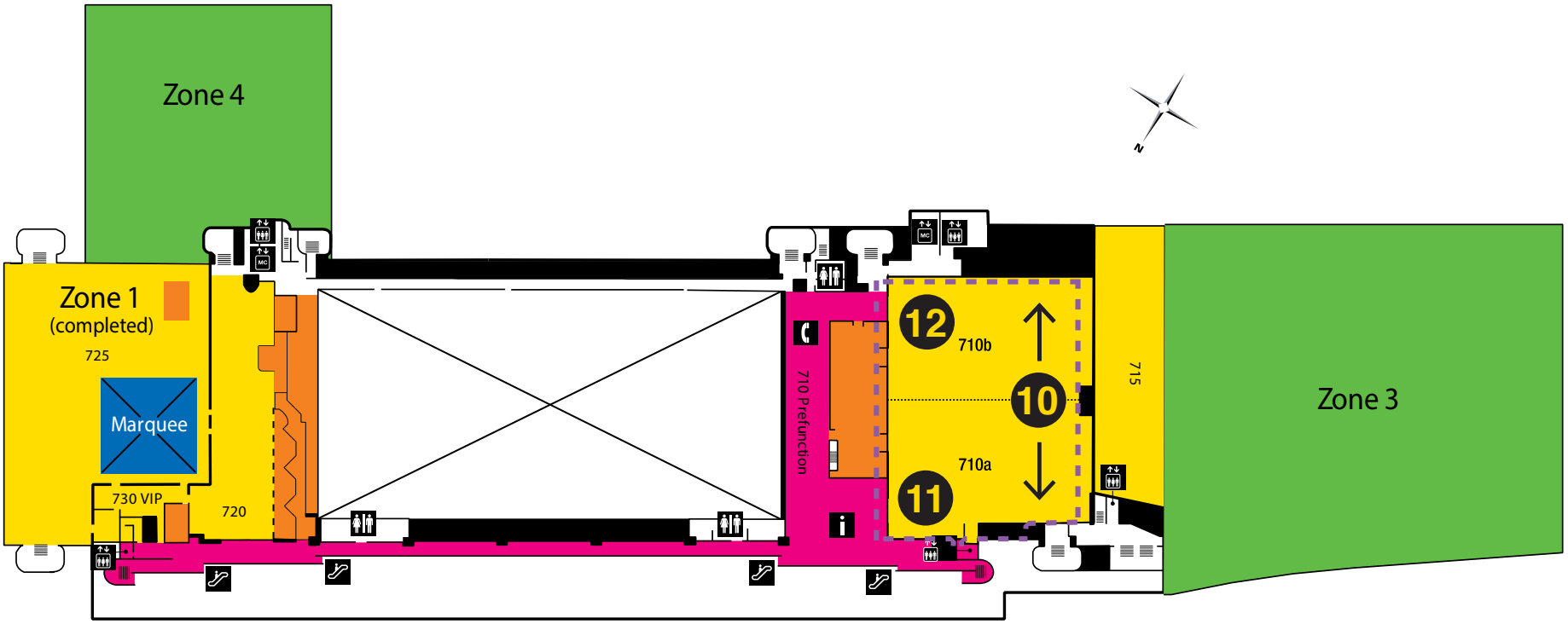
6 **Speakers' Room**
Salle des conférenciers 518a

7 **Media Centre**
Centre des médias 518b

8 **Nursing Room for Mothers & Babies**
Salon d'allaitement.
Réservé aux mères et enfants 525a

9 **Prayer Room**
Salle de prière 525b

Level 7 / Niveau 7



10

Dr. Ian McWhinney Keynote Address - Wednesday
Discours d'ouverture Dr Ian McWhinney - mercredi

Section of Researchers Business Meeting / Lunch - Wednesday
Déjeuner et réunion de la Section des chercheurs - mercredi

11

Ancillary Session - Friday
Séance auxiliaire - vendredi

Medical Student and Family Medicine Resident Networking Luncheon - Saturday
Déjeuner de réseautage des étudiants et des résidents en médecine familiale - samedi

12

CFPC Annual Meeting of Members - Thursday
Assemblée annuelle des membres du CMFC - jeudi

Ancillary Session - Thursday
Séance auxiliaire - jeudi

Teachers and Preceptors Town Hall - Friday
Assemblée générale des enseignants et superviseurs - vendredi

Photography

The College of Family Physicians of Canada (CFPC) will arrange to have professional photography and video footage taken during Family Medicine Forum (FMF). Please be advised that these materials may be published in CFPC materials in print and electronic format, including on the CFPC and FMF websites. By participating in FMF, you agree to:

- Grant the CFPC the right and permission to use any such photographs/video clips in which you may be included, in whole or in part, for such purposes
- Waive any right that you may have to inspect and/or approve any such photographs/video clips
- Transfer to the CFPC any right you may have to such photographs/video clips and waive moral rights, if any
- Release and discharge the CFPC from any liability that may arise from the use of such photographs/video clips by the CFPC

All photographic materials become the property of the CFPC and may be displayed, distributed, or used by the CFPC for any purpose. Names and/or brief bios would be included with permission.

Photographie

Le Collège des médecins de famille du Canada (CMFC) prendra les dispositions nécessaires pour que des photos professionnelles soient prises et qu'une séquence vidéo soit tournée pendant le Forum en médecine familiale (FMF). Veuillez noter qu'il se peut que ce matériel soit publié dans les documents du CMFC en formats papier et électronique, notamment sur les sites Web du CMFC et du FMF.
En participant au FMF, vous :

- accordez au CMFC le droit et la permission d'utiliser, pour les fins susmentionnées, les photographies et les bandes vidéo dans lesquelles vous pourriez figurer, en tout ou en partie ;
- renoncez à tout droit que vous pourriez avoir d'inspecter ou d'approuver ces photographies ou bandes vidéo ;
- transférez au CMFC tout droit que vous pourriez avoir sur ces photographies ou ces bandes vidéo et renoncez à tous droits moraux, le cas échéant ;
- dégagez le CMFC de toute responsabilité pouvant découler de l'utilisation de ces photographies ou de ces bandes vidéo par celui-ci.

Tous les documents photographiques deviennent la propriété du CMFC et peuvent être présentés, distribués ou utilisés par le CMFC à quelque fin que ce soit.
Les biographies et/ou les noms sont inclus avec la permission des personnes concernées.

OTHER MEETINGS (by invitation only)
AUTRES RÉUNIONS (sur invitation seulement)

Monday, November 6 / Lundi 6 novembre		
CFPC Board of Directors Meeting	InterContinental | Sherwood	08:00–12:00
Chapter Elected Leaders Meeting	InterContinental | W. Wilcom	08:00–12:00
Chapter Administrators and Executive Directors Meeting	InterContinental | Fraser	08:00–12:00
Chapter Symposium	InterContinental | Ravel	13:00–16:00
Tuesday, November 7 / Mardi 7 novembre		
Chapter Symposium Meeting	InterContinental | Ravel	09:00–16:00
Wednesday, November 8 / Mercredi 8 novembre		
Family Medicine National Education Administrators (FMNEA) Meeting	Hyatt Regency | Ovation	09:00–17:30
Accreditation Chairs Meeting	Hyatt Regency | Symphonie 4	15:30–17:00
Thursday, November 9 / Jeudi 9 novembre		
Enhanced Skills Program Directors Meeting	Hyatt Regency | Symphonie 4	10:00–17:30
Undergraduate Directors' Meeting - (CUFMED)	Hyatt Regency | Ovation	10:00–17:30
McMaster Family Medicine 50th Anniversary Reception (by invitation only)	Palais des congrès | 700 Foyer	17:30–18:30
Alberta House Reception (U of A, U of C, ACFP) (by invitation only)	Palais des congrès | 700 Foyer	17:30–19:00
Friday, November 10 / Vendredi 10 novembre		
Academic Coordinators Meeting	Hyatt Regency | Symphonie 2	10:00–12:00
Emergency Medicine Directors Meeting	Hyatt Regency | Symphonie 4	09:00–12:00
Health Professionals Educators Network (HPEN) Meeting	Hyatt Regency | Symphonie 2	13:30–17:30
WONCA North America Meeting and Lunch	Palais des congrès | 513CD	12:30–13:30
Board and Partner Organization Meeting	Palais des congrès | 513AB	13:45–16:30
In-training Evaluation Directors Meeting	Hyatt Regency | Ovation	13:30–17:30
Northern Ontario School of Medicine (NOSM) Reception (by invitation only)	Palais des congrès | 700 Foyer	17:30–19:30
University of Ottawa Reception (by invitation only)	Palais des congrès | 510-511 Foyer	17:30–19:30
Newfoundland Chapter Reception (by invitation only)	Hyatt Regency | Imagination	17:00–18:00
Saturday, November 11 / Samedi 11 novembre		
AACFM (Chairs)	Hyatt Regency | Symphonie 4	08:00–15:00
Faculty Development Interest Group (FDIG)	Hyatt Regency | Symphonie 4	13:30–17:30
FM Program Directors	Hyatt Regency | Ovation	08:00–15:00
Section of Medical Students (SOMS) Meeting	Palais des congrès | 513AB	09:30–17:00
Sunday, November 12 / Dimanche 12 novembre		
Presidents' Breakfast	InterContinental | Sherwood/Stratton	08:00–10:00

You're invited...
Vous êtes invité...

★ ★ ★ ★ ★

SECTION OF RESEARCHERS DINNER | SOUPER DE LA SECTION DES CHERCHEURS
Wednesday | Mercredi | InterContinental Montréal | $125

Celebrate achievements
Célébrez les réalisations

★ ★ ★ ★ ★

FMF WELCOME RECEPTION | RÉCEPTION D'ACCUEIL AU FMF
Thursday | Jeudi | Palais des congrès de Montréal | Complimentary | Gratuit

Connect with colleagues and friends
Renouez avec vos collègues et vos amis

★ ★ ★ ★ ★

SECTION OF TEACHERS DINNER | SOUPER DE LA SECTION DES ENSEIGNANTS
Thursday | Jeudi | Le Westin Montréal | $125

Represent your school proudly!
Affichez fièrement les couleurs de votre université !

CFPC AWARDS GALA | GALA DE REMISE DES PRIX DU CMFC
Friday | Vendredi | Hyatt Regency Montréal | $150

Raise your glass to recognize the best of the best

Levons nos verres à la santé de la crème de la crème

STUDENT AND RESIDENT SOCIAL EVENING
SOIRÉE SOCIALE DES ÉTUDIANTS ET DES RÉSIDENTS
Saturday | Samedi | Forum de Montréal | $65

Bowling, billiards, and sports– something fun for everyone!

Quilles, billard et sports – il y en a pour tous les goûts !

CONVOCATION CEREMONY | COLLATION DES GRADES
Saturday | Samedi | Palais des congrès de Montréal | Complimentary | Gratuit

Celebrate family medicine
Célébrez la médecine familiale

Don't miss these incredible opportunities to connect with colleagues and celebrate achievements in family medicine. We look forward to seeing you at these highly anticipated events.

Details are available online and in this program.
Visit **fmf.cfpc.ca** to register and purchase tickets.

Ne manquez pas ces occasions en or de tisser des liens avec vos collègues et de célébrer les réalisations en médecine familiale. Au plaisir de vous voir à ces événements très attendus.

Des renseignements détaillés sont disponibles en ligne et dans ce programme. Pour vous inscrire et acheter des billets, visitez le **fmf.cfpc.ca**.

THE BESROUR CENTRE
LE CENTRE BESROUR

The Besrour Forum:

Join us on Tuesday, November 7, 2017 in Montreal, Quebec

Participants will have an opportunity to:

- Hear from Canadian and international leaders in primary care and family medicine
- Network and discuss emerging hot topics in primary care research and quality improvement
- Exchange ideas on how to strengthen access to health care for patients around the globe

For more information about the Besrour Forum and related workshops planned for Family Medicine Forum 2017, visit **Besrour Forum 2017. Register today!**

The Besrour Centre is a hub of international collaboration dedicated to advancing family medicine globally.

Le Forum Besrour :

Soyez des nôtres le mardi 7 novembre 2017 à Montréal (Québec)

Les participants pourront :

- Entendre les propos des chefs de file canadiens et internationaux en soins de première ligne et en médecine familiale.
- Faire du réseautage et discuter de sujets chauds émergents qui portent sur la recherche en soins de première ligne et sur l'amélioration de la qualité.
- Échanger des idées sur l'amélioration de l'accès aux soins de santé pour les patients partout au monde .

FPour de plus amples renseignements sur le Forum Besrour et sur les ateliers connexes offerts au Forum en médecine familiale, visitez **Besrour Forum 2017. Inscrivez-vous aujourd'hui.**

Le Centre Besrour est un lieu d'échange international pour l'avancement de la médecine familiale à l'échelle mondiale.

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

Foundation for Advancing Family Medicine
Fondation pour l'avancement de la médecine familiale

FONDATION Dr Sadok Besrour
PLANÈTE EN SANTÉ ET EN PAIX

FMF

Family Medicine Forum
Forum en médecine familiale

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

NOVEMBER 14-17, 2018
NOVEMBRE

Metro Toronto Convention Centre

Palais des congrès du Toronto métropolitain

CREATE CRÉER | EDUCATE APPRENDRE | CELEBRATE CÉLÉBRER

fmf.cfpc.ca | familymedicineforum | @familymedforum