Rural Continuing Professional Development Program (RCPD)

Annual Report
April 01, 2010 - March 31, 2011

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I. **RCPD Executive Overview and Vision**

The UBC Rural Continuing Professional Development Program (RCPD) plans to continue to work closely with the Rural Coordination Centre of BC (RCCbc) to fulfill their vision for meeting the continuing education needs for rural health care providers throughout British Columbia. The overall vision of the RCPD for 2011 to 2014 is to further move the program into the community, specifically we plan to:

a) **BECOME A RURALLY BASED ORGANIZATION THAT SEAMLESSLY SUPPORTS CME NEEDS AT BOTH THE LOCAL COMMUNITY AND REGIONAL LEVELS.**

The RCPD aims to continue seeking more rural input into programming through needs assessment surveys and data collection of learning needs through provincial BCMA CME coordinators and community-based physicians. For example, the RCPD rural videoconferencing rounds have become more rural relevant and focused in that the speakers and moderators are rural physicians and from distributed sites around the province. Additionally, the RCPD has continued to develop the idea of increasing the presence of RCPD at the community level by establishing a partnership with an office that is located in a rural community (e.g. an office in Nelson). The rural office is an office that will work closely not only with the RCCbc and the RCPD but will intimately linked with the regional Divisions of Family Practice, The Shared Care Committee, the Community of Practice, as well as the BCMA CME coordinators in the region. RCPD has been instrumental in assisting the local CME coordinators to develop a proposal for a Regional CME Coordinator in IHA (e.g. Kootenay Boundary Region). Establishing this office and partnership is innovative because there is currently no direct support by the Interior Health Authority for a regional CPD office whereas a CPD office currently exists in NHA and VIHA.

b) **SUPPORT PROVINCIAL LEVEL COLLABORATION OF RURAL CME PROCESSES**

The RCPD is focused on building provincial networks and furthering collaboration on CME projects. For example, the Specialist Journal Club is a new educational pilot initiative focused on this vision. RCPD is currently linking with the UBC CPD Specialist Medical Director Dr. Jeff Plant to develop this project. This pilot project is especially exciting as it has the ability to be rolled out across the province to benefit many rural specialist groups. We project a high educational and networking value for the dollars spent on developing this project. This project is being developed with cooperative input from a similar project in Alberta, which has allowed our project to benefit from their extensive experience in this area. Jeff’s work focuses on providing CME for specialists in BC and this partnership is beneficial to RCPD to help increase provincial collaboration around CME development and implementation in the area of programming for rural specialists. As part of this portfolio, Jeff Plant is working to link rural specialists with regular videoconferencing programs through the academic departments at UBC and Vancouver-based hospitals (e.g. academic rounds).

The RCPD would like to support broader delivery of simulation-based learning to the rural sites through partnership with those providers in the province currently providing this learning opportunity, including but not limited to, the Simulated Emergency Medical Program (SEMP) and the IHA SIM program as well as by linking existing emergency educational programs such as Shock and CARE. It has been identified that procedural skills are an important need for rural physicians and simulation in partnership with existing programming is a way to meet this need throughout the province through strategic collaboration.
c) **CONTINUE TO BUILD UPON OUR CURRENT PROGRAMMING AND NETWORKS**

RCPD plans to continue our ongoing educational programs and will continue to assess needs and understand evaluation data to continuously improve existing and future programming. RCPD is continuing to expand existing programs; for example the monthly rural videoconference rounds could be offered more frequently in a weekly or bimonthly distribution rate. The number of doctors participating in the program has grown significantly over the past year due to our efforts in both the quality and the marketing of the program. (i.e. linking with the BCMA CME Coordinators). RCPD also hopes to develop other procedural based courses in areas of identified needs, such as an obstetrics course on basic ultrasound skills for family physicians. This course could be a certificate based course or enhanced skills program. Specifically the student would learn the basic fundamentals of sonography (i.e. how to turn on the machine, archive images): 1. Fetal number, presentation, and position; 2. Confirmation of fetal life or death; 3. Amniotic fluid assessment; 4. Placental assessment (location, identification of placenta previa, major abruption); 5. Biophysical profile. Additionally, the RCPD has engaged Dr. John Soles to lead a pilot CME program which has the additional goal of providing physician networking opportunities and building relationships between rural family doctors and regional and visiting specialists (call the Visiting Specialist-Local GP Pilot Program).

d) **EXPAND OUR SCOPE BEYOND TRADITIONAL CME INITIATIVES**

We plan to encourage programming that supports the entire rural health care team, and thus programming should be inter-professionally focused. As well, all programming should apply the principles of educational effectiveness which are known to lead to improved patient outcomes, and not just knowledge transfer. We would like our programming to be responsive to the learning needs of the practicing rural physician or health care team member.

The RCPD program acts as an administrative resource, advocate, coordinator, instructional design, and educational programming centre.

**The RCPD Overall Objectives are:**

- To continue to build upon our current programming and networks, by supporting, facilitating, and developing Continuing Medical Education programming that is directed by rural health care professionals and meets the needs of rural health care professionals.
- To continue to develop and deliver CME programming that is evidence based, up to date and leads to state of the art patient care.
- To have both a rurally based and central provincial presence that seamlessly supports rural CME needs at both the local community and regional levels.
- To support provincial level collaboration of rural CME processes.
- To expand our scope beyond traditional CME initiatives, in order to empower and support rural practitioners in their many roles as health care providers, learners, teachers, and community members.
- To model best practices for intra and inter professional communication, mutual respect and teamwork, and to model sharing of resources and ideas.

As agreed with the Rural Coordination Centre of BC, the RCPD program continued to work on the following deliverables:
i. Develop and integrate new “Closer to home” programs with the event staff at UBC CPD, at low-cost, high-return for rural communities to meet identified CME/CPD needs;

ii. Create an inventory of speakers and available topics for rural physicians and develop a complementary system for tracking the successes and challenges with each presentation.

iii. Connect with existing programs: build relationships with CME coordinators, speakers and others as necessary; build upon CME/CPD programs offered to rural practitioners and coordinated by Rural Education Action Plan.

iv. Build relationships with rural practitioners so that they can give ongoing input and direction to the RCPD; integrate rural programming for both rural specialists and GP’s so that they can give input and participate in educational programs.

v. Develop web communications: develop and design a BC Rural CPD webpage in collaboration with the RCCbc website; develop an up-to-date inventory of rural CPD programs and enable web viewing.

The purpose of this report is to fully describe the RCPD program for the period of April 1, 2010 to March 31, 2011. The following topics are discussed: summary of current activities; program development; and the goals and deliverables for the 2011-2012 year. This report summarizes the RCPD vision and program development in the five deliverable areas named as priorities by RCPD. Further this report highlights the evaluations of the programs.

II. Summary of RCPD Activities for 2010-11

Engagement

RCPD has a new webpage on the UBC CPD website which provides rural physicians in BC a link on the home page to access rural educational through a “Rural CME” link. This update to the RCPD page will create an electronic resource that is more user friendly to physicians investigating programming and initiatives in rural medicine. RCPD has decided to establish a new “Rural CME Award of Excellence” which is being developed and will be announced at the RECC conference in Kelowna BC in June. A formal application process will be established and one award will be offered each year to recognize a rural physician demonstrating excellence in rural CME. The RCPD continues to have an engaged and effective Rural Medical Advisory Committee led by a rural physician and Chair of the MAC, Dr. Tandi Wilkinson. Dr. Wilkinson is now into her second year as the RCPD Medical Director. The RCPD continues to work on establishing a rural office in Nelson, BC. The RCPD has continued to deliver and refine our core CME programming (e.g. Shock Course, webinar series, rural videoconferencing rounds). The Shock course has been delivered in 19 BC communities and has reached 219 rural physicians to date (see course evaluation details below). Below are some examples of the RCPD closer to home programs:

- Education on Emergency Medicine
  - Shock Course
    - 19 communities; 307 participants (219 physicians, 88 nurses and 6 other and a few paramedics (audited the course))
  - Videoconferences on Emergency Medicine
- Four sessions in the fall of 2010 reaching 257 participants
- 23 hospital sites connected to the 2010-2011 program which is a drastic increase from 7 to 8 sites being connected in the fall of 2008 before this program was under the auspice of the RCPD.
  - Re-analyses of REAP Needs Assessment 2005, focusing on GP/FP feedback on emergency medicine CPD
  - Obstetrics and Gynecology
    - Webinar on Ovarian Cancer
      - One session; 74 participants
  - Chronic Disease Management / Palliative Care
    - Webinars on Chronic Disease Management
      - Three sessions; 114 participants
    - Videoconferences on Cardiology (spring of 2011)
      - Four sessions; 320 participants
    - Palliative Collaborative Care Course – in development

**Connecting with Existing Programs**

- UBC CPD conference sponsored webinars (fall 2010 – spring 2011)
  - Seven sessions; 426 participants
- Other CPD conferences / workshops
  - The BC Physician Integration Program (BC-PIP) – Providing IMGs with orientation and ongoing support to practice integration in BC
  - Ovarian cancer workshops
    - Four locations (Vancouver, Victoria, Kelowna and Prince George as part of the UBC medical school distributed sites); 53 participants; 4 engaged facilitators
  - Family Practice Oncology Network (BC Cancer Agency) webinars
    - Six sessions; 240 participants
  - Dementia Education Project Part 2 which will include 20 community-based workshops and other interactive educational deliverables

Building relationships with rural stakeholders

- RCPD videoconference needs assessment 2011
- Future pilot programs
  - GP-Specialist pilot program (Dr. John Soles engaged)
  - Specialist virtual network (collaboration with Dr. Jeff Plant)

**Shock Course**

RCPD has established the infrastructure, faculty development, and delivery expertise to support implementation of the Shock Course to two communities per month (i.e., instructors, admin support).

The Shock program is now cost effective in that this course can now recoup delivery and some development costs. The Shock course is inter-professional as there is a nursing module integrated into the program. Development for paramedical content is underway with partnership through the Justice Institute in BC with Dr. Stuart Donn. We intend to launch this educational piece in the fall of 2011.
Both physician and nurse instructors are part of the course faculty. The instructors are rural docs from around the province, and the nurse educators are from the home community. This allows the nursing piece to be easily adapted to the learning level of the participating nurses. The Shock course now has a new Ultrasound provider and has purchased new equipment through generous funding support of the RCCbc. This new equipment will allow the Shock Course to operate independent of industry support. Delivery of the Shock Course throughout the province has given RPCD a unique insight into the status of rural emergency in the province through analysis of evaluation data and personal observation of course participants.

The “in-community” sessions are especially considered a significant contribution to the community. The local CPD coordinators have gathered the physicians and nurses in their communities to attend and enjoy this intense all-day skills-based course. In the course evaluations, the participants highly rated their satisfaction with the course content, interactivity, format and support materials of the course. In particular, the course has met physicians’ learning needs in ultrasound use for shock and nurses’ learning needs for nurse specific education for shock.

**Shock Evaluation Data**

The Shock course participants’ feedback have highlighted that: 1) generally this course takes a comprehensive approach to help them recognize the various syndromes of shock and how to resuscitate patients; 2) the instructors convey the main information with very experienced, credible emergency care providers’ background; 3) the hands-on part is composed of “digestible pieces” for the learners; and 4) target audience specified content designed for physicians and nurses are very well received.

The course participants have continued perceiving significant knowledge increase and changes they will make in practice as a result of this educational intervention. In particular, the key learning they report has reflected the core values of this comprehensive course towards rural practitioners: 1) the theories and physiological features of shock are embraced with clinical application in the real life scenarios; therefore the learning is rich on multi levels; 2) the approaches to shock management are more “aggressive goal oriented” and fairly organized; therefore the learners have received a critical message that shock has to be and can be recognized and treated promptly; and 3) resources available in rural Emergency Departments are introduced, including practical concerns regarding arranging patient transfer. In general, the Shock course plays the role of practice enabler to the rural practitioners.

| Table 1 - Shock Course April 2010 – February 2011: Physician participants knowledge increase (n=125) |
| --- | --- | --- |
| | Before the course | After the course | % Increase |
| Diagnosis and treatment of shock | 35% | 95% | 60% |
| Central venous lines | 29% | 87% | 58% |
| Ultrasound use for shock | 8% | 75% | 67% |

* Aggregates of rating scales 4 & 5 were reported. (1=Very little; 5=A great deal)

The Shock Course will continue to be delivered over the next two years to all appropriate rural healthcare facilities with Emergency Departments, upon solicited invitation from the communities.

**Shock course quotes**

Course participants said the most helpful part of the Shock program was...
“Good mix discussion/lectures/practical hands-on”
“Ultrasound and central line practice- both very useful skills for our ER”
“Hands on and case discussion”

Course participants’ general comments on the course...

“Enjoyed the rural focus and the team approach – so important in rural medicine”
“Great job. Very worthwhile. Nice to see this education type making it to rural areas like ours”
“Friendly, informative, casual. Both instructors excellent/videos + AV presentation excellent”

Course participants said they will do differently as the result of this course...

“Better differential/more goal oriented Rx”
“Be more vigilant in considering shock in my approach to ER patients”
“Pay increased attention to NS and meds patient is taking. Think sepsis and tx early. Initiate 10 access.”
“Be more aware of the early signs of shock (Sirs criteria). I would also be a bit more liberal with NS fluids.”
“Use ultrasound more. Glucagon use. Way of approaching shock - increase recognition.”

**RURAL VIDEOCONFERENCING ROUNDS**

This program has drastically expanded in the 2010-2011 series. There are now more communities than ever participating in this program. There are now 23 communities participating in this program in BC and the Yukon. All four videoconferences offered in fall of 2010 were on emergency medicine and delivered from rural communities. The program to date has focused on psychiatry, trauma, chronic disease management, and cardiology. Below, the participating communities are listed. In Appendix 2, the participant numbers for this program and the free evening webinar program are indicated. This program also includes local faculty and moderators located in rural sites. This program continues to expand and has grown in popularity. Webinars are also offered to all rural physicians. The webinar technology has the ability to play videos in the presentations and all presentations are archived on the UBC CPD/RCPD website. Below are the communities participating in the videoconferencing program:

<table>
<thead>
<tr>
<th>Videoconference sites</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elkford Medical Clinic</td>
<td>Elkford</td>
</tr>
<tr>
<td>Arrow Lakes Hospital</td>
<td>Nakusp</td>
</tr>
<tr>
<td>Bella Coola General</td>
<td>Bella Coola</td>
</tr>
<tr>
<td>Bulkley Valley District Hospital</td>
<td>Smithers</td>
</tr>
<tr>
<td>Castlegar and District Community Health Centre</td>
<td>Castlegar</td>
</tr>
<tr>
<td>Dr. Helmcken Memorial Hospital</td>
<td>Clearwater</td>
</tr>
<tr>
<td>Fraser Canyon Hospital</td>
<td>Hope</td>
</tr>
<tr>
<td>Houston Health Centre</td>
<td>Houston</td>
</tr>
</tbody>
</table>
Rural Videoconferencing Rounds Evaluation Data

In the evaluation of the session on intubation (Sept 2, 2010), 55% of respondents said that they would do something differently in practice as a result of the session, including “more education of staff” and “more consideration of goals prior to intubation”.

In the evaluation of the session on Status Asthmaticus (Oct 7, 2010), 63% of evaluation respondents stated that they would change something in their practice, most notably, that they would use Magnesium sulphate, as recommended in the session, for severe exacerbations of asthma as presented in the emergency department.

In the evaluation of the session on arrhythmias (Nov 4, 2010), 50% of evaluation respondents stated they would do something differently as a result of the session, including “do more serial ECGs” and “repeat ECGs more frequently when trauma in ER to observe changes”.

In the evaluation of the session on advanced cardiac life support (ACLS) (Dec 2, 2010), 82% of evaluation respondents indicated they would do something differently as a result of the session, including “more likely to use large-volume cooled fluids for indication of therapeutic hypothermia” and “changing ER stocking practice so we have cold saline”.

Table 3 - Videoconferences 2011

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Topic &amp; Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 3, 2011</td>
<td>Dr. John Bosomworth – Anticoagulation Broadcast from Oliver, BC</td>
</tr>
<tr>
<td>March 3, 2011</td>
<td>Dr. Brett Heilbron - Post PCI care</td>
</tr>
<tr>
<td>April 7, 2011</td>
<td>Dr. Kevin Pistawka – Gizmos and Gadgets</td>
</tr>
</tbody>
</table>
Table 4 - Videoconference and webinar sessions September 2010 – December 2010: Physician participant feedback on learning

<table>
<thead>
<tr>
<th></th>
<th>Videoconference (n=153)</th>
<th>Webinar (n=226)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The amount I learned a</td>
<td>70%</td>
<td>79%</td>
</tr>
<tr>
<td>The information I learned will be used in my future practice b</td>
<td>69%</td>
<td>83%</td>
</tr>
</tbody>
</table>

a Aggregates of rating scales 4 & 5 were reported. (4=Moderate; 5=A lot)

b Aggregates of rating scales 4 & 5 were reported. (4=Agree; 5=Strongly agree)

**Other RCPD Programs**

The RCPD continues to partner with the College of Physicians and Surgeons of BC to offer the workshop on “Finding Medical Evidence” in various communities around BC. This course is being offered to NHA in the spring of 2011. The RCPD partnered with UBC CPD and Ovarian Cancer Canada and BC Cancer Agency (Family Practice Oncology Network) to develop and deliver case-based workshops to family physicians on ovarian cancer. These were offered in regional centres. The rollout of future workshops on Dementia, cancer care, and palliative care are in the development and planning stages.

**III. Program Development**

RCPD is establishing a new rural office in Nelson BC (described in section 1).

**New Pilot Projects**

Dr. Shiraz Moola, an Obstetrician from Nelson, has approached the RCPD to develop an Obstetrics course which teaches basic ultrasound skills in maternity care for family physicians. To our knowledge, this does not exist and is an identified need for rural physicians. This would be an inter-professional course where physicians would learn alongside midwives. The provision of this knowledge in the rural setting has potential to reduce transfers of pregnant and/labouring women outside of the community for ultrasounds. The RCPD continues to engage Dr. Nancy Humber on developing an OB course. Dr. Nancy Humber, GP Surgeon and member of the RCPD MAC is currently taking the lead to conceptualize a possible course on obstetrics. Dr. Humber is currently outlining the learning objectives for three distinct learning modules, each based on the obstetrical service delivery level of the community. The course remains in discussion and development. To date, a framework and existing outline has been developed for a rural CME program on OB for rural hospitals incorporating team building principles and contextualizing learning to the current practice domain of each hospital.
SPECIALISTS VIRTUAL NETWORK

The RCPD will be piloting a Rural Specialist Virtual Journal Club. The programs will provide participants an opportunity to acquire an enduring peer learning network, and to discuss together the possible applications to rural practice of new developments and best practices; and to stay abreast of advances in their field.

For the virtual journal club, we are taking the following steps:

- Investigating a successful program for rural psychiatrists in Alberta; Dr. Steve Simpson, the project lead in Alberta with the University of Calgary, Division of CME, has been extremely generous with his learning and expertise on the project, which will enable us to provide a program that will maximize ease of use for the target group of specialist physicians.
- Examining data on numbers of rural specialists to determine the pilot group; now determined to be internal medicine
- Seeking a CME champion to lead the group; we are currently negotiating with an excellent candidate
- Assessing our web platform for suitability;
- Investigating accreditation requirements.

There is opportunity for this innovative program to create links between rural specialists, networking within specialties at the provincial level. This specialist journal club will also incorporate provincial experts as guests in the journal club discussion forum. This specialist journal club will have an electronic platform so that learning and resources can be accessed remotely and asynchronously which promotes better uptake by reducing distance and time barriers for specialist physician participants.

COMMUNITY DINNERS – VISITING SPECIALIST-GP PILOT PROGRAM

Dr. John Soles, a member of the RCPD MAC, has agreed to direct this pilot project. The RCPD will help with the creation and pilot of five “workshops” in rural BC communities, in order to experiment with community-driven design and implementation of education. In the community, GPs (in conjunction with the local BMCA CME coordinator or local GP champion) would identify topics for discussion. Then a case-based practical workshop would be developed by the local or visiting specialist. The program will be delivered in the community at a dinner in order to provide a supportive forum for relationship building. The RCPD will provide logistical and educational coordination of the program; and assist with conducting pre-workshop needs assessments in consultation with the community and relevant specialists. Development of this program has to date highlighted barriers to accessing information that speak to the need for data to inform CME needs, opportunities, and existing structure. RCPD has acquired data from NHA, VIHA, and VCHA, and is still working on obtaining the list from IHA of the specialists who provide medical outreach to communities in the respective health authorities. Further supporting the need for networking, we are being approached by urban specialists who have messages for rural docs on issues of clinical care. Acquiring access to community databases in order to inform the program on rural CME is needed to develop programming.
**Other Initiatives**

There has been considerable progress on increasing rural sensitivity in presentations at conferences such as the St. Paul’s Emergency Medicine conference and the OB Update conference. The RCPD has provided conference planning input to Kelowna RECC conference. The speakers’ inventory is fully developed and is in the hands of RCCbc awaiting posting on their website. The RCPD is championing/supporting the idea of provincial collaborative to build a provincial network of rural CME providers (e.g. provincial CME calendar). The RCPD is supporting the RCCbc initiative of a visioning day to discuss rural CME needs at the provincial level, in the hope of supporting and developing Collaborative partnerships on projects.

**IV. Goals and Deliverables for 2011-12**

**Overall Objectives**

The RCPD is prioritizing the expansion of the RCPD profile so that rural physicians become more familiar with the program and so we can further incorporate the voices of rural physicians into the ongoing development of our educational programming. Effort will continue to be directed towards engaging rural physicians in meeting their context specific educational needs. This is being accomplished through the refinement of the RCPD website, ongoing needs assessments, increased marketing strategies and efforts directed at to promote a stronger RCPD presence at the community-level, as well as by increasing the number of networking opportunities for the RCPD. The establishment of the new Rural Office in Nelson BC is also seen as an important step in the further engagement of rural doctors. It is important to elevate the profile of RCPD so we can get more input, feedback, and engagement from the rural practitioners. The RCPD is aiming to expand the role of RCPD MAC members and support raising their profile in this capacity.

The RCPD will continue to refine needs assessment strategies in order to expand from the global understanding that was established in the REAP needs assessment program to getting more relevant data and that informs the identified needs in specific content areas (e.g. procedural skills, obstetrical skills, etc). The RCPD will look to obtain more regional and local input into the planning, development and delivery of programming as well as develop a mechanism for participants to vote/rank upcoming topic themes and specific topic choices through evaluation plans. The RCPD aims to improve linkages with BCMA CME coordinators, regional groups such as Divisions of Family Practice, Communities of Practice, health authorities, regional CME centres and offices (VIHA, NHA), other rural CME providers, (i.e. IHA simulator, CARE). In particular, the RCPD is keen to participate and support the current BC rural CPD visioning process under the guidance of the RCCbc. As well, RCPD hopes to contribute to improved provincial networking and delivery of emergency medicine courses to avoid overlap and support sharing of resources including the use of existing simulators. We also plan to develop a mechanism where we do follow up analysis of Shock Course participants to demonstrate practice changing behaviours.

The RPCD continues to improve, refine, and expand our ongoing programming, and follow the guiding principle of providing more “closer to home” programs. Now that shock is cost recovery, we hope to recoup some development costs on this programming which we can use for new program development. Links to other programs such as urban rounds especially for special needs groups in the areas of ER, GP anesthesia, and OB/GYN are underway. Incorporating the entire health care team into CME programming (i.e. RN, paramedic) is an important direction that RCPD will continue to follow. The RCPD
will work with other organizations who have developed rurally relevant CME programming to deliver these programs rurally and contextualize their content for rural practice. This is a cost effective and efficient method for RCPD to implement needed programming for rural physicians.

The RCPD continues to raise awareness of provincial level CME programming planning committees in terms of the needs of rural docs (i.e. RECC course, St. Paul’s ER, OB Update, etc). We will begin to address CME needs around common complex medical and social problems whose solutions transcend simple knowledge acquisition (i.e. obesity, addictions). The establishment of a rural office presence is critical to the vision of the program. As well, RCPD will continue to develop and deliver the existing successful rural programming and new initiatives mentioned previously in this report.

With the active support of the RCCbc, and many other partnerships, the RCPD has had some recent successes in developing and delivering inter-professional CME, notably in the Shock course. The RCPD anticipates that the Shock course developers will continue to integrate curriculum and participation by other professions, with the next logical target group being paramedics.

The RCPD has also maintained the accessible, technology-enabled education programs such as the videoconferences and webinars. Physicians across BC know that they can go to their hospital one morning a month and participate in rurally relevant education. Rural physicians have the regular convenience of participating in free, accredited evening webinars that are of high educational value with up to date information and time for questions. They can participate in a webinar from any computer with internet access. The RCPD is also continuing to seek opportunities to partner with other programs or to be facilitative of the delivery of the rural CME courses to a wider BC audience in order to further realize its vision.

V. Conclusion

With the active support of the RCCbc, and many active partnerships, the RCPD has had some recent successes in developing and delivering interprofessional continuing medical education, notably in the Shock course. The RCPD anticipates that the Shock course developers will continue to integrate curriculum and participation by other professions, with the next logical target group being paramedics. The summarized evaluation data shows the numbers of health care professionals this course is reaching and the positive impact it is having on skill development and practice change.

The RCPD has also maintained the accessible, technology-enabled education programs such as the videoconferences and webinars. Physicians across BC can go to their hospital one morning a month and participate in rurally relevant education. There are now 24 hospital communities participating in this program and all of the speakers and moderators are rurally located. Rural physicians have the regular convenience of participating in free, evening webinars that are compelling, with up to date information and time for questions. They can participate from any computer.

New program development is underway for initiatives on obstetrics and education that support rural specialists and help foster meaningful relationships and collaborations with community-based physicians and regional specialists. RCPD will continue to follow the principles of physician and community engagement to build upon current programming to continue to develop innovative rurally relevant future initiatives that are delivered interprofessionally and ‘closer to home’.
RCPD has continued to develop the idea of increasing the presence of RCPD at the community level by establishing a partnership with an office that is located in a rural community (e.g. an office in Nelson). The rural office is an office that will work closely with the RCCbc and the RCPD and other key provincial partners on behalf of rural physicians.

The RCPD is continuing to seek opportunities to partner with other programs or to be facilitative of the delivery of the rural CME courses to a wider BC audience, to realize its vision. The RCPD will achieve this vision through building collaborations and establishing networks as part of the larger strategy to support rural physicians.
Rural Continuing Professional Development Program Vision 2011–2014: Moving into the Community

The UBC Rural Continuing Professional Development Program plans to continue to work closely with the Rural Coordination Centre of BC to fulfill their vision for meeting the continuing education needs for rural health care providers throughout British Columbia.

1. We plan to continue to build upon our current programming and networks

With the active support of the RCCbc, the RCPD has successfully fulfilled the mandate of its first two years. We are supporting, facilitating and developing Continuing Medical Education programming that is by rural physicians and for rural physicians. We are providing rurally specific CME in rural communities throughout BC, and these programs have been well received by participants. Programs include “The Shock Course”, a RCPD developed initiative, which is an all---day, hands on course delivered in the community setting, focusing on the management of the shock patient in the rural emergency department. This course emphasizes hands on opportunities for bedside ultrasound use and central line insertion, and new standards of care in the treatment of sepsis. With the aim of providing inter---professional education, we are adding a nursing specific education module to “The Shock Course”, which has been developed in collaboration and with the financial support of the Interior Health Authority Emergency Services Coordinating Committee. Other valuable programs delivered to the rural setting include “The Dementia Workshops” (funded by the Ministry of Health Services) and the “Finding Medical Evidence Workshops” (in partnership with the BC College of Physicians and Surgeons Library), as well as the ongoing rural videoconference education series and webinars.

These programs were developed after extensive input from rural physicians, in the form of the Rural Education Action Plan funded and Continuing Professional Development (CPD) conducted rural physician learning needs assessment, our Medical Advisory Committee (MAC) members, and rigorous evaluation of feedback data from program participants.

The delivery of these programs has created a network of rural linkages for RCPD in communities throughout the province-- local CME coordinators, rural physicians demonstrating leadership in education, rural specialists, hospital support staff, and nurse educators. As well, we have developed an RCPD office that is well supported by our own staff and the UBC CPD resources, and is able to provide administrative, academic and technology---enabled support to Rural CME initiatives. We have also
benefited from the 2 network of UBC CPD linkages, which include numerous provincial level conferences, conference planning resources, faculty development resources, research and accreditation expertise, and the provincial webinar series.

2. We plan to become a rurally based organization that seamlessly supports CME needs at both the local community and regional levels.

To be most effective, RCPD needs Local medical community engagement in the process. To achieve this, RCPD must have a strong presence rurally. This can happen literally and virtually. We need to have RCPD representatives spread throughout the province, covering all geographical areas. (Ideally these representatives would represent RCCbc as well.)

This will be the virtual face of RCPD in rural communities. As well, we plan to move our office from Vancouver and into the rural setting. This will allow us to build closer linkages with rural health practitioners, and enhance networking opportunities with other rural CME stakeholders. By responding to the CME needs of rural practitioners, we hope to facilitate their retention in and ability to provide optimal health care to their communities.

We aim to move command and control of rural CME to the healthcare community. We will support and build upon the current existing infrastructure of CME providers and stakeholder in rural communities, such as the BCMA CME coordinators, Practice Support Program GP champions, Divisions of Family Practice, UBC Dept of Family Medicine rural faculty, the RCCbc, the health authorities, and the UBC CPD International Medical Graduate Practice Integration Program. We want our strategies to support the rural CME needs and initiatives of these groups, although this list of groups is not inclusive. RCPD will work to support the CME needs by whatever means necessary – providing tools and breaking down barriers to locally driven CME. Thus, we need to be a program that is connecting with, listening to and responsive to its target audience, and can adjust to meet evolving needs. This will contribute to local community engagement and a sense of ownership over the process. Rural physicians often model this effective style of leadership.

3. We plan to support provincial level collaboration of rural CME processes.

There is a need for provincial level collaboration around rural CME issues. Currently in BC, rural CME is happening in a piecemeal fashion, in independent silos, often geographically isolated by health authority divisions. Certainly many rural CME initiatives are only locally distributed. Excellent work is being done, however the entire province often does not benefit from this work. This leads to unnecessary duplication of efforts, costs to the system, and delays the delivery of excellent programming to the entire province of rural health care providers. There is a need for two processes. The first is a need for dissemination across the province of those existing excellent locally developed rural CME programs that should have a wide audience. The larger need is for a process that allows rural CME stakeholders to gather, discuss their successes, share their needs and develop a coordinated, shared strategy to meet those needs. For example, there is a need in the province for a shared equipment bank for the expensive human patient simulators and lifelike models used to deliver hands on CME. Such equipment is very expensive, and in rural areas is often idle. Shared usage would be of benefit to everyone.

The RCCbc is the organization best positioned to facilitate this provincial forum, and RCPD can offer our services to the provincial collaboration group to assist this process in the way that the group decides would best serve them.

By receiving and responding to input on the CME needs from the local rural communities and the middle level CME stakeholders as well as supporting CME needs on a provincial level, we will then have a program that can fully support rural CME in BC. We should also move beyond our provincial silo to
develop networks with like-minded organizations throughout Canada, to learn from other models and approaches.

4. We plan to expand our scope beyond traditional CME initiatives.

Beyond offering traditional style CME, our vision is to empower and support rural practitioners in their many roles — as health care providers, learners, teachers, and community members. We need to provide practical support for faculty development, especially in the area of presentation and teaching skills, to build a strong infrastructure of rural CME providers throughout the province, building upon the RCPD/RCCbc local speakers’ inventory. This supports the principle of rural practitioners as the best teachers of rural CME. There is also a need to build upon the skills for utilizing the technologies that can make rural CME more accessible.

We also want to support CME initiatives that meet the special health care needs of the whole community, not just those of the rural family doctor/generalist. We want to support rural specialists, nurses and other professional groups providing rural health care. These groups have unique CME needs that may not be addressed by traditional CME programming. We strongly believe that our work needs to model best practices for intra and inter professional communication, mutual respect and teamwork. As well, identified rural health care gaps and unperceived needs must be supported by relevant educational interventions (i.e. First Nations health issues). Our vision of CME includes modeling sharing of resources and ideas as well as creating CME that is open source and accessible. It also supports CME programming that is evidence based, up to date and leads to state of the art patient care.
AGENDA

Rural Continuing Professional Development (R-CPD) Medical Advisory Group

Sept 20, 2010 7:30-9:00 AM

302, 3rd floor, 855 West 10th Ave, Vancouver

Teleconference, Call: 1-877-323-2005

Conference ID: 7389980

Co-Chairs: Dr. Tandi Wilkinson & Deirdre Maultsaid

1. Greetings
2. Calls for input (videoconf & webinars)
3. Confirmation of Notes from last all day meeting
4. RCPD vision
5. Questionnaire answers –anything to discuss?
6. Other items?
AGENDA

Rural Continuing Professional Development (RCPD) Medical Advisory Group

Jan 20, 2011, 7:30-9:00 AM
302, 3rd floor, 855 West 10th Ave, Vancouver
Teleconference, Call: 1-877-323-2005
Conference ID: 7389980

Co-Chairs: Dr. Tandi Wilkinson & Deirdre Maultsaid

1. Greetings
2. Confirmation of Notes from Sept 20
3. Updates on Current Programming (Tandi):
   - Videoconferences
   - Webinars
   - Shock course
   - Conferences
   - Networking

4. Calls for input on current programming (Tandi/MAC)
   - Videoconference theme fall 2011?
   - Webinar on lung disease—topic ideas?

5. New CME/CPD Pilots (Tandi/MAC)
   - Funding proposal submitted

   • Pilot rural GP – Specialist dinner workshops
     • Which five communities?
Which specialties?
Visiting or local specialists?
Other ideas?

- Specialist virtual network/journal club
  - Specialist facilitator contacts?
  - Best ways to engage specialists?
  - How to pave the way for virtual education?
  - Other ideas?

6. Questionnaire answers — anything to discuss?
7. Provincial calendar (RCCbc)
Appendix 3: RCPD MAC Pre-meeting Questionnaire

RCPD Medical Advisory Committee Questionnaire
Please fill out this form and email it back to deirdre.m@ubc.ca

1. PLEASE TELL US ABOUT THE CURRENT CME INITIATIVES IN YOUR REGION. NAME THREE OR FOUR. PLEASE INCLUDE ANY NEW INITIATIVES AND THE ORGANIZATION PROVIDING THE CME.

2. PLEASE TELL US ABOUT ANY NEW CME IDEAS YOU HAVE HEARD ABOUT THAT YOU THINK ARE NEEDED/USEFUL/INTERESTING/INNOVATIVE.

3. PLEASE LIST THE LOCAL PHYSICIANS WHO ARE ACTIVE OR HAVE AN INTEREST IN CME IN YOUR REGION.

4. PLEASE TELL US WHO YOUR LOCAL CME COORDINATOR IS. IS THIS CME COORDINATOR THE BCMA COORDINATOR OR SOMEONE ELSE? PLEASE DESCRIBE THEIR ROLE.

5. PLEASE LIST ANY SUGGESTIONS YOU HAVE FOR PHYSICIANS OR OTHER HEALTH CARE PROFESSIONALS WHO ARE EXCELLENT RURAL EDUCATORS.

6. WE ARE CURRENTLY LINING UP SPEAKERS FOR OUR SPRING VIDEOCONFERENCE ROUNDS. THE TOPIC WILL BE CARDIOLOGY - MAINLY CHRONIC DISEASE MANAGEMENT BUT COULD INCLUDE ACUTE CARE. PLEASE SUGGEST SPECIFIC TOPICS AND POSSIBLE SPEAKERS.

7. HAS YOUR HOSPITAL SIGNED UP FOR OUR VIDEOCONFERENCE SERIES? IF NOT, WHY NOT?

8. PLEASE STATE A SPECIFIC AREA OF INTEREST THAT WE MAY ASK YOU FOR INPUT ON FROM TIME TO TIME - ER, SPECIAL SKILLS, OB, CHRONIC DISEASE MANAGEMENT, WOMEN'S HEALTH, PROCEDURAL SKILLS, PALLIATIVE CARE, PSYCHIATRY, WOMEN'S HEALTH, TECHNOLOGY IN MEDICINE, ETC

9. ANYTHING ELSE YOU'D LIKE TO PASS ON TO THE MAC?

Thank you for filling out this form.
Appendix 4: RCPD Program information in UBC CPD Course Calendar

Rural Continuing Professional Development (RCPD) Outreach Program

UBC CPD, with support from the Rural Coordination Centre of BC, started the Rural Continuing Professional Development (RCPD) Outreach Program in 2008 to deliver CME/CPD to the 1,900 rural family physicians and specialists in BC. The RCPD program works with and on behalf of rural physicians to build valuable CME/CPD educational programs.

Our program purposes are to:
1. Educate rural physicians closer to home;
2. Support educational development by rural physicians for rural physicians;
3. Nurture rural physicians and recognize their special skills and exemplary work;
4. Help overcome geographic isolation by maximizing the use of increasingly accessible technologies and communications systems to facilitate closer to home CME;
5. Strengthen relationships intraprofessionally (between physicians) and within multiprofessional healthcare teams;
6. Monitor emerging and state-of-the-art evidence-based medicine in order to develop rurally relevant, innovative CME;
7. Support physicians in a variety of professional roles, including practitioner, advocate, teacher, business manager, mentor, and scholar;
8. Create a collaborative approach, using rural physician input, university input and organizational stakeholder input to ensure that program objectives are sensitive to the identified needs of rural health care professionals; and
9. Work collaboratively with other stakeholders to share wisdom and resources, and to help overcome challenges to build educational initiatives for rural physicians.

The RCPD program, led by a Medical Director and Project Manager, and with input from its Medical Advisory Committee, acts as an administrative resource, advocate, coordinator, instructional design and educational programming centre. We would also like to welcome our new Medical Director, Dr. Tandi Wilkinson.

“

The Rural CPD program is an exciting initiative designed to provide and promote continuing medical education initiatives that meet the specific needs of rural physicians. We do this in a number of ways. The Shock Course is a hands-on, full day course designed for the rural hospital setting. Developed and taught by rural physicians, this course will come to your emergency room! It emphasizes small group discussion and practice with procedural skills. We have regular videoconferences with topics specific to the needs of rural physicians. The general topics we cover include emergency medicine issues, rural psychiatry needs, cardiology and chronic disease management topics. We also provide selected lectures from recent BC CME conferences as webinars throughout the year. These free events are lectures delivered live over the internet to the comfort of your own home! We are currently working on developing rural obstetrical education opportunities, and support for rural specialists as well! This project has a tremendous opportunity to improve CME resources for rural docs, and I’m proud to be a part of this initiative. We’d love to hear from you about your needs and your opinions!

Please contact me with your questions at doctor.tandi@telus.net or c/o UBC CPD 604-875-4111, ext.69139”

-Dr. Tandi Wilkinson, Rural Continuing Medical Education Medical Director

Shock Course – Invite us to your Community

This accredited course is targeted to rural physicians, providing a comprehensive approach to the work up and diagnosis of various causes of shock, as well as reviewing the most up-to-date concepts in the resuscitation of the shock patient.

COURSE FORMAT
• Hands on practice of relevant skills, discussions of scenarios and your cases, and short lectures on different types of shock.
• 8am-4pm, on a weekend day, with a maximum of 12 physicians/residents.
• Accredited for up to 7.0 Section 1 and Mainpro-M1 study credits.

Learning Objectives
• To recognize and treat all types of shock, even with no immediate specialist backup.
• To become confident placing central venous catheters and intravenous needles.
• To learn the many ways that ultrasound can help you in your practice.
• To be familiar with early goal directed therapy for sepsis, and to know how to apply these concepts in your setting.
Rural CPD’s Videoconferences

We are pleased to continue offering you our Videoconference Series. Designed for rural physicians, CPD’s Rural Outreach Videoconference Program delivers timely clinical discussions and updates on topics from speakers with both clinical and rural experience. Held at your local community hospital’s videoconference room, this is an opportunity for you to stay abreast of the latest information using distance education technologies. This interactive program will allow you to build relationships with other practitioners and give you an opportunity to discuss cases as well as your own clinical experiences. The series for fall 2010 will focus on Emergency Medicine.

TOPICS

- The Occasional Intubation (Dr. Julie Paget, Sept 2)
- Status Asthmaticus (Dr. Tara Gill, Oct 7)
- Cardiac Emergencies (Dr. John Pawlovich, Nov 4)
- Post Resuscitation Care (Dr. Frank Ackerman, Dec 2)

MORNING VIDEOCONFERENCES
THURSDAYS 8:00AM - 9:00AM

Please note all times listed are in the Pacific Time Zone. Each session is accredited for up to 1.0 Mainpro-M1 and 1.0 Section 1 (Royal College) credits and is an interactive case-based discussion and Q&A.

Videoconference Dates:
- September 2, 2010
- October 7, 2010
- November 4, 2010
- December 2, 2010
- January 6, 2011
- February 3, 2011
- March 3, 2011
- April 7, 2011
- May 5, 2011

Time: 8:00AM – 9:00AM PT

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CPD/CME Education Research Grant for Specialty and Family Practice Residents

1. Two awards will be given every year to support resident research projects (one for Specialty and one for Family Practice)
2. Applicant must be enrolled in a UBC Faculty of Medicine residency program and have an identified research project

Applications due Monday, November 1, 2010

For more information about our criteria please go to www.ubccpd.ca/announcements or contact Dr. Brenna Lynn at 604 875-4111 Local 69126, brenna.l@ubc.ca

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UBC RATES

Stay at the Park Inn & Suites Vancouver Broadway, located on the bus route to UBC. Ask about our UBC rates.

Because you plan to succeed

MD. Specializing in you.

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Appendix 5: Shock Course Information Sheet

Rural Continuing Professional Development: Invite the Shock Course to your community

The final outcome of shock patients is largely determined in the rural emergency room. This Shock Course gives rural healthcare practitioners a comprehensive approach to the work-up and diagnosis of various causes of shock, and it reviews the most up-to-date concepts in resuscitation of the shock patient.

Course Format:
- Hands-on practice of central line insertion, use of the intraosseous drill, and practicing bedside ultrasound for diagnosis of undifferentiated shock.
- Short lectures on: Approach to the Shock Patient, Drug Therapies, and Seizure.
- Case discussions on cardiogenic, hypovolemic shock and hemorrhagic shock.
- Discussions of treatment, with the opportunity to review your own recent cases.

Learning Objectives:
1. To recognize and treat all types of shock with emphasis on those that can successfully be treated in the rural emergency room that has no immediate surgical setup.
2. To become familiar with early goal directed therapy for sepsis and know how to apply these concepts in your setting.
3. To become confident placing central venous catheters and intraosseous needles.
4. To learn the many ways that ultrasound can help you in your practice.

Target Audience:
- This course has been designed for physicians, residents and nurses in rural BC. It is a credited up to 7.0 Section 1 and Non-credit study credits. Medical students may audit (space dependent).

Instructors:
- Rural physicians with emergency room experience. Our instructors include Dr. Anna Reid, Dr. Todd Whitney, Dr. Jeff Peri, Dr. Francois Loug, Dr. Frank Ackerman, Dr. Tara Gills, Dr. Julie Page and Dr. Daren Jalles.

Course Details:
- Course dates run: 8:00 AM - 4:00 PM on weekend days, with breakfast at 7:30 AM.
- Fee: $150.00 per community, includes breakfast, lunch and snacks.
- Registration is limited to 12 physicians and 6 nurses.

Past participants have said:
- “It was important that the rural approach was presented to rural physicians - someone who understands our situation will know what to do.”
- “A well-balanced, well-spent 8 hours. This is much more helpful and empowering than any course out there.”
- “An excellent day spent. This is much more helpful and empowering than any course out there.”

To bring this course to your rural community:
- Please contact the UBC Rural Continuing Professional Development Program via Project Manager,
  - ucm@ubc.ca
  - 604-822-4114 x5231, to discuss possible dates, local education needs, and logistics.

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Appendix 6: Shock Course Flyer
## UBC CPD Shock Course (April 2010 - March 2011)

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* Starting from the fall 2010, the Shock Course has nurse related content added in.

a Nurse educator

b Medical student

c Resident

d Paramedic
UBC CPD Shock Course (April 2011 - April 2012)

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<td>7. Sept 28 (Wednesday)</td>
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<td>21. April?</td>
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Appendix 8: Sample of videoconference moderator instruction


We would like to welcome everybody for an hour long videoconference on Cardiology Topics hosted by the UBC Rural Continuing Professional Development Program. This program is designed for rural physicians and hopes to help you keep abreast of the latest information, as well as allow you to build relationships with other practitioners and give you an opportunity to discuss cases as well as your own clinical experiences.

Before we begin, let me talk about the videoconference format and etiquette.

Our presenter, Dr. Heilbron, will be presenting "What's New in Atrial Fibrillation" cases for discussion. A PDF of the presentation should be in the room with you. Once the case is presented I will ask if the sites have questions or comments to discuss. Please identify your site before you speak.

- Please turn off pagers and other noise making devices
- Please ensure that your microphone is muted, unless you are speaking.
- Muting prevents the video feed from switching away from a speaker to another location that might register a noise, such as a cough, phone call or hospital page.
- The videoconference system will be voice-activated during the discussion periods. The speaking site will appear in a larger window on the screen and the windows on the other sites will shrink.
- I will try to repeat the question for clarity.
- Each site should have handouts, an attendance form and evaluation forms.

In order to obtain CME Mainpro-M1 and Section 1 Study Credits for this event, you must complete the attendance form, which should be available in the room.

Please also complete the evaluation form to help us to improve our programs.

Upcoming Announcements:

- The 7th Annual Hot Topics in Cardiology Conference in Vancouver is coming up on April 9th. Registration will be open soon.
- Please visit the UBC CPD website for information and upcoming dates for our online webinar program. Our next webinar is the evening of January 20th. Dr. Paul Farnan will be presenting Highlights of the Practice Survival Skills Conference, “Doc, I Need a Note for Work...Pesky Forms and Practical Advice”
The next videoconference session, Anticoagulation, is on Feb 3rd and will presented by Dr. John Bosomworth and broadcasted from Oliver.

INTRO:

Today Dr. Brett Heilbron will be presenting his talk, What's New in Atrial Fibrillation.

Dr. Heilbron completed his undergraduate degree at the University of Cape Town (South Africa), and then practiced as a rural family physician in Newfoundland and Manitoba for 4 years. He completed Internal Medicine and Cardiology training at the University of British Columbia in 1995.

He is currently a Clinical and Invasive Diagnostic Cardiologist and Co-Director of the Advanced Cardiac Imaging Program at St. Paul's Hospital / Providence Heart + Lung Institute, and a Clinical Associate Professor at the University of British Columbia.

His interests include noninvasive cardiac imaging and information technology.

Welcome Dr. Heilbron!
Appendix 9: UBC CPD Videoconference and Webinar at a Glance

### UBC CPD Videoconference & Webinar Sessions (April 2010 - March 2011)

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<td>8-Apr-10</td>
<td>W</td>
<td>Highlights of the 45th Annual Post Graduate Review in Family Medicine</td>
<td>74</td>
</tr>
<tr>
<td>6-May-10</td>
<td>W</td>
<td>Ovarian Cancer: What A Family Physician Needs to Know</td>
<td>75</td>
</tr>
<tr>
<td>6-Sep-10</td>
<td>W</td>
<td>Highlights of the 45th Annual Post Graduate Review in Family Medicine - Part 2</td>
<td>42</td>
</tr>
<tr>
<td>21-Oct-10</td>
<td>W</td>
<td>Highlights of the 8th Annual Live Well with Diabetes Conference</td>
<td>42</td>
</tr>
<tr>
<td>9-Dec-10</td>
<td>W</td>
<td>Medication Treatment for Alzheimer’s disease: Current Therapies and Future Directions</td>
<td>46</td>
</tr>
<tr>
<td>20-Jan-11</td>
<td>W</td>
<td>Highlights of the Practice Survival Skills Conference</td>
<td>87</td>
</tr>
<tr>
<td>25-Jan-11</td>
<td>W</td>
<td>CME on the Run Highlights</td>
<td>64</td>
</tr>
<tr>
<td>8-Mar-11</td>
<td>W</td>
<td>Paediatric Dermatology: Managing Eczema and Acne in Paediatric Patients</td>
<td>71</td>
</tr>
<tr>
<td>23-Sep-10</td>
<td>W*</td>
<td>Oral Oncology Issues in Family Practice</td>
<td>34</td>
</tr>
<tr>
<td>28-Oct-10</td>
<td>W*</td>
<td>Canadian Association of General Practitioners in Oncology (CAGPO) Conference Recap</td>
<td>34</td>
</tr>
<tr>
<td>18-Nov-10</td>
<td>W*</td>
<td>Early Lung Cancer: Detection, Treatment and Management</td>
<td>48</td>
</tr>
<tr>
<td>20-Jan-11</td>
<td>W*</td>
<td>Bisphosphonates in Cancer Treatment and Osteonecrosis of the Jaw</td>
<td>41</td>
</tr>
<tr>
<td>17-Feb-11</td>
<td>W*</td>
<td>Psychiatric Issues in Oncology</td>
<td>45</td>
</tr>
<tr>
<td>17-Mar-11</td>
<td>W*</td>
<td>Prostate Cancer Screening</td>
<td>38</td>
</tr>
</tbody>
</table>

Total # of sessions: 24
Total # of attendants: 1392

Abbreviations: VC—Videoconference, W—Webinar

* The Family Practice Oncology Network (BC Cancer Agency) is partnering with UBC CPD to present the Oncology CME Webcasts.
Appendix 10: Screenshot of UBC CPD Webinar Interface
Appendix 11: Screenshot of Archived Webinar Sessions
Appendix 12: Ovarian Cancer Workshop Flyer

Case-based Workshop

OVARIAN CANCER: WHAT A FAMILY PHYSICIAN NEEDS TO KNOW

Workshop Overview:
The UBC Division of Continuing Professional Development (UBC CPD) has developed a case-based workshop to encourage discussion on diagnosis, referral, ongoing management and hereditary risk assessment of ovarian cancer. This two-hour interactive workshop will help family physicians understand their roles in ovarian cancer diagnosis and management. A local expert/specialist will facilitate the discussion and guide participants through the workshop case.

Target Audience:
This workshop is designed for family physicians.

Accreditation:
This workshop is accredited for up to 2.0 MAINPRO M1 and Section 1 credits.

Learning Objectives:
• Be able to recognize that ovarian cancer is a difficult diagnosis;
• Be more confident with the investigation procedures for differential diagnosis;
• Be familiar with the referral process in BC;
• Be able to understand the roles of family physicians and specialists in ongoing management and palliative care for the patients; and
• Be able to understand the genetic/hereditary risk of ovarian cancer.

Find a workshop location near you!
Nov. 16 - Prince George
Nov. 17 - Vancouver
Nov. 18 - Victoria
Nov. 30 - Kelowna

www.ubccpd.ca
# Ovarian Cancer: What a Family Physician Needs to Know

## Table of Contents

1. Participant’s Guide
   1) Learning objectives
   2) Case scenario

2. Pre-readings
   1) Ovarian Cancer: An overview
   2) Diagnosis and Management of adnexal masses
   3) Joint SOGC/GOC/SCC clinical practice guideline: Initial evaluation and referral guidelines for management of pelvic/ovarian masses
   4) Epidemiological and genetic factors associated with ovarian cancer

3. Supplemental Materials
   1) Ovarian Cancer Canada: Think Ovarian! (fact sheet for health professionals)
   2) Ovarian Cancer Canada: Think Ovarian! (generic fact sheet)
   3) Ovarian Cancer Canada: CA-125 fact sheet
   4) Ovarian Cancer Canada: Survivor Stories _ Dancing with NED (No Evidence of Disease)
   5) Management algorithm for average-risk women with symptoms suggestive of ovarian cancer
   6) BC Cancer Agency: Patient referral form
   7) BC Cancer Agency: HBOC (Hereditary Breast and/or Ovarian Cancer) referral criteria
   8) BC Cancer Agency: Hereditary cancer program referral form
   9) BC Cancer Agency: Coping with cancer _ Palliative support
   10) BC Cancer Agency resource list

Participant Workshop Evaluation Form
Appendix 14: RCPD Videoconference Needs Assessment 2011 Survey Questionnaire

RCPD Videoconference Needs Assessment 2011

1) I am a:
   ☐ GP/FP
   ☐ Specialist
   ☐ Other (please specify)

If you selected other, please specify
______________________________________________________________________

2) I graduated from medical school in: [YYYY]

______________________________________________________________________

3) My primary practice is located in the following health authority in BC:
   ☐ Northern
   ☐ Interior
   ☐ Fraser
   ☐ Vancouver Coastal / Providence HC
   ☐ Vancouver Island
   ☐ Not applicable
   ☐ Other (please specify)

If you selected other, please specify
______________________________________________________________________

4) The city/town that I practice in:

______________________________________________________________________

5) I currently practice as:
   ☐ Full-time
   ☐ Part-time
   ☐ A locum
   ☐ Retired
   ☐ Other (please specify)
6) How often do you participate in RCPD videoconference sessions?

- 1=Never
- 2=Seldom
- 3=Sometimes
- 4=Often
- 5=Always

Additional comments

7) The following hospital medicine related topics are suggested by the participants of previous RCPD videoconference sessions. Please rank top five of these topics as your preference for the upcoming session(s). You will get the same drop down list of the topics when ranking from 1 to 5 in order.

- Acute urinary retention
- Antibiotic use in hospital patients
- Chest tubes
- COPD
- Diabetes starting on insulin
- Frail elderly with failure to thrive
- Heart failure, or end stage heart failure
- IV drug use and management
- Palliative care
- Renal failure
- Sepsis
- Venous thromboembolism / PE

8) Among the following areas, which ONE would be your preference for a potential videoconference series (i.e. 4-6 sessions in a season) in the near future?
Chronic disease management
- Emergency Medicine
- Obstetrics
- Palliative care
- Psychiatry
- Trauma
- Other (please specify)

If you selected other, please specify
______________________________________________________________________________

9) Would you like to volunteer to be a presenter or recommend a presenter for our videoconference series?

- Yes
- No

10) Please provide your name or the names of recommended presenters:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

YOU'RE ALMOST DONE! Please click on 'SUBMIT SURVEY' to submit your responses.

Thank you for taking the time to complete this important needs assessment survey.
Appendix 15: GP/FP Feedback on Emergency Medicine CPD

GP/FP Feedback on Emergency Medicine Continuing Professional Development (RCPD)
2011

Based upon the 2005 REAP Needs Assessment:
By: CPD-KT (2004-2005)

UBC CPD RCPD

March 7, 2011
1. Introduction

In order to update the Rural Coordination Centre of BC CARE Course, a course designed for front line rural physicians in the emergency room, Dr. Carl Whiteside, Director and his Rural Education Action Plan (REAP) team would like to further investigate the 2005 REAP learning needs assessment findings. (The REAP Rural Needs Assessment was funded by REAP, Workers’ Compensation Board of BC and CFPC, and conducted by CPD-KT in 2004-2005, with Dr. Rebecca Lindley and Dr. Robert Bluman as Principal Investigators). Now the REAP data is being analyzed to specifically reveal emergency medicine related aspects. This report focuses on FP/GP responses and feedback of the needs assessment study, including both quantitative and qualitative findings. Along with describing the results, we have presented some interpretation of what the results may suggest for educational design (see interpretation, page 7).

2. Characteristics of the GP/FP participants in 2005 REAP needs assessment study

Three hundred and seven out of the 991 (invited) GP/FPs responded to this needs assessment (response rate 31%). The majority of the participants have been in practice for over 10 years (Table 1). In particular, 41% of the participants have practiced for over 20 years, which means the feedback in this study was collected from a fairly experienced physician cohort.

Over half of the participants practiced in communities that had a population over 10,000 (Table 2). The top five patient categories in their workload that the participants estimated at relatively high percentages were women’s health (excluding maternity care), aboriginal people, recreational injuries, people living in poverty, and transient/seasonal population (Table 3).

Half of the participants worked in the emergency department (although not exclusively) (Table 4). Table 5 shows the top five areas in which the participants had sub-specialization(s). The top sub-specialization was emergency medicine (23%).

Table 1 (Survey Question XI_1)

*Since completing your training, how many years have you been in practice?*

<table>
<thead>
<tr>
<th>Years in Practice</th>
<th>% (n=227)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>12</td>
</tr>
<tr>
<td>6-10 years</td>
<td>15</td>
</tr>
<tr>
<td>11-20 years</td>
<td>33</td>
</tr>
<tr>
<td>21-30 years</td>
<td>28</td>
</tr>
<tr>
<td>31 years and longer</td>
<td>13</td>
</tr>
</tbody>
</table>
Table 2 (Survey Question IX_1)
What is the approximate size of the community/population in which you are situated?

<table>
<thead>
<tr>
<th>Size of the population</th>
<th>% (n=228)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000</td>
<td>3</td>
</tr>
<tr>
<td>1,000-2,999</td>
<td>9</td>
</tr>
<tr>
<td>3,000-4,999</td>
<td>10</td>
</tr>
<tr>
<td>5,000-9,999</td>
<td>22</td>
</tr>
<tr>
<td>10,000-30,000</td>
<td>38</td>
</tr>
<tr>
<td>Over 30,000</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 3 (Survey Question IX_2)
Approximately what percentage of your workload is comprised of the following patient categories? Please check ALL that apply.

<table>
<thead>
<tr>
<th>% of workload</th>
<th>None</th>
<th>Under 10%</th>
<th>10-25%</th>
<th>26-50%</th>
<th>Greater than 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s health (excluding maternity care)</td>
<td>1</td>
<td>21</td>
<td>34</td>
<td>32</td>
<td>12</td>
</tr>
<tr>
<td>Aboriginal people</td>
<td>5</td>
<td>58</td>
<td>19</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Recreational injuries</td>
<td>1</td>
<td>49</td>
<td>37</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>People living in poverty</td>
<td>2</td>
<td>63</td>
<td>26</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Transient/seasonal populations</td>
<td>6</td>
<td>55</td>
<td>31</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Occupational injuries</td>
<td>2</td>
<td>52</td>
<td>38</td>
<td>7</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Maternity care</td>
<td>21</td>
<td>53</td>
<td>19</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Cultural minorities</td>
<td>2</td>
<td>74</td>
<td>17</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Chronic mental illness</td>
<td>1</td>
<td>58</td>
<td>37</td>
<td>5</td>
<td>--</td>
</tr>
<tr>
<td>Addiction/substance abuse</td>
<td>2</td>
<td>70</td>
<td>25</td>
<td>4</td>
<td>--</td>
</tr>
<tr>
<td>Palliative care</td>
<td>6</td>
<td>70</td>
<td>22</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>Permanent physical disabilities</td>
<td>2</td>
<td>77</td>
<td>19</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>HIV/AIDS patients</td>
<td>49</td>
<td>50</td>
<td>1</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>Recent immigrants</td>
<td>20</td>
<td>76</td>
<td>4</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 4 (Survey Question X_1)
Please indicate which setting(s) best describe where you work. Please check ALL that apply.

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>% (n=285)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/clinic</td>
<td>76</td>
</tr>
<tr>
<td>In-patient care</td>
<td>55</td>
</tr>
<tr>
<td>Emergency department</td>
<td>52</td>
</tr>
<tr>
<td>Long-term care facility</td>
<td>43</td>
</tr>
<tr>
<td>Hospital out-patient care</td>
<td>30</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>29</td>
</tr>
</tbody>
</table>
Table 5 (Survey Question II_11)
In what areas do you possess areas of sub-specialization? Please check ALL that apply.

<table>
<thead>
<tr>
<th>Top five areas</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medicine</td>
<td>23</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>16</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>15</td>
</tr>
<tr>
<td>Palliative care</td>
<td>11</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>6</td>
</tr>
</tbody>
</table>

3. GP/FP perceived learning needs

The participants identified emergency medicine, obstetrics / gynecology and psychiatry as the top three of 20 suggested learning need areas. Almost 60% of the participants ranked emergency medicine within the top three of their learning need areas (Table 6). Similarly, nearly 60% of the participants believed that as a learning area, emergency medicine had high priority in terms of meeting their patients’ needs (Table 7). The specific suggested topics in emergency medicine that the participants listed include airway management/intubation, trauma, ACLS/ATLS, cardiology, pediatrics, and drugs.

Table 6 (Survey Question II_3)
What are your top three learning need areas?

<table>
<thead>
<tr>
<th>Emergency medicine in top three learning need area</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ranked 1st</td>
<td>28</td>
</tr>
<tr>
<td>Ranked 2nd</td>
<td>19</td>
</tr>
<tr>
<td>Ranked 3rd</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 7 (Survey Question II_4)
Considering your situation, what priority level do you place on these areas in order to meet the needs of your patients?

<table>
<thead>
<tr>
<th>Emergency medicine as an area</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High priority</td>
<td>58</td>
</tr>
<tr>
<td>Moderate priority</td>
<td>23</td>
</tr>
<tr>
<td>Low priority</td>
<td>15</td>
</tr>
<tr>
<td>Not a priority</td>
<td>5</td>
</tr>
</tbody>
</table>

4. GP/FP perceptions on interprofessional learning

Participants showed some interest in learning more about interprofessional team development (Table 8). Nearly half of the participants ‘sometimes’ participated in interprofessional CPD activities (Table 9). Slightly over 10% of participants ‘often’ participated in such CPD activities. Half of the participants were ‘moderately’ or ‘very’ interested in increasing their participation in interprofessional educational activities (Table 10).

Table 8 (Survey Question II_15)
How interested are you in learning more about the following area?

<table>
<thead>
<tr>
<th>Interprofessional team development as an area</th>
<th>% (n=222)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very interested</td>
<td>8</td>
</tr>
<tr>
<td>Moderately interested</td>
<td>22</td>
</tr>
<tr>
<td>Slightly interested</td>
<td>36</td>
</tr>
<tr>
<td>Not interested</td>
<td>34</td>
</tr>
</tbody>
</table>

Table 9 (Survey Question VI_1)

To what extent do you currently participate in interprofessional CPD activities?

<table>
<thead>
<tr>
<th></th>
<th>% (n=232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>12</td>
</tr>
<tr>
<td>Sometimes</td>
<td>47</td>
</tr>
<tr>
<td>Rarely</td>
<td>31</td>
</tr>
<tr>
<td>Never</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 10 (Survey Question VI_2) To what extent would you be interested in increasing your participation in interprofessional educational activities?

<table>
<thead>
<tr>
<th></th>
<th>% (n=232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very interested</td>
<td>15</td>
</tr>
<tr>
<td>Moderately interested</td>
<td>37</td>
</tr>
<tr>
<td>Slightly interested</td>
<td>32</td>
</tr>
<tr>
<td>Not interested</td>
<td>16</td>
</tr>
</tbody>
</table>

5. GP/FP feedback from interview/focus group

The participants voiced their opinions on various aspects of CPD in the REAP needs assessment interviews and focus groups. Feedback that might be related to emergency medicine is highlighted below.

1) Challenges Related to CPD Content

Many participants defined the value of CPD in terms of its applicability to rural practice. Overall, many participants felt that if CPD was not highly relevant to the day-to-day aspects of their practice, they did not consider it a valuable experience. A quote from one participant (focus group) succinctly represented this idea:

*I think the other big challenge is to go back to the whole idea that CME needs to include information that actually changes practice patterns. We need to learn how that can be more effectively done...You want to have results and there should be an easy way to translate what you learn into what you practice.*

2) Challenges Related to Rural Context
Three types of challenges were experienced by most participants: 1) rural GPs required more diverse knowledge and skills than urban GPs; 2) information resources in rural communities were limited; and 3) rural practice was ‘all-consuming’ requiring 24/7 attention.

The observation that GPs needed to know a ‘little bit of everything’ was echoed by several participants. Some participants explained that they either saw a certain presentation infrequently, but still had to maintain the skills required to deal with it at all times, or had to know about a wide range of topics areas. The following quote from one participant illustrated this point:

There are a lot of rural doctors doing general practice, and that includes chronic disease management, emergency medicine and obstetrics, so you have to keep up with three huge areas of medicine that all have their own challenges. And I think that is a challenge for a lot of rural physicians who are doing all aspects of medicine.

3) Systemic Support for CPD

Participants believed that UBC could play a larger role in improving the quality of CPD available to rural physicians. Participants of the locum focus group noticed that rural communities with a university affiliation (e.g. a UBC teaching site) had much better access to CPD than communities without the academic presence.

4) Learning Formats

Participants emphasized their desire for practical, hands-on CPD. They were less interested in learning about theory or new research, but rather, how the information delivered could lead to improvements to their practice. Given the scope of information that rural physicians need to know, many participants believed that honing their skills on the essential elements of their practice was the main purpose of attending a CPD event in the first place. This was expressed in the following quote:

You do not care about why or what the theory is behind it is, all you want to know is what to do in a certain situation...it is a very reductionist point of view in medicine, but when you are dealing with a very broad spectrum and you cannot possibly expect to remember all the details of all those different things, you just have to try and remember the things that are the most important.

Many participants mentioned small-group learning as their preferred learning format, as distinct from large conference or lecture-style CPD. Some specific suggestions included having a maximum of 20 people to a group, doing role-playing exercises, and reviewing patient-based problems. The ability to have in-depth discussion between the teacher and other learners was considered highly valuable to most participants. One participant (focus group) summarized this idea as follows:

The key thing about how adults learn is that when they participate in an event, they need to be able to express their ideas and get immediate feedback from it...if somebody is going to call you back in two to three days, you’ve forgotten what your questions were. It has to be part of the group discussion.
6. Interpretation of the findings and implications for educational design

The GP/FP response rate of this needs assessment was 31%, considered a strong and representative set of responses from engaged rural practitioners (particularly for a survey that needed over 30 minutes to complete). From this needs assessment study, we are hearing the “voices” of experienced GP/FPs who have participated in many education programs. Their opinions and suggestions are based on much experience; therefore, they should be taken into consideration in educational design.

Even though the participants of the study seem to be very capable, they express high learning needs in emergency medicine. This might indicate that even the experienced clinicians still and always require ongoing educational support in emergency medicine.

The participants’ comments on CPD content suggest that, for educational design, baseline knowledge assessments could be conducted. This would enable the particular courses to be tailored and delivered to mostly experienced physicians who need to improve practice, while not necessarily being tailored to new physicians who need to institute practice. Further, the participants express a post-education need for both follow up on practice change and ongoing support. This confirms that the physicians need support for their practice improvement, (subject to resources), not just stand-alone courses.

In terms of rural context, the participants’ opinions might indicate that CME/CPD courses on emergency medicine need to be as comprehensive as possible for the target audience—the “rural generalists”. To mitigate the effect of having a course that tries to be “all things to all GPs”, supplementary materials or resource lists, relevant to the rural ER, could be offered as part of the course. In addition, physicians could pursue issues further with self-directed learning, including their own College of Family Physicians of Canada Reflective Pearls Exercises.

Participants’ feedback on learning format suggests that clinical decision-making algorithms and other decision support tools should be provided along with course materials so that learning can be directly and quickly applied in practice. Any knowledge conveyed could be summarized into a few concise, topical teaching points that can clearly communicate the standard of care, and communicate how to integrate the “take home messages” into practice. Given many other needs assessment findings and literature reviews, it is gratifying to hear that small group learning with their health care professional colleagues is a preference for the participants.

In summary, revisiting the 2005 REAP needs assessment findings has helped us to confirm GP/FPs’ large learning needs in emergency medicine. In particular, the design for CME/CPD in emergency medicine has to consider the rural generalists’ needs and preference in educational content, format, and provision of ongoing support.