
# Mainpro+® Certified Program

**November 6–9, 2024**

Vancouver Convention Centre

**fmf.cfpc.ca**

@FamilyMedicineForum @FamilyMedForum @familymedforum #myFMF #monFMF

# Welcome to FMF 2024!

On behalf of the College of Family Physicians of Canada (CFPC)'s Family Medicine Forum (FMF) Committee, we are thrilled to extend a warm welcome to FMF 2024!

Our dedicated committee has been working hard behind the scenes to craft a scientific program that offers the gold standard in educational content. With a focus on delivering the highest quality, evidence-based education, our extensive scientific program is designed to enrich your teaching, research, and clinical practice.

Join us in person at FMF, with the option to access select sessions on demand for 50 days post-conference. This provides you with the opportunity to delve into more content, catch up on missed sessions, and earn additional Mainpro+ CPD credits.

FMF is taking place this year in the vibrant city of Vancouver, renowned for its breathtaking natural beauty and innovative spirit. This dynamic city serves as the perfect backdrop for engaging discussions, networking opportunities, and professional growth.

As you immerse yourself in our diverse program offerings and connect with colleagues, we encourage you to explore all that Vancouver has to offer. Whether you're strolling along the iconic seawall, indulging in local culinary delights at world-class restaurants, or immersing yourself in the city's rich arts and cultural scene, Vancouver promises to captivate your senses and ignite your imagination.

We hope you enjoy this year's conference and leave feeling renewed in your passion for family medicine.

Welcome to FMF 2024!

# FMF Committee Members

**Dr. Leslie Griffin** Co-chair | Nova Scotia

**Dr. Stephen Hawrylyshyn** Co-chair | Ontario

**Dr. Ian Alexander** Manitoba

**Dr. Marie-Dominique Beaulieu** Section of Researchers

**Dr. Katherine Bell** Rural | British Columbia

**Dr. Kiran Dhillon** First Five Years in Family Practice

**Dr. James Goertzen** Section of Teachers

**Dr. Moulay Jbala** Quebec

**Dr. Louise Oborne** Section of Residents

**Dr. Taryn O'Neill** New Brunswick

**Dr. Ovie Albert** Member Interest Groups Section

**Dr. Amanda Tzenov** Newfoundland and Labrador

**Dr. Amanda Wang** Alberta

**Dr. Matthew Wong** Saskatchewan

# FMF Schedules • November 6–9, 2024

## Wednesday November 6th to Friday November 8th

All events listed are in the Vancouver Convention Centre West Building

| TIME | EVENT | LOCATION |
|---|---|---|
| 07:00 – 15:30 | Registration open | Level 1 |
| 07:30 – 15:30 | Exhibit Hall open | Exhibition Level |
| 07:30 – 08:15 | Breakfast / Exhibits / Networking | Exhibit Hall |
| 08:15 – 08:40 | Opening remarks / Welcome | Ballroom AB |
| 08:40 – 09:45 | Keynote address | Ballroom AB |
| 09:45 – 10:15 | Coffee break / Networking / Exhibits | Exhibit Hall |
| 09:45 – 10:15 | Poster viewing | Ballroom Foyer |
| 10:15 – 11:15 | Mainpro+ certified sessions | Levels 1 and 2 |
| 11:30 – 12:30 | Mainpro+ certified sessions | Levels 1 and 2 |
| 12:30 – 14:00 | Bistro lunch / Exhibits / Networking | Exhibit Hall |
| 12:30 – 14:00 | Poster viewing | Ballroom Foyer |
| 12:45 – 13:45 | Ancillary sessions / Events | Levels 1 and 3 |
| 14:00 – 15:00 | Mainpro+ certified sessions | Levels 1 and 2 |
| 15:00 – 15:30 | Coffee break / Exhibits / Networking | Exhibit Hall |
| 15:00 – 15:30 | Poster viewing | Ballroom Foyer |
| 15:30 – 16:30 | Mainpro+ certified sessions | Levels 1 and 2 |

## Saturday November 9th

All events listed are in the Vancouver Convention Centre West Building

| TIME | EVENT | LOCATION |
|---|---|---|
| 07:30 – 15:00 | Registration open | Level 1 |
| 07:30 – 08:30 | Breakfast | Level 3 |
| 08:30 – 09:30 | Mainpro+ certified sessions | Levels 1 and 2 |
| 09:30 – 09:45 | Coffee break / Networking | Foyer |
| 09:45 – 10:45 | Mainpro+ certified sessions | Levels 1 and 2 |
| 11:00 – 12:00 | Mainpro+ certified sessions | Levels 1 and 2 |
| 12:00 – 13:30 | Bistro lunch | Level 3 |
| 12:15 – 13:15 | Ancillary sessions / Events | Levels 1 and 2 |
| 13:30 – 14:30 | Mainpro+ certified sessions | Levels 1 and 2 |
| 14:45 – 15:45 | Mainpro+ certified sessions | Levels 1 and 2 |
| 17:00 – 19:00 | Convocation Ceremony | Ballroom AB |

# Schedule-At-A-Glance

Photo: Destination Vancouver/Sara Borck Photography

## General Hours

**07:00 – 15:30 Registration Desk**
**07:00 – 17:00 Reflection / Prayer Room**
**07:00 – 17:00 Infant Feeding Room**
**07:00 – 17:00 Coat Check**
**07:00 – 15:30 Speakers Room**

## Exhibit Hall and Breaks – fmf.cfpc.ca/exhibit-hall-guide

This year the Exhibit Hall will feature a Bistro Lunch area with a variety of food vendors. Complimentary breakfast and breaks are also provided while you explore the Hall, and engage and interact with the FMF exhibitors.

**07:30 – 15:30 Exhibit Hall open**
**07:30 – 08:15 Breakfast / Exhibits / Networking**
**09:45 – 10:15 Coffee break / Exhibits / Networking**
**12:30 – 14:00 Bistro Lunch / Exhibits / Networking**
**15:00 – 15:30 Coffee break / Exhibits / Networking**

## Daily Certified Schedule – fmf.cfpc.ca/program

| Wednesday, Thursday, Friday | | Saturday | |
|---|---|---|---|
| 08:15 – 09:45 | Keynotes | 08:30 – 09:30 | Sessions 1 |
| 10:15 – 11:15 | Sessions 2 | 09:45 – 10:45 | Sessions 2 |
| 11:30 – 12:30 | Sessions 3 | 11:00 – 12:00 | Sessions 3 |
| 14:00 – 15:00 | Sessions 4 | 13:30 – 14:30 | Sessions 4 |
| 15:30 – 16:30 | Sessions 5 | 14:45 – 15:45 | Sessions 5 |

**Live streaming daily from Ballroom AB and C.**
**Simulataneous Interpretation from Ballroom AB.**

## Ancillary Session Schedule – fmf.cfpc.ca/program

Ancillary sessions may be available early morning, lunch and after sessions. See program for details. Explore the Hall, and engage and interact with the FMF exhibitors.

## Scientific Posters – fmf.cfpc.ca/program

Wednesday to Friday from 8:00 a.m. to 5:00 p.m. (PT) in the Ballroom Foyer. Posters rotate each day.Visit daily over breaks and lunch to support new important research, clinical and teaching innovations.

## Pre-Registered Workshops – fmf.cfpc.ca/program

These half-day and full-day workshops offer engaging, hands-on, two- and three-credits-per-hour learning opportunities. These require pre-registration and have an additional fee.

# FMF Schedule of Certified Sessions

## Monday, November 4

### Virtual Workshops

**9:00–13:30 PAACT: Anti-infective 2024**
Session ID: 230 | Mainpro+® certified workshop | Pre-registration required
Room: **Virtual – ZOOM Meeting**

**10:00–14:30 VitalTalk Canada: Serious illness communication skills simulation**
Session ID: 136 | Mainpro+® certified workshop | Pre-registration required
Room: **Virtual – ZOOM Meeting**

**14:00–18:30 PAACT: Respiratory (COPD/Asthma) 2024**
Session ID: 231 | Mainpro+® certified workshop | Pre-registration required
Room: **Virtual – ZOOM Meeting**

## Tuesday, November 5

### Virtual Workshops

**9:30–13:00 Decision-Making Capacity Assessment Level 1 Workshop**
Session ID: 93 | Mainpro+® certified workshop | Pre-registration required
Room: **Virtual – ZOOM Meeting**

**13:30–17:00 Decision-Making Capacity Assessment Level 2 Workshop**
Session ID: 94 | Mainpro+® certified workshop | Pre-registration required
Room: **Virtual – ZOOM Meeting**

## Wednesday, November 6

### In-Person Workshops

**9:00–12:30 Canadian MAiD Curriculum Topic 3: How to do a MAiD Assessment**
Session ID: 283 | Mainpro+® certified workshop | Pre-registration required
Room: 122

**10:00–17:00 Self-Compassion Training for Healthcare Communities**
Session ID: 287 | Mainpro+® certified workshop | Pre-registration required
Room: 121

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

**14:00–15:30 Canadian MAiD Curriculum Topic 4: Assessing Capacity and Vulnerability**
Session ID: 284 | Mainpro+® certified workshop | Pre-registration required
Room: 122

## Keynote: 8:15–9:45

**Ian McWhinney Keynote Address: Unlearning and Undoing Systemic White Supremacy and Indigenous-Specific Racism in Settler Healthcare Teams**
Session ID: 499 | 🎧 | 🎬 | Keynote
Room: Ballroom AB

## Session time: 10:15–11:15

**Key Messages From the 2023 Consensus on Concussion**
Session ID: 132 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Dealing with Severe Asthma in Your Practice**
Session ID: 27 | 🎬 | Clinical
Room: Ballroom C

**Cognitive Biases Are Making You Kill Your Patients**
Session ID: 35 | Clinical
Room: 109-110

**Finding Meaning in Our Work: Enhancing burnout resilience**
Session ID: 150 | Clinical
Room: 118-120

**Excellence in Research: Featuring Family Medicine Resident Research Award Winner and Family Medicine Researcher of the Year**
Session ID: 122 | Research
Room: 114-115

**Improving Health for All: Leading change as educators - PART 1 of 2**
Session ID: 502 | Teaching | Preceptorship
Room: Ballroom D

## Session time: 11:30–12:30

**AFABulous Review: PEER presents an ode to women's health**
Session ID: 256 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Top 10 Emergency Medicine Articles to Change Your Practice**
Session ID: 261 | | Clinical
Room: Ballroom C

**Pharmaceutical Industry Influence and Primary Care: Is there a role for collaboration in our current healthcare system?**
Session ID: 227 | Clinical
Room: 109-110

**Pillars of Chronic Pelvic Pain Management**
Session ID: 320 | Clinical
Room: 118-120

**The 3Ds Blueprint: Empowering physicians for work-life balance**
Session ID: 336 | Clinical
Room: 116-117

**Outstanding Research: Showcasing Award-Winning Research Articles and Top Scoring Free Standing Papers**
Session ID: 123 | Research
Room: 114-115

**Professionalism Coaching for Remediation of Academic Difficulties in the Professional Role**
Session ID: 248 | Teaching | Preceptorship
Room: 205-206

**Improving Health for All: Leading change as educators - PART 2 of 2**
Session ID: 502 | Teaching | Preceptorship
Room: Ballroom D

## Session time / Bloc de séance : 12:45–13:45

**From A1C to Z: GLP-1 and GIP/GLP-1 RA Therapies Case 1: Managing Type 2 Diabetes & Case 4: Tackling Type 2 Diabetes and CKD in Primary Care**
Session ID: 508 | Ancillary session
Room / Salle : Ballroom C

## Session time: 14:00–15:00

**Pick Your Briefs: Audience-selected topics from PEER's game-board**
Session ID: 182 | | | Clinical
Room: Ballroom AB

**12-Years Later, 3 Guidelines! Osteoporosis in Canada unpacked**
Session ID: 155 | | Clinical
Room: Ballroom C

**Mast Cell Activation Syndrome: The new fibromyalgia?**

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

Session ID: 196 | Clinical
Room: 109-110

**Freestanding Papers on Practice Organizations and Health Services Research**
Session ID: 118 | Research
Room: 114-115

**Global Emerging Women FM Leaders: A virtual course**
Session ID: 58 | Teaching | Preceptorship
Room: 116-117

**The Art and Science of Giving Critical Feedback**
Session ID: 77 | Teaching | Preceptorship
Room: 205-206

**Thriving Through Turbulence: Leadership strategies mid-flight**
Session ID: 75 | Teaching | Preceptorship
Room: 202-204

## Session time: 15:30–16:30

**COPD for Primary Care: Incorporating new CTS guidelines**
Session ID: 26 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Seizures Unmasked: Distinguishing real events from mimics**
Session ID: 317 | 🎬 | Clinical
Room: Ballroom C

**I Need a Note for Work, Doc!**
Session ID: 301 | Clinical
Room: 118-120

**Social Media and Adolescent Mental Health**
Session ID: 102 | Clinical
Room: 109-110

**Navigating CPD Certification: Getting started**
Session ID: 221 | Clinical
Room: 116-117

**Freestanding Papers on Educational Research 1**
Session ID: 119 | Research
Room: 114-115

**Building Effective Interprofessional Teams in Postgraduate Education**
Session ID: 267 | Teaching | Preceptorship
Room: 202-204

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Creating Cost-Effective, High-Fidelity Models to Teach Procedural Skills**
Session ID: 106 | Teaching | Preceptorship
Room: 205-206

# Thursday, November 7

## In-Person Workshops

**9:00–12:30 Canadian MAiD Curriculum Topic 5: Providing MAiD**
Session ID: 286 | Mainpro+® certified workshop | Pre-registration required
Room: 121

**14:00–15:30 Canadian MAiD Curriculum Topic 6: Navigating Complex Cases with Confidence**
Session ID: 288 | Mainpro+® certified workshop | Pre-registration required
Room: 121

**7:30–18:00 Airway Interventions & Management in Emergencies (AIME) Course 1**
Session ID: 140 | Mainpro+® certified workshop | Pre-registration required
Room: 223-224

## Session time: 7:30–8:30

**Prevent & Protect: Championing pneumococcal disease prevention in primary-care**
Session ID: 503 | Ancillary session
Room: Ballroom C

## Keynote: 8:15–9:45

**Family Medicines Cross Country Hiccup: How family medicine/primary care lost its mojo and the journey to get it back**
Session ID: 500 | 🎧 | 🎬 | Keynote
Room: Ballroom AB

## Session time: 10:15–11:15

**Diabetes Tools for Your Practice**
Session ID: 207 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**PEER: What's new, what's true and what's poo?**
Session ID: 245 | 🎬 | Clinical
Room: Ballroom C

**Enhancing Dementia Diagnosis Communication: The CLEAR Communication Toolkit**
Session ID: 307 | Clinical
Room: 109-110

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Perinatal Mental Health: An update and new topics**
Session ID: 309 | Clinical
Room: 118-120

**Sharing Identities: Cultivating compassion inside and out**
Session ID: 251 | Clinical
Room: 111-112

**Freestanding Papers on Educational Research 2**
Session ID: 120 | Research
Room: 114-115

**Virtual Care for Teachers: A new frontier**
Session ID: 254 | Teaching | Preceptorship
Room: 205-206

**Caught in the Middle: Intervening microaggressions from patients**
Session ID: 217 | Teaching | Preceptorship
Room: 202-204

## Session time: 11:30–12:30

**Top 10 Practice Changing Tips From Practice-Based-Learning-Program Modules-2023-2024**
Session ID: 199 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Approach to Bipolar Disorder in Primary Care**
Session ID: 14 | 🎬 | Clinical
Room: Ballroom C

**Caring for Your Hospitalized Diabetic Patients**
Session ID: 61 | Clinical
Room: 118-120

**RxFiles: Menopause quick hits**
Session ID: 33 | Clinical
Room: 116-117

**We Aren't Immune: FPs and intimate partner violence**
Session ID: 109 | Clinical
Room: 111-112

**Impact of a Rural Research Skills Development Program**
Session ID: 304 | Research
Room: 114-115

**Preparing our Future Family Physicians: A Guide for Curriculum Renewal**
Session ID: 269 | Teaching | Preceptorship
Room: 202-204

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Pearls From the Prairies: Our best teaching hacks**
Session ID: 270 | Teaching | Preceptorship
Room: 205-206

## Session time: 12:45–13:45

**Basal Insulin Blueprint – Module 1A and 2A**
Session ID: 505 | Ancillary session
Room: Ballroom D

**Menopause: Focus on vasomotor symptoms**
Session ID: 507 | Ancillary session
Room: Ballroom C

## Session time: 14:00–15:00

**Transgender Health: How to diagnose/support/prescribe/monitor**
Session ID: 98 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Is This Skin Cancer?**
Session ID: 68 | 🎬 | Clinical
Room: Ballroom C

**First Five Years: Financial management in early-career**
Session ID: 334 | Clinical
Room: 118-120

**New Approach to Environmental Action in Primary Care**
Session ID: 70 | Clinical
Room: 111-112

**Co-Creating Psychological Safety on Clinical or Administrative Teams**
Session ID: 80 | Clinical
Room: 116-117

**Using Validity Evidence to Improve Learner Assessments**
Session ID: 222 | Teaching | Preceptorship
Room: 202-204

## Session time: 15:30–16:30

**Mixing and Matching: Layering psychopharmacology in primary care**
Session ID: 15 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Prostate Cancer Screening: Generalists navigating decades of changes**

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

Session ID: 154 | | Clinical
Room: Ballroom C

**CHANGE National Update: Treating metabolic syndrome**
Session ID: 326 | Clinical
Room: 118-120

**An Approach to Pelvic Floor Health in the Peripartum Period**
Session ID: 308 | Clinical
Room: 109-110

**Reflecting and Engaging: Advancing Indigenous health medical education**
Session ID: 219 | Clinical
Room: 116-117

**Enhancing Accessibility in iOAT: A Clinical prospective on the experiences of patients with disability**
Session ID: 226 | Clinical
Room: 111-112

**Effective Strategies that Excellent Teachers Utilize When Having Learners in Clinical Practice**
Session ID: 246 | Teaching | Preceptorship
Room: 205-206

**Unpacking Ableism in Family Medicine Training and Practice**
Session ID: 137 | Teaching | Preceptorship
Room: 202-204

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

# Friday, November 8

## In-Person Workshops

**7:30–18:00 Airway Interventions and Management in Emergencies (AIME) Course 2**
Session ID: 142 | Mainpro+® certified workshop | Pre-registration required
Room: 223-224

**8:00–12:30 PAACT: Pain Management 2024**
Session ID: 232 | Mainpro+® certified workshop | Pre-registration required
Room: 121

**14:00–16:30 Insomnia Care Without Medication: A pragmatic approach**
Session ID: 216 | Mainpro+® certified workshop | Pre-registration required
Room: 121

## Session time: 7:30–8:30

**Multiple Myeloma: Primary care management and referral**
Session ID: 506 | Ancillary session
Room: Ballroom C

## Keynote: 8:15–9:45

**Keynote: Reality and Hope: Polarities or pals**
Session ID: 501 | 🎧 | 🎬 | Keynote
Room: Ballroom AB

## Session time: 10:15–11:15

**What's New? The 2024 Rourke Baby Record!**
Session ID: 152 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Axe the Rx: Deprescribing chronic medications with PEER**
Session ID: 187 | 🎬 | Clinical
Room: Ballroom C

**Patient Safety and Medico-legal Risk Amidst Limited Resources**
Session ID: 133 | Clinical
Room: 109-110

**Managing Emotional-Behavioural Crises in Patients with Developmental Disabilities**
Session ID: 322 | Clinical
Room: 118-120

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Indigenous Engagement for Physician CME: A case study**
Session ID: 127 | Clinical
Room: 116-117

**Freestanding Papers on Clinical and Family Practice**
Session ID: 121 | Research
Room: 114-115

**Learner in Difficulty: Identification, diagnosis and treatment pearls**
Session ID: 165 | Teaching | Preceptorship
Room: 205-206

**Reducing Unnecessary Care While Teaching Family Medicine Learners**
Session ID: 195 | Teaching | Preceptorship
Room: 202-204

## Session time: 11:30–12:30

**Your Patient Has ADHD: But now what?**
Session ID: 332 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Timber! A common sense approach to syncope**
Session ID: 176 | 🎬 | Clinical
Room: Ballroom C

**Let's Talk About Sex: Women's sexual function complaints**
Session ID: 163 | Clinical
Room: 116-117

**First Five Years: Essential snappers for early-career physicians**
Session ID: 174 | Clinical
Room: 118-120

**Caring for 2SLGBTQIA+ Seniors**
Session ID: 113 | Clinical
Room: 114-115

**Big Ideas Soapbox**
Session ID: 117 | Research
Room: 109-110

**Basics of Assessment: Key principles for assessing learners**
Session ID: 263 | Teaching | Preceptorship
Room: 202-204

**Health Professional Educators in Family Medicine (HPEs-FM): An untapped teaching resource**
Session ID: 275 | Teaching | Preceptorship
Room: 205-206

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

## Session time: 12:45–13:45

**Differentiating Causes of Dyspnea and Cough: Could your patient have interstitial lung disease?**
Session ID: 498 | Ancillary session
Room: Ballroom D

**Moving Beyond Weight: Understanding obesity and its comorbidities**
Session ID: 504 | Ancillary session
Room: Ballroom C

## Session time: 14:00–15:00

**Caring for Rare Hearts: Inherited cardiovascular disease pearls**
Session ID: 162 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Approach to Psychotherapy in Primary Care**
Session ID: 17 | 🎬 | Clinical
Room: Ballroom C

**Locums 101: A guide for early-career physicians**
Session ID: 300 | Clinical
Room: 109-110

**Mainpro+ 2024: Simplified and refreshed**
Session ID: 218 | Clinical
Room: 118-120

**Meaningful Moments in Teaching: A quilting journey**
Session ID: 238 | Teaching | Preceptorship
Room: 205-206

**Mountains and Valleys: Preparing an educational leader's portfolio**
Session ID: 62 | Teaching | Preceptorship
Room: 202-204

## Session time: 15:30–16:30

**Top 10 Family Medicine Articles to Change Your Practice**
Session ID: 291 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**One for the Aged: Improving long term care**
Session ID: 247 | 🎬 | Clinical
Room: Ballroom C

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Review of the 2024 Guidelines on Minimal Intervals for Repeat Lab Testing**
Session ID: 242 | Clinical
Room: 109-110

**Implementing Trauma and Violence-Informed Care**
Session ID: 312 | Clinical
Room: 118-120

**When Interest Wains...Re-igniting distributed clinical teacher engagement**
Session ID: 289 | Teaching | Preceptorship
Room: 205-206

**Empowering Preceptors: A clinical reasoning remediation toolbox**
Session ID: 126 | Teaching | Preceptorship
Room: 202-204

# Saturday, November 9

## In-Person Workshops

**7:30–13:00 ECGs for Family Docs: A comprehensive review**
Session ID: 175 | Mainpro+® certified workshop | Pre-registration required
Room: 121

**8:00–12:00 Shift Your Mindset to Optimize Your Diagnostic Approach**
Session ID: 134 | Mainpro+® certified workshop | Pre-registration required
Room: 122

## Session time: 8:30–9:30

**Recognize The POOP: Pain out of proportion**
Session ID: 43 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Transitioning to Practice 101**
Session ID: 111 | 🎬 | Clinical
Room: Ballroom C

**Red-Eye Simple Approach: Evidence, pearls, medico-legal pitfalls**
Session ID: 129 | Clinical
Room: 109-110

**Wound Care: A workshop for family physicians**
Session ID: 239 | Clinical
Room: 118-120

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Peer Review Primer: Practical Tips from Journal Editors**
Session ID: 178 | Research
Room: 114-115

**Mentorship: Early career to retirement. Pearls and pitfalls**
Session ID: 198 | Teaching | Preceptorship
Room: 202-204

**Be the Change: Cultural safety in family medicine**
Session ID: 280 | Teaching | Preceptorship
Room: 205-206

## Session time: 9:45–10:45

**Assessment and Treatment of Anxiety in Older Adults**
Session ID: 235 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Understanding Breast Cancer Risk and Risk Reducing Tools**
Session ID: 167 | 🎬 | Clinical
Room: Ballroom C

**Adapting Clinical Reasoning for Excellent Virtual Care**
Session ID: 253 | Clinical
Room: 116-117

**An Introduction to Refugee Health Primary Care: The basics**
Session ID: 268 | Clinical
Room: 109-110

**Protecting Our Patients From Extreme Heat**
Session ID: 31 | Clinical
Room: 205-206

**What Work? Whose work? Cultural safety in our health care system**
Session ID: 259 | Clinical
Room: 118-120

**Measuring Comprehensive Family Practice**
Session ID: 149 | Research
Room: 114-115

**Lights, Camera, Write! Method acting in FM simulation**
Session ID: 104 | Teaching | Preceptorship
Room: 202-204

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

## Session time: 11:00–12:00

**Tails of Anemia: You are prescribing iron incorrectly**
Session ID: 153 | 🎧 | 🎬 | Clinical
Room: Ballroom AB

**Social Isolation and Loneliness in Seniors: What's new?**
Session ID: 327 | 🎬 | Clinical
Room: Ballroom C

**CaRMS and Electives Q&A**
Session ID: 110 | Clinical
Room: 118-120

**Responding to the Call: Centering indigenous knowledge systems**
Session ID: 138 | Clinical
Room: 109-110

**Enabling Difficult Conversations with Colleagues and Team Members**
Session ID: 99 | Clinical
Room: 116-117

**Optimizing Psychological Safety in Medical Education**
Session ID: 201 | Teaching | Preceptorship
Room: 205-206

## Session time: 13:30–14:30

**Polycystic Ovary Syndrome: Beyond just the ovaries**
Session ID: 164 | 🎬 | Clinical
Room: Ballroom C

**Primary Care for People Experiencing Houselessness**
Session ID: 328 | Clinical
Room: 109-110

**Hacking Cough Treatments: What works for subacute cough?**
Session ID: 97 | Clinical
Room: 118-120

## Session time: 14:45–15:45

**2024's Hot Topics in STI/HIV Prevention, Testing and Treatment**
Session ID: 241 | 🎬 | Clinical
Room: Ballroom C

**Medication Abortion: Updated guidance and resources for practice**

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

Session ID: 212 | Clinical
Room: 109-110

**Building Teams to Enhance Comprehensive Longitudinal Family Medicine: Learning from grassroots team-based care developments**
Session ID: 274 | Clinical
Room: 116-117

**Preventive Screening: Teaching strategies for optimal practice integration**
Session ID: 273 | Clinical
Room: 118-120

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

# FMF Scientific Program

## Monday, November 4

**Monday, November 4** **Session ID: 230** **Room: Virtual – ZOOM Meeting**

**9:00–13:30** **PAACT: Anti-infective 2024**

Frank Martino, MD, CCFP (EM), FCFP; Alan Kaplan, MD, CCFP (EM), FCFP

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 12 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Participate in small group case discussion pertaining to diagnosis and treatment of infectious diseases commonly presenting in family medicine
2. Feel more comfortable investigating and managing common infectious diseases including: upper and lower RTI, skin and urinary tract infections
3. Become familiar with strategies to implement antibiotic stewardship in your practice

**Description:**

An independent educational program developed by family physicians and based on the 30th Anniversary Edition of the "Anti-infective Guidelines for Community-acquired Infections". Cases are designed to highlight common infectious diseases. Materials: 2024 Anti-infective Guidelines ('orange book'); Participant manual; viral prescription pads (if not a virtual presentation). Recognized internationally as one of the longest standing antibiotic stewardship programs in the world.

**Monday, November 4** **Session ID: 136** **Room: Virtual – ZOOM Meeting**

**10:00–14:30** **VitalTalk Canada: Serious illness communication skills simulation**

Warren Lewin, MD, CCFP (PC)

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 8 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Describe an evidence-based approach an interprofessional team can use to lead serious illness conversations (ACP/GOC)
2. Observe and practice skills that will enhance empathic communication

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

3. Feel empowered and confident to efficiently engage in advance care planning conversations

**Description:**

This half-day workshop introduces evidence-based communication skills and conversation roadmaps to structure and more efficiently lead conversations with seriously ill patients and families. Serious Illness Communication (SIC) skills are critical to the delivery of high-quality care, are associated with favorable healthcare outcomes and mitigates burnout. Most practicing physicians receive little-to-no SIC training yet are faced with leading complex and emotionally-charged conversations everyday that would benefit from them. To help clinicians hone skills related to empathy, clarity, prognostic uncertainty, and advance care planning, we created, to our knowledge, Canada's first standalone SIC training program, The Conversation Lab. It merged, adapted, and built upon the two most evidence-based North American SIC training programs. This workshop reviews the SIC evidence, introduces participants to practical SIC tools and uses role play allowing participants to practice and hone skills. The first hour is spent reviewing and demonstrating the practical skills and approaches to communication that help family physicians navigate serious illness and challenging conversations. Concrete skills include a succinct way to break bad news, two methods to discuss prognostic uncertainty, an approach to respond to strong emotion empathically (instead of cognitively), and an approach to making empathic treatment recommendations. The bulk of the workshop is spent in small groups deliberately practicing the discrete skills using real-world cases played by standardized patients. All participants are engaged throughout the entire session and real-time feedback is provided by facilitators that completed 40+ hours of faculty development with a non-profit communication skills program called VitalTalk. This workshop serves as an official pre-requisite for physicians wishing to later take VitalTalk's faculty development course, which provides certification to lead structured SIC skills teaching at the bedside and through workshops using their off-the-shelf course materials. Workshop participants will also be introduced to various ongoing learning opportunities to continue to hone skills.

**Monday, November 4** **Session ID: 231** **Room: Virtual – ZOOM Meeting**

**14:00–18:30** **PAACT: Respiratory (COPD/Asthma) 2024**

Alan Kaplan, MD ,CCFP (EM), FCFP; Frank Martino, MD, CCFP (EM), FCFP

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 12 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Participate in small group case discussion pertaining to treatment of respiratory conditions commonly seen in family medicine
2. Review and become familiar with the 2024 'Respiratory Guidelines for Family Practice' ('orange book')
3. Review of 'practice pearls' on a case by case basis, including the role of available inhalers in therapy and barriers to practice change

**Description:**

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

An independent educational program developed by family physicians. Primary reference will be the Respiratory Handbook (Asthma/COPD) for Family Medicine 2024 ('orange book'). Cases are designed to highlight respiratory conditions seen commonly in primary care and include: AECB/AECOPD, COPD, asthma/COPD differentiation, pediatric and adult asthma. Materials: 2024 edition Respiratory (Asthma/COPD) Handbook for Family Medicine, Participant manual, inhaler review, patient materials. Teaching method: interactive, case-based, small group.

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

# Tuesday, November 5

**Tuesday, November 5** **Session ID: 93** **Room: Virtual – ZOOM Meeting**

**9:30–13:00** **Decision-Making Capacity Assessment Level 1 Workshop**

Lesley Charles, MBChB, FCFP (COE)

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Identify the guiding principles in decision-making capacity assessment (DMCA) (FM Expert/Health advocate)
2. Explore an interdisciplinary approach to Capacity Assessment (Leader/Collaborator/Communicator)
3. Integrate the above information in assessment of capacity through case examples (FM Expert/professional)

**Description:**

As the life expectancy of Canadians and prevalence of complex chronic health conditions continues to rise, assessment of independent decision-making capacity emerges as an issue of increasing importance. 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 from their residency training. Physicians play a key role in capacity assessment as they are able to declare persons incapable under the Adult Guardianship and Trusteeship Act as well as the Personal Directives Act and the Power of Attorney Act. They thus 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 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, standardised 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 standardised 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 3-hour workshop is now being offered to physicians given their pivotal role in capacity assessment and has been accredited by the CFPC for 6 Group Learning Credits

**Tuesday, November 5** **Session ID: 94** **Room: Virtual – ZOOM Meeting**

**13:30–17:00** **Decision-Making Capacity Assessment Level 2 Workshop**

Lesley Charles, MBChB, FCFP (COE)

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 9 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Explain the capacity assessment process (FM Expert, Professional)
2. Indicate the significance, timing and key elements of capacity interview (FM expert)
3. Apply the above information in assessment of capacity through case examples (FM Expert)

**Description:**

As the life expectancy of Canadians and prevalence of complex chronic health conditions continues to rise, assessment of independent decision making capacity emerges as an issue of increasing importance. 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 from their residency training. Physicians play a key role in capacity assessment as they are able to declare persons incapable under the Adult Guardianship and Trusteeship Act as well as the Personal Directives Act and the Power of Attorney Act. They thus 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 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, standardised 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 standardised 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 3 hour Level 1 workshop is now being offered to physicians given their pivotal role in capacity assessment and has been accredited by the CFPC for 6 Group Learning credits. A Level 2 workshop was developed to look further at the capacity interview.

# Wednesday, November 6

**Wednesday, November 6 Session ID: 499 Room: Ballroom AB**

**8:15–9:45** **Ian McWhinney Keynote Address: Unlearning and Undoing Systemic White Supremacy and Indigenous-Specific Racism in Settler Healthcare Teams**

Danielle Behn-Smith, MD, CCFP

**Learning objectives:**

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

1. Name intersecting systems of settler colonialism, white supremacy, and Indigenous specific racism in Canada (LEARN)
2. Identify foundational obligations to Indigenous peoples and specific instructions related to health and wellness, including substance use (UNDERSTAND)
3. Be ready to apply two methodological frameworks for unlearning and undoing systemic white supremacy and Indigenous-specific racism (ACT)

**Description:**

Identify intersecting systems of settler colonialism, white supremacy, and Indigenous specific racism in Canada (LEARN). Identify foundational obligations to Indigenous peoples and specific instructions related to health and wellness, including substance use (UNDERSTAND). Be ready to apply two methodological frameworks for unlearning and undoing systemic white supremacy and Indigenous-specific racism (ACT).

**Wednesday, November 6 Session ID: 283 Room: 122**

**9:00–12:30** **Canadian MAiD Curriculum Topic 3: How to do a MAiD Assessment**

Stefanie Green, MD; Konia Trouton

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 15 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Successfully prepare for and complete a MAiD assessment. Discuss the eligibility criteria for MAiD
2. Identify the differences in the assessment of patients whose natural death is and is not reasonably foreseeable
3. Practice skills and identify strategies to bring one's "best self" to MAiD assessments and address challenges that may arise in this deeply meaningful work

**Description:**

In this session, participants will gain valuable insights on successfully preparing for and completing a Medical Assistance in Dying (MAiD) assessment. Discussions will cover the eligibility criteria for MAiD, emphasizing the distinctions in assessing patients whose natural death is and is not reasonably foreseeable. Participants will also engage in skill-building exercises and identify strategies to bring their "best selves" to MAiD assessments, addressing the unique challenges that may arise in this profound and meaningful aspect of their work.

**Wednesday, November 6** **Session ID: 287** **Room: 121**

**10:00–17:00** **Self-Compassion Training for Healthcare Communities**

Anne DuVall, MD, CCFP (PC), FCFP

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 12 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Implement at least 5 skills to care for themselves emotionally to increase resilience
2. Describe the key components of mindful self-compassion and incorporate them as healthcare professionals
3. Develop strategies to avoid emotional exhaustion through understanding the difference between empathy and compassion

**Description:**

Self-Compassion Training for Healthcare Communities (SCHC) is a 6-hr evidence-based adaptation of Mindful Self-Compassion (MSC). This is an empirically supported program of Dr. Kristin Neff at the University of Texas, Austin and Dr. Chris Germer at Harvard Medical School. This training aims to improve wellbeing and personal resilience in healthcare professionals by teaching mindful self-compassion skills to deal with distressing situations as they occur at work and at home. This workshop will equip you with a toolkit of practices to cope with stress and burnout, through didactic teaching modules, experiential learning, and group discussion. Mindfulness and self-compassion practices are offered that are easily incorporated in-the-moment on the job to look after yourself while you look after patients. Practices and tools easily translate to difficult moments off the job as well. In research published in the Journal of Clinical Psychology, Neff. Knox, Long & Gregory, 2020, the SCHC program was found to significantly decrease depression, stress, secondary traumatic stress, and burnout and increase self-compassion, mindfulness, compassion for others, job satisfaction in healthcare professionals. Summary of Evidence Based Benefits for Heatlhcare Workers: Enhanced wellbeing in the form of reduced depression and stress; Increased work life satisfaction; Increased feelings of personal accomplishment; Reduced burnout, depression & anxiety; Reduced emotional exhaustion

**Wednesday, November 6** **Session ID: 132** **Room: Ballroom AB**

**10:15–11:15** **Key Messages From the 2023 Consensus on Concussion**

Pierre Fremont, MD, PhD, FCFP (SEM)

**Learning objectives:**

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

1. Assess a patient presenting with symptoms of a possible concussion
2. Provide standard initial recommendations for relative rest and early gradual cognitive and physical activation
3. Provide a follow-up assessment to a patient with protracted recovery following a diagnosis of concussion

**Description:**

Although concussions are not always sport-related (ex: intimate partner violence, work-related, etc.), their high incidence in sports contributes to a rapidly evolving body of knowledge that allows to further understand this type of traumatic brain injury an improve its clinical management for any context of injury. In June 2023, an international collaboration of experts on sport-related concussions, updated the recommendations for concussion prevention detection and management (BJSM 2023; 57: 11). This 6th international consensus on sport-related concussion was informed by 9 systematic reviews (BJSM 2023; 57: 11 and 12), and includes 5 clinical tools (https://www.concussioninsportgroup.com/scat-tools) including a new tool designed for the office assessment and follow-up: the Standardized Concussion Office Assessment Tool (SCOAT6). The general objective of this session is to familiarize clinicians with the simple principles that allow to identify and successfully manage most concussions and present the new clinical tool that can support the assessment and follow-up of concussion in primary care, namely in the presence of protracted recovery. This session will present an overview of the recommended clinical assessment and management through the course of this injury, with a focus on key updates from the most recent recommendations. Using key elements of the SCOAT6, the role of the family physician in the assessment and management of concussions with persisting symptoms will be discussed. Namely, simple functional impairment screening tests that can contribute to the identification of relevant trajectories of care will be discussed.

**Wednesday, November 6** **Session ID: 27** **Room: Ballroom C**

**10:15–11:15** **Dealing with Severe Asthma in Your Practice**

Alan Kaplan, MD, CCFP (EM), FCFP

**Learning objectives:**

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

1. Define what is severe asthma
2. Define the assessment and treatments of difficult to control asthma
3. Review treatments for severe asthma and how these patients should be followed in primary care

**Description:**

Severe asthma patients is estimated to be 5-10% of all our asthmatic patients, but those patients end up with a disproportionate degree of suffering, reduced quality of life, adverse effects from medications, exacerbations and health care costs. We will review how to assess asthma control, with a step by step review of how to approach those who are not controlled. We will review assessment and management including non-pharmacologic management steps as well as how to step up pharmacotherapy to achieve control. If these steps are not sufficient, we are left with the subset of patients who may well have severe asthma. We now have biologic therapies that while outside the treatment paradigm of most primary care practitioners, still are medications that need to be understood, especially in the context of how to follow these patients.

**Wednesday, November 6 Session ID: 35 Room: 109-110**

**10:15–11:15 Cognitive Biases Are Making You Kill Your Patients**

Vu Kiet Tran, MD, FCFP (EM), MHSc, MBA, CHE, ICD.D

**Learning objectives:**

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

1. List the most common cognitive biases in family medicine
2. Enumerate factors that increase cognitive biases in practice
3. Develop strategies to reduce cognitive biases in practice

**Description:**

A cognitive bias is a systematic pattern of deviation from norm or rationality in judgment. Individuals create their own reality from their perception of inputs. An individual's construction of reality may dictate their behavior. Thus, cognitive biases may sometimes lead to perceptual distortion, inaccurate judgment, illogical interpretation, and irrationality. Biases make it difficult for people to exchange accurate information or derive truths. Biases lead us to avoid information that may be unwelcome or uncomfortable, rather than investigating the information that could lead us to a more accurate outcome. Biases can also cause us to see patterns or connections between ideas that aren't necessarily there. A cognitive bias distorts our critical thinking, leading to possibly perpetuating misconceptions or misinformation that can be damaging, especially while formulating a diagnosis or management plan. We, as clinicians, often fall into cognitive bias traps without knowing, often leading to wrong diagnosis and treatment plans and often leading to serious adverse outcomes. Understanding and developing concrete plans to counteract our own brain is a must of clinicians want to reduce diagnostics and management errors.

**Wednesday, November 6 Session ID: 150 Room: 118-120**

**10:15–11:15 Finding Meaning in Our Work: Enhancing burnout resilience**

Alan Katz, MBChB, MSc, CCFP, FCFP; Alex Singer, MD, CCFP; Aaron Jattan, MD, MMEd, CCFP; Batya Grundland, MD, CCFP; Kulamakan (Mahan) Kulasegaram, PhD

**Learning objectives:**

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

1. Review the causes of family physician burnout

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

2. Understand the linkage between meaning in our work and the patient centred clinical method
3. Explore adding the benefit to physicians of meaningful patient relationships to the patient centred method

**Description:**

The issue of family physician burnout requires the attention of all teachers of family medicine. This workshop builds on a fundamental understanding of why our discipline is different (including the importance of meaningful provider-patient relationships built over time) and how this understanding can support resilience against burnout. Participants will share their reasons for attending the session with each other. This will be followed by a short (10 minutes) description of the evidence about the causes of burnout for family doctors. Participants will respond to the evidence through facilitated group discussion. The importance of finding meaning in work will be discussed (facilitated with appropriate questions) following a presentation on the evidence supporting this concept. The final didactic component will consist of another short presentation linking the patient centred clinical method to the previous discussion. This will be followed by a facilitated discussion exploring the challenges in including the potential benefit to family doctors of finding meaning in the provider-patient relationship and in teaching the patient-centred clinical method. The workshop participants will have the opportunity to consider joining a group to explore next steps in exploring the workshop impact for future teaching and practice.

**Wednesday, November 6** **Session ID: 122** **Room: 114-115**

**10:15–11:15** **Excellence in Research: Featuring Family Medicine Resident Research Award Winner and Family Medicine Researcher of the Year**

**Learning objectives:**

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

1. Review new research in family medicine
2. Apply family medicine research results
3. Stimulate interest in family medicine research

**Description:**

Please join this year's research award recipients as they present some of the most relevant and impactful family medicine research in Canada. The session spotlights contributions of Canada's Family Medicine Researcher of the Year and two resident research presentations who have been selected from all submissions to the 2024 Research Awards for Family Medicine Residents. Awardees are nominated by their academic institutions based on peer, teacher, and researcher review processes. 1. Presentation by the recipient of the 2024 Research Awards for Family Medicine Residents. (2 x 15 minutes each = 10 mins to present and 5 minutes for Q&A); 2. Presentation by the Family Medicine Researcher of the Year (30 minutes = 20 mins presentation and 10 minutes for Q&A). The Family Medicine Researcher of the Year Award recognizes a College of Family Physicians of Canada (CFPC) member who has made original contributions to research and knowledge creation in family medicine. Nominated by colleagues and their academic institutions, this award honours researchers who inspire excellence. Award recipients are recognized for having been a pivotal force in the definition, development, and dissemination of scholarship that is central to the discipline and practice of family medicine.

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

### 10:20–10:35 Presentation by the Research Award for Family Medicine Residents (1)

**RESIDENT ICE CREAM ROUNDS To assess the impact of Resident Ice Cream Rounds on resident wellbeing and program satisfaction**

Author: Andrea Zukowski Project Advisor: Dr. Wendy Thomas - Queen's University, Faculty of Medicine

**Introduction:** Primary care practitioners (PCPs) are well-placed to care for patients with opioid use disorder (OUD). However, there are multiple factors noted in the literature that can limit access to primary care management of OUD, including systemic-, clinician-, and patient-level barriers. The goal of this project was to develop capacity for local PCPs to adequately manage, and feel supported in managing, OUD within a primary care setting. Peterborough, Ontario was selected as the focus of this project as the city has been disproportionally affected by high rates of opioid-related harms in comparison to the rest of the province. **Methods:** There were four components to the project, which were conducted iteratively. First, an anonymous online survey of Peterborough PCPs (family doctors and nurse practitioners) was conducted to identify a baseline of current management of OUD, barriers to care in primary care, and current local needs to better improve clinician comfort in primary care management of OUD. Second, semi-structured interviews were held with local stakeholders to identify current local resources for those with OUD, identify potential management pathways for OUD locally, and discuss barriers to care and role of PCPs in managing OUD. Third, a literature review was conducted to summarize current practices in OUD management in Canada. Finally, the data collected was compiled into a streamlined pathway for local OUD management. **Results and Discussion:** The surveys [N=12; 10 family physicians, 2 nurse practitioners (1 partially completed)] indicated that most felt a responsibility to treat OUD and felt it was within their scope of practice. Noted barriers to management of OUD in primary care included a lack of knowledge in opioidagonist therapy prescribing, perceived inadequate remuneration for care, and inadequate access to psychosocial supports for patients. 8 semi-structured interviews were conducted, which highlighted the importance of appropriate utilization of local resources and the benefits of PCP-managed OUD care. A streamlined management pathway was created to address locally identified barriers, concerns, and potential misconceptions with OUD management. Once distributed, this point-of-care tool will hopefully facilitate increased provider comfort in managing OUD in primary care.

### 10:35–10:50 Presentation by the Research Award for Family Medicine Residents (2)

**A comprehensive guideline for the management of opioid use disorder in primary care in Peterborough, Ontario**

Author: Anne Dube - iFMEM Resident in Sydney, NS

**Background:** This study aims to assess the impact of monthly Resident Ice Cream Rounds on the wellbeing and program satisfaction of residents in the Dalhousie Family Medicine residency programs in Cape Breton, NS.**Methods:** The study adopted a pre- and post-intervention design, enrolling all 21 Family Medicine residents on Cape Breton Island. Assessments were conducted utilizing the Physician Wellbeing Index and program-specific questions to assess satisfaction. The intervention involved five monthly Resident Ice Cream Round sessions, voluntary gatherings for peer support, debriefing, and fostering connections. Data analysis employed unpaired t-tests, with statistical significance at a p-value of 0.05. **Results:** Over the study period, the average wellbeing score increased from 3.9 / 7 (s.d. 1.94, 95% CI 2.99 - 4.81), to 4.1 / 7 (s.d. 1.44, 95% CI 3.30 - 4.83, p-value 0.782). First-year residents scored

significantly higher than second-year residents pre-intervention, 4.9 vs. 2.9 / 7 (p-value 0.017) while post-intervention the scores were no longer significantly different, 3.9 vs. 4.3 / 7 (p-value 0.601). The average program satisfaction score for all residents was 3.2 / 4 (s.d. 1.14, 95% CI 2.62 - 3.68) which increased to 3.4 / 4 (s.d. 0.96, 95% CI 2.92 - 3.95, p-value 0.426) post-intervention. First-year residents consistently reported higher satisfaction than second-year residents (pre-intervention p-value 0.076, post-intervention p-value 0.112). **Interpretation:** While the results suggest a positive impact of Resident Ice Cream Rounds on overall wellbeing and program satisfaction, the study's short duration and small sample size limit generalizability. The differing trends between first- and second-year residents warrant further exploration. Despite study limitations, the low overall wellbeing scores highlight the need for ongoing wellness monitoring and support.

**10:50–11:15 Presentation by the Family Medicine Researcher of the Year**

**Building a Primary Care Research Program: One Step at a Time**

Catherine Hudon MD, PhD, CMFC

**Learning objectives:**

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

1. Describe the V1SAGES approach, an integrated care program in primary care
2. Give evidence of this approach
3. Better understand steps to develop a research program in primary care

**Wednesday, November 6 Session ID: 502 Room: Ballroom D**

**10:15–11:15 Improving Health for All: Leading change as educators - PART 1 of 1**

Christy Anderson, B.Com; Danièle Behn Smith, MD, CCFP (EM); Jamaica Cass, MD, CCFP; Darlene Kitty, MD, CCFP; Janelle Syring, MD, CCFP; Brent Young, MD, CCFP; James Goertzen, MD, MClSc, CCFP, FCFP; Ivy Oandasen, MD, CCFP, MHSc

**Learning objectives:**

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

1. Identify foundational obligations to Indigenous peoples with specific instructions related to health and wellness
2. Embed actions and accountability for foundational obligations within family medicine educational activities
3. Employ Indigenous health resources and supports as family medicine teachers to unlearn and undo systemic racism

**Description:**

Indigenous Peoples have provided nearly 1000 detailed instructions and potential solutions on how to uphold inherent rights, embrace anti-racist approaches, and engage in Truth and Reconciliation. Building on Dr. Daniele Behn Smith's Ian McWhinney Keynote Presentation, this session highlights specific actions for family medicine teachers, preceptors, and educational leaders to consider in meeting foundational obligations within their own spheres of influence that relate to the health and wellbeing of Indigenous Peoples. To meet foundational obligations, there are specific actions for both Indigenous and

non-Indigenous People. Working together, we can make a difference. This session will support both Indigenous and non-Indigenous family medicine teachers to organize and strategize on how to take courageous action to elevate and advance true and meaningful Reconciliation. The session will spotlight recently released resources including the CFPC Indigenous Health Curriculum Guide that can assist family medicine teachers, preceptors, and educational leaders in meeting their collective responsibility to unlearn and undo systemic racism. Session participants will be provided with opportunities and support to better understand one's own personal journey towards Reconciliation. In 2022, the CFPC signed a Declaration of Commitment to Cultural Safety and Humility. As part of the action plan related to the Declaration of Commitment, opportunities to engage with Indigenous Health topics are offered annually at Family Medicine Forum.

**Wednesday, November 6** **Session ID: 256** **Room / Salle : Ballroom AB**

**11:30–12:30** **AFABulous Review: PEER presents an ode to women's health**

Jessica Kirkwood, MD; Tina Korownyk, MD, CCFP; Danielle Perry, MSc RN

**Learning objectives:**

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

1. Describe common treatments for vasomotor symptoms related to menopause, nausea and vomiting related to pregnancy and more
2. Evaluate new clinical studies in the area of women's health
3. Summarize the evidence around common questions in women's health including contraception, menopause, and sexual desire

**Description:**

This interactive and entertaining session by the PEER team will be a fast-paced review of answers to common clinical questions in primary care: all about women! With new content for 2024, audience members will be able to select from topics focused on women's health including topics on pregnancy, menopause, and contraceptives. Additionally, a selection of recent clinical trials in the area of women's health will be available to choose from. The best available evidence, including a bottom-line summary and practical recommendation for practice will be described for every topic selected, each in less than five minutes!

**Wednesday, November 6** **Session ID: 261** **Room: Ballroom C**

**11:30–12:30** **Top 10 Emergency Medicine Articles to Change Your Practice**

Jock Murray, MD, MSC, CCFP (EM), FCCP; Colin Boyd, MD, CCFP (EM); Michael Clory, MD, CCFP (EM); Matthew Clarke, MD, CCFP (EM); Rebecca Haworth, MD, CCFP (EM); Constance LeBlanc, MD, MSc, CCFP (EM)

**Learning objectives:**

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

1. Become familiar with 10 recent articles are potentially practice changing
2. Review the evidence for changing practice for 10 specific clinical scenarios

3. Decide if the presented evidence supports changing practice in ten clinical senarios

**Description:**

This is a recurring session which typically attracts 200-500 participants. It is highly reviewed and often included in the FMF Loved Sessions. Ten recent articles with potentially practice changing conclusions are critiqued and reviewed in approximately 4 minutes each. An evidence based and "Choosing Wisely" approach is implemented. The remaining 20 minutes is reserved for audience questions. The articles are chosen to be relevant to a general audience of Family Physicians who occasionally practice in an Emergency Department.

**Wednesday, November 6** **Session ID: 227** **Room: 109-110**

**11:30–12:30** **Pharmaceutical Industry Influence and Primary Care: Is there a role for collaboration in our current healthcare system?**

Trudy Huyghebaert, PharmD, BScPharm, ACPR, CDE; Melanie Hnatiuk, MD, CCFP, FCFP

**Learning objectives:**

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

1. Review relevant literature on the influence of industry activities on prescribing
2. Discuss ways to mitigate the risk of bias involved in collaborating with industry activities while leveraging ways to help our patients
3. Recognize potential biases and blind spots of industry relationships and medical professionals

**Description:**

We are inundated with new therapies in our practice, and it seems that every day there is new article or guideline that we need to review and incorporate into our practices to provide the best care to our patients. When time is our most precious resource, we may consider attending an industry sponsored Continuing Education event (CME) as it provides us with an opportunity collaborate with our colleges as well as learn something new about a new medication. We may also get a chance to get a meal as well. We may meet with industry representatives to provide us with an overview of their new medication and provide us with samples so we can get comfortable prescribing this new therapy. This seems like an efficient use of our time… but is it? We would like to challenge some of our biases regarding industry sponsored education and other influences on our prescribing practices and discuss ways to mitigate the risks of bias involved when collaborating with industry activities while leveraging ways to help our patients. We hope this presentation will inspire practitioners to evaluate their relationship with the pharmaceutical industry and increase awareness of their potential biases and discover ways to mitigate this risk when providing care to our patients. We will also provide resources for unbiased information and evidence-based summaries to help incorporate best practices and a check list to evaluate your practice and identify personal biases and ways to mitigate this influence in your clinic.

**Wednesday, November 6** **Session ID: 320** **Room: 118-120**

**11:30–12:30** **Pillars of Chronic Pelvic Pain Management**

Virginia McEwen, MD, CCFP (FP); Catherine Allaire

**Learning objectives:**

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

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

1. Identify relevant clinical diagnoses and develop approach to recognizing different facets of pelvic pain
2. Implement approaches to reduce inflammatory, central sensitization, and neuropathic pain burden comorbid in pelvic pain
3. Integrate multidisciplinary recommendations for pelvic floor physiotherapy and when to involve psychology or counselling

**Description:**

Chronic pelvic pain is more common than appreciated, with 1 out of 10 women living with symptoms of endometriosis. Pelvic pain is often comorbid with other chronic overlapping pain conditions and can be difficult to manage if not using a multipronged approach. When primary care physicians recognize endometriosis and other causes of pelvic pain, approaches are often limited to hormonal management and surgical consultation. While these options are crucial, they reflect only part of a wider multidisciplinary approach that has evidence of being helpful. Pelvic pain management pillars include medical approaches that take into consideration hormonal management, central sensitization, myofascial pain, and widespread inflammation. Allied health approaches imperative in many patients includes pelvic floor physiotherapy and psychology. These factors in combination with pain education are key in the wholistic management of people living with pelvic pain. Primary care clinicians who have awareness of pelvic pain syndromes and basic principles of management can substantially improve the quality of life for such patients. At the conclusion of this activity, participants will be able to: identify relevant clinical diagnoses ; use a stepwise approach to addressing different facets of pelvic pain; implement approaches to reduce inflammatory, central sensitization, and neuropathic pain burden comorbid in pelvic pain ; integrate multidisciplinary recommendations for pelvic floor physiotherapy and when to involve psychology

**Wednesday, November 6** **Session ID: 336** **Room: 116-117**

**11:30–12:30** **The 3Ds Blueprint: Empowering physicians for work-life balance**

Vanessa Kustec, MD CM, DPD

**Learning objectives:**

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

1. Identify the signs and symptoms of burnout and administrative overwhelm commonly experienced by healthcare workers
2. Learn practical strategies for setting boundaries and reclaiming personal time to achieve better work-life balance
3. Explore the 3Ds (Delete, Delegate, Defer) as tools for prioritizing tasks and managing workload effectively

**Description:**

In the face of increasing complexity and administrative burdens in medicine, healthcare professionals often find themselves overwhelmed and at risk of burnout. This presentation introduces the "3 Ds" approach—Delete, Delegate, Defer—as a practical strategy for reclaiming control over workload and

fostering work-life balance. Through personal anecdotes and actionable insights, attendees will learn how to apply these principles to prioritize tasks, set boundaries, and optimize time management. The session aims to empower healthcare professionals with practical tools to mitigate burnout and cultivate sustainable career satisfaction.

**Wednesday, November 6** **Session ID: 248** **Room: 205-206**

**11:30–12:30** **Professionalism Coaching for Remediation of Academic Difficulties in the Professional Role**

Heather Waters, MD, CCFP, FCFP; JoAnn Corey, MD, FRCPC; Dorothy Bakker, MD, MA, CCFP, FCFP; Dale Guenter, MD, MPH, CCFP, FCFP; Danielle O'Toole, MD, MSc, CCFP, FCFP

All teachers welcome. Highlight's novice and developing concepts for educational leaders.

**Learning objectives:**

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

1. Situate the role of a professionalism coach in the context of trainee academic difficulty and remediation
2. Implement effective professionalism coaching of trainees, including management of common challenges
3. Access key resources to support professionalism coaching of trainees

**Description:**

This session is designed for faculty involved in residency training, academic coaching, remediation support, and education leadership who are interested in learning about effective coaching strategies to support trainees in the remediation of professionalism difficulties. While CanMEDS highlights the importance of competency development in the Professional role as foundational to upholding society's trust in the medical profession, it is the second most common role, after Medical Expert, for which trainees require remediation support. The identification and remediation of trainee professionalism difficulties can be stressful and resource-intensive for residents, faculty, and programs. And while effective strategies for professionalism remediation are described in the literature, few faculty feel equipped to confidently engage with trainees in professionalism coaching as a component of remediation. This session will provide a foundational overview of the concepts of professionalism, professional identity formation, and professionalism difficulties in postgraduate medical training, including the roles of context and culture in evolving definitions of professionalism behaviours. Frameworks will be provided for understanding professionalism development and difficulties. This session will introduce the Professionalism Coach as a key relationship in the remediation of professionalism difficulties. Principles for effective coaching will be discussed based on current literature, with a focus on promoting reflective practice and the ability to appreciate one's impact on others. Content will include overarching principles for coaching relationships, preparation, format, and content for coaching sessions. Common challenges and strategies to manage them will be discussed. Format will include small-group, case-based learning. Valuable resources for professionalism coaching and remediation will be shared.

**Wednesday, November 6** **Session ID: 123** **Room: 114-115**

## 11:30–12:30 Outstanding Research: Showcasing Award-Winning Research Articles and Top Scoring Free Standing Papers

**Learning objectives:**

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

1. Review new research in family medicine
2. Apply family medicine research results
3. Foster enthusiasm and curiosity for family medicine research

**Description:**

Canada's family medicine researchers make significant scientific contributions on a global scale. This session features the most acclaimed and highest ranked family medicine research based on peer-reviewed articles published in 2023. The session also spotlights the top two scoring free-standing papers and top scoring poster submitted to FMF 2024. These studies earned the highest accolades from conference abstract reviewers and, much like the showcased outstanding research articles, represent the pinnacle of excellence and practice of family medicine.

### 11:30–11:45 CFPC Outstanding Family Medicine Research Article

### Impact of Breast Cancer Screening on 10-Year Net Survival in Canadian Women Age 40-49 Years

Anna N. Wilkinson, MD, MSc, CCFP

**Purpose:** In Canada, some provincial/territorial mammography screening programs include women age 40-49 years, whereas others do not. This study examines the impact of this dichotomy on the 10-year breast cancer (BC) net survival (NS) among women age 40-49 years and 50-59 years at diagnosis. **Methods:** Using the Canadian Cancer Registry data record linked to death information, we evaluated the cohort of Canadian women age 40-49 years and 50-59 years diagnosed with BC from 2002 to 2007. We compared 10-year NS estimates in the jurisdictions with organized screening programs that included women age 40-49 years, designated as screeners (Northwest Territories, British Columbia, Alberta, Nova Scotia, and Prince Edward Island), with comparator programs that did not (Yukon, Manitoba, Saskatchewan, Ontario, Quebec, New Brunswick, and Newfoundland and Labrador). **Results:** BC was the primary cause of 10-year mortality in women age 40-49 years diagnosed with BC (90.7% of deaths). Among these women, the 10-year NS for screeners (84.8%; 95% CI, 83.8 to 85.8) was 1.9 percentage points (pp) higher than that for comparators (82.9%; 95% CI, 82.3 to 83.5; P = .001). The difference in favor of screeners was significant among women age 45-49 years (2.6 pp; P = .001) but not among women age 40-44 years (0.9 pp; P = .328). Similarly, the incidence-based BC mortality rate was significantly lower in screener jurisdictions among women age 40-49 years and 45-49 years, but not for 40-44 years. Provincial/territorial NS increased significantly with higher mammography screening participation (P = .003). The BC incidence rate was virtually identical in screener and comparator jurisdictions among women age 40-49 years (P = .976) but was significantly higher for comparators among women age 50-59 years (P < .001). **Conclusion:** Screening programs that included women in their 40s were associated with a significantly higher BC 10-year NS in women age 40-49 years, but not an increased rate of BC diagnosis. These results may inform screening guidelines for women age 40-49 years.

**11:45–12:00 Canadian Family Physician Best Original Research Article**

### Changes in comprehensiveness of services delivered by Canadian family physicians. Analysis of population-based linked data in 4 provinces

Ruth Lavergne, MSc PhD

**Objective:** To describe changes in the comprehensiveness of services delivered by family physicians across service settings and service areas in 4 Canadian provinces, to identify which settings and areas have changed the most, and to compare the magnitude of changes by physician characteristics. **Design:** Descriptive analysis of province-wide, population-based billing data linked to population and physician registries. **Setting:** British Columbia, Manitoba, Ontario, and Nova Scotia. **Participants:** Family physicians registered to practise in the 1999-2000 and 2017-2018 fiscal years. **Main Outcome Measures:** Comprehensiveness was measured across 7 service settings (home care, long-term care, emergency departments, hospitals, obstetric care, surgical assistance, anesthesiology) and in 7 service areas consistent with office-based practice (prenatal and postnatal care, Papanicolaou testing, mental health, substance use, cancer care, minor surgery, palliative home visits). The proportion of physicians with activity in each setting and area are reported and the average number of service settings and areas by physician characteristics is described (years in practice, sex, urban or rural practice setting, and location of medical degree training). **Results:** Declines in comprehensiveness were observed across all provinces studied. Declines were greater for comprehensiveness of settings than for areas consistent with office-based practice. Changes were observed across all physician characteristics. On average across provinces, declines in the number of service settings and service areas were highest among physicians in practice 20 years or longer, male physicians, and physicians practising in urban areas. **Conclusion:** Declining comprehensiveness was observed across all physician characteristics, pointing to changes in the practice and policy contexts in which all family physicians work.

**12:00–12:15 Top Scoring Free Standing Paper**

### eConsult Utility for Identifying Hereditary Cancer Knowledge Gaps

June C Carroll*, MD, CCFP, FCFP; Alison Rusnak, MD, FRCPC, FCCMG; Marjolaine Champagne, MD, FRCPC; Shawna Morrison, MS, CGC; Danica Goulet, MSc; Erin Keely, MD, FRCPC; Clare Liddy, MD, MSc, FCFP

**Learning objectives:**

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

1. Identify eConsult's value for managing patients with personal and/or family history of cancer
2. Identify primary care practitioners' knowledge gaps in hereditary cancer that can be addressed through CME
3. Identify reliable clinical resources for primary care genomic medicine

**Description:**

**Objective:** To explore the utility of eConsult for enhancing delivery of cancer genetic services. To identify knowledge gaps in hereditary cancer emerging from primary care practitioners' (PCP) eConsult questions to geneticists that could direct future continuing medical education (CME). **Design:** Retrospective mixed methods study evaluated 200 randomly selected PCP eConsult cases submitted to the Cancer Genetics

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

eConsult group. Approved by Ottawa Hospital REB. **Setting:** The Champlain eConsult BASE Service allows PCPs to communicate asynchronously with a geneticist about a patient's care on a secure web-based platform. **Participants:** Family physicians, nurse practitioners and clinical geneticists in the Champlain region of Ontario, Canada, comprising a linguistically, culturally diverse population. **Main Outcome Measures:** PCP close-out survey indicating eConsult value and impact on in-person referral, validated taxonomies to classify PCP questions and geneticist recommendations, and investigator classification of knowledge gaps. **Results:** In 64% (128/200) of eConsults, PCPs indicated they received clear advice for a new course of action, in 34% (68/200) referral was contemplated but now avoided, and for 88% (176/200) eConsult was considered valuable. In most (63%, 126/200), PCPs agreed eConsult addressed a clinical problem that should be incorporated into CME. PCPs' questions were mainly about cancer screening (114), genetic testing (107) or genetics referral (76). Geneticist recommendations were mainly: cancer screening (142 patient, 12 family member), genetics referral (46 patient, 58 family member), high-risk breast cancer screening program (OBSP) (41). PCP knowledge gaps identified from eConsult questions included: awareness of cancer screening guidelines (112), genetics referral criteria (100), OBSP screening criteria (71); understanding of genetics principles (e.g. characteristics of a high risk family (93), optimal approach to test affected individual first (83)). **Conclusion:** PCPs find eConsult useful for patient management of cancer genetic services with potential to increase access and avoid referrals. Identified knowledge gaps can be used to enhance CME.

**Session ID: 366**

### 12:15–12:30 Top Scoring Free Standing Paper

### "Short" Musculoskeletal Case Simulations: A randomized control trial

Veronica Wadey, MD, MA; Ashley Brown, MD; Stan Hamstra, PhD; Anne Wideman*, MD, CCFP; Nishchay Kaushal, MD, CCFP; Sam Keshen, MD; Purti Papneja, MD, CCFP (20MSKShortCaseDevGp - Shahnawaz Khan, MD; Christoph Boehler, MD; Ivan Kamikovski, MS; Julia Bowes, MS; Lukas Mortensen-Truscott, MD; Thrmiga Sathiyamoorthy; Kalter Hali; Noah Carr-Pries; Shervin Forootan; Joshua Tuazon) and Alex Kiss, PhD

**Learning objectives:**

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

1. Determine if 20 musculoskeletal authentic case simulations improves knowledge and skills in family medicine education
2. Recognize the importance of case based learning in development of medical educational tools
3. Explore the need to determine patient satisfaction and resident competency in musculoskeletal knowledge and skills

**Description:**

**Objective:** To determine if Family Medicine residents completing 20 MSK Short Case Simulations would improve knowledge and satisfaction in learning about identifying and initially managing patients with various MSK conditions when compared to learners not exposed to the same educational tool. **Design:** A Randomized Control Trial – Pilot Study. **Setting:** A Family Medicine Residency Training Program. **Participants:** Twenty-six learners including postgraduate year one and two residents who were positioned to assess and initially manage patients with various musculoskeletal (MSK) conditions were recruited and

randomized into a control (CTL) or experimental (EXP) group. **Intervention:** The EXP group were exposed to 20 MSK Short Case Simulations reflecting authentic patient case scenarios reflecting: 1) upper extremity; 2) lower extremity; 3) spine; 4) trauma and; 5) MSK infections that were previously developed and tested. All module were embedded into on-line links with the following outcome measures: 1) Participant Demographics; 2) Pre-multiple choice questions (T1-EXP); 3) MSK Case Simulation (Intervention); 4) Post-multiple choice questions (T1a-EXP); 5) Satisfaction questionnaire pertaining to each MSK case simulation. **Main Outcome Measures:** The main outcome measures were the T1 and T2 questionnaires reflecting the 100 knowledge questions associated with each of the 20 MSK case simulations. **Results:** Twenty-six residents consented and were randomized for the study (CTL=13; EXP=13). The response rate for the CTL group was 92% and EXP group was 85.4%. The average CTL group T1 score was 59.7% and T2 score completed 2 months later was 60.1% ($p<0.73$). Thirteen residents completed 222 MSK short case simulations. Frequency tables computed demonstrated average pre-test scores of 55% and post-test scores of 73% ($p<0.0001$). The T2 average score for the EXP group was 68% and when compared to CTL group there was a significant difference ($p<0.04$). **Conclusion:** Online interactive MSK case simulations were useful as a learning tool for family medicine residents.

**Wednesday, November 6 Session ID: 502 Room: Ballroom D**

**11:30–12:30 Improving Health for All: Leading change as educators - PART 2 of 2**

Christy Anderson, B.Com; Danièle Behn Smith, MD, CCFP (EM); Jamaica Cass, MD, CCFP; Darlene Kitty, MD, CCFP; Janelle Syring, MD, CCFP; Brent Young, MD, CCFP; James Goertzen, MD, MClSc, CCFP, FCFP; Ivy Oandasen, MD, CCFP, MHSc

**Learning objectives:**

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

1. Identify foundational obligations to Indigenous peoples with specific instructions related to health and wellness
2. Embed actions and accountability for foundational obligations within family medicine educational activities
3. Employ Indigenous health resources and supports as family medicine teachers to unlearn and undo systemic racism

**Description:**

Indigenous Peoples have provided nearly 1000 detailed instructions and potential solutions on how to uphold inherent rights, embrace anti-racist approaches, and engage in Truth and Reconciliation. Building on Dr. Daniele Behn Smith's Ian McWhinney Keynote Presentation, this session highlights specific actions for family medicine teachers, preceptors, and educational leaders to consider in meeting foundational obligations within their own spheres of influence that relate to the health and wellbeing of Indigenous Peoples. To meet foundational obligations, there are specific actions for both Indigenous and non-Indigenous People. Working together, we can make a difference. This session will support both Indigenous and non-Indigenous family medicine teachers to organize and strategize on how to take courageous action to elevate and advance true and meaningful Reconciliation. The session will spotlight recently released resources including the CFPC Indigenous Health Curriculum Guide that can assist family medicine teachers, preceptors, and educational leaders in meeting their collective responsibility to unlearn and undo systemic racism. Session participants will be provided with opportunities and support

to better understand one's own personal journey towards Reconciliation. In 2022, the CFPC signed a Declaration of Commitment to Cultural Safety and Humility. As part of the action plan related to the Declaration of Commitment, opportunities to engage with Indigenous Health topics are offered annually at Family Medicine Forum.

**Wednesday, November 6** **Session ID: 508** **Room: Ballroom C**

**12:45–13:45** **From A1C to Z: GLP-1 and GIP/GLP-1 RA Therapies Case 1: Managing Type 2 Diabetes & Case 4: Tackling Type 2 Diabetes and CKD in Primary Care**

James Kim, CFPC, MBBCh, PgDip (Diabetes)

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

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

1. Identify the relationship between type 2 diabetes and different cardiometabolic conditions
2. Determine how a multifaceted approach to type 2 diabetes management can improve cardiometabolic outcomes
3. Discuss current evidence that support GLP-1 RAs and GIP/GLP-1 RAs and determine how to individualize treatment

**Description:**

The management of type 2 diabetes rarely occurs in isolation, as it is often accompanied by other cardiometabolic complications such as obesity, liver disease, cardiovascular disease, and chronic kidney disease. As patients commonly present with these overlapping health challenges, clinicians must address a range of complexities to provide effective, comprehensive care. This comprehensive program entitled, "From A1C to Z: GLP-1 and GIP/GLP-1 RA Therapies" will explore the interconnected nature of these conditions and provide practical strategies to optimize patient care. Learn about the expanding role of GLP-1 receptor agonists and GIP/GLP-1 receptor agonists in improving glycemic control, supporting weight management, and reducing cardiovascular risk. Through interactive case studies, you'll gain valuable insights on implementing guideline-recommended assessments, selecting appropriate pharmacotherapy, and addressing common comorbidities. This 1-hour session will focus on 2 modules of this program: Case 1: Managing Type 2 Diabetes, and Case 4: Tackling Type 2 Diabetes and CKD in Practice.

**Wednesday, November 6** **Session ID: 182** **Room: Ballroom AB**

**14:00–15:00** 🎧 🎬 **Pick Your Briefs: Audience-selected topics from PEER's game-board**

Tina Korownyk, MD, CCFP; Jennifer Young, MD, CCFP; Adrienne J Lindblad, BSP, ACPR, PharmD

**Legend:**
🎧 **Simultaneous interpretation**
🎬 **Live-stream and on-demand**

**Learning objectives:**

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

1. Summarize high level evidence for a number of clinical questions
2. Incorporate best evidence for common primary care questions in patient care
3. Differentiate between interventions with minimal benefit and strong evidence for patient-oriented outcomes

**Description:**

This popular, fast-paced presentation provides answers to common clinical questions in primary care. The audience will select the questions from a list of possible topics and then one of the presenters will review the evidence and provide a bottom-line, all in less than five minutes. Topics will include management issues from pediatrics to geriatrics including a long list of medical conditions that span the breadth of primary care.

**Wednesday, November 6** **Session ID: 155** **Room: Ballroom C**

**14:00–15:00** **12-Years Later, 3 Guidelines! Osteoporosis in Canada unpacked**

Anmol Lamba, MD, MMSc, GDip (Clin Epi), CCFP

**Learning objectives:**

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

1. Gain awareness of the three new Canadian guidelines on osteoporosis released in 2022 and 2023
2. Review the latest changes in the screening of, and treatment of, osteoporosis
3. Develop strategies to consolidate contrasting advice on osteoporosis in a patient centered way

**Description:**

Osteoporosis screening and treatment in Canada has largely been governed by the 2010 Osteoporosis Canada Guidelines. Now, almost suddenly, we have had a triple threat of recommendations. In 2022, the Society of Obstetricians and Gynaecologists of Canada released guidelines on osteoporosis in menopause. In early 2023, the Canadian Task Force of Preventative Health Care released an updated recommendation on screening for Osteoporosis. Finally, in late 2023, Osteoporosis Canada updated their comprehensive guidelines over a decade after their initial recommendations. What's the same? What's different? How do we consolidate these guidelines and provide effective patient care? This talk is given from the lens of a generalist who was not involved in the formation of any of these documents. This talk has been developed from a front line family medicine lens to stay on top of guideline-directed testing and treatment.

**Wednesday, November 6** **Session ID: 196** **Room: 109-110**

**14:00–15:00** **Mast Cell Activation Syndrome: The new fibromyalgia?**

Virginia McEwen, MD, CCFP (FP)

**Learning objectives:**

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

1. Describe mast cell activation syndrome (MCAS)
2. Implement a practical clinical diagnostic approach toward MCAS based on pain and other inflammatory symptoms
3. Initiate low-risk management for such patients while considering some patients for specialty consultation

**Description:**

Family physicians are the first point of contact for many of the 1 in 5 Canadians living with chronic pain. Mast cell activation syndrome (MCAS) is theorized to be a common, yet relatively unknown, chronic multisystem inflammatory disorder in which mast cells are overly reactive, releasing a host of mediators with widespread physiological effects. Of these effects, chronic pain and fatigue are the symptoms of highest prevalence. Pain conditions potentially related to mast cell activation often present with fatigue, "fibromyalgia-like" pain, headaches (often migrainous), pruritus, paresthesia, abdominal pain and IBS symptoms, insomnia, and many other symptoms common to the chronic pain population. Individuals with MCAS experience significant delays in diagnosis, if the diagnosis is considered at all given its novelty in the medical literature over the last decade. MCAS can be diagnosed by clinical history and measurable biomarkers. Symptoms can often be effectively managed with an array of low-risk tools both non-pharmacological and pharmacological. MCAS pain symptoms are often refractory to typical medications such as opioids or TCAs. Avoiding triggers and medications directed at stabilizing mast cells and the effects of their mediators can be helpful, and many are available over the counter. Family physicians who have awareness of MCAS can substantially improve the quality of life for such patients. At the conclusion of this learning activity, participants will be able to: Describe mast cell activation syndrome; Implement a practical clinical diagnostic approach toward MCAS based on pain and other inflammatory symptoms; Initiate low-risk management for such patients while considering some patients for specialty consultation

**Wednesday, November 6** **Session ID: 58** **Room: 116-117**

**14:00–15:00** **Global Emerging Women FM Leaders: A virtual course**

Praseedha Janakiram; Baraa Alghalyini, MD; Hathaitip Tumviriyakul, MD; Meseret Zerihun, MD; Orowan Tawaytibhongs, MD; Jamie Rodas; Thuy-Nga (Tia) Pham, MD

All teachers welcome. Highlight's novice concepts for clinical preceptors.

**Learning objectives:**

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

1. Identify gender specific advancement challenges in your own departments and institutions
2. Review highlights of our international needs assessment, rationale, and early evaluation findings for this course
3. Consider this innovative course programming in supporting the development of early-mid career global women physicians

**Description:**

As we strive to build diverse leadership in family medicine, demands in primary care are extensive, exacerbated by post-pandemic human resource challenges that are felt globally in family medicine. As

women represent the majority in this specialty, enhancing leadership development and teaching critical skills in change management will support women family physicians in meeting the demands of our time. The Department of Family and Community Medicine (DFCM) at the University of Toronto and its international collaborators have played an important role in advancing leadership curricula at the undergraduate, postgraduate and faculty level. In 2023, we launched a leadership program for women physicians emerging into family medicine leadership roles globally. Women increasingly represent the majority in family medicine, yet leadership development targeting specifically early to mid-career women family physicians are lacking. We will engage participants interactively and anonymously in creating a safe space to reflect on individual and departmental experiences of advancing leadership in academic physicians who identify as women in family medicine. This session will outline our six module course delivered globally through an innovative, hybrid, on-line program focusing on critical skills to support women in their leadership journey. We will highlight key themes from an international needs assessment we conducted prior to establishing the course and share early feedback from the inaugural course evaluation. This session will provide a brief demonstration of the utility of our innovative teaching portal in facilitating high interactivity between global course participants and faculty from around the world throughout the course.

**Wednesday, November 6** **Session ID: 77** **Room: 205-206**

**14:00–15:00** **The Art and Science of Giving Critical Feedback**

James Goertzen, MD, MClSc, CCFP, FCFP; Aaron Johnston, MD, CCFP (EM), FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for educational leaders.

**Learning objectives:**

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

1. Describe barriers that impact giving critical feedback within the clinical setting
2. Identify three strategies to support effective critical feedback conversations
3. Apply the ask-tell-ask feedback framework to facilitate two-way feedback conversations

**Description:**

Feedback in the clinical setting has evolved from one-way exchanges dominated by the preceptor giving feedback to a two-way conversation where preceptors and learners have shared responsibilities. Although providing critical feedback is essential to learner development, challenges include finding time for the conversation, uncertainty about learners' emotional responses, possible erosion of learner confidence, and fear of damaging the learner preceptor relationship. Critical feedback conversations are optimized by trusting relationships and growth mindsets linked to educational plans and actions. Attendees will identify feedback challenges using a word cloud app. Giving and receiving feedback strategies will be highlighted using short videos and a teaching case woven throughout the session. Participants will be introduced to the Ask-Tell-Ask feedback framework which provides learners and preceptors with opportunities to share educational responsibilities along with supporting reflection and clarification. In breakout groups, attendees will practice giving and receiving feedback. Post-session learning will be supported with a tip sheet.

**Wednesday, November 6** **Session ID: 75** **Room: 202-204**

**14:00–15:00** **Thriving Through Turbulence: Leadership strategies mid-flight**

Christie Newton, MD; Brady Bouchard, MD; Shirley Schipper, MD

All teachers welcome. Highlight's experienced concepts for educational leaders.

**Learning objectives:**

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

1. Examine real-world examples of effective medical leadership during challenging times
2. Develop strategies for conveying critical information with empathy and understanding
3. Reflect on your own leadership and communication styles identifying areas for growth

**Description:**

As three past presidents of the CFPC who had to navigate significant change in the profession, the organization or our lives; we will use personal accounts of real events, to delve into the intricacies of family medicine leadership during challenging and complex times. Crisis in uncertainty can feel like building the runway, or managing repairs whilst midflight. We will highlight the unique pressures faced by family physicians in leadership during a crisis. Participants will gain an understanding of the demands of crisis management and consider essential skills to survive (and possibly thrive) in such environments. We will also share when things went sideways and did not have the outcomes we expected. We will use our personal examples focusing on both individual and organizational aspects of leadership. Communication skills take center stage as we discuss effective strategies for conveying critical information with clarity, vulnerability and empathy. Collaborative decision-making and adaptive leadership are explored as crucial tools in navigating an unpredictable environment. We hope to offer practical insights from our own real world case studies. We will share a few ideas and learn from each other to prioritize well-being and realistic outcomes, recognizing the significance of a supportive work and home environment.

**Wednesday, November 6** **Session ID: 118** **Room: 114-115**

**14:00–15:00** **Freestanding Papers on Practice Organizations and Health Services Research**

**Learning objectives:**

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

1. Gain an in-depth comprehension of diverse research methodologies and findings across various facets of family medicine
2. Develop the ability to critically evaluate and assess the implications, strengths, and limitations of presented research papers, honing skills in discerning high-quality research
3. Foster an interactive learning environment by engaging in discussions with presenters and peers, facilitating the exchange of ideas, perspectives, and potential applications of research in clinical practice or academia

**Description:**

Innovation, reflection, research, evaluation, and quality improvement are part of the fabric of family medicine. The facilitated free-standing paper session is an opportunity to hear from and talk with colleagues who are leading studies that have been selected for presentation through peer review. These sessions are an exciting opportunity to learn from and engage in the study of family medicine education and practice.

**Session ID: 436**

### 14:00–14:10 Assessing the Impact of Unattachment Duration in Ontario

Jonathan Fitzsimon, MBChB; Shawna Cronin, PhD; Anastasia Gayowsky, MSc; Antoine St-Amant, MSc; Lise M. Bjerre*, MDCM, PhD, CCFP

**Learning objectives:**

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

1. Gain an understanding of the impact of unattachment duration on healthcare utilization in Ontario
2. Gain an understanding of the impact of unattachment duration on healthcare costs in Ontario
3. Gain a better understanding of the interaction between comorbidities and unattachment

**Description:**

**Background and Objectives:** Insufficient access to primary care remains a critical issue in Ontario, particularly for unattached residents who do not have access to a regular primary care provider (usually a family physician, occasionally a nurse practitioner). This study evaluates healthcare utilization and costs among unattached residents province-wide and within the Ottawa Valley Ontario Health Team (OVOHT), focusing on the impact of unattachment duration. **Methods:** We conducted a population-based retrospective cohort study, comparing residents who were eligible for provincial healthcare and who maintained a consistent attachment status over the 12-month period from April 1st, 2021, to April 1st, 2022. We used multivariate regression analyses to examine the associations between attachment status, duration of unattachment, demographic and patient health characteristics and healthcare outcomes. **Results:** The study cohort consisted of n=13,126,740 Ontario residents, with 65,054 of these residents attributed to the Ottawa Valley Ontario Health Team. The unattachment rate in Ontario was 15%, notably lower than the 22% unattachment found in the OVOHT service area. In the moderate to high-comorbidity groups, the long-term unattached patients incurred substantially higher healthcare utilization and cost. For attached residents with low comorbidities, the median healthcare cost over one year was $287. For attached residents with high comorbidities, the cost increased to $3,702 (cost ratio: 12.90, CI: 12.86-13.01, $p < 0.0001$), while the long-term unattached with high comorbidities faced an even steeper increase, with their total healthcare cost escalating to $8,177 (cost ratio: 28.49, CI: 24.27-25.26, $p < 0.0001$). **Interpretation:** Our findings underscore the impact on individual patients and the healthcare system, of long-term unattachment and high levels of chronic disease. These results are key for shaping healthcare programs and policies, to maximize their impact on reducing emergency department (ED) utilization, hospitalizations, and overall healthcare cost.

**Session ID: 444**

### 14:10–14:20 Addressing Primary Care Administrative Workload in Atlantic Canada

Ruth Lavergne*, PhD; Catherine Moravac, MSc; Fiona Bergin, MD, CCFP, MEd, FCFP; Richard Buote, PhD; Julie Easley, PhD; Agnes Grudniewicz, PhD; Lindsay Hedden, PhD; Myles Leslie, PhD; Madeleine McKay, MA; Emily Gard Marshall, PhD; Ruth Martin-Misener, NP, PhD, FAAN, FCAN; Melanie Mooney, MN, NP; Erin Palmer, MD, CCFP, FCFP; Joshua Tracey, MD, CCFP, FCFP

**Learning objectives:**

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

1. Describe the challenges with primary care administrative workload in Atlantic Canada
2. Describe potential strategies to reduce the volume of low value administrative work
3. Identify strategies for local implementation or advocacy at the provincial level

**Description:**

**Objective:** Administrative activities, including work related to caring for individual patients and clinic administration, may play a substantial role in understanding changes to primary care workload. The objective of the qualitative component of this mixed methods study was to conduct interviews with family physicians, nurse practitioners, and administrative team members providing primary care: i) to describe their current experiences of administrative workload, ii) to understand how administrative workload has changed over time, and iii) to explore strategies that might be utilized to streamline processes and reduce the volume of administrative work. **Design:** We used a screening questionnaire to purposively select interview participants. Interviews were approximately one hour in duration and were conducted via Zoom. We followed Braun and Clarke's approach to reflective thematic analysis, which fit well with our critical qualitative approach and relativist epistemology. Research ethics approval was obtained. **Setting and Participants:** Interviewees were primary care providers and administrative staff representing a range of payment models, a variety of clinic models, from both urban and rural locations in Nova Scotia and New Brunswick. **Findings:** Information management is central to health care delivery, but often not valued or actively supported. Within primary care most administrative work requires both information management and clinical judgment. Therefore we developed a typology as part of the analysis. Participants recommended electronic medical record connectivity with other parts of the health system, pre-population of information from patient charts on forms, changes to insurance and disability forms, re-distribution of administrative tasks, assistance with overhead expenses, improved training for administrative staff, development of competencies and guidelines for clinic operations, and other actions. **Conclusion:** Identifying practical strategies to make information management more efficient can support innovative healthcare models, improve patient care, and improve the wellbeing of primary care providers.

**Session ID: 440**

### 14:20–14:30 Changes in the Family Physician Workforce in Ontario: 1993-2022

Susan E Schultz, MA, MSc; Michael E. Green*,MD, MPH; Eliot Frymire, MA; Paul Nguyen, PhD; Rick H. Glazier, MD, MPH

**Learning objectives:**

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

1. Describe the trend in family physician practice in Ontario, Canada
2. Describe changes in comprehensive family practice over the past 20 years
3. Describe changes in focus family practice over the past 20 years

**Description:**

**Objective:** Comprehensive primary care is the foundation of an effective healthcare system but has been on the decline as more family physicians pursue careers in focused practice. The objective is to explore the changes in family physician practice type over the past 30 years. **Design:** Using health administrative data held at ICES, we developed an algorithm to identify physicians who specialize in primary care, and then, described their type of practice (comprehensive, focused practice, other) based on the physician billings and number of days worked in a typical year. **Setting:** ICES contains administrative data collected from April 1,1993 to March 31, 2022, in the province of Ontario, Canada. **Participants:** We identified an increase in primary care physicians from 11,103 in 1993/1994 to 17,411 in 2021/2022. **Results/Findings:** From 1993 to 2022, the annual percentage of comprehensive primary care has decreased from 71.1% to 56.5%, while focused practice has significantly increased from 5.4% to 14.5%. The trend of part time primary care physicians (i.e., physicians who work <44 days or treat <5 patients per day in a typical year) follows a U-shaped distribution, starting at 20.5% in 1993/1994, dropping to a low of 15.0% in 2009/2010 and ending at 20.4% in 2021/2022. **Conclusion:** Over the past 30 years, there has been a substantial increase in the proportion of primary care physicians pursuing focused practice with a corresponding decrease in the number of comprehensive primary care physicians per capita. This is a significant factor contributing to our current crisis in access to primary care in Ontario specifically, and Canada as a whole.

**Session ID: 377**

### 14:30–14:40 Outcomes Associated With Timing of Screening for GDM

Helena Piccinini-Vallis*, MD, PhD, FCFP; Lynn Bussey, MD, FCFP; Jillian Coolen, MD, FRCSC; Mathew Grandy, MD, CCFP; Leanne MacKeen, RN, MN; Sarah Sabri, MSc.

**Learning objectives:**

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

1. Recognize the importance of the appropriate timing when screening for GDM
2. Recognize the potential for research linking primary care and hospital administrative databases
3. Explore future database linkage studies pertaining to prenatal care

**Description:**

**Objectives:** Building on previous work that pioneered the first step in establishing a platform for the systematic extraction of prenatal and postpartum data at the primary care level, the objective of this study was to link primary care prenatal data to intrapartum data contained in a provincial hospital administrative database to explore the association between the timing of gestational diabetes (GDM) screening and several outcomes. **Design:** This was a retrospective cohort study. Ethics approval was obtained from both the Nova Scotia Health and the IWK REBs. Deterministic linkage between the two databases was undertaken using a unique identifier. The main independent variable was the "timing of

screening for GDM" (appropriate or not appropriate). Significance was set as $p < 0.05$. **Participants:** Women with singleton pregnancies who received prenatal care from a family physician MaRNet-FP sentinel between July 1, 2019 and December 31, 2022 were included in the study. A pre-pregnancy diagnosis of type 1 or type 2 diabetes constituted exclusion criteria. **Main Outcome Measures:** The main outcomes included caesarean section, shoulder dystocia, LGA and macrosomia. **Results:** This study had a total of 199 participants. 69.4% of participants had initial screening for GDM undertaken at an appropriate time during pregnancy based on their risk for GDM. Appropriate timing of GDM screening was associated with lower rates of LGA ($p = .016$). When only participants who had elevated risk for GDM were examined as a subgroup, appropriate timing of GDM screening was still associated with lower rates of LGA ($p = .047$). **Conclusion:** Linking longitudinal (primary care) data to hospital administrative data creates opportunities for future studies pertaining to prenatal care, potentially resulting in improvements in the care provided to all pregnant individuals and in particular individuals from vulnerable populations that experience disproportionate rates of GDM, type 2 diabetes and obesity.

**Session ID: 396**

### 14:40–14:50 Clinic-Based Longitudinal Care in Alberta: A current census

Samantha Horvey*, MD, CCFP; Lauren Eastman, MD, CCFP; Xinran Zhang, BSc (Hons); Amanda Coyle, MPH; Makayla Watt, MSc; Ryane Fyith-McArthur, BScKIN; Mitchell Chorney, BSc; Tina Korownyk, MD, CCFP

**Learning objectives:**

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

1. Examine what data is available to assess and quantify family medicine delivery in Canada
2. Describe current metrics in Alberta regarding clinic-based longitudinal care
3. Identify the implications of the study findings for healthcare policy and family medicine

**Description:**

**Objective:** Alberta has a deficit of Family Physicians providing clinic-based longitudinal care, however the exact degree of that deficit is unknown. In the last year, primary care reform has been at the forefront of public interest and political agendas. Understanding the current landscape of primary care is essential to make effective health policy recommendations and evaluate the efficacy of changes. The objective of this study was to determine key metrics on the delivery of clinic-based longitudinal care in the Edmonton area. **Design:** Survey administered by phone or in-person to Family Medicine clinics. Secondary data analysis using publicly available College of Physicians of Alberta information. Approved by REB Pro00130555 **Setting:** Edmonton Area. **Participants:** Family Medicine clinics providing longitudinal care in the Edmonton area. Sample size N=188. **Main Outcome Measures:** Clinic-reported data on the number of family physicians and clinic time committed to the delivery of longitudinal care. Data illustrating the operational timeline of the clinic and anticipated expansion/contraction of services were reported. **Results:** Of the 340 clinics contacted, surveys were completed by 188 (55%) clinics, which represented 670 family physicians who provide longitudinal care. Of those 670 physicians, 40% graduated from medical school in Alberta and 51% graduated from an international medical school. 78 % of physicians providing longitudinal care graduated earlier than 2010. Physicians delivering longitudinal care are working an average of 7.7 half days per week. Greater than 40% of clinics were more than 10 years old and more than 40% of clinics were recruiting physicians. Most clinics anticipated

no changes to size and panelling of patients. **Conclusion:** This study utilized a survey-based approach and provides a snapshot of the current family medicine landscape in the Edmonton area. It reveals an in-demand, yet stagnant industry in need of recruitment and retention of more family physicians providing longitudinal clinic-based care.

**Session ID: 403**

**14:50–15:00 DelphAI - AI Delphi Describes Primary Care Nursing Scope**

Morgan Price*, MD, PhD, CCFP, FCFP

**Learning objectives:**

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

1. Recognize how AI can be used to simulate Delphi processes
2. Identify the pitfalls and possibilities in supporting policy development
3. Highlight nursing scope of practice in primary care

**Description:**

**Objective:** Design and run "DelphAI", an AI simulated Delphi study to generate a list of primary care visits that can be shared with registered nurses (RNs). Then, compare the DelphAI results to the results from an actual Delphi study with human experts asking the same question. **Design:** An "In silico" AI study using large language models (LLMs) to simulate a panel of 9 primary care experts with AI agents. **Round 1:** The DelphAI agent panel was asked to independently generate a list of primary care visits that could be shared with an RN. This was compared with a previously completed Delphi of similar design with human experts. AI agents were also asked to provide rationale for inclusion. **Round 2:** the DelphAI agents were given the list of visits generated by the human experts and asked to include or exclude each of 40 visits and provide rationale. AI results were compared to the human expert panel's results from the original Delphi. Feasibility and cost were assessed. **Results:** DelphAI proved feasible and inexpensive, using current LLMs like LLaMa2 and GPT 4. In round 1, DelphAI agents were able to generate a list of suggested primary care visits with rationale that were similar to those suggested by experts (e.g., "cervical screening tests", "Influenza clinic", "Blood pressure screening"). DelphAI agents more consistently provided rationale for their suggestions (e.g. "Nurses can measure blood pressure and provide education on maintaining healthy levels."). In round 2, there was 87.5% agreement between DelphAI and the human experts, with DelphAI panel including fewer visits. **Conclusion:** Early results are promising, even with off-the-shelf LLMs like GPT-4. Selective use of DelphAI could streamline future Delphi processes allowing human experts to review AI generated draft materials. Given the pace of generative AI, applications such as DelphAI will likely expand.

**Wednesday, November 6 Session ID: 284 Room: 122**

**14:00–15:30 Canadian MAiD Curriculum Topic 4: Assessing Capacity and Vulnerability**

Stefanie Green, MD; Konia Trouton

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 15 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

**Learning objectives:**

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

1. Discuss strategies for navigating challenging capacity assessments. Assess whether consent is truly voluntary and informed
2. Identify how vulnerabilities are relevant to MAiD requests/assessments. Reflect on and manage implicit bias
3. Recognize societal discrimination in MAiD assessments

**Description:**

This session will guide participants through strategies for navigating challenging capacity assessments, ensuring voluntary and informed consent, and recognizing the relevance of vulnerabilities in MAiD requests. Attendees will also engage in reflections on implicit bias management and gain insights into identifying societal discrimination within the realm of MAiD assessments.

**Wednesday, November 6 Session ID: 26 Room: Ballroom AB**

**15:30–16:30** **COPD for Primary Care: Incorporating new CTS guidelines**

Alan Kaplan, MD, CCFP (EM), FCFP

**Learning objectives:**

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

1. Define how to diagnose and assess a patient with COPD
2. Define non-pharmacologic management of COPD
3. Tailor pharmacologic management of COPD to your patient

**Description:**

COPD or Chronic Obstructive Pulmonary Disease is a common condition, with significant morbidity, hospitalizations, health care costs and mortality. The number of people worldwide with chronic obstructive pulmonary disease (COPD) is predicted to increase by 23% in three decades, amounting to nearly 600 million patients by 2050. Furthermore, it is a source of great suffering for many of our patients. We will define how to diagnose and categorize our patients' disease to allow an organized approach to therapy, with treatment tailored to the individual patient in front of you. We will touch on drug classes, inhaler devices and vaccinations for the best patient outcomes. The Canadian Thoracic Society has revised its pharmacologic guidelines, which will simplify how you can approach these patients. We will also touch on the significant impact of comorbid conditions and how to approach these multi-morbid patients effectively and safely.

**Wednesday, November 6 Session ID: 317 Room: Ballroom C**

**15:30–16:30** **Seizures Unmasked: Distinguishing real events from mimics**

Katie Muir, MD, FRCPC

**Learning objectives:**

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

1. Differentiate epileptic seizures and the most common seizure-mimics
2. Recognize patients that have epilepsy
3. Identify when to start anti-seizure medication

**Description:**

Epilepsy is one of the most common neurologic disorders affecting Canadians. 1 in 10 Canadians will have a seizure in their lifetime. 1/100 Canadians will receive a diagnosis of epilepsy. Identification of seizures and prompt work-up is important to make the diagnosis of epilepsy and to begin treatment. Being able to differentiate epileptic seizures from seizure mimics allows prioritization of patients that need further investigations and saves unnecessary investigations in those who do not need them. This session will use a case based approach to build knowledge about seizures and seizure mimics, highlighting which features most strongly suggest epileptic seizures. The most common types of seizures will be shown and their key features discussed. The focus will be on events which present in childhood, but common seizure presentations in adults will be covered as well. An approach to making the diagnosis of epilepsy, using the International League Against Epilepsy Diagnostic Criteria, will be reviewed and participants will have the opportunity to see this approach applied using the cases. Finally, the most common anti-seizure medications and evidence based recommendations on when to start them will be covered.

**Wednesday, November 6 Session ID: 301 Room: 118-120**

**15:30–16:30 I Need a Note for Work, Doc!**

Brian Ng, MD, MPH, CCFP, FCFP; Celina Dunn, MD, CCFP, CIME; Olivia Sampson, MD, CCFP, MPH, FRCPC

**Learning objectives:**

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

1. Describe the adverse health effects of worklessness
2. Recognize the needs of third parties while respecting boundaries of the physician-patient relationship
3. Use occupational medicine principles in writing sick notes and disability forms to third parties

**Description:**

Writing a sick note for a patient often presents challenges to the busy family physician. Physicians are often time-limited and are often pressured to write “what the patient wants”. This poses several challenges for physicians, including: alignment with patients, expected role of a physician and potential for undue medico-legal and regulatory risks. Furthermore, simply “giving patients time off work” may lead to downstream excess morbidity and loss of livelihood for patients whose workplace may be able to (and may be required to) accommodate their impairment. This session will provide an approach to patient and workplace requests for sick/disability notes that can be used broadly for numerous situations. The session will discuss patients with workers compensation claims in the province of BC and will review Standards and Guidelines from the College of Physicians and Surgeons of BC as an example that can be extrapolated to other jurisdictions. The session will present the approach broadly adopted in the field of

occupational medicine that respects the information a physician can helpfully provide and the information that is beyond medicine to assist with. Further, this approach uses language that can be understood and used by all parties to collaborate on safely helping patients back to work and school in a timely way, with the goal of reducing tensions between patients and family physicians regarding the prescription of disability.

**Wednesday, November 6 Session ID: 102 Room: 109-110**

**15:30–16:30 Social Media and Adolescent Mental Health**

Alison Yeung, MD, BSc

**Learning objectives:**

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

1. Describe the data associating social media usage to mental health outcomes in children and teens
2. Explain role of dopamine in causing a social media behavioural addiction
3. Explain practical strategies to prevent and/or reduce harm from social media

**Description:**

There is a growing body of research to suggest that social media platforms are harming the mental health of young children and teens. During this session, trends in youth mental health over the past two decades will be examined. The association between these trends and the rise in popularity of social media will then be presented. Participants learn how dopamine can leads to a social media behavioural addiction, especially as it relates to a child's under-developed prefrontal cortex. After understanding the signs and symptoms of social media overuse and/or addiction, participants will gain an understanding of practical advice they can use to council teens and parents to reduce harm. An overview of 'when is my child ready for social media?' will also be discussed.

**Wednesday, November 6 Session ID: 221 Room: 116-117**

**15:30–16:30 Navigating CPD Certification: Getting started**

Tyrone Czernon; Leonora Lalla, MD, CCFP, FCFP, CPC (HC)

**Learning objectives:**

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

1. Understand the simplified certification process for journal clubs, rounds, and faculty development activities
2. Apply strategies for identifying and incorporating EDI considerations into professional development activities
3. Identify opportunities for active involvement in CPD

**Description:**

This presentation will inform and encourage family physician involvement the development of certified Continuing Professional Development activities by providing valuable insights into the updated certification processes, launching in 2024. Attendees will gain an understanding of the certification

criteria and procedures for program applications as well as how their local journal clubs, hospital/clinical rounds, and faculty development activities can be certified under the new simplified process. The presentation will delve into the latest updates in Mainpro+ certification standards, specifically focusing on the incorporation of Equity, Diversity, and Inclusion (EDI) principles. Attendees will explore the significance of integrating EDI considerations into professional development activities and learn how to navigate the revised certification standards seamlessly. Furthermore, the session will explore avenues for member engagement in CPD. Detailed guidance will be provided on member opportunities to contribute to the development of the CPD that they participate in, such as participating on planning committees or becoming a physician reviewer. Through interactive discussions, participants will discover the impactful role they can play in shaping CPD initiatives, and fostering a collaborative environment that promotes continuous learning within the family medicine community.

**Wednesday, November 6 Session ID: 267 Room: 202-204**

**15:30–16:30 Building Effective Interprofessional Teams in Postgraduate Education**

Fanny Hersson-Edery, MD, CFPC, FCFP; Alison Baker, MD, CCFP, FCFP; Deborah Kopansky-Giles DC, FCCS, MSc; Aaron Johnston MD, CCFP, FCFP

All teachers welcome. Highlight's novice concepts for clinical preceptors.

**Learning objectives:**

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

1. Identify key factors for building effective interprofessional teams in postgraduate Family Medicine education
2. Explore collaborative competencies in interprofessional primary care education
3. Describe approaches from existing models to strengthen interprofessional team teaching

**Description:**

Interprofessional teamwork is recognised as essential for optimal patient care and is a priority of the CFPC Residency Training Curriculum Renewal. Teamwork can have many benefits in Family Medicine education beyond learning to work with others. Teamwork supports the development of transferable skills that can impact identity formation, career trajectory, wellness, job satisfaction, and importantly, improve care that patients receive. Teaching as a team can help to elucidate an understanding regarding the differences between one's scope of practice, one's role within the team and one's additional skills that can be optimized both in teaching and in the provision of patient care. It also provides opportunities for modeling collaborative behaviors to learners and has been shown to strengthen teams in the delivery of collaborative care. An effective team fosters a collaborative and supportive environment and is a strong enabler for educational leadership. Learning in a team environment allows the delivery of comprehensive educational programs by the sharing of diverse skills, knowledge, and perspectives and the promotion of patient centered care. While most learners start residency with some undergraduate interprofessional education (IPE), explicit and defined IPE varies among postgraduate programs. This session is aimed at medical educators wishing to enhance the continuity of IPE for learners with a focus on interprofessional teamwork. We will explore how to build and lead effective interprofessional teams in Family Medicine education. We will highlight the competencies elucidated by the Canadian Interprofessional Health Collaborative (CIHC) framework and those described by other professional bodies. Participants will be

engaged by polling activities and group discussions to reflect on their experiences with team teaching and with building effective IPE teams. Practical examples of strategies from across the country will be shared. This session is suitable for both early and established family medicine educators and leaders.

**Wednesday, November 6 Session ID: 106 Room: 205-206**

**15:30–16:30 Creating Cost-Effective, High-Fidelity Models to Teach Procedural Skills**

Clara Rocha Michaels, MD, CCFP; Andrea Vasquez Camargo, MD, MSc, CCFP

All teachers welcome. Highlight's developing concepts for educational leaders.

**Learning objectives:**

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

1. Recognize the challenges faced when teaching procedural skills to learners across the education continuum
2. Create low-cost models to teach procedural skills to medical students and residents
3. Identify different options to create low-cost simulation models through discussion and experience sharing

**Description:**

Simulation-based education provides medical students and residents with opportunities to develop procedural skills via hands-on learning experience. Preceptors have identified different challenges to teach outpatient procedural skills to learners including but not limited to, lack of reality in existing models, scarce models for specific procedures, and insufficient resources. A needs assessment was performed to identify challenges teaching procedures by faculty in the Department of Family Medicine, University of Saskatchewan. Faculty members at the Family Medicine residency program, developed cost-effective, high-fidelity simulation models to assist preceptors in teaching procedures. Knowing that other preceptors likely face similar challenges teaching procedures, and the successful results using low-cost simulation models to teach learners, encouraged us to share the models we created. This session will serve as a space to share experiences, interact, and create networks among participants that will allow us to exchange ideas and enhance our journey of teaching procedure skills to our learners.

**Wednesday, November 6 Session ID: 119 Room: 114-115**

**15:30–16:30 Freestanding Papers on Educational Research 1**

**Learning objectives:**

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

1. Gain an in-depth comprehension of diverse research methodologies and findings across various facets of family medicine
2. Develop the ability to critically evaluate and assess the implications, strengths, and limitations of presented research papers, honing skills in discerning high-quality resear
3. Foster an interactive learning environment by engaging in discussions with presenters and peers, facilitating the exchange of ideas, perspectives, and potential applications of research in clinical practice or academia

**Description:**

Innovation, reflection, research, evaluation, and quality improvement are part of the fabric of family medicine. The facilitated free-standing paper session is an opportunity to hear from and talk with colleagues who are leading studies that have been selected for presentation through peer review. These sessions are an exciting opportunity to learn from and engage in the study of family medicine education and practice.

**Session ID: 148**

### 15:30–15:40 Preparing Healthcare Educators for Teaching Roles Using Technology

Deanna Telner*, MD, Med, CCFP, FCFP; Heather MacNeill, MD, MScSH, FRCPC; Nick Petton, MA

**Learning objectives:**

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

1. Describe the evidence why faculty development in educational technology is needed for academic family physicians
2. Discuss how validated scales (eg. TPACK) can be used to evaluate faculty development needs
3. Reflect on how to prepare themselves as academic family physicians for future technology enhanced roles

**Description:**

**Objective:** The COVID-19 pandemic caused technology use in healthcare education to go from 'niche' to 'necessity'. Studies demonstrate that medical teachers feel ill-prepared to teach using technology and there are few pedagogically driven Faculty Development opportunities for them. The objective of this study is to evaluate the impact of healthcare educators participation in a master's level course on educational technology on their perception and use of technology in teaching. **Design:** Mixed method study design consisting of validated survey questions using modified Technology Acceptance Model (TAM) and Technological Pedagogical and Content Knowledge (TPACK) standardized questionnaires and focus groups. **Setting:** University of Toronto, Department of Family and Community Medicine. **Participants:** Physicians and other healthcare educators. **Intervention:** Participation in a 40 hour master's course covering theory, evidence and practical application of educational technology in the healthcare context. **Main Outcome Measures:** Comparison of pre-course survey to survey results 6 months after course completion; focus group sessions immediately after course completion. **Results:** Twenty participants over two cohorts experienced changes in technology knowledge but much larger changes in pedagogically informed teaching and self-efficacy. At 6 months post course completion, participants were using technology differently and could identify why they chose certain technological tools to teach. Focus groups revealed a decrease in 'imposter syndrome', which participants identified experiencing prior to taking the course, increased confidence in using technology and increased awareness of the pedagogy behind the tools being used in education. They described an ability to speak a 'common language' with other educators and advocate for technology use in curriculum design and delivery. **Conclusion:** As we move beyond the post COVID-19 era, this study helps to identify Faculty Development needs of healthcare educators in technology-enabled teaching and the enduring impacts training in this area may have.

**Session ID: 469**

### 15:40–15:50 Examining Teaching About the OTP National Curriculum Priorities

Patrick Alex Hicks*; Shelley Ross, PhD, MCFP (Hon); Mawada Tarhuni, MBBS; Tarleen Dhanoa, BA

**Learning objectives:**

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

1. List the OTP Phase 2 national curriculum priority areas
2. Describe the types of clinical learning opportunities residents experience relevant to the curriculum priority areas
3. Evaluate how FieldNotes can be used for learning analytics to identify program gaps and strengths

**Description:**

**Objective:** In 2023, the College of Family Physicians of Canada (CFPC) initiated Phase 2 of the Outcomes of Training Project: "Team Primary Care -Training for Transformation: Family Medicine Curriculum Renewal Planning". The CFPC's expectations for Curriculum Renewal planning identified six areas of priority social need: Home and Long-term Care (LTC); Addiction and Mental Health (AMH); Emergency/Acute Care Medicine (E/AC); Indigenous Health (IH); Health Equity and Anti-racism (HE/AR); Virtual Care and Health Informatics (VC/HI). Our objective in this study was to explore clinical learning opportunities about these areas in one family medicine program, using completed workplace-based assessments as a proxy for clinical teaching. **Design:** Retrospective cross-sectional cohort study using secondary data analysis (learning analytics). **Setting:** Mid-sized family medicine residency program. **Database:** De-identified FieldNotes (workplace-based assessment forms that include narrative capture of feedback shared with a resident) from July 1, 2016 to June 30, 2023 (N=42,376). **Main Outcome Measures:** We extracted relevant FieldNotes using search terms related to each recommended area (e.g. For Virtual Care and Health Informatics (VC/HI), sample search terms included: EMR, telehealth, MedAccess, and document). Extracted data were analyzed using descriptive statistics and data visualization. **Results:** An average of 6053 FieldNotes were completed per year. Search results showed variation in evidence of teaching across the OTP recommended areas: highest numbers of FieldNotes were found for E/AC (12,653), AMH (4753), and VC/HI (2908). Comparatively low numbers of FieldNotes were identified for HE/AR (235), LTC (165), and IH (38). However, 1685 FieldNotes were categorized as "Underserved communities", and may have included HE/AR and IH learning experiences. **Conclusion:** Residents in our program have been experiencing multiple learning opportunities across all of the OTP recommended areas and topics, although opportunities are not equal. Using FieldNotes for learning analytics allows us to identify where further learning experiences are needed.

**Session ID: 422**

### 15:50–16:00 EHR Use Impacts Patient-Centredness in Virtual Encounters

Lisa Shah, MD, MSc; Laura Santos, MD; Douglas Archibald, PhD; Farhad Motamedi, MD; Helen Monkman, PhD; Andre Kushniruk, PhD; Kendall Noel, MDCM, MEd; Gary Viner*, MD, MEd

**Learning objectives:**

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

1. Determine how to minimize the negative impacts of EHR use on patient-centredness
2. Explore ways to maintain patient-centredness while using the EHR during virtual encounters
3. Explore how to educate residents on effective contemporaneous charting during virtual encounters

**Description:**

**Objective:** To assess the impact of electronic health record (EHR) use on primary care physician patient-centredness and clinical performance in simulated patient virtual encounters. **Design:** Mixed-methods study which adapted simulated patient standardized clinical scenarios from family physician certification oral examinations to include use of the EHR. This project was approved by the local Research Ethics Board. **Setting:** An academic primary care clinic based in a hospital. **Participants:** Ten resident physicians and six staff physicians. **Intervention:** Participants each completed two simulated patient scenarios with instructions to document their encounters in the EHR. Sessions were virtual and recorded over Zoom. Recordings were analyzed for patient-centredness, overall clinical performance, and EHR use. **Main Outcome Measures:** Patient-centredness scores, Simulated Office Oral (SOO) exam scores. **Results/Findings:** There was a wide variation in use of the EHR during virtual encounters. In 11 of the 32 encounters, participants only clicked on one section of the EHR while interacting with the simulated patient. Scatter plot visualization of the data revealed a trend of lower patient-centredness and SOO scores with increased proportion of time actively using the EHR and navigating within the EHR while the simulated patient was present. Overall, this was not a statistically significant correlation. However, for residents only, there was a statistically significant difference between their time spent actively using the EHR and their patient-centredness scores ($p=0.041$). Independent samples t-tests showed a significant difference between resident and staff physician patient-centredness scores ($p=0.027$). **Conclusion:** Active use of the EHR during virtual encounters negatively impacted resident and staff physician patient-centredness and overall clinical performance. Resident patient-centredness scores were negatively impacted to a greater extent by EHR use than were staff physician patient-centredness scores. A need for formal instruction in maintaining patient-centredness while using an EHR during virtual encounters was identified. This instruction will allow effective contemporaneous charting.

**Session ID: 455**

### 16:00–16:10 In-Person Versus Virtual Teaching Among Health Professional Learners

Ann Stewart*, MD, MSc, CCFP, FCFP; Deborah Kopansky-Giles, BPHE, DC, FCCS, MSc; Joyce Nyhof-Young, BSc, MSc, PhD; Andrée Schuler, PhD; Grace Zhou; Josh Plener, BSc, DC, MSc; Pegah Rahbar, BSc, DC; Judith Peranson, MD, MSc, CCFP

**Learning objectives:**

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

1. Evaluate learner perspectives on in-person versus virtual Inter-Professional Education (IPE)
2. Evaluate facilitator perspectives on in-person versus virtual IPE
3. Determine how future IPE sessions should be conducted

**Description:**

**Context:** Inter-professional Education (IPE) modules focusing on inter-professional collaboration were delivered in person from 2005-2018, then pivoted to virtual format during COVID-19 (2020-2023). As the modality of teaching may impact participant learning, we questioned whether transitioning to virtual

learning served as a new opportunity, a setback, or had no significant impact. **Objectives:** 1.To evaluate learner perspectives on in-person versus virtual Inter-Professional Education (IPE). 2. To evaluate facilitator perspectives on in-person versus virtual IPE 3. To determine how future IPE sessions should be conducted. **Design:** Mixed methods were used involving a retrospective review of pre- and post-module learner questionnaires (2018-2023) and facilitator focus groups (FG). Descriptive and bivariate analysis was completed and thematic coding used for qualitative results. Institutional ethics approval was obtained. **Setting:** Inter-professional education sessions are provided to all health profession learners at St Michael's Academic Family Health Team, an inner-city inter-professional family practice unit in Toronto, to support optimization of future workforce team-based care. **Participants:** 212 learners representing 10 different professions completed pre- and post-module questionnaires. 108 responses were gathered from 4 in-person modules (2018- 2019) and 104 from 4 virtual modules (2021-2022). In 2023, 6 module facilitators participated in two FG. **Results:** Learner data demonstrated high satisfaction with the modules both in-person and virtually, however close comparison identified differences in learners' level of self-perceived collaborative competency (lower among virtual learners), as well as preferences of learners related to module delivery (joy with learning together in person). Post-module facilitator debriefs and FG results identified challenges and opportunities for virtual delivery, as well as preferences for mode of delivery. **Conclusions:** Results demonstrated high satisfaction with the module in both delivery modes; however preferences and nuances described by both learners and teachers will be considered in planning future IPE module delivery.

**Session ID: 352**

### 16:10–16:20 Family Medicine Residents' Perceptions on an Innovative Clinic for Asylum Seeking Patients: An exploratory qualitative study

Serina Achkar*, MD; Shayla Achkar, MD; Juliette Paul, MD; Lara Gautier, PhD; Emma Glaser, MD MSc, CCFP

**Learning objectives:**

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

1. Describe an innovative pedagogical clinic that aims to teach cultural competency with asylum seeking families
2. Explore the training experience of residents who participated in the innovative clinic
3. Identify strategies going forward to improve this clinic

**Description:**

**Context:** In order to adequately respond to the growing clinical care needs of asylum seekers in Canada, it is essential to train the next generation of healthcare professionals to be culturally competent. There is in fact little literature exploring the learner's perspective when it comes to teaching and learning for this population. Our teaching unit, Bordeaux-Cartierville (University of Montreal), started an innovative clinic for asylum seeking patients with the involvement of family medicine residents to meet this pedagogical goal. To our knowledge, this clinic is unique in Quebec. **Objective:** Our primary objective was to explore the training experience of residents who participated in the innovative clinic for asylum seeking patients. We wanted to identify the facilitators, barriers, and learning outcomes in relation to providing care for migrants. We aim to optimize care for this population within a culturally competent perspective. **Design and Participants:** We used an exploratory qualitative case study and sought a purposive sample of first

and second-year family medicine residents (n=13) at the clinic. Data collection was done through three focus group discussions (n=4 or 5). Thematic analysis using qualitative data analysis software Dedoose revealed five key themes: residents' lived experience within the clinic, their relationships with their asylum-seeking patients, their desired improvements for the clinic as well as the aspects they appreciated, and the competencies acquired throughout the training. **Results and Impact:** Generally, residents appreciated the unique training experience of working alongside asylum-seeking patients. We observed that the primary frustrations stemmed from perceived cultural and communication barriers, coupled with a shortage of healthcare resources. However, they acquired skills in providing culturally competent care by learning to empathize with the reality of these patients, overcoming these barriers. Residents also faced challenges in balancing the divergent expectations of the patient and healthcare team within the clinic. Despite many learners expressing a sense of powerlessness in delivering efficient care for asylum-seeking populations, it was noteworthy that they were able to better help patients navigate through the healthcare system.

**Session ID: 90**

### 16:20–16:30 Instilling Criticality Through a Health Humanities Seminar Series

Shane Neilson*, MD, MFA, MA, PhD

**Learning objectives:**

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

1. Provide a case for skilled expertise in delivering health humanities educational opportunities to med students
2. Demonstrate the lack of scholarly health humanities offerings in medical education
3. Demonstrate the effect of an intervention - a seminar series - at McMaster

**Description:**

The main impediment to a health humanities curriculum grounded in theory and criticality in medical schools is philosophical: the institution of medicine generally purports that a firm grip on biomedical principles and information is of primary concern for any prospective physician. This, despite the fact that the Association of American Medical Colleges deems “the role of the arts and humanities in medical education and physician development” as “fundamental”. When health humanities curriculum is present in North American medical schools, the pedagogy tends to be either instrumental in nature, in which the objective is to build clinical skills. Criticality is less in service to medicine, though a service is performed, and moreso wondering how the practice of medicine itself might be improved and reimagined. Because the possibilities for theoretical pedagogical approaches designed to instill criticality within students seem vast, an initiative was undertaken at the Waterloo Regional Campus of McMaster University to determine how valid a theory-based humanities seminar curriculum might prove to students themselves. To wit, seminars were conducted from September 7 2023 – November 16 2023 on a broad range of health humanities topics (biomedical epistemology; metaphor in medicine; narrative medicine and Indigenous story medicine; cripping medicine; neoliberalism and resilience; professionalism). A qualitative, cross-sectional survey using both structured and unstructured questions was administered employing the convenience sampling method. My presentation will discuss the theoretical background informing the development of the seminar series, the goals of the series, and its outcomes.

# Thursday, November 7

**Thursday, November 7** **Session ID: 140** **Room: 223-224**

**7:30–18:00** **Airway Interventions & Management in Emergencies (AIME) Course 1**

George Kovacs, MD, MHPE, FRCPC

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 18 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Practice making acute care airway management decisions (Family Medicine Expert)
2. Organize a practical staged approach to airway management (Leader)
3. Choose most appropriate method of airway management based on variety of patient presentations (FM Expert)

**Description:**

This program is designed for physicians working in an acute care setting requiring them to competently manage patients in need of emergency airway management. AIME program highlights include: Case-based clinical decision making; NEW algorithms based on Canadian Airway Focused Group Guidelines; NEW managing patients with high risk infections; Optimizing your patient prior to airway management; Hyperangulated, Macintosh and channelled video laryngoscopy; Managing the contaminated airway; When, why and how to perform awake or rapid sequence intubation; Management of the difficult airway and rescue oxygenation and ventilation; How to make the decision and safely execute a cruicothyrotomy; On-line open access textbook Infinity Edition of Airway Management in Emergencies; Unique, customized clinical videos; Limited registration to ensure clinician to instructor ratio of 5 or 6:1; Clinician to simulator ratios of 2:1

**Thursday, November 7** **Session ID: 503** **Room: Ballroom C**

**7:30–8:30** **Prevent & Protect: Championing pneumococcal disease prevention in primary-care**

Shannon Walker, MD

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

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

1. Communicate the burden of pneumococcal disease and the importance of pneumococcal vaccination
2. Identify at-risk populations that would likely benefit from pneumococcal vaccinations
3. Apply current recommendations for pneumococcal vaccination in pediatric and adult patients
4. Address vaccine hesitancy and counsel patients and caregivers on the importance of pneumococcal vaccines

**Description:**

Prevent & Protect – Championing Pneumococcal Disease Prevention in Primary Care is an educational program designed to help family physicians further their education level with respect to the prevention of pneumococcal disease. The program is designed to be flexible and interactive, with the use of clinical questions to further enhance learning strategies.

**Thursday, November 7** **Session ID: 500** **Room: Ballroom AB**

**8:15–9:45** **Family Medicines Cross Country Hiccup: How family medicine/primary care lost its mojo and the journey to get it back**

David Price, MD, CCFP

**Learning objectives:**

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

1. Understanding the political, ministry, regulatory and professional colleges roles' in not learning lessons from Barbara Starfield and others
2. Audience members will experience a snapshot of primary care exemplars from coast to coast to coast and will hear about common principles from these communities
3. Explore some of the ways they can influence political, ministry, regulatory and professional colleges and champion a system fit for the next 20 years (or know how they might allocate an extra billion dollars into the primary care system)

**Description:**

An exploration of the political, ministry, regulatory, and professional colleges roles in not learning lessons from Barbara Starfield and others. An opportunity to experience a snapshot of primary care exemplars from coast to coast and hear about common principles from these communities, exploring ways to influence political, ministry, regulatory and professional colleges and champion a system fit for the next 20 years.

**Thursday, November 7** **Session ID: 286** **Room: 121**

**9:00–12:30** **Canadian MAiD Curriculum Topic 5: Providing MAiD**

Stefanie Green, MD; Konia Trouton

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 15 Mainpro+ credits.

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Plan for MAiD provision. Manage the practical and emotional aspects of MAiD provision. Prepare the MAiD team, patient, family/friends for the provision
2. Support the MAiD team, patient, family/friends before, during, and after provision. Use a waiver of final consent. Anticipate and manage adverse events
3. Manage the post-provision period. Reflect on the gravity of providing MAiD and the impacts on MAiD providers. Identify resilience practices that can support a sustainable MAiD practice

**Description:**

This session provides a comprehensive guide on planning for Medical Assistance in Dying (MAiD) provision, covering both practical and emotional aspects. Participants will learn how to prepare the MAiD team, patients, and their families for the process, offering support before, during, and after provision. The session addresses the use of a waiver of final consent, strategies for anticipating and managing adverse events, and insights into managing the post-provision period. Additionally, participants will reflect on the profound impact of providing MAiD and explore resilience practices for sustaining a meaningful and ethical MAiD practice.

**Thursday, November 7** **Session ID: 207** **Room: Ballroom AB**

**10:15–11:15** **Diabetes Tools for Your Practice**

Susie Jin, RPh, CD,E CRE; James Kim, CFPC, MBBCh, PgDip (Diabetes)

**Learning objectives:**

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

1. Learn to use Diabetes Canada's Quick Reference Guide for effective diabetes management in clinical practice
2. Learn how to integrate Diabetes Canada's prescription tools into clinical workflows for tailored treatment plans
3. Learn to utilize Diabetes Canada's healthcare provider resources to enhance diabetes care plans and education

**Description:**

Join primary care physician James Kim and pharmacist and certified diabetes educator Susie Jin for a session designed to equip family doctors with essential tools and resources from Diabetes Canada to enhance diabetes care in their practices. Throughout this session, participants will engage in learning aimed at mastering the use of Diabetes Canada's Quick Reference Guide, prescription tools, and other valuable resources tailored for healthcare providers. The session will begin with an in-depth exploration of the Quick Reference Guide, focusing on its practical application in the management of diabetes. Participants will learn how to efficiently navigate the guide's sections and utilize its recommendations to optimize patient care. Next, participants will delve into the integration of Diabetes Canada's prescription tools into their clinical workflows. Through interactive exercises and case studies, attendees will learn

how to tailor treatment plans according to individual patient needs, set achievable treatment goals, and effectively monitor patient responses to therapy. By the end of this session, participants will leave with a deeper understanding of Diabetes Canada's tools and resources for healthcare providers, equipped with the skills and knowledge to enhance diabetes care in their practice settings. Don't miss this opportunity to elevate your diabetes management skills and make a positive impact on the health outcomes of your patients.

**Thursday, November 7** **Session ID: 245** **Room: Ballroom C**

**10:15–11:15** **PEER: What's new, what's true and what's poo?**

Betsy Thomas, BSc Pharm; Danielle Perry, MSc RN; Michael Allan, MD, CCFP

**Learning objectives:**

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

1. Describe evidence of new diagnostic tests or therapies that should be implemented into current practice
2. Compare articles and evidence that may reaffirm currently utilized diagnostic tests, therapies or tools
3. Identify articles that highlight diagnostic tests, therapies or other tools that were misrepresented in studies/media

**Description:**

In this session, we will review top studies from the past year that have the potential to impact primary care. Topics will vary depending on recent studies. The presentations summarize the most impactful studies, condensed into one slide or at times rapid fire key findings from multiple studies. We will discuss whether the research implications of these studies are practice-changing or re- affirming or whether they should be ignored. Each will have clear and practical bottom-lines for implementation into practice. Lastly, we'll add a few humorous studies and content - this is medicine and laughter which is the best medicine.

**Thursday, November 7** **Session ID: 307** **Room: 109-110**

**10:15–11:15** **Enhancing Dementia Diagnosis Communication: The CLEAR Communication Toolkit**

Sid Feldman, MD, CCFP (COE), FCFP, CMD; Vivian Ewa, MBBS, CCFP (COE), CCFP, FCFP, PG DipMedEd, FRCP Edin; Jhnelle McLaren-Beato, MD

**Learning objectives:**

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

1. Recognize challenges of disclosing a dementia diagnosis from both patient and provider perspectives
2. Describe how the CLEAR Communication Toolkit was developed and its purpose
3. Implement the CLEAR Communication Toolkit in clinical practice

**Description:**

Supporting patients living with dementia and their care partners is a challenge for family physicians, and disclosing a new diagnosis can be particularly difficult. The Alzheimer Society of Canada, the Public Health Agency of Canada, the Canadian Consensus Conference on Diagnosis and Treatment of Dementia, and the CFPC Members Interest Group in Care of the Elderly collaborated to create evidence-based guidelines to improve the process of communicating a dementia diagnosis, with a cultural focus on Black and Chinese communities. There is growing recognition that guidelines alone are not enough to support health care providers in making changes to their clinical practice. As a result, six teams inclusive of family physicians and other health care providers, dementia specialists, persons with lived experience, and ethnocultural groups co-designed the CLEAR Communication Toolkit for communicating a dementia diagnosis. During the first portion of the session, participants will learn from both patient and family physician perspectives about why the Toolkit is important and valuable for improving the communication of a dementia diagnosis. Participants will also be provided a brief overview of the co-design process that led to the creation of the Toolkit, including results from a two-phase evaluation process. Following this, participants will be led through a detailed description of the Toolkit, including instructions on how to use the Toolkit in practice. The majority of this section will be dedicated to interactive case scenarios demonstrating how the Toolkit can be used to support the communication of a dementia diagnosis in different situations. These situations may include examples of positive disclosures, more challenging disclosures (e.g., lack of acceptability from the patient and/or care partner), and how to provide culturally competent disclosures. Lastly, there will be an opportunity for open discussion with session experts, including a person living with dementia and a disclosing practitioner.

**Thursday, November 7** **Session ID: 309** **Room: 118-120**

**10:15–11:15** **Perinatal Mental Health: An update and new topics**

Jennifer Leavitt, MD, CCFP; Milena Forte, MD; Dr. Sanja Kostov, MD; Michelle Carter, RN, MSN

**Learning objectives:**

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

1. Determine risk factors, protective factors, and approaches to screening for perinatal anxiety and depression
2. Incorporate evidence-based universal approaches to improve mental health in the peripartum period
3. Apply an approach to the treatment of anxiety and depression in pregnancy and postpartum

**Description:**

Perinatal mental health including anxiety and depression can have negative impacts on maternal, family and child health during pregnancy and the postpartum period. It is estimated that in Canada, perinatal mental health disorders affect up to 20% of birthing individuals. This multidisciplinary, case-based presentation will highlight approaches to office-based screening for common perinatal mental health disorders, including reviewing both protective and risk factors. It will describe a common approach that can be used by all patients to reduce the risk of perinatal mental health disorders and strategies of how to include this information as part of regular antenatal care. Participants will feel comfortable with an approach to treatment for anxiety, depression and suicidality in the perinatal period that can be applied in their practices. Time will be given to participants to get into groups to discuss cases including a discussion of local resources.

**Thursday, November 7** **Session ID: 254** **Room: 205-206**

**10:15–11:15** **Virtual Care for Teachers: A new frontier**

Tania Rubaiyyat, MD, CCFP, FCFP; Fanny Hersson-Edery, MD, CCFP, FCFP; Lisa Graves, MD, CCFP (AM), FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Describe the role of virtual care in Family Medicine clinical settings
2. Provide key curriculum objectives for teaching virtual care in postgraduate programs
3. Plan to optimize teaching virtual care competencies to residents in their clinical settings

**Description:**

Virtual care has been widely used in rural and remote Family Medicine for over a decade. The Covid-19 pandemic pushed the wider adoption of virtual care across Family Medicine clinical settings. Physicians and learners were challenged to rapidly learn and teach how to deliver clinical care using virtual care. The future of virtual care includes an expansion of digital health delivery in multiple care settings and as a tool for addressing equity in healthcare. This session will review what we know about teaching virtual care in Family Medicine postgraduate programs. Essential virtual care skills including effective communication, history taking, physical examinations and management will be explored. Examples of available curricula and studies of their impact will be discussed. Participants will be invited to discuss the role of virtual care in their practice milieus and how to optimize the training of family medicine residents to meet evolving health care delivery needs, developing digital technology, and societal expectations.

**Thurday, November 7** **Session ID: 251** **Room: 111-112**

**10:15–11:15** **Sharing Identities: Cultivating compassion inside and out**

Vanessa Brcic, MD, CCFP, MSc; Nicole Marcia MA, MC, RCC, C-IAYT

**Learning objectives:**

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

1. Define concepts that impact our work and relationships including: intersectionality, structural violence, and somatic abolitionism
2. Recognize and compassionately navigate signals of discomfort that arise in ourselves and intersections with others
3. Increase our capacity to bear witness to ourselves and others, while noticing our edges of comfort and discomfort in a supportive group space

**Description:**

A lot comes up for us when we consider the challenges faced by the health care system, particularly systemic discrimination and racism. Creating space for us to notice who we are and how we feel in this

context is important to developing language, capacity, and mobility to face challenges within our profession. Noticing discomfort in a way that is supportive and manageable is an important ingredient to shifting culture and creating positive change; it creates a felt sense of possibility in the context of discomfort. We will begin by defining key concepts from the literature informing this practice, and move into group dialogue rooted in practices of mindfulness, and compassionate listening. As a group, we will practice social location / positionality disclosure, experimenting with what we are / are not comfortable disclosing about ourselves, how we know what our edges of comfort are, and building new experiences of connection and compassion while safely navigating the edges of comfortable and uncomfortable terrain. This practice is informed by the presenter's training in trauma and violence-informed care and relational somatic therapy, as well as evidence from neuroscience, decolonizing practice (Shawn Wilson, UBC), and somatic abolitionism (Resmaa Menakem). It is also informed by the work of Gabor Mate, who describes the misconceptualization of compassion fatigue: We are innately compassionate, and do not fatigue of being our true selves. We do, however, fatigue of overwork and martyrdom, and the tension of being enculturated into work environments relying upon personal sacrifice, over-extension, and neglect of the self. In all of these approaches, we can mobilize by resisting unhealthy norms, and investing in healthy relationships, relational accountability, and standing behind or "being" our research/practice/work. This workshop will be an opportunity to examine and practice some of these concepts in connection with colleagues.

**Thursday, November 7** **Session ID: 217** **Room: 202-204**

**10:15–11:15** **Caught in the Middle: Intervening microaggressions from patients**

X. Catherine Tong, MD, CCFP (EM), FCFP, DRCPSC; Hannah Jordan; Aaron Geekie-Sousa; Judy Mackinnon, MD, CCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Define microaggressions and their harmful impact to the learning environment
2. Review principles and policies relevant to microaggressions in the clinical teaching environment
3. Learn one technique in disarming microaggressions effectively while navigating physician-patient and preceptor-learner relationships

**Description:**

Microaggressions in the learning environment have significant and cumulative harmful effects. Academic family medicine departments' stated strategic goals in inclusive excellence, although widely accepted, are rarely called up and acted upon in the moments of microaggressions due to many barriers. The incidences are especially challenging when the source of the microaggression is a patient and the target is a learner. In social sciences, it is known that bystanders play an important role in defining or affirming organizational culture by their action or inaction. The idea of using simulation based education design for bystander training to empower faculty members to intervene microaggressions was previously described at FMF 2021 as one of the top 4 Big Ideas Soap Box https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9842182/. Since then, a workshop based on this idea has

been delivered multiple times to local, national and international faculty members with positive feedback https://doi.org/10.1136/leader-2023-000784. In this session, a team of experienced facilitators including family medicine educational leaders and simulation education teachers bring FMF 2024 attendees a tailored experience in the specific context of a family medicine teaching clinic. The workshop will open with a briefly review of the harmful effects of microaggressions and the principles of simulation-based education design. The facilitators will present two new cases focusing on microaggressions from the patients to learners. Attendees are invited to volunteer to practice this technique in simulation with a trained actor. During debrief, a sample of provincial policies governing physician-patient relationships, and institutional policies governing clinical supervision relationships will be reviewed. In the context of these policies and rules, attendees will leave the session with one new technique in mitigating microaggressions from patients.

**Thursday, November 7 Session ID: 120 Room: 114-115**

**10:15–11:15 Freestanding Papers on Educational Research 2**

**Learning objectives:**

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

1. Gain an in-depth comprehension of diverse research methodologies and findings across various facets of family medicine
2. Develop the ability to critically evaluate and assess the implications, strengths, and limitations of presented research papers, honing skills in discerning high-quality research
3. Foster an interactive learning environment by engaging in discussions with presenters and peers, facilitating the exchange of ideas, perspectives, and potential applications of research in clinical practice or academia

**Description:**

Innovation, reflection, research, evaluation, and quality improvement are part of the fabric of family medicine. The facilitated free-standing paper session is an opportunity to hear from and talk with colleagues who are leading studies that have been selected for presentation through peer review. These sessions are an exciting opportunity to learn from and engage in the study of family medicine education and practice.

**Session ID: 449**

**10:15–10:25 Teaching POCUS in a Rural Family Medicine Residency**

Adam Jones-Delcorde*, MD, MSc, CCFP (EM); Sean D. Higgins, MD, CCFP; Paul Pageau, MD, CCFP (EM), FCFP; Vikas Bhagirath, MD, CCFP (EM); Michael Woo, MD, CCFP (EM), FCFP

**Learning objectives:**

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

1. Discuss the barriers that limit POCUS training and how those barriers might be overcome
2. Describe a POCUS curriculum that relies on independent practice and asynchronous feedback
3. Consider implementing a similar POCUS curriculum in your Family Medicine residency program

**Description:**

**Objective:** To describe and evaluate a scalable model for teaching POCUS in a rural Family Medicine residency program where access to instructors, machines, and curriculum time is limited. **Design:** Program evaluation. REB exemption was obtained. **Setting:** A small rural hospital in Winchester, Ontario. **Participants:** All Family Medicine residents (n = 10) training at our site from 2022-2024 participated. **Intervention:** At the beginning of each academic year, residents in our program receive training in POCUS at 4 half-day workshops. Residents practice by scanning each other to eliminate the need for standardized patients, and PGY2 residents are asked to help teach PGY1 residents. Afterwards, residents are given access to a handheld ultrasound device and asked to practice scanning independently when they encounter patients in clinical practice. A single POCUS instructor reviews the recorded images and provides asynchronous feedback. **Outcome Measures:** A workplace-based assessment of competency was performed every 6 months from July 2022 until January 2024. At each assessment, a preceptor with POCUS skills directly observes the resident while they scan a patient and scores their performance using the Ultrasound Competency Assessment Tool (UCAT). **Results:** UCAT scores showed a trend towards improving competency and increasing levels of entrustment. The mean UCAT scores were 76% (SD = 15%) on the first assessment and 94% (SD = 10%) at the final assessment. The proportion of preceptors describing their entrustment as "I needed to be there just in case" or "I did not need to be there" was 42% at the first assessment and 100% at the final assessment. **Conclusion:** In our program, Family Medicine residents build competency with POCUS over time, despite receiving a limited amount of didactic instruction. Our model, where residents practice independently and a single POCUS instructor provides asynchronous feedback, could be implemented at other sites where resources are similarly limited.

**Session ID: 362**

### 10:25–10:35 Modules de lecture critique - Innovation en enseignement

Tania Riendeau*, MD, CCMF; Hugues De Lachevrotière, MD, CCMF; Marie Authier, PhD; Janusz Kaczorowski, PhD; Dragos Vlad, MD (résident au moment de la création); Jean-Pierre Pellerin; Nadia Sourial, PhD; Élise Develay, M.Sc; Louis Lochhead, MBA (patient partenaire); Emma Glaser, MD, CCMF; René Wittmer, MD, CCMF

**Learning objectives:**

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

1. Déterminer des objectifs d'apprentissage en lecture critique qui sont adaptés à la pratique et aux besoins de la communauté
2. Concevoir des modules d'apprentissage innovant répondant à ces objectifs
3. Implanter et évaluer les modules

**Description:**

**Objectif:** Déterminer des objectifs d'apprentissage en lecture critique qui sont adaptés à la pratique et aux besoins de la communauté; Concevoir des modules d'apprentissage innovant répondant à ces objectifs; Implanter et évaluer les modules. **Public cible :** Résidents du programme de médecine de famille de l'Université de Montréal. **Intervention :** Des groupes de travail formés de médecins de famille, de chercheurs, de résidents et d'un patient partenaire ont travaillé à l'élaboration en 2020 des objectifs d'apprentissage à partir de différentes sources (besoins normatifs et ressentis) puis à la conception de quatre modules d'apprentissage qui ont été déployés en 2021 et révisés en 2022. Au-delà de

l'apprentissage des notions statistiques et de la recherche traditionnelle de la littérature, les modules permettent aux résidents de: développer une stratégie de recherche efficace; d'interpréter les guides de pratiques d'un point de vue du médecin de famille et du patient; d'interpréter l'information des sources non traditionnelles (balados, vidéos, site web, etc.); de vulgariser et d'appliquer les données probantes et les recommandations à la diversité des patients rencontrés en pratique. Les modules ont été conçus dans un environnement d'apprentissage ludique et sont basés sur la réalité clinique vécue au quotidien par le médecin de famille. **Résultats et constats :** Les évaluations ont été compilées pour deux cohortes de résidents (2022 et 2023) pour un total variant entre 263 et 288 évaluations reçues pour chacun des quatre modules. Les résidents ont évalué la pertinence et l'organisation du contenu comme adéquate à plus de 97%. 44/49 objectifs d'apprentissage ont été jugés atteints (seuil de 80%) par les résidents. Les commentaires qualitatifs étaient globalement excellents. **Conclusion :** Les modules de lecture critique atteignent les objectifs établis et permettent de mieux préparer les futurs médecins de famille à la réalité moderne de la lecture critique.

**Session ID: 460**

### 10:35–10:45 Exploring Differences in Resident-Entered Versus Preceptor-Entered Narrative Feedback

Kelsey Compagna*,BScN; Ann Lee, MD, MEd, CCFP; Shelley Ross, PhD, MCFP (Hon.)

**Learning objectives:**

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

1. Define the four areas of feedback focus proposed by Hattie and Timperley (2007)
2. Apply the four areas of feedback focus to narrative feedback
3. Describe differences in feedback focus in narrative feedback on FieldNotes entered by residents versus preceptors

**Description:**

**Objective:** Findings from published research have established that while there is a connection between feedback and learning, the degree to which feedback helps learners improve varies greatly. This variance can be due to differences in how feedback is shared and interpreted. We explore these differences by examining learner-entered and preceptor-entered FieldNotes. Each FieldNote includes a narrative summary of a feedback conversation. Our objective was to explore differences in the feedback on FieldNotes written by residents compared to those written by preceptors to gain insight into what each population considers to be important and worthy of documentation. **Design:** Retrospective cross-sectional cohort study using secondary data analysis. **Setting:** Mid-sized family medicine residency program. **Database:** De-identified FieldNotes (workplace-based assessment forms that include narrative capture of feedback) from two academic teaching sites electronically completed between July 1, 2015 to March 12, 2020 (onset of COVID-19 restrictions). **Main Outcome Measures:** Narrative feedback in FieldNotes was coded using Hattie and Timperley's four areas of feedback focus: Task, Process, Self-Regulated Learning (SRL), and Self. We compared FieldNotes entered by residents to those entered by preceptors using independent-samples proportions to look for differences in feedback focus. **Results:** A total of 6804 FieldNotes were included in our analyses. "Task" was the most frequently identified area of focus (Resident-entered: 51.5%; Preceptor-entered: 47.2%). Significant differences were found between the two groups, with Process coded in a higher proportion of preceptor-entered FieldNotes [(0.458 vs 0.537), z=-4.047, p<.001], while higher proportions were found in resident-entered notes coded as No Feedback

[(0.212 vs 0.165), z=2.414, p=0.008], Self-Regulated Learning [(0.086 vs 0.05), z=3.773, p<.001], and Self [(0.0.142 vs 0.038), z=10.713, p<.001]. **Conclusion:** Our findings suggest there are differences in what preceptors and residents focus on when documenting feedback. These differences may have an impact on how useful feedback may be to individual learners.

**Session ID: 443**

### 10:45–10:55 Family Medicine Residents' Practice Intentions and Future Practice

Mahsa Haghighi*, MSc; Ivy Oandasan, MD, CCFP, MHSc; Lorelei Nardi, MSc; Dragan Kjlujic, MA; Steve Slade, BA

**Learning objectives:**

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

1. Describe trends related to family medicine residents' intentions for their practice
2. Describe trends for what domains of care early career family physicians include in their practice
3. Compare reported practice intention trends of exiting FM residents with actual practice choices

**Description:**

**Objective:** Family medicine (FM) training enables family physicians (FPs) to tailor their practices to support the broad needs of patients and communities. This study compares trends in FM residents' intention to practice various FM domains with actual practice trends among FPs after residency training. **Design:** The study utilized weighted, self-reported data from surveys of exiting FM residents and practicing FPs, conducted as part of the FM Longitudinal Survey. Trends were analyzed across 15 FM practice domains. **Participants:** We examined exiting cohorts of FM residents from 2016 to 2020 (average cohort n=862, average response rate=60%) and corresponding early career FPs at three years post-residency, from 2019 to 2023 (average n=318, average response rate=20%). Survey groups include the same individuals at exit from training and three years into practice. **Results:** Analysis reveals declining practice intention trends among exiting FM residents for over half the domains of care. In contrast, upward practice trends were observed for 9 out of 15 domains among early career FPs. Most notably, when comparing the 2014 and 2018 cohorts, there is an increase in the percentage of early career physicians reporting including Indigenous health (34% to 55%), elderly care (83% to 95%), rural community care (39% to 49%), care for marginalized populations (59% to 83%), palliative/end-of-life care (63% to 77%), and intrapartum care (31% to 43%) in their practice. **Conclusions:** Despite declining practice intentions declared across the comprehensive domains of FM among FM residents, there are notable increases in the inclusion of specific practice domains among early graduates. The results may indicate a responsiveness to population healthcare needs, as perceived by FPs once in practice. The analysis also underscores the continued importance of preparing residents across a broad spectrum of domains during residency, thus enabling FPs to ultimately practice in areas that they might not have anticipated.

**Session ID: 331**

### 10:55–11:05 Implementation and Evaluation of RESPECT and Serious Illness Conversation Training to Support Long-Term Care Homes' Palliative Approach to Care

Maya Murmann, MSc; Ishika Tripathi, BSc; Rhiannon Roberts, MSc; Cathryn Espadero, MSc(c); Jacob Crawshaw, PhD; Justin Presseau, PhD; Lysanne Lessard, PhD; Carol Bennett, MSc; Peter Tanuseputro, MD MSc; Douglas Manuel, MD MSc; Amy Hsu*, PhD

**Learning objectives:**

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

1. Define what early identification of palliative care means within the context of a palliative approach to care, and understand why it is critical in long-term care
2. Understand the key characteristics of available tools to support earlier identification of palliative care needs in the long-term care populations
3. Be knowledgeable about implementation science frameworks used to evaluate the implementation a novel prognostic tool within Ontario long-term care homes

**Description:**

**Background and Study Objective:** The capacity to embed palliative care approaches in long-term care (LTC) settings can be hindered by challenges with estimating survival as well as poor communication about prognosis. RESPECT (Risk Evaluation for Support: Predictions for Elder life in their Communities Tool) is a risk communication tool that calculates an LTC resident's life expectancy. Used in conjunction with the Serious Illness Conversation Guide - an evidence-based and patient-tested communication tool that assists physicians in providing earlier and better conversations about patients' values, wishes and preferences for care as they approach the end of life - RESPECT can be leveraged to support more timely and personalized conversations about goals of care. In this project, we assessed training provided to LTC staff supporting the implementation of RESPECT and the Serious Illness Conversation Guide in 5 LTC homes in Ontario between June 2023 and March 2024. **Method:** Surveys that were developed based on implementation science frameworks (i.e., the Theoretical Domains Framework and Normalization Process Theory) were administered to capture determinants of behaviour change and factors affecting normalization of novel interventions into practice. Surveys were administered immediately pre-post and six months post-training. **Results:** Training participants comprised physicians and registered nurses. Pre-training survey indicated that 90-100% of participants wanted to identify residents early who could benefit from a palliative approach, capture ongoing discussions with residents and families about wishes and goals of care, and regularly engage with their residents' circle of care. However, only 50%-60% felt adequately skilled and knowledgeable in these domains. Immediately post-training, these figures rose to nearly 100%. Six-month follow-up data is currently being collected. **Conclusion:** LTC staff believed that a RESPECT-enhanced care pathway could become a normal part of their work, with staff reporting significant improvements in their capabilities and knowledge for identifying residents who would benefit from a palliative approach, capturing ongoing discussions with residents regarding their wishes and goals of care, and regularly engaging with the residents' circle of care.

**Session ID: 354**

### 11:05–11:15 Why do Rural Family Physicians Stay in Rural Settings and Why do They Leave?

Ian Scott*, MD, CCFP, FCFP; Margot Gowans

**Learning objectives:**

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

1. Outline the factors that keep or impair family physicians in rural practice
2. Outline the most important factors that support a career in rural practice
3. Provide leaders the evidence to advocate for rural family practice supports

**Description:**

There is a persistent and ongoing challenge in recruiting and retaining physicians for rural practice in Canada. Guided by the current literature, and by key informant rural physicians, we constructed a comprehensive validated survey to investigate the reasons rural Family Physicians who are practicing in or have left rural settings in Canada identify as critical to their recruitment and retention. The survey, produced in both French and English, was mailed to rural physicians across Canada, with more than 1000 completed surveys being returned. Survey respondents represented all provinces, both official languages, and all stages of practice from new graduates to recent retirees. Due to the large number of questions included in the survey, we carried out factor analysis to consolidate them into overarching themes, then employed multiple logistic regression to identify those factors most strongly associated with rural career satisfaction and with staying or leaving rural practice. Critical factors that support or impair both satisfaction with and continuation of rural practice include: schedule adequacy (workload and control), community adequacy (community amenities and a sense of belonging), workplace environment, professional opportunities, lifestyle, teamwork, and a requirement to provide services outside their area of expertise. Our results have identified critical factors that can be acted on by governments, national policy makers, regulators, accreditors and communities to support the recruitment and retention of rural physicians now and into the future.

**Thursday, November 7** **Session ID: 199** **Room: Ballroom AB**

**11:30–12:30** **Top 10 Practice Changing Tips From Practice-Based-Learning-Program Modules-2023-2024**

Peter Tzakas, MD; Heather Armson, MD; Haider Saeed, MD; Melissa Vvey, MD; Dana McKay, MD; Marina Malak, MD

**Learning objectives:**

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

1. Describe the top 10 submitted practice reflection learning points from members in small group learning
2. Evaluate the importance of making commitment-to-change statements to promote practice change
3. Integrate others ideas and barriers of change into own practice reflection

**Description:**

This session will highlight last year's top 10 practice changing tips from the Small Group Practice-Based Learning Program, the Foundation for Medical Practice Education's (FMPE) popular continuing medical education program for family doctors. FMPE is a Canadian not-for-profit that offers practice-based learning programs created by family physicians for family physicians, with a mission to translate evidence-based medicine to the care of patients. FMPE's modules summarize the most up-to-date evidence on topics such as benign prostatic hypertrophy, adult ADHD, and wound care. In this talk, we will bring forward the most common commitment-to-change statements found in the practice reflections of our small group program's participants. Our program has over 6,000 Canadian family physicians and

thus these practice changes are highly likely to be relevant to the average family doctor. Cases, tools and evidence from our modules will be used to teach family doctors how to make these changes in their own practice.

**Thursday, November 7** **Session ID: 14** **Room: Ballroom C**

**11:30–12:30** **Approach to Bipolar Disorder in Primary Care**

Jon Davine, MD, FCFP, FRCP(C)

**Learning objectives:**

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

1. Describe how to make a diagnosis of bipolar disorder in a time efficient manner
2. Describe how to use psychopharmacology to treat bipolar disorder, using current guidelines
3. Describe issues concerning psychopharmacology and pregnancy in bipolar disorder

**Description:**

Bipolar disorder affects millions of people in North America. It can now be diagnosed and treated in the primary care setting. In this presentation, we will discuss how to make the diagnosis of bipolar disorder in a time efficient manner. We will define the different types of Bipolar Spectrum Disorders, including Bipolar Type 1, Bipolar Type 2, and Cyclothymic Disorder. We go on to describe current psychopharmacological treatment of bipolar disorder. We will look at what medications are useful for bipolar manic state, bipolar depressed state, and the prevention of future episodes. We will use current guidelines, based on The Canadian Network for Mood and Anxiety Treatments (CANMAT) 2018 guidelines for bipolar disorder. We will also comment on the National Institute for Health and Care Excellence (NICE) guidelines for bipolar disorder. We will focus on Lithium, Valproic Acid, Lamotrigine and Quetiapine in our discussion of medications. We discuss the workup for each of these medications, along with the pertinent side effects, and dosing. We discuss issues with pregnancy and the use of these bipolar medications. We discuss issues of disability, as related to bipolar disorder.

**Thursday, November 7** **Session ID: 61** **Room: 118-120**

**11:30–12:30** **Caring for Your Hospitalized Diabetic Patients**

Benjamin Schiff, MD CM, FCFP; Cristina Nebunescu Schirliu, MD

**Learning objectives:**

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

1. Determine the appropriate goals of care with respect to diabetes in the in-patient setting
2. Safely and effectively achieve glucose targets In the hospital setting
3. Identify the unique challenges and pitfalls of managing diabetes in the hospital setting

**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 the newer agents, and the safe and appropriate use of insulin sliding scales. For this presentation I will be briefly reviewing the classes of agents currently being used to treat diabetes, with particular emphasis on the newer agents. I will discuss their mechanism(s) of action, metabolism, and potential side effects (including risk of hypoglycaemia). I will then discuss the appropriate goals of care for diabetic patients in the hospital setting as it relates to glucose targets. Next I will discuss the potential challenges and pitfalls in the management of diabetes in the context of their co-morbities and acute medical and/or surgical problems, and how to safely and effectively achieve the glucose targets, with particular emphasis on the utility and use of sliding scale vs basal and basal/bolus insulin using updated guidelines and research. I will then present an approach to the use of insulin sliding scales. Lastly I will present some clinical vignettes illustrating the principles that have been discussed. At the conclusion of this talk you should be able to confidently and effectively care for your patients with diabetes admitted to the hospital.

**Thursday, November 7** **Session ID: 33** **Room: 116-117**

**11:30–12:30** **RxFiles: Menopause quick hits**

Taisa Trischuk; Debbie Bunka

**Learning objectives:**

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

1. Assess menopausal patients for appropriateness of systemic hormone therapy
2. Individualize the choice of hormone therapy (pill, patch, or gel) to the patient
3. Assess and treat genitourinary symptoms of menopause by routinely asking women about vaginal health

**Description:**

RxFiles is Saskatchewan's academic detailing program, operating out of the University of Saskatchewan. In 2023, RxFiles undertook a comprehensive literature review on the topic of menopause, and provided continuing education on migraine management to over 750 health care providers in Saskatchewan. Topic development was done with the assistance of our physician advisory group as well as our internal team of editors. This resulted in hundreds of conversations (primarily with family physicians in their offices), and subsequent submitted evaluations. From this experience, we have distilled the top menopause practice-changing pearls, identified by our learners, into one presentation. These include how to communicate the harms and benefits of hormone therapy to patients; evidence for using a levonorgestrel IUD for endometrial protection; how to choose a dosage form for vaginal estrogen; cost differences between hormone therapies; and how to manage adverse effects from therapy. This presentation will be delivered by two of our top academic detailer pharmacists, Alex Crawley and Tahirih McAleer. After this presentation, learners are expected to report many 'ah-ha' moments as they recognize how to optimize therapy. In general, this presentation will be highly medication focused (rather than diagnostic focused). RxFiles has experience presenting at the national level (for example, through our national annual Virtual Conference and with our FMF presentation on migraines in 2023) and this presentation will be tailored to physicians from all provinces (for example, drug plan coverage of transdermal patches will be presented for all provinces and territories). RxFiles does not receive funding from the pharmaceutical industry. This

helps our presentations stay as objective as possible. To help mitigate conflicts of interest, our materials and messages are reviewed by our physician advisors.

**Thursday, November 7** **Session ID: 109** **Room: 111-112**

**11:30–12:30** **We Aren't Immune: FPs and intimate partner violence**

Katherine Bell, MD, CCFP

**Learning objectives:**

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

1. describe prevalence of IPV/DA among HCPs, protective/risk factors, and unique consequences of IPV/DA among HCPs
2. recognize how systemic factors (health systems, education, institutionalized sexism) create barriers for HCPs experiencing IPV
3. identify solutions, and advocacy pathways to enact these solutions, within our micro/mezzo/macro level medical communities

**Description:**

Family physicians (FP) are not immune domestic abuse (DA) and intimate partner violence (IPV). In fact, we may be more vulnerable to DA/IPV than the general population (2-4x prevalence) and may suffer professional as well as personal consequences, as a result of these relationships. In addition to great personal detriment, HCPs living with IPV significantly impact the health system, both positively and negatively, as "wounded caregivers": both creating a pool of HCPs with lived experience who are able to mobilize their own experiences to provide non-judgmental, high quality care to patients experiencing DA/IPV and potentially by limiting HCPs from functioning at their full capacity due to their own psychological distress. While FPs receive training and support to identify and assist patients, DA/IPV among HCPs, including FPs, is largely unrecognized. This creates barriers in accessing needed supports and ultimately recovery for HCPs living with IPV. Paradoxically, characteristics of health systems and medical education may actually worsen the impact of IPV on HCPs through isolating stereotypes/stigma, harmful medical cultural norms, and unintended professional consequences to IPV disclosure. At this talk, we will apply an intersectional lens (considering diversity of gender/gender identity, sexual orientation, racial identity and economic context) to demystify IPV among HCPs, discuss the protective factors as well as those which increase the likelihood of IPV in FP relationships, and discuss solutions, including the role of health systems and medical education in addressing IPV among HCPs.

**Thursday, November 7** **Session ID: 304** **Room: 114-115**

**11:30–12:30** **Impact of a Rural Research Skills Development Program**

Wendy Graham, MD, CCFP, FCFP, FRRMS; Cheri Bethune, MD, MClSc, CCFP, FCFP; Shabnam Asghari, MD, MPH, PhD

**Learning objectives:**

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

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

1. Recognize the impact of faculty development programs tailored to rural physicians
2. List the barriers rural physicians face to conducting rural research
3. List strategies to combat barriers to research

**Description:**

**Purpose:** Physicians practicing in rural and remote areas find themselves in a unique position to conduct community-relevant, socially accountable research but often face many barriers, including a lack of skills and resources. The 6for6 program, designed by a team of researchers at Memorial University's discipline of Family Medicine, is a faculty development program in research skills tailored to rural and remote physicians. The program utilizes both synchronous and asynchronous content. Since 2014, the 6for6 program has trained 38 rural physicians to research solutions to their community-specific health needs. We assess the effectiveness of the program in the attainment of learner competencies. **Methods:** This study uses a mixed-methods approach with the utilization of qualitative and quantitative data and a pre-post quasi-experimental design. Data were collected prior to and after completion of the program by means of surveys, focus groups, and observation. 38 rural physicians participated in this study from 2014 to 2023. **Results:** Pre-post survey results from 2014-2021 show that participants report a significant increase in knowledge (51.7, 83.3), attitudes (89.1, 95.7), and skills (49.5, 80.0) regarding research covered in the training. Focus group results corroborate this data. The resulting participant research has made numerous impacts at the community level, and anecdotal evidence suggests that a robust community of research practice is forming among 6for6 alums. For example, graduates have worked on projects ranging from Indigenous maternal health to physician resilience, lowered emergency department wait times, and several 6for6 alumni have collaborated on a manuscript discussing 'tips' for novice rural researchers. **Conclusion:** 6for6 is a unique faculty development program making a difference at the community level. By equipping rural physicians with the tools to conduct research, we empower and enable them to research solutions to community-specific health needs to help ensure residents receive the quality of care they deserve.

**Thursday, November 7** **Session ID: 269** **Room: 202-204**

**11:30–12:30** **Preparing our Future Family Physicians: A Guide for Curriculum Renewal**

Roy Wyman, MD, CCFP, FCFP; Nancy Fowler, MD, CCFP, FCFP; Christy Anderson, B.Com; Michelle Mayne, MEd; Tatjana Lozanovska, MEd; Sonia Labbé, MSc

All teachers welcome. Highlight's experienced concepts for educational leaders.

**Learning objectives:**

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

1. Explore and discuss the new CFPC Curriculum Renewal Guide (and related workbooks) with your peers from around the country
2. Receive, provide, and share resources and tools that will help further advance curriculum renewal efforts both locally and nationally
3. Consider implementation strategies that promote uptake and continuous quality improvement

**Description:**

Postgraduate medical education is full of amazing potential. Getting 17 family medicine programs with more than 200 teaching sites excited about curriculum change – especially when they all have different strengths and needs – is hard work, and too often we try to do it on our own. We also know that educational leaders and curriculum designers need more than a new box of materials. Needed are defined expectations, content, pedagogy, and a process. Among national activities to support residency programs, the College of Family Physicians has developed a Curriculum Renewal Guide consisting of workbooks in 8 curriculum priority areas. These include (1) Health Equity and Anti-Racism (2) Indigenous Health (3) Mental Health and Addiction Care (4) Digital Health (5) Home and Long-Term Care (6) Emergency and Acute Care Medicine (7) Procedural Skills, and (8) Advocacy, Consultancy, Leadership and Scholarship in Enhanced Skills. This Curriculum Renewal Guide is a supplement to local planning efforts and is a learning tool rooted in quality improvement principles intended to assist program leadership in developing purposeful learning, teaching, and assessment in support of graduate preparedness. We are excited to launch the guide at FMF 2024! In this interactive workshop, we'll ask you to roll up your sleeves and actively engage with the workbooks. You will be able to choose a topic area(s) that is relevant to you and your program and learn and share with your peers. Your insights, experiences, and perspectives will help co-create both local and national implementation efforts.

**Thursday, November 7** **Session ID: 270** **Room: 205-206**

**11:30–12:30** **Pearls From the Prairies: Our best teaching hacks**

Shirley Schipper, MD; Kathy Lawrence, MD; Keith Wycliff-Jones, MD

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Learn about our top teaching tips and how to apply them in your context
2. Discuss interactive and engaging learning experiences that cater to the diverse needs and preferences of medical learners
3. Learn strategies for encouraging the development of critical thinking and decision making among medical learners

**Description:**

We are three FM preceptors keen to share our top teaching tips, guided by evidence but honed in clinical practice. Whether you're a seasoned educator looking to refine your teaching skills (and share with us!), or a novice educator eager to learn from experienced mentors, you will learn and share in engaging discussions, interactive activities, and real-life examples. You will also gain practical insights and actionable tips to elevate your teaching effectiveness, enhance the learning experiences of medical learners, discuss ensuring inclusive learning environments, adapt teaching techniques to diverse learner needs, and leverage tools to enhance teaching outcomes. Finally, you will be encouraged to reflect on your own approaches and identify areas for continued growth as we coach the next generation health professionals.

**Thursday, November 7** **Session ID: 505** **Room: Ballroom D**

**12:45–13:45** **Basal Insulin Blueprint – Module 1A and 2A**

Ritu Kumar, MD, FRCPC

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

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

4. Determine when insulin should be initiated in the diabetes treatment continuum
5. Differentiate between the basal insulin options available
6. Determine the initiation and titration of a person with type 2 diabetes starting basal insulin
7. Describe common barriers associated with basal insulin initiation and titration and identify strategies to mitigate risk
8. Describe how to switch a person from one basal insulin to another

**Description:**

Primary care clinicians play a pivotal role in addressing the multifaceted management of diabetes. While regularly encountering patients navigating the complexities of this condition, providers face countless challenges. This practical education program provides an overview of the current landscape of insulin options as well as advances in new and emerging long-acting insulins.

**Thursday, November 7** **Session ID: 507** **Room: Ballroom C**

**12:45–13:45** **Menopause: Focus on vasomotor symptoms**

Shafeena Premji, MD

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

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

1. Discuss the prevalence and burden of menopausal symptoms, including vasomotor symptoms (VMS)
2. Explain the pathophysiology of VMS due to menopause

3. Recognize and assess menopausal symptoms and formulate options for treatment, with a particular focus on VMS

**Description:**

Vasomotor symptoms (including hot flashes and night sweats) are common with 60-80% of women experiencing vasomotor symptoms during the menopausal transition. These symptoms can negatively affect a women's quality of life and interfere with daily activities. Family physicians are in a unique position to initiate the conversation on bothersome symptoms of menopause with their patients. This program will focus on the identification, assessment and management of vasomotor symptoms due to menopause.

**Thursday, November 7** **Session ID: 98** **Room: Ballroom AB**

**14:00–15:00** **Transgender Health: How to diagnose/support/prescribe/monitor**

Robert Obara, MBBChBAO, MIPH, CCFP; Leon Waye, MD, PhD, CCFP

**Learning objectives:**

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

1. Learn how to diagnose gender dysphoria / gender incongruence
2. Learn how to support your transgender and gender diverse patients
3. Learn how to prescribe for and monitor your trans patients

**Description:**

In this presentation led by physicians involved with Manitoba's adult transgender health program, learn about how to provide quality care to your transgender and gender diverse patients. An adaptation of this presentation was given by the same presenters at the World Organization of Family Doctors (WONCA) Global Conference late 2023.

**Thursday, November 7** **Session ID: 68** **Room: Ballroom C**

**14:00–15:00** **Is This Skin Cancer?**

Lawrence Leung, MBBChir (Cambridge) DipPractDerm, FRACGP, FRCGP, FCFP

**Learning objectives:**

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

1. Common skin cancers: Types, prevalence and etiology
2. How to differentiate and diagnose using appropriate tools
3. Management and Prognosis of common skin cancers

**Description:**

"Is it skin cancer?" remains as a ever-resounding question raised by family medicine patients and also, by the family doctors themselves. Instead of making an instant dermatological referral for any dark or red spot seen and commit the patient to a 3-6 months' wait, it will be more ethical and fruitful to arrive at an initial impression which will greatly benefit clinical triage and management in the best interest of patient.

This presentation will provide a skeleton of basic knowledge of common skin cancers and their presentations in Family Medicine setting, upon which the presenter will flesh up with a pragmatic assessment protocol (+/- dermatoscopy) that can enhance the clinical care for any suspicious skin lesion.

**Thursday, November 7** **Session ID: 334** **Room: 118-120**

**14:00–15:00** **First Five Years: Financial management in early-career**

Stephen Hawrylyshyn, MD, MSc, CCFP

**Learning objectives:**

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

1. Differentiate between key financial concepts relevant to family physicians and family practice
2. Evaluate and assess their own financial literacy, and explore financial management basics impacting family physicians
3. Implement strategies to improve financial management in early-career and create a financial management plan

**Description:**

This session supported by the CFPC's First Five Years in Family Practice Committee will demystify financial concepts for early-career family physicians and make financial planning and management more approachable and less overwhelming. The transition from residency to independent practice can be a period of uncertainty for many new-in-practice family doctors, as they decide where and how they will practice. While many feel prepared for clinical practice, they are less prepared for the business-side of independent practice. The added pressure of finishing residency and starting practice with significant debt can be difficult to manage. This session will improve financial literacy by explaining key financial topics that impact family physicians and empower attendees to take control of their personal financial management. The presentation will cover how to choose financial advisors, planning for taxes, managing debt, important considerations for incorporation, and other lessons learned, as well as an opportunity to ask questions.

**Thursday, November 7** **Session ID: 70** **Room: 111-112**

**14:00–15:00** **New Approach to Environmental Action in Primary Care**

Ilona Hale, MD, FCFP; Samantha Green

**Learning objectives:**

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

1. Describe the interconnections between health, the healthcare system and the environment
2. List the principles of environmentally sustainable care and its patient, provider and payor co-benefits
3. Apply practical changes in to day-to-day clinical practice that reduce environmental impacts

**Description:**

There is growing awareness that environmental degradation and climate change pose immediate threats to both individual and population health. Paradoxically, the healthcare system itself contributes to the problem, accounting for approximately 5% of the total greenhouse gases produced in Canada and globally. Many healthcare providers would like to make changes to help address the problems but it is often difficult to know where to begin and how to have the most impact. Traditionally we have focused on reducing physical waste (e.g.- recycling) and saving energy in our facilities. Recent studies have shown, however, that approximately 80% of the environmental impacts in healthcare arise from energy used upstream in the supply chain. There is therefore an opportunity for family physicians to play a significant role in reducing the environmental impact of the healthcare system by using an environmental lens when making clinical decisions about investigations and treatments. The four principles of environmental sustainability in clinical practice provide a framework for approaching environmental action every day in our work: 1) Reducing unnecessary care, 2) empowering patients, 3) shifting towards health promotion and disease prevention and 4) choosing environmentally sustainable alternatives. Adopting these principles can also improve patient outcomes, reduce burdens on patients and providers, reduce costs and increase the resilience of the healthcare system. Through this lively, interactive session, participants will learn about practical, easy-to-implement practice changes that can make an immediate difference in both environmental impact and patient care - Sugar Sheets, Boogie Boards, Disposal Draws and much, much more - to help create a better healthcare system and a more liveable planet for our patients today and into the future. Learners will be provided with resources to support these changes including the newly developed Planetary Health in Primary Care guide.

**Thursday, November 7** **Session ID: 80** **Room: 116-117**

**14:00–15:00** **Co-Creating Psychological Safety on Clinical or Administrative Teams**

James Goertzen, MD, MClSc, CCFP, FCFP; Sarah Newbery, MD, CCFP, FCFP

**Learning objectives:**

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

1. Describe the importance of psychological safety within a clinical, administrative or educational team
2. Demonstrate three strategies to co-create psychological safety within a clinical, administrative, or educational context
3. Identify post-session resources to assess and support psychological safety within a team

**Description:**

Psychological safety is a key attribute of high performing teams: a belief that team members feel comfortable sharing ideas, concerns, questions, a diversity of opinions, and mistakes without being punished or humiliated. Innovation, improved performance, human resource retention, and team resiliency are nurtured by a foundation of psychological safety. Establishing psychological safety requires team leaders and members willing to co-create conditions for learning and growth. Strategies include framing activities with clear expectations, demonstrating situational humility, expressing appreciation, and destigmatizing failure. The principles of psychological safety will be introduced and demonstrated using short videos, case examples, and breakout group activities. Co-creating psychological safety is best framed as a team culture shift that occurs over time. Additional post-session resources will be provided to

assess and nurture the development of psychological safety. Session will be relevant to those in the first five years of practice along with developing and experienced leaders.

**Thursday, November 7** **Session ID: 222** **Room: 202-204**

**14:00–15:00** **Using Validity Evidence to Improve Learner Assessments**

Christina Cookson, MD, CCFP; Daniel Grushka, MSc, MD, CCFP(EM), FCFP; Jay Taylor, MD, MSc, CCFP (EM); Eric Wong, MD, MClSc (FM), CCFP, FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for clinical preceptors.

**Learning objectives:**

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

1. Describe the validity evidence needed to make assessment decisions in the workplace
2. Appraise a workplace-based assessment method or tool using a validity framework
3. Describe an approach to improve validity of assessment decisions

**Description:**

Assessments in the workplace are expected to be rigorous with the implementation of competency-based medical education. As a preceptor/supervisor, how valid are your assessment decisions about your trainees? How do the tools that you use in your assessment impact the validity of your decisions? This workshop will review validity evidence for assessment in the workplace from the perspective of individual preceptors and help participants develop a strategy of enhancing the validity of their assessment decisions. Anyone who is involved in the assessment of trainees, especially those involved in workplace-based assessments. Both new and experienced teachers/preceptors are welcome. This workshop will include a combination of brief didactic sessions mixed with small group work and discussions.

**Thursday, November 7** **Session ID: 288** **Room: 121**

**14:00–15:30** **Canadian MAiD Curriculum Topic 6: Navigating Complex Cases with Confidence**

Stefanie Green, MD; Konia Trouton

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 15 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Compare and contrast factors that make a MAiD case complex. Identify factors that make a case logistically, clinically, and emotionally/interpersonally complex
2. Identify and apply an approach(es) to navigating complex MAiD cases based on identification of the above factors. Recognize professional, clinical, and program boundaries that may impact the management of complex MAiD cases

3. Identify the emotional aspects of complex cases and their impacts on clinicians. Practice strategies to support clarity, reflection, and resilience in the midst of complexity

**Description:**

Join us for an insightful and comprehensive exploration of the intricate landscape of Medical Assistance in Dying (MAiD). This session will delve into the multifaceted nature of complex MAiD cases, offering participants a deeper understanding and practical strategies to navigate these scenarios with confidence. This facilitated session is one of the 7 topics included in the Canadian MAiD Curriculum and will be facilitated by two experts in the field of MAiD provision in Canada.

**Thursday, November 7** **Session ID: 15** **Room: Ballroom AB**

**15:30–16:30** **Mixing and Matching: Layering psychopharmacology in primary care**

JonDavine, MD, FCFP, FRCP(C)

**Learning objectives:**

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

1. Describe how to combine medications when augmenting a partial response in depression
2. Describe how to combine medications in anxiety disorders
3. Describe how to combine medications in bipolar disorder

**Description:**

Family doctors deliver the majority of mental health care to Canadians. The mental health care will often include the use of psychiatric medications. It is often necessary to use several different psychiatric medications at the same time. In this session, we will discuss different examples of combining psychiatric medications. We will discuss choosing and optimizing psychiatric medications for unipolar depression. We discuss augmenting techniques, where a second medication is added to the first to boost a partial response of depression. We will address combining psychiatric medications to deal with insomnia in primary care. We discuss using medications to treat bipolar disorder in the depressed phase. Combining medications in the manic phase of bipolar disorder will be reviewed. The combination of psychiatric medications for the treatment of anxiety disorders, specifically generalized anxiety disorder, social anxiety disorder, panic disorder, obsessive-compulsive disorder, and post traumatic stress disorder will be presented. We will discuss when not to mix drugs due to problematic interactions. We will be using recent studies and guidelines to support our recommendations. This will include the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for depression (2016) and bipolar (2018), the Martin Katzman et al 2014 Canadian Clinical Practice Guidelines for the management of anxiety, posttraumatic stress, and obsessive compulsive disorders, and The National Institute for Health and Care Excellence (NICE) guidelines for depression, bipolar, anxiety disorders and PTSD.

**Thursday, November 7** **Session ID: 154** **Room: Ballroom C**

**15:30–16:30** **Prostate Cancer Screening: Generalists navigating decades of changes**

Anmol Lamba, MD, MMSc, GDip (Clin Epi), CCFP

**Learning objectives:**

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

1. Review the evolving evidence in the use of Prostate Specific Antigen (PSA) testing for screening
2. Compare and contrast various guidelines that inform the use of PSA testing in primary care
3. Develop strategies for shared decision making with patients on cancer screening

**Description:**

Across countries, organizations, and medical societies - guidance on using Prostate Specific Antigen (PSA) testing for screening of prostate cancer has been challenging to navigate. Guidelines may offer conflicting directions and specialist practice in your region may differ from provider to provider. How do we make sense of the evolving landscape and provide safe, patient-centered care? Largely, trends in testing have shifted with large longitudinal studies that we will review. These evolving studies have resulted in different guidelines over the last decade interpreting the latest data that was available to them. Finally, there is a greater focus on involving your patient in shared decision-making on the benefits and harms of screening, and we review guidance on how to best conduct these conversations. This talk has been developed by, and delivered from, a family medicine lens.

**Thursday, November 7** **Session ID: 326** **Room: 118-120**

**15:30–16:30** **CHANGE National Update: Treating metabolic syndrome**

Doug Klein, MD, MSc, FCFP; Robert Boushel, PhD; Onura Odoh, MD; Greg Linton, MD; Laurie Flood; Colleen Enns, RD; Amanda Radil, PhD

**Learning objectives:**

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

1. Define metabolic syndrome and describe CHANGE, a protocol used to treat metabolic syndrome
2. Assess the current evidence and Compare the different provincial implementations of the CHANGE protocol
3. Apply the CHANGE toolkit in their clinical practise

**Description:**

Metabolic syndrome (MetS) refers to a combination of factors (dyslipidemia, elevated glucose, elevated triglycerides, high blood pressure, and elevated waist circumference) that increase the risk for cardiovascular disease (CVD) and type 2 diabetes (T2DM), among other diseases. In Canada, 20% of adults have MetS. MetS is of great importance as it precedes T2DM and CVD by several years. Progression of MetS to T2DM and CVD can be significantly reduced by nutrition modifications and personalized exercise prescriptions supported through an interprofessional CHANGE approach. Canadian Health Advanced by Nutrition and Graded Exercise (CHANGE) is an evidence-based, culturally safe protocol, co-created in primary care to help support patients living with MetS. This protocol is a personalized approach to nutrition and exercise supported by an interprofessional team (family physician, kinesiologist, dietitian, and other allied health professionals). The protocol includes: 1) individualized, culturally safe, graded nutrition and exercise coaching; 2) implementation of the program in a collaborative way that strengthens community of practice between health professionals. 3. co-creation of pentagram + community and academic partnerships that sustain enduring models of CHANGE, in alignment with the Quintuple AIM. CHANGE has been implemented across the country and this session

will focus on providing participants with a national update on the implementation in rural and remote, small to mid-sized communities, as well as urban settings, focusing on British Columbia, Alberta, Ontario, and Prince Edward Island, and sharing the customizable CHANGE toolkit. Findings from a cluster randomized control trial in Alberta PCNs as well as community implementation in the other provinces will be examined. National and provincial results suggest that CHANGE is an effective lifestyle intervention that can help to manage or reverse MetS risk factors. Greater integration of CHANGE into primary care can proactively treat the symptoms that later manifest in CVD, T2DM, and other chronic health conditions.

**Thursday, November 7** **Session ID: 308** **Room: 109-110**

**15:30–16:30** **An Approach to Pelvic Floor Health in the Peripartum Period**

Jennifer Leavitt, MD, CCFP; Sanja Kostov, MD; Stephanie Crouch, RM

**Learning objectives:**

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

1. Describe common presentations of pelvic floor issues including incontinence, prolapse and diastasis recti
2. Identify ways to prevent and minimize pelvic floor trauma during pregnancy, intrapartum and postpartum
3. Demonstrate an approach to assessment and management of common pelvic floor issues

**Description:**

Pregnancy, birth (both vaginal and cesarean) and postpartum recovery all have a major impact on core muscles of the abdomen and the pelvic floor. This can lead to various clinical issues that have a large impact on the quality of life of patients both in the peripartum but also long into the future. Common issues of the pelvic floor and core muscles include incontinence (urinary and rectal), prolapse and diastasis recti. In this case-based, multidisciplinary session, participants will learn how to teach patients about their core and pelvic floor during pregnancy and what they can do to prevent injury and strain. They will learn about best practices to minimize core and pelvic floor injury during the peripartum period, with a focus on intrapartum care. Participants will learn how to assess the core and perineum in the postpartum period and prescribe management plans including lifestyle changes, pelvic floor and core exercises and a graduated return to exercise to optimize patients function.

**Thursday, November 7** **Session ID: 137** **Room: 202-204**

**15:30–16:30** **Unpacking Ableism in Family Medicine Training and Practice**

Caroline Bowman, MD, CCFP, FCFP; Nadine Abughazaleh, MD; Sarah Kinzie, MD, CCFP, FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Define ableism, accessibility, accommodations, disability and common disability models

2. Recognize implicit biases about disability and reflect on how these may impact physicians with disabilities
3. Explore strategies to challenge implicit ableism and support family medicine trainees with disabilities

**Description:**

This session will begin with a short didactic component where we will define disability and related concepts, and share a brief overview of the literature about physicians living with disabilities. We will then move to a story-telling component, where we will present lived experience from three different perspectives: a resident living with disability, a mid-career community-based family physician living with disability, and a former family medicine program director experienced in navigating accommodations alongside residents with disabilities. Finally, through a combination of journaling and small group discussion, we will ask participants to reflect on their implicit biases and their relationship to disability.

**Thursday, November 7 Session ID: 219 Room: 116-117**

**15:30–16:30 Reflecting and Engaging: Advancing Indigenous health medical education**

Mandy Buss, MD, CCFP; Ojistoh Horn, MD, CCFP; Veronica McKinney, MD, CCFP; Leah Seaman, MD, CCFP; Janelle Syring, MD, CCFP

**Learning objectives:**

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

1. Broaden their foundation of Indigenous health and cultural safety knowledge
2. Enhance and facilitate their own, their peers' and learners' engagement with Indigenous health resources
3. Take steps to address culturally unsafe care within their medical institutions and the healthcare system

**Description:**

The CanMEDS-FM Indigenous Health Case Study Compendium was designed to acknowledge the culturally unsafe care that exists throughout the health care system and broaden the foundation of knowledge for family physicians, medical trainees, and educators to better engage in care that authentically respects Indigenous peoples' right to health justice that considers their cultural, historical, political, and social contexts. Storytelling, also referred to as case studies and/or narratives, is a powerful way to support health professionals to learn from and reflect on personal or systemic biases that may shape their practice. The narratives offered in this session provide information about encounters in the health care system from the perspective of First Nations, Inuit, and Métis peoples. The patient and family perspectives help to facilitate an understanding of the challenges of seeking and receiving care in the health care system, as well as the strength patients can derive from cultural, community, and family support. This session will support participants to enhance their ability to provide culturally safe and humble care through case study examples provided in the Compendium. The Compendium's newly added facilitation guide will be explored. Attendees will learn how to use the Compendium to engage authentically and meaningfully with the cases presented and will help them to support peers and learners to use the compendium to do the same.

**Thursday, November 7** **Session ID: 226** **Room: 111-112**

**15:30–16:30** **Enhancing Accessibility in iOAT: A Clinical prospective on the experiences of patients with disability**

Speakers: Scott MacDonald, MD*[1]; Claudia West

Authors: Liam Quinn[2,3], Jennifer Gagnon[4], PhD; Eugenia Oviedo-Joekes, PhD[2,3]

Affiliations: Providence Health Care, Providence Crosstown Clinic[1]; Centre for Advancing Health Sciences, Providence Health Care[2]; School of Population and Public Health, University of British Columbia[3]; School of Journalism, Writing, and Media, University of British Columbia[4]

**Learning objectives:**

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

1. Identify the key challenges patients face to access Injectable Opioid Agonist Treatment (iOAT)
2. Analyze the benefits of take-home iOAT for patient autonomy and community integration
3. Distinguish the intersectional relationship between disability and opioid use in the context of iOAT

**Description:**

Injectable Opioid Agonist Treatment (iOAT) is a vital intervention for severe opioid use disorder (OUD). However, access to iOAT presents significant challenges, particularly for clients with disabilities. Current iOAT guidelines, which often require multiple daily on-site visits and restrict flexible options like take-home doses, make this treatment option highly inaccessible. This lack of accessibility hinders equitable health outcomes, especially for clients experiencing chronic pain. The intersection of disability, marginalized identities, and opioid use exacerbates these barriers. Such clients often navigate physical, social, and institutional landscapes that were not designed with their needs in mind, leading to further marginalization by forcing participation without necessary accommodations.

The first part of this session will address the unique challenges of iOAT accessibility from both patient and clinician perspectives, and explore strategies to enhance client engagement and care continuity. The session aims to provide family physicians with insights into the barriers faced by people with OUD in iOAT and examine how they intersect with equity-stratifying identities when obtaining appropriate care. The presentation will delve into take-home iOAT and its transformative impact on clients' autonomy and mental health. The benefits of increased autonomy, such as the ability to participate more fully in community life, care for family members, and even return to school or work, will be discussed. Clients' perspectives and expert knowledge on iOAT, particularly from those who have been able to access take-home doses, will be shared. The second part of the session will be dedicated to interactions among clinicians, researchers, patients, and participants, focusing on exploring opportunities to enhance iOAT accessibility and identifying tangible solutions to address the gaps in care.

**Thursday, November 7** **Session ID: 246** **Room: 205-206**

**15:30–16:30** **Effective Strategies that Excellent Teachers Utilize When Having Learners in Clinical Practice**

Lillian Au, MD, CCFP, FCFP, MEd (HSE); Ann Lee, MD, CCFP, FCFP, MEd (HSE)

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

All teachers welcome. Highlight's novice concepts for clinical preceptors.

**Learning objectives:**

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

1. Discuss the importance of a clinic orientation, appropriate scheduling & learning plan in setting appropriate expectations for learners
2. Review strategies on how to focus the learner during a clinical encounter
3. Discuss benefits of multi-level learning and how excellent teachers can teach to different learner levels effectively

**Description:**

This session is targeted to clinical preceptors and will discuss effective and time-saving strategies that excellent teachers utilize when having medical students and family medicine residents in their busy clinical practices. We will discuss the importance of building a supportive learning environment and the utilization of a learning plan in creating rapport and setting up appropriate learner expectations. Attendees will have opportunities to practice evidence-based and time saving frameworks such as One Minute Preceptor or SNAPPS in focusing the learner. This session will also discuss the benefits of multi-level learning (layered learning), and outline strategies on how to teach to multiple learners concurrently by using appropriate questioning as a tool to augment learning.

# Friday, November 8

**Friday, November 8 Session ID: 142 Room: 223-224**

**7:30–18:00 Airway Interventions and Management in Emergencies (AIME) Course 2**

George Kovacs, MD, MHPE, FRCPC

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 18 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Practice making acute care airway management decisions. (Family Medicine Expert)
2. Organize a practical staged approach to airway management. (Leader)
3. Choose most appropriate method of airway management based on variety of patient presentations. (FM Expert)

**Description:**

This program is designed for physicians working in an acute care setting requiring them to competently manage patients in need of emergency airway management. AIME program highlights include: Case-based clinical decision making; NEW algorithms based on Canadian Airway Focused Group Guidelines; NEW managing patients with high risk infections; Optimizing your patient prior to airway management; Hyperangulated, Macintosh and channelled video laryngoscopy; Managing the contaminated airway; When, why and how to perform awake or rapid sequence intubation; Management of the difficult airway and rescue oxygenation and ventilation; How to make the decision and safely execute a cruicothyrotomy; On-line open access textbook Infinity Edition of Airway Management in Emergencies; Unique, customized clinical videos; Limited registration to ensure clinician to instructor ratio of 5 or 6:1; Clinician to simulator ratios of 2:1

**Friday, November 8 Session ID: 232 Room: 121**

**8:00–12:30 PAACT: Pain Management 2024**

Frank Martino, MD, CCFP (EM), FCFP; Alan Kaplan, MD, CCFP (EM), FCFP

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 12 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Review and discuss management of common presentations of pain in general practice including: lower back pain, neuropathy, fibromyalgia, musculoskeletal pain and migraine headaches

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

2. Engage with a series of real life case studies and discuss with a diverse group of other family physicians
3. Become familiar with various clinical and patient resources and strategies to address barriers to integrating them into your practice

**Description:**

An independent educational program developed by family physicians that is based in the Pain Management Handbook for Family Medicine ('orange book'). Cases focus on common presentations of pain in family medicine and there management. Materials: 2024 Pain Management for Family Medicine ('orange book'); Participant manual. Teaching method: interactive, case-based, small group

**Friday, November 8 Session ID: 506 Room: Ballroom C**

**7:30–8:30 Multiple Myeloma: Primary care management and referral**

Graham Segal, MD; Nicole White-Al Habeeb, MD

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

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

1. Assess patients with signs and symptoms suggestive of multiple myeloma and precursor conditions
2. Integrate high-impact practices from MM evidence to optimize investigations and patient outcomes
3. Initiate referral as needed based on relevant information gathered from multiple myeloma work up

**Description:**

Why Multiple Myeloma Matters:  Multiple myeloma, a cancer of the bone marrow, is a formidable adversary. Understanding its intricate nuances is paramount to providing the best care for your patients. This course delves deep into the world of abnormal plasma cells, exploring their role in our immune system and the creation of monoclonal proteins, or M-proteins.

Critical Insights Await:

- Learn about the importance of M-proteins in blood or urine, and their role in tracking disease progression and relapse.
- Discover why multiple myeloma is the second most common hematologic malignancy in adults, affecting thousands every year.
- Understand the increasing prevalence of this condition and its correlation with an aging population and advances in therapeutic strategies.

MGUS and Beyond: Delve into the crucial precursor to multiple myeloma, Monoclonal Gammopathy of Undetermined Significance (MGUS). By understanding this silent precursor, you can significantly impact early intervention and patient outcomes. The evolving landscape of treatment options means more patients are surviving longer because of improved pathways to treatment, improved supportive care, and new techniques for management. This is your chance to add these tools and approaches to your practice.

**Friday, November 8** **Session ID: 501** **Room: Ballroom AB**

**8:15–9:45** **Keynote: Reality and Hope: Polarities or pals**

Constance LeBlanc, MD, MSc, CCFP (EM)

**Description:**

Healthcare is in crisis. As frontline physicians, we strive to care for our patients and our communities. We do this work in a system that is egregiously failing us. Is hope impossible in a system so broke? Is the only answer to endure or get out? Come explore the facts and clinical realities, the challenges we are facing and acknowledge the magnitude of change required to provide the care we deserve and need. Together we will explore the notion of critical hope that can allow a path forward.

**Friday, November 8** **Session ID: 152** **Room: Ballroom AB**

**10:15–11:15** **What's New? The 2024 Rourke Baby Record!**

Leslie Rourke, MD, FCFP, MClSc (FM), FRRMS; Denis Leduc, MD, CCFP, FRCP(C), FAAP

**Learning objectives:**

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

1. Explore the new features of the 2024 edition of the Rourke Baby Record
2. Apply recent evidence on preventive health care in infants and young children
3. Implement the 2024 RBR resources and recognize their relevance in clinical practice

**Description:**

What's new in well-baby/well-child care in Canada? Explore, apply, and implement the new 2024 edition of the Rourke Baby Record (RBR)! The RBR is a widely used knowledge mobilization tool that helps clinicians and parents/caregivers optimize the well-being of infants and young children by providing evidence-based recommendations and resources for preventive healthcare up to five years of age. The early years clinical visits during this critical time of child and family development offer a unique opportunity for clinicians to answer parental queries, provide anticipatory guidance, identify strengths and areas needing further investigation, and establish safe and trusted relationships with the infants, children, and families in their care. In this interactive case-based session, we will share new research which has guided development of updated recommendations found in the 2024 RBR, including: i) Promotion of early relational health, which is the emotional connections between children & trusted adults that promote health and development. ii) Surveillance of development using updated evidence-based milestones. iii) Demonstration of updates in the 2024 RBR using a variety of resources to support clinical practice. Pearls for practice will help participants maximize the effectiveness of the care for their patients and answer parents'/caregivers' questions more effectively. This session will appeal to all clinicians caring for infants and young children (including family physicians, paediatricians, nurse

practitioners, family practice nurses, and community/public health nurses), as well as to medical learners and teachers, and to parents/caregivers of young children.

**Friday, November 8 Session ID: 187 Room: Ballroom C**

**10:15–11:15** **Axe the Rx: Deprescribing chronic medications with PEER**

Jessica Kirkwood, MD, CCFP (AM); Betsy Thomas, BSc Pharm; Jennifer Young, MD, CCFP (EM)

**Learning objectives:**

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

1. Identify low value medications for common chronic diseases
2. Develop an approach to deprescribing within your practice
3. Apply patient oriented approaches to deprescribing challenging medications like opioids and sleeping aids

**Description:**

We all have patients, particularly the elderly, whose pill bag is heavier than their lunch bag. Polypharmacy is inevitable as patients accumulate chronic diseases and yet not all medications are equally helpful for patient-oriented outcomes. In addition, medications for symptoms such as chronic pain can lead to harms but reducing or stopping these medications is challenging. In this interactive, case-based presentation, the presenters will review approaches to deprescribing less useful medications for common chronic illnesses and reducing or simplifying challenging medications such as opioids and sleeping pills.

**Friday, November 8 Session ID: 133 Room: 109-110**

**10:15–11:15** **Patient Safety and Medico-legal Risk Amidst Limited Resources**

Katherine Lariviere, MD, MSc, CCFP, FCFP; Cheryl Hunchak, MD, CCFP (EM), MPH, FCFP

**Learning objectives:**

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

1. Describe medico-legal risk and patient safety considerations when health resources are limited
2. Outline a novel 'ABCD' framework to optimize patient safety and minimize medico-legal risk
3. Apply key strategies for optimizing patient safety in resource-constrained environments to tailored case scenario(s)

**Description:**

Caring for patients in a resource-constrained health care system is an evolving area of pressing concern and a practical reality for many family physicians across Canada. Important contributors include a deepening lack of human health resources and rising patient and system complexity. This practical and interactive workshop will equip family physicians with relevant, data-driven medico-legal insights and practical communication and documentation skills to promote patient safety and reduce medico-legal risk in the current health care environment. A tailored, case-based approach will allow participants to apply a novel "ABCD" framework to explore strategies for optimizing patient safety and minimizing

medico-legal risk in daily clinical practice using a systems-based approach that examines patient, team and system factors. The 'ABCD' framework encompasses considerations regarding effective advocacy efforts, the best interests of patients, communication pearls and strategies and documentation tips to optimize patient safety.

**Friday, November 8** **Session ID: 322** **Room: 118-120**

**10:15–11:15** **Managing Emotional-Behavioural Crises in Patients with Developmental Disabilities**

Laurie Green, MD, CCFP (EM), FCFP; Alicia Thatcher, MD, CCFP

**Learning objectives:**

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

1. Identify factors contributing to emotional-behavioural crises in patients with intellectual and developmental disabilities
2. Apply clinical tools and a trauma-informed approach to assess/support their physical and mental health
3. Develop an action plan with hospital, community services and caregivers to prevent future emotional-behavioural crises

**Description:**

Patients with intellectual and developmental disabilities (IDD), make up 1-3% of the population and are encountered in most family medicine practices. About one third of those with ID meet criteria for autism spectrum disorder. Additionally about 1 in 2 adults with developmental disabilities may be diagnosed with psychiatric disorder. Persons with intellectual and developmental disabilities experience adversity (e.g., poverty, neglect), abuse (emotional, physical and sexual) and trauma at greater rates than the general population. These experiences may manifest in emotional dysregulation and behaviours that challenge. This session presents a new mental health toolkit (Developmental Disabilities Primary Care Program, 2024) that assists primary care providers in the implementation of the Canadian consensus guidelines on the primary care of adults with intellectual and developmental disabilities. The HELP model (Health, Environment, Lived Experience, Psychiatric Disorder) offers a systematic approach to investigating factors underlying emotional dysregulation and behaviours that challenge. In addition, the toolkit provides guidance on risk assessment, psychotropic medication review, mental health interventions and crisis debrief conversations. Finally, participants will learn practical and effective strategies for collaboration between the family physician, community supports, hospital, caregivers and patients to prevent repeating emotional and behavioural crises that can lead to further trauma.

**Friday, November 8** **Session ID: 127** **Room: 116-117**

**10:15–11:15** **Indigenous Engagement for Physician CME: A case study**

Ava Butler, MD, CCFP (EM); Nicole Esligar, MA; Janina Krabbe, MPH, MDiv, PhD(c); Celestine Sampson, HCA; Chris Morrow, MD, CCFP (EM); Chelsea Termuende, BHK, MD(c)

**Learning objectives:**

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

1. Identify relevant and local sources of healthcare-specific Indigenous Cultural Safety knowledge
2. Plan practical steps in engaging with local Indigenous community members for physician continuing education
3. Use information gathered from Indigenous community engagement to direct local physician education programs

**Description:**

One way family physicians (FPs) can promote culturally safer care is to engage Indigenous Nations in the development of locally relevant continuing medical education (CME). The 2020 report "In Plain Sight'' confirmed widespread Indigenous-specific racism is prolific within the BC healthcare system. One of the recommendations in the report was that there be a "refreshed approach to anti-racism, cultural humility and trauma-informed training for health workers." As standardised Indigenous specific anti-racism training is developed, FPs have the opportunity to engage in relationship with Indigenous community members to ensure the content of education is relevant to their local context, whether regionally, provincially or nationally. Prioritizing local Indigenous knowledge and experience avoids pan-Indigenous approaches. Making space for meaningful specific input involves engagement in and guidance of all stages of the design, delivery, and evaluative processes of CME, including knowledge translation. By participating in locally driven CME, FPs have the opportunity to make changes at the point of care, allowing care that is safer for Indigenous patients. Using a quality improvement case study, this session will report and reflect on an engagement journey with 11 local Nations and other Indigenous service users as an existing Indigenous-specific anti-racism course for physicians was evaluated, adapted and implemented in the emergency department. Reflections will include multiple perspectives including an FP, a course manager, a health equity researcher and a community member. Efforts to maximize benefits, minimize harm and participate in iterative consent relationships will be described. Participants will have the opportunity during this practical session to reflect individually and in groups on similar applications in their own context and practices - regionally, provincially, and nationally - with an aim to equip and encourage attendees to consider local Indigenous-guided CME as a tool for promoting culturally safer care at the bedside.

**Friday, November 8 Session ID: 165 Room: 205-206**

**10:15–11:15 Learner in Difficulty: Identification, diagnosis and treatment pearls**

Samantha Horvey, MD, CCFP; Joanne Baergen, MD, MEd (HSE), CCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for clinical preceptors.

**Learning objectives:**

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

1. Identify and work through the differential diagnosis for the learner in difficulty
2. Discuss how to communicate and provide feedback in difficult learner situations
3. Identify methods to create a learning plan best suited for the identified learner

**Description:**

In this case-based interactive workshop, we will present the most recent evidence in medical education regarding learners in difficulty infused by our practical experience as the Family Medicine residency

program remediation leads. Participants will be guided through the process of identifying learners in difficulty, from the obvious to the confusing to the subtle. Pearls for communication with the difficult learner will be presented, along with methods to narrow the differential diagnosis of the reason for concern. Finally, practical tips will be provided to create learning plans for the learner, including how to select the setting, learning tools and how to use appropriate wording to limit any misunderstanding of expectations and objectives. These presenters have had highly rated presentations on learners in difficulty for their local faculty development.

**Friday, November 8 Session ID: 195 Room: 202-204**

**10:15–11:15 Reducing Unnecessary Care While Teaching Family Medicine Learners**

All teachers welcome. Highlight's developing and experienced concepts for clinical preceptors.

Alexander Singer, MB BCh BAO, CCFP, FCFP; Kirsten Hildahl, MD, CCFP

**Learning objectives:**

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

1. Recognize the importance of integrating resource stewardship into family medicine curricula
2. Describe relevant educational frameworks and training opportunities, where reducing unnecessary care can be incorporated
3. Discuss approaches to develop Family Medicine centred teaching to reduce unnecessary care

**Description:**

It is one thing to incorporate resource stewardship into one's own practice, but how do we teach these principles to those learning to be family doctors? Medical students and family medicine residents are frequently taught to be comprehensive and to consider a wide range of potential differential diagnoses. Additionally, they often lack the clinical experience or understanding of the evidence to determine specifically which tests are required to confirm or refute a diagnosis. Concerning management, learners typically have not yet seen large volumes of patients in follow-up, leading to an underappreciation of the harms caused by over-treatment and over-diagnosis. Encouraging stewardship can be at odds with explicit teaching and the hidden curriculum. Nevertheless, given the harms of unnecessary care and limited health resources, the Choosing Wisely Canada campaign has successfully promoted stewardship for over 10 years. Family medicine teacher have several opportunities to incorporate the concepts of reducing unnecessary care, which are well-aligned with the CanMedsFM roles. Many programs already include this as part of Quality Improvement and Patient Safety curricula. Going beyond these constructs, this workshop will encourage participants to consider areas in their existing curricula that incorporate these principles to share beyond their programs. We will then facilitate discussion through an exploratory exercise that encourages the development of new or revised approaches to teach this important topic. In addition to engaging the participants in sharing and learning about this topic, the facilitators, with support from Choosing Wisely Canada, will leverage the content discussed in this workshop to initiate the development of a Family Medicine guide on teaching how to reduce unnecessary care.

**Friday, November 8** **Session ID: 121** **Room: 114-115**

**10:15–11:15** **Freestanding Papers on Clinical and Family Practice**

**Learning objectives:**

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

1. Gain an in-depth comprehension of diverse research methodologies and findings across various facets of family medicine
2. Develop the ability to critically evaluate and assess the implications, strengths, and limitations of presented research papers, honing skills in discerning high-quality research
3. Foster an interactive learning environment by engaging in discussions with presenters and peers, facilitating the exchange of ideas, perspectives, and potential applications of research in clinical practice or academia

**Description:**

Innovation, reflection, research, evaluation, and quality improvement are part of the fabric of family medicine. The facilitated free-standing paper session is an opportunity to hear from and talk with colleagues who are leading studies that have been selected for presentation through peer review. These sessions are an exciting opportunity to learn from and engage in the study of family medicine education and practice.

**Session ID: 344**

**10:15–10:25** **Frailty Assessment in Primary Care Using Electronic Comprehensive Geriatric Assessment (eCGA): Feasibility, reliability, and validity of an eCGA-based Electronic Frailty Index (eFI-CGA)**

Xiaowei Song, PhD, MSCS; Grace Park, MD, CCFP; Barry Clarke*, MD, CCFP, COE; Ken Rockwood, MD, FRCPC; Jodie Penwarden; Kaitlin Harding; Sherri Fay; Belinda Robinson

**Learning objectives:**

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

1. Demonstrate reliability with family doctors making frailty assessments in primary care clinics
2. Demonstrate the highly comparable frailty assessments by family doctors and geriatricians
3. Demonstrate validity with the eCGA-FI determination by family doctors with CFS

**Description:**

**Background:** To promote early management of frailty, we developed an electronic Frailty Index (eFI-CGA) based on deficit accumulation in a Comprehensive Geriatric Assessment (eCGA) in electronic health records. Here, we examined the feasibility, reliability, and validity of the eFI-CGA by Family doctors. **Method:** We enrolled 100 community-dwelling older adults with mild/moderate frailty under the care of Fraser Health and Nova Scotia Health. A Family Doctor and a Geriatrician assessed each patient independently and assigned an eFI-CGA score at baseline and six months. Family Doctor and Geriatrician intra- and inter-rater agreements were tested using the intraclass correlation coefficient (ICC). The eFI-CGA characteristics and splitting-site analyses were also performed. **Results:** Ninety-eight percent of the participants (83.7±6.4 years, 62% women) completed both Family Doctor and Geriatrician

assessments at baseline; 83% of them also completed the assessments at follow-up. The mean baseline eFI-CGA was 0.285±0.113 by Family Doctor and 0.290±0.123 by Geriatricians, which changed insignificantly over six months (0.284±0.117 by Family Doctors and 0.282 ±0.124 by Geriatricians). The eFI-CGA scores were correlated with the Clinical Frailty Scale ($r \geq 0.64$ by Family Doctors, $r \geq 0.73$ by Geriatricians, $p<.001$) and with age ($r \geq 0.44$ by Family Doctor, $r \geq 0.45$ by Geriatrician, $p<.010$). The intra-rater agreement rate for eFI-CGA was 0.93 (95% confidence interval 0.89-0.96) for Family Doctor and 0.95 (0.92-0.97) for Geriatrician. The inter-rater agreement rate between Family Doctor and Geriatrician was 0.91 (0.86-0.94) at baseline and 0.87 (0.80-0.92) at follow-up. **Conclusion:** The highly comparable frailty assessments by Family Doctors and Geriatricians suggest that the eFI-CGA is reliable and feasible in geriatrilizing primary care for early frailty assessment and management

**Session ID: 360**

### 10:25–10:35 Validation of Urine Culture Classifier in Family Medicine

Jack Zhang*, MD, MSc, BEng; Rachael Morkem, MSc; Akshay Rajaram, MD, MMI

**Learning objectives:**

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

1. Recognize MicrobEx as a promising tool for automating urine culture interpretation in family medicine
2. Recognize that current inbox commentary is insufficient as the ground truth for validation studies

**Description:**

**Objective:** 1) To evaluate the performance of MicrobEx in classifying urine culture results in an academic family medicine setting; 2) To assess the accuracy of physician inbox annotations in reflecting the culture results. **Design:** A single-centre retrospective algorithm validation study. **Setting:** Urine cultures from a single academic family health team between 2017 and 2018 were used. **Participants:** Urine culture reports were manually reviewed and labelled by an epidemiologist with guidance from a family physician. Reports without a clear organism, sensitivity data, and multiple organisms were excluded. 1999 urine culture reports from 981 adult patients between 2017 and 2018 were included in the validation. 20,164 comments associated with these urine culture reports were found. 989 reports were associated with comments that were deemed unambiguous and used in the analysis. **Intervention:** MicrobEx is a regular-expressions (RegEx) based algorithm derived from urine cultures collected from the intensive care unit of a hospital located in the United States. A second RegEx model was developed to discern positive or negative interpretations of inbox annotations of culture reports. **Main Outcome Measures:** The study compared MicrobEx's classifications ("positive" or "negative") and the inbox annotations made by physicians with the assigned labels. Accuracy, recall (sensitivity), specificity, precision, and F1 score were calculated. **Results:** MicrobEx achieved 95.3% accuracy, 88.6% recall, and 100% specificity. Physician inbox annotations achieved 91.8% accuracy, 89.6% recall, and 92.9% specificity. **Conclusion:** MicrobEx demonstrates high accuracy in classifying urine culture reports from a primary care setting with a single organism. However, further validation with a larger dataset, including reports with multiple organisms, is needed. Ambiguity in physician inbox annotations renders these comments unsuitable for use as a reliable ground truth for validation studies. Future efforts will focus on refining the algorithm and exploring ways to improve the quality of inbox annotations.

**Session ID: 410**

### 10:35–10:45 Administrative Duties: The "ball and chain" of practice

Judith Belle Brown*, PhD; Cathy Thorpe, MA; Sharon Bal, MD, CCFP, FCFP; Catherine George, MSc; Saadia Hameed Jan, MBBS, MClSc(FM), CCFP, FCFP, DipPDerm(UK); Maria Mathews, PhD; Kamila Premji, MD, CCFP, FCFP; Bridget L. Ryan, PhD; Amanda L. Terry, PhD

**Learning objectives:**

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

1. Identify and acknowledge the challenges of administrative services by family physicians
2. Recognize the impact of administrative burden on physician well-being
3. Explore the potential solutions to minimize administrative burden in family practice

**Description:**

**Objective:** To describe family physicians' (FPs) experiences of administrative burden in practice. **Design:** Grounded theory study using in-depth interviews via Zoom. Individual and team analysis. **Setting:** FP practices in Ontario, Canada. **Participants:** 38 FPs practicing in Ontario, who completed their training between 2018 – 2022. **Findings:** Participants spontaneously raised the issue of administrative burden, describing it as both the volume of paperwork and "never ending" inbox management decreasing time for direct patient care. They expressed feeling frustrated, stressed, and overwhelmed with the many hours (2-3 hours) per day spent on administrative tasks. Participants strongly emphasized the lack of compensation for this work. Some participants described being "sheltered" from the realities of administrative burden during medical school and residency, leaving them unprepared to manage multiple administrative tasks. Participants perceived administrative burden as contributing to burnout and their declining joy in practicing comprehensive care. Participants offered solutions to address administrative burden at both personal and system levels. On a personal level, they proposed creating "flex time" to complete administrative tasks and setting boundaries to prevent administrative burden from "bleeding" into personal time. However, often the volume of the work eroded this solution. At the system level, participants underscored the need for compensation for administrative time and funding to increase clinic staff (e.g. physician assistants, nurse practitioners) to help "de-clutter the inbox" and manage referrals. The need for dedicated funding for an integrated EMR in the province and establishment of a centralized referral system were also proposed system solutions. **Conclusion:** For over 25 years, the burden of clinical administrative services has been cited as contributing to the stress and burnout experienced by family physicians. This study supports prior literature, emphasizes the negative impacts of administrative burden on time for direct patient care, and provides current solutions to guide practitioners and policymakers.

**Session ID: 408**

### 10:45–10:55 Assessing Digital Health Interventions for Postpartum Weight Loss

Logan Rabougi, MBChB, Mmed; Jacob Shabani, MBChB, Mmed; Anthony Ngugi, PhD; Catherine Gathu*, MBChB, MMed, MSc, FHEA

**Learning objectives:**

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

1. Evaluate the effectiveness of Digital Health Interventions (DHIs) on weight loss in postpartum women based on the meta-analysis findings
2. Assess the role of continuous support, group interaction, and convenience in digital health interventions for weight loss in postpartum women
3. Identify factors influencing attrition rates within digital health intervention groups, as reported in the systematic review

**Description:**

**Objective:** This systematic review and meta-analysis aimed to determine the effectiveness of digital health intervention (DHI) components on weight loss in postpartum women, assess the effect of DHIs on body mass index, and evaluate attrition rates within DHIs. **Design:** Electronic searches were conducted on PubMed (MEDLINE), Cochrane Library, Google Scholar, and Web of Science from inception to 22nd April 2020. Eligible studies included randomized controlled trials (RCT), quasi-experimental trials, and controlled before-after studies of weight loss interventions delivered digitally to postpartum women. **Setting:** Not applicable. **Participants:** A total of 3228 postpartum women were included in the analysis of body weight change, while 458 women were included for BMI change. **Intervention:** Interventions delivered via website, internet, email, computer, apps, SMS, phone call, or video player were considered. Studies involving medicines or surgeries for weight loss were excluded. **Main Outcome Measures:** Primary outcome was weight mean difference (MD), with secondary outcomes including BMI MD and attrition rates. Cochrane Collaboration's tool for assessing risk of bias and Quality Assessment Tool for Quantitative Studies were utilized for quality assessment. Results/Findings: Twenty studies (19 RCTs and 1 non-RCT) were included. DHIs significantly reduced body weight (MD: -1.41 Kg; 95% CI: -2.04 to -0.77 Kg) and BMI (MD: -0.94 Kg/m2; 95% CI: -1.37 to -0.52 Kg/m2). On-demand information services showed the largest weight loss (-2.4 Kg, 95% CI: -3.4 to -1.41 Kg). Mixed-site interventions had more weight loss (-1.62 Kg; 95% CI: -2.99 to -0.25 Kg) compared to home-based interventions (-1.35 Kg; 95% CI: -2.13 to -0.57 Kg). Mixed-target interventions had more weight loss (-1.67 Kg; 95% CI: -2.89 to -0.46 Kg) compared to individual-only targeted interventions (-1.30 Kg; 95% CI: -2.11 to -0.49 Kg). Attrition within intervention groups ranged from 0% to 85%. **Conclusion:** Digital health interventions lead to weight loss in postpartum women irrespective of type or mode of delivery and are a good recommendation as a scalable weight loss promotion option. The most effective interventions had components catering to continuous support, group interaction and convenience.

**Session ID: 465**

### 10:55–11:05 Post-COVID-19 Outcomes in Long-Term Care Home Residents

Gordana Rajlic*, PhD; Janice M. Sorensen, PhD; Akber Mithani, MD, MCFP (COE)

**Learning objectives:**

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

1. Describe mortality in long-term care (LTC) home residents after contracting COVID-19
2. Describe functional outcomes, including activities of daily living, cognitive function, and clinical/care needs post-COVID-19
3. Describe and compare outcomes in LTC home residents with and without history of COVID-19

**Description:**

**Objective:** To explore outcomes after contracting COVID-19 in a cohort of LTC residents, including: 1) mortality – short- and long-term after infection; 2) functional outcomes, including activities of daily living (ADLs), cognitive function, and clinical care needs; and 3) symptomatology over time. **Participants:** Residents in 19 LTC homes in Fraser Health Authority, BC, at any time from March 01, 2020 to April 30, 2022 (N = 4310). During this time, 1596 residents had a positive COVID-19 test while 2724 residents did not have a history of COVID-19. **Design:** In a retrospective longitudinal design, we followed outcomes of residents with a positive COVID-19 test from the day of the test. Mortality was examined until January 31, 2023. Functional outcomes were obtained from three quarterly Resident Assessment Instrument – Minimum Data Set 2.0 assessments after COVID-19, as well as from the last assessment before COVID-19 (baseline assessment). Change from baseline to each of the post-COVID assessments was examined in the COVID and No-COVID groups. In a smaller subgroup of survivors, symptomatology over six months was investigated. **Results:** After contracting COVID-19, 30-day mortality was high (16.9%). 30-day mortality was decreasing over years (from 28% in 2020 to 8.3% in 2022). Over longer time, monthly mortality among the COVID-19 acute phase survivors was similar to mortality in the No-COVID group. About functional outcomes, there was a greater deterioration in ADLs and clinical care needs from baseline to the first follow-up assessment in the COVID-19 survivors compared to the No-COVID group; in subsequent assessments, the change was similar in both groups. Symptoms over 6 months are presented. **Conclusion:** Beyond 30-day mortality, there was no evidence of increased mortality risk among COVID-19 survivors. Initially greater deterioration in ADLs and clinical care needs in COVID-19 survivors was followed by a trajectory resembling the one in the No-COVID group.

**Session ID: 438**

### 11:05–11:15 A Better Story of Family Practice in Canada, Told by Data and Evidence

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

**Learning objectives:**

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

1. Acquire and more complete, balanced, and evidence-informed understanding of family practice
2. Cite broad data sources that describe family medicine and practice in Canada
3. Communicate evidence-based, positive messages about family practice in Canada

**Description:**

**Objective:** Concerns about family practice are well-founded, but also negatively biased. This may fuel poor impressions of family medicine among medical students and dispirit practicing family physicians. Using broad data, this study tells a better story, providing a more balanced and encouraging image of family practice in Canada. **Design:** Quantitative, descriptive analysis using multiple data sources, including the Association of Faculties of Medicine of Canada (AFMC), Canadian Resident Matching Service (CaRMS), Canadian Institute for Health Information (CIHI), Canadian Medical Association (CMA), and College of Family Physicians of Canada (CFPC). **Setting:** Data sources are pan-Canadian and capture information from medical students, family medicine (FM) residents, and practicing physicians in all provinces and territories. Aggregate-level results are reported for all of Canada. The most recent publicly available data is used for each data source. **Participants:** The AFMC Graduate Questionnaire (GQ) gathers data from all graduating medical students in Canada (1,838 responses and response rate of 60% in 2022). CaRMS manages matching processes for entry to all residency programs in Canada (2,937 applicants in

2023). The CMA's National Physician Health Survey (NPHS) was an open-link survey with 3,489 responses from practicing physicians in 2021. CIHI's National Physician Database (NPDB) contains fee-for-service billing data for all physicians in Canada (269 million services in 2021). The CFPC Family Medicine Longitudinal Survey (FMLS) surveys all second-year family medicine residents and had a 53% response rate in 2022. **Results:** More than all other disciplines, 42% of graduating medical students rate the quality of their family medicine experiences as being "excellent" (compared to an average of 30% for all other disciplines). Medical students who choose FM experience high rates of success in the CaRMS match; for 80% FM is their top-ranked discipline and 98% match in the first iteration. The CMA NPHS shows that 81% of general practitioners have high emotional well-being, compared to 78% of medical specialists and 75% of surgical specialists. CIHI's NPDB shows that family physicians can pursue broad areas of practice; they account for 52% of all medical services, including 47% of psychotherapy counselling, 49% of hospital-based assessments, and 21% of anesthesia services. The CFPC FMLS shows that 90% of FM residents are proud to become family physicians and 98% feel they make valuable contributions. **Conclusion:** Canada's prevailing narrative about family practice needs to change, to be more informed by evidence and to reflect strengths and challenges in a more balanced way. Medical students have positive experiences in family medicine. Family physicians can be happy in their work and they have great latitude to shape their professional practice. These positive messages are supported by evidence and need to come more readily to mind when we think about family practice.

**Friday, November 8 Session ID: 332 Room: Ballroom AB**

**11:30–12:30** **Your Patient Has ADHD: But now what?**

Danielle Chard, MD, CM, CCFP, BSN; Aisling Nebor

**Learning objectives:**

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

1. Address common medication challenges for adults with ADHD
2. Identify executive functioning challenges in their adult patients with ADHD
3. Teach practical strategies to manage executive functioning deficits

**Description:**

Your patient has been diagnosed with ADHD, and has started medication, but now what? What can you do as a family physician to support this adult population? In this clinical session, participants will learn from a family practice physician and an occupational therapist team about research-based strategies to support adult patients who have a diagnosis of ADHD. We will begin with troubleshooting common medication challenges and then dive into how to have useful and practical follow up visits that help you better understand your patients' needs. Once you can identify patients' needs we'll offer some practical interventions to address common deficits experienced by adult patients with ADHD. We hope you leave the workshop with a strong foundation to provide a practical, strengths-based, approach to caring for adults with ADHD that can be integrated into your busy primary care practice. Specifically we will review the effect of ADHD on the executive function system and how potential deficits in these areas may present and impact individuals with ADHD. We will explore the areas of: attention, planning and problem-solving, working memory, inhibition, time management, and emotional regulation. You will discover how to identify the common areas of difficulty through targeted questioning. We will pinpoint

typical challenges within each executive function domain and equip you with practical strategies to share with your patients during clinic appointments.

**Friday, November 8 Session ID: 176 Room: Ballroom C**

**11:30–12:30** **Timber! A common sense approach to syncope**

Filip Gilic, CCFP (EM)

**Learning objectives:**

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

1. Understand the physiological basis of syncope
2. Know the high-risk features of syncopal attacks
3. Apply appropriate assessment and testing strategies

**Description:**

Syncope is a bewildering presentation that encompasses a wide variety of benign and serious causes. In this session, we will go over the physiological basis of syncope and will describe a step-by-step evaluation process that will help us separate the serious from the benign. We will learn what features on history and physical exam are reliably associated with cardiac syncope; and what questions should be asked of all syncope patients. We will then review an evidence-based testing strategies that ensures the right patients get the right tests ordered, while avoiding the expense and trouble of over-testing.

**Friday, November 8 Session ID: 163 Room: 116-117**

**11:30–12:30** **Let's Talk About Sex: Women's sexual function complaints**

Stephanie Hart, MD, CCFP

**Learning objectives:**

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

1. Review the biopsychosocial model of sexual function
2. Quick clinical pearls for assessment and management of low libido in the office
3. Quick clinical pearls for assessment and management of dyspareunia in the office

**Description:**

Patients with complaints about sexual function problems are a challenge in the family medicine office, and many of us aren't comfortable discussing these issues - especially when it feels like we have nothing to offer. There are easy, evidence-based ways to assess sexual complaints, and interventions that can make these visits less frustrating for physicians and improve patient quality of life. This presentation will review some common causes of low libido and dyspareunia that can be assessed and managed in the office in quick, sequential visits, and an algorithm to help you work through these diagnostic possibilities, as well as recommendations for when to refer (and to who).

**Friday, November 8 Session ID: 174 Room: 118-120**

**11:30–12:30 First Five Years: Essential snappers for early-career physicians**

Frantz-Daniel Lafortune, MD, CCFP

**Learning objectives:**

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

1. Recognize common clinical challenges encountered by new-in-practice family physicians
2. Implement specific strategies and tools to address practice management issues frequently faced in early career
3. Apply the actionable methods and phrases discussed when similar situations arise in day-to-day practice

**Description:**

This snappers-style session will focus on common areas of concern for early career physicians in brief 15-minute presentations on key topics identified by family doctors in their first five years of practice. The topics will range from clinical questions to practice management challenges. The presenters will identify a challenge commonly encountered by new family physicians, share their personal experience, and offer concrete approaches to manage it in day-to-day practice. The suggestions offered will be specific and actionable to provide attendees with the confidence to tackle difficult situations as they begin practicing family medicine. Over the course of an hour, established family physicians will share their strategies to address concerns that often arise during the first five years in practice in a series of highly informative but bite-sized presentations, followed by an opportunity for questions.

**Friday, November 8 Session ID: 263 Room: 202-204**

**11:30–12:30 Basics of Assessment: Key principles for assessing learners**

Shelley Ross, PhD, MCFP (Hon); Kathy Lawrence, MD, CCFP, FCFP; Cheri Bethune, MD, MClSc, CCFP, FCFP; Theresa Van Der Goes, MD, CCFP; Keith Wilson, MD, PhD, CCFP, FCFP; Alison Baker MD, CCFP, FCFP; Erich Hanel, MD, CCFP; Annelise Miller, MD, CM, CCFP (EM)

All teachers welcome. Highlight's novice and developing concepts for clinical preceptors.

**Learning objectives:**

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

1. Describe basic principles of assessment in the context of medical education
2. Apply the principles of assessment to choosing appropriate tools for various assessment settings
3. Evaluate how the principles of assessment can be applied in their home program

**Description:**

If you are involved in teaching, you are also involved in assessment. Assessment is fundamental to helping learners grow, yet many of us feel some uncertainty about how to approach assessment. Specific needs may vary by role: 1) Clinical preceptors need confidence and competence in assessment strategies to enhance day-to-day learning; 2) Site directors need their preceptors to understand, feel capable of, and

effectively perform assessment of learners; and 3) Program Directors and Enhanced Skills Directors need to be confident that appropriate assessment of learners has been carried out and documented to ensure that learners are ready for promotion. However, there is a common element to all of these needs: they require both an understanding of the basic principles of assessment, and knowledge of how to apply those principles to create a culture of rigorous, accountable, and trust-worthy assessment of the learners. In this interactive introductory workshop, participants will learn the basic principles of assessment relevant to the context of Family Medicine. Participants will have the opportunity to work in small groups on case examples provided to give context to the theories and principles discussed. Participants are invited to bring examples or challenges from their own programs or experiences that they would like to share. The workshop will conclude with a summary of key learnings from the interactive portions, linked to the basic principles of assessment.

**Friday, November 8** **Session ID: 275** **Room: 205-206**

**11:30–12:30** **Health Professional Educators in Family Medicine (HPEs-FM): An untapped teaching resource**

Jill Berridge, BA(Hons) PE, BHScPT; Louis-François Dallaire, MSW; Bethany Rolfe, RN, BSN; Payal Patel, BSc(Pharm), ACPR, PharmD; Sheila Renton, MPH, OT Reg.(Ont.)

All teachers welcome. Highlight's novice and developing concepts for clinical preceptors.

**Learning objectives:**

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

1. Learn the where, what, and how HPEs teach FM learners
2. Outline the benefits of HPE teaching for learners and educators within the evolving expectations of team-based education and collaboration
3. Leverage collaboration with HPEs to support teaching and clinical practice while identifying strategies to make HPEs better teachers

**Description:**

Health Professional Educators in family medicine (HPEs-FM) provide substantial training and education for undergraduate and postgraduate FM learners at each of the 17 Canadian academic FM programs. HPEs have been proven to provide FM learners with critical opportunities to examine collaborative teaching and highlight the lifelong CanMEDS core competency of being a 'collaborator'. Within the context of family medicine, health professional educators work together to enhance the education of family medicine residents and other interprofessional learners. This workshop will offer examples of this from select Canadian FM programs and provide tips and tools to facilitate effective team-based teaching in family medicine. This will include how to identify HPEs and their support for your own teaching. Specific recommendations for engagement and collaboration with HPEs at your institution or in your clinic will be provided. Practical scenarios where HPEs are integrated into FM teaching will be demonstrated while challenges associated with team-based teaching will also be discussed. This session will engage the audience in learning through both didactic and small group learning with facilitated questions, ending with an open sharing opportunity for take home strategies.

**Friday, November 8** **Session ID: 117** **Room: 109-110**

**11:30–12:30** **Big Ideas Soapbox**

**Learning objectives:**

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

1. Acquire new perspectives on the scope of and approach to primary care practice, innovation, and research
2. Gain a critical understanding of new, leading-edge innovations that seek to address complex problems 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 Big Ideas Soapbox session showcases ideas that could make a profound difference to clinical practice, faculty development, post-graduate or undergraduate education, patient care and outcomes, or health policy. This session offers a platform for innovators to present and share fresh ideas, innovative thinking, and fledgling developments with the potential to initiate change. The audience puts ideas to the test and decides which one takes home the prize. Get ready to vote!

**Friday, November 8** **Session ID: 113** **Room: 114-115**

**11:30–12:30** **Caring for 2SLGBTQIA+ Seniors**

Robyn Moxley, MD, CCFP, MPH

**Learning objectives:**

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

1. Appreciate the history of discrimination and the resilience of 2SLGBTQIA+ seniors
2. Understand some of the unique challenges faced by 2SLGBTQIA+ seniors today
3. List three ways to provide safer healthcare to this patient population

**Description:**

2SLGBTQIA+ seniors are a diverse and extremely resilient group who have experienced many unique challenges during their lifetime. Unfortunately, they often face discrimination when accessing health care. This can lead to worse health outcomes, and may even force people to go back into the closet in order to avoid discrimination. Many steps can be taken to create a safer healthcare environment, including at the institutional and interpersonal levels. Family physicians can demonstrate inclusivity to 2SLGBTQIA+ older adults by using the right language for each person, involving chosen family, and using their leadership roles to create more inclusive policies and spaces. This presentation will provide a brief overview of queer and trans history in Canada, explore current challenges to the aging 2SLGBTQIA+ community as they access healthcare, and describe ways to provide more affirming care to this group.

**Friday, November 8** **Session ID: 498** **Room: Ballroom D**

**12:45–13:45** **Differentiating Causes of Dyspnea and Cough: Could your patient have interstitial lung disease?**

Raj Mainra, MD; Moderator, Jessica Chan, MD

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

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

1. Explain the prevalence and impact of interstitial lung disease (ILD) and address the barriers to identifying ILD patients
2. Determine the initial assessment of a patient with suspected ILD, including patient history, examination, and diagnostic tests
3. Differentiate between ILD and other common conditions with similar clinical presentations

**Description:**

Interstitial lung disease (ILD) is a group of pulmonary conditions characterized by diffuse parenchymal lung infiltration. This is caused by lung inflammation and/or lung fibrosis. Although less common than other respiratory conditions, ILD can be associated with significant mortality risk, higher than many different types of cancer. There is also a lack of public awareness of this condition. With treatments available to reduce ILD progression and mortality risk, time lost before diagnosis translates to lung lost. The webinar is designed to help provide the primary care clinician with guidance regarding when to suspect ILD and their role in the assessment and referral of these patients.

**Friday, November 8** **Session ID: 504** **Room: Ballroom C**

**12:45–13:45** **Moving Beyond Weight: Understanding obesity and its comorbidities**

Walter Chow, MD

*This is an Ancillary Session, sponsored and paid for by a CPD provider that may have also received external funding for program development. All conflicts of interests will be fully disclosed on slides and shared verbally at the start of the presentation.*

*Cette présentation est une séance auxiliaire, parrainée et financée par un fournisseur de DPC qui pourrait avoir reçu un financement externe pour la conception du programme. Tout conflit d'intérêts sera entièrement divulgué sur les diapositives et mentionné verbalement au début de la présentation.*

**Learning objectives:**

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

1. Address some of the most frequently asked questions on the topic of obesity using the latest data and evidence-based guidelines
2. Recognize the correlation between obesity and its impact on cardiovascular disease and outcomes

**Description:**

Primary care clinicians play a crucial role in managing obesity and its related comorbidities, often encountering patients who struggle with this complex, chronic condition. Despite the frequency of these encounters, many patients are not offered a comprehensive, evidence-based obesity management plan. Instead, they often receive generic advice like "eat less and exercise more," which typically does not lead to significant improvements in weight or health and can reinforce obesity-related stigma. This approach oversimplifies the complexity of obesity management and fails to address its multifaceted nature. To address these gaps, this practical education program is designed to equip clinicians with the knowledge and tools to manage obesity more effectively. The program focuses on the pathophysiology of obesity, current guideline recommendations, and strategies for addressing bias and weight plateaus in clinical practice. By enhancing clinicians' understanding and skills, the program aims to improve patient outcomes and reduce the stigma associated with obesity management.

**Friday, November 8 Session ID: 162 Room / Salle : Ballroom AB**

**14:00–15:00** **Caring for Rare Hearts: Inherited cardiovascular disease pearls**

June Carroll, MD, CCFP, FCFP; Shawna Morrison, MS, CGC; Kirsten Bartels, MSc, CCGC

**Learning objectives:**

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

1. Determine who/how to offer genetic testing and/or specialist assessment for FH, HCM and HTAA
2. Discuss clinical utility of genetic testing for FH, HCM, HTAA with family members
3. Identify where to find credible resources for applying genomics in their practice

**Description:**

This session will use a primary care case-based approach to discuss common inherited cardiac conditions including familial hypercholesterolemia (FH), hypertrophic cardiomyopathy (HCM) and hereditary thoracic aortic aneurysms (HTAA). Often presenting first in primary care, early identification, surveillance, genetics referral when appropriate, and facilitation of familial genetic testing are essential for improved outcomes and lifesaving intervention. We will provide point of care tools and emphasize pearls for everyday practice. Clinical questions and discussion are welcomed. FH is a common (1/250) hereditary condition that results in a 6 to 22-fold increase in cardiovascular disease and early death. FH is significantly under-recognized in Canada, where only about 10% of affected persons are thought to be identified. Early diagnosis and treatment can normalize life expectancy. Genetic testing is a key approach to the diagnosis of FH, allows for early, cost-effective detection of at-risk relatives, can be used in risk stratification, and can be of personal utility to patients. HCM affects more than 1 in 500 individuals. Sudden cardiac death is the most feared complication and can be the first clinical presentation. Once HCM is identified, it can be a manageable condition with appropriate evaluation and risk stratification.

While the role of genetic testing in risk stratification is uncertain, it is recommended for confirmation of diagnosis and identification of at-risk relatives requiring ongoing surveillance and possibly treatment. HTAA accounts for approximately 20-25% of all thoracic aortic aneurysms (TAA) and dissections. HTAA presents at a younger age and is more aggressive than other TAAs. Appropriate recognition of HTAA allows initiation of management, intervention, and imaging surveillance of at-risk relatives.

**Friday, November 8 Session ID: 17 Room: Ballroom C**

**14:00–15:00** **Approach to Psychotherapy in Primary Care**

Jon Davine, MD, FCFP, FRCP(C)

**Learning objectives:**

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

1. Describe the different models of supportive and cognitive behavioural therapy
2. Describe the factors involved when choosing a specific psychotherapeutic approach
3. Describe specific techniques used in cognitive behavioral therapy

**Description:**

25-35% of patient visits to a family physician may involve predominantly psychological issues. Due to their longitudinal relationship with their patients, family doctors have lots of opportunities to do meaningful psychotherapy with their patients. Often, family doctors may be the person that patients feel most comfortable with to do this kind of work, due to the trusting relationship that is already present. In this presentation, we present two different types of psychotherapy, those being "supportive" therapy and "change" therapy. We discuss how to choose the appropriate therapy, for the appropriate person, at the appropriate time. We discuss "supportive" therapy, and how to best apply this in the primary care setting. We then will focus in some detail on "change" therapy, particularly Cognitive Behavioural Therapy (CBT). We discuss techniques of CBT, including setting up cognitive logs, and how to challenge distorted thinking patterns. We go on to discuss behavioural homework as a therapeutic modality to complement the cognitive work. Currently, there are a number of self-management books, and online CBT resources and apps that can be helpful for patients. Some of these resources will be presented. Some studies have shown that if family doctors have an understanding of CBT principles, they can "coach" their patients appropriately when using these self-management books or online CBT resources. Studies have shown that positive results can then be achieved in a lesser amount of time, than if the doctors had delivered the CBT themselves.

**Friday, November 8 Session ID: 300 Room: 109-110**

**14:00–15:00** **Locums 101: A guide for early-career physicians**

Anna Schwartz, MD, CCFP; Stephen Hawrylyshyn, MD, CCFP (EM)

**Learning objectives:**

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

1. Evaluate locum opportunities and address essential questions to ensure successful locum coverage is provided

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

2. Prepare for contract negotiations and determine key areas where terms/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, and especially important for physicians to be aware of at the start of their careers, as many new family physicians provide locum coverage before beginning their own practice. This interactive session is presented by the First Five Years in Family Practice Committee to provide a complete overview to locums coverage. It will prepare attendees for each aspect of the process. Family physicians who have experience with locums will identify the essential information for those considering locums through lessons learned from their personal experiences. They will share strategies for success to be applied by attendees in their own locums, and to ensure a successful locum for both family physicians involved and maintain continuity of care for Canadian patients. Presentation topics include: how to find a locum, evaluating locum opportunities, locum contracts and negotiations, key questions to ask, red flags, and what to consider before accepting a locum position. The presenters will also demonstrate how locum experiences in early career can be used to compare different family practices models 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 presenters will respond and address any specific challenges or concerns raised by attendees.

**Friday, November 8** **Session ID: 218** **Room: 118-120**

**14:00–15:00** **Mainpro+ 2024: Simplified and refreshed**

Melissa Lujan; M.Sc., CPC(HC); Leonora Lalla, MD, CCFP, FCFP, CPC(HC)

**Learning objectives:**

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

1. Describe the new Mainpro+ program requirements
2. Explore how their CPD activities fit in the 3 new Mainpro+ credit categories
3. Participate in a discussion on how to effectively plan your CPD to meet the requirements

**Description:**

A new Mainpro+ program and platform are launching in December 2024. We are excited to show you the simplified, and enhanced program. Join us to learn about the reduced credit categories, new program requirements and see a demonstration of the refreshed Mainpro+ platform. We will discuss ways you can plan your CPD to meet the new requirements and explain how the learning activities you do on a regular basis can earn Mainpro+ certified credits.

**Friday, November 8** **Session ID: 238** **Room: 205-206**

**14:00–15:00** **Meaningful Moments in Teaching: A quilting journey**

Martina Kelly, MBBChBAO, PhD, CCFP, FCFP; Lara Nixon, MD, CCFP (COE), FCFP; Heather Buckley, MD, CCFP, FCFP, MHP; Cathy MacLean, MD, FCFP, MCISc (FM), MBA, CCPE

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Legend:**
**Simultaneous interpretation**
**Live-stream and on-demand**

**Learning objectives:**

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

1. Acknowledge and explore a teaching moment that is a source of inspiration
2. Collaborate with colleagues to synthesize moments of meaning for family physician educator identity
3. Design a quilt of teaching moments (yes, we will make a quilt!)

**Description:**

Most family physicians teach because they experience a sense of reward when teaching and learning with students. Demands of day-to-day clinical work, administration, juggling multiple demands can eclipse this motivation. Identifying meaning by attending to individual, subjective experiences is associated with higher self-reported quality of life, improved self-reported health, and job satisfaction. Sharing meaning, through collaborative reflection, is associated with a collective sense of connection, togetherness, and enhanced professional identity. While much reflection emphasizes verbal exchange, creative processes, such as quilt-making, can enhance reflection by facilitating embodied and socio-material interactions. The workshop will open with introductions, to share breadth of family physician educator roles (10 minutes). Next participants will be introduced to quilting as a metaphorical and hands on concept for collaborative reflection, situated in literature on positive psychology. Participants will be invited then to think-pair-share, reflecting on and describing a meaningful moment from their experience of clinical teaching. In small groups, participants will identify commonalities/similarities and shared experiences of meaning, themes – and translate these into a visual representation, creating quilt blocks, using materials provided. (15 minutes). The large group will reconvene to share themes, and from this the group will position the blocks to create a quilt representative of collective experience. The quilt will be displayed at the end of the workshop. Participants may take images of the quilt to take home, to wrap around themselves and keep them warm on days when teaching feels just that bit more challenging.

**Friday, November 8 Session ID: 62 Room: 202-204**

**14:00–15:00 Mountains and Valleys: Preparing an educational leader's portfolio**

X. Catherine Tong, MD, CCFP (EM), FCFP, DRCPSC; Alim Nagji, MD, CCFP (EM), DRCPSC; Stephen G Miller, MD, CCFP(EM), FCFP, MEd, DRCPSC; Anthony Davies, MD, CCFP; Alison Baker, MD, CCFP, FCFP, DRCPSC

All teachers welcome. Highlight's developing concepts for educational leaders.

**Learning objectives:**

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

1. Define and discuss the foundational competencies of an educational leader
2. Identify individual gaps in experience and learning needs towards a complete educational leader's portfolio
3. Create a personal learning plan to address gaps in experience and learning needs

**Description:**

In Departments of Family Medicine in Canada, academic promotion is not always a clear process. Those who are in their first five years of family practice may consider embarking on clinical teaching as a path towards professional development and promotion. Experienced clinical teachers may need guidance in fulfilling promotion requirements to work towards the portfolio of an educational leader (EL). As defined by the Fundamental Teaching Activities (FTA) framework, ELs support an educational program or curriculum development in a leadership role. They evaluate programs, create or curate resources, and generate educational scholarship. While the FTA provides a competency framework for the role of EL, individuals must devise a plan to operationalize it in their own contexts. This is a faculty development workshop that facilitates this process. Experienced family medicine ELs from two institutions will define the term EL and provide a diversity of prototypes of ELs to illustrate the foundational competencies of an EL. Attendees will engage in a guided audit exercise to review their own professional experiences and competencies. Some of the competencies reviewed are 1. Foundational knowledge in educational theories 2. Pedagogical best practice 3. Curriculum design 4. Program evaluation 5. Working with learners in difficulties 6. Educational scholarship and 7. Educational leadership. This process is valuable for both novice family medicine teachers and experienced clinical teachers in preparing a teaching portfolio for their next promotion. The attendees will gain a clear view of their areas of interest and expertise while identifying gaps in their portfolio. The facilitators will allocate space for conversations about how learning needs may be addressed with open-access resources and practical opportunities to address gaps in knowledge and experience. The attendees will leave the session with a personal learning plan for career development in preparation for the role and responsibilities of an EL.

**Friday, November 8** **Session ID: 216** **Room: 121**

**14:00–16:30** **Insomnia Care Without Medication: A pragmatic approach**

Shayna Watson, MD, MEd, FCFP; Judith Davidson, PhD; David Gardner, PharmD, MSc CH&E; Erin Desmarais, MSW; Katherine Fretz, PhD; Stephanie Lynch, PharmD; Eileen Sloan, MD, FRCPC

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Adopt a stepped care model to improve sleep outcomes of your patients with insomnia
2. Simplify sedative deprescribing using tools that engage and motivate your patients with insomnia
3. Develop skills and apply tools based on CBT-I to help your patients with insomnia

**Description:**

Insomnia is the most common sleep complaint in primary care with its prevalence, and sedative use, increasing with age. Cognitive-behavioural therapy for insomnia (CBT-I), the recommended first-line intervention for chronic insomnia, is practical and well suited to primary care environments. The long-term use of sedative medications remains the default therapeutic intervention for insomnia in primary care, despite their limited effectiveness and inherent risks. Using a hands-on approach, this workshop will focus on the practicalities of managing insomnia with CBT-I in primary care. We will include a brief overview of CBT-I and share a range of tools (print, online, apps, group programs) relevant to the

assessment and treatment of chronic insomnia following a stepped care model. Working in a series of small groups, participants will be introduced to and try evidence-based tools and approaches in the context of clinical cases that will have direct application to their practice. There will be opportunity to learn about the role of sleep diaries, other critical components of CBT-I, and how to overlap CBT-I with sedative deprescribing. Guidance will be provided by our team of professionals with expertise in these areas. Participants will rotate through a series of five stations and will interact with and learn from each other as well as members of our inter-professional team. Common barriers to behaviour change will be specifically identified and effective strategies to overcome them will be discussed. This workshop will offer direct experience with practical approaches to effectively support patients in reversing their insomnia and preventing its return. Participants will complete a pre- and post-survey to document their learning and change in skill level across a range of CanMEDS roles.

**Friday, November 8 Session ID: 291 Room: Ballroom AB**

**15:30–16:30** **Top 10 Family Medicine Articles to Change Your Practice**

Jock Murray, MD, MSC, CCFP (EM), FCCP; Roop Conyers; Deanna Field; Anna Neumann

**Learning objectives:**

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

1. Become familiar with 10 recent articles that are potentially practice changing
2. Review the evidence for changing practice in 10 clinical scenarios
3. Decide if the presented evidence supports changing practice

**Description:**

This is a recurring session at FMF. It is highly rated and typically attracts 200-500 participants. Ten recent articles are chosen to be practice changing and relevant to a broad spectrum of Family Physicians. An Evidence and "Choosing Wisely" approach is applied to the articles. Four minutes will be spent reviewing and critiquing each article. The remaining time is reserved for audience questions. This session is different from the excellent "Tools for Practice sessions" in that a more in depth review of each article is taken.

**Friday, November 8 Session ID: 247 Room: Ballroom C**

**15:30–16:30** **One for the Aged: Improving long term care**

Adam Gurau, MD, CCFP (COE)

**Learning objectives:**

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

1. Identify common issues encountered when caring for long term care residents
2. Discuss strategies to improve resident and family-centered care
3. Explore radical change ideas and discuss their feasibility and ethics

**Description:**

There are over 200,000 nursing home residents in Canada and the complexity of their medical and social issues continues to increase. Many of these residents have spent prolonged periods of time in hospitals

and other health care facilities during the pandemic, experiences that have drastically impacted their physical and mental health and led to significant caregiver stress and burnout. The long term care environment has also endured significant challenges, with limitations and stressors that continue to impact care delivery. As primary care providers, we have the ability to act as leaders in this care environment and effect positive change not only through providing high quality clinical care but also through relationship building and communication. This presentation will review current challenges in the care of long term care residents and propose strategies to both improve the quality of care and positively impact the long term care experience for staff, residents and their families. We will also raise some radical change ideas and discuss the feasibility and ethical considerations related to their implementation.

**Friday, November 8** **Session ID: 242** **Room: 109-110**

**15:30–16:30** **Review of the 2024 Guidelines on Minimal Intervals for Repeat Lab Testing**

Alexander Singer, MB BCh BAO, CCFP, FCFP

**Learning objectives:**

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

1. Describe specific guidance on retesting intervals for common laboratory tests
2. Consider strategies to incorporate these changes into daily practice
3. Explore the key findings and evidence supporting the CADTH/CWC guideline committee recommendations

**Description:**

Choosing Wisely Canada (CWC) and the Canadian Agency for Drugs and Technology in Health (CADTH) are currently developing a guideline to identify minimum testing intervals of 7 tests frequently ordered by family doctors. For the following tests; ANA, Lipase, SPEP, BNP, Lipid Panel, TSH and HbA1c a panel including family doctors and specialists will develop recommendations aimed at reducing over-testing and promoting resource stewardship. The definition of a "minimum retest interval" is the minimum time before a test should be repeated. The guideline panel's work is part of an ongoing collaboration between CADTH and CWC under the umbrella of the "Using Labs Wisely" initiative which is, a national consortium whose goal is changing the lab utilization landscape in Canada. Several stakeholders in the Using Labs Wisely group have identified a need for guidance on the re-test intervals for lab tests to support decision making. This is a consistent challenge for family doctors since despite having longitudinal relationships with our patients the evidence for re-testing is rarely taught in residency training nor is it typically a key component of speciality focused guideline recommendations. We propose presenting the findings of the multi-disciplinary panel on the minimum re-testing intervals for lab tests focusing on the recommendations relevant to the care of patients in primary care settings. The panel's work includes considerations for equity-deserving populations and in the future will be a key component of promoting ongoing stewardship efforts. Thus, this presentation has high relevance to ensure that family doctors continue to be at the forefront of delivering care that improves patient outcomes and experiences, while controlling the expanding costs of healthcare. Participants will learn about the specific recommendations as well as consider approaches to incorporate them into their current practice.

**Friday, November 8** **Session ID: 312** **Room: 118-120**

**15:30–16:30** **Implementing Trauma and Violence-Informed Care**

Vanessa Brcic, MD, CCFP, MSc

**Learning objectives:**

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

1. Define trauma and violence informed care (TVIC) and the importance of "V" for structural violence
2. Recognize barriers and accomplices to implementation of TVIC across different practice settings
3. Identify one principle of TVIC that they are already practicing, and one opportunity for further practice

**Description:**

How do we create healing rather than harming spaces within health care institutions that feel good to both work in and also access care within? How do we provide safe, sustainable primary care within a health care system currently and historically rooted in colonialism, in which many people are systemically marginalized, feel unsafe, and may be re-traumatized, and in which health care providers are increasingly experiencing burnout and moral distress? This session offers an evidence- and story-based, actionable approach to Trauma and Violence-informed Care (TVIC) to help us understand this inspiring approach to care, as we build a community of peers walking on the pathway towards equitable, sustainable health system renewal. We will begin with an overview of evidence, experiences, and tools describing the work, so participants can understand what TVIC is and why it is important in building individual and health system resilience. The presentation will draw connections between the presenter's thesis research, a newly published Handbook on "Implementing Trauma- and Violence-informed Care" (2023), and reflections on the day-to-day work of moving our workplaces towards TVIC. The goal of the session is to make this impactful and inspiring approach, and the body of literature describing it, accessible to primary care providers in diverse settings. We will reflect as a group about how TVIC relates to our practices, our personal values and priorities, or the systems we work in. We will aim to identify one element of TVIC that is meaningful and actionable to each of us, and leave with shared language and resources to support movement towards TVIC in our workplaces and professional relationships.

**Friday, November 8** **Session ID: 289** **Room: 205-206**

**15:30–16:30** **When Interest Wains...Re-igniting distributed clinical teacher engagement**

Cheri Bethune, MD, MClSc, CCFP, FCFP; Wendy Graham, MD, CCFP, FCFP, FRRMS; Shabnam Asghari, MD, MPH, PhD

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Describe the Adaptive Action Method (AAM) as an approach to addressing complex problems

2. Apply the AAM to an identified vexing problem (in community teacher engagement) in their own context
3. Utilize peer feedback and discussion to formulate an action plan to address their challenge

**Description:**

Purpose: When interest wains, how do you maintain or re-ignite distributed clinical teacher engagement? Medical schools are expanding, while those we rely on to teach at the community level struggle with increased demands on their time/energy and good will. This workshop is designed to explore innovative strategies for the vexing problem of sustaining community physician teaching engagement. Grounded in our own challenge of maintaining a rural faculty development program in research skills (6for6), the facilitator will share principles, strategies, and lessons learned to help attendees think about, discuss, and shape novel solutions to their faculty engagement challenges. We will discuss barriers, enablers, and key strategies to empower community physicians to pursue faculty development opportunities. Using the Adaptive Action Method (AAM), the participants will be engaged in a thoughtful and creative exploration of methods to engage and sustain community-based physicians. The goal is to catalyse creative solutions by asking three crucial questions: What? So what? And now what? Delivery methods: A brief overview of our experience developing a successful rural faculty development program in research skills (6for6) will be followed by a group activity and discussion using the AAM. Participants will share and gain pragmatic strategies to build and maintain community teacher engagement using AAM to tackle this 'wicked' issue.This workshop will include: 1. Brief didactic presentation of the Adaptive Action Method 2. Identification and (small group) discussion of problems or challenges in faculty engagement. 3. Utilization of the AAM in groups to clarify their problem and create an action plan.

**Friday, November 8 Session ID: 126 Room: 202-204**

**15:30–16:30 Empowering Preceptors: A clinical reasoning remediation toolbox**

Danielle O'Toole, MD, MSc, FCFP

All teachers welcome. Highlight's developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Analyze the diverse factors influencing an educational diagnosis for a learner experiencing academic challenges
2. Develop skills in formulating an educational diagnosis for a learner with academic difficulties
3. Apply effective strategies to adapt and enhance the curriculum for learners facing academic challenges

**Description:**

Medical education faces unprecedented challenges due to pandemic-induced shifts in learning, reduced hands-on experiences, and increased assessments, resulting in heightened demand for academic support. Identifying and supporting learners with academic difficulties is challenging, exacerbated by constraints in time, resources and faculty development. However, ensuring competent physician graduates is paramount. In response to this need, we developed a specialized toolbox tailored to clinical reasoning

challenges, a primary concern in postgraduate medical education. Grounded in evidence-based principles, this toolbox equips preceptors with user-friendly checklists, resources, and simulated cases for making an educational diagnosis and implementing personalized teaching strategies. It empowers preceptors to proactively address learning gaps during real-time clinical encounters (in-situ learning), instead of awaiting formal remediation. Designed for clinicians serving as supervisors or primary preceptors, this workshop caters to diverse stages of clinical reasoning skill development in medical students, clerks, residents, fellows, and interprofessional healthcare providers. It particularly benefits clinicians serving as tutors or coaches for learners on enhanced education or remediation plans, as it addresses their unique challenges.This session adopts a multifaceted approach, leveraging the potential of our specialized toolbox. Participants engage in succinct didactic presentations to understand its components and development process. Interactive case-based learning, including structured group discussions, and hands-on simulations using templates and handouts, enables participants to work collaboratively through cases in small groups, honing their practical skills and knowledge, all while applying the resources and strategies provided by the toolbox.

# Saturday, November 9

**Saturday, November 9** **Session ID: 175** **Room: 121**

**7:30–13:00** **ECGs for Family Docs: A comprehensive review**

Filip Gilic, CCFP (EM); Elizabeth Blackmore

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 15 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Understand the electrophysiology basis of ECG deflections
2. Identify and treat tachy and brady arrhythmias
3. Identify and treat signs of ischemia

**Description:**

ECG interpretation is a core competence of Family Physicians but is often taught using pattern recognition that leads to difficulty with complex or atypical ECGs. This course explains the basics of electrophysiology using a simplified approach that is well suited to Residents and practicing Family Physicians. 4 hours of preparatory videos on ECG basics, bradycardias, tachycardias and ST changes ensures that you need to know everything you need to know before you show up for the course. Once at the session, we do a brief review then spend the next 4 hours practicing ECG interpretation in a progressive fashion in order to build mastery of each ECG facet. We finish with a 60 min integrated interactive exam that allows you to test your knowledge and correct any lingering deficiencies.

**Saturday, November 9** **Session ID: 134** **Room: 122**

**8:00–12:00** **Shift Your Mindset to Optimize Your Diagnostic Approach**

Katherine Lariviere, MD, MSc, CCFP, FCFP

This Group Learning program has been certified by the College of Family Physicians of Canada for up to 13.5 Mainpro+ credits.

**PRE-REGISTRATION REQUIRED**

**Learning objectives:**

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

1. Explain the use of the FOAM tool in supporting clinical documentation and diagnostic decision-making
2. Define situational awareness and its role in diagnostic decision-making
3. Discuss strategies to safeguard diagnostic decision-making and raise situational awareness

**Description:**

Diagnostic error happens in all care settings, and by some measures may be involved in up to one in 20 clinical encounters. According to Canadian data, diagnostic error is the most frequent contributing factor to medicolegal difficulties for physicians. The role and impact of diagnostic error on patient safety is largely unappreciated in efforts to improve quality and safety. One element that is often left out of patient safety and quality improvement initiatives is the cognitive process of diagnosis – efforts have largely focused on factors such as reporting culture. Diagnosis is an iterative process that is often undocumented and very closely tied to individual physician factors and there is a great deal of complexity surrounding both the process of diagnosis and determining if and how an error occurred. This case-based interactive workshop will review use of the FOAM tool to support diagnostic reasoning, documentation as a tool to support diagnostic reasoning, the concepts of cognitive bias and situational awareness, and will allow for peer-feedback and group interaction. This workshop aims to raise awareness of the diagnostic process and to provide an opportunity for participants to commit to one small increment of change to support clinical reasoning in their own practices.

**Saturday, November 9** **Session ID: 43** **Room: Ballroom AB**

**8:30–9:30** **Recognize The POOP: Pain out of proportion**

Vu Kiet Tran, MD, FCFP (EM), MHSc, MBA, CHE, ICD.D

**Learning objectives:**

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

1. Enumerate the ENT, abdominal, extremity, and Skin POOPs
2. Recognize the pitfalls in the physical exam fort hese POOPs
3. List the immediate management plans for each of these POOPs

**Description:**

Pain is a frequent presentation to the emergency department and hospital. But when "pain is out of proportion", what should we do? What diagnoses are at play? What are our immediate course of action? There are many cognitive biases that will cloud our judgement. Don't be fooled, or else, your patients will die from these conditions presenting with "pain out of porportion".

**Saturday, November 9** **Session ID: 111** **Room: Ballroom C**

**8:30–9:30** **Transitioning to Practice 101**

Louise Oborne, MD

**Learning objectives:**

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

1. Understand essential skills and resources to facilitate a smooth transition into independent practice
2. Learn about various job opportunities across the country, and how to choose the right fit
3. Hear diverse perspectives of newly independent physicians, including helpful tips and challenges

**Description:**

Second year family medicine residents are often anxious and indecisive when considering future career pathways after graduation. Guidance, resources, and advice from our peers through firsthand experiences has shown to reassure many residents and those in their first five years of practice. This interactive session, facilitated by the Section of Residents of the CFPC, will consist of a diverse panel of newly practicing family doctors from across Canada. Panelists will discuss useful tips and strategies for choosing the right job for you, different types of practice options that exist (ie. team-based care, salary, fee for service, focused/specialized practices, hospital medicine, family medicine obstetrics, full spectrum care, etc.), what to expect when transitioning to practice, and how to handle the daily challenges that come with independent practice. Panelists will share helpful information for second year residents about their personal experiences and what they wished they knew before transitioning to practice. The session will conclude with an opportunity to ask the panelists questions related to transitioning to practice.

**Saturday, November 9** **Session ID: 129** **Room: 109-110**

**8:30–9:30** **Red-Eye Simple Approach: Evidence, pearls, medico-legal pitfalls**

Simon Moore, MD, CCFP, FCFP

**Learning objectives:**

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

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 energetic lecture is to 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 pearls that every family physician should know about red eye. This presentation is the updated version of a highly rated presentation at FMF regularly since 2014 as well as at OCFP ASA, CME On the Run, and NP On the Run. It incorporates updated recommendations and feedback from the previous presentations, plus a new algorithm adapted from the ophthalmology guideline.

**Saturday, November 9** **Session ID: 239** **Room: 118-120**

**8:30–9:30** **Wound Care: A workshop for family physicians**

Karen Chien, MD, MSc, CCFP (COE, PC), FCFP; Evan Chong, MD, MScCH(WPC), CCFP (COE)

**Learning objectives:**

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

1. Identify the physiology and function of the skin that affects wound development and healing
2. Apply an approach to evaluate wound healing issues through several cases
3. Formulate treatment and prevention plans with basic and advanced wound care treatments

**Description:**

Wounds are an increasingly common occurrence that pose an immense burden on our healthcare system. For 2022, the cost to the Canadian system was estimated at $8.28 billion or 3.5% of total health care costs (1). We recently led a wound care workshop and conducted a needs assessment which revealed that family physician participants wanted to learn more about wounds and their treatment (2). Wounds presenting to the family physician may include acute wounds – such as burns, skin tears and other traumatic injuries. Family physicians also manage more complex wounds such diabetic neuropathic foot wounds, venous stasis ulcerations, arterial wounds and pressure injuries. These wounds are considered chronic wounds when they are not healed after 3 months. Acute wounds can become chronic wounds if interventions are not timely and appropriate. In this workshop, Family Physicians will have the opportunity to review the physiology of skin and wounds, typology and identification of wound etiology and how they can be healed. From there, a readily implemented and standard approach will be presented to aid all physicians in wound management and to recognize the complex biosocial and medical factors that contribute to the best healing of wounds. To facilitate this learning, attendees will be divided into groups and several cases will be presented which will highlight the interconnectedness of the healthcare system, social system and need for a collaborative healthcare approach to wound care. We will emphasize the need for early identification, intervention, treatment of infection and debridement. We will bring wound care enablers and products to facilitate learning. These cases will be real-world examples and transition us into a comprehensive discussion on current basic and advanced treatments. Further discussion will take place on the evidence-based practices and the lack of evidence in this growing field. Sources: 1. Queen D, Botros M, Harding K. International opinion-The true cost of wounds for Canadians. Int Wound J. 2024 Jan;21(1):e14522. doi: 10.1111/iwj.14522. Epub 2023 Dec 12. PMID: 38084491; PMCID: PMC10777746. 2. Toronto Geriatrics Workshop, Sinai Health. November 2023.

**Saturday, November 9** **Session ID: 198** **Room: 202-204**

**8:30–9:30** **Mentorship: Early career to retirement - Pearls and pitfalls**

Alison Baker, MD, CCFP, FCFP; Molly Whalen-Browne, MD, MSc, DTM&H, CCFP; Amy Gausvik, MD, CCFP, FCFP; Deborah Kopansky-Giles, DC, FCCS, MSc; Viola Antao, MD, CCFP, MHSc, FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Identify tips for successful mentorship
2. Recognize how to integrate mentorship through one's career trajectory
3. Describe the difference between a mentor, coach, advisor, and preceptor

**Description:**

Mentorship is a strong enabler in strengthening leadership development and can impact identity formation, career trajectory, wellness, and job satisfaction. Family Medicine and other health professional leaders usually seek a mentor early in their career. However, good quality mentorship can benefit both the mentor and mentee and improve effective leadership throughout one's career, all the way to retirement. Evidence shows that a strong leadership foundation involves mentorship, peer support,

coaching, and a Community of Practice. Aspects unique to mentorship will be highlighted in this session. Polling activities will engage participants to reflect on their specific mentoring needs and how those needs may change throughout their career. Through reflective exercises, participants will actively apply mentorship concepts to challenges at their career stage. In small groups, participants will explore enablers and barriers to maintaining an effective mentoring relationship. We will discuss potential strategies through various career stages and offer practical tips on continuing professional development through mentorship. This session will build on last year's mentorship for new Family Medicine leaders and is suitable for both novice and experienced primary care educators, providing information relevant to both mentors and mentees.

**Saturday, November 9** **Session ID: 280** **Room: 205-206**

**8:30–9:30** **Be the Change: Cultural safety in family medicine**

Rebekah Eatmon, MD

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Describe the historical impacts of anti-Indigenous racism and health inequity experienced by Indigenous People
2. Deepen their understanding of cultural safety and humility in primary care
3. Understand how to apply principles of cultural safety and humility in practice, in different clinical settings

**Description:**

Family physicians have a vital role to play in transforming health care, to ensure that it is culturally safe for Indigenous People. Practising culturally safe care requires: a commitment to resetting the relationship between Indigenous communities and our health system; recognizing Indigenous right to self-determination in the health care system; incorporating Indigenous ways of knowing into treatment plans. A family physician is often an Indigenous Person's first point of interaction with the health care system. The physician must prioritize cultural safety in those interactions, as a fundamental part of providing excellent care. This 60-minute interactive session will be led by Dr. Rebekah Eatmon, a BC family physician and the Indigenous Physician Lead for the BC College of Family Physicians (BCCFP). Dr. Eatmon will review the historical and present context that necessitates a shift to culturally safe care, as well as provide examples of existing tools and resources available to support family physicians in this work. The presentation will feature successful case studies utilizing these resources and there will be an opportunity for questions and constructive conversation.

**Saturday, November 9** **Session ID: 178** **Room: 114-115**

**8:30–9:30** **Peer Review Primer: Practical Tips from Journal Editors**

Nicholas Pimlott, MD, PhD, CCFP, FCFP; Sarah Fraser, MSc, MD, CCFP

**Learning objectives:**

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

1. Be able to define peer review in academic publishing and the purpose behind it
2. Understand Canadian Family Physician (CFP)'s review process, including how to do a thorough review
3. Understand the benefits of becoming a peer reviewer

**Description:**

Have you ever wondered how medical journals decide what gets published—and what doesn't? As part of its 70th anniversary celebrations, CFP invites you to peek behind the editorial curtain to see what goes into peer reviewing articles submitted for publication. In this interactive one-hour session, CFP's Editor and Deputy Editor will explain the purpose of peer review; the value and limitations of this process; and how to perform a good peer review. In addition, we will outline the many benefits of being a peer reviewer for journals like CFP, such as contributing to the evidence base of family medicine and adding variety to your work. Join us to find out how volunteering as a peer reviewer might complement your career plans.

**Saturday, November 9** **Session ID: 235** **Room: Ballroom AB**

**9:45–10:45** **Assessment and Treatment of Anxiety in Older Adults**

Erica Weir, MD, MSc, CCFP, CoE, FRCPC; Anthony Yeung, MD, FRCPC, DRCPSC

**Learning objectives:**

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

1. Detect older adults with anxiety and anxiety disorders in your practice
2. Develop an approach to the assessment and diagnosis of older adults with anxiety
3. Apply current evidence for treatment to the care of an older adult with anxiety

**Description:**

**Background:** Anxiety is not a normal part of aging, and misconceptions about anxiety in older adults lead to it being under recognized and undertreated. Anxiety has a negative impact on quality of life, increases disability and caregiver burden, and is a risk factor for depression and dementia. Anxiety in older adults is a treatable mental health condition and there are many evidence-based interventions that are helpful. To address the need for up-to-date, comprehensive clinical guidelines aimed at the assessment, treatment, and prevention of anxiety in older adults, the Canadian Coalition for Seniors Mental Health led a guideline project which has engaged with older adults and caregivers, healthcare providers, and community organizations across Canada to produce guidelines and tools that establish best practices for the care of older adults with anxiety. **Method:** Guideline development followed the Guidelines International Network (GIN)-McMaster Guideline Development checklist. An interdisciplinary working group was convened, and consultations completed with older adult and healthcare provider stakeholders to set priority questions and outcomes. The guideline working group included representation from psychiatry, psychology, geriatrics, family medicine, nursing, social work, and pharmacy. Systematic reviews and meta-analyses were conducted across priority areas, with certainty of evidence evaluated using the GRADE methodology. These informed Evidence to Decision Frameworks which consolidated evidence on the benefits and harms of each intervention to establish the recommendations. **Results:** The

guideline contains a total of 32 recommendations. This presentation will provide a case-based overview of the recommendations with a focus on non-pharmacological and pharmacological interventions. Knowledge translation tools to support dissemination of the guidelines will also be shared. **Conclusion:** There are effective treatments for anxiety in older adults. This session is designed to help disseminate evidence and best practice for the assessment and treatment of anxiety in older adults.

**Saturday, November 9** **Session ID: 167** **Room: Ballroom C**

**9:45–10:45** **Understanding Breast Cancer Risk and Risk Reducing Tools**

Dedeshya Holowenko, MD, CCFP

**Learning objectives:**

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

1. List population and individual factors that increase the risk for breast cancer
2. Utilize tools available to assess % 5year risk of breast cancer in individuals
3. Identify patients that may benefit from high-risk breast screening, prevention medication, and genetic testing

**Description:**

According to Canadian Cancer Society data, breast cancer is the number one cancer diagnosis accounting for 25% of cancers diagnosed in Canada. The lifetime probability of developing breast cancer is 12.1% in persons identified female at birth. 16.3% of breast cancers are diagnosed in cis-gender women between the age of 30-49, and in this young population the mortality rate is 16%. Since the Women's Health Initiative Study in 2002 much attention had been focused on the role of combined Premarin plus Provera increasing the incidence of breast cancer in the peri and post-menopausal woman. In recent years more data has identified personal and lifestyle risks that can significantly affect a person's (cis-gender and trans-gender) risk for developing breast cancer. As we assess cardiovascular risk in individuals with standardized tools to help guide the use of prevention measures and medications, here we examine tools developed to identify persons at increased risk of breast cancer, guiding earlier and more specific screening programs, genetic testing and lifestyle and prevention interventions to reduce the incidence of breast cancer in our communities.

**Saturday, November 9** **Session ID: 253** **Room: 116-117**

**9:45–10:45** **Adapting Clinical Reasoning for Excellent Virtual Care**

Batya Grundland, MD, Med; Risa Freeman, MD, CCFP, MEd FCFP; Karina Prucnal, MD,CCFP

**Learning objectives:**

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

1. Identify the ways in which clinicians adjust their clinical reasoning when caring for patients virtually based on up to date scholarship
2. Reflect on their own practice of virtual care and how it differs from in person care
3. Adopt best practices in clinical reasoning for virtual care and teach those practices to learners

**Description:**

Virtual care has remained a core component of clinical practice since the COVID 19 pandemic and has been identified as a national family medicine curricular priority in Canada. However, how the clinical reasoning of expert clinicians is impacted by the shift to virtual care is still poorly understood. This research project systematically explored the ways in which clinical reasoning is transformed in virtual care settings. This session will describe the key components of clinical reasoning in virtual care and the ways in which it differs from in-person care using the results of our work. Participants will have the opportunity to reflect on their own practices and to consider ways in which to adapt their clinical reasoning to the virtual setting. Key messages to incorporate when teaching and assessing clinical reasoning for virtual care will also be discussed.

**Saturday, November 9** **Session ID: 268** **Room: 109-110**

**9:45–10:45** **An Introduction to Refugee Health Primary Care: The basics**

Praseedha Janakiram, MD, CCFP, FCFP; Leila Makhani; Vanessa Redditt; Vanessa Wright; Shazmah Hussein; Ellen Tang; Semhar Musael; Krissha Fortuna; Sihat Monserrate; Meb Rashid

**Learning objectives:**

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

1. Implement key preventative health screening/primary care interventions relevant to health care for refugees
2. Identify key resources/approaches to guide the clinical care of refugee patients
3. Explore barriers to access to care for refugees and the value of team-based care

**Description:**

Refugees to Canada represent a vulnerable population requiring clinical care tailored to meet their specific health care needs as they arrive from around the world. This session will provide an overview of key primary care screening opportunities, vaccination recommendations, basic infectious disease screening priorities, and additional primary care interventions based on Canadian guidelines and our collective clinical experience at the Crossroads Refugee Clinic in Toronto Ontario. As the discussion around team-based primary care continues to grow and take hold, session leaders will reflect on the deep value of the interdisciplinary team in serving the refugee population and addressing preventative care through a health equity lens.

**Saturday, November 9** **Session ID: 31** **Room: 205-206**

**9:45–10:45** **Protecting Our Patients From Extreme Heat**

Samantha Green, MD, CCFP

**Learning objectives:**

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

1. Identify heat exhaustion/heat stroke, and recognize which chronic medical conditions are exacerbated by extreme heat
2. Assess which of our patients are most vulnerable to heat-related illness
3. Intervene at the micro (patient), meso (clinic or community), and macro (policy) levels

**Description:**

Climate change has been called the biggest health threat of this century. Extreme heat is increasing as a result of climate change, with many regions in Canada projected to see a 3-fold to 4-fold increase in days above 30 degrees celsius. Extreme heat poses a direct threat to health in the form of heat exhaustion, heat stroke, and increased mortality. Heat waves also worsen common chronic conditions, including asthma, heart disease, mental health disorders, diabetes, and renal insufficiency. Family physicians are well positioned to help their patients avoid heat-related illness. Family physicians can intervene by identifying those individuals who are at increased risk; counselling at risk patients; and advocating for resources for patients and policy change.

**Saturday, November 9** **Session ID: 259** **Room: 118-120**

**9:45–10:45** **What Work? Whose work? Cultural safety in our health care system**

Danièle Behn Smith, MD, CCFP (EM); Mandy Buss, MD, CCFP; Veronica McKinney, MD, CCFP; Janelle Syring, MD, CCFP

**Learning objectives:**

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

1. Recognize how Indigenous-specific racism impedes the health and well-being of Indigenous Peoples
2. Understand our roles/responsibilities in addressing anti-Indigenous racism within the health care system
3. Identify everyday examples of systemic white supremacy and how to unlearn/undo them

**Description:**

This session supports participants to develop knowledge and skills to help shift their practice and advocacy towards an environment of cultural safety, anti-racism, and trust for Indigenous patients, families, and communities. Participants will learn about roles and responsibilities of both settler and Indigenous communities have in addressing anti-Indigenous racism within the health care system and beyond. Dr. Danièle Behn Smith will offer teachings from her work at the Office of the Provincial Health Officer (OPHO) in British Columbia. The OPHO is committed to upholding the inherent rights of Indigenous Peoples in BC, as well as anti-racist approaches, and truth and reconciliation. The OPHO is committed to seeing the ways that anti-Indigenous racism and white supremacy show up in our day-to-day work (i.e., policies, practices, processes), and deliberately taking anti-racist approaches to arrest white supremacy and racism. CFPC Leadership and members the Indigenous Health Committee of the CFPC will also share how the CFPC is acting on its Declaration of Commitment to Cultural Safety and Humility, sharing work in progress, work completed, and next steps to advance Indigenous health equity. The session will offer an interactive component, allowing participants to reflect on their experiences and challenges as family doctors in addressing anti-Indigenous racism within their institutions, and encourage considerations around how to move towards cultural humility and provide equitable care.

**Saturday, November 9** **Session ID: 104** **Room: 202-204**

**9:45–10:45** **Lights, Camera, Write! Method acting in FM simulation**

Lisa Graves, MD, CCFP (AM), FCFP; Kathy Lawrence, MD, CCFP, FCFP; Douglass Dalton, MCCM, FFCFP, FCFP; Susan MacDonald, MD, CCFP (PM), FCFP; Marlow Anduze, MD, CCFP; Pauline Desrosiers, MD, CCFP, FCFP; Samantha Horvey, MD, CCFP; Vivan Kilvert, MD, CCFP, FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Identify opportunities for practice centred simulation activities
2. Integrate the principles of the patient centred clinical method into the development of simulations
3. Develop simulations for use in family medicine residencies and across the learning continuum

**Description:**

During this workshop, participants will build skills to develop simulations for residency teaching using the patient centred clinical method. Simulation is a valuable tool for teaching. Within the safe confines of simulation, learners can practice approaches and succeed and fail safely. Simulation centres are widely used in medical education but may not be accessible to learners due to geography and funding. Every day family physicians encounter situations from which there are opportunities to develop simulations. As the family physician, they can create and act a scenario using their clinical experience to explore the patient centred clinical method with a learner. In the acting world, this is known as method acting or the Stanislavski Technique. Method acting is well suited to the role of the family physician. This development technique is one of the features of the Simulated Office Oral (SOO) development process. The workshop is not designed as an exam preparation workshop, but for physicians who are interested in simulation development, using the patient-centred clinical method, and linking this with the SOO exam. At the conclusion of this workshop, participants will have the tools to develop their own simulations for use in programs and in personal, as well as program, exam preparation.

**Saturday, November 9** **Session ID: 149** **Room: 114-115**

**9:45–10:45** **Measuring Comprehensive Family Practice**

Steve Slade, BA; Asha Mohamed

**Learning objectives:**

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

1. Recognize the importance and health system implications of robust measurement of comprehensive family practice
2. Identify priority metrics for measuring trends related to comprehensive family practice
3. Identify potential applications of the Resource within their own contexts for use

**Description:**

Family physicians provide comprehensive primary care to patients and communities throughout Canada's health care system, including but not limited to care for people of all ages and with diverse health conditions. Defining and measuring comprehensive family practice can help describe family physicians' diverse professional roles and practice contexts. Having a set of consensus driven measures would enable robust comparative research and quality improvement opportunities. There is a lack of a widely recognized, pan-Canadian definition and aggregated metrics for comprehensive family practice. The College of Family Physicians of Canada (CFPC) has developed a resource to address this gap. This session highlights statistical trends and seeks input on the continued evolution and utility of a measurement approach that fully reflects the scope of family practice and can help describe family medicine's role in healthcare. The CFPC Resource for Measuring Comprehensive Family Practice (Resource) has been developed to reflect a broad definition and identify indicators that encapsulate the concept of comprehensiveness. Building upon existing key CFPC documents and literature from colleagues, the Resource utilizes a broad spectrum of data sources to incorporate provider and patient perspectives, emphasizing longitudinal data. The Resource is designed to encompass a wide range of clinical and non-clinical services and settings, including care provided by individual practitioners and collaborative teams. It integrates metrics from diverse dimensions, such as health regions, urban and rural geographies, and across provinces/territories. During the session, participants will receive an overview of the Resource, begin to interpret statistical trends and delve into potential applications and uses. Discussion will focus on the Resource's utility in various contexts, including standardized research, support for quality improvement, informing health workforce planning, and guiding educational program design.

**Saturday, November 9** **Session ID: 153** **Room: Ballroom AB**

**11:00–12:00** **Tails of Anemia: You are prescribing iron incorrectly**

Anmol Lamba, MD, MMSc, GDip (Clin Epi), CCFP

**Learning objectives:**

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

1. Develop judicious habits in ordering of screening bloodwork
2. Discuss recent evidence in treatment of iron deficiency
3. Counsel patients on common over the counter iron formulations

**Description:**

Last delivered at FMF 2021, where this session was attended by over 1200 attendees and chosen for the FMF Loved showcase, the generalist review of iron deficiency is back. With a re-review and interval 3-year update, we continue to change practices on iron is prescribed effectively and safely in a patient-centered manner. We untangle the many, many over-the-counter products that are marketed directly to patients, and take a deeper look at the evidence and studies that have informed recent innovations. We also review the different tests available to us, and form strategies on when they should actually be ordered (if at all), to reduce unnecessary patient testing and overdiagnosis.

**Saturday, November 9** **Session ID: 327** **Room: Ballroom C**

**11:00–12:00** **Social Isolation and Loneliness in Seniors: What's new?**

Amy Freedman, MD, CCFP (CoE), FCFP

**Learning objectives:**

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

1. Use practical evidence-based screening tools for those at increased risk of social isolation and loneliness
2. Assess an older adult who is socially isolated or lonely using a novel patient-centred framework
3. Compare interventions for social isolation and loneliness based on evidence, patient factors and clinical setting

**Description:**

There is growing recognition that the impact of social isolation and loneliness on morbidity and mortality compares to established risk factors such as smoking, alcohol, obesity, and frailty. Popular media has captured this with the phrase "loneliness is the new smoking." Research from the Canadian Coalition for Seniors' Mental Health (CCSMH) shows that while clinicians report they understand the risks and impact of social isolation and loneliness, they do not feel well-equipped to address this issue. In response to this societal challenge, in 2024 CCSMH released the first clinical guidelines on social isolation and loneliness specific to older adults. These guidelines were developed by an interdisciplinary group with particular attention paid to the needs of primary care providers. The guidelines provide evidence-based recommendations on prevention, screening, assessment and interventions for social isolation and loneliness among older adults. Participants will be introduced to brief tools that can be used to screen for loneliness and social isolation in patients with risk factors. An individualized, patient-centred approach to the assessment and management of social isolation and loneliness will be demonstrated. The evidence for specific management interventions including social prescribing, social activity, exercise, psychological therapies, animal assisted therapies and leisure skill development will be highlighted. Practical tools and knowledge translation materials for patients and health care providers will be provided. Participants will share and explore opportunities for incorporating these guidelines into a range of practice settings.

**Saturday, November 9** **Session ID: 110** **Room: 118-120**

**11:00–12:00** **CaRMS and Electives Q&A**

Louise Oborne, MD

**Learning objectives:**

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

1. Learn about various family medicine residency programs and streams across Canada
2. Obtain useful information related to CaRMS and electives preparation
3. Hear diverse perspectives from family medicine residents, including IMGs, and from family medicine program directors

**Description:**

Medical students are an essential part of the future of family practice in Canada. This interactive session, facilitated by the Section of Residents of the CFPC, will help prepare medical students considering a future career in family medicine. The panel will consist of residents from different family medicine residency programs and streams (urban, rural, remote, bilingual, international), as well as program directors. The panelists will share helpful tips and tricks for those considering applying to family medicine. Topics will include choosing electives, what to consider when applying to family medicine, what to do if you are considering other specialities, and tailoring your CARMS application towards family medicine. The panelists will also discuss their personal CARMS journeys and residency experiences in different programs across Canada. The session will conclude with an opportunity to ask the panelists any questions related to family medicine.

**Saturday, November 9** **Session ID: 138** **Room: 109-110**

**11:00–12:00** **Responding to the Call: Centering indigenous knowledge systems**

Mandy Buss, MD

**Learning objectives:**

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

1. Understand the TRC health calls to action and our resposibility to answer the call
2. Describe an approach to incorporating Indigenous Knowledge systems into primary care
3. Discuss barriers, lesson and solutions to incoporating Indigenous Knowledge into primary care

**Description:**

We are compelled to listen to the thousands of Indigenous voices that went into the creation of the Truth and Reconciliation Commission Calls to Action. Call to action #22 calls upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. This also aligns with the Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA calls to Justice 3.3 and 3.2. In March of 2023 a group of health care providers at Northern Connections Medical Center in Winnipeg, Manitoba collaborated and successful received a grant through CFPC Team Primary Care to incorporate an Indigenous Elder/Knowledge Keeper and Indigenous Mental health worker into our Primary health Care team to provide access to Indigenous healing practices, support our Indigenous team members, provide ongoing knowledge and faculty development for all faculty and learners and recognize the value of Indigenous knowledge and expertise within health care systems. This acknowledges the need for ongoing, culturally safe mental health care that recognizes the ongoing harms of colonialism on First Nations, Metis and Inuit. Research on the value of Indigenous Elders/knowledge keepers in primary care to support mental health and wellbeing, suggest the presence of Elders has a positive influence on the culture of the clinic by disrupting and narrowing the felt power imbalances. Care that addresses not only the physical aspect of wellness but also the emotional, spiritual and metal wellness of a person or community strengthens spiritual and cultural identity. This requires that Elders/knowledge keepers and Indigenous mental health supports with lived experience, who understand and can address the negative impacts of cultural oppression and historical trauma be a part of the interprofessional team.

**Saturday, November 9** **Session ID: 99** **Room: 116-117**

**11:00–12:00** **Enabling Difficult Conversations with Colleagues and Team Members**

James Goertzen, MD, MClSc, CCFP, FCFP

**Learning objectives:**

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

1. Describe key components of a difficult conversation
2. Demonstrate strategies for creating safe dialogue during a difficult conversation
3. Identify post-session resources to prepare and practice enabling difficult conversations

**Description:**

Effective conversations, even those involving important issues, intense emotions or different opinions are grounded when individuals feel safe sharing their opinions and identifying common interests. Unfortunately, difficult conversations are often avoided leading to communication failures which are a patient safety issue and contributor to healthcare professional burnout and medical error. Enabling difficult conversations requires awareness of personal tendencies during conversational stress, positive intention, and a curiosity mindset. Conversational skills include the ability to engage others through collaborative dialogue and relationship building when communicating with colleagues, healthcare professionals, team members, or administrative staff. During the session, strategies for enabling difficult conversations will be explored using short videos, case examples, and breakout group activities. Additional post-session resources will be provided to better prepare for your next difficult conversation. Session will be relevant to those in the first five years of practice along with experienced practitioners and developing leaders.

**Saturday, November 9** **Session ID: 201** **Room: 205-206**

**11:00–12:00** **Optimizing Psychological Safety in Medical Education**

Abir Hussein, MBBCH, CCFP; Giovanna Sirianni, MD, CCFP (PC), FCFP, MScCH; Viola Antao, MD CCFP, MHSc. FCFP

All teachers welcome. Highlight's novice, developing and experienced concepts for preceptors, educational leaders and teachers outside the clinical setting.

**Learning objectives:**

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

1. Define the concept of psychological safety and compare enablers/barriers to a safe environment
2. Explore the role of psychological safety in creating productive, clinical learning environments
3. Use the R2C2 model to optimize safety in the learning environment and support clinical courage

**Description:**

In a healthcare system that is full of uncertainty and complexity, it is important that learners take risks by asking questions, admitting mistakes, and voicing their ideas. This can be challenging if learners do not feel supported and safe to be courageous in the clinical setting. A psychologically safe learning and work

environment is one where members of the team feel secure to provide constructive feedback without fear of judgment or punishment. Prioritizing psychological safety in medical education also reduces the inherent vulnerability associated with learning and assessments. This approach allows learners to truly engage in learning and collaborating with the team while facilitating a sense of security. This session will explore what a psychologically safe learning environment looks like by discussing its enablers and barriers. Through a case-based approach, strategies to optimize safety in the clinical setting will be outlined. The R2C2 model for effective coaching and feedback will be presented as a potential tool to help optimize the learning environment.

**Saturday, November 9** **Session ID: 164** **Room: Ballroom C**

**13:30–14:30** **Polycystic Ovary Syndrome: Beyond just the ovaries**

Xyza Brual, MD, CCFP

**Learning objectives:**

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

1. Review the recommendations from the PCOS international evidence-based guidelines released in 2023
2. Recognize the impact of PCOS on a person's health beyond just infertility
3. Develop practical recommendations and a "whole person" approach to the management of PCOS

**Description:**

Polycystic ovary syndrome (PCOS) is the most common endocrinopathy affecting reproductive-aged women, impacting the lifespan from adolescence to post-menopause. As physicians, we need to acknowledge its complexity as a multifaceted chronic disorder associated with obstetrical, cardiovascular, metabolic, psychological and neoplastic risks, and educate our patients appropriately. While the Rotterdam criteria is the most widely accepted criteria for diagnosis, it is important to also address the variety of symptoms and presentations that patients can have so as not to dismiss this important disorder in our differential diagnoses. Utilizing current literature as well as recommendations from the new 2023 international guideline, this session will educate on a more practical and comprehensive approach to diagnosis, treatment, monitoring, and counselling of this complex condition.

**Saturday, November 9** **Session ID: 328** **Room: 109-110**

**13:30–14:30** **Primary Care for People Experiencing Houselessness**

Ginetta Salvalaggio, MD, MSc, CCFP (AM)

**Learning objectives:**

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

1. Elicit a trauma-informed housing history
2. Manage common clinical presentations in people experiencing houselessness
3. Identify opportunities for housing-related advocacy and allyship

**Description:**

Housing is essential for human health, but 25,000-35,000 people in Canada experience houselessness every night with many more experiencing precarious housing. Family physicians can play an important role in preventing, "treating", and reducing the harms of houselessness. Referencing current guidelines and using case based learning, the session will introduce how to elicit a trauma-informed housing history, and explore common clinical presentations for people experiencing homelessness, including emerging infectious diseases and exposure related illnesses. We will also discuss intersecting issues impacting this population such as drug toxicity and climate change. Finally, we will discuss practice-level considerations to support safe and effective care delivery, and review opportunities for family physician advocacy and allyship.

**Saturday, November 9** **Session ID: 97** **Room: 118-120**

**13:30–14:30** **Hacking Cough Treatments: What works for subacute cough?**

Jessica Otte, MD, CFPC, FCFP

**Learning objectives:**

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

1. Compare the efficacy of common remedies and medications for acute & subacute (including post-viral) coughs
2. Evaluate the known harms of cough treatments
3. Develop a script for talking with patients about how to manage prolonged cough

**Description:**

Upper respiratory tract infections and the coughs that accompany them are, at a minimum, inconvenient and uncomfortable. Many patients struggle with the long durations of cough after an acute respiratory infection and the disruption it causes to their life. Most family physicians and NPs are uncertain about what to recommend, if anything. This session will share the evidence of efficacy (and harm) when it comes to commonly recommended treatments, including home remedies (eg. honey, steam, etc), over-the-counter drugs (eg. acetaminophen, dextromethorphan), and prescription drugs (eg. salbutamol, ipratropium, codeine) for adult patients with acute and subacute cough. By the end of the session, you should be better equipped to guide patients, answer their questions about specific remedies, and inform them of what to expect.

**Saturday, November 9** **Session ID: 241** **Room: Ballroom C**

**14:45–15:45** **2024's Hot Topics in STI/HIV Prevention, Testing and Treatment**

James Owen, MD, CCFP; Jordan Goodridge, MD, CCFP

**Learning objectives:**

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

1. Describe recent developments in bacterial STI testing, treatments and prevention (including DoxyPEP, vaccinations, and more)
2. Address the recent rise of syphilis and LGV chlamydia cases through counseling, testing, and treatment of at-risk populations

3. Describe important strategies for HIV prevention and treatment (including HIV PrEP and TasP)

**Description:**

Care for STBBIs (sexually transmitted and blood-borne infections) in our current era has gotten more complicated! Do you do extragenital swabs? Prescribe HIV Pre-exposure prophylaxis? What's this about doxycycline after sex ... does it help prevent certain STIs, and do the benefits outweigh the risks? Can people living with HIV have condomless sex with HIV-negative partners? And why are syphilis serologies so confusing?! This rapid-fire, interactive, case-based session explores the most recent guidelines, research and controversies around care for STBBIs, and is an opportunity for family doctors with all levels of experience to share their current practices and approaches.

**Saturday, November 9** **Session ID: 212** **Room: 109-110**

**14:45–15:45** **Medication Abortion: Updated guidance and resources for practice**

Sheila Dunn, MD, MSc, CCFP (EM), FCFP; Regina Renner, MD, MPH, FRCS; Renee Hall, MD, CCFP

**Learning objectives:**

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

1. Integrate new evidence-based recommendations for mifepristone-misoprostol abortion up to 10 weeks gestation into practice
2. Assess pregnant patients for suitability for low - or/ no touch medication abortion
3. Use newly developed clinician and patient-facing information tools, and clinical mentorship to support abortion care

**Description:**

First trimester medication abortion (FTMA) using a Mifepristone-misoprostol regimen is highly effective, safe and improves access to abortion care. Providing FTMA is not complicated and is increasingly being offered by family physicians and nurse practitioners. As this practice is still new to many family physicians and others provide it infrequently, and as new evidence and guidance on FTMA becomes available, further education and provider support is needed to expand access to high quality abortion care. In this session we will review updated evidence-based protocols for mifepristone-misoprostol FTMA developed for the recently revised SOGC Medical Abortion Training Program. We will discuss new guidance on gestational limits, use of ultrasound and Rh testing. We will use case-based discussion to introduce protocol options for in person care, virtual care as well as a low- or no-touch approach for selected patients. We will share clinician and patient resources, some multilingual and tailored to underserved groups, developed in the Health Canada funded CART-Access project to enhance the delivery of safe, acceptable abortion care. These include a patient decision aid, charting and information forms and new ways to access on-line information and clinical mentorship. Participants are encouraged to bring questions about mifepristone abortion practice for discussion.

**Saturday, November 9** **Session ID: 274** **Room: 116-117**

**14:45–15:45** **Building Teams to Enhance Comprehensive Longitudinal Family Medicine: Learning from grassroots team-based care developments**

Lawrence Grierson, PHD; Aimun Shah, BSc; Asiana Elma, MSc; Augustine Okoh, PhD(c); Laurie Yang, BHSc; Hila Shnitzer, BSc; Michelle Howard, PhD; Alan Katz, MD, CCFP; David Price, MD, CCFP; Jose Francois, MD, CCFP; Artem Safarov; Arlen Keen, MBA

**Learning objectives:**

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

1. Describe a variety of team-based practice models
2. Understand the essential components and processes for developing a interprofessional family medicine practice team
3. Identify strategies for engaging with government and community to promote team-based practice reform

**Description:**

The Patient's Medical Home vision espouses family physician-led interdisciplinary healthcare teams as critical to mitigating the crisis of primary care access in Canada. While governments are supportive of this type of practice, investments in building these models have thus far been insufficient to ensure the widespread adoption of healthcare teams across the country. Nevertheless, some practices have been able to mount, in a grassroots manner, a transition to an effective interprofessional healthcare team. The current workshop leverages data collected from 17 such practices. Facilitators will begin with an overview of the provider, practice, and system-level benefits of team-based care. Through a mix of large and small group sessions, participants will hear stories of these locally-driven transformations and the key processes (needs assessment, quality improvement) and resources (funding, human, technological) that were leveraged in their development. The information shared will be applicable to a wide range of jurisdictions across Canada. Attendees will then progress in immersive small-group learning activities in which they reflect on case scenarios, map factors relevant to their context, discuss strategies, and build tailored plans to promote the adoption of team-based care within their practice. The workshop is intended for family physicians, primary care clinicians, residents, clinic managers, and medical educators who wish to enhance primary care through team-based approaches.

**Saturday, November 9** **Session ID: 273** **Room: 118-120**

**14:45–15:45** **Preventive Screening: Teaching strategies for optimal practice integration**

Viola Antao, MD, CCFP, FCFP, MHSc; Donna Reynolds, MD, CCFP; Neil Bell, MD SM, CCFP, FCFP; James Dickinson, MB BS, PhD,CCP, FRACGP

**Learning objectives:**

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

1. Consider how to prioritize preventive care in their practice
2. Acknowledge challenges of providing comprehensive care in today's primary care crises (time, delegation, equity, resources)
3. Question the magnitude of harms vs benefits of screening tests to appraise their relative merit

**Description:**

Preventive health care is appealing as we all want to keep our patients healthier to avert disease and premature death. However, implementing preventive health care is complex and time consuming. Family physicians are required to understand an exhaustive array of guidelines, and effectively communicate the harms and benefits to patients, while engaged in busy practices. Clinicians daily navigate: the complexities of providing timely and comprehensive acute and chronic patient care, quality improvement, population and community health, addressing health delivery to marginalized patients, pandemic stressors, increasing administrative burdens, and dysfunctional EMR systems. How can family physicians adopt a sustainable approach to preventive care, given the struggle to meet community demand. This interactive workshop will incorporate a mix of educational strategies including, case-based scenarios, polling, small group learning, test enhanced leaning, reflective exercises and commitment to change activities to facilitate an approach to preventive screening in primary care. Strategies and tools to support teaching preventive health concepts at the clinician, learner, patient interface will be demonstrated and utilized (thousand-person tool, shared decision making and conditional recommendation table -Canadian Task Force on Preventive Health Care (CTFPHC). The flow of the session will include the following: Land Acknowledgment; Introduction, disclosure objectives; Case Based learning; Polling: Which screening test would you choose?; Shared Decision Making (SDM): conditional recommendation table- in small group learning format; SDM: how to use the thousand-person tool in small group learning; Back to polls: correct answers reviewed; Test Enhanced learning 3 MCQ's; Reflective exercise: How to integrate learnings; Commitment to Change Activity.

## FMF On-Demand Schedule
### November 13, 2024, to January 3, 2025

Available 24/7 to watch sessions, continue to earn credits, and engage in interactive learning.

### Are you a fan of virtual learning?

Here are two other ways to engage:

**Live streaming and on demand:** Can't quite squeeze Vancouver into your schedule? Join us via the live stream and on demand, and earn credits virtually with some of our most popular sessions.

**On-demand add-on:** In-person attendees can add on demand to their registration and gain access to approximately 35 additional sessions for 50 days following FMF.

## Direct Credit Entry

**In person:** Badge scanners will be used to track all certified sessions attended in person.

**Live streaming:** Attendance will be tracked when participants log in for a live-streamed session.

**On demand:** Attendance will be tracked when participants log in for an on-demand virtual session.

**Direct credit entry (DCE):** All credits will be added automatically to an individual attendee's Mainpro+ holding area whether earned in person, via live steam, or on demand. These will be uploaded in February 2025. If you want to manually add credits before this, please contact us at **fmfinfo@cfpc.ca**.

**Exception for workshops:** Credits for two- and three-credits-per-hour workshops will be entered by the participant once the workshop post-reflective exercise is completed. The workshop provider will send the exercise to all workshop participants.